

Innovative & Consistent Application of Resources and Engagement (iCARE) Innovation Plan

GENERAL REQUIREMENT:

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 is based on the experience of the San Bernardino County Department of Behavioral Health's Innovation Plan approved in 2015 as well as the experience of other health care systems in implementing transformative practices increasing consumer engagement in healthcare, specifically hospitals and providers in Camden, New Jersey.

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.

Sutter-Yuba Behavioral Health's primary purpose for implementation of the iCARE Innovation project is: *to increase access to behavioral health care for underserved groups experiencing difficulty engaging in outpatient behavioral health and substance use disorder treatment services.* Secondary results will also be demonstrated through the project as evidenced by: increased quality of mental health services, including measurement of outcomes, promotion of interagency and community collaboration related to Mental Health Services, supports or improved individual and community level outcomes.

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.

The purpose for creation of the Innovative & Consistent Application of Resources and Engagement (iCARE) Team in Sutter County and Yuba Counties is to better address the needs of the community on three levels:

- 1) At the individual level for consumers through increased engagement with available behavioral health services.
- 2) At the behavioral health system level through transformation of professional provider engagement practices.

At the community level through transformation of community views on behavioral health conditions and accessing behavioral health care.

Specifically, iCARE is intended to increase consumer engagement in outpatient behavioral health care for individuals experiencing severe and chronic behavioral health conditions who primarily access emergency, crisis and inpatient services. iCARE also seeks to dispel misconceptions, myths, address stigmas related to behavioral health care and increase engagement support for those accessing behavioral health services. iCARE is designed to increase levels of comfort individually and in the community related to accessing behavioral health care in a rural, small, bi-county setting, while fostering collaborative cross-sector working relationships, positive behavioral health experiences and wellbeing for consumers served by Sutter-Yuba Behavioral Health.

On November 13th, 1972 Sutter-Yuba Behavioral Health (SYBH), then- Bi-County Mental Health Department established a JPA approving a Bi-County Mental Health Program for the counties of Sutter and Yuba. Since 1972, SYBH has continued to provide services to individuals and families who are experiencing serious or ongoing mental health and/or substance use disorders in Sutter and Yuba counties. These services have traditionally been provided in the conventional or clinical manner, i.e., in-office visits, office-based groups, occasional home visits, and embedded models within programs such as children and family services and probation, but with limited community engagement on the benefits of behavioral health services.

Per the 2010 Census, the total population for Sutter and Yuba Counties combined is 167,888. According to 2014 population estimates, Sutter County is home to approximately 95,733 people. There are two incorporated cities, Yuba City with a population of 65,677 (2014), and Live Oak with 8,481 (2014) residents. The remaining residents live within the small communities of Tierra Buena, Meridian, Rio Oso, Trowbridge, Sutter, Pleasant Grove, Nicolaus, East Nicolaus, Riego or Robbins, or reside in the vast rural, agricultural areas which make up Sutter County.

The 2010 U. S. Census shows that Caucasians made up nearly 65.5% of Sutter County's population. The remainder of the population includes Hispanic or Latino (28.8%), Asian/Pacific Islander, including Sutter County's large East Indian population (11.1%), African Americans (1.8%), and Native Americans (1.4%).

The median age in Sutter County, according to the 2010 census, was 34.5 years, and children accounted for over 32.7% of the population while seniors (65 and older) made up approximately 12.7%.

In the 2015 Report of Registration, there were 41,508 registered voters in Sutter County with party affiliations of Republican (43%), Democrat (31%), declined to state (no party) (18%), American Independent (3%), other (2%), Peace and Freedom (.33%), Libertarian (.68%), and Green (.31%).

In a California Employment Development Department February 2019 Monthly Labor Force Data for Counties study, the unemployment rate in Sutter County was 9.7% (4,500 individuals unemployed). Sutter County is currently number 50 of 58 counties, where 1 is the lowest county unemployment rate and 58 is the county with the highest unemployment

rate. Many people who choose to live in Sutter County commute to work in one of the many surrounding counties.

The availability of water, plus long sunny growing seasons, make Sutter County a fertile area for agriculture. With over 77% of the County's total acreage classified as "important farmland," with 43.5% considered prime, coupled with the high value of agricultural production, Sutter County is one of the most intensively farmed counties in California. Agricultural products grown in Sutter County are exported throughout the world.

Yuba County is one of California's original 27 counties founded on February 18th, 1850. Agriculture plays a major role in Yuba County's economy, especially fruit orchards, rice fields, and cattle grazing. Other major employers include Government and Healthcare. The 2010 United States Census reported that Yuba County had a population of 72,155. The demographics of Yuba County, at the time of the Census, was 49,332 (68.4%) White, 2,361 (3.3%) African American, 1,675 (2.3%) Native American, 4,862 (6.7%) Asian, 293 (0.4%) Pacific Islander, 8,545 (11.8%) from other races, and 5,087 (7.1%) from two or more races. Hispanic or Latino of any race were 18,051 persons (25.0%).

The median age in Yuba County, according to the 2010 census, was 32.2 years, with children accounting for 32% of the population and seniors (65 and older) making up approximately 10.1%.

In the 2015 Report of Registration, of the 47,937 eligible voters, there were 27,318 (57%) registered voters in Yuba County. Party affiliations included, Republican (39%), Democrat (30%), declined to state (no party) (24%), American Independent (5%), other (.25%), Peace and Freedom (.37%), Libertarian (.96%), and Green (.51%).

In a California Employment Development Department February 2019 Monthly Labor Force Data for Counties study, the unemployment rate in Yuba County was 7.8% (2,300 individuals unemployed). Yuba County is currently number 42 of 58 counties, where 1 is the lowest county unemployment rate and 58 is the county with the highest unemployment rate.

Established in 1842, Marysville, is located on the west county-line. The only other incorporated city, in Yuba County, Wheatland, is located on the southeastern county-line. In the 2010 Census, 12,072 people resided in Marysville and 3,456 people resided in Wheatland, with the remaining 56,879 residents (79%) of Yuba County living in an unincorporated area. Residents also live within the small communities of Linda, Olivehurst, Arboga, and Plumas Lake. Additionally, Beale Air Force Base, a local military base in Yuba County was established in 1942, then- referred to as Camp Beale, and housed POWs during WW II. Today the Air Force Base covers nearly 23,000 acres. The remaining Yuba County townships in the Sierra Nevada foothills are the communities of Iowa City, Smartsville, Browns Valley, Loma Rica, Camptonville, Dobbins, Rackerby, Challenge-Brownsville, Oregon House and Strawberry Valley which is located 43 miles from Marysville.

Yuba County has one major river, the Yuba River, which is comprised of three forks that begin in the Sierra Nevada Mountains and feed the larger watershed. The availability of water, plus long sunny growing seasons, make Yuba County a fertile area for agriculture. In 1997, Yuba County was ranked 6th among the nation's counties in production of peaches and sixth in production of plums and prunes. A 2010 Yuba County Crop Report states, "the top six agricultural commodities in Yuba County were, rice, walnuts, plums/prunes, peaches, milk and cattle, in that order."

Sutter and Yuba County residents value the local geography, proximity to two rivers, rich agricultural soil and foster a sense of community appreciation for a slower pace that increases quality of life, including affordability. While social media use is less typical for all ages, youth and young adults primarily access information via social media, while adults, older adults and elderly value more traditional media to include printed or web-based newspapers, mailed letters, or gaining information at community gathering places such as senior/community centers and churches.

Sutter and Yuba counties are served by one large hospital, Adventist Health+ Rideout Hospital, two Medi-Cal Managed Care Plans (Anthem Blue Cross and California Health and Wellness), commercial insurances and several large and small healthcare practices. Network availability for healthcare providers, to include primary care and specialty providers has been historically low, with Sutter and Yuba counties struggling to attract healthcare providers to the region with the hospital serving as a main source of healthcare access.

In a 2016 Community Health Needs Assessment, Adventist Health+ Rideout Hospital and Sutter Surgical Hospital – North Valley Service Area, identified access to transportation and mobility as the sixth highest priority for significant health need in the Bi-County region, to include populated city areas. Residents living in both city and rural areas experience economic disparities which contribute to difficulty in accessing services as vehicles are unavailable to some of them.

In some instances, residents live in rural mountain towns on dirt roads. To make a drive into "town" takes more than an hour over 40 plus miles of winding mountain roads, which are often affected by inclement weather and flooding during winter months. In these rural areas public transit is not accessible, there are no street lights and the remote nature of the location is an attraction for residents.

Residents who live in various rural areas of both counties often appreciate the ability to live independently, with little reliance on others. This includes efforts to avoid being a "burden" to taxpayers and limited interaction with government or public health care providers. Due to the goldrush history of the region, as well as the proximity of Beale Air Force Base, residents often identify with "pulling themselves up by their boot straps" when it comes to behavioral health care conditions.

According to the 5-year strategic plan to respond to homelessness in Sutter and Yuba Counties published in January 2019, Sutter and Yuba Counties have experienced a

particularly striking increase in homelessness over the past decade. Specifically, the reported number of persons experiencing homelessness has more than doubled from 362 in 2007 to 760 in 2017. During the same time period, the number individuals experiencing chronic homelessness has more than tripled – from 44 persons in 2007 to 150 persons in 2017. The severity of this increase in the prevalence of homelessness is exacerbated by the fact that the majority (62.2%) of persons experiencing homelessness are unsheltered.

This is true for several populations of focus among persons experiencing homelessness as well, including individuals with severe mental illness (51.9% unsheltered), Veterans (57.4% unsheltered), unaccompanied youth (62.5% unsheltered), parenting youth (66.6% unsheltered), and children of parenting youth (70% unsheltered). It is important to note that the reported numbers of persons experiencing homelessness for 2017 are likely underestimated. For example, the number of self-declared persons experiencing homelessness reporting to the Yuba County Department of Health and Human Services Department far exceeds that count. It is estimated, in actuality, the Bi-County region has a total homeless population ranging from 800 to 1,000 individuals (*5-year strategic plan to respond to homelessness in Sutter and Yuba Counties, January 2019*).

As the Mental Health Plan for Sutter and Yuba counties, SYBH is responsible for providing specialty mental health services (SMHS) to include community-based mental health and substance use disorder treatment programs for those who have Medicare, Medi-Cal, are uninsured, have low income and are underserved, unserved or inappropriately served. In FY 17-18, SYBH served 5,408 unique individuals, approximately 3.22% of the total population of 167,888 residents. Per the National Institute of Mental Health (NIMH), prevalence rates for individuals estimated to live with severe and persistent behavioral health conditions is 4%, or for our region, 6,715 individuals. Thus, it is likely that SYBH is underserving our target population.

Of the 5,408 persons seen, 53% identified as female, 47% as male, and less than one percent as other. Additionally, 65% identified as White, 14% Latino, 4% African American, 4% Asian/Pacific Islander, 1.5% Native American, with an additional 6% identifying as two or more ethnicities, 4% not reporting and less than one percent as other.

Services for those with chronic and persistent behavioral health conditions have historically been provided in conventional service delivery structures focusing on inpatient care, outpatient programs requiring consumers to “come to” the public behavioral health clinics, and traditional case management for both behavioral health and substance use disorders treatment.

A previous behavioral health crisis services innovation effort that began in FY 15/16 has resulted in a unique collaboration between SYBH and Adventist+ Rideout Regional Hospital. In this model, SYBH embeds crisis counselors and licensed staff, while Adventist+ Rideout provides telehealth in the local emergency room. Despite this collaborative effort, the rest of SYBH’s Behavioral Health Outpatient Service Delivery System remains largely unchanged. Service provision is dependent upon the consumer’s

ability to come to office visits or attend structured appointments. While Full Service Partnership (FSP) programs exist, they are underutilized.

SYBH works collaboratively with nine law enforcement entities between Sutter County and Yuba County to include county probations, sheriff's departments, city police and the California Highway Patrol. Interagency and department relationships with law enforcement partners are highly collaborative and strong. However, SYBH law enforcement partners continue to receive a high number of behavioral health related calls, including 5150 evaluations.

During calendar year 2018, SYBH provided crisis/emergency psychiatric services to 2,702 individuals. Of those seen, 1,995 were seen via 5150 or involuntary holds. In 2018, law enforcement wrote 997 (49%), of the total 1,995 holds placed in both counties for children and adults. The remaining 998 holds were written by SYBH crisis staff, with 404 of 998 being written at the hospital for individuals transported to the hospital via law enforcement. Thus, adding holds placed at the hospital with holds written by law enforcement, is 70% (1,401) of the total 1,995 holds, a significant percentage of total crisis contacts.

Of those 2,702 who were provided crisis services, over 500 received inpatient hospital care. Of those 500 who had both mental health and substance use disorders (co-occurring conditions), less than 2% followed up with outpatient behavioral health and substance use disorder treatment within 30 days of receiving psychiatric emergency services or discharge from a psychiatric inpatient setting. Of the 25 individuals receiving the most hospital care, some with more than 200 days of acute inpatient hospital care in one year, only 8% were enrolled in FSP services.

Based on this data it is clear to SYBH that a large percentage of individuals seeking emergency, crisis and hospital care are not successfully connecting with outpatient care and are caught in an emergency services pattern.

When SYBH has asked consumers why they aren't connecting with outpatient care after seeking emergency or crisis care, they have reported:

"Services at SYBH don't/won't help me."

"The wait is too long."

"There is too much paperwork."

A large percentage of consumers accessing emergency and crisis services are new to the public behavioral health system, presumably because SYBH has been fully imbedded in the local emergency room 24/7 since FY 15/16. Additionally, there is a sense among consumers that they suffer from discrimination due to being diagnosed with a mental illness, having a mental illness, or seeking mental health services, even with some SYBH staff.

Consumers report being aware of negative feelings, attitudes, beliefs, perceptions, and stereotypes in the local community that make them hesitant of “being seen” at the behavioral health sites in the local community. Behavioral health stigma is considerably high and public education regarding behavioral health care, benefits of services, and positive impacts of recovery and wellness have not been widely discussed. This is due to the rural nature of both counties and a slower pace for behavioral health system transformation. Thus, community behavioral health education aimed at addressing stigma associated with behavioral health care has been slower to develop within the community at large. This includes the general healthcare community, with some practitioners questioning the effectiveness of behavioral health care services and remaining generally distrustful of psychiatric care.

Also, a percentage of consumers do not believe they have mental illness and this belief informs their lack of interest in coming to outpatient care despite accessing significant amounts of emergency and crisis services.

Thus, SYBH is proposing the iCARE team, a mobile, field capable, non-clinical, relational based engagement team meeting consumers where they are in a “go to” model. The iCARE Team will also offer therapy and psychosocial education to family members/support persons of individuals with chronic mental health conditions and substance use disorders to strengthen coping skills, knowledge of behavioral health care conditions and treatments. Lastly, the iCARE Team will partner its approach with a large scale, concurrent public education effort widely offering community and employer-based training related to behavioral health care conditions, wellness, recovery, and stigma reduction.

PROPOSED PROJECT:

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

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

SYBH’s outpatient service delivery system is currently built to serve individuals able to engage in available outpatient treatment. Thus, based on consumer and provider feedback, data review of service patterns, and community feedback, SYBH is proposing to implement the iCARE Team, which will include Peer staff with lived experience working alongside clinicians in Sutter and Yuba counties. The iCARE Team is based on successful engagement practices tested in San Bernardino County’s Department of Behavioral Health, Recovery Based Engagement Support Teams (RBEST) innovation project, and Camden Coalition of Healthcare Provider’s COACH model, engaging and empowering patients. The iCARE Team would focus on safely working with individuals not ready or able to engage with available outpatient treatment while concurrently working to strengthen individual and community support systems.

Specifically, SYBH is proposing the iCARE Team respond to individuals in a non-clinical, mobile, field-based approach prior to and after hospitalization, in consumer homes, homeless encampments, emergency rooms, with law enforcement or other community settings who:

- Utilize crisis, emergency, and inpatient hospital care as their main source of behavioral health treatment
- Have high contact with law enforcement
- Are unengaged in available outpatient behavioral health and substance use disorder treatment, or engaging ineffectively in available outpatient care
- Are vulnerable due to difficulty making transitions between hospital and outpatient care
- Experience difficulty accessing behavioral health care for the consumer and or family member/caregiver
- Have inadequate support from family or support systems
- Have numerous negative past experiences with behavioral health care
- Experience discrimination and or isolation due to behavioral health illness
- Have difficulty traveling to and dealing with wait times for appointments
- Are unable to complete multi-step processes and multiple assessments without support
- Have difficulty utilizing follow-up instructions in managing their own health care needs, independently managing their care or identifying their needs

The iCARE Team is not a case management approach, but rather an engagement approach. The iCARE Team will engage with consumers using open ended questions to understand what the consumer truly wants for themselves, observe the consumer without judgement and seek to understand how the consumer manages his/her behavioral health care condition to better partner with them. Additionally, the iCARE Team will aim to transform engagement practices of clinical and administrative staff throughout the entire department.

The iCARE Team will consist of culturally competent peer advocates in paid positions with lived experience, alcohol and drug counselors, nursing and behavioral health clinicians that will respond to consumers where they are.

Consumer engagement will be based on the Listen Empathize Agree Partner (LEAP) model developed by Dr. Xavior Amador and the COACH model developed by the Camden Coalition of Healthcare Providers in Camden, New Jersey. The LEAP model is specific to those with chronic behavioral health conditions and focuses on transforming relationships with consumers first. The COACH model is specific to health care practices and techniques employed by care teams to establish an authentic healing relationship resulting in measurable change in the consumer's health status. In addition to the iCARE Team, SYBH's entire behavioral health workforce will be trained in the LEAP model, including administrative staff to ensure all programs are utilizing LEAP engagement strategies from reception to clinical and medical services. Clinical staff will also be trained

in the COACH model. Both models, COACH and LEAP contain elements of the recovery model established by the Substance Abuse and Mental Health Services Administration (SAMHSA).

The iCARE Team approach will be non-traditional. The goal is that the highest utilizers of psychiatric emergency services, (those having contacts with law enforcement and the emergency room), will be engaged by a team that doesn't focus on the traditional clinical aspect of treatment. Rather, the team changes their approach to meet the needs of the individual in settings outside of the clinic. The team will focus on peer support, psycho-education and assistance that does not require a person to "jump through hoops" to begin the treatment engagement process. Simply stated, the focus will be to build trust, consistency with professionals, and improvement in the life of the individual until they are at a point that they are able to engage in clinical treatment. Once the person feels comfortable and ready to engage, the identified team member will help the individual navigate the clinical treatment process at their pace and without the stringent requirements placed on traditional methods of engagement.

Because a high percentage of individuals needing behavioral health services are presenting to law enforcement and emergency room staff as their chosen source of care, the iCARE Team will deploy with members from community partners having good rapport with consumers, including law enforcement, emergency department case managers, or other supports as appropriate. The iCARE Team may also deploy with law enforcement if there is a concern of safety for the mobile engagement team or the consumer. Additionally, ER case managers who also participate in the street medicine team, which is a hospital based mobile medical team, may also deploy with the iCARE team to better meet consumer medical needs in the spirit of whole person care, and as appropriate.

If available and interested, the iCARE team will also work with family members of those consumers they are seeking to engage to offer coping skills, education about chronic behavioral health conditions, types of services available, and how to access them. Family members may also make referrals to the iCARE Team at any time. Once established, the iCARE Team will conduct community presentations to family member specific groups, and individually to family members in the community or loved ones seeking services with SYBH on how to refer to the iCARE team. The iCARE Team will also present to support groups at the local hospital and other community settings to ensure that we reach family members. The referral process will include a referral form that will identify how to make a referral and will contain the following information:

1) What does the iCARE Team do?

- The iCARE Team provides community (field-based) services in the form of outreach, engagement, care management, family education, support, and therapy for the most challenging diverse adult clients in the community who suffer from untreated mental illness in an effort to "activate" the individual into the mental health system to receive appropriate services.
- The iCARE Team is **not** a resource connection or case management program for someone who is compliant with their treatment. However, if a

referral is received, the screening process will identify appropriate resources and the referral may be re-routed to the appropriate program.

2) When did the iCARE Team begin providing services?

The iCARE Team is funded by the Innovation component of the Mental Health Services Act (MHSA), which is a time limited project, with services beginning in March, 2020.

3) In order to be served by the iCARE Team, the adult (age 18 and over) must meet at least one (1) of the following criteria:

- Does not follow through or refuses necessary outpatient treatment.
- Often uses crisis services (police, psychiatric hospitals and emergency departments) without outpatient treatment follow-up.
- Has been cared for in private residences by families and loved ones without the assistance of needed effective behavioral health supports.

4) How does someone make a referral?

A referral form for the iCARE Team has been created and can be completed by anyone by doing one of the following:

- Call an iCARE staff member at TBD
- Email the completed the referral form to TBD
- Fax the completed referral form to TBD **Attn: iCARE Team**
- Mail the completed referral form to: TBD

The iCARE Team will also be implemented concurrently with a large community education strategy focused at community level education and stigma reduction funded by prevention and early intervention funds. Over the last year, SYBH has recognized the need to develop a more robust, upstream approach to behavioral health needs by increasing efforts that engage, encourage, educate and facilitate learning for recognizing and responding effectively to early signs mental illness.

Thus, SYBH is proposing to significantly increase community education by several thousand available hours utilizing universal and selective prevention activities in much greater numbers than in the past. Universal prevention activities are aimed at the general public or whole population groups that have not been identified on the basis of individual risk and includes stigma reduction and suicide prevention activities. Selective prevention activities are aimed at individuals who may have an increased risk of developing behavioral health conditions (*Mrazek & Haggerty (1994) and Commonwealth of Australia (2000)*).

Potential community members served through increased community education and outreach include, but are not limited to families, local employers including all county and city staff, behavioral, primary, specialty, and hospital health care providers, law

enforcement, and school personnel. Through this effort, SYBH hopes to train thousands of community members. Because the training will be voluntary, and provided with partnership agencies, SYBH's strategy will be to purchase and offer thousands of training hours to thousands of community members through multiple, diverse, accessible community-based venues in a simultaneous deployment of training opportunities both in person and online.

Additionally, SYBH is aiming to train all SYBH staff, a total of 225 employees, and at least 100 local health care providers. This will include staff from the local hospital provider, Adventist Health + Rideout Regional Medical Center, paramedic and ambulance staff. Trainings aimed at healthcare providers will be deployed in collaboration with local Medi-Cal Managed Care health plans and commercial insurance providers. All trainings offered will be culturally competent and include engagement strategies and best practices for ethnically and culturally diverse populations, as well as how to better work with the forensic population.

SYBH's increased community education efforts will include offering training activities focused on how to reach out to individuals with early signs and symptoms of a mental illness and promotion of activities that reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services and to increase acceptance, dignity, inclusion, and support for individuals with mental illness, substance use disorders and members of their families. Trainings will include but are not limited to mental health first aid, community LEAP, Safe Talk, ASSIST, and several trauma informed care trainings.

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

SYBH will be making a change to an existing practice in the field of mental health, including but not limited to, application to a different population, which will be applied in a rural, bi-county setting.

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

SYBH has determined the iCARE Team approach is appropriate based on conversations with stakeholders including consumers of SYBH services, family members, law enforcement, emergency room providers, hospital staff, and health and human service providers such as those working in children and family services, probation, and jail settings. Specifically, feedback from stakeholders has been provided to SYBH over the past several years around a common theme related to discomfort of accessing outpatient care after an inpatient or emergency service. Additionally, feedback from stakeholders has included that stigma related to their behavioral health condition is a major factor in their accessing care.

Because of this feedback and rapidly increasing rates of hospital care, SYBH began reviewing data related to the rate at which consumers accessed emergency and crisis services as compared to outpatient care. As described above, the data revealed a significant pattern of crisis and emergency services access without outpatient engagement. SYBH began researching how other counties, behavioral health systems, and health care entities were approaching this same issue.

SYBH reviewed several programs across the nation seeking to increase consumer access, activation and or engagement in health care services for individuals with high hospital and emergency utilization to include:

- **Calaveras County**, Enhancing the Journey to Wellness Peer Specialist Program
- **San Bernardino County**, Recovery Based Engagement Team
- **Camden, New Jersey Coalition of Healthcare Providers**, the COACH Model
- **Department of Health Care Services**, Whole Person Care Pilots - Alameda County Care Connect, Mendocino County – Recovery Oriented System of Care
- **Rural Information Hub, Rural Pennsylvania**, The Behavioral Health Plus Program
- **Rural Information Hub, Rural Pennsylvania**, Optimal Health Behavioral Health Home Models
- **Rural Information Hub, Rural Michigan**, The Health Belief Model
- **Rural Information Hub, Rural Texas** Collaborative Approaches to Well-Being in Rural Communities

Additionally, SYBH reviewed several published reports and articles to include:

- **Robert Wood Johnson Foundation**, *A Revolutionary Approach to Improving Health Care Delivery*, February 1, 2014
- **US Department of Health and Human Services**, *As Assessment of Innovative Models of Peer Support Services in Behavioral Health to Reduce Preventable Acute Hospitalization and Readmissions*, December 2015
- **ACHMA**, *Peer Services Tool Kit, A Guide to Advancing and Implementing Peer Run Behavioral Health Services*, April 30, 2015
- **World Psychiatry, Official Journal of the World Psychiatric Association**, *Treatment Engagement of Individuals Experiencing Mental Illness: Review and Update*, February 2016
- **Substance Abuse and Mental Health Services Administration (SAMHSA)**, *Illness Management and Recovery Evidence-Based Practices*, March 2010
- **German Medical Science**, *Interventions for reducing self-stigma in people with mental illnesses: A systematic review of randomized controlled trials*, April 2017
- **World Health Organization**, *Mental Health Action Plan 2013-2020*, 2013
- **Georgia Department of Behavioral Health**, *The provider Tool Kit for Emerging Adults with Serious Mental Health Conditions*, September 2015

Several themes were identified among the programs/articles:

- Trust is key to engagement
- Consumers must see their own goals and vision for themselves in the care being offered
- Care being offered must be patient centered and recovery based
- “Tug of War” scenarios occur when the priorities of care teams don’t align with the priorities of consumers
- Engagement is one of the most powerful tools in increasing and maintaining health and wellness
- Influence occurs through flexibly working with individuals
- Positive relationships with peers enhances engagement
- An individual’s beliefs about their health conditions predict their health-related behaviors
- Disengagement may be related to individuals feeling that treatment is not working, feeling coerced into treatment, or experiencing hardship in accessing services due to services being hard to get to or being hard to schedule
- Individualized strategies that occur out of the office are more effective for those that don’t respond to traditional outpatient therapy
- Traditional mental health settings for some individuals have been linked to alienation and treatment drop out
- Critical time interventions immediately after hospitalization increase engagement
- Efforts that connect with individuals while transitioning levels of care increase engagement
- Stigma can have an impact on help-seeking behavior, treatment adherence, and recovery
- Communities need to work with skepticism, mistrust and local perceptions in order for stigma to decrease and multi sector collaboration to increase
- Trust must be built so stakeholders feel comfortable talking about something as stigmatized and private as mental health

While many practices reviewed focused on engagement as an element of peer run programs, peer support, enhanced case management, self-sufficiency in treatment, or patient “activation” into health care, SYBH is looking to modify the best strategies in all programs reviewed to build a transformative and innovative strategy aimed at engagement as our primary intervention.

Thus, based on feedback from stakeholders including consumers, and review of programs and literature, SYBH has determined that we must work on our relationship with our consumers and community as a priority before influencing an increase in outpatient treatment engagement. As both the LEAP and the COACH model are relational approaches to increased consumer engagement, they have been selected as appropriate interventions to be utilized by the iCare Team.

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

The iCare mobile engagement team is expected to serve 50 individuals at any given point in time, and potentially up to 150 individuals per year. This number was derived by reviewing our total numbers served (5,408), the top utilizers of hospital care (500), total crisis contacts in a year (2,702), and conversations with law enforcement, emergency room staff, consumers, and family members. The number 50 is inclusive of individuals who may need supported engagement in outpatient services and family members who may be ready to engage before their loved ones are ready. Because the engagement process can be long, up to 17 non-clinical contacts, it was important to keep the estimated numbers served appropriate to the needs of those being engaged to allow for the time needed to engage. Additionally, the estimated numbers to be served is based on the amount of available innovation funding per year.

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?

The iCare Team approach is distinguished first, by the rural setting of both counties that it will be implemented in. San Bernardino County is a large county system with numerous behavioral health resources not present in Sutter and Yuba Counties. Additionally, San Bernardino has engaged in a twelve-year sustained effort to educate county residents on the benefits of behavioral health services with significant investments in infrastructure to include outreach staff, marketing campaigns, media investments and the creation of hundreds of paid peer advocate positions throughout its system of care. The iCARE Team will test if the application of the LEAP model, applied in the context above in San Bernardino, will work in a context in which behavioral health and health resources are scarce and large-scale community education efforts are in an early stage.

Calaveras County is a small California county that has an approved innovation plan as of January 2019 integrating peer specialists into a peer lead case management effort for consumers that experience a high rate of hospitalization. The goal of Calaveras's project per its innovation plan is to, "increase the connection of consumers to existing mental health services and provide housing supports." While SYBH's iCARE team will include strong peer leadership, the iCARE team will not provide case management, and will focus on engagement as its primary intervention. Also, SYBH's iCARE team seeks to change the engagement strategy of current case managers, therapists, psychiatrists and support staff throughout the entire department to more relational-based interactions with consumers for which traditional care is not effective.

The COACH model developed by the Camden Coalition of Health Care Providers is an innovative strategy developed in its earliest form in the 2000's based on the observations of a family physician, Dr. Jeff Brenner, in Camden New Jersey. Specifically, Dr. Brenner noticed that patients habitually frequented the emergency room and hospital inpatient wards for easily treatable conditions but were often seeking care for advanced conditions

that could have been prevented if diagnosed and treated earlier. The COACH model was further developed in 2012 through a collaborative of hospitals, primary health care providers, community providers and social service partners and put into practice at the Camden Coalition in 2014 and codified into a manual in 2016 by the Policy Lab at the Children's Hospital of Philadelphia.

In 2016 Dr. Brenner launched the National Center for Complex Health and Social Needs to share learning and build a movement for complex care. The COACH model targets the hospital to home transition and emphasizes the importance of an authentic healing relationship between care team and consumer that drives behavior change in the utilization of health care services. SYBH would like to explore if the COACH model can be applied to those experiencing severe and persistent behavioral health conditions and train practitioners as empowerment coaches rather than solely providers for consumers. The COACH model, while utilizing some of the practices of behavioral health practitioners, has evolved the tool kit for engagement significantly beyond current practices of most public mental health systems, especially for those with complex medical, social and psychiatric conditions.

The LEAP model was founded by Xavier Amador, a clinical psychologist providing individual, family, child and couples therapy based on his professional experience as a behavioral health practitioner. Dr. Amador's personal experience with a family member suffering from Schizophrenia also influenced the development of the LEAP model. LEAP was initially developed by Dr. Amador to assist health care professionals and family members in "persuading," their loved ones with mental illness to accept services but has evolved to a collaborative communication model focusing on better understanding of consumer experiences.

The LEAP model focuses on assisting professionals with listening to consumers in new ways, transforming the relationship with the consumer first, and emphasizing that practitioner relationships are among the strongest influencing factors for those unable to connect in outpatient care. The LEAP model requires time and flexibility as its most successful intervention, both of which are not routinely available to health care practitioners based on reimbursement and claiming systems supporting health care services. For consumers utilizing high levels of emergency, hospital and crisis care that have no effective connection to outpatient care, through LEAP, it has been found that *time and flexibility is the medicine*.

In speaking with San Bernardino County about the successes and learning from the RBEST project, it was noted that training the entire behavioral health workforce in the LEAP model as well as the engagement team was a critical step they would take if they had the project to do over again. Thus, this is one of the distinguishing features of SYBH's iCARE proposal that is different, as we plan to train all behavioral health staff on the model, as well as several of the physical health care providers at the local emergency room. Additionally, distinctive, will be our use of the COACH care management model perfected in health care settings in conjunction with the LEAP model.

Also, distinctive from rural health practices reviewed by SYBH and implemented in Pennsylvania, Michigan, and Texas, as well as Whole Person Care Practices in the California Counties of Alameda and Mendocino, is the focused emphasis on engagement as the prime or most singularly powerful influencer of health care costs for a group of specific consumers. All other models SYBH reviewed deployed elements of enhanced engagement through case management structures, but the iCARE project will take an opposite approach and deploy elements of transformed case management, or behavioral health care services through an engagement structure.

In reviewing data from the San Bernardino County Department of Behavioral Health's innovation project deployed from 2015-2019, it was noted that consumers who sought care in crisis or hospital systems as a main source of care, and who were unengaged in outpatient care, it took an average of 17 non-clinical contacts before the consumer was willing to come to an outpatient clinic appointment with engagement staff.

Once experiencing a successful outpatient clinic appointment, consumers would typically be accompanied an average of 2 more times to outpatient clinic appointments with engagement staff before consumers felt comfortable enough to attend a clinic appointment on their own. For individuals who had also been chronically homeless and suffered from chronic behavioral health conditions, it took more than 17 non-clinical, trust building contacts and at the top of the range, required up to 70 contacts.

Thus, iCARE will be focusing on changing the system to better address the identified needs for a specific target population for whom the system is not working, instead of forcing the consumer to conform to the needs of the system. Because iCARE's focus is on building trust and improving the relationship with the consumer, the clinical aspects of engagement can be grown in small, flexible intervals, instead of the traditional model requiring the person to engage in structured clinic-based interactions.

The iCARE approach asserts that the time for engagement is the "medicine," influencing a consumer's increased utilization of outpatient care in greater measures when caught in crisis utilization patterns, and not the actual service provided (i.e., case management, medication support services, or therapy). Certainly, case management, medication support and therapy will be provided to consumers, but the measurement of the engagement and its transformed application will be the factor this innovation project will influence, study and fund. This same philosophy applies to the community education effort funded in parallel to this innovation project through PEI funding, which seeks to engage the community systemically in transformation regarding comfort in accessing and experiencing the benefits of behavioral health care services.

Increasing flexibility for a percentage of consumers circling in crisis and hospital services at a systemic level while still maintaining a structured, standardized system for consumers for which it is working, will be the crux of the iCare Team's challenge. This challenge is at the heart of all current health care reform efforts locally and nationally, and for a percentage of our population, has not yet been figured out. On behalf of those with chronic and persistent behavioral health needs, SYBH, our consumers, stakeholders and

providers believe we can bring considerable insight and learning to this challenge though the iCARE Team – we are ready to transform.

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.*

SYBH reviewed several programs across the nation seeking to increase consumer access, activation and or engagement in health care services for individuals with high hospital and emergency utilization to include:

- **Calaveras County**, Enhancing the Journey to Wellness Peer Specialist Program <http://mhsoac.ca.gov/document/2019-01/enhancing-journey-wellness-peer-specialist-program-calaveras-county-innovation-plan>
- **San Bernardino County**, Recovery Based Engagement Team, <http://wp.sbcounty.gov/dbh/mental-health-services/adults/rbest/>
- **Camden, New Jersey Coalition of Healthcare Providers**, the COACH Model <https://www.camdenhealth.org/the-coach-model/>
- **Department of Health Care Services**, Whole Person Care Pilots - Alameda County Care Connect, Mendocino County – Recovery Oriented System of Care
https://www.dhcs.ca.gov/services/Documents/MCQMD/WPC%20Narrative%20Reports/Alameda_2017_Annual_Narrative_Report.pdf
https://www.dhcs.ca.gov/services/Documents/MCQMD/WPC%20Narrative%20Reports/Mendocino_2017_Annual_Narrative_Report.pdf
- **Rural Information Hub, Rural Pennsylvania**, The Behavioral Health Plus Program <https://www.ruralhealthinfo.org/project-examples/901>
- **Rural Information Hub, Rural Pennsylvania**, Optimal Health Behavioral Health Home Models <https://www.ruralhealthinfo.org/project-examples/1022>
- **Rural Information Hub, Rural Michigan**, The Health Belief Model <https://www.ruralhealthinfo.org/toolkits/health-promotion/2/theories-and-models/health-belief>
- **Rural Information Hub, Rural Texas** Collaborative Approaches to Well-Being in Rural Communities <https://www.ruralhealthinfo.org/project-examples/1048>

Additionally, SYBH reviewed several published reports and articles to include:

- **Robert Wood Johnson Foundation**, *A Revolutionary Approach to Improving Health Care Delivery*, February 1, 2014 <https://www.rwjf.org/en/library/articles-and-news/2014/02/improving-management-of-health-care-superutilizers.html>
- **US Department of Health and Human Services**, *As Assessment of Innovative Models of Peer Support Services in Behavioral Health to Reduce Preventable Acute Hospitalization and Readmissions*, December 2015 <https://aspe.hhs.gov/system/files/pdf/205411/PeerSupServ.pdf>

- **ACHMA**, *Peer Services Tool Kit, A Guide to Advancing and Implementing Peer Run Behavioral Health Services*, April 30, 2015 https://www.mentalhealthamerica.net/sites/default/files/Peer_Services_Toolkit%204-2015.pdf
- **World Psychiatry, Official Journal of the World Psychiatric Association**, *Treatment Engagement of Individuals Experiencing Mental Illness: Review and Update*, February 2016 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4780300/>
- **Substance Abuse and Mental Health Services Administration (SAMHSA)**, *Illness Management and Recovery Evidence-Based Practices*, March 2010 <https://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/sma09-4463>
- **German Medical Science**, *Interventions for reducing self-stigma in people with mental illnesses: A systematic review of randomized controlled trials*, April 2017 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5404117/#R1>
- **World Health Organization**, *Mental Health Action Plan 2013-2020*, 2013 https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf;jsessionid=AEA76B5C814F4670525306F63187CFDC?sequence=1
- **Georgia Department of Behavioral Health**, *The provider Tool Kit for Emerging Adults with Serious Mental Health Conditions*, September 2015 https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/HTI%20Toolkit%209.10.15.pdf
- **Health Services Research**, *Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers*, August 2004 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361049/>
- **Administrative Policy Mental Health**, *Development of the Patient Activation Measure for Mental Health (PAM-MH)*, June 2010 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3536445/>
- **Frontiers in Psychology**, *Measuring Patient Engagement; Development and Psychometric properties of the Patient Health Engagement Scale (PHE)*, March 2015 <https://www.frontiersin.org/articles/10.3389/fpsyg.2015.00274/full>
- **Consortium for Patient Engagement**, *Measuring Patient Engagement: A Must for Effective Health Care Reform*, January 2016 <http://cope.tips/measuring-patient-engagement-a-must-for-effective-healthcare-reform/>

While significant information exists in practice and health care literature on the impact of improved case management practices, with elements of engagement embedded in the case management model including patient activation, there is little developed research on the effects of engagement in behavioral health as a single factor influencing consumer access to care, quality of services, and costs related to inadequate utilization of care.

Per an article published in August 2004 in Health Services Research, "Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and consumers," researchers convened a national expert consensus panel and multiple patient focus groups to define the concept of "activation" and identify the domains of activation. The study resulted in a 100-point patient activation scale determining patient engagement in health care.

After over a decade of use the PAM has been validated in the United States and some countries. In August 2009 the PAM was updated to adapt it's use among individuals with mental health conditions resulting in the PAM - MH. In an article published in Administrative Policy in Mental Health in 2010 on the use of the PAM-MH in three studies for 230 individuals, results indicated that the PAM-MH is a valid and reliable measure of activation among individuals with mental health conditions, but that greater activation was related to, "higher levels of recovery, better mental health care, better physical and mental health, and fewer mental health symptoms." This suggests that study participants utilizing the PAM-MH were already engaged. Furthermore, the PAM-MH does not appear to be widely used or represented in the literature as to its use beyond the initial documented study in 2009.

Per an article published in Frontiers in Psychology, March 2017, "Measuring Patient Engagement: Development and Psychometric Properties of the Patient Engagement (PHE) Scale," the "PAM is a powerful instrument able to detect the level of activation of patients towards their care management." Furthermore, the article asserts that, "Although the concepts of 'activation' and 'engagement' have some areas of conceptual overlapping, they differ according to the breadth of the health care considerations related. The concept of 'activation' is mainly limited to the prototypical situation of doctor-patient consultation while the concept of 'engagement' seeks to consider multiple levels of the patients' fruition of the healthcare." The article goes on to state that current practices devoted to improving patient engagement in healthcare management suffer from a lack of shared guidelines to achieve this goal and confusion exists about what patient engagement is and how it may be conceptualized and achieved.

Per an article published on the Consortium for Patient Engagement, "Growing acknowledgement is played to the emotional and psychodynamic components of the patients' illness experience that appears to be the first movers of the patients' confidence and ability to acquire information about their health status and to master self-management of behaviors. The emotive component of engagement, conceived as the patients' process of elaboration and adjustment to the disease, is also being demonstrated to be a crucial mediator of patients' activation and adherence."

In the literature there is consensus and emerging conversation about distinction of engagement as an element of activation, or a stand-alone factor from activation

that requires further research. Thus, a gap in the literature exists on the impacts of engagement in general, and even more so for behavioral health conditions.

Evaluation of this innovation project will attempt to achieve a focused study on how levels of engagement impact utilization of health care services for those with behavioral health conditions and lead to the generation of substantive and meaningful research advancing the theory, practice and understanding of engagement.

LEARNING GOALS/PROJECT AIMS:

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

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

Through this new innovation project, SYBH will focus on the following key learning questions:

- 1) Will the implementation of a flexible, mobile engagement team trained in the LEAP and COACH models result in increased outpatient utilization of services (increased access to care), including SUD treatment, for consumers utilizing crisis and emergency services as their main source of care?
- 2) Will training a field-based engagement team as well as all SYBH staff in the LEAP and COACH models lead to increased levels of consumer engagement evidenced by consumer self-report, and patient activation and engagement measures?
- 3) Will the implementation of a flexible, mobile engagement team trained in the LEAP and COACH models result in a decrease in the number of behavioral health related calls to law enforcement?
- 4) Will the implementation of a flexible, mobile engagement team trained in the LEAP and COACH models result in a reduction in the 5150s brought to the emergency room?
- 5) Will the implementation of increased community education trainings aimed at increasing the knowledge of behavioral health treatment benefits create an increased level of comfort in accessing behavioral health services?
- 6) Will family members and caregivers who ordinarily don't know much about chronic behavioral health conditions increase their knowledge of coping skills, support strategies and understanding about how to support their loved ones who are accessing the behavioral health system?

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

Through the iCARE Team, SYBH would like to understand if the utilization of transformed engagement practices through the LEAP and COACH models will increase outpatient utilization of services (increased access to care) for consumers utilizing crisis and emergency services as their main source of care. Through this engagement effort, SYBH would like to understand if consumers are more able to engage in outpatient behavioral health care or substance use treatment services, and if they experience an increased quality of care, knowledge of their condition, and feel better able to manage their condition utilizing outpatient care.

SYBH would also like to understand if engagement practices at every level of the organization, and the emergency room, can be transformed through training with the LEAP and COACH models. At the community level, SYBH would like to understand if community level training regarding the benefits of behavioral health services will result in an increase in comfort in accessing behavioral health care and increase the general knowledge of community members related to behavioral health care, to include early signs and symptoms of behavioral health illness.

SYBH as a rural county mental health plan would like to contribute to emerging research and study of the impact of engagement, further defining engagement activities and definitions, quantifying engagement using scales such as the PAM-MH, the PHE and others that may be developed or identified. If successful, this project will significantly contribute to the potential for changed practices in behavioral health care, physical health care, care management and care coordination at both the state and national levels.

The learning goals as detailed above have been developed based on community and stakeholder input, including consumers with lived experience, review of SYBH service and access data related to crisis, emergency, hospital and outpatient use, law enforcement and emergency room data, and the current prevalent research in patient engagement as it relates to health care utilization and increased quality of care. Additionally, these goals have been developed based on the need for a more flexible and effective service response to consumers in a “go to” model, community partners and the community at large.

Lastly, SYBH seeks to learn how to better incorporate stakeholder participation in program development, to include the implementation of the iCARE Team through a partnership with the patient centered outcomes research institute (PCORI) under this innovation project. The PCORI was established to fund research that can help patients and those who care for them make better-informed decisions about the healthcare choices they face every day, guided by those who will use that information. Specifically, the mission of PCORI is to improve health care delivery and outcomes by producing and promoting evidence-based information from stakeholder guided research. SYBH’s goal will be to use PCORI’s engagement planning tools for effective engagement of consumers and stakeholders in the implementation, evaluation and research design of the iCARE Team innovation project.

EVALUATION OR LEARNING PLAN:

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

SYBH will measure iCARE Team success using both process and outcome indicators. Process indicators measure the extent to which the project was implemented as intended, while outcome measures will provide information on the effect of the project on consumers, the mental health system and the community overall. SYBH, in partnership with evaluators, including stakeholders, will identify/confirm data points and the evaluation methods below to measure project implementation and impact.

Data points may include baseline data regarding utilization of services, consumer, family member and community surveys. Evaluation activities will aim to address the key learning questions of the project. The following table outlines the data to be collected (i.e., measurement metrics) and potential data sources listed by their respective key learning question. An evaluation plan with a timeline, deliverables, metrics and implementation specifics will be further developed through stakeholder engagement sessions utilizing an engagement plan from PCORI that outlines how stakeholders will be involved in all aspects of the evaluation.

ICARE TEAM LEARNING FRAMEWORK

Learning Question	Outcome	Measurement Metric	Data Source (s)
1. Will the implementation of a flexible, mobile engagement team trained in LEAP and COACH models result in increased access to care for outpatient utilization of services, including SUD treatment for consumers utilizing crisis and emergency services as their main source of care?	<p>§ Increased utilization of outpatient behavioral health care services for underserved groups</p> <p>§ Decrease in homelessness</p>	<p>Change in (increase or decrease) of Behavioral Health Services delivered by the Mental Health Plan from baseline when available including:</p> <ul style="list-style-type: none"> • Individual therapy • Group Therapy • Collateral • SUD Outpatient • Medication Support • Case Management • Crisis intervention • Crisis Stabilization • SUD Residential Treatment • Inpatient Hospital Care <p>Number of consumers engaged that received housing support</p>	<p>SYBH Medical Record and Claiming System</p> <p>MORS</p> <p>PES Service LOG</p> <p>Training Evaluations for LEAP and COACH Model</p> <p>Continuum of Care Database</p> <p>Consumer Report</p>
2. Will training a field based engagement team as well as all SYBH staff in the LEAP and COACH models lead to increased levels of consumer engagement	<p>§ Increased consumer engagement</p> <p>§ Increased family</p>	<p>To be further defined with consumers/stakeholders:</p> <ul style="list-style-type: none"> • Level of disengagement 	<p>Patient Activation Measure (PAM) Survey</p> <p>Patient Activation Measure – MH Survey</p>

<p>evidenced by consumer self-report, and patient activation and engagement measures?</p>	<p>support and/or engagement with consumer recovery and wellness</p>	<ul style="list-style-type: none"> • Elements of disengagement • Becoming engaged but still struggling • Taking action • Maintaining Engagement and Pushing Further 	<p>COACH dominant core needs survey</p> <p>Patient Health Engagement (PHE) Scale</p>
<p>3. Will the implementation of a flexible, mobile engagement team trained in LEAP and COACH models result in a decrease in the number of behavioral health related calls to law enforcement?</p>	<p>§ Decreased Hospitalizations</p> <p>§ Decreased abuse of alcohol and illegal drugs</p>	<ul style="list-style-type: none"> • Number of 5150 evaluations • Number of Psychiatric Emergency Services (PES) • Number of hospitalizations • Number of days hospitalized • Number of Emergency Room visits • Number of emergency room visits which have not led to hospitalization • Number of co-occurring diagnosis consumers with PES/hospitalizations • Number of substance abuse/misuse episodes/relapse (e.g. use of drugs or alcohol beyond a slip, that goes unaddressed and did not get immediate attention) 	<p>SYBH Medical Record and Claiming Systems</p> <p>PES Service LOG</p> <p>Law Enforcement Call Logs</p>
<p>4. Will the implementation of a flexible, mobile engagement team trained in LEAP and COACH models result in a reduction in the 5150's brought to the emergency room?</p>	<p>§ Decreased Emergency Room visits</p> <p>§ Decreased PES visits</p>	<ul style="list-style-type: none"> • Number of 5150 evaluations • Number of Psychiatric Emergency Services (PES) • Number of hospitalizations • Number of days hospitalized • Number of Emergency Room visits • Number of emergency room visits which have not led to hospitalization 	<p>Cerner Hospital Medical Record and Claiming System</p> <p>SYBH Medical Record and Claiming Systems</p> <p>PES Service LOG</p>

		<ul style="list-style-type: none"> • Number of co-occurring diagnosis consumers with PES/hospitalizations • Number of substance abuse/misuse episodes/relapse (e.g. use of drugs or alcohol beyond a slip, that goes unaddressed and did not get immediate attention) 	
<p>5. Will the implementation of increased community education trainings aimed at increasing the knowledge of behavioral health benefits create an increased level of comfort in accessing behavioral health services?</p>	<p>§Increased community awareness of behavioral health services</p> <p>§Increased awareness of behavioral health knowledge</p> <p>§Increased comfort in accessing behavioral health care</p>	<p>To be further defined with consumers/stakeholders:</p> <ul style="list-style-type: none"> • Level of information received from trainings about behavioral health conditions • Level of information received in training about what to do access behavioral health services • Level of information provided to care givers from mental health professionals • Level of satisfaction with information received 	<p>Community Training Evaluations</p> <p>Community Engagement Surveys</p> <p>Family Engagement and Intervention Survey (FEIS)</p> <p>Focus Groups</p>
<p>6. Will family members and care givers who ordinarily don't know much about chronic behavioral health conditions increase their knowledge of coping skills, support strategies and understanding about how to support their loved ones accessing the behavioral health system?</p>	<p>§Increased community awareness of behavioral health services</p> <p>§Increased awareness of behavioral health knowledge</p> <p>§Increased comfort in accessing behavioral health care</p>	<p>To be further defined with consumers/stakeholders:</p> <ul style="list-style-type: none"> • Level of information received from trainings about behavioral health conditions • Level of information received in training about what to do access behavioral health services • Level of information provided to care givers from mental health professionals • Level of satisfaction with information received 	<p>Community Training Evaluations</p> <p>Community Engagement Surveys</p> <p>Family Engagement and Intervention Survey (FEIS)</p> <p>Focus Groups</p>

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?

SYBH plans to contract out the project in three distinct project areas:

- 1) The iCARE Team is a hybrid model that integrates contractor leadership and iCARE staff into the ongoing operations of SYBH. This contract will include the mobile field-based engagement team, including all staff and engagement team related costs and will be overseen by SYBH program managers for Acute Psychiatric and Forensic Services and Adult Services. The iCARE Team members will attend routine meetings with SYBH as determined, including iCARE regularly established operations meetings lead by SYBH and will include consumers, law enforcement representatives, hospital staff, and other community partners. Contractors may include non-profit, community-based agencies or groups with the expertise in health and human services needed to provide required services.
- 2) The evaluation portion of the iCARE project will be contracted out to a qualified evaluation vendor and will be overseen by the Branch Directors for Acute Psychiatric and Forensic Services and Adult Services. Contractors may include qualified university, community based or data analytics vendors.
- 3) The organization of the LEAP, COACH and community training efforts will be contracted out and overseen by the Branch Directors for Acute Psychiatric and Forensic Services and Adult Services and managed by the MHSA coordinator. Community training contractors may include Yuba College, UC Davis, and other community-based training vendors, as well as training vendors not local to the region such as the LEAP institute and the Camden Coalition.

The iCARE Team and related contracts will be included in SYBH's routine and customary contract monitoring and review processes staffed by contract analysts, and SYBH's administrative and fiscal officers and will be further monitored by branch directors and the MHSA coordinator. Additionally, SYBH will utilize the expertise of a fiscal consultant in reviewing the expenditures of MHSA, including innovation funding.

COMMUNITY PROGRAM PLANNING:

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

Through the community's local newspaper, The Appeal Democrat, and other resources such as the Sutter and Yuba County One-Stops, Sutter and Yuba County libraries, Sutter and Yuba County Administrative Offices, Facebook, email blasts, and flyers posted at all service sites, SYBH posted information on how to attend a community planning session. SYBH hosted four public planning sessions as follows:

In Sutter County: Thursday, April 25, 2019, 3:30 – 4:30 pm and Thursday, April 25, 2019, 5:00 – 6:00 pm at Veteran’s Hall – Tucker Room 1425 Veterans Memorial Circle, Yuba City.

In Yuba County: Tuesday, April 30, 2019 3:30 – 4:30 pm and Tuesday, April 30, 2019 5:00 – 6:00 pm at Yuba County Government Center, Board of Supervisors Chambers 915 8th Street, Marysville.

Additionally, SYBH hosted 10 targeted stakeholder forums as follows, including one session in Spanish:

- 1) Homeless Union – April 23, 2019 12:00 – 1:00 pm
- 2) Yuba County Health and Human Services – April 24, 2019 10:00 – 11:00 am
- 3) Wellness and Recovery Town Hall – April 29, 2019 9:30-10:30 am
- 4) Latino Outreach Center – April 29, 2019 2:30-4:30 pm
- 5) Yuba County Law Enforcement and Adventist Health + Rideout Hospital (including emphasis on Emergency Room Staff) – April 30, 2019 11:30 am – 1:30 pm
- 6) Sutter County Law Enforcement Staff – May 2, 2019 2:00 – 3:00 pm
- 7) Behavioral Health Advisory Board – May 9, 2019 5:00 – 6:00 pm
- 8) Family Member Support Group – May 9, 6:00- 8:00 pm
- 9) Hmong Outreach Center – May 21, 2019 10:00 – 11:00 am
- 10) Sutter Emergency Operations Center – June 14, 11:00 am – 12:00 pm

A total of 14 stakeholder meetings were held. All sessions included stakeholders with interest in behavioral health services in the State of California, including but not limited to individuals with behavioral health conditions, and/or their family members, providers of behavioral and physical health care, social services, educators or representatives of education, law enforcement and other organizations representing interests of those with behavioral health care needs.

As of the posting of this draft plan SYBH has received feedback from 95 stakeholders attending stakeholder meetings. Of those who attended, 84 filled out stakeholder feedback forms. While not all questions on all forms were answered, of those that were, the demographics for stakeholders attending stakeholder meetings are as follows, including a rating of the CPP process itself.

Of those who attended the stakeholder meetings and completed a stakeholder comment form, 82% of respondents were between the ages of 26-59, 15% were age 60 and older, 32% were male and 64% were female. 46% of respondents reported being from Yuba County, while 46% of respondents reported being from Sutter County. 21% of respondents reported they are a family member of someone with a behavioral health issue, 10% reported they are a consumer, 6% reported they are law enforcement, 1% reported attending for an educational purpose, 9% were from a community agency, 2% were from a faith community, 11% were County staff, 6% were from a social service agency, 3% were from a healthcare provider, 20% were community members, 2% were

active military/veterans and 2% were alcohol and drug providers. 27% of respondents identified as Latino, 2% identified as African American, 39% identified as Caucasian, 19% identified as Asian/Pacific Islander, 5% identified as American Indian and 11% stated Spanish is their primary language.

60% of stakeholders who completed feedback forms indicated they were very satisfied with the Community Program Planning Process, while 30% reported they were satisfied and 5% reported being somewhat satisfied, for a total of 90% of stakeholders being either satisfied or very satisfied with the Community Program Planning Process for the ICARE innovation plan.

The draft innovation plan was publicly posted on Sutter County's website from May 6 – June 5, 2019. Additionally, the link to the publicly posted plan was emailed to approximately 391 stakeholders, including individuals participating in stakeholder meetings that provided email addresses to SYBH. The link to the publicly posted draft plan was sent out via email to all Health and Human Services staff in both Sutter and Yuba Counties, law enforcement, and Adventist Health + Rideout Regional Medical hospital staff.

Two press releases noticing the posting of the plan was sent to the local newspaper with a full article detailing stakeholder meeting dates and the process for the posting of the plan published in the local newspaper, the Appeal Democrat, on April 14 and April 28, 2019. Flyers posting the dates of the public hearings were posted at Sutter-Yuba Behavioral Health (SYBH), SYBH's Latino Center, Hmong Center, Public Health, the County Administrator's offices for both Sutter and Yuba counties, both Sutter and Yuba County libraries, and other various county buildings in the two counties. Additionally, the iCARE Stakeholder meeting flyers were shared on Sutter County's Network of Care Website on April 18, 2019 in addition to email blasts also being sent out to Sutter and Yuba County employees and five additional non-county agencies on April 18, 2019.

While no written comments were received during the time the plan was publicly posted, (May 6, 2019 – June 5, 2019), several verbal comments and one email comment were provided to SYBH in addition to written comments via stakeholder feedback forms collected at stakeholder meetings. Written comments as provided by stakeholders via stakeholder comment forms and submitted during stakeholder meetings are included in this proposal in the stakeholder's own words in the appendices. Additionally, a summary analysis of comments received is as follows.

Verbal comments included requests for SYBH to clarify in the innovation project narrative how family members will be noticed of the existence and availability of the iCARE Team including how referrals could be made. Additional clarification was also requested as it related to the number of training hours to be offered, number of community members, SYBH staff, and health care providers projected to be trained under this effort. Stakeholders requested trauma informed trainings be added to the roster of trainings offered and that trainings be offered to EMTs and paramedics providing care in ambulance response. Suggestions were made to offer trainings to local business owners

to include convenience stores, gas stations and laundry mats. Clarifications for referrals, family outreach and additions for types of trainings, and recipients of training have been made to include all suggestions above in the section of this proposal titled, *proposed project, section A*.

In the law enforcement stakeholder session, it was verbally noted that, “There is more stigma for community members in receiving mental health care than getting arrested,” and there was hope through the community training component of this plan that this stigma could be reduced.

Verbal suggestions also included an emphasis on cultural and language competency to include competencies in working with forensically involved consumers. These suggestions have also been incorporated in the training offerings under this plan and included for implementation of the project.

While this project will serve adults 18 years old and older, several stakeholders requested that SYBH consider if a mobile engagement team like the iCARE Team could work for children and youth. While SYBH did not change the age range to be served by the iCARE Team in this innovation project, SYBH will keep this request in mind as we study the engagement strategy under this project, as well as other MHP programs focused on serving children and youth.

Other comments highlighted the value of paid peer mentor positions within county mental health plans, to include a suggestion for integrating paid peer mentors within local Red Cross programs. While this project will not integrate paid peer mentors within local Red Cross programs, SYBH acknowledges the value that peer mentors could bring to the Red Cross. SYBH will include the Red Cross in the group of community partners to which community training will be offered. SYBH will also offer a community presentation about what the iCARE team does and how to refer to the local Red Cross. Paid peer mentor positions are included in this proposal as integral members of the iCARE mobile team.

Additionally, verbal and written comments provided by stakeholders, both in direct quotes and in summary points as discussed in stakeholder meetings are detailed below. No changes to the publicly posted plan were required as comments were in alignment with the plan. Some comments as listed below are direct quotes and others are summarized from stakeholder conversations.

Support for the benefits of, “Training of outside systems to better support individuals with behavioral health needs.”

“Working with Law Enforcement to ensure measurement of engagement of forensically involved consumers, specifically those with substance use treatment needs.”

“Better educating first responders including ambulance staff about behavioral health conditions and working with community members needing care.”

“Ensuring the iCARE Team was collaborating and coordinating with the Rideout street medicine team and physical health care providers to include the emergency room.”

“Meeting consumers where they were.”

“Building trust and respecting consumers as people.”

“Partnering with consumers in ways that have a balance of power and allow for true partnership in behavioral health care.”

“Partnering with consumers in ways that allow for dignity.”

“Understanding that consumers don’t want to be, “owned by the behavioral health system.”

“Address consumer transportation needs.”

“NAMI or increased family supports should be present in the community.”

“Peer positions can, “show other consumers the ropes,” or “let new consumers know they got a lot of help here at SYBH.”

“Have engagement approaches that allow consumers to, “develop their own personal check list for insight,” and read books on behavioral health conditions on their own terms.”

“Deploy the mobile team in ways that respect consumer rights and liberties.”

“Deploy the mobile team in non-descript ways that don’t increase the stigma of behavioral health.”

“Respect community neighborhoods by coming there but maintaining confidentiality and anonymity - Don’t put SYBH or the county logo on the van.”

“Ensure peer positions incorporated in iCARE team are paid positions.”

“Respect the time of health care providers whose skill sets are greatly impacted because of severe provider shortages.”

“Ensure the innovation project includes the homeless community, to include the collaboration with the homeless union and peers with lived experience in the deployment of the project.”

“Family members trying to access care and encountering barriers find those barriers traumatizing and feel, “There MUST be something better than this,” of experiences with 5150’s for loved ones.”

In summary, there was overwhelming support for both aspects of the innovation proposal with an overwhelming majority of stakeholders saying the mobile team and wide-reaching community education strategy has been, “needed for years,” and that better engagement strategies were “crucial.”

Stakeholders commented the proposal was, “Spot on,” with consumers stating that the proposal “did better than they expected,” in recognizing needs.

Stakeholders also commented that the proposal sounded, “too good to be true,” and they hoped it was successful.

While clarifying language was added to the innovation proposal as indicated above and in response to consumer and stakeholder requests, no substantive changes to the proposal or publicly posted plan were made.

Consumers, family members, community partners, service providers, and educational partners helped Sutter-Yuba Behavioral Health with the program planning process for this project, and will continue to help with program implementation, monitoring, quality improvement, and project evaluation.

Additionally, if approved, SYBH will create an innovation operations committee comprised of family members, consumers, stakeholders, community representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial composition of the two counties to be involved in the implementation, evaluation and operation of the project.

MHSA GENERAL STANDARDS:

The iCARE Project will be planned for and implemented in ways that are consistent with the general standards and core values of the Mental Health Services Act and Title 9, CCR, section 3320, including the values of community collaboration; creating an integrated-service experience; promoting wellness, recovery, and resiliency; creating a consumer and family-driven mental health system; and creating a culturally competent system of care.

A) Community Collaboration:

The iCARE Team Innovation Project initiates and supports a collaborative relationship between consumers, family members, Sutter-Yuba Behavioral Health, Yuba County Sheriff’s Department, Sutter County Sheriff’s Department, Marysville Police Department, Yuba City Police Department, local Highway Patrol, Live Oak Police Department, and other agencies such as emergency department staff, hospital inpatient staff, probation departments, local shelter/housing authority, food banks, and other social service systems.

In partnering with stakeholders, SYBH has established a shared vision and goals for the iCARE innovation project. SYBH will work with and learn together with stakeholders regarding how SYBH can provide consumer centered care and improved outcomes for individuals who have not been successfully connected in the public mental health system but have chronic behavioral health needs that are often only addressed through emergency, hospital care, or law enforcement. Additionally, if successful, SYBH would

like this model of collaborative engagement, to include the community training portion, to be replicated by other counties and health care systems.

B) Cultural Competency:

The innovation project targets underserved populations and the uniqueness of individuals that aren't engaged with the public mental health system but have chronic behavioral health needs. The iCARE Team innovation project is focused on addressing challenges and needs by finding the best approach to target outreach and services in a culturally competent manner. Additionally, project measurements and evaluation efforts will include data by gender, race/ethnicity, linguistic categories, religious preferences and other cultural factors to help us learn/utilize strategies or approaches that are effective within specific groups and targeted populations.

SYBH is committed to providing cultural competence training to ensure a culturally competent workforce. Training plan goals aim to increase cultural competence skills and knowledge at all levels of Sutter-Yuba Behavioral Health. Additionally, Sutter-Yuba Behavioral Health's mission statement, policies, procedures, and organizational culture demonstrate a commitment to cultural competence. All new employees, including new staff hired through the iCARE Team Innovation Project will participate in an employee orientation that describes their staff responsibilities, to further drive SYBH's mission to provide services to the community in a manner that is culturally appropriate.

Services provided by the iCARE Team will be subject to review by the SYBH Cultural Competence Committee. This subcommittee of the Quality Improvement Council reviews SYBH policies and practices to ensure that services are provided in a way that is culturally and linguistically competent, including adherence to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) for health and health care.

C) Client-Driven:

The iCARE Team Innovation project is driven by the needs of consumers. The communities served by SYBH face multiple challenges specific to rural northern counties, specifically, minimal connections with current outpatient systems, and stigma as a result of experiencing a behavioral health condition. In the creation of this project, SYBH spoke with over 50 consumers of behavioral health care and 12 family members. Consumers shared their support for this project, specifically stating that sometimes accessing behavioral health services, including hospital care, feels like, "I'm here to surrender my dignity. I don't want to surrender, I want a partner in my treatment."

The LEAP and COACH engagement models are consumer focused and work on first building trust and understanding about how the consumer sees their own health care conditions, needs and treatment plans. The project allows the iCARE

team to take the time necessary, which is not currently available in our system of care, to address goals related to health care in a flexible way. It further studies the impact of this flexibility on increased access and quality of behavioral health care. The iCARE team approach will allow consumers to drive systemic changes in the public behavioral health system and local community, transforming our current system of care, by embedding engagement practices that make consumers feel “welcome” and “invited.” Additionally, this project will aim to support the community in understanding behavioral health care needs, signs and symptoms, and supportive resources, thereby collectively raising wellness awareness in the community, decreasing stigma and directly impacting a consumer’s experience of behavioral health care in the communities in which they live and work.

D) Family-Driven:

The iCARE TEAM Innovation project will also work with family members to increase knowledge, awareness and coping skills in supporting a loved one with chronic behavioral health conditions. In many cases, chronic behavioral health conditions can last the lifespan of a loved one, and while recovery and wellness is possible, family members often lack the tools and information necessary to best assist in their loved one’s recovery. This includes an understanding of the etiology or development of the condition, current interventions and treatments, the chronicity of conditions and tools to assist in the ongoing care of their loved one. Specifically, this project seeks to concurrently increase, strengthen and educate community, social and familial support systems of those living with chronic behavioral health conditions.

E) Wellness, Recovery, and Resilience-Focused:

The iCARE TEAM Innovation Project plans for and promotes an approach that is reflective of the philosophy, principles, and practices of the recovery vision for consumers. The primary purpose of this project is to increase the quality of services, including improved outcomes for persons living with one or more chronic behavioral health conditions. SYBH expects the iCARE Team Innovation Project to result in improved outcomes for Sutter and Yuba counties’ populations and improved community recognition of the principles and possibilities of behavioral health wellness and recovery. These results will be measured through increased levels of engagement in outpatient care, decreased levels of stigma, increased levels of wellness, and increased levels of knowledge for family and community support practices related to resiliency, and wellness and recovery for individuals with chronic behavioral health needs.

F) Integrated Service Experience for Clients and Families:

The iCARE Team Innovation Project is designed to include a higher level of coordinated care for both consumers and families through increased engagement. The engagement models, LEAP and COACH, seek to integrate engagement efforts after key events, with the outpatient system of care resulting in an improved treatment experience for consumers. Specifically, the iCARE project seeks to better integrate the consumer experience at key transition points from inpatient or

psychiatric emergency care, to outpatient care, in a manner that allows the consumer to feel accessing outpatient care is easy, effective and meeting their needs. Additionally, the iCARE project seeks to integrate family members, with consumer permission, in consumer treatment planning sessions and psychoeducation. For those family members that do not receive their loved one's permission to be more closely integrated in their care, the iCARE team will work to provide support and psychoeducation that will increase the family members' knowledge of the public behavioral health system, services and supports.

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.

The iCARE Team Evaluation Plan was developed in accordance with SYBH's Cultural Competence Plan – updated December 2018. SYBH provided interpretation services at each of the public stakeholder sessions and held one session entirely in Spanish to include all written material and spoken discussion. SYBH also hosted a stakeholder session at the Hmong Center in which the presentation was interpreted in Hmong. SYBH will utilize the feedback gathered in stakeholder sessions to ensure the approach of the mobile engagement team and community education efforts are culturally competent. Members from the Cultural Competence Committee will be invited to sit on the innovation implementation/operations committee which will review iCARE policies, trainings and operational program elements. Per MHPA requirements - WIC section 5848, subdivisions (a) and (b) and CCR, Title 9, sections 3300 and 3315, the iCARE Team Innovation Plan was developed with local stakeholder involvement and made available in draft form and then circulated for review and comment for the minimum 30 days to representatives of stakeholders, and any party who requests a copy of the document.

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.

Based on what is learned during the evaluation of the iCare team project, SYBH will consider funding successful elements of the innovation project in whole, or in part, with the following funding sources:

- DHCS pilot projects as defined under the 1115 waiver renewal, 1915(c) waiver renewal or other care coordination projects funded at the State level such as whole person care, or health homes.
- Mental Health Services Act (MHSA) funding, specifically Community Services and Supports (CSS) and Prevention and Early Intervention (PEI)
- Medi-Cal for activities determined to be eligible for Medi-Cal reimbursement

- Quality Improvement Collaboratives with or service contracts with local Medi-Cal Managed Care Plans or Commercial Insurance Plans
- Hospital Based and/or Community Based Grants or Funding
- Grant Funding

As learning will be concurrent with the implementation of the innovation project, planning for sustainable funding of successful elements will begin immediately upon approval of the innovation plan.

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?

Project updates will be provided at monthly innovation implementation/operations committee meetings, which will include stakeholders as well as quarterly MHSA community program planning meetings. These will address progress, goals, expected outcomes, and the overall approach of the iCARE project.

SYBH will also work with both Sutter County and Yuba County Public Health and Social Service Departments, as well as other community groups to discuss how SYBH can disseminate education on iCARE, specifically regarding family support and stigma reduction. Additionally, SYBH will provide numerous targeted community presentations of the project to community groups, service providers, law enforcement, fire, local colleges, and other significant partners, to include how to refer to the mobile iCARE Team.

SYBH will work with local newspaper and media outlets, including social media, to advertise, market and promote community trainings. These efforts will include working with local employers, church congregations, community groups, and other social organizations to deploy community trainings via employee learning systems, in community venues or through other structures where training and public information can be deployed.

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.

1. Mental Health
2. Alcohol and Drug Treatment
3. Help
4. Support
5. Behavioral Health

TIMELINE:

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

The tentative start date for the iCARE project is August 1, 2019 or as soon as MHSOAC approves the use of Innovation funds to fund and begin this project. The end date is scheduled for five years from the start date; e.g., if the CARE project is approved 08/01/2019 the end date will be 07/30/2024, with the final INN report completed six months from end of project date.

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

Five years, tentatively August 1, 2019 – July 30, 2024, final report by December 2024.

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

The project is expected to last five years and will consist of three phases. The project will begin upon approval (potentially in August of 2019), with an end date in July 2024.

Phase 1: August 2019 – March 2020 (first eight months): Contractors for the mobile engagement team, evaluation of the innovation project and community training will be sought. Training will be provided to all of Behavioral Health and the iCARE team members utilizing Dr. Xavier Amador, founder of the LEAP Institute specializing in engagement practices and Dr. Jeffrey Brenner’s Camden COACH Model specializing in coaching techniques to empower consumers in shaping their treatment engagement. Non-violent Crisis Intervention training and Motivational Interviewing will also be provided to the iCARE team. Policies and procedures will be created for the delivery of mobile engagement practices. Staffing, to include peer hiring practices, equipment, supplies, and vehicles will be secured during this first phase. Staff will become familiar with the region, resources, and collaborative partners. The evaluation model will be collaboratively developed with the involvement of stakeholders. Community presentations to community groups on how to refer to the iCARE mobile team will be completed. The stakeholder driven evaluation model will be created, and the implementation/operations committee established.

Phase 2: March 2020 – January 2024 (three years and 8 months): The middle phase of the project will be devoted to full implementation of the services outlined in this project description. The team will be deployed in the Sutter and Yuba areas and will provide field-based services. Modifications will be made to the project as learning occurs. Program evaluation information and data will be collected on a regular and to be determined basis, evaluated continuously, and will be shared at monthly implementation/operations committee meetings, quarterly MHSO Program Planning Meetings and integrated with the work of the project analyst contracted through Kings View and servicing SYBH’s medical record. Significant amounts of community training hours will be offered, tracked and measured.

Phase 3: January 2024 – July 2024 (six months): During the last six months of the project, SYBH will evaluate all of the data collected and make a final determination of the project's success. However, project evaluation will be continuous and occur from day one of the project. To allow for appraisal of the iCARE project, the numbers of consumers served may be reduced in the last six months of the project. All consumers receiving care will be provided appropriate transitional and continuity of care based on their individual needs.

If plans are made to sustain the project or integrate it into current clinical operations because of the learning obtained during this project, staff will work with the consumers receiving services through the project to integrate fully into continued services.

It is anticipated that this timeline and sample population will provide an adequate opportunity to measure the project's success. Data will be collected throughout the implementation of the project and analysis of progress towards the learning goals completed. This will allow for modification to the project as necessary as learning occurs.

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 amount associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

The total requested innovation project expenditures are \$5,939,288 over 5 years including both Innovation and PEI funding. The iCARE Project will initially use AB114, MHSa Reversion funds from prior years. Once the initial Reversion Funds of \$1,575,878 have

been spent, additional Innovation Funds that are subject to Reversion in the amount of \$1,252,810 will be used, and lastly the ongoing Innovation funds for FY 2019-20 through FY 2023-24 will be used. In addition, it is projected that MHSA PEI Funding will be utilized that is at risk of reversion to integrate into this project for community-based training.

Direct costs will total \$3,979,838 over the 5-year project and will include fuel, supplies, and support and care costs for consumer outreach and engagement. Indirect costs total \$1,637,600 over the 5-year project, which include rent and utilities, LEAP, COACH, and Community-based Trainings and \$500,000 dedicated to Project Evaluation. This Indirect Cost budget also includes contracted evaluation costs and anticipated administrative support by limited Sutter-Yuba Behavioral Health staff.

Year one of the iCARE Project includes the purchase of five mobile care vans with conversion packages for a total approximate cost of \$260,600. These vans will be used to go into the community to make the outreach and engagement connections with the consumers and potential consumers. They will be able to be used as mobile offices, a safe place for consumers, and a space to hold supplies and equipment for the outreach teams. \$53,450 in other equipment such as laptops, cell phones, wireless printers, and furniture will be purchased in year one to set up the iCARE teams.

A total of \$7,800 over the 5-year project is budgeted to purchase polo shirts, sweatshirts, and rain jackets to identify the iCARE team members in certain locations within the community.

AB114: This Innovation plan will use FY 08/09, 09/10, 10/11, 11/12, 12/13, 13/14, and 14/15 funds that were deemed reallocated to Sutter County via AB114. The amount of AB114 funds that will be expended during FY 2019-20 is \$875,550. The amount that will be expended during FY 2020-21 is \$1,375,800 and the amount that will be expended during FY 2021-22 is \$577,338.

Other funding: MHSA PEI Funding is also being budgeted at \$710,600 over the 5-year plan to be spent on LEAP, COACH, and Community-based Trainings.

Amount Subject to Reversion - Description		Spent FY19-20	Spent FY20-21	Spent FY21-22
Innovation Funds -MHSA (to be spent by 6/30/2020)	\$1,575,878	875,550	700,328	
Innovation Funds -MHSA (to be spent by 6/30/2022)	\$799,815		675,472	124,343
Innovation Funds -MHSA (to be spent by 6/30/2023)	\$452,995			452,995
Yearly INN Allocation	\$2,400,000			
PEI Funding	\$710,600			
Total INN Funding Available	\$5,939,288			

Federal Financial Participation (FFP) – Non-MHSA Funding: The iCARE Budget does not include any FFP Funding due to the unknown nature of what Medi-Cal billable activities the iCARE team will be performing. After the first two years this will be re-evaluated and if Medi-Cal billable services are being performed the budget will be amended to include such billable services.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY						
EXPENDITURES						
PERSONNEL COSTS (salaries, wages, benefits)	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
1 Salaries						
2 Direct Costs						
3 Indirect Costs	40,000	40,000	20,000	20,000	7,000	\$ 127,000
4 Total Personnel Costs	\$ 40,000	\$ 40,000	\$ 20,000	\$ 20,000	\$ 7,000	\$ 127,000
OPERATING COSTS						
	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
5 Direct Costs	59,200	149,200	149,200	77,700	44,538	\$ 479,838
6 Indirect Costs	\$60,000	\$60,000	\$60,000	\$60,000	\$60,000	\$ 300,000
7 Total Operating Costs	\$ 119,200	\$ 209,200	\$ 209,200	\$ 137,700	\$ 104,538	\$ 779,838
NON-RECURRING COSTS (equipment, technology)						
	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
8 Vehicles	260,600					\$ 260,600
9 Other Equipment	53,450					\$ 53,450
10 Total Non-Recurring Costs	\$ 314,050	\$ -	\$ -	\$ -	\$ -	\$ 314,050
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)						
	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
11 Direct Costs	300,000	1,025,000	1,025,000	875,000	275,000	\$ 3,500,000
12 Indirect Costs	510,600	200,000	175,000	175,000	150,000	\$ 1,210,600
13 Total Consultant Costs	\$ 810,600	\$ 1,225,000	\$ 1,200,000	\$ 1,050,000	\$ 425,000	\$ 4,710,600
OTHER EXPENDITURES (please explain in budget narrative)						
	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
14 Clothing	2,300	1,600	2,300	1,600	-	\$ 7,800
15						
16 Total Other Expenditures	\$ 2,300	\$ 1,600	\$ 2,300	\$ 1,600	\$ -	\$ 7,800
BUDGET TOTALS						
Personnel (line 1)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Direct Costs (add lines 2, 5, and 11 from above)	\$ 359,200	\$ 1,174,200	\$ 1,174,200	\$ 952,700	\$ 319,538	\$ 3,979,838
Indirect Costs (add lines 3, 6 and 12 from above)	\$ 610,600	\$ 300,000	\$ 255,000	\$ 255,000	\$ 217,000	\$ 1,637,600
Non recurring costs (line 10)	\$ 314,050	\$ -	\$ -	\$ -	\$ -	\$ 314,050
Other Expenditures (line 16)	\$ 2,300	\$ 1,600	\$ 2,300	\$ 1,600	\$ -	\$ 7,800
TOTAL INNOVATION BUDGET	\$ 1,286,150	\$ 1,475,800	\$ 1,431,500	\$ 1,209,300	\$ 536,538	\$ 5,939,288

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR							
ADMINISTRATION:							
A.	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
1.	Innovative MSHA Funds	40,000	40,000	20,000	20,000	7,000	127,000
2.	Federal Financial Participation						-
3.	1991 Realignment						-
4.	Behavioral Health Subaccount						-
5.	Other funding* (PEI)						-
6.	Total Proposed Administration	40,000	40,000	20,000	20,000	7,000	127,000
EVALUATION:							
B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
1.	Innovative MSHA Funds	100,000	100,000	100,000	100,000	100,000	500,000
2.	Federal Financial Participation						-
3.	1991 Realignment						-
4.	Behavioral Health Subaccount						-
5.	Other funding* (PEI)						-
6.	Total Proposed Evaluation	100,000	100,000	100,000	100,000	100,000	500,000
TOTAL:							
C.	Estimated total mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
1.	Innovative MSHA Funds	875,550	1,375,800	1,356,500	1,134,300	486,538	5,228,688
2.	Federal Financial Participation						-
3.	1991 Realignment						-
4.	Behavioral Health Subaccount						-
5.	Other funding* (PEI)	410,600	100,000	75,000	75,000	50,000	710,600
6.	Total Proposed Expenditures	1,286,150	1,475,800	1,431,500	1,209,300	536,538	5,939,288

Appendix:

- 1. Stakeholder Comments in Their Own Words***
- 2. MHSA Stakeholder Meeting Materials***
- 3. Stakeholder Meeting PowerPoint***
- 4. Stakeholder Meeting Flyers***

Stakeholder Comments in Their Own Words

Of What You Learned about the Project Discussed Today, What is Most Important to Your Community? (in their own words)

- 1) *Access to Services*
- 2) *All*
- 3) *Engagement*
- 4) *Bridging the gap between crisis patients and outpatient care*
- 5) *Continuing services for behavioral health. Integrate multiple community properties*
- 6) *Being able to access services easily*
- 7) *Meeting the clients where they are (mobile unit)*
- 8) *Outreach*
- 9) *The new plan for outreach to meet folks where they are and get them the help they need*
- 10) *New opportunity for high utilizers of emergency and acute services to engage and build relationships of trust*
- 11) *To engage with members of our community that are in need of mental health services*
- 12) *Training*
- 13) *ICARE project sounds amazing*
- 14) *Access to services and changing the role of law enforcement*
- 15) *Team members go out to mental health persons*
- 16) *I think the important in the community is know about mental health*
- 17) *Transportation*
- 18) *I believe the response team concept for those who suffer chronic behavioral health issues*
- 19) *24-H community response teams that will be put together*
- 20) *Connecting those who most frequently visit the emergency systems to follow-up care by going to where those people are, being client driven and "whatever it takes" mentality*
- 21) *Improved access for an engagement of high utilizers*
- 22) *Better access to services and engagement of clients*
- 23) *Improved behavioral healthcare, specifically encouraging entrance into the system of care and continuing care*
- 24) *Support to mental health patients and their family which leads to a healthier community, early detection*
- 25) *Access to services, increase assistance for dual diagnosis*
- 26) *Learned about the program*

- 27) *The outreach to increase engagement in our services for healthier community. In recidivism in emergency law enforcement responses, hopefully*
- 28) *The gaps in service need to be bet - data*
- 29) *Meeting people where they are at, respecting their perspective and decisions*
- 30) *Getting mental and behavioral health services out into the community. Reducing challenges and reducing barriers to care such as stigma*
- 31) *That people need help that don't want to go to a mental health center, can get the help they need*
- 32) *Transportation*
- 33) *Prevention/ Early intervention*
- 34) *Money allotted*
- 35) *I think what is important to our community is for them to help us, not judge us. Be straight with us and not to lie to us. We need help with bathroom, garbage downstairs, water*
- 36) *Trust communication*
- 37) *Going out in the camps to meet the people first, gain their trust because trust is a must. I believe a 1 on 1 with people, lets them know and feel at ease*
- 38) *Possible availability of training for family members who are caregivers*
- 39) *Multidisciplinary to include police, healthcare workers behavioral health*
- 40) *I learned the community has to help one another*
- 41) *Mobile outreach, jail behavioral re-entry (more info)*
- 42) *1 on 1 capacity; team oriented; useful community involvement, multi-departmental interaction*
- 43) *PC-first slide take out 'folks' to refer to people*
- 44) *Good*
- 45) *Help what they need something to use for Yuba Sutter*
- 46) *Access to care in a simple way making people welcome*
- 47) *For the mental health help*
- 48) *Mobile team*
- 49) *The mobile services that is going to work together with the hospital and the clinic*
- 50) *The most important thing is that we are going to have more help and more professionals in the area of mental health*
- 51) *That there is a team that could help to improve medical services*
- 52) *Must be easy to access and no long wait time*
- 53) *Project needs to address physical health needs too, not just mental health because it is connected*
- 54) *New ideas to engage the community*
- 55) *Engaging and developing trust*
- 56) *Interested in this program*
- 57) *Outreach service-community engaging*

- 58) *Doing outreach services like maybe having mobile services as well. Also, the need for more bilingual services to meet the needs of those with limited English skills*
- 59) *I liked the idea of having a mobile team*
- 60) *Engaging interpreter, Hmong primary care provider and the new program*

What Aspects of the Project Do You See as Most Valuable and Important to Implement? (in their own words)

- 1) *Reduction in emergency room visits*
- 2) *All*
- 3) *Getting clients the treatment they need*
- 4) *Meeting clients where they are in the field*
- 5) *Working to treat the individuals to decrease the revolving doors*
- 6) *The team, positive interactions with law enforcement*
- 7) *Providers going into homes meeting clients where they are*
- 8) *Same*
- 9) *Diversity of services and flexibility*
- 10) *Education and being able to go out in the community, building relationships*
- 11) *Engagement team, community/service provider training*
- 12) *The warm hand off from our clients to Sutter county employees*
- 13) *Outreach and training*
- 14) *The mobile field base engagement and collaboration*
- 15) *Training for community members*
- 16) *Helping others with help*
- 17) *More buses to mental health*
- 18) *Response team and training for our line staff*
- 19) *24 hour community response, mental health services are of high demand and we need to build the capacity to serve all and this includes more community forums, schools and billboards*
- 20) *Identifying the highest utilizers of systems; providing critical time interventions-where people are; using true evidence based practices*
- 21) *Peer members on the team; drug and alcohol services engagement*
- 22) *Family information and support is also important*
- 23) *Allowing trust*
- 24) *Support to those individuals who are also trying to help mental health patients*
- 25) *Collaborating as a team*
- 26) *Consistent contact with repeat triage clients*
- 27) *Building trusting relationships and the training; I really like the different and unique ideas of where to have the trainings so maybe offer incentives or embed the training with something else that interests people and is more familiar to them*
- 28) *Everything*
- 29) *They want to come out meet sound great*

- 30) *How to take medication*
- 31) *They were all good*
- 32) *That there are many unthought of ways to use the additional money*
- 33) *To educate us, to help you how to get back into the community*
- 34) *Just to establish relationship*
- 35) *Going face to face with people to let them know that they matter, that you do care*
- 36) *Making contact with the mentally ill instead of waiting for them to make the initial contact*
- 37) *Case management aspect; ability to maintain compliance with meds; Provide complimentary therapies*
- 38) *More Spanish speaking staff*
- 39) *Training - code enforcement, etc*
- 40) *Personal contact, case work involvement, first contact*
- 41) *FSP innovation*
- 42) *Will you help people in need?*
- 43) *Going to the consumer*
- 44) *Mobile team*
- 45) *Combine the medical with mental health*
- 46) *They are coming to us*
- 47) *That they are going to help with depression*
- 48) *Trained people and Spanish-speaking people*
- 49) *Trained people who speak Spanish*
- 50) *That the clinics can help us also*
- 51) *That they will have mobile services*
- 52) *That we might have a team in our own language*
- 53) *Reduction in emergency room visits*
- 54) *Bilingual staff or quality interpreters*
- 55) *Services need to be quick, no long wait*
- 56) *Bilingual and good interpreter services-provide training to all outpatient providers*
- 57) *Bilingual and quality interpreters*
- 58) *Mobile services with language assistance*
- 59) *Interpretation services*
- 60) *Having medical coverages and interpretation services*
- 61) *Interpretation services*
- 62) *Medical coverages, interpretation services*
- 63) *Better/bigger place for the Hmong community for group setting*

How Can We Best Let the Community Know about this Project? (in their own words)

- 1) *Educate agencies on referral process*
- 2) *Assorted social media platforms*
- 3) *Social media*
- 4) *Continue to provide information on FAQs*
- 5) *Radio, newspaper, word of mouth, law enforcement*
- 6) *Facebook*
- 7) *Social media, clinician/client*
- 8) *Ads, mail, social media*
- 9) *TV, newspaper, churches*
- 10) *Educate at training sessions that are being held in the community*
- 11) *Social media, facebook, newspaper*
- 12) *Town hall type meetings*
- 13) *Meetings, brochures at schools, clinics*
- 14) *Probably continued mention in Appeal Democrat*
- 15) *Posters*
- 16) *They go to the SYMH to get the help for them or they owe come's up*
- 17) *In meaning*
- 18) *Working with various community partners and presenting a unified message. All partners should use and advertise this message to their clients*
- 19) *Marketing on social media, billboards, bus stations, busses, at the hospital and at crisis*
- 20) *Multiple forms/forums-social media, news releases, targeted outreach, etc*
- 21) *News releases, social media; community organizations; community stakeholder meetings just don't seem to draw in the community*
- 22) *Community members are unlikely to come to this type of meeting. I don't know what would motivate better attendance, except a personal need*
- 23) *Word of mouth, advertise on local radio stations*
- 24) *BOS; community events*
- 25) *Good job*
- 26) *I believe social media would be helpful, but advertising or posting individuals at places where they scan services (Rideout, Health & Human Services, homeless encampments (areas near there) is needed*
- 27) *Newsletter*
- 28) *Meeting*
- 29) *Use radio and local Appeal Democrat*

- 30) *Newspaper, have yours or the California Homeless Union go out and talk to them about this program, and if you bring in cops, no uniforms or guns, it scares them*
- 31) *Word of mouth*
- 32) *I think you're doing it just work with us*
- 33) *Going out into the community to camps (to the feeds that other community members, go to parks, feed the homeless)*
- 34) *Articles in the newspaper*
- 35) *Education; 1 to 1 contacts; training-share successes*
- 36) *Give the need to gather and inform ourselves about these projects*
- 37) *Outreach, life center*
- 38) *Territorial Dispatch-personal involvement is a must for community success - radio*
- 39) *Outreach to organizations, locations in community, coffee shops*
- 40) *Music*
- 41) *What you project have a plane today?*
- 42) *Grassroots, find all the groups who can connect you*
- 43) *Talk about the meeting*
- 44) *Having these meetings*
- 45) *Flyers*
- 46) *Meeting*
- 47) *Be part of the team, take flyers*
- 48) *Coming to the meetings and preparing us to be able to explain*
- 49) *Passing out the phone number or reference to the program*
- 50) *Sharing our experiences and sharing flyers*
- 51) *Educate agencies on referral process*
- 52) *Radio broadcast or through community agencies like family resource centers*
- 53) *More info sessions to different parts of the community*
- 54) *I can tell others I learn about it*
- 55) *Word of mouth*
- 56) *Be present at community events. Make your service known to churches and other religious groups, and market places.*
- 57) *Maybe going out to community events to talk people about services that you provides*
- 58) *Speaking out letting everyone know in the community*

What Suggestions Do You Have for Future Innovation Projects? (in their own words)

- 1) *Instead of asking for whomever to come from organizations, ask for representatives*
- 2) *Talking to mothers after birth about post-partum depression*
- 3) *I am excited and have an amazing feeling about this innovation project*
- 4) *More training for community, stigma reduction*
- 5) *Ways to show them why they can't see what they can't or come out to them*
- 6) *Transportation to Live Oak*
- 7) *I strongly would like to see our law enforcement take a more proactive role in identifying the habitual clients and be involved in a response plan, not just take clients to Y-S MH or Rideout*
- 8) *Keep having an open mind-I love this project*
- 9) *More beds in our local psych hospital/SYBH/More psych clinics for mild to moderate clients, associated with primary care such as Sutter Health or Rideout Health, Ampla, Peach Tree, etc.*
- 10) *A lot of family give up on patients, more family support*
- 11) *My head is still spinning from all the amazing information-I'm just focused on this innovation*
- 12) *One step at a time*
- 13) *Affordable housing, meds and how they help*
- 14) *I think if you give someone your trust, then they will have trust in you, and not to tell them you're going to help them but never does*
- 15) *Not sure, will comment when I can think some things over*
- 16) *I think you're doing the best at this time*
- 17) *Myself, I work with the homeless everyday, so I pretty much know what they need. 1) Trust 2) Needs for personal 3) A better way to communicate*
- 18) *Look at continuum of care for behavioral health/Dementia/Substance abuse management*
- 19) *Training funds in professional services, grants, medical, psychological and social services. Requiring internships of 1 year or more in field studies upon graduation. A term of free service on call basis 1 year or more.*
- 20) *Good ones*
- 21) *What your project have names to be help for the time*
- 22) *Invite more people*
- 23) *Go out more/food*
- 24) *Having these meetings/inviting more people to have more information*
- 25) *Child care*
- 26) *Having everything translated to the patient's language and having the organizers give us a presentation*

- 27) *That it could be done a little later in the day and having child care*
- 28) *Recreation group to support mental health recovery that is not tied to mental health*
- 29) *An easy access to transportation-no paperwork and no hard process so we can get to places we need to better care for our health*
- 30) *Focus on traditional or spiritual healing*
- 31) *Transportation to appointment, related to mental health treatment*
- 32) *Gardening programs to support mental health wellbeing*

MHSA Stakeholder Meeting Materials



Sutter-Yuba Behavioral Health (SYBH) Mental Health Services Act (MHSA) Innovation Stakeholder Meeting

HOW TO GET THE MOST FROM TODAY'S MEETING AND MAKE SURE YOUR VOICE IS HEARD

This Community Planning Process for MHSA is meant to give community members a chance to learn about the Innovation project that SYBH is seeking approval for. In this meeting, we would also like your feedback on several important questions:

1. Which part of this proposed project is most important to you as a community member?
2. What aspects of the project do you see as most valuable and important to implement?
3. How can we best let the community know about this project?
4. What suggestions do you have for future innovation projects?

Meetings like this get the best results when we listen to other perspectives and encourage different voices to be heard. Here are some suggestions for how you can best participate in the process:

- ❖ Start from a place of learning — we are all here to learn together and from one another.
- ❖ Keep an open mind and engage fully in the process.
- ❖ Listen with curiosity to understand the project and how they can better serve people in your community.
- ❖ Share your opinions in a respectful and constructive way.
- ❖ Help us keep an atmosphere of professionalism and considerate discussion. Some ways you can do this:
 - Give thoughtful, kind and constructive feedback.
 - Share information when appropriate.
 - Stay focused on the topic at hand.
 - Respect the moderator and timekeeper.
 - Treat any personal information that others share with respect and confidentiality.

Here are some tips on how your input can best influence the results of this Community Planning Process:

- ❖ The notes taken by your small group's scribe will be the official record of the discussion that go into our report. Help make sure that they are a complete and accurate reflection of the key points in the conversation.
- ❖ During this meeting, you will only be able to sit in a small group focused on one particular innovation project. If you are interested in learning or giving feedback on another topic, please come to a future community meeting.
- ❖ If you have thoughts that you did not get to contribute in the small group, be sure to fill out the comment form and turn it in to us. All comments will be read and included in the plan.

MHSA Stakeholder Meeting Materials (continued)



**Sutter-Yuba Behavioral Health (SYBH)
Mental Health Services Act (MHSA)
Community Planning Process**

Stakeholder Comment Form

What is your age?

- 0 -15 yrs
- 16 - 25 yrs
- 26 - 59 yrs
- 60 + yrs

What is your gender?

- Male
- Female
- Other: _____

What county do you live in?

- Sutter County
- Yuba County

Zip code: _____

What group(s) do you represent?

- | | | |
|---|---|---|
| <input type="checkbox"/> Family member or caregiver of consumer | <input type="checkbox"/> Faith Community | <input type="checkbox"/> Active Military or
<input type="checkbox"/> Veteran |
| <input type="checkbox"/> Consumer of Behavioral Health Services | <input type="checkbox"/> County Staff | <input type="checkbox"/> Representative from
Veterans Organization |
| <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> Social Services Agency | <input type="checkbox"/> Provider of Alcohol and Drug
Services |
| <input type="checkbox"/> Education | <input type="checkbox"/> Health Care Provider | |
| <input type="checkbox"/> Community Agency | <input type="checkbox"/> Community Member | |

What is your Ethnicity?

- | | |
|---|--|
| <input type="checkbox"/> Latino/Hispanic | <input type="checkbox"/> Asian/Pacific Islander |
| <input type="checkbox"/> African American | <input type="checkbox"/> American Indian/Native American |
| <input type="checkbox"/> Caucasian/White | <input type="checkbox"/> Other: _____ |

What is your primary language?

- English
- Spanish/Español
- Vietnamese/tiếng Việt
- Other: _____

What is your general feeling about this MHSA Community Stakeholder Meeting?

- Very Satisfied
- Satisfied
- Somewhat Satisfied
- Unsatisfied
- Very Unsatisfied

Which breakout discussion did you take part in?

- | | |
|--|--|
| <input type="checkbox"/> Innovation | <input type="checkbox"/> Workforce Education and Training |
| <input type="checkbox"/> Prevention & Early Intervention | <input type="checkbox"/> Capital Facilities/Information Technology |
| <input type="checkbox"/> Community Services & Supports | |

Of what you learned about the project discussed today, what is most important to your community?

What aspects of the project do you see as most valuable and important to implement?

How can we best let the community know about this project?

What suggestions do you have for future innovation projects?

Thank you again for taking the time to review and provide input on
MHSA programs/projects!

Stakeholder Meeting PowerPoint



Sutter-Yuba Behavioral Health (SYBH)
Office of MHSA

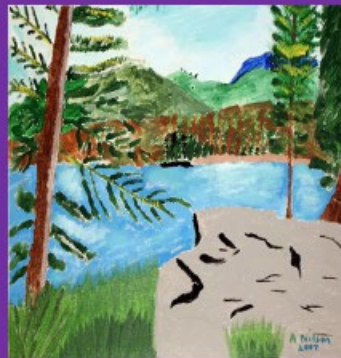
MHSA Proposed Innovation Project

Mental Health Services Act (MHSA)
Innovation Component

Sarah Eberhardt-Rios, MPA, Health and Human
Services Branch Director

Peter Sullivan, MBA, MHSA Coordinator

April 15, 2019



Artist Credit: A. Wilson

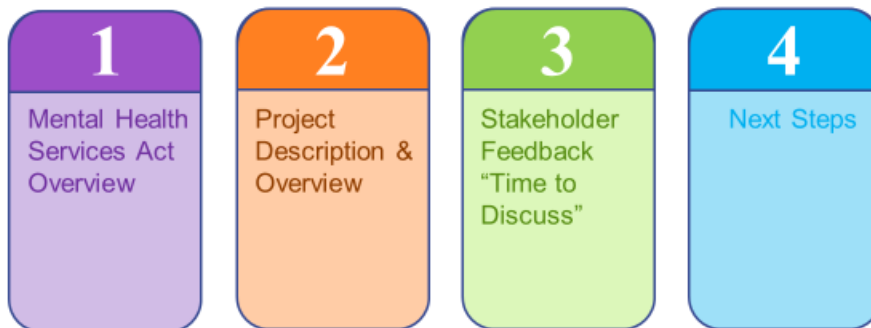
www.suttercounty.org

Presentation Overview

Page 2

Today's Topic:

Proposed Concept for MHSA Funded Innovation Project



Behavioral Health

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- The Mental Health Services Act (MHSA), Prop 63, was passed by California voters in November 2004 and went into effect in January 2005
- The MHSA provides increased funding for mental health programs across the state
- The MHSA is funded by a 1% tax surcharge on personal income over \$1 million per year
- Fluctuations in tax payments impact fiscal projections and available funding



Per the California Department of Mental Health Vision Statement and Guiding Principles (2005)

To create a culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families.



- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI)
- **Innovation (INN)**
- Workforce Education and Training (WET)
- Capital Facilities and Technological Needs (CFTN)
- Community Program Planning (CPP)



Address one of the following **learning purposes** as its primary purpose:

- To increase access to underserved groups
- To increase the quality of services, including measurable outcomes
- To promote interagency & community collaboration
- To increase access to services

WIC § 5830 (b)(1)(A-D)



Goals of Innovation Component

Page 7

Support innovative approaches by doing at least one (1) of the following:

- Introduce new mental health practices or approaches, including, but not limited to, prevention and early intervention
- Make a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community
- Apply to the mental health system a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings

WIC § 5830 (b)(2)(A-C)



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Innovation Legislative Requirements

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- An Innovation project is defined as one that **contributes to learning rather** than a primary focus on providing a service
- County mental health programs shall expend funds for their innovation projects upon approval by the Mental Health Services Oversight and Accountability Commission (MHSOAC)

WIC § 5830(e)



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Time-limited Pilot Project

- Maximum of five **(5)** years from the start date of the project
- Successful parts of the project **may** continue under a different funding source or be incorporated into existing services
- Projects may be terminated prior to planned end date



9 CCR § 3910.10



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Community Program Planning

WIC § 5848 (a) states that counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on:

- Mental Health Policy
- Program Planning
- Implementation
- Monitoring
- Quality Improvement
- Evaluation
- Budget Allocations



Artist Credit: Unknown "The Student"



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Sutter-Yuba Behavioral Health (SYBH) provides services to adults, children, and families who are experiencing significant and ongoing behavioral health conditions and/or substance use disorders in Yuba and Sutter Counties.

SYBH accepts most medical insurance, Medi-Cal, Medicare and serves those with out insurance and are low income. Services include medication support, therapy, case management, groups, residential treatment and inpatient psychiatric hospital care.

SYBH also provides prevention and early intervention services through community education and learning opportunities that increase knowledge of behavioral health conditions, early signs and symptoms, and stigma reduction efforts.

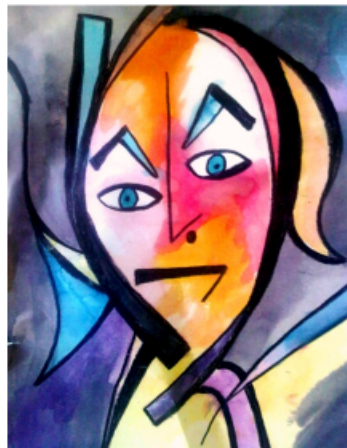


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SYBH Partners in Service

- School Leadership
- Law Enforcement
- Health Care Systems
- Managed Care Plans
 - ✓ California Health & Wellness
 - ✓ Anthem Blue Cross
- Faith Based Community
- Community Based Groups
- Consumers of Care
- Family Members



Artist Credit: Ann Reitan



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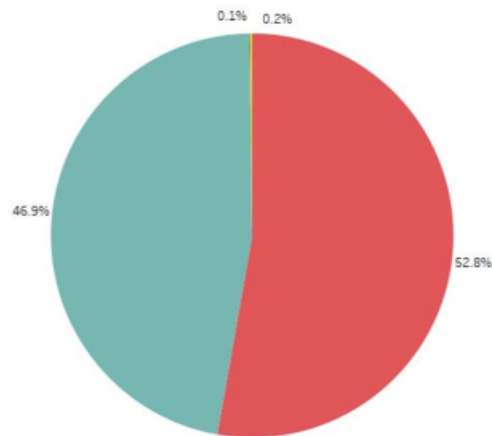
Residents of Sutter County and Yuba County
Total Population 167,888

Residents Served (FY) 17/18
5,408



Demographics Served (FY) 2017-18

- Gender**
- Female
 - Male
 - Other
 - Not Reported

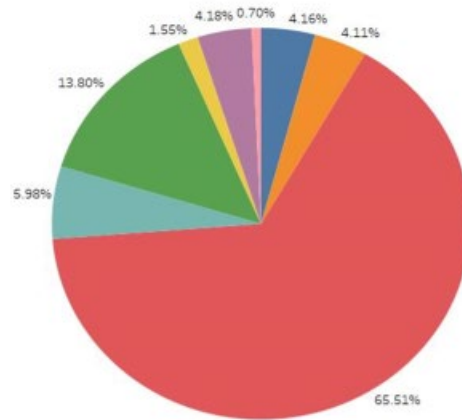


Residents Served
(FY) 17/18
5,408



Ethnicity/race (group)

- African American
- Asian Pacific Islander
- Caucasian
- Identify as Two or More Ethnicities
- Latino
- Native American
- Not Reported
- Other



Residents Served
(FY) 17/18
5,408



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Artist Credit:
Gabriel



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Folks accessing emergency and hospital care as their main source of care for psychiatric needs but are unable or unwilling to connect with available outpatient care including both mental health and substance use disorder treatment:

- Calling Law Enforcement
- Going to the Emergency Room
- Going to the Hospital
- Not connecting with outpatient care



- SYBH Served 5,408 individuals in FY 17/18 or 3.22% of the total population of 167,888 (includes both counties)
- Per the National Institute of Mental Health (NIMH) prevalence rates for individuals estimated to live with Severe and Persistent Behavioral Health Conditions is 4% or for our region, or 6,715 individuals
- Of those 5,408 individuals served, approximately 500 received hospital care in an acute psychiatric hospital



- Of the 500 served who had both behavioral health and substance use disorders, less than 2 percent followed up with outpatient care within 30 days
- Of the 25 highest utilizers of hospital care (some with over 200 days of hospital care), only 8% were enrolled in outpatient Full Service Partnership Services
- In Calendar Year 2018 SYBH provided crisis/emergency psychiatric services to 2,702 individuals (SYBH is embedded in Rideout's Emergency room 24/7)



- Of those seen, 1,995 were seen via involuntary hold (5150)
- In 2018, law enforcement wrote 997 (49%), of the total 1,995 holds placed in both counties for children and adults
- The remaining 998 holds were written by SYBH crisis staff, with 404 of 998 being written at the hospital for individuals transported to the hospital via law enforcement



- Adding holds placed at the hospital with holds written by law enforcement, law enforcement contact with individuals for whom a hold was placed is 70% (1,401) of the total 1,995 holds, a significant percentage of total crisis contacts



What Law Enforcement said:

"Up to 40% of local law enforcement calls are related to behavioral health needs"

What Consumers & Family Members said:

"I feel stigmatized"

"I am worried about being seen at Behavioral Health buildings"

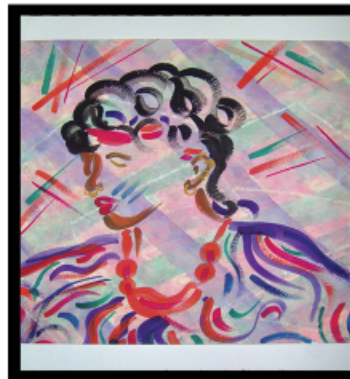
"Services are hard for me to access"

"I don't know how to help my loved one with their needs"

What our Partners said:

"The ER is designed to best treat emergencies"

"We worry patients who come here the most for behavioral health needs aren't connecting with out patient care"



Artist Credit Angela Trent



What we did when we got this feedback and looked at our data:

- Asked other counties if they had similar issues
- Researched County innovation projects and read 20 reports on the practice of engagement for other health care and behavioral health programs across the US and internationally



Several themes were identified among the programs/articles:

- Case management is different than engagement
- Trust is key to engagement
- Consumers must see their own goals and vision for themselves in the care being offered
- Influence occurs through flexibly working with individuals
- Positive relationships with peers enhances engagement



What the Research Said

Page 25

- Critical time interventions immediately after hospitalization increase engagement
- Traditional mental health settings for some individuals have been linked to alienation and treatment drop out
- Stigma can have an impact on help-seeking behavior, treatment adherence, and recovery
- Disengagement may be related to individuals feeling that treatment is not working, feeling coerced into treatment, or experiencing hardship in accessing services due to services being hard to get to or being hard to schedule



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What the Research Said

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- In one 2018 case-study of engagement for individuals with chronic, long-term behavioral health needs, it was found that an average of 17 non-clinical engagements was necessary before an individual became clinically engaged in outpatient treatment after using emergency/hospital care as routine



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What We Are Proposing

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- A mobile, field based engagement team that will come to individuals needing behavioral health care where they are, instead of asking them to come to us
- The mobile team would respond to folks, including their family members, who have been recently hospitalized, or had an emergency psychiatric service, but are having a hard time connecting into outpatient care at a clinic
- Also respond to frequent callers of 911 or to Law Enforcement, Fire, Code Enforcement or the Emergency Room
- The mobile team would consist of Peers (consumers with lived experience), Nurses, Alcohol and Drug Counselors and Therapists



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What We Are Proposing

Page 28

- SYBH, Rideout staff, law enforcement, code enforcement, fire will have the option to be trained in two new innovative non-clinical engagement techniques, LEAP and COACH
- The mobile team would be called the iCARE Team (Innovative & Consistent Application of Resources & Engagement) and is estimated to serve about 50 folks at any given time and potentially up to 150 over a year's time
- The goal of the mobile engagement team would be to work with the individual to decrease their number of unnecessary visits to the emergency room, hospital admissions and calls to law enforcement, fire or code enforcement
- Increase overall engagement in behavioral health care, including increased outpatient services



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- iCARE would be referral based for folks who are calling 911 repeatedly, interacting with fire, law enforcement, code enforcement or homeless outreach teams frequently, have behavioral health needs, but are not effectively engaged in services and/or are overutilizing the emergency room for non-emergency issues, or hospital care
- Quick example of what we think the engagement will look like, including family member support

- The proposed project also includes a large training component widely available to community members
- Trainings would be funded with Prevention and Early Intervention funding under MHSA and be offered at no cost to the community
- Trainings would focus on recognizing and responding effectively to early signs mental illnesses, suicide prevention and how to access services
- Trainings would include Mental Health First Aid, Safetalk, Assist, and others

What We Are Proposing

Page 31

- Trainings would be open to individuals and families in Sutter and Yuba Counties, local employers, behavioral and health care providers, law enforcement, faith-based organizations, college students and school personnel
- Anyone who is interested in attending a training could do so



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How Much Innovation Funding We Have

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- \$4.8 million is available over a five year period through June of 2024
- Some of that \$4.8 million is at risk for reversion
- Reversion is a process whereby the State can take back unspent MHSA county funding
- Innovation Projects must be approved by the Board of Supervisors and a State commission, the Mental Health Services Oversight and Accountability Commission (MHSOAC) before counties can start spending Innovation funding



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2019

May

Post Proposal for 30-days on county website for review

June

Proposal to Board of Supervisors (BOS)

July

Proposal to Mental Health Services Oversight and Accountability Commission (MHSOAC)

August

If approved, Innovation Proposal implementation begins

September to March 2020

Identify evaluation vendor
Contracts process to include staffing, space and collaborative stakeholder evaluation plan



Important Items For You:

- Innovation Proposal will be posted on May 6, 2019 at www.suttercounty.org
- Please review the plan and provide any additional feedback you have
- Watch for more information from us



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Contact Information for Accessing Behavioral Health Services in Sutter and Yuba County

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For additional help in accessing
Behavioral Health Services please call:

(530) 822-7200

Toll Free 1 (888) 923-3800

or TTY-CRS 1 (800) 735-2929



Behavioral Health

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To report any concerns related to MHSA
Community Program Planning, please

Contact

Peter Sullivan, MHSA Coordinator

Psullivan@co.sutter.ca.us

530-822-7237

However, you can tell us at any time how you
think we can improve!



Thank you for your thoughtful
participation!

Your feedback is important to us

Please ensure that you have completed
your comment forms for our
conversation with you today



For questions or comments, please contact:

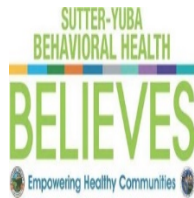
Peter Sullivan
MHSA Coordinator
psullivan@co.sutter.ca.us
(530) 822-7327



Behavioral Health

www.suttercounty.org

Stakeholder Meeting Flyers



Please join Sutter-Yuba Behavioral Health (SYBH)
for a Mental Health Services Act Stakeholder
Engagement Meeting!



Innovative and Consistent Application of Resources and Engagement (iCARE) - Project

These community stakeholder engagement meetings will focus on the Mental Health Services Act (MHSA) Innovation Plan. Special focus will be placed on a proposed project serving community members with behavioral health needs in Sutter and Yuba Counties. Please come join us for the conversation!

Meetings in Sutter County

Thursday, April 25, 2019

3:30 - 4:30 pm

Veteran's Hall – Tucker Room
1425 Veterans Memorial Circle
Yuba City, CA 95993

Thursday, April 25, 2019

5:00 - 6:00 pm

Veteran's Hall – Tucker Room
1425 Veterans Memorial Circle
Yuba City, CA 95993

Meetings in Yuba County

Tuesday, April 30, 2019

3:30 - 4:30 pm

Yuba Co. Government Center
Board of Supervisors Chambers
915 8th Street
Marysville, CA 95901

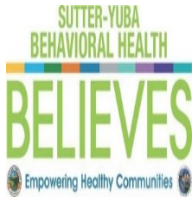
Tuesday, April 30, 2019

5:00 – 6:00 pm

Yuba Co. Government Center
Board of Supervisors Chambers
915 8th Street
Marysville, CA 95901

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact (Valerie Strawmier, (530) 822-7200 x2253). Please request accommodations at least seven (7) business days prior to the event.

MHSA (Proposition 63) was passed by California voters in November 2004 to expand mental health services for children and adults. The Act is funded by a 1% tax surcharge on personal income over \$1 million per year.



Por favor únase con su Departamento de Salud y Bienestar de Sutter-Yuba (SYBH) para esta Reunión Para Conocernos con las Persona Interesadas e Ley Federal de Servicios de Salud Mental (Mental Health Services Act (MHSA) Stakeholder Engagement Meeting)!



Aplicación Innovadora y Consistente de Recursos y Compromiso (iCARE) – Proyecto

Estas reuniones de participación de las partes interesadas de la comunidad se centrarán en el Plan de Innovación de la Ley de Servicios de Salud Mental (MHSA). Se prestará especial atención a un proyecto propuesto que atienda a miembros de la comunidad con necesidades de salud mental/emocional en los condados de Sutter y Yuba. ¡Por favor, únete a nosotros para la plática!

Reuniones en el condado de Sutter

jueves, 25 de abril del 2019

3:30 - 4:30 pm

Veteran’s Hall – Tucker Room
1425 Veterans Memorial Circle
Yuba City, CA 95993

jueves, 25 de abril del 2019

5:00 - 6:00 pm

Veteran’s Hall – Tucker Room
1425 Veterans Memorial Circle
Yuba City, CA 95993

Reuniones en el condado de Yuba

martes, 30 de abril del 2019

3:30 - 4:30 pm

Yuba Co. Government Center
Board of Supervisors Chambers
915 8th Street
Marysville, CA 95901

martes, 30 de abril del 2019

5:00 - 6:00 pm

Yuba Co. Government Center
Board of Supervisors Chambers
915 8th Street
Marysville, CA 95901

Para preguntas, inquietudes, servicios de interpretación o solicitudes de arreglo especial por una incapacidad, comuníquese con (Alex Barela, (530) 674-1885 x102). Por favor, solicite arreglo especial al menos siete (7) días de trabajo antes del evento.

MHSA (Proposición 63) fue aprobada por los votantes de California en noviembre de 2004 para ampliar los servicios de salud mental para niños y adultos. La Ley se financia con un recargo fiscal del 1% sobre los ingresos personales de más de \$1 millón por año.