INNOVATION (INN)

STAKEHOLDER MEETING

JANUARY 23

2018

WELLNESS • RECOVERY • RESILIENCE

INNOVATION

- This is a less-structured meeting.
- All attendees are welcome to comment, ask questions, make suggestions, etc.
- New innovation proposals will be presented
- Stakeholders will rank proposals (via link starting Wednesday, Jan. 24th at 12:00pm)

INNOVATION

- **INTRODUCTIONS**
  - Stakeholders
  - Innovators
  - Staff

AGENDA

1. **Welcome, Introductions, and Goals for meeting**
    1. Frank Warren, SLOBHD
    2. Nestor Veloz-Passalacqua, SLOBHD
2. **INN Proposals**
    1. 3-by-3: A Developmental Screening Partnership Between Parents & Pediatric Practices
    2. Mobile Peer Partnership Program
    3. SLOWRAP Mental Health Care Services for LGBTQ Populations
    4. Brain Training for Improved Mental Health in SLO County: Utilizing Neurofeedback with a Full Service Partnership Population
3. **Budget**
4. **Next Step**
    1. Ranking of each proposal (Stakeholders)
    2. Refine each proposal with OAC

INNOVATION

What is innovation?

- Innovation is focused on learning, not on implementation.
- Innovation funds are used for developing models, testing the models, and communicating the results.

INNOVATION

An innovative project contributes to learning by:

- Introducing a brand new mental health practice or approach including PEI
- Making a change to an existing practice in the field of mental health, including application to a different population
- Introducing a new application or adaptation to the mental health system that has been successful in a non-mental health setting.

INNOVATION

Innovation must include one of the following primary purposes:

- **Increase access to underserved groups**
- **Increase the quality of services, including better outcomes**
- **Promote interagency collaboration**
- **Increase access to services**

INNOVATION

Programs must be aligned with MHSA values:

- Community Collaboration
- Cultural Competency
- Client-driven Programs
- Family-driven Programs
- Wellness, resilience, and recovery
- Integrated service experience

INNOVATION

Planning:

- **Programs seek to solve a persistent, seemingly intractable mental health challenge**
  - Cannot be solved with simple funding
- **Programs promote wellness, resilience, and recovery**
- **Programs developed at the grassroots, community-based level**
- **Includes a plan to share evaluation results and build upon success and lessons learned**

INNOVATION PROPOSALS

- 3-by-3: Developmental Screening Partnership
- Mobile Peer Partner
- SLOWRAP – LGBTQ Mental Health Education & Training
- Brain Training for Improved Mental Health in SLO County

INNOVATION

3-by-3: Developmental Screening Partnership Between Parents and Pediatric Practices

3 by 3: A Developmental Screening Partnership between Parents and Pediatric Practices

MHSA Innovation Proposal Submitted by First 5 San Luis Obispo County

January 23, 2018

An Issue & an Idea

WE HAVE A PROBLEM….

- 1 in 4 children 0-5 are at risk for mental health, behavioral, or developmental delay
- Only 28.5% of California's children receive timely screenings
- 70% of children with delays go undetected until kindergarten

WHY?

- Comprehensive, recurring standardized screening takes time
- Stigma associated with "delay" and mental health concerns
- Mental health and social-emotional development under-addressed in early years

LET'S TEST AN IDEA

- Create a safe context for screening in partnership with local health providers
- Test multiple methods of implementation to identify optimal approach
- Use screening to integrate mental health into early primary care conversations

3 by 3 Proposal: Research Question

What method or methods of administering a comprehensive and recurring screening for children 0-3 produce the strongest results for improved mental and behavioral health through prevention, early identification, and/or intervention?

3 by 3 Proposal: Key Features

- Embedded in Pediatric Practices – CHC and private provider/s who serve Medi-Cal patients
- Use of validated screening tool – Ages and Stages Questionnaire (ASQ-3) and ASQ Social-Emotional (ASQ:SE-2)
- Three developmentally-appropriate screening encounters at ages 9 months, 18 months, and 24-30 months.
- Testing three methods of implementation:
  - Embedded health educator 30-minute meeting prior to appointment
  - Self administration of screening tool prior to appointment by parent/guardian
  - Screening conducted at child's childcare site and provided to pediatrician
- Pediatrician discusses screening results with parent/primary caregiver; makes referrals as appropriate

Innovation Outcomes

- **Short-term Outcomes:**
  - Number of comprehensive screenings conducted per method
  - Increase in parent/primary caregiver knowledge of social-emotional development
  - Increase in parent/primary caregiver comfort level discussing concerns (i.e. stigma reduction)
  - Increase in number of referrals for behavioral and mental health needs of child (and/or family members as appropriate)
- **Long-term Outcomes:**
  - Decreased number of behavioral and mental health issues identified in kindergarten
  - Reduced stigma related to mental health concerns, from birth
- **Contributions to the Field:**
  - Innovative partnerships between parents and providers* (*primary care, mental health, health education, childcare, parenting education)
  - Added focus on mental health as a part of the national Help Me Grow movement

What is Unique About 3 by 3?

- Early childhood focus on mental health as an upstream approach
- Tests multiple methods of implementation within a single pediatric practice
- ASQ-3 and ASQ:SE-2 administered as a Health Education encounter in pediatric clinics
- Formal connections forged between healthcare and childcare providers

Funding Needs

- Project Coordination
  - Program-wide
  - Within Participating Clinics
- ASQ-3 and ASQ:SE-2 Materials
- Health Educator Training (CHC)
- Health Educator Staffing (Private Practice)
- Data Collection
- Project Evaluation

Leveraged Funds and Sustainability

LEVERAGED FUNDS

- First 5 SLO County will be a joint investor in the project
- Pilot will utilize already existing health educators embedded in CHC clinics
- Pilot will build upon funded screening requirements for childcare centers enrolled in Quality Counts

SUSTAINABILITY

- Help Me Grow is a state-wide project with possible future funding support based on results from studies such as MHSA Innovation
- CenCal reimbursement mechanisms
- Positive outcomes increase potential for:
  - County investment
  - Institutionalization within pilot practices
  - Countywide expansion

QUESTIONS?

INNOVATION

Mobile Peer Partnership Program

WELLNESS • RECOVERY • RESILIENCE

Mobile Peer
Partnership Program

MOBILE PEER PARTNERSHIP PROGRAM

Problem:

- **Lack of mental health:**
  - Connection
  - Navigation
  - Continued Support

- **Clients who have come in contact with emergency or crisis services**

MOBILE PEER PARTNERSHIP PROGRAM

Purpose:

1. Provide extended mental health services to individuals referred from MHET, PHF, local hospitals, the jail, SLO Hotline, and other sources.

2. Match a client with a mobile peer partner, with lived experience in:
    1. Navigating the mental health system
    2. Continued connection to services
    3. Personal driver of recovery

MOBILE PEER PARTNERSHIP PROGRAM

Intervention & Test

1. Innovation Component

1. Mobility of Peer Partner: mobile peer partner(s) reaches the community or individuals at their location in need of support, connection, and navigation of mental health services. Reduces time spent for clients to be introduced to services, and offers a direct contact (mobile peer partner) as a success story.

MOBILE PEER PARTNERSHIP PROGRAM

1. Minimum 6-8 month tailored direct mobile peer partner contact
2. 6 months of program development – including inter-agency collaboration and development of referral process with Managed Care, SLO Hotline, local hospitals, and jail.
3. 3 years of program implementation – peer partners begin receiving referral process. Begin with 3 peer partners establishing a plan of connection, recovery, and continuity, which include: support, personal reassurance, services connection, and navigation.
4. 6 months of program evaluation – did the mobile peer partner program met learning goals?

MOBILE PEER PARTNERSHIP PROGRAM

Learning Goals / Project Aims

1. Would adding mobilization to the peer partner role assist clients in navigating the mental health system?
2. Would adding mobilization to the peer partner role reduce…
    1. PHF days
    2. Recidivism
    3. Homelessness
    4. Hospital emergency visits
3. Would adding mobilization to the peer partner role increase access to referrals?
4. Would adding mobilization to the peer partner role increase continued access to services and satisfaction?

MOBILE PEER PARTNERSHIP PROGRAM

Sustainability

1. Continued county funding after testing ends in the form of a contract – modification of the program to leverage established resources.
2. Services provided are expected to meet requirements for being billable services with Medi-Cal.
3. Certain pieces of the program can be included in current peer support services allowing greater access.

MOBILE PEER PARTNERSHIP PROGRAM

QUESTIONS?

INNOVATION

SLOWRAP Mental Health Care Services for LGBTQ Populations

WELLNESS • RECOVERY • RESILIENCE

MHSA Innovation Stakeholders Project Presentation
Date: 1/23/18

Mission: "*Building and supporting emotionally strong individuals, families and community through affordable, confidential, and transformative counseling, education and advocacy*."

Established in 1968

Project Name:

SLOWRAP Mental Health Care Services for LGBTQ Populations

- Primary Problem, Need, & Priority
- Proposed Project, Approach, & Scope

  -Innovative Components

  -Adaptive Components

Why does LGBTQ Mental Health matter in SLO County?

► 48% of SLO County LGBTQ youth have seriously considered suicide in the past 12 months (CA Healthy Kids Survey, 2015).

► Supportive LGBTQ mental health services rated most serious service need in SLO County (Growing Together Initiative, 2015)

► *Provider education* and *peer support* were top two recommendations from SLO focus groups (Growing Together Focus Group Project, 2003)

SLOWRAP Mental Health Services: A two part model

1. <u>Developing an "A-Team" of Mental Health Providers (MPH)</u>
-Adaptation of a new, never tested LGBTQ Cultural Competency Model, *Train the Gap,* for a provincial/rural setting.

2. <u>Pair Doctoral Interns with Peer Counselors</u>
-Innovative and Adaptive LGBTQ Cultural Competence Capacity Building Strategies for Doctoral Level Interns & Peer Counselors.

SLOWRAP Train the Gap: Gender Affirmative Clinical Training

► Created by Ben Geilhufe, LPCC, Director

► Program: 9-12 Month LGBTQ-Affirming Training for MHP

► Outcome: Develop an A-Team of 25 Trained Mental Health Professionals, MHP-in-Training, and Paraprofessional Peer Counselors

SLOWRAP Innovative Therapeutic and Peer Interventions

► Pairing of Doctoral Level Intern Psychologists with trained peer counselors for support groups, triads, and case management circles.

-Innovation & Adaptation: experientially-based LGBTQ mental health education for Doctoral Interns.

SLOWRAP Mental Health Services: Testing the models

►<u>Developing an “A-Team” of providers</u>

-25 A-team providers vs. 25 control group providers

►<u>Pair Doctoral Interns with Peer Counselors</u>

-Doctoral Intern & Peer Counselor vs. Doctoral Intern Control Group

►<u>Training Evaluations:</u>

-Series of Pre and Post tests to evaluate LGBTQ Cultural Competency -Measuring changes in *Knowledge, Awareness, Skills, & Advocacy*

Collaborations

GALA
Gay And Lesbian Alliance
of the Central Coast

TCC
TRANZ CENTRAL COAST

Central Coast
Coalition for
Inclusive Schools

QUEER C.A.R.E.S.
Community Action Research Education & Support

Community
Counseling
Center

TMHA

RISE
RESPECT | INSPIRE | SUPPORT | EMPOWER

GROWING
TOGETHER
INITIATIVE
a fund of
THE COMMUNITY FOUNDATION
SAN LUIS OBISPO COUNTY

STAND
strong
SUPPORT AND RESOURCES
TO END DOMESTIC VIOLENCE

We're in this together: Long term impact & vision

► Sustainability:

-A-team specialists in various agencies and departments across the community.

-Train-the trainer model for on-going LGBTQ-101 trainings throughout the community

-Development of a resources website for LGBTQ community

-Working in partnership with Suicide Prevention Coordinator

Thank you for your continued support!

INNOVATION

Brain Training for Improved Mental Health for SLO County: Utilizing Neurofeedback with a Full Service Partnership Population

WELLNESS • RECOVERY • RESILIENCE

Brain Training for Improved Mental Health in SLO County: Utilizing Neurofeedback with a Full Service Partnership Population

Transitions–Mental Health Association

Mental Health Care Disparities

- Is anyone here a proponent of **institutionalized discrimination** aimed at marginalized, **underserved**, high-risk **mental health** populations?

- Anyone here think that **promising mental health practices** should be **reimbursed** by **private insurance**, but **not** by **managed care (Medi-Cal, Medicare, CenCal)?**

Severely Mentally Ill Excluded from Treatment

- FSP consumers, with SMI, are denied access to neurofeedback, due to a lack of coverage from managed care for these services….while private pay insurers are often reimbursing for the same mental health service.

- Many private pay clinicians exclude persons with psychosis, of any form, from treatment.

- We only found one non-profit, in the nation, who bills state insurance, and they exclude bipolar, schizophrenia and severe personality disorders from treatment.

Neurofeedback (EEG Biofeedback):

Affordable, User-Friendly, Skill-Based Learning

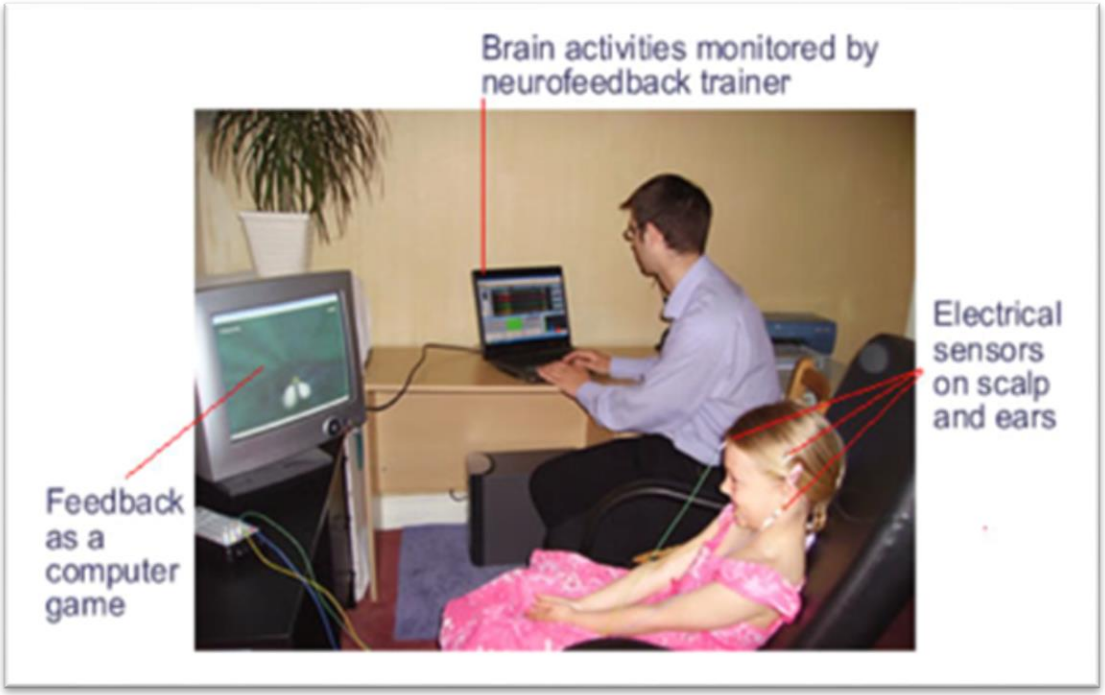
Biofeedback and Neurofeedback

- Traditional **biofeedback** is feedback from **body function signals** that are directly related to the **autonomic nervous system**

- Whereas **neurofeedback (EEG-biofeedback)** means feedback of the **brain activity**, and therefore of the **central nervous system**

Neurofeedback (QEEG Biofeedback)

A computer-aided **skill-based training method** in which selected parameters of the client's **own brain activity**, which can normally not be perceived, are made **visible to the client**. Via **monitor** and/or headphones the brain is shown what it is doing at the moment **(feedback)**.



Through feedback, the consumer learns to better self-regulate their own brain activity

In many studies, this **skill** has demonstrated **long lasting results**, even years after treatment has ended

Neurofeedback for Enhanced Self-Regulation

- Many **illnesses, disorders or unwanted behavior patterns** are due to **dysregulation of brain activity**. With neurofeedback patients can learn to better compensate, and gain **voluntary control** in real world settings, over these dysregulations, leading to **more functionality** (wellness, recovery, and resiliency).

- As a result of the treatment, we can say that we have **enhanced** the **brain's**, and the **person's**, capacity for **self-regulation.**

Brain Markers to Inform Diagnostic Impressions

- Quantitative electroencephalogram (QEEG) and components of event-related potentials (ERPs) are considered the **most effective biological markers** used to inform **diagnoses** and **treatment**.

- Recent research shows that certain **diagnoses** are associated **reliable brain markers** of the **brain function** and **dysfunction**. **Psychiatrists** could use this information to **inform medication treatment** decisions.

Support for Neurofeedback

Neurofeedback is an **innovative** form of **electrotherapeutics** that has demonstrated **promising** results with treating:

- **Attention Deficit Hyperactivity**
- **Anger Control**
- **Anxiety**
- **Autism Spectrum**
- **Depression**
- **Chronic Pain**
- **Intellectual Disability**
- **Migraines**
- **Obsessive Compulsive Disorder**
- **Personality Disorders**
- **Posttraumatic Stress**
- **Schizophrenia**
- **Seizures**
- **Substance Use Disorder**

(Begemann et al., 2016; Feizzadeh et al., 2015; Moore, 2000; Rosenfeld, 2000; Surmeli & Ertem, 2010; Trudeau, 2000; Van Der Kolk, 2016; Walker, 2013; Walter, 2009)

ITMHA

If it's so great, why aren't we already utilizing it as an adjunct treatment option within our community-based mental health system?

Two main reasons…

Limited Research with SMI Populations

- Biofeedback is a broad field, so it is hard to fund research for every type of disorder that it could be used for (like saying “I’m going to study medication or cancer”).
- Would need to study each population, with control groups (experimental designs), which is difficult with an FSP-type population
- Unlike pharmaceuticals, there is **limited funding** for **non-traditional approaches**
- Often times, persons with SMI need to be in a **trusting relationship** with treatment providers to agree to out-of-the-box treatment options

Managed Care: No Reimbursement for Non-Traditional Approaches

Institutionalized discrimination: The unjust and **discriminatory mistreatment** of an individual or **group** of individuals by **society** and its **institutions** as a whole, through **unequal selection** or **bias**, intentional or unintentional.

- Many **private insurance companies** on the west coast (Blue Cross, Aetna, Cigna and Delta) demonstrate fairly **consistent reimbursement** rates for the use of mental health **biofeedback treatment**.

However…

- **Medicare, Medi-Cal** and **CenCal** will **not reimburse** for any type of mental health **biofeedback treatment** and consider it a **non-billable service.**

ITMHA

Unique Opportunity

- We have a **unique opportunity in FSP** because we are able to do more **out-of-the-box approaches** and have **very good rapport** with our clients

- But we need to demonstrate **effectiveness with this population** to be able to **utilize this treatment** within our **FSP program**

Without your support, we will not be able to offer this affordable, promising, non-traditional, skill-based treatment option to our FSP consumers

Neurofeedback in an Adult Full Service Partnership (FSP) Program

Program Mentors (FSP program graduates currently employed by TMHA) **consulted** with current **FSP consumers**. The consumers reported **wanting** the same **access** to safe, **non-invasive, non-toxic, user-friendly**, promising treatment options that are afforded to those with **private pay insurance**.

Innovation Proposal Inception

One FSP client got the ball rolling!

- The client:
  - **could no longer tolerate** an **entire class** of **pharmaceutical drugs** **(this is not uncommon in FSP)** due to significant and **irreversible side effects** **(also not uncommon in FSP)**, that get worse over time;
  - was still experiencing **significant mental health symptoms** even after trying **10-20 psychiatric medications** **(again not uncommon);**
  - and started searching for **adjunct treatment options**.

Innovation Proposal Inception

- The client got a discounted/intro rate assessment and consultation for neurofeedback, only to find out that the treatment was **not covered by Medicare/Medi-Cal** and that it would cost $2k-$6k.

- For advanced assessment/treatment/equipment (for persons with SMI), that number goes up to **$6k-$12k, per person** (depending on symptom severity).

- **FSP clients cannot afford this service** as a typical consumer makes **$857/month** on **SSI benefits**.

- **FSP programs**, even with extra flexible spending for clients, **cannot afford** to pay for **neurofeedback treatment** making it out of reach for FSP clients.

“Trial and Error” Treatment

Consumers eligible for Adult FSP are adults with a **serious mental illness** who, in the last 12 months have been:

- **Homeless**
- In **jail** or have had **frequent contact** with the **criminal justice system**
- Utilizing **frequent psychiatric hospitalizations** or **psychiatric emergency service**

The average FSP consumer:

- Has been engaged with **County Mental Health** for **15+ years**
- Has tried **10-20 different psychiatric medications** over the course of their treatment
- Has been diagnosed with **3+ previous diagnoses** that differ from current diagnosis

TMHA

Average FSP Consumer

- Struggles with a **combination** of **3 or more** of the following:
  - **Complex Trauma**;
  - **Severe Mental Illness**;
  - **Chronic Pain** Disorder;
  - Complex Medical Issues;
  - Co-occurring **Substance Use** Disorders;
  - **Learning/Intellectual** Disability;
  - **Emotional** and **Behavioral Dysregulation** and **Complex Personality Structures**

Impact of Current Practices on FSP Consumers

- Report feeling like a "**guinea pig**" due to **frequent medication changes** in attempts to find an effective combination
- Experience moderate to severe **mental health symptoms** even **when on medications**
- Sustain mild to severe psychiatric **medication side effects**, some to a degree where **entire classes of medications** can no longer be tolerated
- **Feel hopeless** about the possibility of ever being free from severe mental health symptoms, which leads to feelings of **suicidality**
- Feel that they have **restricted access** to promising mental health practices
- Are **not fully experiencing** the **life** they **want** or **deserve**

Impact on the Community

- **On Families**: Watching their loved ones struggle and feeling powerless over the lack of treatment options.

- **On the Local Community**: Homelessness, residential disturbances, interactions with law enforcement, use of jail services, use of the ER to address psychiatric concerns, and engagement with Child and Adult Protective Services.

- **On Tax Payers**: Based on research into the average FSP Client's **current psychiatric medication regime**, which include psychiatric drug combinations that cost as much as **$4,000 a month per person**, the **annual cost** of psychiatric medications is approximately **$1 million dollars** for **30 FSP consumers**.

Cost Savings

- In addition to **priceless benefits** (saved/improved lives), there could also potentially be a huge financial cost savings.

- After upfront training and equipment (approx. $35k for 3 systems) costs, treatment could be **provided by in-house**, **licensed mental health practitioners** as part of **routine treatment options**. If one of these practitioners was also trained reading QEEG reports, this would also be done in-house. If not, basic reports are only **$100/per person**.

Possible Implications

- If the use of medications was only cut by 25%, that could mean a **savings** of approximately **$250,000 per year** (for 30 people).
- If use of the QEEG for guiding diagnostic impressions helped reduce the amount of medications trials and accurate use of therapeutic interventions, this could **improve FSP graduation** rates, which would free up the current 6 months-1 year FSP waitlist.
- Compared to average cost of **psychiatric medications** for one FSP consumer, per month = average **$2k-$4k**
- Post-project: Average cost of **neurofeedback treatment** for one FSP consumer, per month will be **included** in routine FSP therapeutic treatment

It almost seems like we can't afford not to try Neurofeedback…

FSP-Neurofeedback Innovation Plan

Spend a **small fraction** of the cost of **one year's worth of psychiatric medication** for 30 FSP clients, to purchase:

- Advanced Neurofeedback equipment and software
- Training for 4 T-MHA clinicians to operate the equipment and provide treatment
- Training for one T-MHA clinician to assess qEEG results, create treatment plans, and mentor clinicians

- **Leverage** current FSP **clinician's** time/salaries to offer **neurofeedback treatment** to all current **Adult FSP** and **Homeless Outreach FSP consumers (50 people)**.

- Utilize a designated **Program Mentor** to provide peer support and assist with explaining topics related to treatment; modeling NF equipment; relaying client concerns/feedback to clinicians; and travel coordination and completion.

Proposed Outcomes

- **Decreased symptoms** and **improved ability to self-regulate**
- **Decreased need** for **medications** due to **symptom reduction**
- **Increased functioning** (social, occupational, educational, legal, residential)
- **Decreased trial-and-error** pharmaceutical and therapeutic interventions/reduced number of **unsuccessful medication trials**
- Increased **client-driven** treatment options
- Increased **graduation rates**
- Demonstration of a **cost-effective**, **self-sustaining** program, with improved FSP mental health outcomes, that can be **replicated** by other **agencies/counties**
- **Decreased** pain/migraine **symptoms**

Sustainability, Dissemination of Results, and Macro Level Advocacy Plans

- Continue to utilize **Neurofeedback/QEEG Biofeedback** with previously **trained clinicians**.
- Propose to SLO County Behavioral Health **adjunct MHSA funding** for neurofeedback.
- Advocate to **SAMHSA** to add neurofeedback to their list of **Evidence Based Practices**.
- **Advocate** that **CenCal** add neurofeedback to their list of **reimbursable** treatments for mental health.
- Disseminate results at the **CASRA conference** and Innovation platforms.
- **Publish** research innovation **results** in a peer reviewed journal.

Outstanding Community Collaborators and Project Mentors

- **Cynthia Kerson, PhD, QEEGD, BCN, BCB**
  - Founder and director of education for APEd (Applied Psychophysiology Education); BCIA certified in biofeedback and neurofeedback; certification as a diplomate in QEEG; QEEG and neurofeedback mentor; serves as a Board of Directors for the Behavioral Medicine Foundation and AAPB; vice president of FNNR (Foundation for Neurofeedback and Neuromodulation Research); served as president of the AAPB Neurofeedback Section; is two times past president of the Biofeedback Society of California; is an adjunct professor for Saybrook University; and assistant director in psychophysiology specialization at Saybrook University.

- **John C. LeMay, MA, QEEGT, BCN, BCB**
  - Marriage and Family Therapist in Reno, NV and Pismo Beach, CA. He received his degree in Marriage and Family Therapy in 1993 from Azusa Pacific University and started applying biofeedback to interpersonal settings just after graduating. He was licensed in California as an MFT in 1997, licensed in Nevada in 1998, and has been in private practice in Reno, NV since 1997. In 2003 John and his colleague and friend George H. Green, PhD developed a BCI robotic device as proof of concept for weighted autonomy and computerized neural networking. He is past president of The Biofeedback Society of California and specializes in the treatment of anxiety disorders.

Outstanding Collaborators and Partners

- Dawn Bumpus, FSP Program Mentor, TMHA
- Arthur Thompson, TARP Program Mentor, TMHA
- Dr. Chris Howard, QEEG Diplomat, Owner of Coastal Sage Neuroscience
- Scheherazade Collins, MA, MPil, LMFT, West LA Psychotherapy and Neurofeedback
- Greg Vickery, LMFT, Division Manager, Quality Support Team, SLO County Health Agency, Behavioral Health Department
- Nestor Veloz-Passalacqua, M.P.P., Adminstrative Services Officer II, SLO County Health Agency, Behavioral Health Department
- BriAnna Webb-Almanza, FSP Assistant Manager, TMHA
- Meghan Boaz-Alvarez, LMFT, Clinical Director, TMHA
- Doris Bell, LMFT, FSP Program Manager
- Bill Mrklas, LMT, Partner at Brain Master Technologies Inc.

Contact Information

Alicia Dueck, MSW, ASW
FSP Neurofeedback Innovation
Project Lead and FSP Clinician
adueck@t-mha.org
805-366-3346

INNOVATION

FY 2018-19

Potential to add up to $300K

FY 2019-20

Potential to add up to $200K

INNOVATION

STAKEHOLDERS

1. **You will receive an e-mail from me Wednesday, Jan. 24th by noon with:**
   1. A link to prioritize projects, all projects descriptions will be listed in the link.
   2. The e-mail will also have this PowerPoint presentation so you can take the time to read any information you feel is pertinent to your prioritization.

You will have until Sunday, January 28th at midnight to prioritize the projects (extension can be provided)

INNOVATION

INNOVATORS

1. You must submit a final draft of your proposal Monday, January 29th.
2. You will be notified of the ranking on Monday, January 29th by the end of the business day.
3. Once prioritization is released, we will again begin working with each project and the OAC team to finalize any narrative detail of your proposal.

THANK YOU