Meeting Goals
- Acknowledge and celebrate the accomplishments of the Innovation Workgroup
- Share updates, initial concepts and next steps related to the Innovation plan implementation.
- Gather recommendations to guide the formation of the Respite Partnership Collaborative (RPC).

Agenda
Welcome and Introductions
Lunch and Project Overview
Recommendations for Establishing the RPC
Next Steps and Wrap Up

I. WELCOME AND INTRODUCTIONS
Welcome and opening remarks were made by Diane Littlefield, Vice President of Programs and Partnerships at Sierra Health Foundation. Diane spoke briefly about Sierra Health and expressed her appreciation of the hard work done by the Innovation Workgroup.

Diane introduced Sierra Health Foundation. Sierra Health is a 26-year-old organization that helps improve health and well-being for people who live in its 26-county region. Sierra Health’s mission is to invest in and serve as a catalyst for ideas, partnerships and programs that improve health and quality of life in Northern California through convening, educating and strategic grant making. Sierra Health is driven by values that are in alignment with the Innovation project. Sierra Health will strive to develop a responsive, thoughtful, strategic collaborative to make the difference that the Workgroup intends.

Sierra Health will work in partnership with the County, the RPC and the community to implement the innovation plan. Sierra Health looks forward to combining the strengths of the County and the foundation to leverage more resources to benefit the community. Diane introduced Myel Jenkins, the new RPC Program
Officer, along with other Sierra Health staff members who will support the project: Amy Birtwhistle, Program Associate, and Katy Pasini, Communications Manager.

Mary Ann Bennett, Deputy Director of Sacramento County Division of Behavioral Health Services (DBHS), provided a welcome from the funder’s perspective. Mary Ann reminded participants that the Innovation Workgroup came together to determine the best course of action to move the work forward and shape the plan. Mary Ann explained that crisis respite programs are an approach that is tested and proven – the new and innovative component is the public-private partnership to support efficiencies and leveraging of other funding. As we move forward, the next step is to develop a Respite Partnership Collaborative.

Mary Ann thanked all for helping the County get to this point. She also announced some staff changes at DBHS: Michelle Callejas is now Deputy Director at Child Protective Services and Jane Ann Leblanc is now the Director of Mental Health Services Act (MHSA) programs. Kathryn Skrabo will continue to provide expertise to the Innovation project.

Myel Jenkins set the stage and presented the goals for the day. She explained that the day is a bridge meeting between the Innovation Workgroup Planning phase and the Respite Partnership Collaborative implementation.

Deb Marois, facilitator, introduced the process for the day and emphasized the importance of hearing everyone’s perspective and honoring time. Deb introduced Greg Gollaher, graphic recorder, and reviewed the agenda, Workgroup roles and responsibilities and tools for working together: consensus building - levels of agreement, the planning activities rating scale and the agreed upon ground rules. She asked participants to share their name, organization or constituency they represent and one thing they would like Sierra Health Foundation to know about implementing the Innovation plan.
II. PROJECT OVERVIEW

Kathryn Skrabo, DBHS Program Planner, provided an overview of the Innovation plan, outlined in a PowerPoint presentation.

Innovation is one of five strategies within MHSA to help transform and improve mental health treatment. Innovation is defined as novel, creative, ingenious mental health approaches developed within communities in ways that are inclusive and representative, especially of underserved, underserved and inappropriately served individuals. Innovation promotes recovery and resilience, reduces disparities in mental health services and outcomes and leads to learning that advances mental health in California.

The work began in November 2010 with the Innovation Workgroup Kickoff. The process included four full-day meetings. The first meeting focused on data, crisis and what could be done to address it. Next the Workgroup developed five strategies to take to the community to get feedback. The third meeting incorporated the input from the community, refined strategies and the plan began to take shape. The fourth meeting finalized the major elements of the plan. Following the last meeting, the plan was posted for public review, discussed at a public meeting and then sent to the Department of Mental Health for approval.

Goals of the plan are to:
- Promote interagency collaboration in response to crisis, specifically working to integrate the community voice in the planning of respite services to respond to crisis
- Develop new partnerships that will maximize existing resources to establish a continuum of respite services that will reduce mental health crisis in Sacramento
- Increase the quality of services that will lead to better outcomes, reducing mental health crisis

The goals will be reached through partnership among the County Division of Behavioral Health Services, Sierra Health Foundation and the Respite Partnership Collaborative. The DBHS role is to coordinate with Sierra Health to implement the plan, develop criteria for the RPC, provide liaison and technical assistance to Sierra Health and RPC, monitor the contract and report results to the state, and partner with Sierra Health to develop the evaluation framework.

Sierra Health Foundation applied through a competitive bid process and was selected to be the administrative entity for RPC. Their role is to facilitate the RPC and community meetings, oversee distribution of funds and manage contracts in the community, and develop a communication plan and evaluation framework.

The new community respite programs will maximize the inclusion of youth, peers, family and caregivers in employment, volunteer and leadership opportunities; provide youth, peer, family and caregiver support services; consider culturally responsive traditional healing practices and alternative approaches, be accessible to transportation, be located in neighborhoods or home-like settings; use trauma-informed care principles; use wellness and recovery principles, provide
assessment, linkages and triage. The populations to be served include: adults in crisis with dependent children, seriously emotionally disturbed children whose parents/caregivers need a break, teens/transitional age youth, adults/older adults in crisis, and a specialized, or cultural or ethnic population.

Diane Littlefield followed the presentation with an overview of current progress and next steps. Sierra Health recently hired Myel Jenkins to lead the implementation of the project. The next step is to establish the RPC. Once the RPC is seated, they will develop their governance structure and then the RPC will help roll out the grant making process in partnership with Sierra Health and DBHS. Their role will include advising on the criteria for grant making and assisting in getting the word out about funding opportunities.

The RPC will also have a role with the evaluation. Sierra Health will hire an evaluator and will document the process along the way. The RPC will advise the evaluation process by identifying important areas of learning. Finally, Diane spoke of the need to develop a communications plan. The RPC will advise on communications, transparency and the most effective ways to communicate with the public and intended audiences.

Diane provided time for questions and answers from the Workgroup and community members:

### III. RECOMMENDATIONS FOR ESTABLISHING RPC

Myel framed the discussion: Sierra Health is seeking input on development of the RPC because there are some undefined elements of implementation, specifically regarding the structure of the RPC. Sierra Health will take the group’s input in addition to guidance from best practice literature, MHSA principles and other community stakeholders and subject matter experts. Where there are differences of opinion among the Workgroup, Sierra Health will make decisions informed by all input and resources. Once the RPC is formed, it will be a self-governing body and will have the option to make changes in its structure and how it operates.
Myel presented results from the Workgroup member survey conducted in advance of the meeting. The survey provides some insight into ideas about RPC group size, member selection and other factors to consider when convening the group. The response rate was about 50%.

**Membership**

Deb presented the groups that had been listed in the plan. There are two categories: Consumer/Family Member Representatives and Stakeholder Group Representatives. The list of Consumer/Family Member Representatives will have guaranteed seats on the RPC. The remaining seats will be filled with members of prioritized Stakeholder Group Representatives.

![Image of recommended size for RPC and what groups are missing]

The group provided input into the following questions:
1) What would be a manageable size for a collaborative group?
2) Are there other stakeholder groups that should be represented on the RPC?
3) What working definition of cultural broker and non-traditional mental health provider will we use?

Small groups discussed each question, then shared and clarified items as needed. Finally, participants dot voted for the Stakeholder Group Representatives they thought should be prioritized for participation in the RPC.

<table>
<thead>
<tr>
<th>Consumer/Family Member Reps (those in gray added at meeting)</th>
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<tbody>
<tr>
<td>1.   Family Member/Caregiver SED Child</td>
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<td>2.   Teens/Transition Age Youth (TAY, 16-25)</td>
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<td>3.   Adult Consumer</td>
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<td>4.   Adult Consumer with Dependent Children</td>
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<td>5.   Family Member of Adult Consumer</td>
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<td>6.   Older Adult Consumer</td>
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<td>7.   Homeless</td>
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<td>8.   Foster youth</td>
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<td>Stakeholder Group Representative (groups in gray added at meeting)</td>
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<td>9 DBHS</td>
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<td>10 Mental Health Provider (e.g., MH Provider Assn)</td>
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<td>11 Homeless (e.g., Sac Steps Forward, Sac Housing Assn)</td>
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<td>12 System partner – Children/Youth</td>
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<td>13 System partner – Education</td>
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<td>14 System partner – Child Welfare/Foster Care</td>
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<td>15 System partner – Health</td>
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<td>16 System partner – Aging</td>
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<td>17 System partner – Law Enforcement</td>
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<td>18 System partner – Juvenile Justice</td>
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<td>19 System partner – Disability</td>
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<td>20 System partner – Alcohol and Other Drug</td>
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<td>21 Faith-based provider</td>
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<td>22 Cultural brokers/representatives *</td>
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<td>23 Non-traditional Mental Health Providers *</td>
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<td>24 Veterans</td>
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<td>25 Mental Health Board</td>
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<td>26 Patients right advocate</td>
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<td>27 Community clinics/primary care centers</td>
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<td>28 Hospitals</td>
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<td>29 Local government (representative but not an elected official)</td>
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<td>30 System partner – Housing</td>
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<td>31 Hospital Council</td>
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<td>32 Transportation provider - public transit</td>
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**Definitions**

Participants also contributed clarifications to help define the categories of cultural brokers and non-traditional mental health providers, summarized below.

**Cultural Brokers/Representatives**

1) A designated spokesperson or leader who represents the group, common in some Asian communities.
2) Member of a specific cultural community able to help develop a mutual understanding between the program and the community they represent. At least five, possibly more, communities that are representative of underserved communities – LGBTQ, Latino/a, Asian Pacific Islander, African-American, Native American, Arab American/Muslim/Middle Eastern, Hmong, etc.

Nontraditional Mental Health Provider

The group described an array of possibilities that included alternative medicine, spirituality, meditation and yoga, among others.

During the discussion, workgroup members provided additional clarity about RPC membership. They urged Sierra Health not to confuse being a member of a group with being a representative of that group and also noted that RPC members could represent more than one category. The group was reminded that Muslims are members of a religion, not an ethnicity or cultural group, and there is great diversity within the Muslim faith. The group also observed that veterans and homeless are frequently left out of the conversation.

Regarding RPC size, no consensus emerged. Participants mostly supported a range of about 20-40 RPC members and acknowledged that the tasks the RPC is charged with will impact the group size. There was a suggestion that the RPC could establish workgroups and include people who may not be an RPC member to allow for more representation and participation. Additionally, subject matter experts can be included as needed and don’t necessarily need a designated seat. Because the RPC will be self-governing, they may decide to expand or contract the number of stakeholders.

A member of the workgroup asked who will facilitate the RPC. This has not been determined yet. Two workgroup members stated their approval of Deb’s work.

Selection and Outreach

Workgroup and community members brainstormed ideas to inform the RPC selection process and outreach. This discussion resulted in the following recommendations for the application:

- On the application: Include a statement about lived experience being preferred; ask what groups an applicant represents, and identify applicant skills.
• Require an application/nomination or letter of recommendation to ensure that applicants represent a group.
• For hard-to-engage groups, a nominator may need to fill out an application for the nominee, or reach out to a nominee to help or support their application process.
• Consider a phone interview for nominees.
• Ensure we are clear on the commitment – terms of service, schedule of meetings, etc.
• The MSHA Multicultural Coalition may be a model of a selection process that worked well.

Other ideas to consider:
• What about backups/alternates?
• With a large committee, terms kind of take care of themselves – people come and go
• Internships from Sacramento State University

IV. NEXT STEPS AND WRAP UP

Deb encouraged participants to follow up with Myel and provide suggestions of specific groups or organizations to contact about the opportunity to serve on the RPC. Myel announced that a meeting summary and other documents will be available on Sierra Health’s web site in the next few weeks. Participants completed an evaluation of the meeting.

Finally, the group discussed immediate ways to continue being involved. Six Workgroup Members volunteer to participate on the RPC selection process. Once the selection process is developed, everyone has the opportunity to apply to be members. Additionally, everyone in the room is an ambassador for the RPC and is encouraged to nominate others or tell others about the opportunity to apply to be on the RPC.

Diane thanked everyone and expressed her appreciation of all the work to get us to this point. She also thanked the County partners, Sierra Health staff, Deb, Greg and the conferencing staff. Diane also reminded all that the use of meeting rooms at Sierra Health Foundation is a free community service. She asked for a few closing comments on what went well and what could have been better. Comments included Deb doing a great job and appreciating lunch. The one comment about what could have been better was that more time was needed.
What is ONE of the most important things you would like Sierra Health Foundation to know about implementing the Innovation plan?

- Family voice and youth voice is heard and involved every step
- We really worked hard to make this an inclusive process and use existing resources, and we want to see all those things that Sacramento has to offer and be true to the folks that will be served
- Bringing residents across the lifespan and diversity to the conversation
- Consumer voices and as much inclusion with consumer family members in the process and when hiring employees
- Interlocked, when you help one, you are helping all that individual is attached to
- Everyone’s voices including supporters
- Don’t get stuck in the areas we can’t do, keep moving in the areas we can do the best we can
- Hope that respite centers will lead to reducing unnecessary hospitalizations
- This funding is not sustainable, we need to focus on sustainability to continue this after the initial phase
- Remember to think outside the box, extensive community involvement, family voice and remember the children. Save lives now so we can save money in the future
- Think outside the box in the area of how to get families in crisis to know what their options are, how can we reach out to them
- Do not get bogged down in voting and administrative garbage
- Let’s not forget that the bottom line is we are doing these things for the consumers, those who are still suffering and haven’t been served yet
- Respite homes will be both culturally competent and culturally specific
- In order to be ADA compliant we need to consult the experts - those with disabilities - disability advisory commission
- In an attempt to be inclusive, keep our eye on the goal and be efficient as possible
- Identify all community partners who will benefit from successful respite homes, if we have successful respite houses we will have sustainability
- Muslim community would like to be part of this project due to the increased risks of onset of MH crisis. 20-30 languages and at least 20-30 ethnicities make up the Muslim community
- Always be sure that community stakeholders are invited, it is a community process
- Welcome alternatives to in-patient care
- Important for program to bridge gap between those who have just received acute care and provided sufficient community resources to prevent them from coming back
- A place that individuals in crisis can go to, an alternative to the ER for just a few days. Not one-size fits all, something that will fit each community’s need
- Help after crisis is over to prevent more acute ER visits