Mental Health Services
Oversight & Accountability Commission

Through the Chair's Delegated Authority, the following five County Innovation projects were approved:

1. **Modoc County** received authorization for up to $480,000 of Innovation spending authority to prevent or reduce negative health impacts of metabolic syndrome in individuals receiving specialty mental health services and who are prescribed antipsychotic medication. The County proposes to implement and evaluate an integrated approach to healthcare utilizing metabolic screening and various interventions coordinated through partnerships with Modoc's Public Health Department, Modoc Medical Center, and Sunrays peer-run wellness center.

2. **Orange County** received authorization for up to $950,000 of Innovation spending authority to support the Innovation-related Community Program Planning Process (INN related CPPP). To support the County's diverse community, they will use these funds to research concepts, develop materials, invest in translation and interpretation services, consult with subject matter exerts and strengthen their outreach and engagement to reach a broader community.

3. **Tulare County** received authorization for the one-time use of up to $1,000,000 of Innovation funding to complete phase one of a two-phased Innovation project. They will partner with CalMHSA on the Semi-Statewide Electronic Health Record (EHR) Project and multiple counties to affect local level system change by creating a more integrated, holistic approach to county health information technology collection, storage, and reporting, with the goal to increase the quality of mental health services, including measurable outcomes. The EHR Project hypothesizes that reducing the impacts of documentation will improve provider satisfaction, employee retention, and improve patient care and outcomes.

4. **Ventura County** received authorization for up to $966,706 of Innovation spending authority to provide services for seniors who are at risk of becoming homeless. This project will utilize volunteers with CAREGIVERS of Ventura County and partner them with senior clients already enrolled with the CAREGIVERS of Ventura County program in order to create and develop trusting partnerships that will allow home-bound seniors to receive needed services and supports in the form of assessing housing needs, possible relocation, case management, behavioral therapy, financial advice, and assisting with meeting daily basic needs.

5. **Yolo County** received authorization for up to an additional $500,000 to build off the approved project: Planning and Stakeholder Input Process for Crisis System Re-Design and Implementation (approved in June 2021) to support the preparatory work needed to move from planning and stakeholder input to the implementation of a revised approach to crisis response throughout the county for all residents, including Medi-Cal recipients and those without insurance, based on the Crisis NOW principles.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS—Modoc County

Innovation (INN) Project Name:	**Integrated Health Care for Individuals with Severe Mental Illness**
Total INN Funding Requested:	**$480,000**
Duration of INN Project:	**Five (5) Years**
MHSOAC consideration of INN Project:	**May 2022**

Review History:

Approved by the County Board of Supervisors:	January 26, 2021
Mental Health Board Hearing:	January 21, 2021
Public Comment Period:	December 17, 2020-January 20, 2021
County submitted INN Project:	March 22, 2022
Date Project Shared with Stakeholders:	March 8, 2021 and April 8, 2022

Project Introduction:

Modoc County is requesting up to $480,000 of Innovation spending authority to prevent or reduce negative health impacts of metabolic syndrome in individuals receiving specialty mental health services and who are prescribed antipsychotic medication. The County proposes to implement and evaluate an integrated approach to healthcare utilizing metabolic screening and various interventions coordinated through partnerships with Modoc's Public Health Department, Modoc Medical Center, and Sunrays peer-ran wellness center.

What is the Problem?

Modoc County states that there is strong evidence of a high rate of metabolic syndrome among mental health consumers locally. Metabolic syndrome is a group of conditions that together raise your risk of serious health problems like, coronary heart disease, diabetes, and stroke[1]. Individuals may have metabolic syndrome if they have three or more of the following conditions: high blood pressure, a large waistline, low HDL cholesterol and high blood sugar levels[1].

In 2020, the County conducted a twelve-week chart review of consumers living with severe mental illness who also receive antipsychotic medications. The chart review indicated that all (100%) met at least one of the metabolic parameters for metabolic syndrome. In addition, two out of three (67%) consumers had one or more comorbid

[1] https://www.nhlbi.nih.gov/health/metabolic-syndrome

health conditions, such as hypertension, diabetes, or heart disease and more than half (56%) had a body mass index that indicated a large waistline.

Modoc County states that individuals with severe mental illness die, on average, 25 years earlier than the general population, primarily due to preventable chronic disease. The County further presents national research showing that 54% of the adult population living with severe mental illness are estimated to suffer from metabolic disorder as compared to the 34% reported for the general population.

The County identifies metabolic syndrome as preventable and modifiable but states that several barriers contribute to poorer health outcomes for individuals living with serious mental illness, including lack of primary care access and inconsistent patient follow-up, known medication side effects, significant stressors, and unhealthy patient health habits like tobacco use and lack of physical activity.

How this Innovation project addresses this problem:

To address these barriers, the County collaborated with stakeholders to develop this Innovation proposal aimed at testing the effects of improving access to preventative services. **This approach will include mental health care combined with physical health care through a recovery model and holistic care focus.** The project will introduce a metabolic screening protocol for clients who are prescribed antipsychotics, identify high risk patients, and offer appropriate interventions with the goal of preventing or reducing negative health impacts from metabolic syndrome.

Daily Operation

Modoc County has gathered a multi-disciplinary team consisting of partnerships with Modoc's Public Health Department, Modoc Medical Center, Promotoras and peer-specialists connected to the Sunrays peer-ran wellness center. This team will assist in engaging consumers to participate in program activities that are peer support-based and culturally competent.

Participating consumers will be screened and offered the opportunity to participate in the project if they have an elevated body mass index or meet the guidelines for at least one of the metabolic syndrome parameters previously referenced. If they choose to participate in the project, they will be screened initially and then quarterly for diabetes, high blood pressure, substance use, waist circumference, hemoglobin A1c, triglycerides, and HDL cholesterol.

Participating consumers will also be offered the following services:

- Education regarding nutrition support
- Education regarding tobacco cessation
- Psychotropic medication management
- Opportunities for physical activity using different exercise modalities through the Sunray wellness center
- Opportunity to invite consumer family members and friends to support participants, if they are invited to do so by the participant

- On-site lab draw station in the Modoc County Health Services (MCHS) building
- Primary care support, also in the MCHS building
- Motivational interviewing (MI) at each visit to encourage healthy physical self-care (Clinicians and nurses will be trained in this technique as part of the project)

In addition, to measure mental health status, clinicians will offer periodic screenings using the following:

- Public Health Questionnaire (PHQ 9) Depression Identification Tool
- Positive Symptom Rating Scale and Brief Negative Symptom Assessment (PSS-4/BNSS)

Modoc County states that this proposed project represents a substantial change to the way mental health services are currently provided and that current practice does not include detailed monitoring of parameters for metabolic syndrome, nor do they offer on-site primary care support, MI, tobacco cessation education, exercise opportunities, or nutrition classes to consumers who are prescribed antipsychotics.

Related Programs

Tulare County is currently implementing a previously approved, similar Innovation project. Modoc County identified that the design of the two projects is similar, but that Modoc's proposal is different than Tulare's in three critical aspects:

- Modoc proposes to study a different population than Tulare. Tulare is studying only those receiving injectable psychotropics, whereas Modoc will make this study available to everyone receiving an antipsychotic medication in whatever form it is delivered.
- This project will be implemented in a small county with more limited resources than a midsize county like Tulare which Modoc feels gives them a uniquely personalized relationship with the population in this project.
- Modoc's project will include tools to measure the impact of integrated care upon the mental health of the participants.

In addition, Tulare and Modoc Counties are supporting each other in that Tulare County let Modoc pull applicable parts from their project proposal while sharing some of the challenges they encountered. Modoc readjusted this proposed plan based on feedback from Tulare especially in terms of appointment scheduling. The counties both agreed to share learnings when evaluations are performed, and reports written.

Community Planning Process (See pages 19-21 in original plan)

Local Level

Modoc County provides information that the project is strongly client-driven and that peers originally proposed the concept during the June 2020 community/stakeholder planning meeting. The plan was developed in partnership with peers during conversations with Behavioral Health and the Advisory Board, resulting in this proposal to increase access, and improve the quality of care, for patients with serious mental illness who are prescribed antipsychotics.

Modoc County also held a public comment period from December 17, 2021 through January 20, 2021 followed by local Mental Health Board hearing on January 21, 2021 and Board of Supervisor approval on January 26, 2021.

A final plan, incorporating stakeholder input and technical assistance from Commission staff, was submitted March 22, 2022.

Commission Level

Commission staff originally shared this project with its six stakeholder contractors and the listserv on March 8, 2021. The final version of this project was again shared with stakeholders on April 8, 2022. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

One comment was received in response to Commission sharing plan with stakeholder contractors and the listserv and is listed below.

"I am very excited to see and follow this type of study. If you go to LinkedIn and/or Facebook you can find a gentleman by the name of Terrance Kosikar. He runs Camp My Way in Canada. Terrance has a lot to offer. On these sites, you will find empirical data on the benefits of clean living and exercise in addressing mental health and metabolic disorder. Perhaps, these sites could offer you observable insights as to the results of exercise and may provide inspiration for the people you serve. Please take a look at Terrance's story. It will be well worth your time."

Learning Objectives and Evaluation (See pages 16-18 in original plan)

Modoc County will screen all current behavioral health consumers who receive antipsychotic medication. The evaluation will be completed by an outside evaluator who will be contracted to finalize the learning goals, collect, and evaluate data.

Modoc County has identified five learning goals to guide this project with a goal of helping answer the overarching question of whether integrated care will effectively address physical and mental health of SMI consumers who take antipsychotic medications by:

- Screening for the components of metabolic syndrome, diagnosing and treating it, if warranted;
- Improving the participant's indicators of the components of metabolic syndrome; and
- Improving their modifiable health behaviors related to metabolic syndrome
- Improving their quality of life, as evidenced by PHQ 9 scores measuring mood and PSS-4/BNSS measuring positive and negative symptoms and overall wellbeing.

The learning goals are:

1) Can this project increase the number of individuals taking antipsychotics who are diagnosed with, and treated for, metabolic syndrome?

   The outputs could include:
   - Baseline of total # of SMI individuals currently on antipsychotic medication(s).

- Baseline for SMI individuals on antipsychotic medication(s) currently enrolled in integrated health care for a component of metabolic syndrome.
- Number of SMI individuals prescribed antipsychotics who choose to engage in integrated health care to monitor and treat metabolic syndrome over a five-year period.
- Number of SMI individuals who choose not to engage in integrated health care to monitor and treat metabolic syndrome over a five-year period.
- Number of SMI individuals who choose to engage in integrated health care to monitor and treat metabolic syndrome over a five-year period but drop out of program within 12 months.

2) Can this project improve participants' indicators of the components of metabolic syndrome?

   The outputs could include:
   - Waist circumference ≥102 cm (40 in.) in men or ≥88 cm (≥35 in.) in women; if Asian American, ≥90 cm (35 in.) in men or ≥80 cm (32 in.) in women
   - Blood pressure ≥130/80 mm HG (or receiving drug therapy for hypertension)
   - Triglycerides ≥200 mg/dL (or receiving drug therapy for hyperlipidemia)
   - HDL cholesterol <40 mg/dL in men or <50 mg/dL in women (or receiving drug therapy for hyperlipidemia
   - Impaired glycemia: Hemoglobin A1c ≥ 5.7 (or already diagnosed with diabetes or receiving drug therapy for hyperglycemia)
   - Body Mass Index >30

3) Can this project improve participants' modifiable health behaviors related to metabolic syndrome?

   The outputs could include:
   - Documented decrease in tobacco and other substance use, using the Health Assessment
   - Documented participation in nutrition education, using the Health Assessment
   - Documented participation in exercise events, using the Health Assessment

4) Can offering integrated health care improve participants' PHQ 9 scores and global self-report of functioning on the PSS-4/BNSS tool?

   The output could include
   - Documented decrease of PHQ 9 scores and improved global self-report scores on the PSS-4/BNSS tool.
5) Can offering health improvement strategies improve the overall quality of life for SMI consumers?

The County will also perform interviews with those who drop out of the program to determine their reasons for leaving integrated health care.

In addition, demographics of participants that include questions on race, ethnicity, sex, age, etc., as required for MHSA demographic reporting, will be collected.

The Budget

Funding Source	Year-1	Year-2	Year-3	Year-4	Year-5	**TOTAL**
Innovation Funds	$ 74,248	$ 103,387	$ 102,740	$ 102,941	$ 96,684	$ 480,000
5 Year Budget	Year-1	Year-2	Year-3	Year-4	Year-5	**TOTAL**
Personnel	$ 6,894	$ 13,876	$ 13,172	$ 13,316	$ 7,000	$ 54,258
Consultant Costs	$ 64,588	$ 84,588	$ 84,588	$ 84,588	$ 84,588	$ 402,940
Indirect Operating Costs	$ 2,766	$ 4,923	$ 4,980	$ 5,037	$ 5,096	$ 22,802
	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL:	$ 74,248	$ 103,387	$ 102,740	$ 102,941	$ 96,684	**$ 480,000**

The County is requesting authorization to spend up to $480,000 in MHSA Innovation funding for this project over a period of five (5) years.

Personnel Costs total $54,258 and include:

- Lead Supervising Public Health Nurse (PHN), 0.115 FTE, will provide supervision, oversight, and follow up to nurses regarding patients seen in metabolic syndrome project and perform weekly calibration of project equipment.
- Three nurses, 0.01 FTE, will perform lab tests, check patient waist size, calculate Body Mass Index. Documents results and provides documentation to primary care practitioner.
- Consultant Costs/Contracts total $402,940 and include:
  - Contract with Sunrays of Hope Peer Wellness Center/Modoc Medical Center for gym use and provide health living exercise supervision
  - Telehealth Psychiatric Physician Assistant, to provide metabolic review with consumers plus review, analyze, prescribe and provide antipsychotic medication management where appropriate.
  - Primary Care Practitioner (PCP), $30,000 per year incentive (actual patient visit will be billable revenue for PCP through their own office practice). PCP will deliver services on MCHS premises and will review, analyze, and interpret testing results with patient, provide diagnosis based on test results. PCP will also provide primary care for those who don't utilize a personal PCP and coordinate recommendations for continued follow up if the patient has a preferred PCP.
  - **Evaluation Contractor costs are figured at 10% of the full INN project of $480,000 ($9,600 per year).**

Indirect Operating Costs total $22,802 and include:

- Overhead expenses, general and administrative expenses are calculated at approximately 14.5% of personnel cost for each year of operations.
- Funding to support stakeholder involvement at approximately $2,103 for four years for a total of $8,416.

Sustainability Plan

The County will determine whether to continue the project, or parts of the project, based on evaluation outcomes in consultation with stakeholders and the Behavioral Health Advisory Board. If the project is continued, the County will sustain the project with MHSA CSS funding. If the project is not sustained, the County will ensure continuity of care to the participants.

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations.

INNOVATION

TOOL KIT


MHSOAC
Mental Health Services
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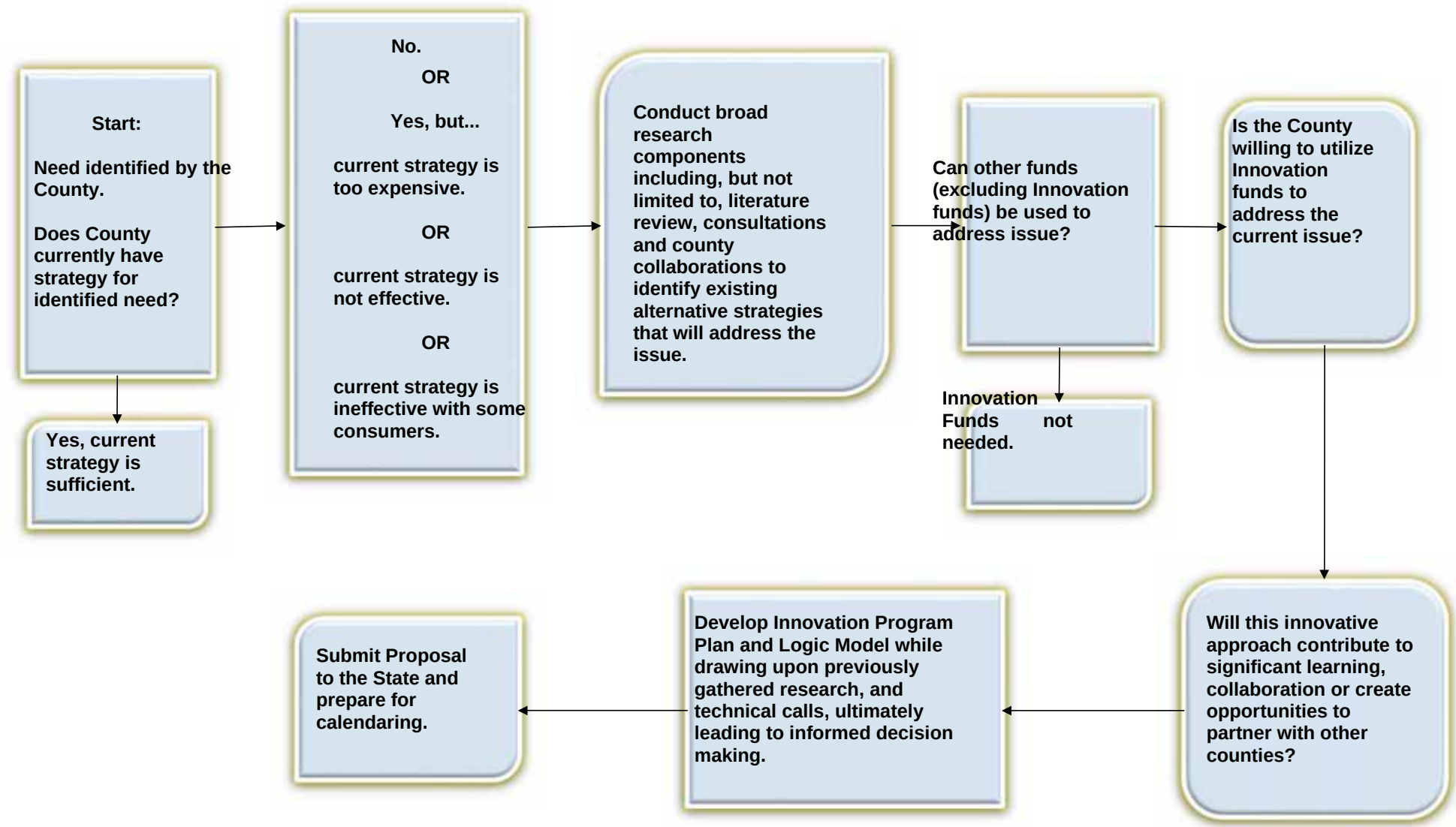
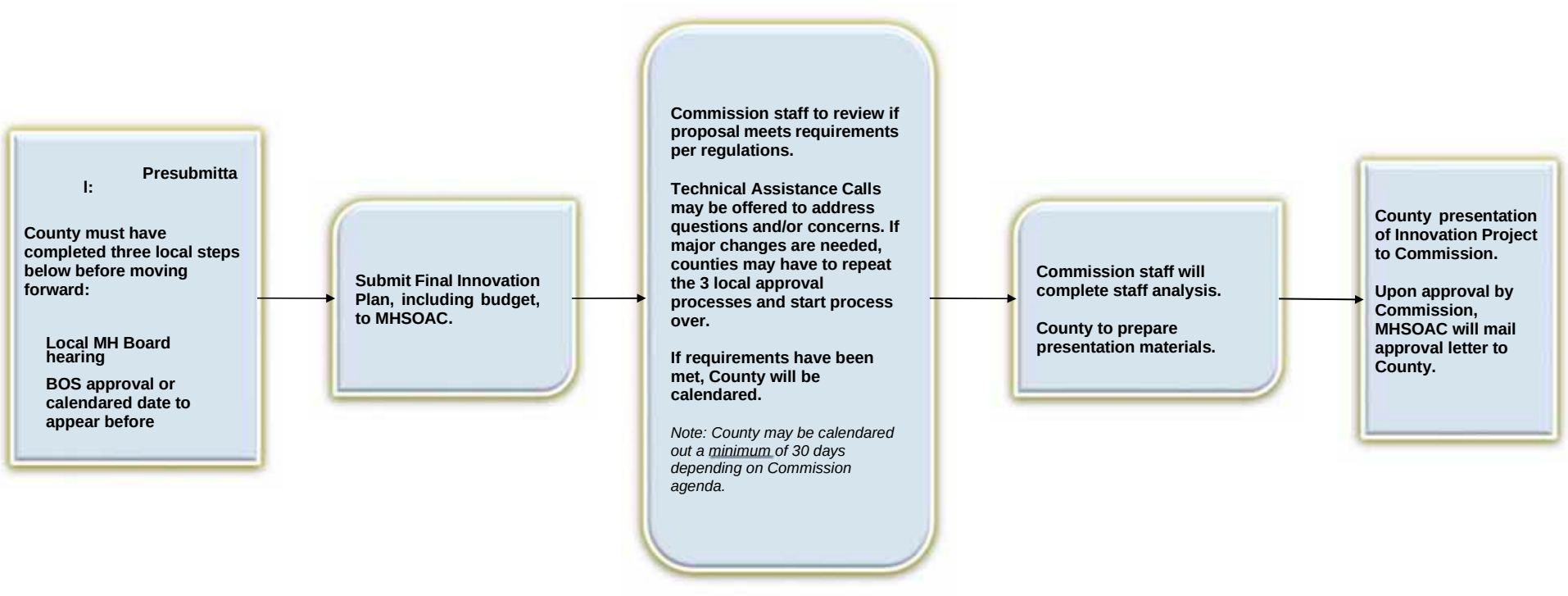
Innovation Framework Decision Tree



MHSOAC Innovation Review Process



INNOVATIVE PROJECT PLAN
RECOMMENDED TEMPLATE

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 the Board of Supervisors. *(Refer to CCR Title9, Sections 3910-3935 for Innovation Regulations and Requirements)*
X Local Mental Health Board approval Approval Date: 1/21/21
X Completed 30 -day public comment period Comment Period: 12/17/20-1/20/21
X BOS approval date Approval Date: 1/26/21 If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: ____NA_____ *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: __July 21, 2021_____ ***Note: Date requested above is not guaranteed until MHSOAC staff verifies <u>all requirements</u> have been met.***

County Name: Modoc County

Date submitted:

Project Title: **Integrated Health Care for Individuals with Severe Mental Illness (SMI)**

Total amount requested:

Duration of project: Five 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
- X 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
- X 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.

Individuals with serious mental illness die, on average, 25 years earlier than the general population, primarily due to preventable chronic disease.[1] A review of the literature reveals there are many variables which lead to this higher mortality rate, including cardiovascular diseases, diabetes, obesity, obesity-related cancer, stroke, and cigarette smoking (Parks et al., 2006).[2],[3],[4],[5]

Metabolic syndrome is a cluster of risk factors that includes obesity, high blood pressure,

[1] Parks, J., Svendsen, D., Singer, P., & Foti, M. E. (2006). *Morbidity and mortality in people with serious mental illness.* Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council.
[2] De Hert, M., Correll, C. U., Bobes, J., Cetkovichbakmas, M., Cohen, D., Asai, I., Detraux, Jl, Gautam, S., Moller, H., Ndetei, D. M., Newcomer, J. W., Uwakwe, R., & Leucht, S. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry,* 10(1), 52-77. doi:10.1002/j.20515545.2011.tb00014.x
[3] De Hert, M., Dekker, J. M., Wood, D., Kahl, K. G., Holt, R. I., & Moller, H. J. (2009). Cardiovascular disease and diabetes in people with severe mental illness position statement from the European Psychiatric Association (EPA), supported by the European Association for the Study of Diabetes EASD) and the European Society of Cardiology (ESC). *European Psychiatry*, 24(6): 412-24. Doi: 10.1016/j.eurpsy.2009.01.005.
[4] Glasheen, C., Hedden, S. L., Forman-Hoffman, V. L., & Colpe, L. J. (2014). Cigarette smoking behaviors among adults with serious mental illness in a nationally representative sample. *Annals of Epidemiology*, 24(10): 776-80. doi: 10.1016/j.annepidem.2014.07.009.
[5] Parks, J., Svendsen, D., Singer, P., & Foti, M.E. (2006). *Morbidity and mortality in people with serious mental illness*.

elevated blood glucose and triglyceride levels, and a low level of high-density lipoprotein (HDL) cholesterol.[6] While criteria for diagnosing metabolic syndrome has evolved and is still a topic of debate, there is a general consensus within the medical community that in order to be diagnosed with metabolic syndrome, blood glucose must be elevated, in combination with at least 2 other criteria from this list. (Add citation: Huang P. L. (2009). A comprehensive definition for metabolic syndrome. *Disease models & mechanisms*, *2*(5-6), 231–237. https://doi.org/10.1242/dmm.001180) The prevalence of metabolic syndrome is high among people with schizophrenia, ranging from 19.4% to 68.0%, depending on the metabolic syndrome criteria used, gender, ethnicity, county, age groups, and antipsychotic treatment. The prevalence of metabolic syndrome is 25-50% among people with bipolar disorder, 42% among those with schizoaffective disorder, 12-36% among individuals with recurrent depression, and 32-35% among those with combat post-traumatic stress disorder.[7] A recent large national medical survey in Australia found that 57.8% of people with psychosis had metabolic syndrome.[8] Prevalence of metabolic syndrome is highly relevant to individuals with SMI because it is well accepted that metabolic syndrome "substantially augments risk for the development of type 2 diabetes mellitus and atherosclerotic cardiovascular disease", which, as referenced above, are leading contributors to morbidity and mortality in this population. (Add citation: Tune, J. D., Goodwill, A. G., Sassoon, D. J., & Mather, K. J. (2017). Cardiovascular consequences of metabolic syndrome. *Translational research : the journal of laboratory and clinical medicine*, *183*, 57–70. https://doi.org/10.1016/j.trsl.2017.01.001)

METABOLIC RATE AMONG SMI IS HIGH IN MODOC COUNTY

There is strong evidence of a high rate of metabolic syndrome among mental health consumers in Modoc County. In the early spring of 2020, a twelve-week period of chart review of SMI patients receiving psychotropic medications found that all (100%) had at least one of the metabolic parameters. Of the SMI subjects, two out of three (67%) had one or more comorbid health conditions, such as hypertension, diabetes, or heart disease and more than half (56%) had a BMI in the obese category.

There is strong evidence of high risk for metabolic syndrome among mental health consumers in Modoc County. In the early spring of 2020, a twelve-week period of chart review of SMI consumers receiving antipsychotic medications found that all (100%) met at least one of the metabolic parameters for metabolic syndrome. Of the SMI subjects in Modoc County, two out of three (67%) had one or more comorbid health conditions, such as hypertension, diabetes, or heart disease and more than half (56%) had a body mass index (BMI) in the obese category.

A primary reason for this high rate of metabolic syndrome among people with psychosis is that individuals who take antipsychotic medications are more likely to develop components of metabolic syndrome: "Antipsychotic medications are widely prescribed and carry a variable propensity to cause weight gain and its attendant sequelae – hyperglycemia, hypertension

[6] Ahima, R. S. (2016) [Ahima 1]. Overview of metabolic syndrome. In R. S. Ahima (ed.), *Metabolic syndrome: a comprehensive textbook*. Cham, Switzerland: Springer International Publishing.

[7] Jakovljević, M., Crencević ?., Ljubicić, D., Babić, D., Topić, R., & Sarić, M. (2007). Metabolic syndrome and depression in war veterans with post-traumatic stress disorder, *Psychiatria Danubia,* 19(12), 76-86.

[8] Waterreus, A., Di Prinzio, P., Watts, G. F., Castle, D., Galletly, C., & Morgan, V. A. (2016). Metabolic syndrome in people with a psychotic illness: is cannabis protective?. *Psychological Medicine*, 46(8), 1651-62. doi: 10.1017/S0033291715002883.

and hyperlipidemia. These metabolic risks . . . occur between two and five times more often in patients with psychosis than in the general population".[9]

Lambert also points out that older psychotropics caused unintended neurological effects, and newer psychotropics cause problems with cardiovascular and metabolic disease. However, even with these risks, Lambert says, "Antipsychotic drugs remain the cornerstone of treatment for a number of psychiatric illnesses, including schizophrenia and bipolar disorder."

A study of data from 2007 – 2012 showed that 34% of the general population had metabolic syndrome.[10] A separate meta-analysis stated that metabolic disorder in individuals with SMI was 58% higher than that of the general population.[11] Thus, 54% of the SMI adult population are estimated to suffer from metabolic disorder as compared to the 34% reported for the general population.

Researchers relate the strong bidirectional association between metabolic syndrome and mental conditions. They report that shared underlying neurological and physiological mechanisms explain the high comorbidity between these two disorders. They recommend, based on these shared mechanisms, that treatment should address both mental health and metabolic disorders.[12]

The impact on consumers of mental health services is that metabolic syndrome can lead to serious diseases, such as cardiovascular disease and type 2 diabetes,[13] which can both shorten people's lives and reduce their quality of life.

Studies indicate causal links between metabolic components and mental health [14],[15],[16],[17],

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[9] Lambert, T. (2011). Managing the metabolic adverse effects of antipsychotic drugs in patients with psychosis. *Australian Prescriber*, 34(4), 97-99. doi: 10.18773/austprescr.2011.057.

[10] Moore, J. X., Chaudhary, N., Akinyemiju, T. (2017). Metabolic syndrome prevalence by race/ethnicity and sex in the Uniter States. National Health and Nutrition Examination Survey. 1988-2012. Pre CChronic Dis 2017;14:160287. http://dx.doi.org/10.5888/pcd14.160287external_icon.

[11] Vancampfort D., Stubbs, B., Mitchell, A. J., De Hert, M., Wampers, M., Ward, P. B., Rosenbaum, S., Correll, C. U. (2015). Risk of metabolic syndrome and its components in people with schizophrenia and related psychotic disorders, bipolar disorder and major depressive disorder. A systematic review and meta-analysis. *World Psychiatry.* 2015 Oct; 14(3):339-47.

[12] Nousen, E. K., Franco, J. G., & Sullivan, E. L. (2013). Unraveling the mechanisms responsible for the comorbidity between metabolic syndrome and mental health disorders. *Neuroendocrinology*, 98(4), 254-66. Doi: 10.1159/000355632.

[13] Kamkar, M. A., Sanagoo, A., Zargarani, F., Jouybari, L., & Marjani, A. (2016). Metabolic syndrome in patients with severe mental illness in Gorgan. *Journal of Natural Science, Biology, and Medicine,* 7(1), 62-67. http://doi.org/10.4103/00976-9668.175073.

[14] Luppino, F. S., de Wit, L. M., Bouvy, P. F., Stijnen, T., Culjpers, P., Penninx, B. W. J. H., & Zitman, F. G. (2010). Overweight, obesity, and depression: a systematic review and meta-analysis of longitudinal studies. *Archives of General Psychiatry,* 67(3), 220-229.

[15] Ehrmann, D., Kulzer, B., Haak, T., & Hermanns, N. (2015). Longitudinal relationship of diabetes-related distress and depressive symptoms: analyzing incidence and persistence. *Diabetic Medicine*, 32(10): 1264-71. doi: 10.1111/dme.12861.

[16] Perry, B. I., Salimkumar, D., Green, D., Meakin, A., Gibson, A., Mahajan, D., Tahis, T., & Singh, S. P. (2017). Associated illness severity in schizophrenia and diabetes mellitus: A systemic review. *Psychiatry Research,* 256, 102-110. doi: 10.1016/j.psychres.2017.06.027. Epub 2017 Jun 13.

[17] Reimer, A., Schmitt, A., Ehrmann, D., Kulzer, B., & Hermanns, N. (2017). Reduction of diabetes-related distress predicts improved depressive symptoms: A secondary analysis of the DIAMOS study. *PLoS One,* 12(7), e0181218. doi: 10.1371/journal.pone.0181218.

[18],[19] thus underscoring the need for monitoring metabolic syndrome in order to address "not only the physical burden, but also psychiatric outcomes."[20]

Changes in modifiable health behaviors that address components of metabolic syndrome can directly foster mental health, according to research. Increasing physical activity as an adjunct to treatment, for example, can improve mental health, including reducing symptoms of schizophrenia, psychosis, and depression.[21],[22],[23]

Lack of primary care access and inconsistent patient follow-up, known medication side effects, and poor patient health habits, have all been identified as contributing to less optimum health outcomes in the SMI population.[24]

The health habits that contribute to worsening of these chronic medical conditions include smoking tobacco, poor nutrition and lack of physical activity. Improved access to preventive services (i.e. metabolic screening for those on antipsychotics), diet and exercise programs, tobacco cessation and consistent coordinated primary care could play a role in narrowing the mortality gap for persons with mental illnesses.[25]

Significant stressors in one part of a consumer's life – such as physical health – can have a large impact on their mental health. As stressors are reduced or eliminated, mental health consumers are better able to focus on, and are more likely to succeed on their journey to wellness and recovery. Modoc County Behavioral Health Department has fully embraced the Wellness and Recovery Model and takes a holistic view of consumer's wellness.

PROPOSED PROJECT

[18] Goughari, A. S., Mazhari, S., Pourrahimi, A. M., Sadeghi, N. M., & Nakhaee, N. (2015). Association between components of metabolic syndrome and cognition in patients with schizophrenia. *Journal of Psychiatric Practice*, 21(3), 190-7. Doi: 10.1097/PRA.0000000000000065.

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[25] CDC. (2015). Data and statistics—Mental health. Retrieved from https://www.cdc.gov/mentalhealth/data-stats.htm

Mental Health Services
Oversight & Accountability Commission

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.

Provide a brief narrative overview description of the proposed project.

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

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.

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

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

A) Description of Project:

Purpose:
The purpose of this project is to implement and evaluate an integrated approach to healthcare for Modoc County residents receiving specialty mental health services (SMS) who are prescribed antipsychotics. This approach will include mental health care combined with physical health care. The project will introduce a metabolic screening protocol for clients with SMI who are prescribed antipsychotics, identify high risk patients, and provide appropriate interventions with the goal of preventing or reducing negative health impacts. Nutrition, exercise, and tobacco cessation support are planned to be provided to help individuals with risk factors such as high blood pressure, diabetes, and obesity. Additionally, participants will be screened periodically, using the nine-question Public Health Questionnaire (PHQ 9) Depression Identification Tool and a tool that combines a 4-item Positive Symptom Rating Scale and Brief Negative Symptom Assessment (PSS-4/BNSS), by Behavioral Health nurses and licensed or waivered mental health clinicians, to measure mental health status, along with metabolic monitoring and on-site primary provider care.

The Modoc Health Service's Public Health Department and Modoc Medical Center will partner with the Modoc County Behavioral Health (MCBH) to provide an on-site lab draw station in the Modoc County Health Services (MCHS) building and primary care support, also in the MCHS building. Education regarding nutrition support, and tobacco cessation, will be provided to support consumers in addition to psychotropic medication management, along with opportunities for physical activity using different exercise modalities. We will engage our Promotoras and peer specialists to support the program and encourage meaningful consumer participation. This multi-disciplinary team will assist in engaging consumers to participate in program activities that are peer support-based and culturally competent. Providing the proposed on-site medical care will require modifications to rooms in the MCHS building; this project will also require the purchase of medical and exercise equipment.

In conjunction with primary care medical support, consumers will receive motivational interviewing at each visit. consumers' status will be monitored using the PHQ 9 and PSS-4/BNSS to assess mental health, along with periodic health assessments (tool in EMR), to track overall response to interventions provided.

Behavioral Health nurses will administer the health assessment, designed to summarize the physical health of SMI patients, and direct consumers towards interventions available to address their identified health problems as appropriate. This is included as an intervention because it has been shown that SMI individuals are less likely to demonstrate healthy physical self-care, or receive appropriate preventative medical care.[26]

Clinicians and Behavioral Health nurses will be trained to use Motivational Interviewing (MI), a "well-known, scientifically tested method of counseling clients developed by Miller and Rollnick and viewed as a useful intervention strategy in the treatment of lifestyle problems and disease."[27] The use of MI by both clinicians and Behavioral Health nurses will be used to encourage healthy physical self-care as a means

[26] White, J, Gray, R., Jones, M. (2009). The development of the serious mental illness physical Health Improvement Profile. Journal of Psychiatric Mental Health Nursing. 2009 Jun;16(5):493-8. PMID: 19538607. doi: 10.1111/j.1365-2850.2009.01375.x. Epub 2008 Mar 9.

[27] Rubak S, Sandbaek A, Lauritzen T, Christensen B. (2005) Motivational interviewing: a systematic review and meta-analysis. *Br J Gen Pract*. 2005;55(513):305-312.

to improve their mental health, measured by the tools selected by MCBH.

Modoc County Behavioral Health believes that the proposed supports to be provided to SMI consumers receiving psychotropic medications are necessary to maximize successful treatment of mental health symptoms in this population. Medical supports are shown to be essential to positive mental health outcomes as an appropriate approach to whole-person wellness and recovery. Providing these supports in the context of a behavioral health setting is an innovative approach to meeting the comprehensive needs of Modoc County's SMI consumers.

Current consumers and new consumers will be offered the opportunity to participate in the program to receive the proposed additional medical supports if they have elevated Body Mass Index (BMI), or they meet the guidelines for at least one metabolic syndrome parameter. If they choose to participate, they will be screened at initial presentation, and thereafter quarterly, for diabetes, high blood pressure, substance use, waist circumference, hemoglobin A1c, triglycerides, and HDL cholesterol. They will also be offered the opportunity to participate in nutrition classes, tobacco cessation education and exercise events.

Nutrition classes will be available either in person or by Zoom through the Public Health Department. Logistics of providing primary care support is currently in discussion and most likely to be accomplished in collaboration with Modoc Medical Center. Exercise opportunities are planned to be available through Sunrays, our peer-run wellness center. Tobacco cessation education will be provided by Public Health.

If a person chooses to opt in, or out, MCBH will request they sign a form designating their choice and stating the reason for their decision. Participation will be voluntary and there will be no consequences for consumers that choose not to participate.

An outside evaluator will be contracted to collect and evaluate data. Careful evaluation of data will determine whether or not the program was successful. This data and a comprehensive evaluation of such will be brought before the Behavioral Health Advisory Board to determine if the project, or parts of the project, should continue.

B) Project General Requirement

X Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population

This proposed project, if approved and implemented, would represent a substantial change to the way mental health services are presently provided by MCBH. Current practice does not include detailed monitoring of parameters for metabolic syndrome, nor does MCBH at present offer on-site primary care support, MI, tobacco cessation education, exercise opportunities, or nutrition classes to SMI consumers prescribed antipsychotics.

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?

Modoc County is proposing a project that differs from other projects in three ways:

1) The full population of SMI patients receiving antipsychotic medication will be offered participation rights in the study.
2) Given the small population involved, the study will be longitudinal in that it will cover five years. One study on collaborative care approaches for people with SMI covered a time frame of three years. The final analysis was that, even though hospital readmission rates seemed to have improved, there just wasn't enough evidence to show full confidence in the results.[28] We feel the longer time frame would be advantageous in determining validity to our findings.
3) All participants will be administered the nine question version of the Patient Health Questionnaire (PHQ 9) which is the major depressive disorder (MDD) module of the full PHQ. It is used to provisionally diagnose depression and grade severity of symptoms in general medical and mental health settings. Higher PHQ-9 scores are associated with decreased functional status and increased symptom-related difficulties, sick days, and healthcare utilization.[29] In addition to assessing depressive symptomatology, participants will be screened using the PSS-4/BNSS, which in combination with the PHQ 9 will provide a more comprehensive picture of participating consumers' mental health functioning. The brief symptoms screening scale has been validated as a valuable tool which can be effective to "rapidly assess negative symptoms in patients with schizophrenia". (citation: Alphs, L., Morlock, R., Coon, C., van Willigenburg, A., & Panagides, J. (2010). The 4-Item Negative Symptom Assessment (NSA-4) Instrument: A Simple Tool for Evaluating Negative Symptoms in Schizophrenia Following Brief Training. *Psychiatry (Edgmont (Pa. : Township))*, *7*(7), 26–32.) The PSS-4/BNSS tool selected for use by MCBH includes a "global self report" question that captures consumers' level of functioning from their own perspective.

When searching for similar projects, we found that Tulare County is conducting an approved Innovation Project which, on the surface, seemed to be almost identical in design to what we envision. We found that, though the design is much the same, Modoc's proposal is different than Tulare's in three critical aspects:

1) Modoc proposes to study a different population than Tulare. Tulare is studying only SMI who are receiving injectable psychotropics, whereas Modoc will make this study available to everyone receiving an antipsychotic medication in whatever form it is delivered; injectable, or otherwise.
2) The Project will be implemented in a small county with more limited resources than a midsize county like Tulare. However, because of its small population size, Modoc County boasts a very personalized relationship with the population in this project.
3) Modoc's project will include tools to measure the impact of integrated care upon the mental health of the participants. We did not see that Tulare's project included this.

Tulare and Modoc Counties are supporting each other in that Tulare County graciously agreed to let Modoc pull from their project proposal what was applicable to our proposal. They also told us of some of the challenges encountered, including Covid 19, and how they are pivoting to meet that emergency. We have taken their words of advice and have readjusted our proposed plan, especially in terms of appointment scheduling. In return, Modoc County has agreed to share our learning with Tulare when evaluations are performed and reports written. Tulare recently finished their first round of evaluation and promised to share their findings with Modoc when published. Modoc County looks forward to continued

[28] Reilly, S., Planner, C., Gask, L., Hann, M., Knowles, S., Druss, B., Lester, H. (2013). Collaborative care approaches for people with severe mental illness. Cochrane Database of Systematic Reviews 2013, Issue 11. Art. No.: CD009531. doi: 10.1002/14651858.CD009531.pub2.
[29] https://www.mdcalc.com/phq-9-patient-health-questionnaire-9#pearls-pitfalls

communication between the two counties about these projects.

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.

The Tulare County Project proposal indicated they conducted an extensive literature review using PubMed and Google Scholar. Tulare County graciously consented to let Modoc County use their exploration of this topic as a resource, and report the research discovered by Tulare County, along with references collected in our own research through Google and Google Scholar.

Tulare cited 21 programs found in their literature review. They found that none of these programs offer pharmacological treatment for any of the components of metabolic syndrome. They postulated it might be because none of these programs appear to include care from a licensed health care provider, which was part of Tulare's plan, and also part of Modoc's Project.

Of all the programs cited by Tulare County only one included monitoring for substance use. This study, "Team Solutions," included help for participants to reduce or eliminate their substance use, in order to address metabolic syndrome or its components. All of the other programs only address exercise and/or nutrition. [30] Holt & Peveler (2010), posit that steps can be taken to decrease the prevalence of physical disease for those with SMI such as addressing the cardiac and diabetic modifiable risk facts including obesity, smoking, and high cholesterol levels.[31] Others agree that tobacco use increases the prevalence of metabolic syndrome.[32] For this reason, we believe it is important to help participants not only exercise more and eat more healthfully, but also to reduce or eliminate their tobacco use.

Further research indicates that adults with SMI and chronic medical conditions are confronted with challenges in accessing care. In addition, the impairment that may occur in an exacerbation of their mental illness can significantly impact their ability to function. Those with SMI may struggle with altered perception, thoughts and behaviors.[33] This population is less likely to receive health promotion and preventative services, such as immunizations, preventative screenings (i.e., mammography or colonoscopy) and health education, including tobacco cessation education. Lack of these services can have negative health impacts for this population.[34] Other obstacles in receiving these services

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[30] "Solutions for Wellness" and "Team Solution": Lindenmayer, J.P., Khan, A., Wance, D., Maccabee. N., Kaushik, S., & Kaushik, S. (2009). Outcome evaluation of a structured educational wellness program in patients with severe mental illness. *Journal of Clinical Psychiatry,* 70(10), 1885-96. doi: 10.4088/JCP.08m04740yel. Epub 2009 Sep 22.

[31] Holt, R., & Peveler, R. (2010). Diabetes and cardiovascular risk in severe mental illness: A missed opportunity and challenge for the future. *Practical Diabetes International, 27*(2), 79-84ii. doi: 10.1002/pdi.1451.

[32] Kolovou, G. D., Kolovou, V., & Mavrogeni, S. (2016). Cigarette smoking/cessation and metabolic syndrome. *Clinical Lipidology*, 11(1): 6-14.

[33] Holt, R., & Peveler, R. (2010). Diabetes and cardiovascular risk in severe mental illness: A missed opportunity and challenge for the future. *Practical Diabetes International, 27*(2), 79-84ii. doi: 10.1002/pdi.1451.

[34] SAMHSA [Substance Abuse and Mental Health Services Administration}. (2006). Definitions and terms relating to co-

include poverty, discrimination (stigma) and lack of transportation.

Resources found at Advancing Integrated Mental Health Solutions (AIMS) of the University of Washington focused on collaborative care in a myriad of settings, but these primarily focused on depression and anxiety in a medical model and materials developed for psychiatric guidelines specifically stated the psychiatrist would not be prescribing medications.[35] Therefore, this program is substantially different from the Modoc proposal, which uses telehealth psychiatry to prescribe and manage psychotropic medication for the study population. And, though anxiety and depression are frequently encountered diagnoses amongst Modoc's medicated population, schizophrenia and other psychotic disorders are also often encountered; this proposal is broader in scope and more applicable to the SMI population served by MCBH.

The University of Washington's AIMS outcomes indicate that when patients and their families are part of integrated care, it increases "motivation, empowerment, adherence, and satisfaction." They also assert that involving patients and families typically resulted in better health outcomes.[36]

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?

Our learning goals are as follows:

1) Can this project increase the number of individuals taking antipsychotics who are diagnosed with, and treated for, metabolic syndrome?
2) Can this project improve participants' indicators of the components of metabolic syndrome?
3) Can this project improve participants' modifiable health behaviors related to metabolic syndrome?
4) Can offering integrated health care and improvement in health indicators improve participants' mental health symptoms as indicated by better PHQ 9 and PSS-4/BNSS scores?
5) Can offering health improvement strategies improve the overall quality of life for SMI consumers?

These learning goals are prioritized because they will help us answer the overarching question of

occurring disorders (DHHS Pub. No. [SMA] 06-4163). Rockville, MD.

[35] https://aims.uw.edu/collaborative-care/team-structure/psychiatric-consultant

[36] https://aims.uw.edu/collaborative-care/tean-structure/patient

whether integrated care will effectively address physical and mental health of SMI consumers who take antipsychotic medications by:

- Screening for the components of metabolic syndrome, diagnosing and treating it, if warranted;
- Improving the participant's indicators of the components of metabolic syndrome; and
- Improving their modifiable health behaviors related to metabolic syndrome
- Improving their quality of life, as evidenced by PHQ 9 scores measuring mood and PSS-4/BNSS measuring positive and negative symptoms and overall well being.

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

These goals relate to the approach of offering integrated care to SMI individuals in the form of in-house care which will offer lab draws, appointments with a licensed primary health care provider, nutritional and tobacco cessation education, exercise opportunities, and support from the entire mental health clinical team, all in the same building. Improvement in participants' overall physical and mental health is the goal of this project. This approach will help identify risk factors, offer medical treatment for metabolic syndrome, and support healthy lifestyle changes that research has demonstrated to impact metabolic syndrome and mental health.

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.

An evaluation consultant will be contracted and monitored by the MHSA Health Program Manager to formally evaluate the innovation project. This will likely be someone from California Institute of Behavioral Health Solutions (CiBHS), who has worked with Modoc County previously and is well-acquainted with small county limitations and opportunities. The following depicts a proposed evaluation plan,which will be more fully developed after the project is approved. All data will be collected from electronic health records. Modoc County will work with KingsView to develop queries to collect the data. Data will be collected quarterly and reviewed by the evaluator and the Behavioral Health Branch Director. Quarterly and annual reports will provide trends and be reported to the Behavioral Health Advisory Board.

Depending on the size of the population studied, appropriate statistical analyses will be performed to determine confidence, reliability and validity as the project progresses.

Learning goal #1: Can this project increase the number of individuals taking antipsychotics who are diagnosed and treated for metabolic syndrome?

The outputs for Learning Goal #1 could include:

- Baseline of total # of SMI individuals currently on antipsychotic medication(s).
- Baseline for SMI individuals on antipsychotic medication(s) currently enrolled in integrated health care for a component of metabolic syndrome.
- Number of SMI individuals prescribed antipsychotics who choose to engage in integrated health care to monitor and treat metabolic syndrome over a five-year period.
- Number of SMI individuals who choose not to engage in integrated health care to monitor and treat metabolic syndrome over a five-year period.
- Number of SMI individuals who choose to engage in integrated health care to monitor and treat metabolic syndrome over a five-year period but drop out of program within 12 months.

Perform interviews with those who drop out of the program to determine their reasons for leaving integrated health care.

In addition, demographics of participants will be collected that include questions on race, ethnicity, sex, age, etc., as required for MHSA demographic reporting.

Learning goal #2: Can this project improve participants' indicators of the components of metabolic syndrome?

The outputs for Learning Goal #2 could include:

- Waist circumference ≥102 cm (40 in.) in men or ≥88 cm (≥35 in.) in women; if Asian American, ≥90 cm (35 in.) in men or ≥80 cm (32 in.) in women
- Blood pressure ≥130/80 mm HG (or receiving drug therapy for hypertension)
- Triglycerides ≥200 mg/dL (or receiving drug therapy for hyperlipidemia)
- HDL cholesterol <40 mg/dL in men or <50 mg/dL in women (or receiving drug therapy for hyperlipidemia
- Impaired glycemia: Hemoglobin A1c ≥ 5.7 (or already diagnosed with diabetes or receiving drug therapy for hyperglycemia)
- Body Mass Index >30

Learning goal #3: Can this project improve participants' modifiable health behaviors related to metabolic syndrome?

The outputs for Learning goals #3 could include:

- Documented decrease in tobacco and other substance use, using the Health Assessment
- Documented participation in nutrition education, using the Health Assessment
- Documented participation in exercise events, using the Health Assessment

Learning goal #4: Can offering integrated health care improve participants' PHQ 9 scores and global self-report of functioning on the PSS-4/BNSS tool?

The output for Learning goal #4 could include

- Documented decrease of PHQ 9 scores and improved global self-report scores on the PSS-4/BNSS tool.

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?

All Modoc County Health Services (MCHS) agreements (contracts, MOU's) are monitored by a MCHS Manager that has the subject matter expertise. Reporting deliverables are established in the agreements (after approved through legal counsel and by the Board of Supervisors), and linked to invoicing. Payments for services are contingent on the reporting requirements being met. The MHSA Manager will monitor the evaluation contract for this project in collaboration with the MCHS Behavioral Health Branch Director.

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.

In June 2020, during a community/stakeholder planning meeting, this project was proposed by peers. In subsequent conversations with MCBH and the Advisory Board, peers participated in formulating this proposal as a possible plan to increase access, and improve the quality of care, for patients with SMI prescribed antipsychotics.

During 2020, in lieu of having our normal in-person groups and stakeholder meetings, due to Covid-19, we sent out a survey in both electronic and printed form asking for input from the general community, our partners, stakeholders and colleagues within other County government departments. Additional input was sought from the Community Corrections Partnership during regular monthly meetings, particularly as we continue to collaborate on Continuum of Care for Behavioral Health consumers who are involved in the Criminal Justice System.

A formal survey was conducted from October 15-30, 2020, in English and Spanish. The survey was sent directly to community stakeholders, after advertising it in the newspaper and via flyers. Additionally, it was offered to individuals when they received services at MCBH, or visited Sunrays, the local wellness center.

In total, 100 individuals, or a little over one percent of the county population, completed this year's community planning survey. Of those, 56% were Modoc County residents and 46% used behavioral health services. Some survey respondents were connected to behavioral

health in the following ways: family members of someone who uses behavioral health services, behavioral health care providers, physical health care providers, social services staff, county or government staff, school employees or volunteers, and medical or health care organization staff.

The majority of survey respondents were adults and identified as white and non-Latino. Approximately two-thirds of respondents were female and one-third male. Eight-one percent of the respondents were heterosexual or straight. Sixteen percent of respondents indicated they had a physical disability, and 34% had a mental or emotional disability.

Survey responses indicated that behavioral health counseling, medication management and telehealth psychiatry were three of the most important services offered by the county (mean scores 3.7, 3.6, and 3.4 respectively). Only case management and suicide prevention topped telehealth psychiatry (mean scores 3.5 each).

One person responding to the survey wrote in a request for more up-to-date scales in the offices, which would be addressed in this Project.

This Innovation proposal was included in the MHSA FY 2021-2022 Annual Update and FY 19/20 PEI Evaluation Report. It was posted for a 30-day public review and comment period from Dec. 17, 2020 through January 20, 2021. An electronic copy was available online at modochealthservices.org/index.php/MHSA. Hard copies of the document were available at the Behavioral Health clinic and in the lobbies of all frequently accessed public areas, including the Court House, County Administration, and the local library. In addition, hard copies of the MHSA Annual Update FY 2021-2022 and FY 19/20 PEI Evaluation Report were distributed to all members of the Behavioral Health Board; consumers (on request); staff (on request); and Sunray's of Hope Wellness Center. The FY 2021-2022 Annual Update and FY 19/20 PEI Evaluation Report was also sent electronically to the Community Partnership Group/partner agencies and other stakeholders.

A public hearing was conducted on Thursday, January 21, 2021, at 3:30 pm, at Modoc County Health Services, 441 N. Main Street, Alturas, CA, in the large conference room.

The Innovation proposal was highlighted during the public hearing with discussion and participants in the hearing expressing support of the possible project. As part of the discussion, our involvement in Help@Hand was questioned, as stakeholders had previously voted to discontinue that INN project. The group unanimously supported pausing Help@Hand until this new INN could be approved, then to roll over any funding left in the Help@Hand project.

The final document was approved by the County Board of Supervisors (BOS) on January 26, 2020; and submitted within 30 days, to the California Mental Health Services Oversight and Accountability Commission (MHSOAC) and the California Department of Health Care Services (DHCS), as required.

We will continue to distribute annual INN reports to our stakeholders, both client and community. We will bring regular reports to our Behavioral Health Advisory Board, and seek their input when discussing the continuation of the project. This discussion will include

focus on the sustainability of the project, or parts of the project, without INN funds, if the stakeholders remain positive about the project and want it to continue.

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.

Community Collaboration

Cultural Competency

Client-Driven

Family-Driven

Wellness, Recovery, and Resilience-Focused

Integrated Service Experience for Clients and Families

A) **Community Collaboration**

The proposed project will require collaboration with SMI individuals to ensure the most culturally relevant engagement strategies are employed; with service providers to bring appropriate services to the SMI population and allow for integrated care between behavioral health, public health, and service providers; and the community at-large. These services may utilize some physical therapy resources of Modoc Medical Center, or other infrastructure within the community, necessitating a collaborative approach.

B) Cultural Competency

In order to deliver culturally responsive services, MCHS utilizes staff and peers that are bilingual/bicultural, Spanish-speaking, and/or those with personal experience with mental health, to represent the SMI individuals being served. Modoc County is proud to have a patient navigator and health promotora program embedded in its rural communities to assist with engaging participants in culturally appropriate outreach activities. Furthermore, MCBH staff receive periodic training on the topic of cultural competency as required by MHSA; the knowledge acquired through ongoing training will be applied in working with participants in this program.

C) Client-Driven

This project is strongly client-driven. First and foremost, it was proposed by peers. Secondly, participation is completely voluntary; consumers taking antipsychotics may choose to participate, or decline to participate in the project, or any of its elements, at any time with no impact to their treatment.

If they are diagnosed with a component of metabolic syndrome, the participant will work with the Behavioral Health nurse, clinician, and provider, to develop an individualized treatment plan tailored specifically to meet their needs. This is completely voluntary on the part of the participant. The plan can be revised at the request of the participant, in collaboration with the Behavioral Health nurse, clinician, and/or provider. The consumer is genuinely the primary driver of this process. A focus on the client's satisfaction of services, PHQ9, and PSS-4/BNSS scores will be closely monitored for positive progress toward client-driven recovery.

D) Family-Driven

Participating consumers' family members and friends will be encouraged to help participants, if they are invited to do so by the participant. Family members' active participation could prove to be invaluable, especially in encouraging participants to engage in treatment for metabolic syndrome or its components, if needed, and in supporting them as they make changes in their health behaviors.

When the Behavioral Health nurse completes a Health Improvement Plan (HIP) with a participating consumer, a family member, friend, or other support person can be included in the plan development process if the participant wants to have them involved. With participant's written permission, the nurse will give the involved family member/friend/support person a second copy of the HIP. If the participant so chooses, he or she may share their own copy with additional family members or friends whom the participant believes will support him or her as they make health behavior changes, which can often be challenging.

E) Wellness, Recovery, and Resilience-Focused

Modoc County Behavioral Health believes that supporting wellness, recovery and resilience is accomplished through relationships and social networks, flexibility, respect, and responsiveness, while taking a holistic approach that considers the overall health and independence of consumers. These principles are embodied in the strategies of the proposed project because this agency has fully embraced a wellness and recovery model for all of our consumers. This is evidenced by our robust FSP program for consumers, and Sunrays, a non-profit wellness center to provide support to individuals struggling with mental health concerns, which works closely with MCBH. This project provides integrated mental health care and physical health care in a plan tailored specifically for each individual SMI participant receiving antipsychotic medications, if they desire to participate.

F) Integrated Service Experience for Clients and Families

The provision of an integrated service experience is the essence of this project, as it will address specific physical health needs of SMI consumers in a mental health clinic setting, with the ultimate goal of improving both their mental and physical health. Integration of systems of physical health care and mental health care for the participating consumers is fundamental to this project. Key project elements that demonstrate integration include:

(1) Having a licensed medical provider see mental health consumers in a physical exam room inside the mental health clinic building.
(2) Including physical health information of participating consumers related to metabolic syndrome in the mental health electronic health records system, and encouraging psychiatric providers, Behavioral Health nurses, and clinicians at the mental health clinic to review it, and use the information in their work with the participants.
(3) A Behavioral Health nurse works with SMI consumers in the mental health clinic to develop modifiable health behavior improvement plans related to metabolic syndrome, in collaboration with consumers and family members/support people.

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.

We will continue to distribute annual INN evaluation reports to our stakeholders, including both clients and to the community in general, in our threshold languages of English and Spanish. We will present quarterly reports to our Behavioral Health Advisory Board, and seek their input when discussing the continuation of the project. This discussion will also include the sustainability of the entire project, or parts of the project, without INN funds, if the stakeholders remain positive about the project.

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 the evaluation outcomes for the project demonstrate a sufficient level of effectiveness, as determined by the Behavioral Health Advisory Board based on data analysis, we will plan to continue to support the project, or parts of the project deemed worthwhile, with Community Services and Supports (CSS) funds. If the project is determined not to be effective, the project will end relative to data collection and evaluation; however, we will ensure continuity of care for project participants, to the fullest extent possible.

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

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

A) Communication

An overview of the project and key evaluation findings will be presented in a public forum during our Behavioral Health Advisory Board's general meeting on an annual basis, if the Board so chooses. We will also publicly share our project reports, including our comprehensive final report, with stakeholders and community members interested in an in-depth review of the project. Information on the project will also be published in online social media posts (including Facebook) of Modoc County Health Services and on the Agency's website.

We will distribute our comprehensive final project report to other counties via their MHSA coordinators. This report will include all evaluation results as well as detailed descriptions of the project and all of its elements and its work process. It will describe barriers the project encountered, how they were overcome, and any changes that were made in the project over time. All of this will be provided to other counties with the aim of helping them to replicate the project, if they so choose.

B) Search Key Words

1. Metabolic syndrome
2. Health behaviors
3. Health integration
4. Innovation
5. Modoc County

TIMELINE

A) Specify the expected start date and end date of your INN Project

April 1, 2022 – June 30, 2027

B) Specify the total time frame (duration) of the INN Project

Five years, three months (effectively five years)

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

The timeline will be negotiated with the contracted entities and may change during implementation.

April – July, 2022—Administrative Startup

- Consideration and specification of the project goal
- Deliberations regarding project objectives
- Deciding which services the project should offer to achieve the objectives
- Development of the work process and evaluation plan
- Discussion of the information that currently exists in the electronic health record system and how project information could best be extracted from it.
- Consideration of needed staff and policies and procedures

August – December, 2022—Administrative Startup

- Construction of the physical exam room in the mental health building completed
- Deciding upon hours of operation
- Selection of internal staff for the project
- Finalizing the release of information form

March – April, 2023—Preparation Phase

- Finalizing the objectives, services, work process, and evaluation plan.
- Completing the policies and procedures.
- Continuing enrollment of project participants.
- Finishing changes to the electronic health record system to facilitate the entry and retrieval of project information.
- Finishing changes to the electronic health record system to flag when services are due to participants.
- Finalizing the menu of information, services, and supportive resources to offer participants, to help them make changes in their modifiable health behaviors.
- Finalizing development of forms

April – June, 2023—Preparation Phase

- Educating mental health clinic staff about metabolic syndrome and policies and procedures related to the project and the physical examination room.
- Training select clinic staff in the use of the blood testing equipment.
- Providing basic training to the staff members (licensed medical provider, behavioral

health nurses) who will primarily implement the project.

- Enrolling project participants on a voluntary basis. Participants sign release of information form.
- Conduct an operations test “walk-through” just prior to implementation, for final trouble-shooting.
- Development and selection of new project interventions to implement starting in July, 2023.

July, 2023 – September, 2026—Implementation Phase (presented as a compilation of eight quarters due)

- Participants see the licensed medical provider, on a quarterly basis in a physical exam room in the mental health clinic, on the same days when they receive antipsychotic medication, refills, and/or telehealth appointments, if possible.
- Psychiatric providers, nurses, and clinicians at the mental health clinic review the participants’ metabolic syndrome-related information in the mental health electronic record system. The purpose is to use the information in their work with the participating consumers and help and encourage consumers as they work to achieve the modifiable health behavior goals established in their individual client plans.
- Entry/scanning of data into the electronic health record systems.
- Communication with PCPs of metabolic syndrome-related information.
- Attendance at Treatment Team Meetings and solicitation of feedback from the Behavioral Health Cultural Competency Committee on the level of cultural competence in the project.
- Instructing licensed psychiatric providers, nurses, and clinicians at the mental health clinic in how to review the metabolic syndrome information, including the modifiable health behavior plans, of participating consumers in the electronic health record system.
- Instructing licensed psychiatric providers, nurses, and clinicians in how to assist and encourage participating consumers to meet their modifiable health plan goals.
- Review of process and outcome evaluation data by the Treatment Team, at least on a quarterly basis, to ensure that the project implementation is continuing as planned.
- External evaluator will write annual reports for presentation to the Behavioral Health Advisory Board, if the Board so chooses, and for inclusion in MHSA Annual Updates and new three-year plan, if needed.

October – December, 2026—Final Outcome Evaluation and Dissemination Phase

- Administration of any final surveys, interviews, etc.
- Comparative pre- and post-review of participants’ mental health records to gauge the extent to which metabolic syndrome or its components were considered by licensed psychiatric providers in their work with participants.
- Analysis of all project data, including statistical significance testing if applicable, by the External Evaluator.

January – March, 2027—Final Outcome Evaluation and Dissemination Phase

- Writing of the comprehensive final project report by the External Evaluator. Development of summaries of varying lengths, to aid in dissemination.
- Dissemination of the comprehensive final project report and summaries to local stakeholders, for as wide a distribution as possible, and to MHSA Managers in other California counties based upon interest.
- Continue services to participants, to the fullest extent possible.

April – June, 2027—Final Decision-Making Phase

- Decide whether to continue the project, or parts of the project, with other funding source, or sources, based on the evaluation outcomes. This decision will consider stakeholder input, including that of program participants and family members, in the process.
- Writing up of the final comprehensive report by the External Evaluator, for submission to MHSOAC by June 30, 2027.

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.

The total Innovation funding request for 5 years is $480,000, which includes $300,000 new Innovation funding and $180,000 rollover from predicted unused Help@Hand Innovation funding.

Personnel

2022-2023 Salaries:

1. Lead Supervising Public Health Nurse (PHN), 0.115 FTE, $12,179—Provide supervision, oversight and follow up to LVNs regarding patients seen in metabolic syndrome project. Weekly calibration of project equipment. (This position is also supported by other funding** for FY 22/23.)
2. Three LVNs, 0.01 FTE, $6,894—Perform lab tests, (blood test by finger pokes, drawing blood, measurements). Check patient waist size, calculate Body Mass Index (BMI). Documents results and provides documentation to primary care practitioner.

2022-2023 Total Personnel Costs (includes benefits/worker's comp): $6,893 (LVNs only)

Annual increases for personnel costs are calculated for subsequent years, based on an average of 2% increase per year. These costs include benefits/worker's comp).

2023-2024: $13,876—LVNs and PHN

2024-2025: $13,172

2025-2026: $13,316

2026-2027: $7,000—LVNs only, PHN will be funded from other sources

Total Five-Year Personnel Costs: $54,258

Operating Costs

Direct Costs:

Consumable medical and office supplies: Purchase of medical supplies to perform required tests.

Items include but are not limited to: test kits, test strips, needles, gauze, medical tape, sanitized wipes, alcohol pads, paper towels, drapes, paper table covers, face masks, hand sanitizer, and gloves. Healthy Living Classes materials, food.

2022-2023: $0

2023-2024: $0

2024-2025: $0

2025-2026: $0

2026-2027: $0

Total Five-Year Direct Operating Costs: $0**

Indirect Costs: Program Oversight and administrative costs. Indirect cost for overhead expenses, general and administrative expenses are calculated at approximately 14.5% of personnel cost for each year of operations. Also included is funding to support stakeholder involvement at approximately $2,103 for four years for a total of $8,416.

2022-2023: $2,766—Stakeholder expenses incurred before approval of INN by MHSOAC

2023-2024: $4,923

2024-2025: $4,980

2025-2026: $5,037

2026-2027: $5,096

Total Five-Year Indirect Operating Costs: $22,802

Non-recurring Costs: Purchase of equipment, furniture, technology, and remodel- Medical exam room have been fully completed with needed medical equipment, EKG machine, Lipid/Cholesterol machine, urinalysis machine, and Hgb A1C Machine. Furniture includes a medical table, chairs, wall cabinets, rolling cabinets, computer mount. Technology includes electronic health records computer monitors, keyboard, mouse, lap top, printer, and label printer. Health indicator tracking dashboard in the electronic health records system.

2022-2023: $0

2023-2024: $0

2024-2025: $0

2025-2026: $0

2026-2027: $0

Total Five-Year Non-Recurring Costs: $0**

Consultant Costs/Contracts—contract with Sunrays/Modoc Medical Center for gym use

1. Telehealth Psychiatric Physician Assistant, $26,988 per year based on five minutes of metabolic review with consumers (12 patients/day, 3 days/per week at $173/hr.)--Review, analyze, prescribe and provide antipsychotic medication management with patients.
2. Primary Care Practitioner (PCP), $30,000 per year incentive (actual patient visit will be billable revenue for PCP through their own office practice; they will deliver services on MCHS premises; first year funded by additional funding**)—Review, analyze, and interpret testing results with patient. Provide diagnosis based on test results. Provide primary care for those who don't utilize a personal PCP. Coordinate recommendations for continued follow up if the patient has a preferred PCP.
3. Evaluation Contractor costs are figured at 10% of the full INN project of $480,000. This comes to $9,600 per year.
4. Sunrays of Hope peer wellness center for healthy living exercise supervision; $28,000 first year (includes $10,000 for equipment purchase), then $18,000 per year thereafter. Modoc has no suitable gym accessibility for SMI individuals.

2022-2023: $64,588—does not include Telehealth Psychiatry Assistant's first year of $30,000 covered by additional funding**

2023-2024: $84,588

2024-2025: $84,588

2025-2026: $84,588

2026-2027: $84,588

Total Five-Year Consultant Costs/Contracts: $402,940

Total Personnel Costs: $54,258

Total Operating Costs: $22,802

Total Non-Recurring Costs: $0

Total Contract Costs: $402,940

Total Five-Year Innovation Budget: $480,000*

*Funding Sources:

Integrated Health Care for Individuals with Severe Mental Illness INN project: up to $300,000

Help@Hand Innovation Rollover Funds: $180,000

Total: $480,000

**Additional Funding:

DHCS Behavioral Health Integration Grant already approved for FY 21-22 = $330,000; covers capital improvement, technology, equipment costs, some personnel costs for the initial start-up and partial first year funding.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
1.	Salaries	6,894	13,876	13,172	13,316	7,000	54,258
2.	Direct Costs						
3.	Indirect Costs						
4.	Total Personnel Costs	6,894	13,876	13,172	13,316	7,000	54,258
OPERATING COSTS		**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
5.	Direct Costs						
6.	Indirect Costs	2,766	4,923	4,980	5,037	5,096	22,802
7.	Total Operating Costs	2,766	4,923	4,980	5,037	5,096	22,802
NON RECURRING COSTS (equipment, technology)		**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
8.							
9.							
10.	Total Non-recurring costs						
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
11.	Direct Costs	64,588	84,588	84,588	84,588	84,588	402,940
12.	Indirect Costs						
13.	Total Consultant Costs	64,588	84,588	84,588	84,588	84,588	402,940
OTHER EXPENDITURES (please explain in budget narrative)		**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
14.							
15.							
16.	Total Other Expenditures						
BUDGET TOTALS							
Personnel (line 1)		6,894	13,876	13,172	13,316	7,000	54,258
Direct Costs (add lines 2, 5 and 11 from above)		64,588	84,588	84,588	84,588	84,588	402,940
Indirect Costs (add lines 3, 6 and 12 from above)		2,766	4,923	4,980	5,037	5,096	22,802
Non-recurring costs (line 10)							
Other Expenditures (line 16)							
TOTAL INNOVATION BUDGET		74,248	103,387	102,740	102,941	96,684	480,000

*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.

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 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
1.	Innovative MHSA Funds	2,766	4,923	4,980	5,037	5,096	22,802
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**						

EVALUATION:

B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
1.	Innovative MHSA Funds	9,600	9,600	9,600	9,600	9,600	48,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**						

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 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
1.	Innovative MHSA Funds	74,248	103,387	102,740	102,941	96,684	480,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**						

*If "Other funding" is included, please explain.

COMMISSION MEETING RECOMMENDATIONS

These recommendations for innovation plan presentations have been developed to support the dialogue between the Commission and the counties. Please note that the recommendations below regarding length, the county brief, PowerPoint presentation and presenter information are to ensure that counties and the Commission have ample opportunity to engage in a dialogue to gain a better understanding of the needs in the county, how the innovation plan meets those needs, why it is innovative and how will it be evaluated to support shared learning.

1. **Length of Presentation**
    a. County presentations should be no more than 10-15 minutes in length
    b. The Commission will have received the Innovation Project Plan as well as the Staff Analysis prior to the meeting
    c. The remaining time on the agenda is reserved for dialogue with the Commission and for public comment

2. **PowerPoint Presentation**
    a. Recommend bulleted slides to allow County to discuss and highlight project and dialogue
    b. Recommend 5 slides and include the following five (5) items:
        i. Presenting Problem / Need
        ii. Proposed Innovation Project to address need
        iii. What is innovative about the proposed Innovation Project? How will the proposed solution be evaluated (learning questions and outcomes)?
        iv. Innovation Budget
        v. If successful, how will Innovation Project be sustained?

3. **County Brief (optional)**
    a. Recommend 2-4 pages total and should include the following three (3) items:
        i. Summary of Innovation Plan / Project
        ii. Budget
        iii. Address any areas indicated in the Staff summary

4. **Presenters and Biographies**
    a. We request no more than a few (2-4) presenters per Innovation Project
        i. If the county wishes to bring more presenters, support may be provided during the public comment period
    b. Recommend biography consisting of brief 1-2 sentences for individuals presenting in front of the Commission
        i. Include specific names, titles, and areas of expertise in relation to Innovation Plan / Project

Note: Due dates will be provided by Innovation Team upon Commission calendaring for the following items: Presenter Names, Biographies, County Brief, and PowerPoint presentation.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS - ORANGE COUNTY

Innovation (INN) Project Name:	**Community Program Planning Proposal**
Total INN Funding Requested:	**$950,000**
Duration of Innovative Project:	**5 Years**
MHSOAC consideration of INN Project:	**Delegated Authority**

Review History:

Approved by the County Board of Supervisors:	Anticipated June 2022
Mental Health Board Hearing:	April 13, 2022
Public Comment Period:	February 25, 2022 – March 27, 2022
County submitted INN Project:	February 26, 2022
Date Project Shared with Stakeholders:	March 2, 2022

Project Introduction:

Orange County requests authorization to use up to $950,000 of Innovation funding over five years to support the Innovation-related Community Program Planning Process (INN related CPPP). The County proposes to use these funds towards the following activities to meaningfully engage their partners in proposal development and feedback throughout the duration of the project:

- **Innovation staff time** to research concepts, develop materials, and coordinate meetings
- **Translation and Interpretation services** to support County's diverse community
- **Consultants and Subject Matter Experts** to assist in facilitating meetings
- **Marketing Strategies** to reach the broader community
- **Program supplies** (stipends, transportation costs for partners to attend meetings, cost of printing and discussion materials, etc.)

Summary

The Mental Health Services Act specifies that each county may spend up to five percent of their respective total MHSA allocations on the CPP process. The Act and regulations further *require* every county to ensure that the CPP process is adequately staffed, that a diverse set of stakeholders participate in the process - including persons with lived experience, and that

appropriate training is provided to participants to enable more meaningful participation. Additionally, authority to spend INN funds on INN-related CPPP has precedence. The California Department of Mental Health previously advised counties as to the maximum amount of INN funds they could apply to INN-related CPPP during the initial (2008-09 and 2009-10) roll-out of the Innovation Component. The Department of Health Care Services is not opposed to counties using INN funds for the CPPP if the Commission approves budget authority for that purpose. Community program planning for Innovation is more difficult than community planning in other areas. Budgeting more than the 5 percent can be justified.

Orange County has clearly stated in their proposal that they expect an increase in MHSA revenue annually (from $8 million to $11 million-p. 1) and proposes to utilize this increase towards dedicated innovation staff time and resources to develop new Innovation projects, engage meaningfully with their partners and demonstrate their commitment to engage their community in the development and implementation of Innovation projects. Current expenditures are an estimated $7.3M, leaving $73.7M in available INN funding through FY 2027-28. Orange County plans to use approximately 1.3% of their INN funding to determine the use of $73.7 M, which is a reasonable request. If Orange County's request is approved, they will include this proposal in their 2022-23 Annual Update which will be finalized by their Board of Supervisors in late June.

Budget

Category	Annual Budget*	5-yr Budget*
INN Staff Time	$25,000	$125,000
Translation/Interpretation	$50,000	$250,000
Consultants	$50,000	$250,000
Marketing	$15,000	$75,000
Program Supplies	$50,000	$250,000
	Total Requested Budget:	$950,000

**Budget line items are estimates and may vary depending on specific INN CPPP activities and needs that are identified. However, the total INN budget will not exceed $950,000 over five years.*

This proposal was shared with the Commission's list serve, stakeholder contractors and its Client and Family Leadership and Cultural and Linguistic Committees on March 2, 2022. No letters of support or opposition were received.

Orange County plans to share its learning from this new, and more informed community program planning process by sharing the following outcomes with their local communities:

- Type of engagement meetings held
- Target populations reached
- Number of community members who participated
- Projects that were supported
- Number of projects submitted to the Commission

Additional Regulatory Requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations; however, if Innovation Project is approved, the County must receive and inform the Commission of this certification of approval from the Orange County Board of Supervisors before any Innovation Funds can be spent.

CLAYTON CHAU, MD PhD
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Orange County Innovation Community Program Planning Proposal

Primary Need

The community program planning process is a required element of the Mental Health Services Act (MHSA), intended to meaningfully involve the community in identifying mental health needs and priorities, program planning, implementation, etc. (Welfare and Institutions Code, [WIC] § 5848[a]). Orange County's MHSA Office invests a great deal of time and effort in the community program planning process, both for its MHSA Plans and Innovation (INN) projects. The input from the community is vital to effective planning and program development that reflects the voice and needs of Orange County's diverse communities. Over the years, the MHSA Office has strived to continuously improve on its process for more robust community planning, but additional efforts are needed to reach the broader community and gather meaningful input, particularly for INN projects.

Under the Act, counties may use up to 5% of their MHSA funds toward community planning (WIC § 5892[c]), and the development of an INN proposal requires dedicated staff time and ongoing engagement meetings with the community. Based on lessons learned from Orange County's local vetting and community planning for INN projects, the concept development, research activities, community engagement and proposal development can take up to nine months or longer before it is ready for MHSOAC review and approval. With limited staffing resources, the County can only pursue one or two potential ideas at a time. As such, if community feedback results in a decision to stop pursuing a potential idea, INN Staff must restart the process of identifying and pursuing a new INN idea. Thus, the INN planning process is much more labor-intensive than other components of MHSA. The impact of limited staffing and potential for lost time, paired with the need to plan for new and/or carry over INN funds, increases the risk of reverting these funds back to the State.

On average, Orange County receives $8M in INN funds annually. However, based on current revenue projections, Orange County anticipates an increase to $11M annually, which will result in an estimated $81M in new and carryover funds through Fiscal Year (FY) 2027-28. Current expenditures (including provisional approval of the Psychiatric Advance Directives INN project) are an estimated $7.3M, leaving $73.7M in available INN funding through FY 2027-28. Without the ability to utilize INN dollars toward staff time and resources needed to develop new proposals, Orange County will revert these dollars. Having funds dedicated to INN community planning can ensure that the community can meaningfully support the MHSA Office in developing ideas and projects which can be transformational to the mental health and recovery system. It will also demonstrate Orange County's commitment to engage its stakeholders in the development and implementation of INN projects.

INN Community Program Planning Proposal

This proposal seeks approval to utilize INN funds toward community planning and related activities for new and/or ongoing INN Plans over the next five years. INN community planning and related activities will include, but not be limited to:

- INN Staff time, such as researching concepts, developing materials, coordinating and/or facilitating meetings, drafting proposals, etc.
- Translation and interpretation services to support Orange County's diverse community. Orange County's threshold languages currently include Arabic, Chinese, Farsi, Korean, Spanish, Vietnamese. Materials will also be translated in Khmer and Tagalog to support these sub-threshold communities that are highly active and engaged in community planning meetings.
- Consultants/Subject Matter Experts to support and/or facilitate meetings. These may include individuals with expertise in a specific field, consultants with lived experience (i.e., Peers, family members) or individuals from diverse groups (e.g., Veterans and/or military-connected families, LGBTQ, older adults, deaf and hard of hearing, young adults/transitional age youth, etc.). This effort will also support more culturally responsive INN projects by engaging Orange County's diverse communities and incorporating varying cultural views and perspectives into proposals.
- Marketing strategies and materials to reach the broader community (i.e., flyers/announcements, online surveys, etc.).
- Program supplies (i.e., Stipends for consumers and family members; transportation costs for consumers and family members to attend in-person meetings, as appropriate; presentation/discussion materials; printing costs, etc.).

Pending approval, Orange County will be able to utilize INN funding to meaningfully engage stakeholders in proposal development and ongoing feedback throughout the duration of approved projects. INN staff will provide ongoing reports to local stakeholders and the MHSOAC about its community planning efforts, which will include the type of engagement meetings held, target populations reached, number of community members who participated in the planning process, projects that were supported through these efforts and number of proposals submitted to the MHSOAC and Commissioners for approval.

Budget

Through the MHSOAC delegated authority process, Orange County is requesting approval and authorization to use $950,000 of INN funds to support community planning activities over the next five years. This budget will primarily support community planning and related activities for new and/or existing INN projects, as noted above.

This proposal will utilize and encumber funds from FY 2019-20 and future years, as well as any unspent funds from previously approved INN projects. If this request is approved, Orange County will include this proposal in its FY 2022-23 MHSA Annual Plan Update, which will be finalized by the Orange County Board of Supervisors in late June.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS—Tulare County

Innovation (INN) Project Name:	**Semi-Statewide Enterprise Health Record System Improvement**
Total INN Funding Requested:	**Up to $1,000,000**
Duration of INN Project:	**One year (Phase I Planning)**
MHSOAC consideration of INN Project:	**Delegated Authority**

Review History:

Approved by the County Board of Supervisors:	Anticipated
Mental Health Board Hearing:	April 5, 2022
Public Comment Period:	March 8, 2022 through April 8, 2022
County submitted INN Project:	May 17, 2022
Date Project Shared with Stakeholders:	May 18, 2022

Project Introduction:

Tulare County Mental Health (Tulare County) requests authorization for the one-time use of up to $1,000,000 of Innovation funding to complete phase one of a two-phased Innovation project which seeks to make a change to an existing practice in the field of mental health, specifically, the practice of documentation of care provision.

Tulare County will partner with CalMHSA on the Semi-Statewide Electronic Health Record (EHR) Project and multiple counties to affect local level system change by creating a more integrated, holistic approach to county health information technology collection, storage, and reporting, with the goal to increase the quality of mental health services, including measurable outcomes. The EHR Project hypothesizes that reducing the impacts of documentation will improve provider satisfaction, employee retention, and improve patient care and outcomes.

What is the Problem (Pages 3-5)

CalMHSA states that EHRs have been identified as a source of burnout and dissatisfaction among healthcare direct service staff. **CalMHSA explains that EHRs were designed as billing engines and have not evolved to prioritize the user experience of either the providers or recipients of care resulting in an estimated 40% of a healthcare staff's workday currently spent on documenting encounters, instead of providing direct client care.**

CalMHSA continues to explain that the majority of EHR vendors develop products to meet the needs of the larger physical health care market, and that the few national vendors who cater to the behavioral health market have been disincentivized from operating in California due to several unique aspects of the California behavioral health landscape.

CalMHSA highlights three ongoing difficulties:

- Configuring the existing EHRs to meet the everchanging California requirements,
- Collecting and reporting on meaningful outcomes for all the county behavioral health services (including MHSA-funded activities), and
- Providing direct service staff and the clients they serve with tools that enhance rather than hinder care have been difficult and costly to tackle on an individual county basis.

CalMHSA states that the result is county behavioral health plans being dissatisfied with their current EHRs with few choices to implement new solutions.

Aligned with the statewide challenges documented by CalMHSA, Tulare County identifies that their mental health branch faces an increasingly complex task in the upcoming years to:

- Successfully integrate the California Advancing and Improving Medi-Cal state initiatives;
- Successfully integrate the substance use disorder treatment and services provided within the County;
- Grow and retain a robust and dynamic workforce in a Health Provider Shortage Area through eliminating redundancy, improved communication, improved documentation to reduce staff burden, and improved data collection and reporting; and
- Modernize an integrated health record system that can efficiently and effectively provide data for decision making, not just for care provision for the consumers served but also for administration as the County looks to performance outcomes and measures to successfully implement payment reform.

The California Advancing and Innovating Medi-Cal (CalAIM) changes target documentation redesign, payment reform and data exchange requirements will bring California Behavioral Health requirements into greater alignment with national physical healthcare standards resulting in a lower-barrier entry for EHR vendors seeking to serve California.

CalMHSA proposes to maximize the opportunity presented by the CalAIM changes to support County Behavioral Health Plans to revamp their primary service tool to meet the current challenges by partnering with counties and launching the Semi-Statewide EHR initiative.

How this Innovation project addresses this problem (pages 5-6)

CalMHSA proposes to provide a business solution to the challenges facing behavioral health plans across the state that supports the needs of provider staff, administrative leaders, and consumers of services. The EHR project seeks to improve the quality of mental health programs and services by allowing providers the ability to receive data and other information in a timely

manner to make decisions for administering appropriate care while advancing a Whole Person Care delivery system model to include substance use disorder treatment and services seamlessly.

The overall project goals include:

1. Utilizing a human-centered design approach to identify the design elements of a new EHR to improve California's public mental health workforce's job effectiveness, satisfaction, and retention.
2. Implement a new EHR that is more efficient to use, resulting in a projected 30% reduction in time spent documenting services, thereby increasing the time spent providing direct client care.
3. Implement a new EHR that facilitates a client-centered approach to service delivery, founded upon creating and supporting a positive therapeutic alliance between the service provider and the client

CalMHSA will build the EHR Project through a partnership with more than 20 California Counties, including Tulare, who are collectively responsible for over half of the state's Medi-Cal beneficiaries. The EHR will be collaboratively designed with national experts, counties, and the communities they serve through a human-centered design (HCD) process. CalMHSA states that the HCD approach is supported by research and is a key component of this project. By enlisting key stakeholders and providers to share their knowledge and expertise of daily clinical operations, the EHR project is more likely to offer informed solutions as part of the design that will help ensure the new EHR is responsive to the needs of the behavioral health workforce and the clients they serve.

To support a more successful multi-county collaboration, CalMHSA has done a deep dive into the Help@Hand Innovation investment to incorporate lessons learned and to work toward implementing a shared decision-making model.

In addition to initial communications with county partners, CalMHSA released a Request For Proposal to select a vendor who will be responsible for the development, implementation, and maintenance of the Semi-Statewide EHR. Streamline Healthcare Solutions was selected through that extensive and competitive process. CalMHSA stated that their agreement with Streamline Healthcare Solutions includes non-compete terms and provisions for CalMHSA to maintain appropriate intellectual property rights for the customized, California EHR.

Tulare County's phase one Innovation investment into the EHR project will allow the county to build the capacity and complete initial preparation to fully participate in the EHR Project. Phase one activities will include:

- **executing a participation agreement with CalMHSA**
- **hiring staff to support participation in the project**
- **participation in HCD activities**
- **focusing on the integration of local goals into the project.**

Tulare County is the first county to work with their local stakeholders to connect identified needs with the opportunity presented by CalMHSA, complete local approvals, and has emerged as a leading thought partner helping to shape the collaborative learning goals and evaluation strategy.

Once phase one is successfully completed, Tulare County will return to the Commission with CalMHSA and other participating counties to request approval for phase II which will focus on the long-term goal of the statewide project to establish a centralized EHR organization that achieves economies of scale for all partner county behavioral health organizations. In addition to the statewide approach, Tulare County will focus on continuing to integrate substance use disorder services with mental health services for to provide care that addresses all the needs of an individual, at the same time as CalAIM changes are implemented.

The County has been encouraged to work with CalMHSA to reach out to Los Angeles County to share learnings from the Hollywood 2.0 (formerly TRIESTE) Innovation project and use the learnings as appropriate to inform the EHR project. Hollywood 2.0 was approved by the Commission in May 2019 and by the Los Angeles Board of Supervisors in November 2021. The Los Angeles plan included a progressive, hospitality-oriented approach to patient care that planned to embrace recovery-informed care while also complying with Medi-Cal billing to improve the experience of both providers and clients.

Community Planning Process (Pages 9-10)

Local Level

Tulare County is advised by a MHSA Stakeholder Team consisting of representatives from agency partners, consumers of mental health services, family members of consumers of mental health services, mental health providers, faith-based organizations, community-based organizations, and community/cultural brokers. The County also has an established Mental Health Cultural Competency Committee which meets regularly and is made up of peer specialists, community organizations, clinicians and county staff.

The County states that throughout the last year, MHSA stakeholders in various committees, reviewed and discussed strategies to address the challenges related to employee satisfaction and retention, and how to modernize the electronic health record system.

In October 2021, CalMHSA sent a survey to 20 county behavioral health departments regarding an opportunity to participate in this Semi-Statewide Enterprise Health Record Project. Tulare County then introduced the project concept at a Mental Health Board meeting as a potential solution to their ongoing needs.

Following stakeholder input, the County proposed this project plan in their MHSA Three-Year Program and Expenditure Plan. The corresponding public comment period held March 8, 2022 through April 8, 2022 followed by local Mental Health Board hearing on April 5, 2022.

A final phase I plan, incorporating stakeholder input and MHSOAC technical advice, was submitted to Commission staff on May 17, 2022.

Commission Level

This project was shared with stakeholders on May 18, 2022. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

One comment was received in response to Commission sharing plan with stakeholder contractors, the listserv, and Committees. The comment was shared with the county and is supportive of the proposal:

"When I first started this job, I was a bit surprised about how the insufficient amount of data. Not much can be said about the proposal. It's desperately needed. I like this program. I support it and look forward to following the development of the program".

Learning Objectives and Evaluation:

Over the course of the project, Tulare County anticipates serving up to 4,000 individuals locally (800 annually) who are current EHR users. CalMHSA estimates that the project could impact more than 20,000 EHR users throughout the state.

The EHR Innovation project will have three (3) phases:

1) **Formative Evaluation**: Prior to implementation of the new EHR, the project will measure key indicators of time, effort, cognitive burden, and satisfaction while providers utilize their current or "legacy" EHR systems. The data collected by direct observation of staff workflows currently in use will then be assembled and analyzed using quantitative scales. Objective data for example, length of time moving between screens, number of mouse clicks, and amount of time required, as well as subjective data to measure user satisfaction, will be incorporated into the evaluation process.
2) **Design Phase**: Based on data gathered from the initial phase, HCD experts will assist with identifying solutions to problems identified during the evaluation of the legacy products. This process will help ensure the needs of service providers, inclusive of licensed professionals, paraprofessionals, and peers, and in turn their clients, will be at the forefront of the design and implementation of the new EHR. To create as many efficiencies as feasible, the design phase will be iterative, to ensure feedback from users and stakeholders is incorporated throughout the process.
3) **Summative Evaluation**: After implementation of the new EHR, the same variables collected during the Formulative Evaluation will be re-measured to assess the impact of the Design Phase interventions.

As a provider of services to CalMHSA through a master agreement and as an expert in California's behavioral health space, CalMHSA selected RAND to complete the EHR Project evaluation. RAND will assist in ensuring the project is congruent with quantitative and qualitative data reporting on key indicators, as determined by the project planning phase. To

ensure that the project is developed in a manner that is most in line with the needs of the behavioral health workforce and the diverse communities they serve, RAND will subcontract with a subject matter expert in human-centered design.

CalMHSA identified three project objectives with RAND:

Objective I: *Shared decision making and collective impact*. Over the course of the EHR project, RAND will evaluate stakeholder perceptions of and satisfaction with the decision-making process as well as suggestions for improvement.

Objective II: *Formative assessment*. RAND will conduct formative assessments to iteratively improve the new EHR's user experience and usability during design, development, and pilot implementation phases. This will include:

- A discovery process identifying key challenges that the new EHR is aiming to improve and establish strategic areas for testing (e.g., efficiency, cognitive load, effectiveness, naturalness, satisfaction).
- Testing EHR usage with core workflows (e.g., writing progress notes; creating a new client records) as well as common case scenarios (e.g., potential client calls an "Access Center" for services, before or after hours; sending referrals to other agencies or teams) in order to identify opportunities for increased efficiencies / standardization.
- Iterative testing and feedback of new EHR vendor's design (wireframes and prototypes) using agreed-upon scenarios, including interviews and heuristic evaluation workshops as appropriate.
- Identifying performance indicators to gauge success, such as measures of efficiency (e.g., amount of time spent completing a task; number of clicks to access a needed form or pertinent client information), provider effectiveness, naturalness of a task, and provider cognitive load / burden and satisfaction.

Objective III: *Summative assessment*. Conduct a summative evaluation of user experience and satisfaction with the new EHR compared to legacy EHRs, as well as a post-implementation assessment of key indicators.

In addition to the statewide project goals, Tulare County identified that they would focus on growing and retaining the local workforce, by providing a tool with this Project, that is user-friendly, efficient and effective in communicating between providers and teams in order to be able to provide the best possible care for consumers.

Tulare County's Mental Health Cultural Competency Committee will be informed on a regular basis on the status and outcomes of the project.

Evaluation of the project will also be shared with the Mental Health Board, with recommendations from the committees mentioned above regarding the project success and continuation, to be shared with the Mental Health Board for their advice and action.

The Budget

Funding Source	Year-1	TOTAL
Innovation Funds	$ 1,000,000	$ 1,000,000
2 Year Budget	Year-1	**TOTAL**
Contractor costs	$ 922,003	$ 922,003
Personnel Costs	$ 77,997	$ 77,997
	$ -	$ -
TOTAL:	$ 1,000,000	**$ 1,000,000**

The County is requesting authorization to spend up to $1,000,000 in MHSA Innovation funding for this project over a period of one (1) year to complete phase one.

Contractor costs in the amount of $922,003 (92% of total budget) will be paid to CalMHSA and is allocated for Project Management and Administration.

CalMHSA will serve as the Administrative Entity and Project Manager. CalMHSA will execute Participation Agreements with each respective county, as well as contracts with the selected EHR Vendor and Evaluator:

- Streamline Healthcare Solutions: This vendor will be responsible for the development, implementation, and maintenance of the Semi-Statewide EHR.
- RAND: As the evaluation vendor, RAND will assist in ensuring the INN project is congruent with quantitative and qualitative data reporting on key indicators, as determined by the INN project.

Local Personnel costs total $77,997 (8% of total budget) and include the following administrative positions:

1. EHR Specialist Supervisor, .25 FTE who will:
    - Act as INN Coordinator
    - Oversee program development
    - Organize stakeholder meetings
    - Consult with evaluator on program design and data collection methods
    - Schedules training sessions
    - Prepare training materials
    - Arrange schedules for subject matter experts to conduct training
    - Collect program survey data
    - Analyze program data
    - Prepare bi-annual program updates
    - Prepare annual program reports

2. EHR Manager, .1 FTE who will:

- Provide administrative oversight of INN coordinator and program
- Participate in program development
- Facilitate stakeholder meetings
- Review and sign off on bi-annual and annual program reports

3. MHSA Manager, .1 FTE who will:
    - Facilitate stakeholder meetings
    - Review and sign off on bi-annual and annual program reports

4. EHR Specialist, 1 FTE

Tulare County will return to the Commission to seek approval of phase two. The total project budget (Phase 1 and Phase II) is expected to be $5,180,982 over the course of 5 years.

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations.

Tulare County Health and Human Services (HHSA)

Mental Health Services Act (MHSA)

Innovation Project Plan

Semi-Statewide Enterprise Health Record System Improvement

Section 1: Innovations Regulations

CHOOSE A GENERAL REQUIREMENT:

Phases One and Two:

Tulare County Health and Human Services Agency, Mental Health Branch, in partnership with stakeholders, has approved participation with the Joint Powers Authority, CalMHSA, to advance the Semi-Statewide Enterprise Health Record Project. This project will meet the general requirements by making a change to an existing practice in the field of mental health, specifically, the practice of documentation of care provision, which will have multiple downstream impacts to quality of care for consumers, efficiencies in required documentation, and employee retention. The main focus of the project will be to "create a more integrated, holistic approach to county health information technology collection, storage, and reporting, with the goal to increase the quality of mental health services, including measurable outcomes" (from CalMHSA's project summary). The project hypothesizes that reducing the impacts of documentation will 1) improve provider satisfaction; 2) improve provider retention; and 3) improve patient care and outcomes.

The Project Team (consisting of Mental Health staff, to include the Electronic Health Records Team members, Clinic Administrators, Quality Improvement staff, Fiscal and Billing staff) feel this Innovation project **makes a change to an existing practice in the field of mental health.** The collaboration is also focused across the state with 19 other counties to provide feedback on development and requirements of the system. Additionally, the project has been discussed at the Quality Improvement Committee, Adults System Improvement Committee and Wellness and Recovery Committee which include provider partners and peers.

CHOOSE A PRIMARY PURPOSE:

Phase One:

The Semi-Statewide Enterprise Health Record Project Innovation plan will, as its primary purpose, **increase the quality of mental health services, including measurable outcomes**. The proposed INN Project will include the initial cohort of counties who are scheduled to "go live" with the Semi-Statewide EHR during Fiscal Year 2022/2023. A foundational goal of this project is to engage key stakeholders and human-centered design experts *prior to* the new EHR implementation and include their experience and feedback to optimize the user experience and layout of the incoming EHR. (from CalMHSA's Multi-County Innovation Brief).

Phase Two:

The Semi-Statewide Enterprise Health Record Project Innovation plan will, as its primary purpose, **increase the quality of mental health services, including measurable outcomes**. The quality of mental health services, including measured outcomes, will increase through the implementation of this project, by "improving the method and ease of documentation for providers, thus increasing time available to treat individuals in need of care. Numerous studies have reiterated that one of, if

not the, leading cause of provider burnout is the level of documentation and time therein required" (from CalMHSA's project summary).

Section 2: Project Overview

PRIMARY PROBLEM

Tulare County Health and Human Services Agency (HHSA), through the Mental Health Branch, faces an increasingly complex task in the upcoming years to 1) successfully integrate the California Advancing and Improving Medi-Cal state initiatives; 2) successfully integrate the Substance Use Disorder treatment and services provided within the Branch; 3) grow and retain a robust and dynamic workforce in a Health Provider Shortage Area; and 4) modernize an integrated health record system that can efficiently and effectively provide data for decision making, not just for care provision for the consumers served but also for administration as the Branch looks to performance outcomes and measures to successfully implement payment reform.

MHSA stakeholders throughout the year in various committees, like the Adult System Improvement Committee and the Quality Improvement Committee, reviewed and discussed strategies to address these challenges. Through the Joint Powers Authority of CalMHSA, the opportunity arose to participate in their Semi-Statewide Enterprise Health Record Project (the Project).

The Project proposes to provide a new solution, one that is collaborative, and will pull "in national experts in best practices … to develop a lean, high-functioning, enterprise system."

The Semi-Statewide Enterprise Health Record Project developed as an Innovative project to address this primary problem: to provide a business solution to the challenges facing behavioral health plans across the state that supports the breadth and scope of the needs of provider staff, administrative leaders, and ultimately the consumers; improving the quality of mental health programs and services by allowing providers the ability to receive data and other information in a timely manner to make decisions for administering appropriate care, and advancing a Whole Person Care delivery system model to include Substance Use Disorder treatment and services seamlessly.

RESEARCH ON INN COMPONENT

Tulare County Health and Human Services Agency (HHSA) is proposing to participate in the Semi-Statewide Enterprise Health Record Project and work collaboratively to design, procure, and implement a new enterprise EHR solution that will support our current and future business needs. The County Mental Health Plan operates in an increasingly complex environment. As Specialty Mental Health and Substance Use Providers, we are treating an expanded Medi-Cal population in an increasing amount of distress and are being asked to provide meaningful solutions for societal issues from homelessness to mental health impact of COVID-19. Simultaneously, the

requirements for administering our Mental Health Plan are rapidly evolving, with CalAIM documentation and payment reform on the horizon requiring swift adoption of technical changes.

CalMHSA proposed a new solution: using their unique position as a Joint Powers Authority (JPA) to bring counties together into a semi-statewide collaborative to design, procure and implement a new Enterprise EHR solution that will support our current and future business needs. By providing a collaborative solution, the aim is to pool together multiple counties intellectual and technical resources as well as our purchasing power to create a solution during a time of potential risk and rapid change. Approximately twenty (20) counties with an estimated 12,000 consumers, have joined through Partnership Agreements with CalMHSA to work collaboratively to bring forward solutions such as:

•**Master Client Index**: shared repository of clients that begins prior to an assessment and allows complete timeliness tracking and identification of clients who may receive treatment across counties

•**Master Consent**: allows for compliant coordination among all relevant health, mental health, substance use and social service care providers

•**Real Time Medi-Cal Eligibility**: provides current eligibility status maximizing revenue capture

•**Unified Solution for SMHS and SUD services**: promotes coordination and administrative efficiency

•**Flexible Billing Solution:** spans current Short Doyle Phase II and future payment reform requirements

•**Lean Clinical Record** designed for documentation reform to reduce staff burden

•**Structured Staffing/Program Hierarchy:** allows easy access to position vacancy rate, productivity, and reporting relationships

•**Embedded Quality Assurance Logic**: reduces claiming errors and audit risk

•**Natural Data Collection:** meaningful reporting and evaluation by design.

In 2004, the State of Massachusetts successfully evaluated the effects of a statewide intervention on the adoption and use of electronic health records (EHRs) and related health information technology (HIT). The Massachusetts e-Health Collaborative extensively implemented EHRs throughout three diverse communities. This study comprehensively evaluated the intervention and measured trends in HIT adoption across Massachusetts. Through this collaborative it was found that the most important barrier was financial. Working collaboratively with CalMHSA and multiple other counties will provide the financial resources to obtain a more robust pool of EHR providers. The CalMHSA collaborative statewide EHR project would be a new effort for the State of California and in Tulare County.

The California behavioral health market has historically been governed by several unique requirements related to Medi-Cal billing and these requirements presented a barrier to entry for many HIT vendors. Starting with the introduction of the Health Insurance Portability and Accountability Act (HIPAA) and continuing with the implementation of subsequent federal and

industry efforts to standardize codes sets, electronic data interchanges, interoperability standards, etc., California has moved to adopt industry standard approaches and tools. With the upcoming implementation of the state's California Advancing and Improving Medi-Cal (CalAIM) initiative, it is expected that the last of the elements that made the California county behavioral health market difficult for new HIT vendors will be phased out. Through this statewide EHR project CalMHSA and its partner county organizations will be able to attract more HIT vendors into the market.

References:

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California Mental Health Services Authority. (2021). Semi Statewide Enterprise Health Record Request for Procurement. Retrieved from www.calmhsa.org/the-future/bids-and-contracting-opportunities/

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PROPOSED PROJECT

Phase One:

During Phase One Tulare County Mental Health (MH) proposes partnering with CalMHSA on the Semi-Statewide EHR Project as an Innovation project to effect local level system change with the goal of improving the quality of behavioral health services while maintaining workforce development, satisfaction, and retention.

From CalMHSA:

> The Semi-Statewide EHR Project seeks to create a more integrated, holistic approach to county health information technology collection, storage, and reporting. Through these integrated efforts the project will provide a highly sophisticated solution to an ongoing problem, while evaluating and testing downstream impacts on the provider workforce. These downstream impacts to be evaluated seek to improve the method and ease of documentation for providers, thus increasing time available to treat individuals in need of care. Numerous studies have reiterated that one of, if not the, leading cause of provider burnout is the level of documentation and time therein required. The project hypothesizes that reducing the impacts of documentation will 1) improve provider satisfaction; 2) improve provider retention; and 3) improve patient care and outcomes. The INN project to be proposed will focus on the first two hypothesized outcomes, and the third is an outcome to be evaluated at a later date once more data is collected.

Ultimately, the long-term goal of the Project statewide will be to establish a centralized organization that achieves economies of scale for all partner county behavioral health organizations. County behavioral health organizations are being required to provide direct care,

operate as Managed Care Plans, and pull data and report outcomes to various stakeholders including state organizations.

In addition to those demands on Tulare County Mental Health, there are two goals locally. In Phase One Tulare County Mental Health would like to focus on growing and retaining our local workforce, providing a tool with this Project, that is user-friendly, efficient and effective in communicating between providers and teams in order to be able to provide the best possible care for consumers. Tulare County Mental Health is hopeful that employee retention will improve as this Project provides opportunities for eliminating redundancy, improved communication, improved documentation to reduce staff burden, and improved data collection and reporting.

In May 2021, the Branch brought in a consulting firm to survey employees in an effort to gauge employee satisfaction. Overall, 66% of employees surveyed were somewhat-engaged or not engaged. The Administration group had the largest percentage of those not engaged (32%), while the Case Management group had the largest percentage of those only somewhat-engaged (70%). Additionally, when asked about whether employees were considering leaving their current position within the next year, 29% responded yes, and 14% preferred not to say. Drilling down on those responses showed that majority of those considering leaving were not engaged or somewhat-engaged. While there are many varied factors that were assessed in this employee engagement survey, Tulare County Mental Health looks to this Innovation Project as a step to improving employee satisfaction and retention.

The timeline for the Project as an Innovation project will be five years, beginning with fiscal year 2022/2023. During the first year of the project, the CalMHSA proposes baseline data collection and design work, with a pilot starting mid-year (January through April 2023).

Phase Two:

During Phase Two Tulare County Mental Health (TCMH) in collaboration with CalMHSA on the Semi-Statewide EHR Project as an Innovation project to effect local level system change with the goal of improving the quality of behavioral health services.

The long-term goal of the Project statewide will be to establish a centralized organization that achieves economies of scale for all partner county behavioral health organizations. County behavioral health organizations are being required to provide direct care, operate as Managed Care Plans, and pull data and report outcomes to various stakeholders including state organizations.

In addition to those demands on Tulare County Mental Health, there are two goals locally. One goal is to continue integrating SUD services with mental health services for providing care that addresses all the needs of an individual, in tandem with CalAIM changes. This will be the focus of the Project for Tulare County Mental Health during Phase Two of this Project. Tulare County Mental Health is hopeful that this Project will provide opportunities for eliminating redundancy, improved communication, improved documentation to reduce staff burden, and improved data collection and reporting.

Estimated Number Served

The Semi-Statewide EHR Project will impact an estimated number of 800 total current electronic health record users including prescription providers on an annual basis.

Target Population	Year 1	Year 2	Year 3	Year 4	Year 5	Total for Total Time of Program
Enterprise Health Record Users/Providers	800	800	800	800	800	4,000

Target Population

The immediate target population for the Semi-Statewide EHR Project are current and future electronic health record system users. The consumers of behavioral health services are a secondary target population.

Centrally located within the State of California, Tulare County is situated in a geographically diverse region. Tulare County Mental Health provides services to many of the incorporated and unincorporated areas within the County. It is the seventh largest county in California, encompassing 4,863 square miles and is situated on the east side of the San Joaquin Valley. Tulare County, in its entirety, is designated as an urban area although 15.5% is considered rural. In addition to logistical barriers, Tulare County is ranked amongst the lowest in California in several key socioeconomic areas. Tulare County has the highest poverty rate within the State of California at 28.3% which is far greater than the National median poverty rate of 12.3%. The median family income is $45,881 which is more than $15,500 below the average in California. The civilian labor force peaks at 9.6% unemployment rate, which is significantly higher than the State's average of 4.1%. Tulare County is also a Health Provider Shortage Area (HPSA) which means it is harder to attract and retain a health provider workforce. With this Project, the Branch hopes to improve the work experience, reducing the challenges and barriers in providing services, and retain and grow a robust and dynamic workforce.

LEARNING GOALS/PROJECT AIMS

Phase One:

Some key goals with the Project for Tulare County include improved employee satisfaction, higher rates of employee retention, ease of data input and retrieval, and improved consumer outcomes as a result of an improvement in the quality of services. To measure employee satisfaction and employee retention, it is anticipated that a survey similar to the one measuring employee engagement which was mentioned earlier will be utilized.

Currently, EHRs have been identified as a source of burnout and dissatisfaction among healthcare direct service staff. EHRs, which were first and foremost designed as billing engines, have not evolved to prioritize the user experience of either the providers or recipients of care. The impact of this design issue is telling – an estimated 40% of a healthcare staff person's workday is currently spent in documenting encounters, instead of providing direct client care. This estimate does not

consider the full breath of the BHP workforce, which relies on a wide diversity of provider types needed to respond to the Medi-Cal population. (From CalMHSA Multi-County Innovation Brief)

Phase Two:

The current movement toward California Advancing and Innovating Medi-Cal (CalAIM) targets documentation redesign, payment reform and data exchange requirements making it imperative for Tulare County to take a substantial leap toward implementing a new EHR system. CalAIM presents Counties with an optimal opportunity to blend County need with present policy initiatives. CalAIM implementation represents a transformative moment when primary components within an EHR are being re-designed (clinical documentation and Medi-Cal claiming) while data exchange and interoperability with physical health care towards improving care coordination and client outcomes are being both required and supported by the State.

Evaluation or Learning Plan

Phase One:

During the Innovation program implementation, TCMH will evaluate progress with program goals. During the first year of the program implementation the data tracking mechanism will be put in place so that data outcome tracking will start from initial implementation. The Project will include feedback from providers, and administration staff in the evaluation process. The evaluation process will be administered with tools that are culturally appropriate. Qualitative data will be collected through surveys from consumers, community partners, clinical staff, and other participating partners annually. These evaluation tools will be put in place to determine project impact. The utilization of a consumer survey will be available to participating consumers to evaluate their perspective of the clinical services and the settings. A combination of these tools will be used to evaluate the questions and outcomes. The findings from this project will be shared with our stakeholders, community partners, and clinical sites.

Phase Two:

Tulare County Mental Health will work collaboratively with CalMHSA and RAND, based on data gathered from the initial phase, Human-centered design (HCD) experts will assist with identifying solutions to problems identified during the evaluation of the legacy products. This process will help ensure the needs of service providers, inclusive of licensed professionals, paraprofessionals, and peers, and in turn their clients, will be at the forefront of the design and implementation of the new EHR. In order to create as many efficiencies as feasible, the design phase will be iterative, to assure feedback from users and stakeholders is incorporated throughout the process. After implementation of the new EHR, the same variables collected during the Formulative Evaluation will be re-measured to assess the impact of the Design Phase interventions.

The HCD approach is supported by research and is a key component of this project. Enlisting providers' knowledge and expertise of their daily clinical operations in order to inform solutions in the Design Phase is vital to ensuring the new EHR is responsive to the needs of the BHP workforce as well as the clients they serve. (From CalMHSA Multi-County Innovation Brief)

Section 3: Additional Information for Regulatory Requirements

COMMUNITY PROGRAM PLANNING

Tulare County Mental Health views the Community Planning Process (CPP) as an ongoing conversation with our stakeholders. The CPP consists of an inclusive process for consumers, family members, staff, agencies, specialty groups, and general community stakeholders. Feedback opportunities are offered through committee meetings, stakeholder meetings, focus groups, and surveys, as well as through public hearings. Ongoing stakeholder feedback is provided during the year at various committees, which includes consumers, family members, providers, staff, etc.

In alignment with Welfare & Institutions Code § 5858, the MHSA Stakeholder Team consists of representatives from agency partners, consumers of mental health services, family members of consumers of mental health services, mental health providers, faith-based organizations, community-based organizations, and community/cultural brokers.

The Semi-Statewide Enterprise Health Record Project was introduced to the Tulare County Mental Health Board at the March 2022 meeting, as part of the discussion on the Fiscal Year 2021/2022 Annual Update. Next, the Project was detailed for the Mental Health Board at the April 5, 2022, meeting. The Mental Health Board approved the Project on April 5, 2022, for submission to the Tulare County Board of Supervisors and the Mental Health Services Oversight and Accountability Commission.

MHSA GENERAL STANDARDS

A) Community Collaboration – The MH Administration Team will provide updates on the Project at the Quality Improvement Committee, the Adult and Children's System Improvement Committees, as well as the MHSA Provider meetings. These meetings are attended by community-based partners who are part of the Mental Health Plan as well as consumers and family members.

B) Cultural Competency – Tulare County Mental Health has an established Mental Health Cultural Competency Committee which meets regularly and is made up of peer specialists, community organizations, clinicians and county staff. This committee will be informed on a regular basis as to the status of the project. Every effort will be made to ensure staff and tools are culturally aware and linguistically appropriate.

C) Client-Driven – The focus of the Project is to improve the quality of specialty mental health services and substance use disorder services by improving the documentation input, improving the communication between providers and teams, and improving timely access for consumers and clients.

D) Family-Driven – Families will experience the improvement in the quality of services as well, as a part of the improved communication the Project hopes to implement.

E) Wellness, Recovery, and Resilience-Focused – The Project will include wellness and recovery outcomes and performance measures that are currently difficult to input or add to existing electronic health records.

F) Integrated Service Experience for Clients and Families – If the Project is successful in integrating the many required responsibilities and roles of behavioral health organizations across the state, the ability to address the whole person's needs will be a measurable outcome. Referrals and linkages to other non-mental health providers will be easily tracked and reported to see where improvements can be made.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

The MH Administration Team will provide updates on the Project at the Quality Improvement Committee, the Adult and Children's System Improvement Committees, as well as the MHSA Provider meetings. These meetings are attended by community-based partners who are part of the Mental Health Plan as well as consumers and family members. Tulare County Mental Health also has an established Mental Health Cultural Competency Committee which meets regularly and is made up of peer specialists, community organizations, clinicians and county staff. This committee will be informed on a regular basis as to the status and outcomes of the project.

Evaluation of the project will also be shared with the Mental Health Board, with recommendations from the committees mentioned above regarding the project success and continuation, to be shared with the Mental Health Board for their advice and action.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

At the conclusion of the Project, evaluation results will be shared with committees and Mental Health Board and if deemed feasible to continue, and the outcomes indicate that the project or elements of it are successful, the project could then be covered by billing the health insurance providers for the specialty mental health services being provided.

It is a goal of the Project to improve the quality of care for individuals with serious mental illness who will receive direct services from Tulare County Mental Health and ensure the continuity of care throughout the system of care.

COMMUNICATION AND DISSEMINATION PLAN

Annual reports on the project will be shared with the Mental Health Board, and publicly available on the Tulare County HHSA website. Program participants, family members, and stakeholders will be encouraged to participate in stakeholder meetings. Shared experiences on the project's impact in the lives of our community will be welcomed. Additionally, Tulare County Mental Health will share findings statewide with county counterparts through making the

project evaluation available online as well as through email listings and state MHSA associations.

Keywords:

- Semi-Statewide Enterprise Health Record
- Human-centered design
- Quality of services
- Provider satisfaction
- Workforce retention

CONTRACTING

Phase one:

For the Semi-Statewide Enterprise Health Record Project, services that will be contracted out will include costs associated with the partnership with CalMHSA.

Phase Two:

For the Semi-Statewide Enterprise Health Record Project, services that will be contracted out will include costs associated with the partnership with CalMHSA, the EHR Vendor selected and RAND for the evaluation of the project.

TIMELINE

The total duration for the project is five years, and Tulare County Mental Health anticipates being fully operational for the project with one year of project approval.

Full Project Timeline

Milestone/Deliverable	**Year 1**		**Year 2**		**Year 3**		**Year 4**		**Year 5**	
	2022-2023		2023-2024		2024-2025		2025-2026		2026-2027	
	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun
Infrastructure Building										
Project Launch										
Full Implementation										
INN Annual Report										

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

Phase One:

This INN plan will utilize FY 2019/20 funds that are due to revert as of 6/30/22, FY 2020/21 and FY 2021/22 funds, and a portion of FY 2022/23 funds. The total estimated budget for Semi-Statewide Enterprise Health Record System Improvement Project for Tulare County is $1,000,000 for planning phase 1 and $4,180,982 for phase 2 for a total of $5,180,982 over the course of 5 years, as shown in the table below.

Phase 1 Total	**$1,000,000**
FY 2019/20 Funds	$790,627
FY 2020/21 Funds	$290,373
Phase 2 Total	**$4,180,982**
FY 2020/21 Funds	$1,653,379
FY 2021/22 Funds	$1,722,836
FY 2022/23 Funds	$804,767
Project Total	**$5,180,982**

If this INN plan is successful, EHR costs will transition to billing the health insurance providers for the specialty mental health services being provided.

Phase 1 (FY 22/23) includes:

Personnel (Salaries & Benefits)	$77,997
One-Time Fees	
Participant Instance Installation	$250,000
System Acquisition Fee	$94,124
Development Fee	$94,124
Discretionary Development Budget	$94,124
One-Time Implementation Fees	
Professional Services Implementation	$369,231
SmartCare Patient Portal Implementation	$2,400
SmartCare HIE/MCO Interface	$12,000
Disaster Recovery Implementation	$6,000
Total costs for Phase 1	**$1,000,000**

BUDGET NARRATIVE

Phase 1

Personnel (Salaries and Benefits) - $77,997

County of Tulare Staff benefits are calculated at approximately 40%.

<u>Administrative Staff</u>

1. EHR Specialist Supervisor, .25 FTE (for 6 months): $10,758
   EHR Specialist Supervisor responsibilities include:
   a. Acting INN Coordinator
   b. Oversee program development
   c. Organize stakeholder meetings
   d. Consults with evaluator on program design and data collection methods
   e. Schedules training sessions
   f. Prepares training materials
   g. Arrange schedules for subject matter experts to conduct training
   h. Collect program survey data
   i. Analyze program data
   j. Prepare bi-annual program updates
   k. Prepare annual program reports

2. EHR Manager, .1 FTE (for 6 months): $4,878
   EHR Manager responsibilities include:
   a. Administrative oversight of INN coordinator and program
   b. Participate in program development
   c. Facilitate stakeholder meetings
   d. Review and sign off on bi-annual and annual program reports

3. MHSA Manager, .1 FTE (for 6 months): $4,911
   MHSA Manager responsibilities include:
   a. Facilitate stakeholder meetings
   b. Review and sign off on bi-annual and annual program reports
4. EHR Specialist, 1 FTE (for 6 months): $35,971
   EHR Specialist responsibilities include:

5. Benefits (Indirect Costs for 6 months): $21,480
   a. Employee benefits include but not limited to: Medical, Vision, Dental, Retirement, and Life Insurance; calculated at approximately 40%.

Contracts - $922,003

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

Phase Two:

This INN plan will utilize FY 2020/21 and FY 2021/22 funds, and a portion of FY 2022/23 funds. The total estimated budget for Semi-Statewide Enterprise Health Record System Improvement Project for Tulare County is $4,180,982 for phase 2 for a total of$5,180,982 over the course of 5 years, as shown in the table below.

If this INN plan is successful, EHR costs will transition to billing the health insurance providers for the specialty mental health services being provided.

BUDGET NARRATIVE

Phase 2

Personnel (Salaries and Benefits) - $1,268,958

County of Tulare Staff benefits are calculated at approximately 40%.

Administrative Staff

6. EHR Specialist Supervisor, 0.25 FTE (for 4.5 yrs.): $104,618

   EHR Specialist Supervisor responsibilities include:

   a. Acting INN Coordinator
   b. Oversee program development
   c. Organize stakeholder meetings
   d. Consults with evaluator on program design and data collection methods
   e. Schedules training sessions
   f. Prepares training materials
   g. Arrange schedules for subject matter experts to conduct training
   h. Collect program survey data
   i. Analyze program data
   j. Prepare bi-annual program updates
   k. Prepare annual program reports

7. EHR Manager, 0.1 FTE (for 4.5 yrs.): $48,519

   EHR Manager responsibilities include:

   a. Administrative oversight of INN coordinator and program
   b. Participate in program development
   c. Facilitate stakeholder meetings
   d. Review and sign off on bi-annual and annual program reports

8. MHSA Manager, 0.1 FTE (for 4.5 yrs.): $24,557

   MHSA Manager responsibilities include:

   a. Facilitate stakeholder meetings
   b. Review and sign off on bi-annual and annual program reports

9. EHR Specialist, 2 FTE (for 4.5 yrs.): $731,107

   EHR Specialist responsibilities include:

10. Benefits (Indirect Costs for 4.5 yrs.): $360,158

    a. Employee benefits include but not limited to: Medical, Vision, Dental, Retirement, and Life Insurance; calculated at approximately 40%.

Contracts - $2,912,024

1. Direct Costs to CalMHSA contracts

Total Five Year (FY 2023 – FY 2027) Costs by category:

Personnel: $1,346,955

FY 22/23: $212,348

FY 23/24: $274,734

FY 24/25: $282,411

FY 25/26: $288,731

FY 26/27: $288,731

Consultant/Contracts: $3,834,027

FY 22/23: $1,390,484

FY 23/24: $657,040

FY 24/25: $595,501

FY 25/26: $595,501

FY 26/27: $595,501

Total Costs: $5,180,982

FY 22/23: $1,602,831

FY 23/24: $931,774

FY 24/25: $877,912

FY 25/26: $884,232

FY 26/27: $884,232

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)	**FY 22/23**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
1 Salaries	$56,518	$96,220	$196,758	$202,241	$206,791	$206,791	$965,318
2 Indirect Costs (Benefits)	$21,480	$38,131	$77,977	$80,170	$81,940	$81,940	$381,638
3 Total Personnel Costs	$77,997	$134,350	$274,734	$282,411	$288,731	$288,731	$1,346,955
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)	**FY 22/23**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
4 Direct Costs	$922,003	$468,481	$657,040	$595,501	$595,501	$595,501	$3,834,027
BUDGET TOTALS	**FY 22/23**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
Personnel Salaries (line 1)	$56,518	$96,220	$196,758	$202,241	$206,791	$206,791	$965,318
Direct Costs (add line 4)	$922,003	$468,481	$657,040	$595,501	$595,501	$595,501	$3,834,027
Indirect Costs (add line 2)	$21,480	$38,131	$77,977	$80,170	$81,940	$81,940	$381,638
TOTAL INNOVATION BUDGET	$1,000,000	$602,831	$931,774	$877,912	$884,232	$884,232	$5,180,982

BUDGET CONTEXT – EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
A. Estimated total mental health expenditures for **ADMINISTRATION** for the entire duration of this INN Project by FY & the following funding sources:	**FY 22/23**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
Innovation MHSA Funds	$77,997	$134,350	$274,734	$282,411	$288,731	$288,731	$1,346,955
B. 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 22/23**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
Innovation MHSA Funds	$1,000,000	$602,831	$931,774	$877,912	$884,232	$884,232	$5,180,982
	PHASE 1	PHASE 2 ->					

STAFF ANALYSIS – Ventura County

Innovation (INN) Project Name:	**Managing Assets for Security and Health (MASH) Senior Supports for Housing Stability**
Total INN Funding Requested:	**$966,706**
Duration of INN Project:	**Five (5) years**
MHSOAC consideration of INN Project:	**June 2022 via Delegated Authority**

Review History:

Approved by the County Board of Supervisors:	May 10, 2022
Mental Health Board Hearing:	March 21, 2022
Public Comment Period:	February 18, 2022 through March 21, 2022
County submitted INN Project:	May 18, 2022
Date Project Shared with Stakeholders:	March 2, 2022 and May 19, 2022

Project Introduction:

Ventura County is requesting up to $966,706 of Innovation spending authority to provide services for seniors who are at risk of becoming homeless. This project will utilize volunteers with CAREGIVERS of Ventura County and partner them with senior clients already enrolled with the CAREGIVERS of Ventura County program in order to create and develop trusting partnerships that will allow home-bound seniors to receive needed services and supports in the form of assessing housing needs, possible relocation, case management, behavioral therapy, financial advice, and assisting with meeting daily basic needs.

What is the Problem?

Similar to other Counties within California, Ventura residents are struggling with increasing living and rental costs. According to data found for Ventura County, the median household income in 2019 was $92,236 while the median property value for the same time period was $629,600, approximately 2.6 times higher than the national average ($240,500).

Adding to the difficulty in finding reasonable rent/mortgage is the County's geographical nature – it is the 17th most important agricultural-producing county of all 3,175 counties within the United States, producing strawberries, oranges, cilantro, and lettuce to name a few. Due to the agricultural landscape, much of the land is protected and devoted specifically for agricultural use.

Furthermore, the Los Padres National Forest and the Santa Monica Mountain Recreation areas, located partially within Ventura County, are also protected by state and national land initiatives.

The County states that the pandemic has increased the rental prices and house prices and working a minimum wage job is not enough to sustain a one-bedroom rental unit. For seniors who are on a fixed income and no longer able to work, the challenge becomes more severe. Ventura states that providers for senior services have received an upsurge in requests along with the need for financial counseling to address increasing cost of living on a fixed income.

The Community Program Planning revealed the need for supports for seniors at risk of losing their homes as the second highest priority. At this time, the County is experiencing challenges in reaching seniors with the highest risk of becoming homeless. This project will aim to provide services and resources for this high-risk group, as well as providing services to other seniors who may need less supports and resources.

How this Innovation project addresses this problem:

The County proposes to provide services for homebound seniors currently enrolled with CAREGIVERS of Ventura County in order to bring resources and supports by means of case management, therapy, and financial service counseling in an effort to avoid becoming homeless.

CAREGIVERS of Ventura County is a small non-profit agency, established in 1984, that recruits and matches volunteers with seniors who are primarily homebound. CAREGIVERS currently has more than 300 volunteers and all volunteers must complete a live scan background check before being matched up with a senior.

Although the CAREGIVERS organization has been a successful model operating in Ventura County for over 40 years, the County and Organization has realized there are a subgroup of seniors that the organization is not able to currently support sufficiently. This project aims to provide services, supports, and resources for those seniors with the highest risks of becoming homeless by bringing the ***Home Share*** model to Ventura County. The Home Share model, utilized in other parts of the United States, assists in helping older adults regain their independence while remaining in their own homes by matching young people who may need a place to live with older adults with a spare room who may need assistance at home. This model began in the early 1970s with the premise of exchanging of housing for help within the home. The County hopes to bring this model to Ventura County with the hopes of allowing high-risk seniors to remain in their home rather than lose their home and independence.

CAREGIVERS will pair volunteers with enrolled seniors, developing a friendship and bond that will help in identifying and working with seniors that may need additional resources and supports, including the risk of losing their current housing situation. Once matched, the volunteer will work with the senior to create a Customized Housing Budget and Stabilization (CHBS) plan, comprised of four components: Assessment of mental, physical, and financial health; reviewing hurdles they are experiencing and seek opportunities for resolution; exploring options for resolution; and implementing a plan for secure housing and overall wellness.

The results of the CHBS plan will determine the level of resources that may be needed, broken into tiers that increase the need for resources and supports:

- Tier 1 – Education and coaching provided to help them reach a resolution on their own
- Tier 2 – Financial resources and information for aging in place
- Tier 3 –Rapid re-housing, rental assistance subsidies; home sharing, case management
- Tier 4 – Housing placement and concentrated case management (This tier would provide the most intensive level of support)

Senior clients in Tiers 2-4 would be eligible to consider participating in the Home Share model if viable. As indicated above, use of the Home Share Model in this project may entail the renting of an available room in exchange for household chores, cooking, running errands, etc. Dependent upon the CHBS plan that is developed, and based on the identified need and tier, enrolled seniors will fall into one of the project's three phases:

Phase 1: (serving approximately 500 senior clients)
Services offered in this phase include, but may not be limited to:

- External Clinical Support Sessions
- Financial Education Training
- Family Process Meetings
- Light Case Management
- Chores and cleaning within the home
- Non-medical transportation
- Money Management
- Life coaching

Phase 2: (serving approximately 50 clients)
Clients in Phase 2 will also be offered the same supports as those enrolled in Phase 1 but will have more resources to access. **The Clients in this phase are those individuals who CAREGIVERS of Ventura County is currently not able to support.** This phase will offer the following resources and services:

- Immediate support to avoid becoming homeless (short-term financial assistance, temporary shelter, and rapid re-housing)
- Supports for the senior to stay within home by working with family to determine if they are able to move in, any modifications that may need to be made to the home in order for senior to stay in home; researching reverse mortgage options and other bills that need to be brought current
- Moving supports that might include assisting seniors with first and last month's rent, assisting with downsizing and moving into another housing arrangement that may be more practical

The county will also expand the clinical workforce by utilizing MSW interns to provide therapeutic support, as seniors may experience high rates of depression and anxiety during this difficult transitional period. This is a new service not currently provided by CAREGIVERS of Ventura County.

Phase 3: Clients in this phase have progressed from Phase 2 and will continue to receive services and follow-up for a period of 6-12 months. Services in this phase may include:

- Helping to organize the new living space
- Assistance in familiarizing the senior to their new neighborhood
- Continued therapy in order to process the move and adapt to new changes
- Resolution of any interpersonal issues with new housemates, if needed, by CAREGIVERS staff or therapist
- Onboarding a high school or college age youth to assist the senior client with light household chores regularly by way of the Building Bridges Intergenerational Program
    - This Program helps older adults remain in their homes by providing free basic assistance and companionship to seniors

Community Planning Process (see pgs. 10-13 of project plan)

Local Level

Ventura County has provided documentation of a thorough community planning process resulting in the idea and development of this project. Identified by the community, those who are unserved and underserved (Latinx, African American, LGBTQ+, homeless individuals, and those at risk of suicide) remain a priority.

The County facilitated a MHSA stakeholder planning committee comprised of individuals with mental health challenges, family members, LGBTQ+ community, and diverse racial, religious, and gender backgrounds. A total of 28 innovation ideas were submitted, reviewed, and scored by the stakeholder planning committee, who ultimately narrowed down the ideas to the top three.

The idea for this project was ranked second in priority; the highest rated project involved creating a mobilized service center to provide services for those that may not have access to it. That project, titled Mobile Mental Health, was developed approved by the Commission in May 2021. The County is now seeking approval for this project deemed as a priority by their community.

Ventura County held their public comment period from February 18, 2022 through March 21, 2022 followed by their Mental Health Board hearing on March 21, 2022. They received their Board of Supervisor approval on May 10, 2022. A final plan, incorporating stakeholder input and technical consultation provided by Commission staff was submitted on May 18, 2022.

In alignment with MHSA General Standards, this project will offer community collaboration, be culturally competent, as well as client and family-driven with the overarching goal of being wellness and resiliency-focused.

Commission Level

The initial plan was shared with Commission stakeholders on March 2, 2022 while the County was in their 30-day public comment period and comments were directed to the county.

The final version of this project was shared with Commission stakeholders on May 19, 2022. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

There were no comments received in response to Commission sharing the plan with stakeholder contractors, the listserv, and the Committees.

Learning Objectives and Evaluation: (see pgs. 7-10)
The County has set forth four primary learning objectives with measurable outcomes to guide this project with the goal of serving 500 individuals:

1. Does enrollment in the MASH program have an impact on the client's motivation to change their housing situation?
2. How much does the program improve client's sense of security and safety based on both living and fiscal situations?
3. Does enrollment in the program reduce feelings of depression, anxiety, and isolation?
4. Does the program have an effect on enrolled clients' housing situation?

Indicators for the County's learning goals may include a client's willingness to change their living circumstances (new roommate, moving in with family or relocating); improved perception of security and safety; and improvement in the client's overall housing situation which leads to improved health and wellness.

The County will utilize various tools to measure outcomes and assess impacts, including but not limited to self-assessment surveys, scales, and models that may assist in identifying a client's readiness and willingness to adapt healthier, positive changes.

The Budget (see pgs. 17-20)

Five Year Budget	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
Operating Costs	$ 21,468.00	$ 22,952.00	$ 25,045.00	$ 27,325.00	$ 29,302.00	$ 126,092.00
Evaluation Costs	$ 14,000.00	$ 14,420.00	$ 14,853.00	$ 15,298.00	$ 15,757.00	$ 74,328.00
Contractor Costs - VCCA (includes VCCA indirect costs)	$ 129,121.00	$ 138,596.00	$ 152,115.00	$ 166,866.00	$ 179,588.00	$ 766,286.00
Total	**$ 164,589.00**	**$ 175,968.00**	**$ 192,013.00**	**$ 209,489.00**	**$ 224,647.00**	**$ 966,706.00**

Funding Source	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
Innovation Funds	$ 164,589.00	$ 175,968.00	$ 192,013.00	$ 209,489.00	$ 224,647.00	$ 966,706.00
						$ -
Total	**$ 164,589.00**	**$ 175,968.00**	**$ 192,013.00**	**$ 209,489.00**	**$ 224,647.00**	**$ 966,706.00**

The County is requesting authorization to spend up to $966,706 in MHSA Innovation funding for this project over a period of five (5) years.

- The County estimates a budget of $126,902 (13% of total budget) to cover costs associated with administration as well as indirect costs to cover salary and benefits
- A total of $74,328 (7.7% of total budget) has been allocated externally to Evalcorp for the evaluation of this project

- Consultant costs for this project are estimated to be $766,286 (79.2% of total budget) and will cover the following:
    - Program staffing
        - Executive Director (20 hrs per month)
        - Volunteer Engagement Coordinator (1 FTE)
        - Administrative Assistant (12 hrs per month)
        - MSW Intern
    - Senior Advisor / Financial Planning Contract
    - Clinical Services Contract
    - Language Interpretation Services
    - Staff Consultation and Training
    - Housing Assistance to assist seniors on a time limited basis

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations.

References

https://vcrcd.org/#:~:text=Ventura%20County%20is%20the%2017th,counties%20in%20the%20United%20States.

https://venturacountycounts.org/about/#

https://datausa.io/profile/geo/ventura-county-ca/#:~:text=Native-born%20citizens,CA%20are%20getting%20getting%20older.

http://www.vccaregivers.org/

https://www.nhsconfed.org/articles/homeshare-model-preventative-approach-help-older-people-remain-independent-longer

Mental Health Services
Oversight & Accountability Commission

INNOVATIVE PROJECT PLAN
RECOMMENDED TEMPLATE

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 approval Approval Date: March 21,2022
☐ Completed 30 day public comment period Comment Period: 2/18/22-3/21/22
☐ BOS approval date Approval Date: March 29th or _April 5th 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: __May 26, 2022_____ ***Note: Date requested above is not guaranteed until MHSOAC staff verifies <u>all requirements</u> have been met.***

County Name: Ventura County

Date submitted: March 22, 2022

Project Title: Managing Assets for Security and Health (MASH) Senior Supports for Housing Stability

Total amount requested: $966,706

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 provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

The issue of seniors at risk of or currently experiencing homelessness has been highlighted over and over in recent years. A report published by the University of Pennsylvania analyzed historical records of shelter admissions in three of the nation's largest cities projecting that in the next 10 years, the number of elderly people experiencing homelessness will nearly triple as the baby boomer's generation continue to age[1]. Findings were published before the effect of the pandemic could be taken into consideration. Prior to the pandemic, multiple headlines have warned of the impending crisis or the silver tsunami thundering toward social service providers[2]. While multiple reports have warned of the impending crisis, senior support services agencies argue the emergency is already here. Another recent study from University of California San Francisco expert Dr. Margot Kushel found "people over 50 now account for half of unhoused adults – a four-fold increase since 1990 when 11% of homeless adults were over 50. Older people already on the financial edge after decades of working low-wage jobs and with little or no savings or retirement income can be quickly de-stabilized by a rent increase, or injury or death of a partner or caregiver." Many of the above conditions are common occurrences for individuals in the later stages of life. Kushel also found disturbingly, that nearly half of unhoused older people didn't experience their first episode of homelessness until after age 50[3].

In Ventura County rent increases have been steadily on the rise for the past few years. A complicating factor is the County's geography and the voter approved land use agreements. Much of the County is dedicated to the vital agricultural industry, open spaces initiatives and protected state and national resources that include rivers, beaches, and forest areas. As a result, housing, like many other areas in the state, has become scarce. The pandemic has worsened the situation, housing prices have soared, and

[1] Emerging-Crisis-of-Aged-Homelessness-1.pdf (upenn.edu)
[2] Elderly and Homeless: America's Next Housing Crisis - The New York Times (nytimes.com)
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3250535/

rentals remain scarce. Moreover, rents surged in 2021 by 10.9% in the last fiscal year, more than twice the normal rate. According to the National Low-Income Housing Coalition, a person working minimum wage and living in a modest one bedroom would have to work 89 hours per week in order to afford the $1,615 dollars per month in rent[4]. The chances of finding a fair market price rental in the area is equally as challenging with a vacancy rate down to an average of 1.37% in 2021[5]. Social Security Income averages $932 per month, falling far short of being enough for even a studio apartment in the area.

Senior service providers have noticed an increase in requests for services and the need for financial counseling for low-income seniors who never planned on rents or other expenses escalating so quickly. "I regularly speak to seniors who have anywhere from a few years to a few months before their expenses will exceed their incomes. They freeze with anxiety and sink into despair, seeing the cliff that's coming and not knowing what to do about it." -Executive Director of Volunteer CAREGIVERS of Ventura County. Her sentiments were confirmed by the last Community Program Planning (CPP) Process. Innovation community program submissions included 28 program ideas and the support for seniors at risk of losing housing came in as the second most voted for program after mobile mental health.

PROPOSED PROJECT

Project Goal: To provide creative case management, therapeutic, and material support to enrolled seniors at risk of losing their housing due to fiscal, cognitive, or physical restrictions.

Assumptions of Program Approach: By assigning and monitoring volunteers to work with homebound seniors, the clients will build a trusting relationship with the organization and be more likely to engage in a housing resource plan to include essential services and concrete resources as needed. The participants will be able to explore multiple solutions to their housing situation over time, increasing the chances for success in a new placement.

Key Intervention: Matching trained specialty peer volunteers with homebound seniors who can help identify and work with those seniors who are in jeopardy of losing their current housing.

[4]Fair Market Rent Documentation System, HUD
https://www.huduser.gov/portal/datasets/fmr/fmrs/FY2022_code/2022summary.odn

[5]Wilson, Kathleen "'Historically tight' apartment market pinches local tenants as rent hikes surge". *VC Star*, November 7, 2021 https://www.vcstar.com/story/news/2021/11/07/apartments-for-rent-nearby-unlikely-as-rental-market-grips-tenants-rising-costs-few-vacancies/8558423002/

Volunteer CAREGIVERS of Ventura County is a small non-profit agency that recruits volunteers to support home bound elderly. Participants are predominantly women (80%) who live on fixed/limited incomes and are frequently medically fragile and/or disabled. Volunteer support services are provided by other older adults in the area, Volunteer caregivers are comprised mostly (80%) of women over 60. who are retired and interested in contributing there time in ways that are meaningful to them. They provide the services at no cost to the senior and may range from friendly visitation, transportation for medical appointments, shopping for groceries and medical supplies, regular "warm line" phone calls, other supports from the volunteers who may do cooking, minor house cleaning or yard work. Services are primarily provided by volunteers in the community a model that has worked for the last 40 years. All volunteers are put though an application process inclusive of a Live Scan background check before being matched to an older adult. A number of these seniors served (estimated at 10% or more) are on the verge of becoming homeless. These seniors are often physically and emotionally fragile (many are wheelchair bound, experiencing loneliness and confusion) and are experiencing memory loss, or the beginning stages of dementia and Alzheimer's disease. To compound their situation, their families are frequently unable to assist them and/or they live in another state. Local housing authorities have in some cases years-long waiting lists. The CAREGIVERS organization identified a set of previously unprovided services and a focused set of highly trained volunteers to address this unique subset of home bound seniors, and to re-energize the "Home Share" model that has been used in other parts of the country for this vulnerable population of potentially homeless seniors. Home share uses an aging in place model that allows older adults to stay in their own home while obtaining additional income, companionship, and assistance by renting out a room to a home seeker potentially increasing their capacity to remain living independently[6].

The proposed program entitled MASH, an acronym for Managing Assets for Security and Health, will provide multiple vital supports for seniors at risk of homelessness. The general program will consist of three phases and start with a four-step assessment. MASH directly addresses not only the County's current needs, but also our anticipated longer-term needs for affordable, safe, and stable housing for our seniors.

Phase I (500 clients): Outreach will be made to all seniors already enrolled or referred to the Volunteer CAREGIVERS of Ventura County organization who are at risk of losing their current housing. Eligible seniors will be enrolled in the volunteer matching and begin a process of relationship building to expand the participant's support system. The volunteer will help the participant build a Customized Housing Budget and Stabilization (CHBS) plan based on the following four components: (1) to assess a senior's mental, physical, and financial health, (2) to review their challenges and opportunities, (3) to explore their options and empower their choices, and (4) to implement a plan that ensures security in appropriate housing.

The CHBS plan will also determine which tier the participant falls into:

Tier 1: Self-resolve; housing coaching or education only

[6] Martinez, Laura et al. "More Than Just a Room: A Scoping Review of the Impact of Homesharing for Older Adults." *Innovation in aging* vol. 4,2 igaa011. 3 May. 2020, doi:10.1093/geroni/igaa011

Tier 2: On site modifications for aging in place, benefit enrollment, reverse mortgages, or other financial management goals with CPA oversight

Tier 3: Rapid re-housing, light rental subsidy, or home share with intensive case management

Tier 4: Housing placement and intensive case management

Once a plan has been agreed to by the participant, the MASH program volunteers would offer a menu of services customized per the CHBS plan. Essential services would include external clinical support sessions, financial education training, family process meetings, light case management, homemaking services (chores, cleaning), non-medical transportation, independent living skills (life coaching and money management), or other general support services. Essential services would be offered and customized regardless of clients Tier placement. All clients would have access to clinical support by the organization's volunteer LCSW and MSW students at the beginning, and later with a subcontracted clinical services organization as needed. Reports of depression and anxiety have been high, and short-term family counseling has been identified as a critical service expected to be expanded, given the potential of some clients needing to move in with or have a family member move in to assist with care or financial support. Other focus areas could be working though stages of change with a participant who is required to make a change given their fiscal situation but is not yet ready for the adjustments needed. The mental health support will be a new and important aspect to the providers available services.

Phase II (50 clients): Clients placed in Tiers 2-4 will have a wider variety of resources to access. These are the highest risk individuals that the organization currently cannot support. This Innovative service will begin with a test phase serving 4 clients with the following concrete services as needed:

*_Immediate support_ resources to ensure the individual does not become homeless. (e.g., financial assistance, temporary shelter, rapid rehousing, etc.)

*_Age in place supports_ (e.g., include family network to move in if practical, handicap accessible or other home modifications, home share, reverse mortgages, utilities, or other bills requiring backpay, etc.)

*_Moving Supports_ (e.g., secure placement in new housing arrangement, first/last month securities, downsizing, light rental subsidy, etc.)

If the test clients are successful and would recommend the program to others, an additional 25-50 clients will be targeted for admission.

Phase III (15-25 clients) would consist of Graduation and After-Care for a period of 6-12 months. Intensive post-move support would include organizing the new space, learning a new neighborhood, processing the move, and resolving interpersonal issues with any new housemates-to-be provided by a

counselor or a traditional CAREGIVERS volunteer support staff depending on the client's adjustment. This final phase may also include a 1:1 Match from the Building Bridges Intergenerational Program a program that matches 1:1 high school and college age youth to and older adult to do light household chores on a regular basis. Phase III ensures that program participants continue to receive support to ensure sustainability of services received while in program.

RESEARCH ON INN COMPONENT

There is general agreement in the field of gerontology that aging well includes both personal and environmental resources[7]. The CAREGIVERS national organization has been providing light personal services though volunteer matches for nearly 40 years. The MASH program will be the first time combining several initiatives from sister agencies from across the nation (i.e., home shares and home modifications) and adding a housing fund with a specialized economic development team that includes advisement from professional financial services agency. The intent is to offer a small amount of assistance in a flexible fashion to avoid homelessness for older adults living in Ventura County.

A key strategy to improve housing affordability is to increase the availability of rental assistance. According to a recent article by Dr. Margot Kushel, only 1 in 4 households in America that meets the criteria for rental assistance receives it. Among older adults, that number increases to 1 in 3. Rental assistance is not an entitlement, and the various federal programs that provide affordable rental opportunities are not funded to meet the demand[8]. The MASH program will connect clients with any benefits the client may be eligible for and assist in finding locations that will accept tenants receiving rental assistance. In addition, rental assistance fund is being included in the budget as a stop gap measure for clients already past the point of being able to avoid homelessness without immediate assistance.

LEARNING GOALS/PROJECT AIMS

Change can be difficult for anyone but can be an exaggerated barrier for individuals who are disabled, cognitively impaired, or under financial duress. O top of these challenges, many of these clients have not had to think about moving for 20-40 years and have been living in the same places where they raised their families or lost their spouses. The MASH program is designed to offer individuals a partner in that process of identifying the need to make a change and then having the courage to make that life altering move. The following are the identified learning goals and questions to be addressed though the program.

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[7] Lawton, M. P. (1982). Competence, environmental press, and the adaptation of older people. In M. P. Lawton, P. G. Windley, & T. O. Byerts (Eds.), Aging and the environment: Theoretical approaches (pp. 33–59). Springer.
Lawton, M. P., & Nahemow, L. (1973). Ecology and the aging process. In C. Eisdorfer & M. P. Lawton (Eds.), The psychology of adult development and aging (pp. 619–674). American Psychological Association.

[8] Kushel, Margot (2020) Homelessness Among Older Adults: An Emerging Crisis. Generations Journal Summer 2020 Homelessness, Older Adults, Poverty, Health (asaging.org)

1. Does enrollment in the MASH program have an impact on the client's motivation to change their housing situation?

2. How much does the program improve client's sense of security and safety?
   Aim 1: Living situation
   Aim 2: Fiscal situation

3. Does enrollment in the program reduce feelings of depression, anxiety, and isolation?

4. Does the program have an effect on enrolled clients' housing situation? As measured by:
   Aim 1: Prolonged ability to stay in current housing (Tier 1&2 clients only)
   Aim 2: Reduced evictions
   Aim 3: Stably housed 6-12 months post discharge (Tier 3&4 clients only)

EVALUATION OR LEARNING PLAN

The evaluation will use existing scales whenever possible and some that are under consideration are referenced below. The evaluator will work with CAREGIVERS and VCBH staff to finalize all proposed measures, data collection tools, and analysis plans to ensure both process and outcomes/impacts are assessed and reported on through the MASH program evaluation.

Learning Goal	Indicators	Measures under consideration
1. Does enrollment in the MASH program have an impact on the client's motivation to change their housing situation?	Increased wiliness to change living circumstances such as taking on a roommate, moving family in or with family, moving to a new location	The Transtheoretical Model (TTM) or Moving on Initiative developed by the Veterans Administration Homeless Services. The Transtheoretical Model of Behavior Change (TTM) is a framework for understanding, measuring, and intervening in behavior change
2. How much does the program improve a client's sense of security and safety?	Improvement in perceived security, safety, and health rating	Security & Safety Perception Tool (5-point agree–disagree scale Ranging from strongly agree (5) to disagree (1): An example item: "Considering my age, I am in good health" and "I try to maintain a healthy lifestyle."[9]

[9] Anat Toder Alon, Liad Bareket-Bojmel & Avichai Shuv-Ami (2021): The Relationship between Perception of Care, Sense of Security, and Subjective Psychological Well-Being among Older Adults Living in Sheltered Housing vs. Independent Housing in Israel, Journal of Aging and Environment, DOI: 10.1080/26892618.2021.2019867

Aim 1: Living situation	Increase in feelings of security	Security & Safety Perception Tool. Example item: "I feel safe where I live".
Aim 2: Fiscal situation	Increase in feelings of security	Security & Safety Perception Tool. Example Item: "I have sufficient financial resources to stay where I am living," and "I have enough money to live my life the way I want". Supplemental items will include items asking clients to rate their feelings regarding whether they have enough money to pay for their needs (e.g., relative to food, medical services, and daily expenses) on a 3-point scale ranging from enough (1) to not enough (3). Lastly, clients will be asked to rate how easy or difficult it is to pay their monthly bills (i.e., rated on 4-point scale, ranging from not at all difficult (1) to very difficult (4).[10]
3.Does enrollment in the program reduce feelings of depression, anxiety, and isolation?	Increases in overall mental health and well being	Three-item Scale of Life Satisfaction developed by Lumpkin and Hunt[11] Or Revised University of California Los Angeles Loneliness Scale (RULS-V3) Center for Epidemiological Studies Depression Scale (CES-D).
4.Does the program have an effect on enrolled clients housing situation? Measured by:	Enhancements in overall housing situation	Housing Stability Assessment (brief assessment to determine current/later in program overall housing situation) as measured by select items using Likert rating scale.

[10] Kee-Lee Chou & Iris Chi (2001) Financial strain and depressive symptoms in Hong Kong elderly Chinese: The moderating or mediating effect of sense of control, Aging & Mental Health, 5:1, 23-30, DOI: 10.1080/13607860020020609

[11] Lumpkin, F. J., & Hunt, B. J. (1989). Mobility as influence on retail patronage behavior of the elderly: Testing conventional wisdom. Journal of the Academy of Marketing Science, 17(1), 1–12. https://doi.org/10.1007/BF02726348

Aim 1: Prolonged ability to stay in current housing (Tier 1 & 2 clients only)	Months of stability increased as compared to initial assessment	Fiscal longevity assessment
Aim 2: Reduced moves, foreclosures or evictions	Fewer number of moves, foreclosures or evictions than predicted after CHBS assessment	Two items: "How many times have you moved in the last 6 months?" and "Did you experience any foreclosures or evictions in the last 6 months?"
Aim 3: Stably housed 6-12 months post discharge (Tier 3 & 4 clients only)	Number of months at the same address.	Number of changes of address requests and number of moves.

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

The project includes target goals, evaluation support, bi-annual contract meetings, the support of VCBH department staff and an innovation Program Administrator to work with the contractor and ensure compliance with the project plan and deliverables.

COMMUNITY PROGRAM PLANNING

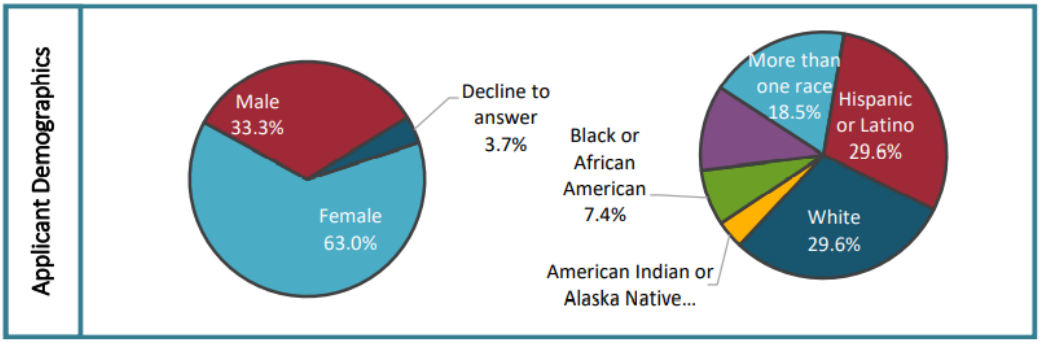
The COVID-19 pandemic has hindered the regular and in person CPP process for the Fiscal Year 20/21 planning process for available Innovation dollars. Ventura County has been building upon its community-wide Mental Health Needs Assessment that was completed for the current three-year plan (Fiscal Year 2020-2023). Results from that effort identified several vulnerable communities and challenges to the mental health services currently being provided in the community. To that end the County advertised for Innovation submissions as described below.

The current local priorities for mental health services are unserved or underserved populations in Ventura County such as: Latinx, African American, LGBTQ+, people who are homeless, people with co-occurring disorders (mental health and substance use), and people at risk of suicide.

Examples of the advertisements that were posted in local newspapers, through social media and internet advertisements are below:

An MHSA stakeholder planning committee was gathered and included individuals living with a serious mental illness, family members of individuals living with serious mental illness, Latinx, LGBTQ+, all geographic regions, genders, religious communities, and community-based organizations. The planning process resulted in 28 Innovation ideas that were submitted though the County website. Committee members had five days to assess the summary proposals and vote for their top three after a brief orientation to Innovation regulation requirements. Mobile Mental Health was the top choice by several votes and was approved in 2021. In second place was the Senior Supports for Housing project.

Results of the virtual CPP Innovation submission process are below. A total of 27 ideas were received through the website and one was submitted directly to the department. Applicants were not required to answer all the demographic questions and could also click more than one answer so not all sections will add up to 100%.



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: CAREGIVERS is a community service provider and was chosen though a Community Planning Process that included individuals living with a serious mental illness, family members of individuals living with serious mental illness, Latinx, individuals who identified as LGBTQ+, all county geographic regions, genders, multiple religious communities, and other community-based organizations.

B) Cultural Competency: CAREGIVERS is committed to providing services, offering employment, and volunteer opportunities to all, without discriminating on the basis of age, gender, race, religion, sexual orientation, ethnicity, national origin or disability. The agency will work closely with the Office of Equity and Diversity though the contracting process to ensure outreach and offering of services is equitable to all eligible participants.

C) Client-Driven: Clients are partners in their CHBS plans and must voluntarily sign off on any plans for housing changes or additional essential or concrete services.

D) Family-Driven: Families will be included in the process whenever viable though family meetings, group therapy, moving in with or having a participant move in with the family. Family members also will be included whenever possible before fiscal decisions impacting clients are made (e.g., perusing a reverse mortgage).

E) Wellness, Recovery, and Resilience-Focused: All services are designed to keep the participant in an environment that is safest for them physically and financially, allowing the client to live with dignity and security.

F) Integrated Service Experience for Clients and Families: CAREGIVERS already works closely with several agencies in the county and would continue these partnerships in order to keep as many options open for clients as possible examples include: VCBH, Jewish Family Services, Grey Law, Public Gradian, Adult Protective Services, Public Health, and the Area Agency on Aging.

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.

CAREGIVERS is committed to proving services, offering employment and volunteer opportunities to all, without discriminating on the basis of age, gender, race, religion, sexual orientation, ethnicity, national origin, or disability. Pairing of volunteer matches is based on geography, skill set and personal interests on which volunteers and care receivers can build a friendship. Using this 40-year tested model of service has resulted in relationships that have endured up to 20 years and enrollment with the organization for up to 36 years. Services and materials are provided in English and Spanish, and the organization is looking into additional cultural competency trainings.

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 elements of the INN project without utilizing INN Funds following project completion.

CAREGIVERS has planned for sustainability with the assumption that this is a one-time grant. The proposed project budget reflects a primarily volunteer staffing base in accordance with the current business model. Learning collaboratives and planning efforts have been built into the grant to build awareness with the broader state and national CAREGIVERS association. The thinking is that with these broader networks, not exclusive to the CAREGIVERS organization, collaboration is ensured, and with successful implementation of the project, the MASH program can be modeled and maintained irrespective of Innovation funding.

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.

It is unknown at this point if the program will serve individuals with serious mental illness. The target population would primarily be for prevention services, however the program model has included individuals experiencing serious mental illness previously. If this does become the case, CAREGIVERS will work closely with the VCBH housing department staff to ensure supports are maintained for any clients living with serious mental illness at the conclusion of the five years.

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?*

Each of the VCBH innovation programs have a dedicated webpage where updates get posted regularly. In addition, an Innovation summary page also exits where reports get posted on the Wellness Everyday website. In order to supplement these efforts, the program has built in three learning communities to help disseminate the projects findings.

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.*

At-risk homeless, prevention, seniors, housing stability, home-share

TIMELINE

A) *Specify the expected start date and end date of your INN Project*

B) *Specify the total timeframe (duration) of the INN Project*

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

Year 1		
Qtr 1-2	Infrastructure Development	Program planning, hiring, additional detail below.
Qtr 3-4	Program Launch	Project activities launch-additional details below Evaluation finalized.
Year 2		
Qtr 1-2	Program Activities	Ongoing program enrollment and engagement. Surveys distributed to enrolled clients. Annual update report is written and distributed.
Qtr 3-4	Program Activities	Ongoing program enrollment and engagement. Implementation with 2-4 test cases of Tier 3 & 4 clients.

		Baseline and initial surveys distributed/collected for enrolled clients.
Year 3		
Qtr 1-2	Program Activities	Ongoing program enrollment and engagement. Surveys distributed/collected for enrolled clients. Annual update report is written and distributed.
Qtr 3-4	Program Activities	Ongoing program enrollment and engagement. Surveys distributed/collected for enrolled clients. First Learning Community takes place.
Year 4		
Qtr 1-2	Program Activities	Ongoing program enrollment and engagement. Annual update report is written and distributed. Surveys distributed/collected for enrolled clients.
Qtr 3-4	Program Activities	Ongoing program enrollment and engagement. Second Learning Community takes place. Surveys distributed/collected for enrolled clients.
Year 5		
Qtr 1-2	Active Enrollment Ends	No additional clients will be enrolled after November of 2026. Annual update report is written and distributed. Surveys distributed/collected for enrolled clients.
Qtr 3-4	Evaluation and Program Wrap-Up Key Stakeholder Interviews	Key stakeholder interviews with clients, staff, and partner agencies. Programs wrap-up activities. Collect follow up surveys. Case closures and transition planning. Final Learning Community takes place.

Detailed Planning for Year One:

*Orientation of current staff and Board of Directors regarding VCBH approved Innovations Senior Housing Project initiative.

*Engage a Certified Senior Advisor to develop the MASH team recruit and contract with Certified Financial Planner (CFP) to serve as lead member of Economic Solutions team.

*Development of job description, recruitment, and training plan for MASH team of volunteers to support the housing initiative; includes protocols for consideration of optional income alternatives (re-fi or reverse mortgage of home, sell assets, explore employment options, etc.).

*Establish internal housing support initiatives workflow model/process, application, screening, enrollment, case planning and assignments.

*Develop management plan of potential resources, establish criteria for approvals (rent subsidy, utilities, temporary relocation, etc.).

*CSA Consultant will work with CAREGIVERS Volunteer Engagement Coordinator to identify and recruit volunteers with appropriate professional experience to participate in Economic Solutions Team.

*Development of external clinical support services.

* Recruit, train and assign social work intern.

*Identify key community partners; define role and inter-agency agreements.

*Develop an SOP and a workflow model that illustrates client pathway.

Marketing and Outreach

* Identification and initial meetings with community partners to assist in successful housing solutions. Continued meetings to negotiate interagency agreements and ongoing program coordination where necessary.

*Develop marketing plan for recruitment of MASH Volunteers, general volunteers.

*Develop a marketing plan to provide outreach to seniors who are currently enrolled or could be enrolled and participate in MASH.

*Engage the Economic Solutions team in the development of client satisfaction survey with VCBH and evaluation team.

*Selection, training, assignment and field supervision of a social work student intern who will work with seniors in need of assessment of their housing needs, relocation and their ongoing support directed toward stabilization.

*Identify additional non-profit partners who can supplement rental assistance and housing essentials, (e.g., Turning Point, St. Vincent de Paul, Jewish Federation)

*Identify professional services and resources necessary to provide project support to seniors served, (e.g., language translation, clinical services, transportation, etc.).

*Identification of moving assistance and time-limited shelter, (e.g., motels, assisted living solutions, city shelters).

*Work with VCBH on project website design and development of links to CAREGIVERS own website offering(s).

*Identification and outreach to local, state, and national programs addressing the issues and supports for homeless seniors.

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

A 3% increase is planned per year per categories.

Volunteer Caregivers Contract Breakdown
Program Staffing Costs
This project time and attention from following staff:
Executive Director (20 hours per month x 32.00 per hour= $44,172)
Volunteer Engagement Coordinator (40 hours per month x 17.50 per hours= $49,075)
Administrative Assistant (12 hours per month x 15.00 per hour= $32,460)
Cost of living increase 3% per year
MSW Intern (1040 hours): $93,600
Payroll Taxes and Benefits: $37,057
A 3% increase is planned per year

Total personnel: $237,364

PROFESSIONAL SERVICES $303,875

A 3% increase is planned per year per categories.

1) Certified Senior Advisor/Financial Planner Contract(s): $145,000

Engagement of CSA/CFP(s) to serve as lead team members of MASH teams providing mentoring, individual and group consultation to seniors and volunteer team members on client financial planning needs.

2) **Clinical Services Contract(s): $109,375** Basic clinical services are projected to be subcontracted with local clinical agencies for more immediate response for staff consultation, individual and group clinical treatment services. Amount based on $65 per hour
3) **Field Supervision** of graduate student(s) by an MSW for a total of 96 hrs. @ $25 per hr. = **$12,500**
4) **Language Interpretation Services**: **$12,500**
5) **Staff Consultation and Training: $25,000**

Housing Gap Assistance: $127,251 Fund availability for temporary and time limited assistance to support 2 to 4 senior(s) served. Examples of expenditures might include and not be limited to:

*Motel expenses @ $80 per night = $40,185
* Rent assistance @ $100 per mo. = $20,836
* Deposit assistance @750 per senior = $22,325
* Utilities assistance @ $375 per senior = $11,160
* Funds for moving assistance @ $500 = $ 14,883
*Two Storage Units available as needed= $17,860

Operational Overhead Costs: $134,324
Project specific marketing costs and program supplies=$11,600.00

Learning Events and Conferences= $12,500
Overhead and indirect five percent = $73,696

Total VCCA Contractor cost: $766,286

Evaluation Contract Costs: $14,000 per year = $74,328

Total Contracts Cost: **$840,614**

County Indirect Costs and 5% of direct Salaries and Benefits and other County Administrative cost: $126,092

Total Budget: $966,706

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*
EXPENDITURES

PERSONNEL COSTS (salaries, wages, benefits)		FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
1.	Salaries						
2.	Direct Costs						
3.	Indirect Costs						
4.	Total Personnel Costs						
OPERATING COSTS		FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
5.	Direct Costs						
6.	Indirect Costs	$21,468	$22,952	$25,045	$27,325	$29,302	$126,092
7.	Total Operating Costs	$21,468	$22,952	$25,045	$27,325	$29,302	$126,092
NON-RECURRING COSTS (equipment, technology)		FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
8.							
9.							
10.	Total Non-recurring costs						
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
11.	Direct Costs	$133,294	$140,249	$152,256	$164,618	$176,502	$766,919
12.	Indirect Costs	$9,827	$12,767	$14,712	$17,547	$18,844	$73,696
13.	Total Consultant Costs	$143,121	$153,016	$166,968	$182,165	$195,346	$840,614
OTHER EXPENDITURES (please explain in budget narrative)		FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
14.	Marketing						
15.	Learning Events and Conferences						
16.	Total Other Expenditures						
BUDGET TOTALS							
Personnel (line 1)							
Direct Costs (add lines 2, 5 and 11 from above)		$133,294	$140,249	$152,256	$164,618	$176,502	$766,919
Indirect Costs (add lines 3, 6 and 12 from above)		$31,295	$35,719	$39,757	$44,871	$48,146	$199,788
Non-recurring costs (line 10)							
Other Expenditures (line 16)							
TOTAL INNOVATION BUDGET		$164,589	$175,968	$192,012	$209,489	$224,647	$966,706

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 and the following funding sources:	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
1.	Innovative MHSA Funds	$21,468	$22,952	$25,045	$27,325	$29,302	$126,092
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Administration	$4,313	$4,383	$4,702	$4,900	$5,100	$23,398
EVALUATION:							
B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY and the following funding sources:	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
1.	Innovative MHSA Funds	$14,000	$14,420	$14,853	$15,298	$15,757	$74,328
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Evaluation	$14,000	$14,420	$14,853	$15,298	$15,757	$74,328
TOTAL:							
C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY and the following funding sources:	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
1.	Innovative MHSA Funds	$164,589	$175,968	$192,012	$209,489	$224,647	$966,706
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Expenditures	$164,589	$175,968	$192,012	$209,489	$224,647	$966,706
*If "Other funding" is included, please explain.							

Additional References

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"Homeless people in their fifties have more geriatric conditions than those living in homes who are decades older, according to researchers who are following 350 people who are homeless and aged 50 and over, in Oakland."

Margot Kushel. Older Homeless Adults: Can We Do More? (2011, November 16) J Gen Intern Med. 27(1):5–6
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Michelle S. Tong, Lauren M. Kaplan, David Guzman, Claudia Ponath, Margot B. Kushel. Persistent Homelessness and Violent Victimization Among Older Adults in the HOPE HOME Study. (September 2019)
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STAFF ANALYSIS – Yolo County Extension (Delegated Authority)

Innovative (INN) Project Name:	**Planning and Stakeholder Input Process for Crisis System Re-Design and Implementation**
Extension Funding Requested for Project:	**$500,000**

Review History:

MHSOAC Original Approval Date:	June 21, 2021
Original Amount Requested:	$114,000
Duration of INN Project:	One Year

Current Request:

County Submitted Innovation Extension:	June 15, 2022
Approved by BOS:	July 27, 2021
MHSOAC Consideration of INN Project:	June 2022

Project Introduction

Yolo County was originally approved for up to $114,000 on June 22, 2021, and now requests an additional $500,000 to build off the approved project to support the preparatory work needed to move from planning and stakeholder input to the implementation of a revised approach to crisis response throughout the county for all residents, including Medi-Cal recipients and those without insurance, based on the Crisis NOW principles.

In 2019, Yolo County Health and Human Services Agency (HHSA) expanded their community engagement planning process and it revealed the need for a more coordinated crisis response system between their community-based organizations, first responders, clinics, and schools. This called for a shift in Yolo County and how their HHSA responds to crises, which has been their top priority and efforts to improve have been continuing.

Background

The Commission launched an Innovation Incubator to deliver technical assistance to counties seeking to collaborate on and learn from innovative investments to reduce criminal justice involvement of people with mental health needs.

The Governor and Legislature authorized the Commission to develop an innovation incubator to leverage mental health innovation funds to transform approaches to mental health by focusing on prevention, early intervention, recovery, and outcomes that promote health, safety, independence, and opportunity.

Crisis response systems are critical infrastructure for local agencies serving individuals with serious mental health needs. Effective systems can improve outcomes for individuals while reducing avoidable law enforcement involvement and preventing incarceration. Many counties, however, particularly smaller, and more rural counties, are challenged to develop and sustain comprehensive crisis response systems.

The National Action Alliance for Suicide Prevention in 2016 produced Crisis Now: Transforming Services is Within our Reach, which documented a proven strategy to crisis response with four core elements:

1. High-tech crisis Call Centers that coordinate all aspects of an immediate crisis response.
2. Mobile Crisis Outreach Teams that work in the community with those at risk and reduce the need for uniformed officers to provide mental health triage in the streets.
3. Facility-based Crisis Centers that divert away from hospital emergency departments and provide crisis-specific interventions in safe and secure environments; and
4. Commitment to evidenced-based safe care practices, such as Trauma-Informed Care, Zero Suicide in Healthcare principles, and a multidisciplinary approach to crisis resolution.

The Crisis Now model enables counties to assess community needs, enhance access to care and realize overall cost savings.

Yolo County has been the lead county participating in the Commission's funded Crisis Now Academy since October 2020, allowing the County to assess its continuum of care crisis services in relation to the National Action Alliance for Suicide Prevention's Crisis Services Task Force model.

Original Plan Approval

As a result of Yolo County's participation in the Crisis Now Academy and local evaluation of their crisis system, Yolo County requested Commission approval for the one-time use of $114,000 in Innovation funding for Crisis Now Innovation-related Community Planning for Crisis System Re-Design and Implementation. This allocation was to specifically engage their community and support the development and implementation preparation of a revised approach to crisis response throughout the County for all residents. Discussions occurred with

local health system providers as well as community service providers. These activities were in alignment with the County's stakeholder engagement process, including the MHSA Community Engagement Work Group (CEWG), the Local Mental Health Board, local law enforcement agencies, consumers and family members and other relevant County agencies.

Extension Request

Yolo County is requesting Commission approval for an additional amount up to $500,000 in Innovation funding to build on the approved plan to take the community planning process to the next phase, which will ultimately result in the re-design coming to fruition. The additional funding and the additional timeframe requests will allow the County to complete the significant amount of work that still needs to be done prior to full implementation of the Crisis Now system in Yolo County.

The below list includes anticipated uses of $500,000 in additional funding to complete the preparatory process and all have been informed by the robust community planning process conducted to date:

- Site location, re-design, engagement, and renovation preparation
- Architect and engineer support for location needs
- Preparatory renovation work to create a suicide-safe Crisis Now
- Train staff, internal and external, on Crisis Now programming needs, expectations, outcomes, policies & procedures
- Policy, procedure, and practice development required to connect high-tech call center with 988 and local dispatch
- Request for Proposal (RFP) development, review, contracting execution
- Purchasing and securing required equipment, suicide-safe furniture
- Staff required to support the above efforts

As Yolo County works to complete the planning and preparation phase, they will continue to work with the Commission to finalize their full Innovation proposal to launch the Crisis Now system redesign.

Yolo County anticipates seeking full Commission approval of the Crisis Now Innovation proposal in late 2022/early 2023 allowing the county to move seamlessly from planning and preparation to full implementation.

Community Program Planning

When the Commission planned to initiate a Multi-County Collaborative with RI International for interested counties, Yolo County expressed their desire to participate in the Crisis Now Collaborative by allocating funding in their 2020-2023 three-year program and expenditure plan.

Local Level

Yolo County proposed a full project plan to engage their community to redesign the crisis system and implement the Crisis Now system redesign in their 2021-2022 Annual Update, complete with required local stakeholder review process in May and June 2021. The County worked with the Commission to launch the project in a phased approached.

Yolo County engaged 151 participants through the CEWG over six meetings in fiscal year 2021-2022, met with each city council, police chiefs in the four largest cities and provided updates to the local mental health board at each meeting through the Director's report.

Additionally, staff presented at the Board of Supervisors once on Crisis Now and included information regarding Crisis Now in a total of 13 different Board of Supervisors agenda items through 2021 and 2022.

The project extension will serve as a bridge between the fiscal year 2021-2022 of approved community planning and the next phase of preparation before the full implementation of their Crisis System of Care.

Commission Level

This proposal was shared with the Commission list serve and stakeholder contractors on June 15, 2022. As of the date of writing, no comments were received.

Learning Objectives and Evaluation

As part of their ongoing learning and commitment to transparency and transformation from this new, and rejuvenated Community Program Planning Process, Yolo County is tracking the following outcomes with input from their local communities:

- What efforts were utilized to engage stakeholders in community planning?
- How many community members and other stakeholders participated?
- How many community planning events were held and when?
- What were the events target populations?
- How did the County's efforts produce a Crisis Re-Design plan?

Additional outcomes to be tracked with the extension request include:

- Architectural and engineering plans presented to the Board of Supervisors for approval
- Training provided to internal and external staff on Crisis Now Core Principles and program implementation
- Policy, procedure, and practice materials developed
- Executed contract for service delivery of high-tech call center and receiving, stabilization, and sobering center facilities
- Crisis Now positions secured for administrative oversight, guidance, and support
- Suicide-safe/Crisis Now appropriate furniture and supplies secured

Budget

Yolo County was originally approved by the Commission for one-time funding in the amount of $114,000 on June 22, 2021 and is now seeking additional funding in the amount up to $500,000 along with a time extension of up to two years for this phase of the project. The new project total will be $614,000 in MHSA Innovation funds for a total of three (3) years.

The budget includes additional allocations for:

- Personnel (internal staff and staff time) of approximately $150,000,
- Administration (architect/engineer, equipment and furniture, documentation prep and purchase, site prep work, etc.) of approximately $200,000, and
- Operation Costs (external staff hiring, training, etc.) of approximately $150,000

Additional Regulatory Requirements

The proposed project extension appears to meet the minimum requirements listed under MHSA Innovation regulations

COUNTY OF YOLO

Health and Human Services Agency

Nolan Sullivan
Interim Director

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June 15, 2022

Toby Ewing, PhD
Executive Director
Mental Health Services Oversight and Accountability Commission (MHSOAC)
1300 17th Street
Sacramento, Ca 95811

Dear Dr. Ewing,

This letter is regarding the approved Yolo County Innovation project: **Planning and Stakeholder Input Process for Crisis System Re-Design and Implementation** managed by the Yolo County Health and Human Services Agency (HHSA). This project was approved by the Commission Chair's delegated authority on June 22, 2021 for $114,000. We are requesting the Commissions' approval and authorization for the following:

- Extended timeline to use the $114,000 funding through FY 22-23, and
- Up to $500,000 of MHSA funds through FY23-24 to build off the approved project to support the preparatory work needed to get from the planning and stakeholder input process, re-design and implementation to full implementation of a revised approach to crisis response for all Yolo County residents, including Medi-Cal beneficiaries and those without insurance, based on the four key components of Crisis Now.
- Total request up to $614,000.

Stemming from this project and the previous Crisis Now Academy participation, Yolo County HHSA staff have worked extensively over the previous year with community, leadership, and partners to gather input and feedback to develop a draft Crisis Now Innovation Proposal and will be submitting the full Crisis Now Innovation Proposal to the OAC for approval in 2022. A preliminary draft has been provided to the OAC for feedback as this proposal will be included in the current draft Annual Update. HHSA will reduce costs on the draft Innovation proposal to account for this request, which falls within the current approved project activities. Yolo County HHSA also commits to work with the OAC to share, disseminate, engage, and provide learning opportunities and best practices on these efforts and the full Crisis Now program once fully implemented in Yolo.

This proposal was informed by multiple stakeholder input processes held over the previous fiscal year and Yolo's desire to tailor crisis response to better meet the needs of our community, however, there is a significant amount of work that still needs to be done prior to implementation. Included in the narrative below is an update on activities, accomplishments, and a revised proposal summary.

We respectfully request the Commissions' approval and authorization.

In Health,

Karleen Jakowski, LMFT
Interim Mental Health Director

Yolo County Health and Human Services Funding Proposal for

Planning and Stakeholder Input Process for Crisis System Re-Design and Implementation

Community and Stakeholder Engagement

The Yolo County Health and Human Services Agency (HHSA), continues to be fully invested in having a dynamic and robust Community Planning Process (CPP) for all MHSA-funded projects, programs and innovations. Input from the residents and community of Yolo County is vital to effective planning and program development. In addition to the traditional community and stakeholder engagement efforts, HHSA incorporated feedback from the Community Health Needs Assessment, Community Corrections Partnership Strategic Planning sessions, the Maternal, Child and Adolescent Health planning process, the County Self-Assessment of Child Welfare and Probation, and Community listening sessions and surveys for County-wide strategic plan. These inputs and processes, as well as data, informed the new 3-year plan.

As of 2019, HHSA expanded the community engagement planning process in development of the three-year MHSA plan (2020-2023). This investment was informed by a 6-month process from August 2019 to January 2020 which included three large MHSA educational sessions and 31 focus groups with over 500 participants from diverse communities and varying roles. To build on momentum generated by the community outreach and education process, the county decided to engage the participants and invite them to be part of an ongoing Community Engagement Workgroup (CEWG). This group has been asked to provide input ongoing and will remain an engaged partner as the county moves forward with implementation, review reporting, etc. The CEWG acts as a partner to HHSA and helps to disseminate information to the community while providing an ongoing opportunity for community engagement around mental health services.

Update-Ongoing
CEWG FY 21-22-The Community Engagement Workgroup (CEWG) meetings were hosted in September, October, and December 2021 and reconvened in February, March, and May 2022. There were 151 participants who attended virtually over these six meetings in total. Each monthly CEWG meeting incorporated an MHSA educational component, specific objectives, and discussion topics to create a forum for community participants to provide input, share ideas, identify community needs, and provide feedback and recommendations to inform HHSA and the MHSA process.

A Need for Change in Crisis Services

The community planning process in 2019 demonstrated the need for a change in the way Yolo County and HHSA provides crisis response. With issues arising in community based settings, with first responders, in hospitals, clinics, and schools, key informant interviews from 2019 emphasized the need for crisis response services based in the community. This need was further described as a need for better joint response between HHSA, local hospital systems and law enforcement, and a demand for increased options for residents to seek crisis services within existing County clinics. Crisis responses remains a top priority for HHSA and improvement efforts have been ongoing.

"This need was further described as a need for better joint response between HHSA, local hospital systems and law enforcement..."

Crisis Service History in Yolo County

Over the last several years, Yolo County HHSA has sought to tailor its crisis response services to better meet the expressed needs of community residents. In 2014, Yolo County secured SB82 funding and contracted with a local provider to offer the Community Intervention Program (CIP) which ran from November 2015 through March 2017. CIP was a collaboration between County law enforcement agencies, HHSA, and community-based behavioral health service providers designed to have trained clinical staff available when law enforcement responds to a mental health crisis. The overarching goals were to:

- Reduce unnecessary emergency department (ED), hospital, and jail service utilization;
- Increase participation in mental health or other necessary services post-crisis; and
- Reduce the overall system and per person costs associated with behavioral healthcare.

Program evaluation revealed some successes, especially for specific in-need community members, however the investment did not result in a return that was sustainable nor did the collaboration effectively assist consumers with remaining in the community and avoiding an ED visit or jail. Further, at some junctures, CIP HHSA staff were not called upon as often as they could be and only 1 to 2 calls per day on average was seen across multiple city CIP teams.

As of 2018, Yolo County HHSA began working closely with its two local EDs to have dedicated, 24-hour HHSA clinicians available to respond to handle crisis evaluations in the EDs for any County beneficiary. These clinicians also coordinated subsequent acute inpatient bed placement for any County beneficiary placed on an involuntary hold. At the same time, HHSA's First Responders Initiative (an MHSA approved Innovations project), involving a community based Mental Health Urgent Care (MHUC) clinic was begun. It was designed to integrate non-law enforcement personnel into first response by providing a drop-in access and crisis clinic for anyone in need. In February 2018, HHSA opened this clinic in West Sacramento after much stakeholder engagement in planning and development. The MHUC was initially open 7-days a week for 9 hours a day (from 12 pm to 9 pm) based on community input of crisis service needs. Contracting difficulties result in a notable delay on the incorporation of contracted psychiatric Nurse Practitioners into the MHUC staff. Further, peer staff were never added to the team as intended. Close tracking of resident usage and law enforcement drop offs revealed notable underutilization. As a result, the MHUC operating hours were reduced to 6 days a week (Monday through Saturday) in January 2020. Ultimately in April 2020, due to lack of fiscal sustainability of the clinic and overall lower than anticipated law enforcement utilization (and a legal barrier preventing County EMS from bring persons in behavioral distress to the MHUC), HHSA management elected to close the clinic. In its place, the County began to offer walk in crisis and access services to the community (restricted to crisis services only during COVID), during business hours at three of its clinics (West Sacramento, Woodland and Davis).

By 2020, it became clear that having a bifurcated crisis assessment system in the ED (i.e. County staff for County beneficiaries and ED staff for all other payor source clients) had become a hindrance to expedient assessment and quality community resident services. Hospital partners urged HHSA to either provide Crisis assessment services in the EDs to all county residents or conversely allow ED staff to handle all crisis assessments that present in the ED, regardless of payor source. HHSA convened the Crisis ReDesign Task Force, comprised of hospital and law enforcement representatives, as well as HHSA crisis staff and managers. Due to COVID-19, the Task Force was suspended, but HHSA elected to give both local EDs approval to have ED staff handle all crisis assessments and resulting involuntary holds. HHSA retained the acute inpatient bed placement duties for County beneficiaries. This duty is currently handled by internal HHSA Crisis staff or an after-hours contractor.

Incorporating the learning from the former CIP project, HHSA developed and implemented the Co-Responder project in 2020, using MHSA CSS funds in combination with city or other funding contributions. Each of Woodland, West Sacramento, and Davis, contributes city funds towards the cost of at least one embedded HHSA Clinician to co-respond with law enforcement in the field for behavioral health emergencies. The County Sheriff and the Probation Department also contribute CCP funds towards the cost of a shared embedded HHSA clinician. In July 2020, HHSA embedded its first clinician Woodland Police Department. By November 2020, a clinician was embedded with West Sacramento Police Department, while a second clinician was added in March 2021, so the city has 7 day a week response. In April 2021, a clinician was added for Davis Police Department.

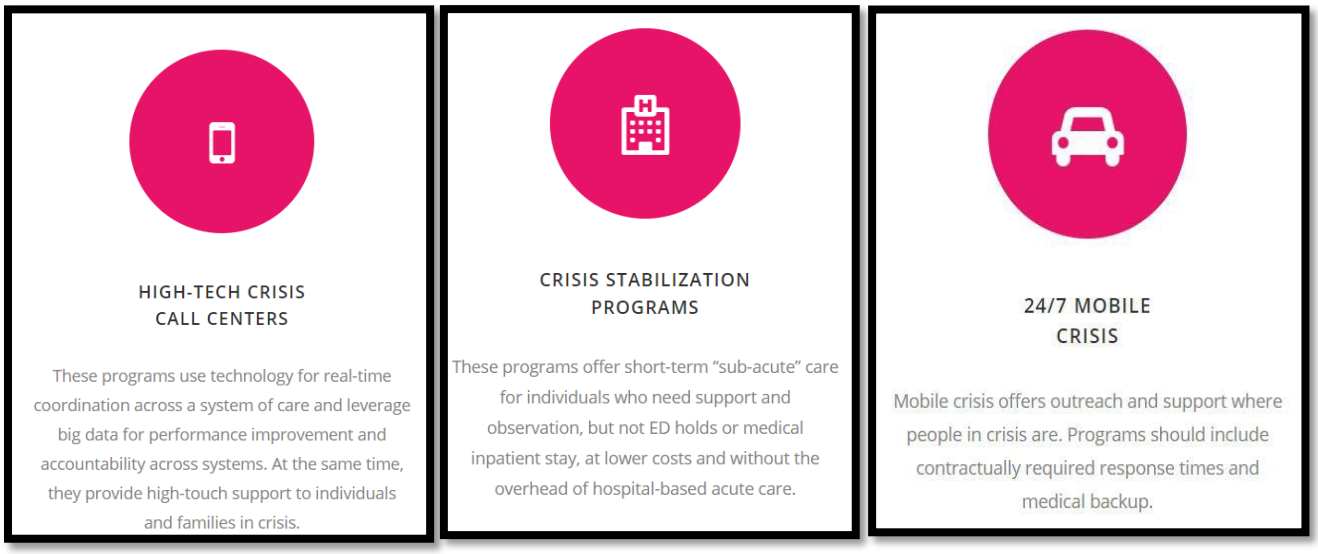
The search for a final clinician for the joint County Sheriff/Probation position is ongoing.

Crisis Now

Late in 2019, HHSA Director Karen Larsen became aware of Crisis NOW, an initiative led by the National Association of State Mental Health Program Directors (NASMHPD) and developed with the National Action Alliance for Suicide Prevention, the National Suicide Prevention Lifeline, the National Council for Behavioral Health, and RI International. Further, when it became clear that the Mental Health Services Oversight and Accountability Commission (MHSOAC) planned to initiate a learning collaborative with RI International for interested counties, Yolo County expressed the desire to participate by allocating $145,000 in FY 20-21 in the current MHSA plan 2020-2023. Crisis Now's three core components; Call Centers, Crisis Stabilization Programs and 24/7 mobile crisis response align closely with needs identified via the community process.

Update

Stemming from Planning and Stakeholder Input Process for Crisis System Re-Design and Implementation and the previous Crisis NOW Academy participation, Yolo HHSA staff have worked extensively over the previous year with community, leadership, and partners to gather input and feedback to develop a draft Crisis Now Innovation Proposal and will be submitting the full Crisis Now Innovation Proposal to the OAC for approval in 2022. A preliminary draft has been provided to OAC for feedback as this proposal will be included in the current draft Annual Update public comment period.



The Plan-Updated Proposal

Yolo County HHSA initially requested MHSOAC approval for the one-time use of $114,000 in MHSA funding for Crisis Now Inn-related Community Planning for Crisis System Re-Design and Implementation. This allocation was to specifically support development and implementation of a revised approach to crisis response throughout the County for all residents, including Medi-Cal beneficiaries and those without insurance, using Crisis Now principles. Discussions occurred with local health system providers as well as community service providers. These activities were in alignment with the County's stakeholder engagement process, including the MHSA CEWG, the Local Mental Health Board (LMHB), local law enforcement agencies, consumers and family members and other relevant County agencies.

Yolo County HHSA is requesting MHSOAC approval for an additional up to $500,000 in MHSA INN funding for the upcoming preparatory work necessary to build on the already approved plan to take the community planning process to the next phase, which will ultimately result in the Re-Design coming to fruition. In the original approved plan language above, there was language included regarding the implementation of a revised approach to crisis response throughout the County. The additional funding and the additional timeframe being requests will allow

HHSA to complete much of the significant amount of work that still needs to be done prior to full implementation of the Crisis Now system in Yolo. All the below are anticipated uses of this additional funding during this preparatory implementation process and all have been informed by the robust community planning process conducted to date:

- **Site location, re-design, engagement, and renovation preparation**
- **Architect and engineer support for location needs**
- **Preparatory renovation work to create a suicide-safe Crisis Now**
- **Train staff, internal and external, on Crisis Now programming needs, expectations, outcomes, policies & procedures**
- **Policy, procedure, and practice development required to connect high-tech call center with 988 and local dispatch**
- **Request for Proposal (RFP) development, review, contracting execution**
- **Purchasing and securing required equipment, suicide-safe furniture**
- **Staff required to support the above efforts**

Budget

Yolo County HHSA is requesting Commission approval and authorization to use up to $614,000 from MHSA INN funds. This request contains two major components:

- **Extended timeline to use the $114,000 funding through FY 22-23, and**
- **Up to $500,000 of MHSA funds through FY 23-24 to build off of the approved project to support the preparatory work needed to get us from the planning and stakeholder input process Re-Design and Implementation to the full implementation of a revised approach to crisis response throughout the County for all residents, including Medi-Cal beneficiaries and those without insurance, based on the 4 key components of Crisis Now.**
- **Total request up to $614,000.**

Outcomes-Update

HHSA is committed to its stakeholders. Further, it is also committed to observing all regulations, with transparency and transformation. The County plans to track specific engagement efforts. The efforts to be tracked will include, but not limited to:

- What efforts were utilized to engage stakeholders in community planning;
- How many community members and other stakeholders participated;
- How many community planning events were held and when;
- What were the events target populations;
- How did the County's efforts produce a Crisis Re-Design plan.
- **Additional Outcomes Added:**
    - **Architectural and engineering plans presented to the Board of Supervisors for approval**
    - **Training provided to internal and external staff on Crisis Now Core Principles and program implementation**
    - **Policy, procedure, and practice materials developed**
    - **Executed contract for service delivery of high-tech call center and receiving, stabilization, and sobering center facilities**
    - **Crisis Now positions secured for administrative oversight, guidance, and support**
    - **Suicide-safe/Crisis Now appropriate furniture and supplies secured**

Update-FY 21-22:

The Community Engagement Workgroup (CEWG) meetings were hosted in September, October, and December 2021 and reconvened in February, March, and May 2022. CEWG is open to the public and is a way to engage our local consumers, family members, and interested partners on the MHSA plan, process, programs, and initiatives. There were 151 participants who attended virtually over these six meetings in total. Each monthly CEWG meeting incorporated an MHSA educational component, specific objectives, and discussion topics to create a forum for community participants to provide input, share ideas, identify community needs, and provide feedback and recommendations to inform HHSA and the MHSA process. Crisis Now has been an update at almost every CEWG meeting throughout 2021 and thus far in 2022.

The Local Mental Health Board meets monthly and convened in September, October, and December 2021 to receive updates on the MHSA fiscal overview and surplus, proposed spending plan and budget, and relevant programmatic updates. The group reconvened in January 2022 and conducted additional meetings in April and May. MHSA funding parameters including challenges, and opportunities for the FY 2022–23 budget were discussed, along with proposed spending and additional proposals. The HHSA Mental Health Director providers a report summarizing large programs, projects, and initiatives and throughout 2021 and thus far in 2022, Crisis Now has been included in every MH Director Report to update the community and LMHB on progress to date.

The Yolo County Board of Supervisors meets twice a month and convened a Budget Ad Hoc Committee that met in November and December 2021 to review the MHSA surplus budget and spending plan. In January 2022, the board was presented with a spending plan and an update on the community engagement process with a follow up presentation provided in March 2022. Additionally, staff presented at the Board of Supervisors once on Crisis Now and included information regarding Crisis Now in a total of 13 different Board of Supervisors agenda items through 2021 and 2022.

Additional key stakeholder engagement occurred throughout 2021. HHSA staff met with the police chiefs in our 4 largest cities (West Sacramento, Woodland, Davis, and Winters) on two different occasions, met jointly with City of Davis and UC Davis leadership on two different occasions and presented at the Davis, Woodland, and West Sacramento City Council meetings at least one each. The Community Corrections Partnership (CCP) received information regarding Crisis Now on multiple occasions and has supported the effort with direct ongoing funding annually as a result.

Conclusion

Yolo County has included this pending request within the County's draft MHSA Annual Update Fiscal Year 22-23 for community transparency in all MHSA endeavors.