COMPLETE APPLICATION CHECKLIST
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:
☒Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors. *(Refer to CCR Title9, Sections 3910-3935 for Innovation Regulations and Requirements)*
☒ Local Mental Health Board Public Hearing Date: August 7, 2018
☒ Completed 30 day public comment period Comment Period: 6/25/18 to 8/6/18
INNOVATIVE PROJECT PLAN **RECOMMENDED TEMPLATE** ☒BOS approval date Approval Date: 9/11/18 If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*
Desired Presentation Date for Commission: November, 2018 ***Note: Date requested above is not guaranteed until MHSOAC staff verifies all requirements have been met.***

County Name: Calaveras County Health and Human Services Agency (HHSA)/Behavioral Health Services (BHS) Division

Date submitted:

Project Title: Enhancing the Journey to Wellness Peer Specialist Program

Total amount requested: $$706,336

Duration of project: 5 years

Purpose of Document: *The purpose of this template is to assist County staff in preparing materials that will introduce the purpose, need, design, implementation plan, evaluation plan, and sustainability plan of an Innovation Project proposal to key stakeholders. This document is a technical assistance tool that is recommended, not required.*

Innovation Project Defined: *As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.*

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☒ *Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention*
- ☐ *Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population*
- ☐ *Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system*
- ☐ *Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite*

CHOOSE A PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☒ *Increases access to mental health services to underserved groups*
- ☐ *Increases the quality of mental health services, including measured outcomes*
- ☐ *Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes*

☐ *Increases access to mental health services, including but not limited to, services provided through permanent supportive housing*

Section 2: 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. 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.

Calaveras County residents who have been hospitalized for mental health crises are not finding their way to the existing mental health treatments available in the county in numbers that are concerning. Since February 2017, Mark Twain Medical Center administrators have been meeting regularly with Health and Human Services Agency/Behavioral Health Division, along with law enforcement (Sheriff Office, Highway Patrol, and Angels Police Department), and Ambulance Service agencies in Calaveras County to create a MOU/agreement that will formalize the commitment to working collaboratively to improve the crisis response and safety of our mental health patients and Emergency Department staff. Through this ongoing collaborative relationship between Mark Twain Medical Center-- the county's only hospital, and Calaveras County Behavioral Health Services (CCBHS), it has been discovered that no less than 20% and sometimes as high as 25% of patients hospitalized for mental health crisis over the last four years had been hospitalized more than once in a year. Some of these patients had been hospitalized as many as four or five times in the same year. Further investigation revealed that not one of these patients has a Wellness Recovery Action Plan (WRAP), and only 9% currently have Full Service Partnership (FSP) services. A recent update for EQRO Audit in November, 2018 showed of the BHS clients that the 102 that were hospitalized in FY 2017/2018, 39% (40) were rehospitalized within 30 days of discharge- so the 25% has jumped to 39% - indicating an increase need to intervene immediately (within 7 days) when clients returns home from hospital.

It is believed that the high incidence of repeat hospitalizations for mental health crisis in Calaveras County is directly attributable to the lack of connecting mental health patients to support.

We know from the literature that recurrent psychiatric hospitalizations and emergency department utilization is common among those with serious mental illnesses and others with behavioral health conditions (HSS and Westat, 2015). The result is excessively high healthcare costs, and in some cases preventable overuse of services. Furthermore, people with serious mental illness die, on average, twenty-five years earlier than those in the population without a serious mental illness. This disparity is largely due to treatable medical conditions that remain unaddressed due to factors at the client, treatment, provider, clinic, and system levels of health and mental health service delivery (Brekke, J. S. et al., 2013).

Further complicating connecting patients to services is the fact that Calaveras County is a remote rural community located in the foothills of the Sierra Nevada mountains. Eighty percent of the county's population of 44,515 lives in unincorporated areas, where public transit is minimal at best. Our rural location and culture increases potential for stigma and delay in seeking mental health services. High rates of recurring hospitalization for residents with mental health issues have been a longstanding challenge in the county. The geographic and transportation barriers, along with lack of affordable stable housing, are likely key contributing factors to those in need not accessing services or high attrition rates following hospitalization. In addition, Calaveras BHS consumers/clients have significant difficulties in affording housing

in this rural community. Most Calaveras BHS clients/consumers are faced with ongoing housing instability and homelessness due to the county's housing shortage and costs of current rentals, as the average cost of a rental in Calaveras County since the Butte Fire is between $800.00 and $1,000.00 a month. (In September, 2015, Calaveras County was devastated by a major fire called the Butte Fire that burned over 70,868 acres, and destroyed close to 1000 homes and structures). Many BHS consumers are very low income and are spending more than 30% of their monthly income on housing, leaving no funds to afford necessities such as food, clothing, transportation, utilities, and medical care. It is estimated that over one hundred BHS consumers/clients are currently at risk of homelessness and/or homeless in Calaveras County. Update- Although this project's learning objective is not about addressing this housing shortage, it is still very relevant to this proposal, as the newly hired Peer Specialist/Case Manager will need to identify stable housing for many of the clients discharged after a hospitalization.

New data made available to us in the last month (November, 2018) clearly documents our county's housing needs. 819 persons (including 205 children) were identified as homeless in FY 2017/2018 (increase of 35% in last 5 years) through the Calaveras HHSA Social Services division and in this same time period 67 homeless persons (increase of 42% in last 3 years) received crisis support through the Calaveras BHS division.

Because of the county's documented spike in homelessness- Calaveras HHSA is planning at a full spectrum and continuum of housing to meet this growing need for all Calaveras residents. Strategies are being developed to improve housing needs specific to homeless prevention, emergency housing, transitional/supportive housing, permanent supportive housing and workforce housing .Working closely with the Sierra Continuum of Care (COC), and the newly formed Calaveras Homeless Task Force, plans are in process for development, construction, and maintenance of safe, decent, and well-built affordable housing for BHS clients, as well as workforce housing.

Calaveras County is working with California Institute for Behavioral Health Solutions (CIBHS) on crafting the Calaveras Homeless Plan, a five year strategic plan that will include input (through focus groups and surveys) from over 100 persons representing all sectors of the community. This plan will identify and provide long range goals to meet our housing crisis, and will be completed by the end of January, 2019. At the same time, the Calaveras Planning and Building Department Directors are working closely with the Calaveras HHSA Director to provide fee waivers and amendments to land use regulations, zoning code development standards, and permitting procedures, to increase affordable residential development.

Working with the Stanislaus Housing Authority, No Place Like Home (NPLH) housing funds are being applied for, beginning with first competitive application to California Housing and Community Development (HCD) oin January 30, 2019. The purpose of the NPLH funding is to acquire, design, construct, rehabilitate, or preserve permanent supportive housing for persons who are experiencing homelessness, chronic homelessness or who are at risk of chronic homelessness, and who are in need of mental health services. Over the next year and a half,year we are planning to build or rehab up to 25 units of housing for BHS homeless clients. This new housing, along with the Vision House (transitional housing services), and the HEAP Emergency low barrier housing, will greatly help the Peer Specialist/Case Manager to access housing resources as needed.

Community planning over the past three years involving consumers, family members, public and community based organizations serving this population, as well as CCBHS staff, noted that peer support for hospital follow up was lacking, and that there is a critical housing shortage in Calaveras County. Stakeholders suggested that consumer driven,

wellness and recovery support strategies, along with providing housing supports immediately once released from hospital, are needed for our most at risk consumers/clients. Stakeholders also affirmed the challenges of isolation, whether it be geographic or social impacts mental health and contributes to repeated hospitalizations. Furthermore, family members of BHS consumers shared concerns that BHS staff do not contact family for input when assessing consumer status after crisis occurs.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) Provide a brief narrative overview description of the proposed project

Program Description
Calaveras County Health and Human Services Behavioral Health Services Division (CCBHS) proposes a new five year MHSA Innovation Peer Specialist Program titled "Enhancing the Journey to Wellness," beginning in January, 2019, to provide Peer Specialist case management support to targeted BHS consumers in Calaveras County who experience high rates of hospitalization for mental health crisis. The goal of this program will be to increase the connection of these consumers to existing mental health services in Calaveras County, and provide housing supports, with the hope that it will reduce the need for repeated mental health crisis hospitalizations. Currently CCBHS has two Community Service Liaisons with lived experience who provide day-to-day operational support to our peer run Wellness Cabin/Peer Center. We want to expand Peer Specialist support by hiring an experienced case manager with lived experience to implement this new Innovation project. This position will require a higher level of skills, training and education – and therefore will be paid at a higher wage as a Case Manager II to carry out the project activities.

Identified Problems and Potential Solutions
We want to learn if quality peer supports offered immediately after a hospitalization can transform the CCBHS systems of mental health care by helping to reduce readmissions of persons with multiple hospitalizations in Calaveras County for all age groups and if this new project can help to create an efficient, effective structure for the proposed small rural county comprehensive peer navigation crisis stabilization model.

The newly hired CCBHS Case Manager Peer Specialist will use their personal experience with recovery from mental health disorders to support others in recovery after a mental health crisis hospitalization, and assist the targeted consumers with housing supports if needed immediately, using the Housing First best practice strategy. Currently, homeless or at risk of homelessness consumers returning from a hospital stay are not offered housing supports until assessed for case management services through Full Service Partnership (FSP) Program (and this can take up to a month once assessed for FSP supports). This delay can create difficulty for BHS direct service staff in locating the consumer to offer services.
By utilizing the Housing First strategy (a recovery-oriented approach to ending homelessness that centers on quickly moving people experiencing homelessness into independent housing and then providing additional case management supports and services as needed) consumers are more apt to engage in needed mental health and community resources due to peer support and stable housing. The Housing First approach is evidence based –connecting individuals and families experiencing homelessness to housing without limits on length of stay – and as quickly as possible. This strategy allows people to exit homelessness quickly and remain stably housed by removing barriers to housing, live past evictions, poor credit, or criminal justice involvement. Housing First conforms to the tenant's needs,

and requires BHS case managers to work with tenants to set goals and strategies for meeting these goals. Tenants drive their own outcomes in a Housing First model.

While working in conjunction with professional therapists, social workers, and psychiatrists, the Peer Specialists will focus on empathy and empowerment that inspires recovery through modeling recovery, sharing skills and education, as well as assisting in navigating the local system of care and services, as well as housing support resources. In addition, CCBHS Peer Specialists support will overcome some of the geographic barriers existing in Calaveras County by offering support where the patient is (through home visits with a county car) rather than asking for the patient to keep an appointment at a centralized location. Transportation support will also be offered by the Peer Specialist Case Manager to mental health and community services when needed. Connections with the family as well as introduction to supporting community groups or services will be part of the Peer Specialist Case Manager responsibilities to address the problems surrounding geographic and social isolation. And if the targeted consumer is homeless, or at risk of homelessness, the Peer Specialist Case Manager will assist the consumer in obtaining stable housing as a priority when they return from a hospitalization stay, securing housing using Innovation funding for first/last rental payments, as well as utility payments if needed. Securing and maintaining adequate housing is critical for crisis stabilization immediately after consumers return from hospitalization stays. Using the Housing First best practice model, the Peer Specialist Case Manager will immediately work toward either locating hard to find housing options in Calaveras County, and/or help to stabilize existing housing if consumer is in arrears of utility and rent payments. Housing First supports will be a short-term strategy while assisting consumer with budgeting and accessing SSI and/or SSDI income and possible supportive employment to cover housing costs themselves over time (3 to 6 months).

Program Implementation

This new CCBHS innovation project plan is to hire, train, and supervise a Peer Specialist with lived experience to be in daily/weekly contact with persons released from hospitalization for severe mental health crisis and who have a history of repeated mental health crisis hospitalizations. Through home visits, utilizing a county car daily with funds from this Innovation project's budget, and phone contact, the trained peer specialist will provide outreach services, developing trust in order to engage the individual and their families in recovery and wellness services and practices over time. The newly purchased county car will be assigned to the Case Manager Peer Specialist over the five year proposal period, and beyond when the program is then funded, if successful, through Community Services and Supports (CSS) for long term sustainability. The Peer Specialist Case Manager will be recruited and selected to meet the identified cultural needs of the target population, and will be required to receive training focused in the following areas of engagement: motivational interviewing; shared decision-making; strengths-based assessment; and including natural supports (e.g., supportive family and friends). This position will be supervised by the MHSA Senior Administrative Analyst and MHSA Program Coordinator (a WRAP trainer with extensive peer support experience) to ensure an ongoing wellness and recovery focus, and to provide the new staff position the ability to work across CCBHS's current systems that include Children's System of Care, Adult System of Care, Crisis and Outreach Unit, Mental Health Clinic and LPS Public Guardian units.

The Peer Specialist Case Manager will arrange a multidisciplinary team (MDT) case conference within one week of mental health crisis hospitalization discharge. The MDT will include CCBHS clinicians, case managers, psychiatrist, nurses, etc. This team will assess the consumer's mental health needs and identify CCBHS services that will address those needs. The services may include: medication monitoring, Integrated Dual Diagnosis Treatment (IDDT) services, FSP, individual and group therapy, psychiatric services, as well as community resources for housing, food, health services, etc. The MDT team will promote collaboration amongst a wide range of systems and service providers, including CCBHS clinicians/case managers, primary care providers, emergency services, law enforcement, housing providers and others. One of the many strengths of a smallest of small county in California is the ability to easily

partner closely with all sectors of Calaveras County, and this project model using the MDT team will actually help to strengthen collaboration.

Peer Specialist Case Manager (with MDT) Key Activities:

- Make initial contact with consumer, focusing on respect and initiating trust;
- Assist CCBHS Case Manager in researching patient background; history of current crisis, prior mental health history, and as permitted by existing privacy laws, invite family members and other loved ones to provide information about the consumer, and the current crisis;
- Assess and immediately provide any needed housing supports, within one week of hospital discharge;
- Organize, and facilitate MDT meetings to assess consumer needs after hospitalization (mental health, medicine, food, primary health care appointments, transportation, etc.);
- Identify specific resources to meet unmet needs;
- Connect consumer to FSP Case Manager;
- Assist FSP Case Manager with connecting consumer to resources, providing encouragement and connection to: general mental health and community services through MDT team planning that could include FSP case management (including life skills/independent living assistance), individual and group therapy, medication monitoring, psychiatrist services, IDDT services, benefits/money management assistance including assistance applying for public benefit programs, referrals for payee services, credit counseling referrals, assistance with budgeting and establishing bank accounts, accessing food supplies from local Food Bank, connection to primary health care services, connection to NAMI and Wellness Center socialization and peer support group activities, referral and follow-up to employment/vocational training and job placement;
- Assist consumer to linkage with IDDT services if needed - the IDDT program provides trauma-informed treatment program within CCBHS. The staff are trained and qualified as both mental health and substance abuse treatment providers, and offer a person-centered approach based on the recovery model and harm reduction, and services range (in coordination with the FSP Program services) from intensive to community based peer support and include concurrent substance abuse and mental health treatment in the form of individual and group counseling, individual and group rehabilitation, case management, drug testing, collaboration with other agencies and transition planning; treatment lasts anywhere from six months to eighteen months;
- Assist consumer in creating a Wellness and Recovery Action Plan (WRAP) during the first eight weeks after hospitalization. WRAP to include consumer's specific recovery goals including identifying triggers and supportive services to access in a crisis;
- Provide daily and weekly contact and support with the targeted consumer after hospital stay, including home visits and phone check-in or follow-up;
- Engage family in education about the nature of mental disorders and their optimal treatment, followed by practical problem solving about how to manage the everyday difficulties they encounter with clients' symptoms and interpersonal difficulties;
- Provide overall advocacy and navigation support;
- Mentor wellness and recovery principles;
- Maintain connection through follow up appointments and referral checks with focus on person-centered care and therapeutic alliance that enables consumers to pursue recovery and life goals across multiple areas—home, school, work, and community. Engagement strategies will be built and sustained on the foundation of hope, mutual trust, respect, effective communication and recognition of the strengths and resources that people experiencing mental illness bring to their recovery;
- Reflect respect and the value that the consumer brings regardless of ability to stay on a treatment plan; and

- Maintain collaborative relationships with MDT and community resources, carrying the message of the importance of consumers having a WRAP and FSP support.

Relevant Participant Roles

The Peer Specialist Case Manager will coordinate and communicate daily as a team member of the CCBHS's newly formed Crisis Outreach and Engagement Unit, located at the Mental Health Clinic. The Crisis Unit is comprised of both clinicians and case managers who are responsible for crisis intervention at both the Mental Health Clinic and local hospital, Dignity Medical Center. Additionally, with MHSOAC funds from two competitive Triage proposals, two mobile Triage Case Managers (targeting both adults and children) will be part of this new team. The two Triage Case Managers are able to intervene in a mental health crisis anywhere in the community. (the Adult Triage Case Manager received an international award at the International Association of Chiefs of Police conference in October, 2018 –in recognition of her involvement in multi-agency collaborative efforts responding to incidents involving mental illness, and in 2016 BHS was asked to provide two best practices presentations about our Adult Triage services to both the California Behavioral Health Policy conference, and the MHSOAC Commission meeting held in San Andreas.). The MDT team will meet daily to share critical information about persons hospitalized due to a mental health crisis, and will coordinate with the new Peer Specialist to ensure post crisis stabilization services occur after an individual returns home from a hospitalization. The Peer Specialist will be responsible to coordinate and facilitate quickly a multidisciplinary team (MDT) case conference to develop a coordinated plan for recovery for the targeted individual. Members of this team will include the consumer, their family, and health and mental health providers who are likely to provide services with the individual, representing a diversity of resources and supports. The team, through collaboration and information sharing, will together with the individual consumer develop and support a strategic individualized plan for successful recovery and wellness. The five year budget will cover one full time benefited Peer Specialist Case Manager position, housing/utilities and transportation supports, and travel and training expenses.

B. Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

Introduces a new practice or approach to the overall mental health system Calaveras County, including, but not limited to, prevention and early intervention services.

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

Based on current research regarding the effectiveness of peer support engagement and outreach practices, we believe that hiring and training a competent Peer Specialist Case Manager will improve the rate of participation in CCBHS services for patients hospitalized for a mental health crisis, and further, that the participation in BCHSS services will decrease the potential for future mental health crisis hospitalizations.

D. Estimate the number of individuals expected to be served annually and how you arrived at this number.

Based on the number of unduplicated clients and numbers of repeat hospitalizations each year, as well as best practice numbers of persons that are appropriate per caseload, we expect to serve an average of up to 40 targeted individuals annually.

E. Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

<u>Description of targeted population:</u>

Targeted CCBHS consumers to be served will be persons of any age who over a period of 36 months have had repeated hospitalizations for a mental health crisis in Calaveras County, and are considered at great risk for relapse based on recent utilization of crisis services. Participants served will include individuals with co-occurring issues, homelessness or at risk of homelessness, dual diagnosis, and a history of involvement with law enforcement and probation. CCBHS's target population is the 47 unduplicated consumers in Calaveras County, who in the last three years have repeated hospitalizations for mental health crises.

Demographics

Ethnicity:

- Three (.06%) of the 47 consumers are Mexican/Chicano;
- Four (.08%) identified themselves as "unknown"; and
- Forty (85%) identify themselves as Caucasian.

Age:

- Ten are 0 to 17 years old (22%)
- Eleven are 18 to 25 years old (23%)
- Twenty-four are 26 to 64 years old (51%)
- Two are 65 and older years old (4%)

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

Calaveras County has not used Peer Specialist support to assist consumers in engaging in BHS services or housing supports following hospitalization. Based on our review of Peer Support models in other counties, and our experience using Peer Support in other settings, we strongly believe that a Peer Specialist support system of care will lead to better connectivity to services, prevent attrition from existing services, and ultimately reduce repeated hospitalizations for mental health crisis. We aim to create a rural county model for peer specialist crisis stabilization that could be replicated in other rural counties in California.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

LITERATURE AND EXISTING PRACTICES REVIEW

Methods

As the innovative component of the proposed program focuses on peer specialists, the literature and existing practices review concentrated on this topic. The goal of the literature and existing practices review was to gain a thorough understanding of how peer supports can help reduce readmissions of persons with multiple hospitalizations in Calaveras County and to help formulate an efficient, effective structure for the proposed small rural county comprehensive peer navigation crisis stabilization model.

Findings

Peer Support Services

In the recovery model, consumers are empowered to take control and assume responsibility of their unique therapeutic journey, which may include productive activities such as work or volunteering, personal management of daily needs, and satisfying peer relationships (Warner 2009). The recovery model also

espouses the tenets that quality of life can improve, daily challenges represent opportunities for growth, and peers with lived experience (i.e., others with serious mental illnesses who are in recovery) can contribute to providing mental health services (Buckley et al. 2007). To support recovery, mental health agencies are including peer providers (peers) on their staffs in recognition of peers as a valuable component of a recovery oriented, best practice approach to rehabilitation services for people with mental health conditions (Gates and Akabas 2007).

Several randomized control trials have demonstrated the impact of services provided by peers on positive client outcomes. When hired as part of a service team, peers have been found to make a major contribution to the recovery of people with serious mental health conditions (Armstrong, Korba, & Emard, 1995; Besio & Mahler, 1993; David-son et al., 1999). Studies have found that consumers who receive peer provided services have fewer hospitalizations, use fewer crisis services, reduce their substance abuse, and experience improved employment outcomes, social functioning and quality of life when compared to those who receive only professional services (Armstrong et al., 1995; Besio & Mahler, 1993; Klien, Cnaan & Whitecraft, 1998; Felton et al., 1995). Further, peer support can stabilize participation in treatment by helping to counter the sense of loneliness, rejection, discrimination and/or frustration that consumers can feel when dealing with the mental health system (Deegan, 1992; Markowitz, 2001; Solomon, 2004).

One literature review of studies examining the impact of peer support services for three services types: peer added services, peers in existing roles, and peers delivering curricula found that the peers added service type, of which eight found some positive benefit, including fewer hospitalizations, better treatment engagement, and lower rates of non-attendance at appointments.

Another randomized controlled trial that studied the feasibility and effectiveness of using peer support to reduce recurrent psychiatric hospitalizations found that seventy-four patients hospitalized ≥3 times in the past 18 months were recruited and randomly assigned to usual care (n=36) or a peer mentor plus usual care (n = 38) and assessed at nine months. The study, which took place at the Yale-New Haven Psychiatric Hospital, included the use of eight peer recovery mentors, who were under the supervision of the hospital and met with mentees at a frequency established in collaboration with the patient. At the 9-month follow-up, participants with peers had significantly fewer admissions and fewer hospital days than those in usual care.

Repper and Carter (2011) reviewed studies that examined peer support services for their effectiveness of peer support, benefits to consumers, empowerment, social support and social functioning, empathy and acceptance, reducing stigma, and hope. They found that “what peer support workers (PSWs) appear to be able to do more successfully than professionally qualified staff is promote hope and belief in the possibility of recovery, empowerment and increased self-esteem, self-efficacy and self-management of difficulties and social inclusion, engagement and increased social networks. It is just these outcomes that people with lived experience have associated with their own recovery; indeed these have been proposed as the central tenets of recovery: hope, control/agency and opportunity.” Many argue that these tenets are the most significant driving factor of peer support services. It could be argued that increasing hope, control/agency, and opportunity are the underlying mechanisms for clients’ overall health.

Rural residents experience many more obstacles to obtaining behavioral health services, which results in distinct mental health disparities compared to urban residents. Peer specialists can provide a critical role in rural communities, where there are often few treatment resources and few healthcare providers. Peer specialists are often members of the communities in which they work and are well positioned to provide culturally sensitive services to the population. Their understanding of their community allows them to develop close relationships with the people they serve, improving quality of care. Peers serve as role models and help personalize, individualize, and enhance the overall meaning of clinical treatment. Since peers embody recovery, peer support services provide inspiration for service recipients to take action to achieve a successful recovery and improve their quality of life.

Family Support and Engagement in Recovery

Family support and engagement can make a difference in consumer recovery. When mental health professionals engage families in care, it helps ensure that everyone supporting an individual's recovery has the same information and works toward the same goals. Mary Giliberti, NAMI's executive director, says, "Families play a vital role in the support of a family member who experiences mental illness. They should be actively invited and engaged in treatment and discharge planning—and they should get the support and education they need to help in recovery." Under the right circumstances, families can improve patient engagement with treatment, respond to early warning signs of relapse (Herz et al., 2000), and lead to better outcomes from both therapy and medication (Glick et al., 2011), resulting in shorter hospital stays and a better quality of life (Schofield et al., 2001).

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

Through this new innovation project we aim to focus on the following **Key Learning Questions:**

1. To what extent does Peer Specialist involvement lead to increased CCBHS mental health service access by consumers that experience repeat hospitalizations?
2. To what extent does working with a Peer Specialist in our rural county lead to improved wellness and recovery outcomes for isolated consumers that experience repeat hospitalizations?
3. To what extent does working with a Peer Specialist lead to increased family support of/engagement in the recovery and wellness of consumers that experience repeat hospitalizations?
4. To what extent does implementation of the *Enhancing the Journey to Wellness* Program contribute to improved collaboration 1) between providers, and 2) between consumers and their providers?
5. To what extent does Peer Specialist involvement using the Housing First model support crisis stabilization and/or recovery and wellness for consumers experiencing repeat hospitalizations?

Due to the high rates of repeat hospitalizations, Calaveras County BHS hopes to learn if providing Peer Specialist support to targeted high-risk BHS consumers will increase the connection of these consumers to existing mental health services in Calaveras County and reduce the need for repeated mental health crisis hospitalizations.

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

The County will measure program success using both process and outcome indicators. Process indicators measure to what extent the program was implemented as intended, while outcome measures will provide information on the effect of the program on consumers, community, and the mental health system overall. Evaluators will work to identify data points and evaluation methods to measure program implementation and impact. Data points may include baseline and ongoing individual-level consumer data from wellness surveys, service utilization records, hospitalization records, and incarceration records; these data will be obtained from county agencies and hospitalization records, and other data sources as identified during the evaluation design. Quantitative data will be collected regularly to assess

program progress and outcomes. Qualitative evaluation activities, including focus groups and stakeholder interviews, will be conducted annually.

The *Enhancing the Journey to Wellness* INN Project will employ a mixed-methods study design to evaluate changes in program-level outcome measures related, as well as individual-level outcome measures among consumers. Evaluation methods will be administered at intake, 3 months, 6 month, and following one year of the implementation of activities each fiscal year. The target population demographics will be analyzed to assess characteristics of consumers. In addition, the evaluation team will analyze process measure data to characterize and report on implementation activities. Data management and analysis methods will be determined based on quality and quantity of data collected.

Evaluation activities will aim to address the key learning questions of the project. The following table outlines the data to be collected (i.e., measurement metrics) and potential data sources listed by their respective key learning question.

Learning Question	Outcome	Measurement Metrics	Data Source(s)
1. To what extent does Peer Specialist involvement lead to increased CCBHS mental health service access by consumers that experience repeat hospitalizations?	§ Increased utilization of mental health treatment and social services	§ Mental health services delivered through individualized treatment plans: o FSP case management o WRAP plan developed o Participation in IDDT o Participation in support groups o Participation in individual therapy o Regular use of prescribed medication § Consumer perceptions of ease/change in access to/utilization of service	§ Treatment logs and service tracking § Participant retrospective questionnaire § Interviews with staff § Family member questionnaire/ interview
2. To what extent does working with a Peer Specialist in our rural county lead to improved wellness and recovery outcomes for isolated consumers that experience repeat hospitalizations?	§ Decreased hospitalizations § Decreased abuse of alcohol and illegal drugs	§ Number of 5150 evaluations § Number of mental health urgent care visits § Number of hospitalizations § Number of days hospitalized § Number of Emergency Room visits § Number of emergency room visits which have not led to hospitalization § Occurrence of dual diagnosis patients with mental health crisis hospitalizations (establish a baseline) § Number of substance abuse episodes/relapse (e.g. use of drugs or alcohol beyond a slip, that goes unaddressed and did not get immediate attention)	§ BHS Treatment team logs § Individualized client treatment plans § Participant retrospective survey § Interviews with staff/providers § Data extracts from partner data bases § Family member questionnaire/ interview
3. To what extent does working with a Peer Specialist lead to increased family support of/engagement in the recovery and wellness of consumers that experience repeat hospitalizations?	§ Increased family support and/or engagement with consumer recovery and wellness	§ Reports of family member support for consumer recovery and wellness § Reports of family member participation in mental health education or support programs	§ Participant retrospective questionnaire § Family member questionnaire/ interview § Interviews with staff/providers

Learning Question	Outcome	Measurement Metrics	Data Source(s)
4. To what extent does implementation of the Enhancing the Journey to Wellness Program contribute to improved collaboration 1) between providers, and 2) between consumers and their providers?	§ Improved coordination and communication among BHS staff due to MDT § Increased interagency collaboration	§ Provider perception of collaboration § Consumer perception of collaboration with providers § Increased stakeholder perceptions of system-wide collaboration	§ Participant retrospective questionnaire § Interviews with staff § Provider & stakeholder interviews
5. To what extent does Peer Specialist involvement using the Housing First model support crisis stabilization and/or recovery and wellness for consumers experiencing repeat hospitalizations?	§ Decrease in homelessness § increase in housing stability	§ Number of homeless consumers that received housing support § Number of consumers that have stable housing	§ Participant retrospective questionnaire § Family member questionnaire/ interview § Interviews with staff/providers
6. To what extent was the program implemented as planned?	§ Program implemented § Eligible participants referred/enrolled § Strengthened and increased crisis support services in Calaveras County that include crisis triage, targeted case management and linkage to services for individuals with mental health illness who require a crisis intervention	§ Staff hired or designated to new program § Number of individuals screened and assessed § Number of individuals accepted § Number of individuals who decline to participate and rationale § Number, type, and source of referrals § Number of repeat crisis calls from persons with SMI § Percentage who complete treatment plans § Percentage who complete program § Number of case conferencing calls § Awareness of program by hospital staff, case managers, clinical staff	§ Activity logs § Tracking system and tools for collection of crisis service activities § Plans available to all partners § Data extracts from databases § Participant retrospective questionnaire § Interviews with staff

It is important to note that our team will gather data on how disconnect from services happens, whether before, during, or after a hospitalization and will also quantify the coexistence of substance abuse issues with mental health patients. No data to this point has been collected on the impact of dual diagnoses on repeated mental health crisis hospitalizations in our county. Information collected throughout the course of this project from consumers, their families and supporting case managers which will be vital for future planning and delivery of mental health services in Calaveras County, not only to connect those in crisis to service, but to prevent attrition, and further hospitalizations.

Findings from evaluation activities will be reported to HHSA, partners, and stakeholders through interim reports. Interim reports will provide updates on program progress through process measures. Upon completion of the Innovation project, findings from overall evaluation activities, including pre/post data analysis, will be summarized in a final report to HHSA, partners, and stakeholders. The final report will summarize findings related to program process, program outcomes, collaboration partners, impact on overall mental health system, and resources (e.g., funding, staff) invested in the Innovation project. The final report will also serve as a documentation of the innovative practices implemented in the Innovation project, which can serve as a model for other counties in California to implement the approach within their jurisdiction. Successful outcomes from the project would support broader implementation of a

Peer Specialist model in community mental health settings with consumers who utilize emergency response services in the context of their mental health needs.

Section 3: Additional Information for Regulatory Requirements

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?

No contracting – N/A

COMMUNITY PROGRAM PLANNING

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

Throughout the current MHSA Annual Update Planning Process (FY 2017-2018), and the MHSA Three-year Community Planning Process (FY 2017-2020), consumers, family members and CCBHS direct service staff have continued to raise concerns about the need for more intensive peer support case management follow-up and housing supports for CCBHS consumers after hospitalizations. Entities involved in current MHSA Annual Update Planning Process, which occurred from January through March 2018, include the following:

1) NAMI Gold County –members of local chapter including persons with mental illness and families of persons with mental illness
2) Mental Health Advisory Board –appointed community representatives
3) MHSA Steering Committee – a peer run consumer group that meets bi-monthly with the MHSA Senior Administrative Analyst to discuss and provide input into any new and ongoing MHSA services throughout the year. This group helped with the design and program elements for the Enhancing the Journey to Wellness Peer Specialist Program.
4) BHS Wellness Cabin/Peer Center participants –consumers/BHS clients
5) BHS staff including Children's System of Care case managers and clinicians
6) Community Corrections Partnership (CCP) representatives of the Sheriff's Office, Probation, County CEO, Health and Human Services Agency and the District Attorney's Office
7) HHSA Social Services (APS/CPS) APS/CPS Social Workers
8) Calaveras County Office of Education Director of Student Support Services and 36 school administrators, counselors, teachers and nurses
9) Resource Connection Crisis Center staff and volunteers
10) Calaveras Veterans Services staff and veteran volunteer
11) Also, as Calaveras County has one threshold language, Spanish. Ana Ruth, BHS Community Health Liaison, was contacted and surveyed 8 Latino families who are clients of BHS in January, 2018. (Ms.Ruth is bilingual and her position is specifically dedicated to do outreach and case management to the Latino/Hispanic community in Calaveras County. She receives a bilingual pay incentive and has been trained to act as an interpreter for Spanish speaking individuals).

Specific input including gaps and concerns identified from the community planning process include the following:

- There is a lack of Peer Support for follow-up post hospitalizations.

- Consumers and family members raised concerns about the need for consumer-driven, wellness and recovery support strategies for the hardest to serve consumers in Calaveras County
- Family members of BHS consumers shared concerns that BHS staff do not contact family for input when assessing consumer status after crisis occurs
- Stakeholders indicated a need to identify solutions to the problems and barriers that limit our rural county's ability to both *access* and fully integrate mental health services to many of the county's most vulnerable residents
- Stakeholders affirmed the challenges many consumers living in isolated areas have in accessing mental health treatment and peer support services. They are often isolated with no transportation, and little social interaction.
- There is a lack of consistent and stable BHS crisis intervention and stabilization staff services that can serve our community
- There is a need for more bilingual BHS staff providing direct services
- Need more proposals to cover crisis intervention and stabilization needs, need increased funding for mobile case management triage services
- There is a critical housing shortage in Calaveras County
- There is a lack of follow-up with medication service support (med trays) and daily checks on medication usage after clients at-risk of medication non-compliance after being released from crisis and hospitalization.

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) *Community Collaboration*

B) *Cultural Competency*

C) *Client-Driven*

D) *Family-Driven*

E) *Wellness, Recovery, and Resilience-Focused*

F) *Integrated Service Experience for Clients and Families*

This project is consistent with the Mental Health Services Act General Standards in that it promotes peer-specialist case management services throughout the isolated areas of Calaveras County - focused on wellness, recovery, and resiliency principles.

Community Collaboration – Community stakeholder input has been the driving force in the planning and development of this project and will continue to be used in the testing, implementation and evaluation phases. Participants, consumers, family members, agencies, organizations such as NAMI, MHSA Steering Committee, Mental Health Advisory Board, BHS direct service staff (clinicians, case managers and peer specialists), BHS administration/management staff and non-profit service providers will continue to share information and resources in order to fulfill the goals of this Peer Specialist Project. Also, incorporating multidisciplinary teams (MDT) that include BHS staff, consumer, families,

and other community providers in the community to best assess consumer's needs after hospitalization will ensure stronger collaboration and linkages for consumers in our community.

Cultural Competency – This plan demonstrates cultural competency and capacity to improve overall health outcomes for all residents of Calaveras County with serious mental illness. *Enhancing Steps to Recovery* will ensure cultural competence of peer specialist staff with lived experience in carrying out the consumer/family driven services, and cultural competency and humility will be incorporated into all aspects of program design and service delivery. At this time Calaveras has only one threshold language, Spanish. CCBHS' Hispanic Community Health Assistant has been involved in review of all the Steps to Recovery services material, and when needed translate into Spanish. This Innovation Project is designed to develop processes that focus on the unique individual, including respecting and valuing individual and family needs. This would not be effective unless cultural and linguistic needs are incorporated.

Client and Family Driven –The foundation of this rural peer specialist support service delivery model is driven by consumer and family involvement. Consumers and family members from the local NAMI chapter and the peer run MHSA Steering Committee have all been involved and included in the planning process of this project and will continue to be involved in the continued planning, development, testing, implementation and evaluation phases of all aspects of this project. Peer Support Specialist staff will play a critical role in supporting and empowering consumers and will ensure that the targeted consumers and BHS direct service staff will be focused on the individual's wellness goals through the completed WRAP plans. All participation in the services provided will be voluntary.

Wellness, Recovery and Resilience focused – This plan's intent is to increase resilience and promote recovery and wellness for hardest to serve BHS consumers to ensure increased access to mental health and community support and services. This project will provide targeted consumers with a continuum of care ranging from peer support recovery groups, WRAP planning, FSP services, participation in the Peer Center Wellness Center, and a range of integrated dual-diagnosis services. The project promotes consumer well-being. Engaging peers in community support services will help to ensure they receive the help and assistance needed to live safely and independently when they return back into our community. Peer staff will reinforce this message, promoting a recovery oriented environment, reducing stigma, and increasing the likelihood of participation by consumers in the project.

Integrated Service Experience for Consumers and Families - At its foundation, this project supports the integration of mental health and substance abuse peer-support and community services for participants. Due to the design of this project participants and their families will have the access needed to peer support, comprehensive case management, WRAP individualized plans and integrated dual-diagnosis treatment services.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

Consumers and family members have all been involved in the planning process of this project and will continue to be involved in the continued planning, development, testing, implementation and evaluation phases of all aspects of this project. The MHSA Steering Committee meets bi-monthly, with twelve consumers who are actively involved and providing input into the Innovation project design, and will continue to be involved with program review and evaluation over the five year proposal period and beyond. Three members of this peer run committee represent the local LGBT community. NAMI Gold Country held a MHSA focus group in February 2018 to discuss the current MHSA

services, as well as to provide CCBHS with input into the newly designed Innovation project, *Enhancing the Journey to Wellness Program.* This NAMI chapter represents persons with mental illness and families of persons with mental illness.

The mission of Calaveras County Behavioral Health Services is to insure the competent provision of services which integrates elements of cultural awareness, sensitivity and receptivity at all organizational levels. BHS further seeks to reflect a spirit of cultural support which meets the needs of cultural and ethnic minorities and addresses conditions that contribute to and are indicators of the need for mental health services. These goals are intended to reflect and quickly adapt to changing county demographics.

Calaveras County recognizes the importance of creating systems of care which welcome individuals from all cultural, ethnic and socio-economic groups. With this in mind, BHS has established the following goals:

1. Provision of a barrier-free access for all residents of the county paying particular attention to those from diverse ethnic, cultural, lower socio economic groups who traditionally have more difficulty accessing services.
2. Recruitment and retention for ethnically diverse staff (which is particularly challenging in rural communities).
3. Provision of cultural competence training for all mental health staff including management, clinical and support staff
4. Development of partnerships with community organizations who have contact with diverse groups to improve access to services
5. Language and communication assistance is offered at all points of service contact for all levels of care at no cost to the consumer (access, crisis, outpatient, placements).

The new Peer Specialist will be trained to partner when needed with the bilingual Community Health Liaison when working with a Spanish speaking person in crisis. The BHS Community Health Liaison provides peer support, case management, advocacy, outreach and engagement to Latino/Hispanic families in Calaveras County, as well as helps to better understand the mental health system. Also, BHS has a 24 hour phone line with statewide toll free access (the Central Valley Suicide Prevention Hotline that has linguistic capability, (including TDD or California Relay Service) who fields all crisis and access calls after hours. They are contracted to provide language interpretations in all languages as needed. During business hours, when available bilingual staff are used to assist with interpretation which is the most desirable options. When bilingual staff are unavailable or for calls where there is no staff who can act as interpreters for a particular language, BHS uses AT&T Language Line.

Available aids for Vision and Hearing Impaired consumers. BHS has audio CD's of the Medi-Cal Beneficiary Booklet available to any beneficiaries with sight impairment. Large print copies of the booklet are also available to those with limited sight. Additionally, BHS contracts with NORCAL Deaf Services to provide sign language for deaf consumers. TDD or the California Relay Service is also available for use with consumers with limited hearing capacity or deafness who must be reached by phone. As needed, BHS also has case management staff available to assist consumers who request assistance with completing paperwork or other types of access concerns.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.

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 upon project completion.

If successful in increasing access and linkages for the targeted consumers to appropriate levels of care after the end of the five year Innovation project – and lowering the hospitalization rates, it will be critical to

continue the full time Peer Specialist position and move the funding for this position to MHSA Community Services and Supports (CSS). As the Peer Specialist will be trained in Medi-Cal billing and the use of the Anasazi EHR, it is anticipated that revenue from Medi-Cal billing for services will partially support this position when moved to CSS.

COMMUNICATION AND DISSEMINATION PLAN

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

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

- Peer Specialist Services,
- Post Crisis Hospitalization Supports
- WRAP,
- FSP,
- Family Engagement
- Wellness and Recovery.

Calaveras County is committed to learning from our Innovation project evaluation, and plans to share findings with stakeholders, including consumers, service providers, our local NAMI chapter, and the Calaveras County Board of Supervisors. We will use the evaluation findings to reflect on what is working well and what could be changed to improve our service to consumers. As we have done in the past, we plan to integrate successful aspects of the project into our ongoing services funded through CSS, and making adjustments as necessary to improve aspects of the project that did not work as well. We will publicize our findings about successes, and communicate widely about the availability of any resulting new ongoing programming through multiple means, including local newsletters reaching consumers and their families, our annual update, and in communications to CIMH and CBHDA.

We are partnering closely with evaluators from Learning for Action (LFA), an independent evaluation and capacity building firm with significant experience in evaluating MHSA-funded programs. LFA evaluators will provide support in ensuring the quality of our data collection instruments and processes, and will conduct analysis of data collected to ensure it addresses the project's learning goals and evaluation questions - in order to be able to share with rural counties once the five year period is completed.

In addition to the external communications plan, the county must effectively communicate internally while still staying within the parameters set by the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state privacy laws. The success of a county *Enhancing the Journey to Wellness* program is contingent upon ongoing communication between collaborative partners and county programs. Intra-county communication is key to breaking down the silos that exist within some county programs. Steps to Recovery staff must stay apprised of other mental health and community programs as well as public and private non-county service options and resources.

TIMELINE

1. *Specify the expected start date and end date of your INN Project*

January 1, 2019 to December 31, 2023

1. *Specify the total time frame (duration) of the INN Project*

Five Years with an anticipated $710, 609 on Innovation funds used for the entire proposal period ($142,122/each calendar year). The MHSA Reversion Plan is completed and posted on the Calaveras County website, and the Calaveras Network of Care and, and will be approved by the Board of Supervisors by the end of August, 2018 – ensuring all the Innovation reversion funds will be spent by June 30, 2019.

C. Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

Year 1

Month 1-3: Implementation Planning and Start Up

- Hire Peer Specialist
- Orient and train new staff
- Develop specific measurable project goals, evaluation framework, indicators, measurement tools and data collection protocols
- Develop service delivery protocols and procedures
- Meet daily with BHS Crisis Unit staff to coordinate post-hospitalization case management and community services
- Initiate and convene MDT meetings for consumers and their families within 30 days of hospitalization stays
- Receive training on WRAP – and become certified as WRAP trainer
- Create monitoring system for targeted consumers to check on progress ongoing after accessing mental health and community services
- Report data from tracking systems at end of quarter – then ongoing
- Get training on Crisis De-escalation, Crisis Intervention Training (CIT), Mental Health First Aid, QPR Suicide Prevention
- Meet quarterly with NAMI, MHSA Steering Committee, and Mental Health Advisory Board on status of new project

· Month 4-6: Early Implementation

- Implementation of project activities
- Initial data collection
- Document gradual increase in number and types of activities during this period
- Data collection of process measures
- Continue to meet daily with BHS Crisis Unit staff to coordinate post-hospitalization case management services
- Offer WRAP services to targeted consumers
- Continue to initiate and convene MDT meetings for consumers and their families within 30 days of hospitalization stays

- Continue to provide monitoring data for targeted consumers to check on progress after accessing mental health and community services
- Report program data from tracking systems at end of quarter
- Meet quarterly with NAMI, MHSA Steering Committee, and Mental Health Advisory Board on status of new project

· Months 7-9

- Implementation of project activities
- Ongoing data collection
- Document number and types of activities during this period
- Data collection of process measures
- Continue to meet daily with BHS Crisis Unit staff to coordinate post-hospitalization case management services
- Continue to initiate and convene MDT meetings for consumers and their families within 30 days of hospitalization stays

- Offer WRAP services to targeted consumers
- Continue to provide monitoring data for targeted consumers to check on progress after accessing mental health and community services
- Report program data from tracking systems at end of quarter
- Continue to meet quarterly with NAMI, MHSA Steering Committee, and Mental Health Advisory Board on status of new project

· Months 10-12

- Implementation of project activities
- Ongoing data collection
- Document number and types of activities during this period
- Data collection of process measures
- Continue to meet daily with BHS Crisis Unit staff to coordinate post-hospitalization case management services
- Continue to initiate and convene MDT meetings for consumers and their families within 30 days of hospitalization stays
- Offer WRAP services to targeted consumers
- Continue to provide monitoring data for targeted consumers to check on progress after accessing mental health and community services
- Report program data from tracking systems at end of quarter
- Continue to meet quarterly with NAMI, MHSA Steering Committee, and Mental Health Advisory Board on status of new project

· Year 2-5

- Project Operations – ensure project is fully implemented with ongoing evaluation activities
- Test additional strategies if process evaluation shows need for changes in project design
- During this timeframe, outcome data will be collected and analyzed and reported to project participants and community stakeholders.
- Continue to meet daily with BHS Crisis Unit staff to coordinate post-hospitalization case management services
- Continue to initiate and convene MDT meetings for consumers and their families within 30 days of hospitalization stays
- Offer WRAP services to targeted consumers
- Continue to provide monitoring data for targeted consumers to check on progress after accessing mental health and community services
- Report program data from tracking systems at end of each quarter
- Continue to meet quarterly with NAMI, MHSA Steering Committee, and Mental Health Advisory Board on status of new project

Final 6 months of Year 5

Project evaluation will be completed, the results analyzed, and recommendations made to BHS as to whether and/or how to incorporate this project as an ongoing program, funded through MHSA Community Services and Supports component with additional Medi-Cal reimbursement. Aspects of the project that were not successful will be reviewed to assess impact on future Calaveras Innovation projects, as well as current BHS services. These results will be disseminated to the stakeholder community. This is expected to begin in Year 5 and will likely continue into Year 5, as we work with MHSOAC to determine how best to communicate results to other small rural counties in California.

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)
C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

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.

Enhancing the Journey to Recovery Budget Narrative

Personnel Costs:

Salaries: Total salaries are $349,034 for five years.

This budget includes one full time Peer Specialist Case Manager II (80 hours bi-week x 26 pay periods). Year 1 position pays Year 1 - $54,813, Year 2- $58,126, Year 3 - $61,069, Year 4 - $64,098, Year 5 - $67,323.

After successfully completing twenty-six (26) pay periods, a 5% merit increase is proposaled. Merit increases may be proposaled annually thereafter to the top step

Additionally, 10% FTE of the MHSA Senior Administrative Analyst is included in the Innovation budget to provide supervision of the Peer Specialist Case Manager II. Year 1 position pays Year 1 - $8,587, Year 2- $8,669, Year 3 - $8,669, Year 4 - $8,799, and Year 5 - $8,880

Under the direction of the MHSA Senior Administrative Analyst, the Peer Specialist Case Manager will use their personal experience with recovery from mental health disorders to support others in recovery after a mental health crisis hospitalization. While working in conjunction with professional therapists, social workers, and psychiatrists, the Peer Specialists will focus on empathy and empowerment that inspires recovery through modeling recovery, sharing skills and education, as well as assisting in navigating the local system of care. In addition, CCBHS Peer Specialists support will overcome some of the geographic barriers existing in Calaveras County by offering support where the patient is rather than asking for the patient to keep an appointment at a centralized location. Connections with the family as well as introduction to supporting community groups or services will be part of the Peer Specialist responsibilities to address the problems surrounding geographic and social isolation. And if the targeted consumer is homeless, or at risk of homelessness, the Peer Specialist will assist the consumer in obtaining stable housing as a priority when they return from a hospitalization stay, and/or coordinate with the CCBHS FSP Case Manager in securing housing using Innovation funding for first/last rental payments, as well as utility payments if needed. Securing and maintaining adequate housing is critical for crisis stabilization.

Benefits: Total benefits are $147,127

Benefits for the full time Case Manager II and MHSA Senior Administrative Analyst include medical, dental, and vision insurance, vacation, holidays, life insurance, sick leave, bereavement leave and retirement.-

Costs for one full time FTE, and 10% FTE include Year 1 - $28,665, Year 2- $29,068, Year 3 - $29,413, Year 4 - $29,794, Year 5 - $30,187.

Personnel Indirect costs: Total Indirect Costs for personnel is $74,424 (15%) for five years

Administration costs are 15% of the total personnel costs, and include prorated application of internal agency and department administrative costs and A-87 Cost, which include administrative costs, personnel department, county counsel, accounting and payroll services, building and equipment maintenance, auditing and insurance, and utilities for administration and government center facilities

Total Personnel Costs = $570,584

Operating Costs:

Office/Program Supplies total $6,000 for five years, and include:

- Binders and filing supplies for maintaining consumer files
- Printing costs for program brochures
- Copy and printer paper
- Labels for mailing
- Storage and organizers
- Post-it Notes
- Pens and pencils, highlighters
- Paper and binder clips, scissors, staplers, pushpins,
- Ink and toner cartridges for printer and copier.
- General office supplies: pens, pencils, paperclips, staples, tape
- Batteries and surge protectors for computer/printer
- Computer accessories – software, cords, adapters, traveling cases, keyboard, mouse pads, speakers and headsets, additional hard drives, flash drives for transporting files, routers, blank recordable CDs
- Ink and toner cartridges
- Office calculator
- Calendars and planners
- postage

Travel/Training Costs total $22,500 for five years, and include:
Travel costs include $50/gas week for outreach activities x 52 wks x 5 years = $13,000 for five years, and Training costs = $9,500 for five years cover registration and training fees, food and lodging, parking and other and travel costs for WRAP, Motivational Interviewing, and specific out of county Peer Specialist trainings

Car maintenance and repair total= $5,000 for five years – to cover maintenance and repair costs for program vehicle- used for program outreach and transportation for consumers

~~Indirect Costs for operating costs is $4,275 (15%) for five years~~

Total Operating Costs = ~~$37,775~~ $33,500

Non Recurring Costs
Office/program equipment total= $6,000 for five years, and includes the purchase of computer equipment and furniture including desktop monitors, laptops, printers, power cables for workspaces, office phone and cell phone, file cabinet, book cases, and desk and chair
Car purchase total $35,000 total for the five years, to purchase an all wheel drive program vehicle in year one for Case Manager outreach ad engagement activities to include house visits and consumer transportation to community services and mental health appointments. This car will be assigned to the Case Manager for the five year proposal period and beyond for ongoing peer support activities.

Total Non Recurring Costs $41,000

Consultant Costs total $75,000 for five years, and provides ongoing program evaluation support from an experienced consultant (Learning for Action) to:

- Develop detailed work plan and timeline for data analysis and reporting.
- Design survey tools
- Coordinate with staff to obtain survey and program data for analysis
- Develop detailed analysis plan to ensure analyses will sufficiently address evaluation and learning questions
- Conduct management and analysis of both qualitative and quantitative program data
- Plan, facilitate, and document discussion of key findings with key staff to identify lessons learned and implications of project findings on program delivery, adjustment, expansion, and sustainability
- Finalize summary report based on staff feedback

Indirect Costs for costs associated with county staff servicing the consultant contractis $11,250 (15%) for five years

Total Consultant Costs $86,250

Other Expenditures Housing supports total $150,000 for five years, to include a range of housing stabilization financial support supports for consumers who are homeless or at risk of homelessness. The Peer Specialist Case Manager, in coordination with FSP Case Managers when applicable, will provide appropriate and timely services and supports to homeless or at risk of homelessness consumers to allow them to quickly stabilize in permanent housing. Individualized Housing plans will be developed and could include the following: housing search and placement, housing stability case management that includes assistance with rental application, negotiating manageable and appropriate lease agreements with landlords, help with understanding leases, arranging and coordinating services from other agencies, assisting with applications for and access to mainstream benefits, moving costs, security deposits, utility deposits, utility payments, and legal fees.

Total Other Expenditures - $150,000

FIVE YEAR TOTAL - LINE ITEMS SUMMARY

$570,584 Personnel Costs
~~$ 37,775~~ $33,500 Operating Costs
$ 41,000 Non Recurring Costs
$ 86,250 Consultant Costs
$150,000 Other Expenditures
TOTAL - ~~$885,609~~ $881,336 Program costs for five years
Less $ 175,000 total Anticipated MediCal Billing Revenue (FFP)
~~$710,609~~ $706,336 total Innovation funds less FFP

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**TOTAL**
1.	Salaries	$63,400	$66,795	$69,738	$72,897	$76,203	$349,034
2.	Direct Costs-Benefits	$28,665	$29,068	$29,413	$29,794	$30,187	$147,127
3.	Indirect Costs	$13,810	$14,380	$14,873	$15,404	$15,958	$ 74,424
4.	Total Personnel Costs	$105,875	$110,243	$114,024	$118,094	$122,348	$570,584
OPERATING COSTS		**FY 2019**	**FY 2020**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**TOTAL**
5.	Direct Costs	$1,200	$1,200	$1,200	$1,200	$1,200	$6,000
6.	~~Indirect Costs~~ Travel Costs	$4,500	$4,500	$4,500	$4,500	$4,500	$22,500
7.	~~Total Operating Cost~~Car Maintenance	$1,000	$1,000	$1,000	$1,000	$1,000	$5,000
NON RECURRING COSTS (equipment, technology)		**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**TOTAL**
8.	Office/program equipment	$6,000	$0	$0	$0	$0	$6,000
9.	Car purchase	$35,000	$0	$0	$0	$0	$35,000
10.	Total Non-recurring costs	$41,000	$0	$0	$0	$0	$41,000
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**TOTAL**
11.	Direct Costs	$15,000	$15,000	$15,000	$15,000	$15,000	$75,000
12.	Indirect Costs	$ 2,250	$ 2,250	$ 2,250	$ 2,250	$ 2,250	$11,250
13.	Total Consultant Costs	$17,250	$17,250	$17,250	$17,250	$17,250	$86,250
OTHER EXPENDITURES (please explain in budget narrative)		**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**TOTAL**
14.	Housing Supports	$30,000	$30,000	$30,000	$30,000	$30,000	$150,000
15.							
16.	Total Other Expenditures	$30,000	$30,000	$30,000	$30,000	$30,000	$150,000
BUDGET TOTALS							
Personnel (line 1)		$63,400	$66,795	$69,738	$72,897	$76,203	$349,034
Direct Costs (add lines 2, 5, 6, 7 and 11 from above)		$50,365	$50,768	$51,113	$51,494	$51,887	$255,627
Indirect Costs (add lines 3, ~~6~~ and 12 from above)		~~$16,915~~ $16,060	~~$17,485~~ $16,630	~~$17,978~~ $17,123	~~$18,509~~ $17,654	~~$19,063~~ $18,208	~~$89,949~~ $85,675
Non-recurring costs (line 10)		$41,000	0	0	0	0	$41,000
Other Expenditures (line 16)		$30,000	$30,000	$30,000	$30,000	$30,000	$150,000
TOTAL INNOVATION BUDGET		~~**$201,680**~~ **$200,825**	~~**$165,048**~~ **$164,193**	~~**$168,829**~~ **$167,974**	~~**$172,899**~~ **$172,045**	~~**$177,153**~~ **$176,298**	~~**$885,609**~~ **$881,336**

*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.

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**TOTAL**
1.	Innovative MHSA Funds	~~$16,915~~ $16,060	~~$17,485~~ $16,630	~~$17,978~~ $17,123	~~$18,509~~ $17,654	~~$19,063~~ $18,208	~~$89,949~~ $85,675
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	~~$16,915~~ $16,060	~~$17,485~~ $16,630	~~$17,978~~ $17,123	~~$18,509~~ $17,654	~~$19,063~~ $18,208	~~$89,949~~ $85,675
EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**TOTAL**
1.	Innovative MHSA Funds	$15,000	$15,000	$15,000	$15,000	$15,000	$75,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**	$15,000	$15,000	$15,000	$15,000	$15,000	$75,000
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**TOTAL**
1.	Innovative MHSA Funds	~~$166,680~~ $165,825	~~$130,048~~ $129,193	~~$133,829~~ $132,974	~~$137,899~~ $137,045	~~$142,153~~ $141,298	~~$710,609~~ $706,336
2.	Federal Financial Participation	$35,000	$35,000	$35,000	$35,000	$35,000	$175,000
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**	~~**$201,680**~~ **$200,825**	~~**$165,048**~~ **$164,193**	~~**$168,829**~~ **$167,974**	~~**$172,899**~~ **$172,045**	~~**$177,153**~~ **$176,298**	~~**$885,609**~~ **$881,336**
*If "Other funding" is included, please explain.							