San Francisco Mental Health Services Act

INNOVATIONS PROJECT PLAN:

Intensive Case Management/Full-Service Partnership to Outpatient Transition Support

FY 2018/19 to FY 2022/23

INN community planning meeting on ICM/FSP-OP transition workflow - June 16, 2017

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

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Local Review

The FY 18-19 MHSA Three-Year Plan for the City and County of San Francisco Community Planning Process (CPP) involved various opportunities for community members and stakeholders to share input in the development of our Integrated Planning effort, which included the Intensive Case Management/Full-Service Partnership (ICM/FSP) to Outpatient (OP) Transition Support Innovation Project. Please see the CPP meetings section below for details.

In fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848, a 30-day public review and comment of San Francisco's MHSA Three-Year Integrated Plan was posted on the SF MHSA website at www.sfdph.org/dph and www.sfmhsa.org. Our 2017-2020 Program and Expenditure Integrated Plan was posted for a period of 30 days from 7/17/17 to 8/16/17. Members of the public were requested to submit their comments either by email or by regular mail. The comments included feedback or questions on current programs, as well as one financial question. None of the comments were specifically focused upon the ICM/FSP to OP Transition Support Innovation Project.

Following the 30-day public comment and review period, a public hearing was conducted by the Mental Health Board of San Francisco and on 9/20/17. The 3-Year Plan was also presented before the Board of Supervisors' Budget and Finance Committee on September 28, 2017 and recommended to be adopted. The San Francisco Board of Supervisors adopted the report on October 17, 2017. San Francisco Mayor Ed Lee approved the report on October 27, 2017 *(See Appendix)*.

Community Planning Process Meetings

The San Francisco Department of Public Health has strengthened its' MHSA program planning for the 2017-2020 Integrative Plan by collaborating with mental and behavioral health consumers, their families, peers, and service providers to identify the most pressing mental and behavioral health-related needs of the community and develop strategies to meet these needs. In early 2017, SF MHSA hosted eleven (11) community engagement meetings inviting participants from the City's eleven Supervisorial Districts to collect community member feedback on existing MHSA programming and better understand the needs of the community. Attendees included mental health and other service providers, consumers of mental health services and their families, representatives from local public agencies, community and faith-based organizations, residents of San Francisco, and other community stakeholders. Five of the meetings were open to the public and six of the meetings were closed meetings at the request of specific community groups. All meetings were advertised on the SF DPH website and via word-of-mouth and email notifications to service providers in the SF BHS, MHSA, and San Francisco Health Network distribution networks. Printed and electronic materials were translated into Spanish, Mandarin, and other languages, and interpretation was provided at all public community meetings, as needed.

CPP Meetings	
Date	**CPP Location**
January 5, 2017	Samoan Community Development Center 2055 Sunnydale Ave San Francisco, CA 94134
January 19, 2017	Mo' Magic Meeting/African Arts Culture Complex 762 Fulton St San Francisco, CA 94102
February 10, 2017	Chinatown Child Development Center 720 Sacramento St San Francisco, CA 94108
February 13, 2017	Filipino Mental Health Initiative/Bayanihan Center 1010 Mission St San Francisco, CA 94103
February 15, 2017	MHSA Advisory Committee/Behavioral Health Services 1380 Howard St San Francisco, CA 94103
February 21, 2017	Client Council/Behavioral Health Services 1380 Howard St San Francisco, CA 94103
March 1, 2017	Chinatown community members at Cameron House 920 Sacramento St San Francisco, CA 94108
March 7, 2017	LEGACY Peer/Community Advisory 1305 Evans Ave San Francisco, CA 94124
March 15, 2017	MHSA Providers Meeting 1453 Mission St San Francisco, CA 94103
March 24, 2017	Latino and Mayan Community Meeting/ Instituto Familiar de la Raza 2919 Mission St San Francisco, CA 94110
April 12, 2017	The Village 1099 Sunnydale Ave San Francisco, CA 94134

ICM/FSP-OP Transition Support Community Planning Meetings

In addition to the CPP meetings, leadership from the Adult and Older Adult System of Care, Quality Management, and Mental Health Services Act staff, supported by facilitators from Learning for Action (LFA), a consulting group, organized a series of six meetings that consisted of ICM/FSP and outpatient program directors and clinicians, consumer/peer advocacy staff, and individual consumers with lived experience in mental health services. The forums were designed specifically to address client and program needs when a client is transitioning from an ICM/FSP to an appointment based outpatient clinic. Please see the Community Program Planning section of the Plan below.

ICM/FSP-OP Transition Support Community Planning Meetings	
Date	**Community Planning Meeting Location**
April 7, 2017	Bank of America Building 1 South Van Ness Ave San Francisco, CA 94103
April 21, 2017	Department of Public Health 25 Van Ness Ave San Francisco, CA 94102
May 5, 2017	San Francisco Main Public Library 100 Larkin St San Francisco, CA 94102
May 19, 2017	Bank of America Building 1 South Van Ness Ave San Francisco, CA 94103
June 2, 2017	San Francisco Main Public Library 100 Larkin St San Francisco, CA 94102
June 16, 2017	San Francisco Main Public Library 100 Larkin St San Francisco, CA 94102

Project Overview

Primary Problem

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community.

The ICM/FSP-OP Transition Support project will focus upon transitions and the flow of clients from Intensive Case Management (ICM) programs, including Full Service Partnership (FSP) programs, to Outpatient (OP) services within Behavioral Health Services (BHS) in the City and County of San Francisco.

ICM services

Behavioral health ICM services are provided to clients with the most acute, severe and chronic behavioral health challenges resulting in the most serious and persistent functional impairments – including co-morbid health conditions such as substance use disorder, and serious and chronic diseases; repeated use of emergency services, acute and institutional care; homelessness; incarceration; and grave disability, and severe risk to themselves or others. These services offer a lifeline to some of the most vulnerable behavioral health system consumers with the goal of empowering individuals to remain safe in the community, preventing acute crisis or avoiding institutional care, and promoting wellness and recovery.

ICM programs are a particular type of intensive mental health outpatient services with low caseloads, multi-disciplinary team approach, and a comparatively richer array of wraparound services (such as relatively greater access to supportive housing, vocational rehabilitation and other health and human services), in order to be able to do whatever it takes to assist clients who are the most severely impacted by serious mental illness achieve wellness and recovery.

FSP services

Full Service Partnership (FSP) programs are a subset of ICM programs and reflect an intensive and comprehensive model of case management based on a client- and family-centered philosophy of doing "whatever it takes" to assist individuals diagnosed with Severe Mental Illness or Severe Emotional Disturbance to lead independent, meaningful, and productive lives. Services include integrated, recovery-oriented mental health treatment; intensive case management and linkage to essential services; housing and vocational support; and self-help.

Primary Problem

When clients no longer need the intensive level of care and service provided by ICM and FSP programs and they are discharged, many individuals do not link successfully to medically necessary regular Outpatient (OP) services.

The electronic health record system (EHR) discharge data from calendar years 2014-2015, 2015-2016, and 2016-2017 show that only 16% of clients discharged from an ICM or FSP have subsequent episodes opened in outpatient programs within four months, and fewer than 10% of those discharges result in

sustained care (a year or over) in the outpatient setting. Furthermore, 38% of discharged clients have no new episodes at all, suggesting that they are most likely disengaged from mental health care.

Unfortunately, several factors at various levels can impede a successful transition, defined as linkage and engagement, to outpatient care. Some examples are below:

- System- Large gap in service and support between ICM/FSP and Outpatient.
- Workflow- No agreed upon set of criteria or conditions agreed upon to assess client readiness.
- Administrative- No single checklist form in use for BHS.
- Clinician- ICM/FSP Case Managers worry about clients relapsing.
- Clients- Clients may feel attached to their ICM/FSP Case Manager.

With better resources in place, fewer clients will be lost from our care, and more will transition safely to outpatient care to continue their in recovery, living more self-directed lives that support their wellness and connection to a community that has meaning for them.

Why is it important to solve for your community.

All ICM/FSP programs must subscribe to the wellness-recovery and evidence-based principles as outlined for FSP programs funded under the Mental Health Services Act (MHSA). The "system transformation" envisioned by the MHSA is founded on the belief that all individuals - including those living with the challenges caused by mental illness – are capable of living satisfying, hopeful, and contributing lives.

In a Wellness and Recovery-oriented system, a grounding principle is that recovery is a "possible and expected outcome of treatment, and that the full range of comprehensive services and supports that an individual needs to meet his or her recovery goals be accessible, flexible, individualized, and coordinated." (Felton et al, 2010, p. 441) A belief in a client's ability to recover from mental illness is central to a Wellness and Recovery service philosophy and in order for a client to be successful in that recovery, they need to receive client-centered, coordinated support from both the program they are leaving and the program they are transitioning to in order to enable them to be successful.

In the past, both providers and clients assumed clients could receive ICM/FSP services indefinitely. In recent years, however, a 3-4 month-long waitlist has formed for ICM/FSP services so it is even more incumbent on the system to learn how to best support clients who are ready to successfully transition to a lower level of care to OP services.

The issue of transitions in various settings is a challenge across the system. Findings from this project can have implications for other areas where clients move from services in one part of the system to the next.

Development and Prioritization of the INN project

Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

The idea for this project emerged from Behavioral Health ICM/FSP program director meetings as an issue needing attention. This group expressed not knowing where clients were ending up after leaving their services. There was a realization that clients did not seem to be getting to or staying in OP services.

In recent years, a few system of care initiatives focused upon checklists, protocols, and measurements for transitions. The intake process varies widely across outpatient programs, causing confusion and miscommunication between ICM and OP providers. The lack of involvement of all levels of staff was identified as a barrier to organizational change.

However over time, investment, commitment, and passion for the issue of transitions has grown among leadership in the adult system. Recently, the Director of the Adult and Older Adult system engaged in a project examining transitions between Psychiatric Emergency Services at the Zuckerberg San Francisco General Hospital and Trauma Center and Behavioral Health Services.

Among the clinical staff as well, there is readiness for this project. Due to the impact of MHSA principles upon the system of care, there has been a cultural shift in the clinics, where the language of recovery and wellness is increasingly being used, and an openness to the idea that recovery is possible for clients is more commonly expressed.

Addressing the Primary Problem

Review of Existing Practices and Evidence-Based Models

Describe the methods you have used to identify and review relevant published literature regarding existing practices or approaches. What have you found? Are there existing evidence-based models relevant to the problem you wish to address? If so, what limitations to those models apply to your circumstances?

An extensive literature review of categories including patient navigation, peer programs, and transitions reveals the closest parallels between the ICM/FSP- OP transition and the transition of youth in the foster care system from youth services into the adult mental health system. These transitions have the following in common:

- Steep drop off in service delivery
- Loss of existing care team and need to transition to a new care team, posing a challenge to engagement
- Physical transitions: Clients seeking services may have to completely uproot from the geographic location of their clinics to obtain services.
- Possible loss of housing, case management, access to long existing relationships within clinics, frequency of available support meetings, and access to any and all social services provided through the originating clinic

The main limitation in exploring foster care youth transitions as a comparable model of service delivery is that the ICM/FSP- OP transition focuses on an adult population, while foster care transition models involve a population undergoing a significant life change in which complex legal issues are at play.

Review of Best Practices

Describe the methods you have used to identify and review existing, related practices in other counties, states or countries. What have you found? If there are existing practices addressing similar problems, have they been evaluated? What limitations to those examples apply to your circumstances?

In reviewing literature focusing on practices specifically related to patient navigation, peer programs, and transitions, it was difficult to find a match that closely mirrored the ICM/FSP- OP transition. Some areas of interest include:

1. Patient Transitions - While there are a large number of studies focusing on patient transitions, the vast majority are written about care linkages in the field of medical care.

2. Patient Navigation for those with mental health issues- Some studies can be found addressing patient navigation in the mental health system, though they are related specifically to exiting institutions such as jail and inpatient facilities.

3. Utilizing peers within the mental health system - While there is a large body of work examining the efficacy of peers in mental health systems, specific information focused on step down of services was not found.

Unfortunately, these examples do not adequately capture the steep drop off in services between ICM/FSP and OP programs, and the mechanisms necessary to successfully link clients to services. The proposed project would address a hybrid of the three categories listed above: patient transitions, patient navigation for those with mental health issues, and utilizing peers within the mental health system.

The Proposed Project

Provide a brief narrative overview description of the proposed project.

The ICM/FSP-OP Transition Support project involves an autonomous peer linkage team providing both wraparound services and a warm hand off. The team will consist of five culturally and linguistically diverse peers and one clinician. Peers will serve as step-down specialists and help connect clients with resources and information, help set expectations, provide follow up, and communicate with providers. The team will outreach to transitional clients in order to support them to have successful linkages to OP services. They will be available to guide the client through all the various steps from preparation to successful placement and/or discharge.

With this Innovation project, some of the major goals are to increase client engagement in OP services among those stepping down from ICM/FSP services, improve the overall client experience for those in transition, and support and further develop a peer-driven model of care.

The model envisioned by stakeholders includes the following elements:

a. Peers to be situated in a cohort with each one being able to respond to any client referred to the peer team
b. As part of training and orientation, the peers do a “rotation” at each ICM/FSP program to gain familiarity with the programs and their staff, and vice versa
c. At their OP site, peers to participate in multidisciplinary group supervision, individual supervision, client case conferences, staff meetings, and clinical training (e.g., Motivational Interviewing, Cognitive Behavioral Therapy, Trauma-Informed Systems, as needed)
d. Clinical supervision to be provided by a licensed therapist or social worker at an agency supporting the peer cohort

e. Regular peer cohort meetings/trainings with all peer transition team members, i.e. weekly
f. As an ICM/FSP client nears readiness for a referral to OP, the peer is invited to the ICM/FSP by the ICM/FSP case manager to meet the client
g. Peer transition team member then conducts outreach with the client to facilitate connections, introduce client to community supports, conduct an orientation to the OP site, and together with the ICM/FSP case manager, connect the client to the new provider
h. Accommodation for the peer member if/when they feel challenged emotionally, re-traumatized, and/or destabilized at work

Identify which of the three approaches specified in CCR, Title 9, Sect. 3910(a) the project will implement (introduces a practice or approach that is new to the overall mental health system; makes a change to an existing practice in the field of mental health; or applies to the mental health system a promising community-driven practice approach that has been successful in non-mental health contexts or settings).

This innovation project will be a change to an existing practice. While linkage, peer services, navigation, and similar services exist within the system, having a cohesive peer transition team that works interdependently with a clinic is a new approach. In this new vision, transitions between the ICM/FSP and OP will be tailored to the needs of the client. Instead of a brief handoff period, we envision a bridge to the new service. In that frame, rather than having the transition be a loss for the client, the client is instead gaining a team of peer professionals that have flexibility in addressing the needs of the client.

Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply to mental health a practice from outside of mental health, briefly describe how the practice has been applied previously.

Peer Navigation is a well-documented, successful practice in both behavioral and physical health settings; however, its efficacy has not been demonstrated in transitions from intensive, wraparound mental health settings to outpatient settings. Data-driven research conducted within the San Francisco Behavioral Health Services system has shown there is a demonstrated need for assistance given the very low rate of engagement in outpatient services after clients have stepped down from the ICM/FSP level. SF BHS has peers working within clinics but there are no peers dedicated to this particular function. Through the Community Planning Process for this project, clients, front line staff, clinic directors, and peer staff recommended peer linkage as a critical piece that could be added to more smoothly facilitate this step down transition process.

Innovation Component

Describe the key elements or approach(es) that will be new, changed, or adapted in your project (potentially including project development, implementation or evaluation). What are you doing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

a) If you are adapting an existing mental health model or approach, describe how your approach adds to or modifies specific aspects of that existing approach and why you believe these to be important aspects to examine.

The ICM/FSP-OP Transition Support project will be adapting an existing mental health approach. While peers are being used all through public health systems for navigation, the specific design of an autonomous peer team that works interdependently with a clinic is a new design. In current models, one or two peers might be used as an extension of a particular clinic, and their roles and functions are designed around the needs of the clinic. In the proposed design, a peer team will be dispatched to work with the focus being the individualized needs of clients. Essentially, the client will be the spoke in a wheel of services designed to assist the client to move smoothly to the next stage of their transition. In this model, the peers will assist in the step down process by linking the client in transition to any and all necessary wraparound services without the constraints of determining what are Medi-Cal billable services. The wheel of support will also be flexible enough to move back and forward seamlessly if there are any client setbacks.

Learning Goals / Project Aims

This project will center on the development of a highly skilled peer transition team to help support behavioral health clients advancing in their recovery from an intensive wraparound case management program to an appointment-based outpatient clinic.

Intensive Case Management (ICM) programs modeled on the Assertiveness Community Treatment (ACT) and Full Service Partnership (FSP) models offer extensive services that are not usually available to support clients in the outpatient setting. As ICM/FSP clients grow in their recovery and no longer need the intensive services, outpatient settings can provide medication management and therapy needed on an ongoing basis.

Peer counselors can offer support to clients in many important ways. Peers model positive recovery through their work and sharing their personal struggles and successes, inspiring hope in clients that they can also recover.

As transition support, peers can offer a continuity of care and relationship during a transition of therapeutic care. Peers can accompany clients to the new site, as well as connect clients to critical community supports that interest them, such as a wellness center, community arts program, vocational training, spiritual center or church, sports or fitness groups, etc. Peers can offer a unique and personal kind of support that is qualitatively different from what a trained professional without lived experience can provide.

Logic Model for Peer Transition Support Team

Identified Concern:	**Contributing Risk Factors:**	**Strengths/Resources:**
Many individuals with serious mental illness experience significant advances in recovery while enrolled in an ICM/FSP wraparound program. Many of these clients could be served effectively in appointment based outpatient care (OP) with proper support. Unfortunately only about **8% of clients leaving ICM/FSP connect to OP care and receive ongoing support.**	• **Very large gap in services** and supports between wraparound ICM/FSP care (24/7 access, intensive outreach and case management, social milieu, groups, food, payee services, vocational programs, etc.) and appointment based therapy in the OP clinics. • Varied and **unclear processes for referral, intake and linkage** at OP sites. • **Provider and client apprehension.**	MHSA Innovations funding, dedicated and highly skilled professional and peer professional staff at BHS, MHSA Principles and practices, strong commitment to peer model of support for clients, community defined practices, consumer resiliency and desire to live a more fulfilling life.

Goals	**Potential Strategies**	**Expected Outcomes**			**Suggested Measurements**
		Short Term	**Intermediate**	**Long Term**	
1) Support clients to live lives increasingly independent of MH services, as appropriate 2) Serve clients at the lowest intensity of services that facilitates recovery 3) Provide seamless continuum of care to clients 4) Facilitate client connections to outpatient services when appropriate 5) Practice MHSA principles of peer-driven model of care	◊ **Hire and train a cohort of experienced peer specialists** to do outreach, mentoring, support and linkage of ICM/FSP clients to OP ◊ **Embed peer transition specialists in the OP clinics**, with in-service rotations and regular, ongoing contact with the ICM/FSP teams ◊ **Link ICM/FSP clients to peer team** members as they transition to OP care ◊ **Peers** to work closely with ICM/FSP clients to **connect to OP, community supports and meaningful activities** ◊ Support the Peer Transition Team with **clinical supervision** and **team bonding**	◊ More peer staff will be in outpatient settings ◊ ICM/FSP clients well be connected to peer transition team members for transition support ◊ Referrals from ICM/FSPs to OP will increase ◊ ICM/FSP clients arriving at the OP clinics will feel more welcome ◊ Clients coming from ICM/FSPs will engage in more OP services	◊ Transitioning clients will participate in more meaningful activities *(e.g. vocational training, employment, education program, social connection, family reunification)* ◊ Client will increase their self-management of life skills ◊ Client will increase their time in stable housing ◊ Client will increase their engagement in peer group activities ◊ Providers will report more confidence in the transition process	◊ More ICM/FSP clients will connect successfully to OP care ◊ Clients eligible for ICM/FSP will wait less time to enroll in an ICM/FSP program ◊ Peer Employees will be more valued and better utilized across the SOC ◊ MH service delivery will better align with client needs.	◊ # of client referrals from ICM/FSP to OP (EHR*, MDC**) ◊ % of referrals to OP that result in a new episode (admin/EHR) ◊ # days ICM/OP episodes overlap (EHR) ◊ # client services at OP w/in 90 days of ICM/FSP episode closing date (EHR) ◊ Client self-report on satisfaction of the transition process (TBD) ◊ Peer Transitions Support self-report of effectiveness of the peer team (TBD) ◊ ICM/FSP and OP provider assessment of Peer Transition Team value and effectiveness (TBD) **EHR=Electronic Health Record system* ***MDC= Manual Data Collection*

Learning Goals / Project Aims (Continued)

Learning Goals:

An expectation of a peer transition team is that clients paired with peers will transition from the ICM/FSPs to less intensive services more successfully than those clients who so not have access to a peer. That is, they will engage with the new provider and participate in OP services for at least 6 months.

Key Learning Questions:

1) How effective is a highly skilled peer transition team in helping clients from intensive wraparound services (e.g. ICM, FSP or ACT) engage in appointment based outpatient (OP) care?

   We hypothesize that a well-trained cohort of peer professionals will allow clients who are advancing in their recovery to transition from intensive case management services to periodic appointment based outpatient care with minimal relapse or interruption of services. Experienced health workers with lived experience can model self-care and self-management behaviors that support recovery. Clients can relate to peers sometimes more readily than to clinical providers, and trust their guidance and support more easily.

2) What program elements need to be in place for a peer transition support team to be successful?

   The plan calls for the peer transition team to have licensed clinical supervisor (such as an LMFT or other), preferably with lived experience. Also essential to the cohort's success will be leadership support from BHS, as well as from the ICM/FSP and OP directors. The peer cohort will also need to feel welcomed, respected and integrated into the OP teams in order to better facilitate new clients' engagement in those settings. Finally, the peer cohort should be provided with the appropriate support and accommodations should the pressure of the role, i.e. exposure to client trauma, threaten to destabilize their own recovery.

3) What factors create a resilient relationship between the client and peer transition team member (e.g., availability, modes of contact/communication, boundary setting)?

   It will be important to identify the specific ways in which clients are most helped by the peer transition team. Do clients respond best to outreach in the clinic, at their homes, or elsewhere in the community? Do clients prefer regular or periodic contact? To what extent does a peer's lived experience help a client find their way to more self-sustaining, independent living? What activities are most supportive in the transition period: sharing stories of recovery, providing transportation to an appointment (mental health or other), or doing activities together?

4) Which practices best support the peer transition team member's wellbeing and professional development?

We hypothesize that the peer cohort will benefit from camaraderie and support of a peer group, as well as from guidance and direction from a clinical supervisor. This can occur individually or in a group setting. At times, client experiences may challenge peers in their own mental wellness and at worse, trigger old memories or behaviors, risking a relapse of their own. It is important that the peer cohort be supported in their wellness and be provided accommodation as needed.

5) What programmatic elements facilitate collaboration and communication between providers at the ICM/FSP and OP programs during a referral and linkage process?

Currently, BHS is in a process to improve communication between providers of the ICM/FSP and OP programs and procedures regarding referrals and linkage to an OP site. A multisite, multidisciplinary workgroup, led by the adult system of care director and supported by Quality Management, is about to launch a structured improvement process (a series of "A3's") to address several aspects of referral and linkage from ICMs/FSPs to OP. From December 2017 through May 2018, improvement testing will focus on:

1) Creating a culture of transition and clarifying client "readiness" for referral to OP,
2) Standardizing protocols for intake at the OP sites, and
3) Clarifying service transition, provision and program flexibility.

Many of the improvements identified and tested are expected to be operational in spring of 2018, laying a foundation for the installation of the peer transition support team. Some processes will be continuously examined and revised as the peer team is established and more learning comes to light.

Evaluation/Learning Plan

The primary goal will be to increase successful linkages of clients from ICMs/FSPs to outpatient care. The San Francisco Health Network has taken up this challenge among its set of mission metrics called "True North" metrics and define the measure as **the percentage of clients who had a subsequent episode in an outpatient clinic where they received 8 or more services within 90 days of the ICMs/FSPs discharge date.**

Recent data from the SF BHS clinical and billing database (EHR) indicate the following discharge rates for the last two fiscal years:

Clients discharged from ICM who engage successfully in Outpatient Settings
(excludes those who died and those who moved out of the area)

	# of clients discharged from ICM with 8 or more OP services within 90 days of ICM discharge	# of clients discharged from ICM and eligible for services	Rate of **Successful Engagement** in Outpatient Setting
FY 2015-16	42	230	**18.3%**
FY 2016-17	43	227	**18.9%**

In order to understand the potential impact of the peer transition team on this outcome metric, we will continue to track ICMs discharge data and subsequent client services in outpatient care, as well as gather data to address the learning questions proposed above. The evaluation plan will address each of these learning questions with qualitative, survey and clinical data.

Learning Question	**Sources of Data**	**Data Collection Strategy**
1) How effective is a highly skilled peer transition team in helping clients from intensive wraparound services (e.g. ICM, FSP or ACT) engage in appointment based outpatient (OP) care?	Peer Staff Clients ICM/FSP and OP Staff	Interviews with Peer Staff Client feedback forms, focus group and/or interviews Surveys of ICM/FSP and OP staff
2) What program elements need to be in place for a peer transition support team to be successful?	Peer Staff Clients	Interviews with Peer Staff Client feedback forms, focus group and/or interviews
3) What factors create a resilient relationship between the client and peer transition team member (e.g., availability, modes of contact/communication, boundary setting)?	Peer Staff Clients	Interviews with Peer Staff Client feedback forms, focus group and/or interviews
4) Which practices best support the peer transition team member's wellbeing and professional development?	Peer Staff	Interviews with Peer Staff
5) What programmatic elements facilitate collaboration and communication between providers at the ICM/FSP and OP programs during a referral and linkage process?	ICM/FSP and OP Staff	Surveys of ICM/FSP and OP staff Interviews with ICM/FSP and OP directors

In addition, process measures will be gathered to track the progress of the implantation of the Peer Transition Team and the effort to link clients. For example,

- Number of peer transition staff hired, trained and their lengths of work stay (administrative)
- Number of days ICM/FSP and OP episodes overlap (EHR)

Finally, it will be useful to know how many referrals from ICMs/FSPs are initiated for new outpatient episodes. However, San Francisco does not currently track systematically in the EHR client referrals to new services. The benefit of this additional data (date referral initiated, referral destination, etc.) will provide sensitivity to detect efforts to link clients to OP that do not conclude in actual open episodes. Quality improvement efforts could focus on the challenges that arise in those scenarios.

It is proposed as part of this project we explore and test options to collect referral data manually from ICM/FSP clinicians as a PDSA (Plan Do Study Act) in the early stages of implementation and review its value. A high degree of usefulness of referral data could justify its incorporation into the EHR for ongoing performance tracking.

- Number of client referrals from ICM/FSP to OP (manual data collection)
- Percentage of ICM/FSP referrals to OP that result in a new outpatient episode (manual combined with the EHR)

Contracting

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

CalOMS and Counselor Certification Regulations Compliance

The contractor must comply with applicable client data collection and reporting requirements of the California Outcomes Measurement System (CalOMS) as required by the State of California Department of Health Care Services (DHCS). Additionally the contactor must comply with applicable counselor, staff training, or certification requirements as mandated by DHCS.

Achievement of contract performance objectives and productivity

The contractor must have a record of continuously monitoring progress towards contract performance objectives and must have established information dissemination and reporting mechanisms to support achievement. All staff (including direct service providers) should be informed about objectives and the required documentation related to the activities and service delivery outcomes.

In regards to management monitoring, the Program Director should report progress/status towards each contract objective in the monthly report to executive management. If the projected progress has not been achieved for the given month, the Program Director will identify barriers and develops a plan of action. The data reported in the monthly report is continually collected, with its methodology

depending on the type of information. In addition, the contractor should monitor service delivery progress (engagement, level of accomplishing service goals/objectives), and termination reasons.

Documentation quality, including a description of any internal audits

The contractor must have a proven record of accomplishment of utilizing various mechanisms to review documentation quality. Case/chart reviews will be conducted by Division management; based on these reviews, determinations/recommendations are provided relating to frequency and modality/type of services, and the match to client's progress and needs. Feedback will be provided to direct staff members while general feedback and summaries on documentation and quality of programming are integrated throughout staff meetings and other discussions.

Mid-year and Annual reports, focusing on program objectives and consumer demographics, will be submitted to MHSA and reviewed by the relevant MHSA Program Manager, and technical assistance and support will be provided when needed. Annual contract monitoring and site visits will be conducted by the Department of Public Health Behavioral Health Services Business Office. Training and support around contract deliverables and evaluation is provided at monthly MHSA Provider Meetings and MHSA Impact Meetings.

The MHSA Impact meetings provide a forum where technical assistance (TA) on program assessment and improvement activities is provided in a collaborative and interactive manner to MHSA-funded programs. These meetings provide an opportunity for providers and consumers to learn about program services and provide feedback to MHSA programs.

Additional Information for Regulatory Requirements

Community Program Planning

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

Include a brief description of the training the county provided to community planning participants regarding the specific purposes and MHSA requirements for INN Projects.

Leadership from the Adult and Older Adult System of Care, Quality Management, and Mental Health Services Act staff, supported by facilitators from Learning for Action (LFA), a consulting group, organized a series of six meetings that consisted of ICM/FSP and outpatient program directors and clinicians, consumer/peer advocacy staff, and individual consumers with lived experience in mental health services. The forums were designed specifically to address client and program needs when a client is transitioning from an ICM/FSP to an appointment based outpatient clinic.

The meetings first focused upon refining our understanding of the problem as informed by data from QM, and then brainstorming and discussing possible solutions and INN project models. A consumer panel shared their experiences of transitions from ICM/FSP to Outpatient programs and additional consumers participated in small group discussions of improvement ideas for specific aspects of the transition. Peer representation was also provided through peer advocacy CBO organizations' (MHA-SF and NAMI) participation in meetings and the MHSA Peer Program Manager's participation in the planning team and ICM/FSP forums.

Training about MHSA Innovations funding took place during the second meeting, and Innovations guidelines were revisited at subsequent meetings as relevant to the discussion. At the second meeting, MHSA Program Evaluator, Diane Prentiss, presented on Innovations funding purposes and MHSA requirements for INN projects guidelines.

At the end of the series of meetings, the following had been created:

- A summary of an INN Transition/Linkage Team with Augmented Services project idea
- A list of interested parties in giving feedback to the project plan writing team
- A list of interested parties in addressing non-INN project ideas to improve communication and protocols between systems

Further feedback was collected from:

- QM conducted further interviews of front line staff using an A3 structured problem solving and continuous improvement tool. These interviews confirmed feedback previously collected
- MHSA Advisory Board presentation, which led to an individual interview with a consumer with relevant experience to this project
- MHSA Director presented ICM Flow INN project idea to SF Health Commission

- MHSA staff presented ICM Flow INN project idea at monthly FSP data meeting and quarterly ICM/FSP Directors meeting

Peers participating in the process included individuals from the black/African American, Hispanic/Latino, and transgender communities. The most recent MHSA Advisory Board members' demographic profile in FY 14-15 showed representation of consumers, service providers, and family members from diverse communities, such as the Asian, black/African American, Hispanic/Latino, American Indian/Alaskan Native, multi-lingual and LGBT communities. The ICM/FSP and Outpatient Clinical Directors, and the planning team reflect the ethnic demographics of the community to some degree, with leadership from the Asian American and Hispanic/Latino communities.

Primary Purpose

Select *one* of the following as the primary purpose of your project. (I.e. the overarching purpose that most closely aligns with the need or challenge described in Item 1 (The Service Need).

a) Increase access to mental health services to underserved groups
b) Increase the quality of mental health services, including measurable outcomes
c) Promote interagency collaboration related to mental health services, supports, or outcomes
d) Increase access to mental health services

MHSA Innovative Project Category

Which MHSA Innovation definition best applies to your new INN Project (select one):

a) Introduces a new mental health practice or approach.
b) Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community. *Peer services, linkage, navigation.*
c) Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

Population

If your project includes direct services to mental health consumers, family members, or individuals at risk of serious mental illness/serious emotional disturbance, please estimate number of individuals expected to be served annually. How are you estimating this number?

Estimate of clients served. The ICM/FSP programs serve approximately 1500 Transitional Age Youth, adult and older adult clients per year, and they are expected to discharge 20% (n= 300) of their clients annually to allow clients with higher acuity to access the ICM/FSP. Clients are discharged for many reasons; some move out of the area, withdraw from the ICM/FSP or are lost to follow up without completing their treatment goals. The optimal outcome is for clients to complete treatment having met treatment goals and transition to less intensive services, such as appointment based outpatient clinic, for continued support as needed.

In an historical 3 year analysis, only 16% of discharged ICM/FSP clients had subsequent episodes opened at outpatient clinics, and half of those clients remained in the outpatient program for a year or more. The more recent analysis of engagement at outpatient, mentioned in the Evaluation Plan section above, showed that 18.3 and 18.9% (FY15-16 and FY16-17, respectively) of discharged clients eligible for outpatient successfully linked to outpatient services.

The proposed innovation project is focusing on **evidence of engagement** at the outpatient clinic (8 services within 90 days of the ICM/FSP episode closing date) rather than time spent (1 year) at the outpatient program.

Goal/Targets:
To increase the percentage of clients who access 8 or more services in outpatient within 90 days of discharge from an ICM

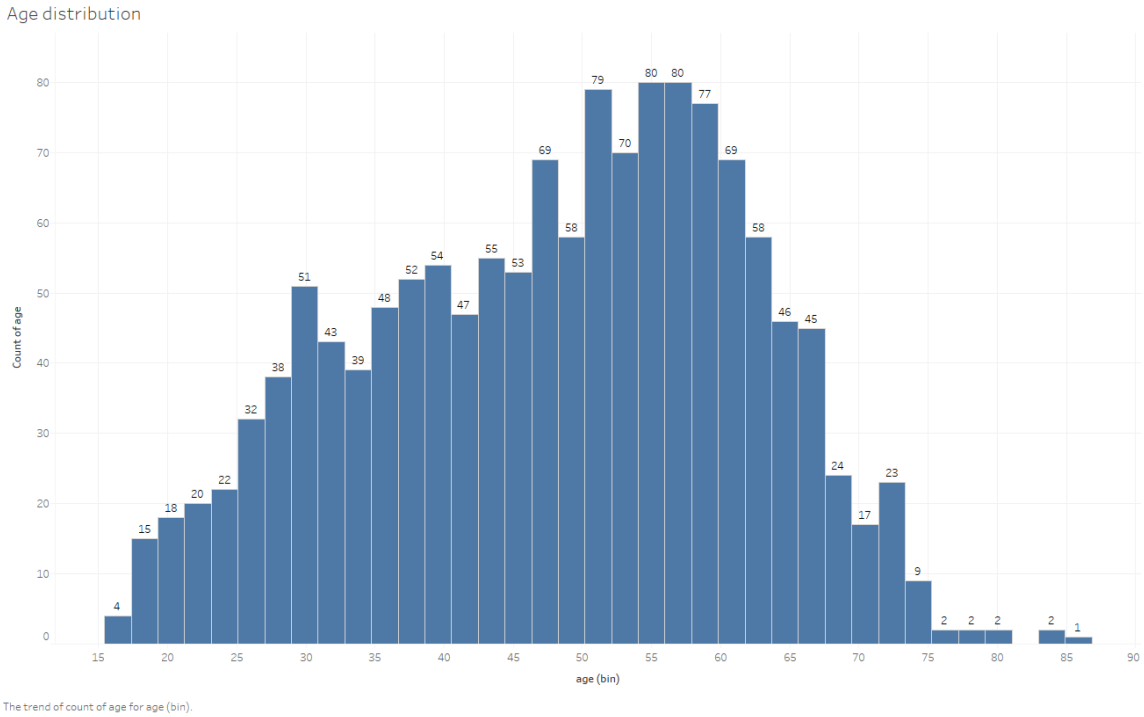
DATES	% of clients who engage successfully at outpatient
Year 1	19%
Year 2	22%
Year 3	25%

Describe the population to be served, including relevant demographic information such as age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate. In some circumstances, demographic information for individuals served is a reporting requirement for the Annual Innovative Project Report and Final Innovative Project Report.

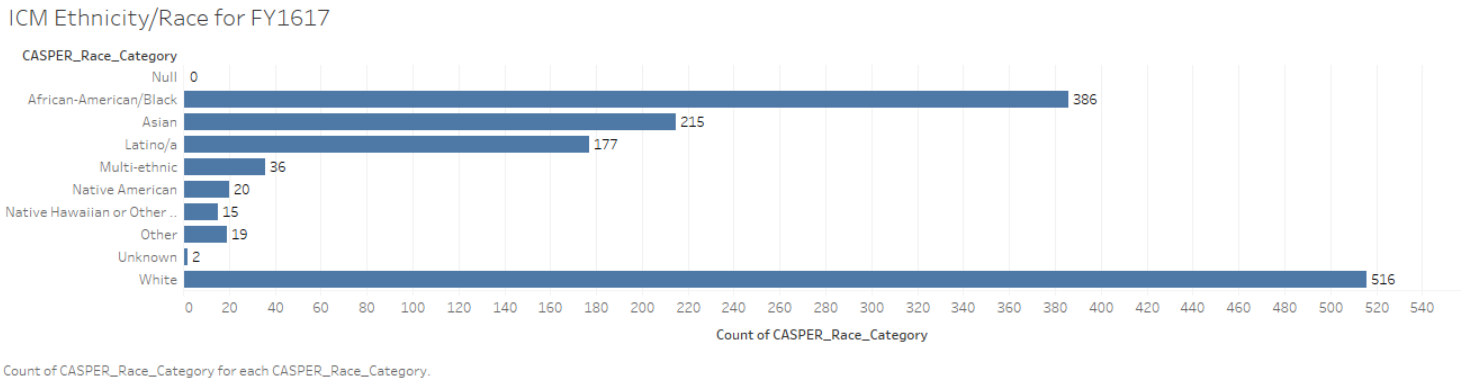
Population description. The project is designed to serve active ICM/FSP clients who are advancing in their recovery such that they no longer need or meet criteria for ICM/FSP services, and could effectively be treated at a less intensive level of care such as an outpatient program.

a. Demographic data of all ICM/FSP clients, active FY16-17.

AGE of Active ICM Clients, FY16-17



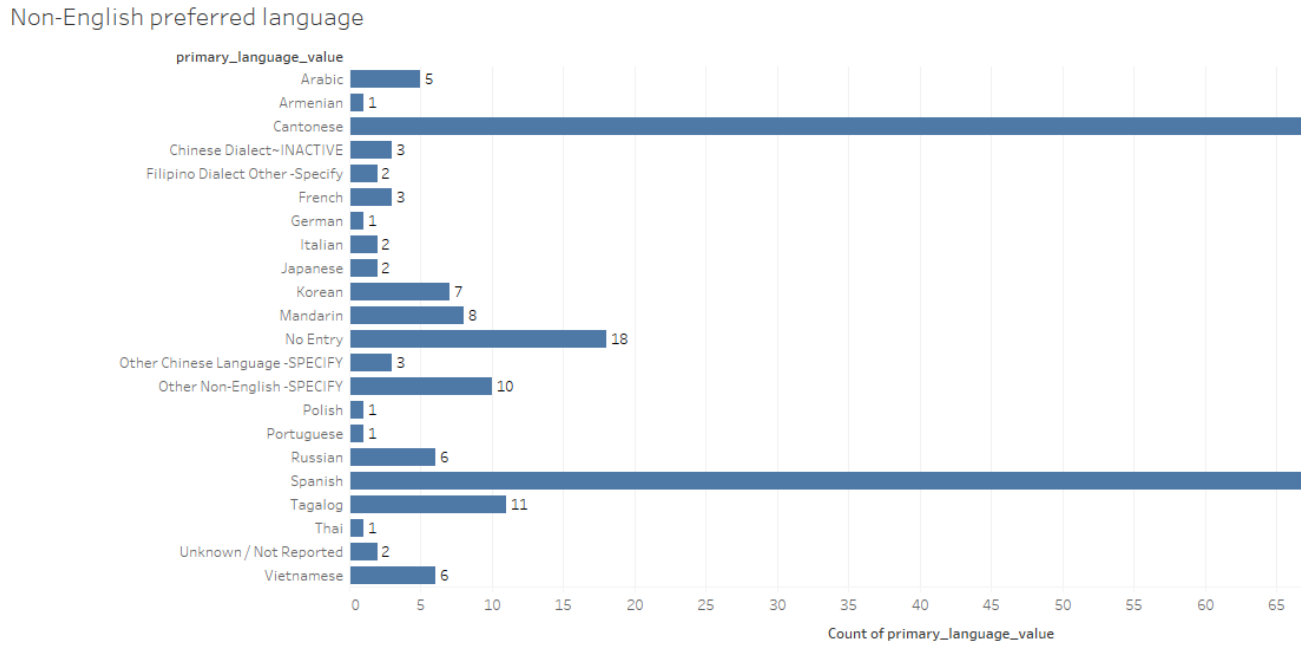
RACE/ETHNICITY of Active ICM Clients, FY16-17



Primary Language

English	83%
Other*	17%

*Other consists of the following:



Reasons for Discharge from ICM/FSP Episodes
(Clients discharged FY1617, n=299)

Unengaged:	**62**	21%
Cannot Locate	13	
Client Dissatisfied	3	
Client Withdrew: AWOL, AMA, No Improvement	23	
Client Withdrew: AWOL,AMA, Treatment Par	11	
No follow through	12	
Program Change/Administrative Reason	**92**	31%
Did Not Need Service	5	
Discharge/Administrative Reasons	29	
Ineligible for Services	1	
Program Transfer	19	
Referred to CBHS Clinic	1	
Referred to non CBHS Services	1	
Client moved out of service area	36	
Unknown/Other	**26**	9%
Other	21	
Unknown	5	
Progress Toward Goals	**61**	20%
Mutual Agreement/Goals Reached	35	
Mutual Agreement/Treatment Goals Partial	21	
Treatment Completed	5	
Client Died	34	
Client Discharged/Program Unilateral Dec	4	
Client Incarcerated	10	
Consumer Choice/Schedule	2	
Consumer Choice/Unspecified	6	
Mutual Agreement/Treatment Goals Not Rea	2	

When an ICM/FSP episode is closed, clinicians record a reason for discharge in the EHR. Some of the reasons are ambiguous and not applied consistently. That said, the data as such indicate very low percentages of clients discharging with “Treatment Goals Reached” (35/299) and “Treatment Completed” (5/299). Many more episode discharges suggest non-engagement, such as “Cannot Locate” (13/299), “Client Dissatisfied” (3/299), “Client Withdrew: AWOL, AMA…” (34/299), and “No Follow Through” (12/299). These 62 clients represent 21% of discharges.

Population (Continued)

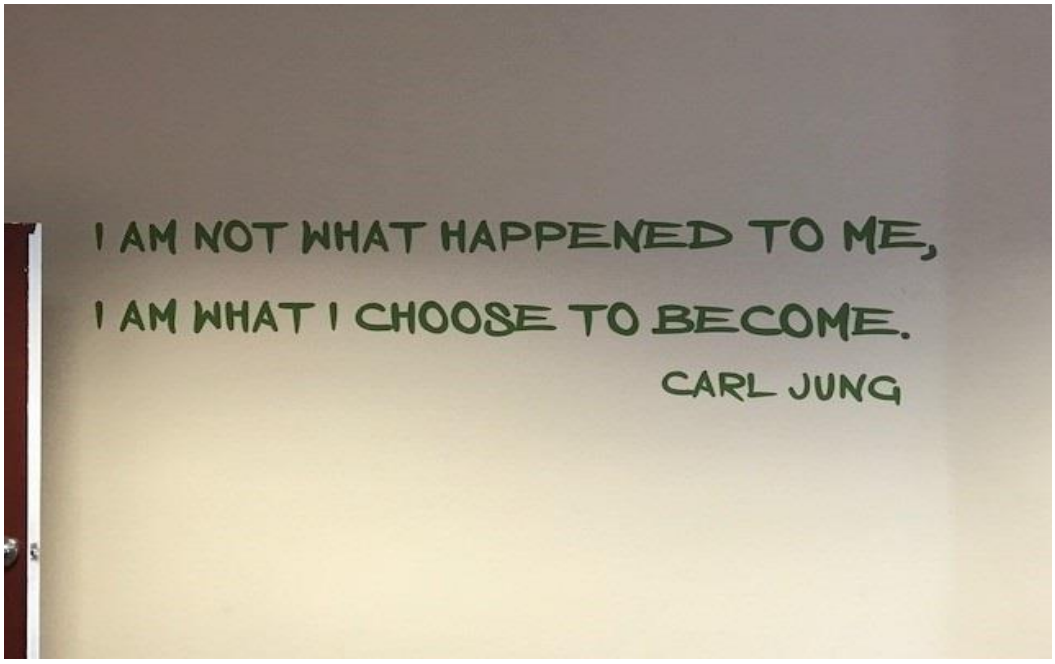
Does the project plan to serve a focal population, e.g., providing specialized services for a target group, or having eligibility criteria that must be met? If so, please explain.

The proposed project will focus on clients enrolled in intensive case management behavioral health programs who are experiencing increasing recovery such that they may soon manage well at a lower intensity of service delivery. Eligibility will include enrollment in an ICM and a degree of increasing recovery as arrived at by the client and the client's ICM case manager based on criteria that are currently in development.

Criteria for Transition

Criteria for "advancing recovery" will be identified by a stakeholder group working on client "readiness" to transition from ICM/FSP to Outpatient in a process taking place from November 2017 to June 2018. The workgroup will consider many of the following: client data in the EHR (e.g. Adult Needs and Strengths Adult/Older Adult outcomes), housing stability, medication self-management, appointment self-management, vocational training, meaningful connections/activities in the community, etc.). After PDSA improvement testing over several months, the workgroup will recommend best practices to be adopted by the system of care.

Connection with a peer transition support team to facilitate linkage and engagement in the outpatient setting, as described in this proposal, will a component of the aforementioned planning process.



MHSA General Standards

Using specific examples, briefly describe how your INN Project reflects and is consistent with all potentially applicable MHSA General Standards set forth in Title 9 California Code of Regulations, Section 3320.

a) Community Collaboration

The project will be a collaboration between peer navigators, BHS, and community-based organizations, who will collaborate to fulfill their common vision and goal of successful transitions between FSPs/ICMs and Outpatient services.

b) Cultural Competency

The Peer Navigators will receive cultural humility training and reflect the diversity of the community they are serving.

c) Client-Driven/ Family-Driven

This project places peers and family members who have lived experience and who have been through transitions between FSPs/ICMs and Outpatient settings at the center of programming. The peer navigators will be a cohesive and highly skilled team who will use their expertise to meet each client where they are at.

d) Wellness, Recovery, and Resilience-Focused

This project design will be consistent with the philosophy, principles, and practices of Wellness and Recovery for mental health consumers. It will promote concepts key to the recovery for mental illness and trauma, such as: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

e) Integrated Service Experience for Clients and Families

This project focuses on bringing a more seamless transition to clients moving from a high level of intensive services to a less structured and resources outpatient setting through the use of peer navigators, a greater level of coordination between providers and the provision of enhanced services in the later setting.

Continuity of Care for Individuals with Serious Mental Illness

Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals when the project ends.

Within the broader system of care, there is a network of peer providers that provide services for clients with severe mental illness. In addition, a segment of peer services exists within a wide variety of MHSA providers. These contractors are funded by MHSA to provide peer services for any BHS clients. The existing menu of services includes; support groups, individual and group counseling, wellness activities including outings, family to family classes, linkage, Dual Recovery Anonymous, Wellness Recovery Action Plan (WRAP) planning, cultural specific activities, services to those with hoarding and cluttering issues, and support for those interested in vocational activities.

One of the ongoing goals for the peer providers involved with this project will be to link clients into relevant peer services in the community. When the project ends, the clients involved in the project will have received an introduction to these services and be able to access them as part of their care plans.

INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement

a) Explain how you plan to ensure that the Project evaluation is culturally competent.

The evaluation of the ICM/FSP-OP Flow Innovation Plan will be conducted with sensitivity and awareness of our clients' diverse experiences related to age, disabilities, as well as cultural, language, ethnic, sexual and gender identities. We seek to generate relevant and useful evaluation results by consulting with key stakeholders who help us ensure that any data collection reflect the values and diverse experiences of our behavioral health community.

b) Explain how you plan to ensure meaningful stakeholder participation in the evaluation.

We have already established a large group of stakeholders that includes ICM/FSP and Outpatient providers, and peer advocates. As the Innovations program is established and the Peer Team identified and trained, the stakeholder group will expand to include members of the Peer Team as well as clients.

The stakeholder group will be consulted on Innovation project learning goals, data collection tools, methods and language for data collection, and how best to summarize and communicate findings to suit diverse audiences. San Francisco also has an active Mental Health Board that meets monthly and a Behavioral Health Services Client Council, where issues important to client representatives, including Innovations project findings, are presented and discussed. Both the Client Council and the Mental Health Board will be integral partners in designing the ICM/FSP-

OP Flow evaluation, interpreting and reporting the findings, and making recommendations for client-focused program improvement.

Deciding Whether and How to Continue the Project without INN Funds

Briefly describe how the County will decide whether and how to continue the INN Project, or elements of the Project, without INN Funds following project completion. For example, if the evaluation does (or does not) indicate that the service or approach is effective, what are the next steps?

Early partnership with the MHSA Quality Management team has resulted in a robust evaluation plan. The findings from evaluation objectives and outcomes will be reviewed by the MHSA team, BHS Executive Team, and the System of Care. Together, they will determine protocols and infrastructure that will be institutionalized to support and sustain cultural change, where they will be located and the appropriate streams of funding for the relevant service components.

Communication and Dissemination Plan

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties?

Project learnings and newly demonstrated successful practices will be shared within our county and to stakeholders. Successful elements of this project can be applied to other areas of the behavioral health system of care, especially given the project is focused on a population that is challenging to engage. Shared practices could change service delivery and the peer employment infrastructure, possibly expanding the focus areas of future peer programs to transitions in various settings.

Successful practices and lessons learned will be shared with the San Francisco Mental Health Board and San Francisco Board of Supervisors, as well as with the BHS Executive Team. Evaluation team members will present at the MHSA Advisory Committee and MHSA Provider Meetings, which include peer based organizations and community based agencies. Project successes and challenges will be presented on at the Client Council, a committee of consumers that perform an advisory role on BHS affairs. Finally, the findings could be presented at state MHSA meetings to provide insight to other counties working on similar projects.

a) **How will program participants or other stakeholders be involved in communication efforts?**

Feedback from project participants will be shared in communication efforts of the successes and lessons learned from this project. Peer navigators will be invited to co-present, along with other system of care staff, on progress, findings, and their experience of the project to stakeholders.

b) **KEYWORDS for search: Please list up to five keywords or phrases for this project that someone interested in your project might use to find it in a search.**

Linkage; Peers; Intensive care for mental health; Seamless transition; Warm hand off.

Timeline

a) **Specify the total timeframe (duration) of the INN Project: ____ Years ____ Months**

The duration of the project will be ***five years***, which will allow time to effectively recruit staff, engage participants, track data, and measure the outcomes of the transitions.

b) **Specify the expected start date and end date of your INN Project: ____ Start Date ____ End Date**
Note: Please allow processing time for approval following official submission of the INN Project Description.

April 2018 Start Date. ***March 2023*** End Date.

c) **Include a timeline that specifies key activities and milestones and a brief explanation of how the project's timeframe will allow sufficient time for**
   i. **Development and refinement of the new or changed approach;**
   ii. **Evaluation of the INN Project;**
   iii. **Decision-making, including meaningful involvement of stakeholders, about whether and how to continue the Project;**
   iv. **Communication of results and lessons learned.**

ICM/FSP- OP Flow Timeline	
Timeframe	**Activities**
April 2018-September 2018	Recruitment, onboarding, and training of peer staff. Presentations to referring agencies and clients.
October 2018	Identification and recruitment of potential participants
July 2019	First data collection point for MHSA; Annual review of referrals and linkages
January 2020	Midyear MHSA outcomes report

July 2020	Data collection point for MHSA; Annual review of referrals and linkages
March 2020	Presentation for MHSA stakeholders on progress of the project including the MHSA Advisory Committee, the MHSA Providers Meeting, the Client Council, the Mental Health Board, and the Adult System of Care.
January 2021	Midyear MHSA outcomes report
July 2021	Data collection point for MHSA; Annual review of referrals and linkages
January 2022	Midyear MHSA outcomes report
March 2022	Presentation for MHSA stakeholders on successes/challenges of the project including the MHSA Advisory Committee, the MHSA Providers Meeting, the Client Council, the Mental Health Board, and the Board of Supervisors. Review project learnings and stakeholder feedback with Adult System of Care leadership and the BHS Executive Team. Possible decision-making point for sustainability of the project or elements of the project.
July 2022	Data collection point for MHSA; Annual review of referrals and linkages
January 2022	Midyear MHSA outcomes report
March 2023	Project End date
July 2022	Data collection point for MHSA; Annual review of referrals and linkages
October 2023	Final Learning Report Due
November 2023	Presentation on final report to key stakeholders

Budget Narrative

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

The following is the budget narrative for the ICM/FSP-OP Transition Support Project:

- $473,009 for annual personnel direct costs and $55,000 for fringe, for 5 years $2,365,045 and 275,000, respectively. Personnel include:
    - 1.0 FTE for one Senior Peer Navigator,
    - 3.0 FTE for three Peer Navigators
    - 1.0 FTE for one bilingual Peer Navigator
    - 1.0 FTE for one Clinician
    - 0.5 FTE for one part-time Program Manager

- $70,000 for annual general operating, including supplies, transportation between sites, food for clients, and client incentives, for 5 years: Total $350,000.

- $97,951 for fiscal intermediary services, for 5 years: Total $489,755.

- $24,040 for annual staff training and development, including support services to prevent burnout among peer staff, for 5 years: Total $120,200.

- $30,000 for annual evaluation costs, for 5 years: Total $150,000.

Revenue

The total amount being requested for this project is ***$750,000 per year*** for a total of five years, hence, a ***total budget of $3,750,000***.

A. ICM/FSP-OP Transition Support Project Budget FY 18-19 to FY 22-23*							
PERSONNEL COSTs (salaries, wages, benefits)		**FY 18-19**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
1.	**Salaries**	**$473,009**	**$473,009**	**$473,009**	**$473,009**	**$473,009**	**$2,365,045**
2.	**Direct Costs**						
3.	**Indirect Costs**	**$55,000**	**$55,000**	**$55,000**	**$55,000**	**$55,000**	**$275,000**
4.	**Total Personnel Costs**	**$528,009**	**$528,009**	**$528,009**	**$528,009**	**$528,009**	**$2,640,045**
OPERATING COSTs		**FY 18-19**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
5.	**Direct Costs**	**$70,000**	**$70,000**	**$70,000**	**$70,000**	**$70,000**	**$350,000**
6.	**Indirect Costs**						
7.	**Total Operating Costs**	**$70,000**	**$70,000**	**$70,000**	**$70,000**	**$70,000**	**$350,000**

NON RECURRING COSTS (equipment, technology)		**FY 18-19**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
8.							
9.							
10.	**Total Non-recurring costs**						
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY 18-19**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
11.	**Direct Costs (HR Management*)**	**$97,951**	**$97,951**	**$97,951**	**$97,951**	**$97,951**	**$489,755**
12.	**Indirect Costs**						
13.	**Total Consultant Costs**	**$97,951**	**$97,951**	**$97,951**	**$97,951**	**$97,951**	**$489,755**

OTHER EXPENDITURES (please explain in budget narrative)	**FY 18-19**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
14. Training	**$24,040**	**$24,040**	**$24,040**	**$24,040**	**$24,040**	**$120,200**
15. Evaluation	**$30,000**	**$30,000**	**$30,000**	**$30,000**	**$30,000**	**$150,000**
16. Total Other expenditures	**$54,040**	**$54,040**	**$54,040**	**$54,040**	**$54,040**	**$270,200**

BUDGET TOTALS						
Personnel (line 1)	**$473,009**	**$473,009**	**$473,009**	**$473,009**	**$473,009**	**$2,365,045**
Direct Costs (add lines 2, 5 and 11 from above)	**$167,951**	**$167,951**	**$167,951**	**$167,951**	**$167,951**	**$839,755**
Indirect Costs (add lines 3, 6 and 12 from above)	**$55,000**	**$55,000**	**$55,000**	**$55,000**	**$55,000**	**$275,000**
Non-recurring costs (line 10)						
Other Expenditures (line 16)	**$54,040**	**$54,040**	**$54,040**	**$54,040**	**$54,040**	**$270,200**
TOTAL INNOVATION BUDGET	**$750,000**	**$750,000**	**$750,000**	**$750,000**	**$750,000**	**$3,750,000**

For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

* Agency to manage the contract.

Glossary

ACT- Assertive Community Treatment (ACT) is a team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness 24/7. ACT is based around the idea that people receive better care when their mental health care providers work together.

BHS- Behavioral Health Services is a division of the San Francisco Department of Public Health. Also known as the San Francisco Behavioral Health Plan, BHS offers a full range of specialty behavioral health services provided by a culturally diverse network of community behavioral health programs, clinics and private psychiatrists, psychologists, and therapists. Services are available to residents of San Francisco who receive Medi-Cal benefits, San Francisco Health Plan members, and to other San Francisco residents with limited resources.

EHR- An Electronic Health Record (EHR) is an electronic version of a patient's clinical history, that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to that persons care under a particular provider, including demographics, progress notes, and treatment goals.

FSP- Full Service Partnership programs are a subset of ICM programs and reflect an intensive and comprehensive model of case management based on a client- and family-centered philosophy of doing "whatever it takes" to assist individuals diagnosed with Severe Mental Illness or Severe Emotional Disturbance. Services include integrated, recovery-oriented mental health treatment; intensive case management and linkage to essential services; housing and vocational support; and self-help.

ICM- Intensive Case Management programs, which include Full Service Partnership (FSP) programs Provide services to clients with the most acute, severe and chronic behavioral health problems. ICM programs have low caseloads, a multi-disciplinary team approach, and a comparatively richer array of wraparound services in order to be able to do "whatever it takes" to assist clients who are the most severely impacted by serious mental illness achieve wellness and recovery.

OP- Outpatient services involve appointment-based mental health office visits for therapy and psychiatric medication management at community mental health agencies or civil service clinics. Select Outpatient services may have adult socialization programs.

PDSA- Plan Do Study Act is a tool for accelerating quality improvement. PDSA is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).

Warm handoff- a referral that is conducted in person, between two members of the health care team, in front of the client (and family if present)

Wraparound services- support aligned with the philosophy of "do whatever it takes" to assist clients who are the most severely impacted by serious mental illness achieve wellness and recovery (i.e. - relatively greater access to supportive housing, vocational rehabilitation and other health and human services)

FILE NO. 170904 RESOLUTION NO. 379-17

[Mental Health Services Act - Program and Expenditure Plan (Integrated Plan)]

Resolution adopting the Mental Health Services Act Program and Expenditure Plan (Integrated Plan) for FY2017-2018 through FY2019-2020.

WHEREAS, The Mental Health Services Act (MHSA) was enacted through a ballot initiative (Proposition 63) in 2004 that provides funding to support new and expanded county mental health programs; and

WHEREAS, The MHSA specifies five major program components (Community Services and Supports; Capital Facilities and Technological Needs; Workforce, Education and Training; Prevention and Early Interventions; and Innovation) for which funds may be used and the percentage of funds to be devoted to each component; and

WHEREAS, In order to access MHSA funding from the State, counties are required to 1) develop Three-Year Program and Expenditure Plan (Integrated Plan), and Annual Updates, in collaboration with stakeholders; 2) post each plan for a 30-day public comment period; and 3) hold a public hearing on the plan with the County Mental Health Board; and

WHEREAS, The San Francisco Mental Health Services Act Integrated Plan FY2017-2018 through FY2019-2020, a copy of which is on file with the Clerk of the Board of Supervisors in File No. 170904, complies with the MHSA requirements above, and provides an overview of progress implementing the various component plans in San Francisco and identifies new investments planned for FY2017-2018 through FY2019-2020; and

WHEREAS, Recently enacted legislation, AB 1467, adds the requirement that MHSA Three-Year Integrated Plans, and Annual Updates, be adopted by County Boards of Supervisors prior to submission to the State; now, therefore, be it

RESOLVED, That the MHSA Integrated Plan FY2017-2018 through FY2019-2020 is adopted by the Board of Supervisors.

City and County of San Francisco
Tails
Resolution

City Hall
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

File Number: 170904 **Date Passed:** October 17, 2017

Resolution adopting the Mental Health Services Act Program and Expenditure Plan (Integrated Plan) for FY2017-2018 through FY2019-2020.

September 28, 2017 Budget and Finance Committee - RECOMMENDED

October 17, 2017 Board of Supervisors - ADOPTED

Ayes: 11 - Breed, Cohen, Farrell, Fewer, Kim, Peskin, Ronen, Safai, Sheehy, Tang and Yee

File No. 170904

I hereby certify that the foregoing Resolution was ADOPTED on 10/17/2017 by the Board of Supervisors of the City and County of San Francisco.

Alicia Somera
for **Angela Calvillo**
Clerk of the Board

Mayor

10/27/2017
Date Approved