December 2022

Mental Health SF Implementation Working Group

December Implementation Report ***DRAFT***

Overview.......................................1
MHSF IWG Progress to Date..........4
MHSF IWG Future Opportunities...10

"The IWG has the "power and duty" to advise the Mental Health Board, the Health Commission, the Health Authority, the Department of Public Health, the Mayor, and the Board of Supervisors on the design, outcomes, and effectiveness of MHSF to ensure its successful implementation."

- **MHSF ordinance**

Overview

December 6, 2019, the San Francisco Board of Supervisors passed an ordinance (the Ordinance) amending the Administrative Code to establish Mental Health San Francisco (MHSF). This legislation is designed to increase access to mental health services, substance use treatment, and psychiatric medications to adult San Francisco residents with serious mental illness and/or substance abuse disorders who are homeless, uninsured, or enrolled in Medi-Cal or Healthy San Francisco. The Ordinance identifies five domains: 1) Mental Health Service Center; 2) Office of Coordinated Care; 3) Street Crisis Response Team; 4) Mental Health and Substance Use Treatment Expansion; and the 5) Office of Private Health Insurance Accountability

In 2020, DPH developed a diagram that conceptualizes the five legislative domains to help ground the design process (Figure 1). The diagram represents two procedural modifications DPH made from the original legislative language and mandate. First, DPH organized the legislation's "Mental Health and Substance Use Treatment Expansion" under their existing work with "New Beds and Facilities" (NB&F) for operational efficiency. As the diagram demonstrates, the IWG advised on the overall array of residential treatment options for the City as well as supported the design three specific residential treatment options. Second, the fifth legislative domain, the Office of Private Health Insurance Accountability, was not included in the diagram and was thus not addressed by the IWG. This domain was excluded because other departments need to be involved in the design and DPH prioritized designing the four domains under their direct purview before turning their attention to this very complicated domain.

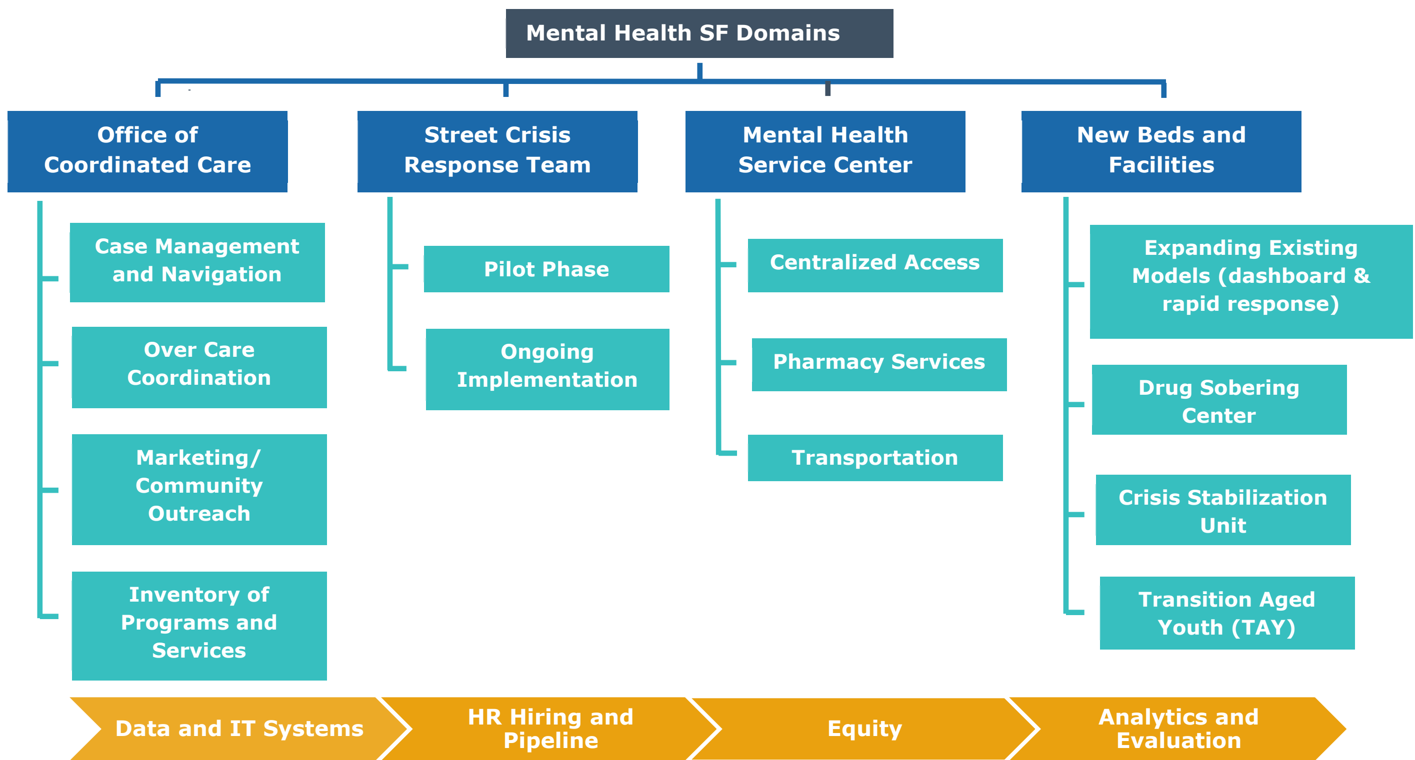
The Ordinance established a MHSF Implementation Working Group (IWG) to advise on the design, implementation, outcomes, and effectiveness of MHSF. This report summarizes the IWG's progress in their role, the progress made on designing the MHSF domains, and concepts for the future of the IWG.

.

harder + co community research

DRAFT

Figure 1: Conceptualization of MHSF Legislation



Overview of the IWG's work and context

The manner in which the IWG operated since its inception is heavily influenced by the underlying context and reality of operating within a public health pandemic (COVID). The pandemic impacted DPH's ability to do the necessary prework to effectively launch the IWG as planned at the beginning of 2020 due to two interrelated factors. First, homelessness, substance use, and mental health concerns increased during the pandemic, presenting such urgent conditions that DPH pivoted to emergency response, directing time and resources away from MHSF design and implementation. Second, the pandemic resulted in a shortage of workers, which caused service disruptions and affected overall capacity. Taken together, DPH did not have the bandwidth to engage with an advisory group as identified in the legislation until later in 2020.

Since December 2020, the IWG has met monthly, dedicating substantial time in and between meetings to develop recommendations for all of the domains of Mental Health SF with the exception of the Office of Private Health Insurance Accountability, as noted above. Each MHSF component (or in the case of New Beds and Facilities, sub-component) followed a "recommendation roadmap" outlined in previous progress reports (October 2021 and October 2022). After initial design, DPH came back to the IWG to update them on progress and to ask continued advice as the MHSF domains were implemented. The IWG also advised on emerging residential treatment programs in response to the homeless, substance use, and mental health crisis in San Francisco that were not specifically outlined as part of the NB&F domain (Figure 1). In sum, the IWG has played a critical role and is fulfilling their role as identified in the legislation. The overall progress of their legislative role and of the specific MHSF domains is presented in "MHSF IWG Progress to Date" section of this report.

IWG members have reflected that they would like a greater, more "upstream" role to ensure that the spirit of the MHSF is fully realized. This desire is in part due to how their work commenced and evolved, given the pandemic-influenced delay in the IWG's inception. Before the IWG was convened, DPH identified that two elements of MHSF- the Street Crisis Response Team and components of the NB&F- that were directly related to addressing the multiple

crises facing San Francisco residents. DPH moved forward on designing and implementing these. When the IWG convened in December 2020, these domains were prioritized for IWG input and then other domains were sequenced for review, discussion, and recommendations. While understandable, this created a context for the IWG in which members expressed feeling that they were behind DPH and playing catch up. Now, as IWG members reflect on what they have achieved, they are considering the optimal role they could play now that the pandemic related pressures have eased. To them, this means enhancing their advisory role from responding to and advising on programs that DPH is developing, to being at the design table for how these domains help to reform the system of care and create transformative change for San Franciscans most at risk. These ideas and requests are identified in the "MHSF IWG Future Opportunities" section of this report, and will require additional deliberation between the IWG and DPH.

MHSF IWG Progress to Date

What follows in this section is a summary of the IWG's progress in two ways. First, we provide an overview of the IWG's overall progress by their legislated role. Second, we provide overview of the recommendations the IWG developed for each of the four MHSF domains and DPH's progress on addressing them.

Overall Progress

The IWG is to advise on the design, outcomes, and effectiveness of MHSF to ensure its successful implementation. The IWG has five key roles:

Role of advisor: The IWG is tasked with advising the Mental Health Board or any successor agency, the Health Commission, the Department of Public Health, the Mayor, and the Board of Supervisors on the design, outcomes, and effectiveness of Mental Health SF.

Overview of Progress: Since December 2020, the IWG has met monthly to advise on 4 of the 5 domains of MHSF. This included both the main domains of MHSF as well as sub-domains and new, responsive programs under the MHSF umbrella. They have not advised on the Office of Private Health Insurance Accountability, which has not been implemented to date. Details of these recommendations are presented in section in the following section.

Role of evaluator: Evaluate the effectiveness of MHSF in meeting the behavioral health and housing needs of eligible participants, by reviewing program data.

Overview of Progress: The IWG has provided feedback on the design of an overarching MHSF analytics and evaluation approach. Additionally, DPH presents evaluation updates on all designed domains and subdomains on a regular basis. The IWG has expressed an interest in contextualizing program level data within the larger DPH and community context. (see Future Opportunities section for a deeper discussion on this interest)

Role of reviewer: The IWG is tasked with reviewing and assessing the Implementation Plan that the Department of Public Health is required to submit to the Mayor and the Board of Supervisors.

Overview of Progress: DPH is currently developing the implementation report for February 2023 and will present to the IWG for review and assessment.

Role of analyst: The IWG is legislated to conduct a staffing analysis of both City and nonprofit mental health services providers to determine whether there are staffing shortages that impact the providers' ability to provide effective and timely mental health services.

Overview of Progress: The staff and wage study conducted for DPH by the Controllers office is currently underway and due to be completed in 2023. The IWG will take up deliberation of the at that time.

Strategic budget and scoping advisor: The IWG is asked to prepare proposals for how to reduce the scope of services provided by MHSF if the cost of those services is estimated to exceed $150 million annually.

Overview of Progress: To date, the cost of MHSF has not exceeded the $150 million annual limit and the IWG has not advised on this matter.

What follows is a presentation of the four MHSF domains recommendations developed by the IWG. The tables below present the original recommendations and, if implementation has occurred, highlights of DPH's progress on the recommendations and what remains to be done related to the recommendations.

Street Crisis Response Team

Recommendation process: DPH developed and began piloting the Street Crisis Response Team (SCRT, also referred to in the Ordinance as Crisis Response Street Team) prior to IWG being convened. This was due to the dual factors of the pandemic delaying the start of the IWG and DPHs need to respond to the growing homeless and mental illness crisis. DPH presented the IWG with the pilot design and initial evaluation results in February 2021. During this meeting, DPH sought the IWG advice on questions and the IWG returned recommendations that addressed these questions as well as broader recommendations related to the system in which the SCRT is part (recommendation #1 and #2). DPH returned two times (October 2021, May 2022) to provide updates and obtain feedback and advice from the IWG related to the program. DPH has not yet addressed the first two larger systems recommendations that extend beyond the MHSF Ordinance (recommendations #1 and #2). The below table summarizes the initial recommendations (the full recommendation wording is found here), DPH progress updates, and what remains to be addressed of the recommendations. NOTE: this below table is not an evaluation the SCRT program, it is a high-level summary of the progress to the recommendations.

Initial recommendations (summarized)	Highlights of progress on the recommendation	What remains to be addressed
1. Map all current crisis response programs. No new MHSF street crisis programs should be planned, implemented, expanded until after the mapping is completed, and proposed programs shall be brought to the MHSF IWG for review prior to launch. (This recommendation included a number of subpoints of what should be included in the mapping.)	DPH developed a map of SCRT coverage and hours for different regions of the city	The IWG recommendation of a system wide mapping of crisis response programs is not yet done. DPH is currently pursuing a mapping project in collaboration with the IWG that may address this recommendation.
2. Once gaps in service are identified, BHS shall undertake a restructuring of current crisis services as needed.	No information reported back to the IWG on this item yet	Addressing this recommendation is contingent on recommendation #1
3.Initial implementation of SCRT was too narrow and the IWG suggested the following:		
3a. SCRT should expand their scope to respond to all 800a and 800b calls for "Mentally Disturbed Person". Even in situations where there are "weapons", or perceived threats involved	3a. No information reported back to the IWG on this item yet	3a, DPH to review and report back on results
3b. Respond from a de-escalation model that challenges racism and stigmatization of persons that are houseless and struggling with mental health challenges.	3b. DPH trained staff with an equity-focused lens, hired individual's representative of communities being served and including peers, providing a series of experiential discussions with the group	3b. Anticipate will require ongoing development and consideration. DPH should revisit and address the various nuanced issues in this recommendation on an ongoing basis.
3c. Eliminate call code criteria of Person must not be displaying self-harm behaviors and Person does not pose an imminent threat to themselves, others, or property	3c. No information reported back to the IWG on this item yet	3c. No information on this item
3d. Improve dispatch protocols to SCRT including alternative number to 911, improved dispatch training, policies/procedures to defer/transfer calls from police to SCRT, data from 311/911 calls, public service announcements	3d. SCRT developed training and expanded on the SCRT transition from police dispatch and Emergency Medical Dispatch (EMD) and the steps that are being taken to monitor the implementation	3d. Anticipate will require ongoing development and consideration. DPH should revisit and address the various nuanced issues in this recommendation on an ongoing basis.

Office of Coordinated Care (yellow highlights are to be discussed during the meeting- We received a comment from Member Gonzalez recommending that we define the terms – care coordination, case management, and care management

Recommendation process: The Office of Coordinated Care (OCC) is a new offering that allowed the IWG to be involved from the initial stages of conceptualization. DPH first presented initial concepts to the IWG from January- March 2022, resulting in the initial recommendations highlighted below. Based on this feedback, DPH worked with an external organization to support engaging service providers in understanding gaps and needs. This engagement will be complete in the first quarter of 2023. DPH returned to the IWG to provide status and design updates and gather general advice as DPH's thinking evolves. The following table offers a summary of the initial recommendations, highlights of progress towards these recommendations, and what remains to be addressed. The below table summarizes the initial recommendations (the full recommendation wording is found here), DPH progress updates, and what remains to be addressed of the recommendations.. NOTE: this is not an evaluation of OCC domain, but rather a high-level outline of the progress to the IWG's recommendations.

Initial recommendations (summarized)	Highlights of progress on the recommendation	What remains to be addressed
1. One care coordinator for one client across systems (DPH, BHS, HSA, HSH, etc.) This role is not another case management project, but a connector role of mapping and oversight to keep track of people and their progress.	The OCC centralized care coordination and case management to support individuals making transitions between levels of care or with needs impacting engagement in behavioral health services. The provider engagement will identify opportunities to further the Office of Coordinated Care's (OCC) design of care coordination methods and development of behavioral health programs that more directly meet the needs of both the service providers and their clients.	Report back on recommendation needed
2. OCC oversight on communication and the need to find optimal technology for a communication process that works across the system AND central record keeping database.	Through the system improvement of established programs, the Behavioral Health Access Line (BHAL) and the Behavioral Health Access Center (BHAC), the OCC has expanded centralized access to behavioral health services. Several OCC programs have also gone live on EPIC since 11/7/22 which will allow for better tracking and coordination of care.	Consider completeness of the approach to the recommendation
3. Create a continuum of care process throughout the care system to ensure that no person should be discharged from care without a safe-landing	The Bridge and Engagement Services Team (BEST) was developed for case management of individuals with high acuity needs.	Consider completeness of the approach to the recommendation
4. Target case load ratios for the care coordinators should be based on client acuity and intensity	No information reported back to the IWG on this item yet	Report back on recommendation needed
5. Enhance case management systems that are already working and effective, including focus units, peer navigators/support services, and coordinated transport	DPH established case management expansion effort, that overlaps with the OCC. Case management expansion includes OCC Care Management and Transition Support, with the Street Crisis Response Team, and with existing system of care treatment services (intensive case management and outpatient case management)	Consider completeness of the approach to the recommendation
6. Open more and build upon Peer Centers and Drop-in Centers to connect people to care	No information reported back to the IWG on this item yet	Report back on recommendation needed

New Beds and Facilities

Recommendation process: Prior to the IWG's involvement, DPH modified the MHSF legislated component of "Mental Health and Substance Use Treatment Expansion" to be "New Beds and Facilities (NB&F)" for operational efficiencies. DPH evolved the sub-components of NB&F from three (Beds Optimization Report; Drug Sobering Center; and MH Urgent Care/Crisis Diversion Facility) to four (expanding existing models-dashboard and procurement updates; Drug Sobering Center, Crisis Diversion, and Transition Age Youth). The IWG underwent the formal recommendation process for three subcomponents - Drug Sobering Center, Crisis Diversion, and Transition Age Youth. DPH returned to the IWG to update them on progress related to the Drug Sobering Center (see this link for Drug Sobering Center full recommendations). Thus the Drug Sobering subcomponent in the below table has both initial recommendations and DPH progress on the recommendation. The IWG developed initial recommendations for both Crisis Stabilization and TAY Residential Treatment, and DPH will begin providing updates in 2023. Thus, only initial recommendations are presented in the below table these two subcomponents (see these links for full recommendations of Crisis Stabilization Unit and TAY Residential Treatment). In addition, the IWG advised on the procurement of a new residential treatment option, the Minna Project. NOTE: this is not an evaluation of any of the NB&F programs, it is a high level outline the progress to the recommendations.

Initial recommendations	Highlights of progress on the recommendation
Drug Sobering Center (summarized)	
Recommendations related to DSC services provided 1. Counseling should include adjunctive/non-traditional therapies and activities to engage clients while coming down. 2. Harm reductions supplies, such as Narcan and Fentanyl test strips, are generously distributed. 3. Have immediate on-site access to resources to connect to services (i.e., housing supports, psychiatry services to prescribe and/or re-fill client Rx., and authorizations necessary to access treatment beds 4. DSC have storage space for client belongings. 5. DSC develop protocols for support, including referral to appropriate services or other sites of care, for clients with families and/or those who have pets. 6. Warm hand off for those under age 18 and/or any who cannot currently be served by the DSC. 7. All clients receive an offer to have staff assist in developing a wellness/safety plan that includes phone numbers and contact information for access to 24-hour community programs and resources. 8. Policies and protocols in place to provide a warm-handoff to access points to support such as Case Management and/or residential/outpatient treatment.	SoMa Rise is the drug sobering center, providing general updates on the evolving program and responsiveness to the IWG's recommendations: • Quiet activities (Recommendation #1) • Storage space for client belongings (Recommendation #4) • Options for those that can't be served, i.e., under 18 • Outreach to under-represented communities • Partner with other community service providers • Outreach to CBOs and DPH outpatient service centers • Pay parity between DPH and CBOs
Recommendations related to DSC community engagement 1. Ensure participants themselves are included feedback gathering process. 2. Broaden community outreach efforts to engage varying and diverse cultural and non-English speaking communities that have been historically under-represented. 3. Partner with other community service providers that work directly with high risk clients with SUD 4. Outreach to CBOs and DPH outpatient service centers to understand how to get a client into the center.	No information reported back yet
Recommendations related to DSC components already established by DPH (Location and Contractor) 1. Explore alternative locations that are not geographically tied to high-use areas. 2. Address pay discrepancy between DPH and CBOs in implementing programs and promote DPH and CBO workforce stability	The City Controller's office wage and staffing report is underway and will be reported on in 2023

Note: For the following sub-domain areas of the New Beds and Facilities component (Crisis Stabilization Unit and TAY), the IWG provided their initial set of recommendations only. The DPH department leads for these areas of work have not yet returned to the IWG to report on how they are addressing these sets of recommendations.

Crisis Stabilization Unit (summarized - initial recommendations only)

1. A 24/7 facility that is able to take individuals that self-present, that are referred by their mental health provider, or emergency personnel. Individuals should be treated at the facility through the duration of their acute crisis.
2. Staffed by nurses and prescribers at all times, including options for telehealth during off peak hours
3. Accept and treat individuals with complicated behavioral presentations, particularly those with co-occurring substance use disorders
4. Staff should be trained and competent in crisis management and de-escalation interventions, trauma informed care, harm reduction, and strength-based case management
5. Participation in the CSU services are optional. Clients can exit the program at any time
6. Accept individuals regardless of justice system involvement particularly individuals with 290s (Registered Sex Offender status)
7. Should be able to accept individuals who will need medical care for withdraw management from alcohol and opiates while they are in the program
8. Transportation should be provided to individuals who are leaving the CSU to the next point of their treatment or other stabilization services
9. Overall intent of the MHSF ordinance to more efficiently organize and provision services across the DPH spectrum of care that the CSU make available live bed availability in order to facilitate referrals from emergency responders and mental health providers
10. BHS//OCC should provide the following data, collect additional data and analyze this data to improve service provision at the CSU, and continue to develop programs to meet the diverse needs of individuals who utilize BHS services
11. Should BHS seek to replicate the CSU model, in keeping with the vision of MHSF to improve equitable access to care, the site should be located in one of the traditionally underserved neighborhoods of the Bayview, Western Addition, Fillmore or Mission
12. CSU and all programs created by the MHSF ordinance are situated along a spectrum of care with the vision of stabilization and long-term housing placement
13. Local and state elected officials, in collaboration with DPH, to strongly consider re-initiating statewide legislation to reform existing state policy to expand Medi-Cal coverage for acute mental health crisis treatment beyond 23 hours

TAY Residential (summarized - initial recommendations only)

Programmatic elements related recommendations

1. Narrow the age limit for the TAY population service to ensure focused, tailored, and age-appropriate services
2. Ensure barrier-free access in terms of cultural competency and language.
3. Utilize a strength based, flexible approach that centers on an individual youth's positive identity development.
4. Consider including access to transportation to needed services that are offsite.
5. Ensure providers are skilled in motivational interviewing.
6. Provide support for making connections for the youth with their families and/or important adult role models.
7. Consider building in training or pipeline component whereby youth with lived experience could be employed to provide peer counseling, mentoring, and support.
8. Build in flexibility so that clients could extend treatment beyond 12 months.
9. Provide housing supports for TAY who are ready at the completion of the program to transition into permanent housing.
10. Create a youth Community Advisory Board to bring the TAY voice into programmatic development.

Evaluation and metric related recommendations

Key metrics suggested for inclusion include. Will require work with MHSF Analytics and Evaluation team to develop into meaningful measure of success:

1. Involvement with justice or behavioral health system before and after engagement in services (PES, Crisis, and jail services)
2. TAY program wait lists and turn away counts by race/ethnicity and sexual orientation gender identity
3. Linkages to needed services- ongoing and outpatient
4. Length of stay, retention rates, and percentage of planned discharges, with particular attention to ethnicity and socio-economic status
5. Improved quality of life, including such measures as transitions to permanent housing, education, successful job acquisition, and relationship-based measures (friend, connection to a caring adult, etc)
6. Include in the evaluation qualitative components which center the youth voice which gives them opportunity to narrate their experience in their own words through diverse mediums, including art and music.

Recommendations that may relate to other, MHSF domains

1. The Office of Coordinated Care should provide support to ensure referrals to this service and to the out-referred services from TAY residential are completed
2. When releasing RFPs ensure it is accessible to groups and providers who have not traditionally received community funds

Mental Health Services Center

Note: The following MHSF component (MHSC), does not have a set of formal recommendations to measure against. To Date, the IWG has provided informal feedback throughout the course of the Controller's pre-design phase of this project.

Recommendation process: Like the Office of Coordinated Care, the Mental Health Service Center (MHSC) is a new component being designed. Unlike the other MHSF components, the MHSC began with an options and cost analysis study lead by the Controller's Office. The Controller's office provided updates during three IWG meetings on the progress of the study and elicited feedback from the IWG during these meetings and through in-between meeting IWG Discussion Groups. At the conclusion of the project, the Controller''s office presented three options for MHSC roll out: a standalone, a multi-location center, and a virtual center approach. The Controller's Office initially intended to integrate IWG feedback and publish the report in September 2022. However, they determined it was more effective to integrate the results of that study into a comprehensive report that includes the staffing analysis and analytics and evaluation work they advised on.

DPH is planning to start the implementation planning process in 2023 and will resume engagement with the IWG for consultation and design.

MHSF IWG Future Opportunities

The IWG identified a number of opportunities they will explore as a working group to improve the process, deepen the impact of their work, and support the vision of MHSF. In general, the IWG believes that while advising on the programmatic elements of MHSF is necessary, it is not sufficient to ensure the achievement of the broader ideals of MHSF to transform the system of care "to provide universal access to treatment for mental health and substance abuse disorders…", and better address the needs of priority populations intended to be served by MHSF (MHSF Ordinance, Section 15.104(b)(1))

The IWG identified six opportunities for realizing its potential to support the transformational opportunity of the MHSF ordinance and to "evaluate the effectiveness of Mental Health SF in meeting the behavioral health and housing needs of eligible participants…" (MHSF Ordinance, Section 5.44-4(a). Opportunities 1 and 2 are intended as a foundational reorientation as to how the IWG evaluates the implementation and effectiveness of MHSF. The remaining four opportunities may fall into place based on the implementation of the first 2.

Note that these opportunities require conditions to be put into place to ensure successful implementation. These conditions for success are provided after the opportunities are presented.

Foundational opportunities

The first two opportunities are based on the recognition that the MHSF ordinance, as quoted above, was intended to be a broad transformation of the system of care. The first two years of MHSF were driven by a number of contextual factors and circumstances, many of which related to the COVID pandemic. This includes, but is not limited to, a delay to the initial convening of the IWG, the overlapping housing and mental illness crises that required a rapid response from BHS, and BHS staffing shortages that called for new staff to take on complicated processes. As a result, the IWG frequently noted they were playing "catch up" to the design of programs and therefore, not able to be more "upstream" in their advising.

Opportunity # 1. Focus on the system of care rather than discrete programs. The IWG recommends expanding its current focus from advising on discrete MHSF-related projects to ensure the MHSF components are strategically placed in the larger system of care and meet the needs of the MHSF target population. For example, the current mapping project offers a foothold for identifying and filling gaps and unmet needs. In addition, the work of the IWG should begin to consider the implementation of section 15.104(G)(4) of the ordinance that calls for Mental Health and Substance Use Treatment Expansion to develop a full continuum of least restrictive, community-based services for the target population. This service expansion mandate calls for a range of services that is much more comprehensive than the current domain of "new beds and facilities."

Opportunity # 2. Shift from responsive to strategic. As the initial design phase for the MHSF components is largely complete, the IWG recommends that their primary contribution shift from responding to discrete programs (such as individual projects within the New Beds and Facilities domains) to be a more focused effort to evaluate, advise and support the implementation of MHSF, including its more complicated components, such as the Office of Coordinated Care and the Mental Health Service Center.

A key process change to support this shift is to add standing discussion groups. Currently, IWG monthly meeting agendas are densely packed and discussion groups are ad hoc, meaning they respond to time-bound, specific needs. Standing, ongoing discussion groups with consistent attendance that are tied to key MHSF components or activities create consistency and move the work forward in between meetings. As such, these groups could make the monthly meetings more focused and deepen understanding of complicated topics.

Standing groups could include the components of the Office of Coordinated Care and the Mental Health Service Center, as well as cross-MHSF component issues, such as system mapping and revenue/sustainability. With these groups in place, the formal IWG monthly meetings would be used for reviewing and confirming standing group progress.

Additional opportunities

The IWG believes that the below opportunities may naturally resolve if Opportunities 1 and 2 are pursued.

Opportunity # 3. Define DPH's accountability to IWG recommendations. In the first two years of the IWG, questions and recommendations for the design of specific programs were presented to the IWG. During the next phase, the IWG will continue to be apprised of and respond to needed programmatic recommendation updates via a revised recommendation process (see sketch of this recommendation process in Appendix A). A stronger focus on accountability measures that address the broader principles and effectiveness of MHSF and that of the IWG are in need of development.

Opportunity # 4. Revisit MHSF's funding base and interconnection with other bodies like Our City, Our Home Committee. The IWG contends that MHSF has been over-equated with Prop C funding. This was not the original intent of Prop C and their advisory body, Our City, Our Home. Conversations about any component of MHSF should include a discussion of how these services will be paid for and consider how to strategically integrate other funding sources, such as existing state funds flowing into the County, Medi-Cal reimbursement, and other revenue streams.

Opportunity # 5. Address how to better incorporate feedback of members with conflicts of interest. Currently, IWG members with the most experience in a particular topic are often conflicted out of the design process. This results in a major source of expertise being removed from the advising process. If the work of the IWG shifts to be more system focused instead of programmatic/component focused, the IWG expects, subject to City Attorney advice, that the conflict of interest may be minimized.

Opportunity # 6. Enhance engagement of those with lived experience and with community. The IWG contends that it has not fully leveraged and integrated the experiences and feedback of those with lived experience, service providers and the community. Updates about current programs are frequently from BHS instead of service providers. Further, the call-in process to receive public input during public meetings does not allow for the engagement that a public hearing affords. The IWG would like to explore opportunities to expand community engagement generally, such as reaching out to MHSF participants, site visits and other means to explore obtain community feedback.

Conditions for success

These six opportunities are a shift in how the IWG currently operates and functions must take into account availability, equity, and capacity. Each of these conditions will be carefully considered before the opportunities are acted upon.

- **IWG member availability for engagement:** These opportunities may increase the time required of IWG members to engage in outside of public meeting work. Current low levels of workgroup participation will need to be addressed.
- **Equity of IWG member participation:** Attention will be given to ensure broad discussion group participation. Any opportunity pursued must be equally available to all members of the IWG. Discussion groups may need to take place outside of work hours to accommodate member schedules.
- **Facilitation capacity**. In consultation with the city attorney's office, a way to maintain flexibility and meet Brown and Sunshine compliance, the IWG can continue to meet on an ad hoc basis as well as establish standing discussion groups.[1] The number of groups and depth of support may require reconsideration of the level of support provided by an external facilitator, who's contractual time is aligned to the current level of effort.

[1] The City Attorney has confirmed the use of two different groups in alignment with the Brown and Sunshine Acts. In keeping with the current process, discussion groups convened for short term advising needs will be convened by a discussion group "captain" and other members will be invited to the discussion. Standing discussion groups that require deeper engagement and understanding- like system mapping and sustainability funding- will be what the Sunshine Ordinance calls a "passive meeting body." These groups will be notified to the public on the City's website and are not otherwise subject to the broad array of rules that apply to the IWG and its subcommittees (i.e., they do not need to post agendas or provide for public comment).

Appendix A:

Suggested Process for Existing Domain Development: ongoing accountability to recommendations and evolving domain programs

MHSF will continue to build and develop the programs that are part of the ordinance throughout 2026. In light of this, the IWG and DPH will deliberate on the most effective process to ensure that the IWG is apprised of the progress and context of MHSF domains and their related programs as they evolve over time and that DPH receives the IWG's timely advice and support. Up to this point, the IWG has followed the "recommendation roadmap" and DPH has circled back to the IWG to provide updates. As nearly all components have developed first round recommendations, the roadmap will be replaced by another process relevant to this stage of the MHSF.

A new process must account for how some domains develop fairly linearly (ex: SCRT and NB&F), while others are more emergent based on availability of property, service and priority population needs, and the larger context of the public sector (ex: OCC and MHSC). Considerations for a future IWG and DPH recommendation process include:

- Progress towards the domains must be regularly connected to the initial and ongoing recommendations provided by the IWG. The recommendations will not always be a direct 1:1 match, but DPH should identify if IWG recommendations are pursued, adapted, or not acted upon.
- The IWG should be apprised of how and why the domain has evolved to ensure they can advise appropriately
- Each domain's progress should be presented in the context of the larger system of care and the evolving needs of the priority population

Suggestions to balance accountability to programmatic recommendations with the developmental nature of the domains:

- Every 6 months, DPH domain leads submit a "traffic light" assessment of their progress to the IWG 's recommendations — green is well underway; yellow is being considered or early stage implementation; red is not acted upon.
- During regular IWG meetings, IWG may request details from the lead and their team about why DPH noted green, yellow, or red.
- IWG conversations with domains leads will largely focus on the overall design and implementation of the domain or considerations to ensure recommendations can be updated or added in light of evolving programs and the larger system of care.
- Domain level evaluations will be calendared for review by the IWG and will integrate the traffic light assessment described above.