SAN MATEO COUNTY
MENTAL HEALTH SERVICES ACT (MHSA)

Amendment to the MHSA Annual Update for Programs & Expenditures Fiscal Year 2024-25

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

This document serves as an Amendment to the approved San Mateo County Health, Behavioral Health and Recovery Services (BHRS) Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2024-25; and includes the following changes to programs and expenditures:

1. Property Purchase Proposal – BHRS South County Adult Clinic
2. INN Project Plan Proposals
    - Peer Support for Peer Workers
    - Animal Care for Housing Stability and Wellness
    - allcove Half Moon Bay
    - PIVOT – developing capacity for MediCal billing
3. MHSA Funding Summary Amendment to CFTN and INN Components

Background

Proposition 63, MHSA, was approved by California voters in November 2004 and has provided dedicated funding to transform behavioral health systems, by imposing a 1% tax on personal income over $1 million dollars. San Mateo County received an annual average of $55.1 million, in the last five years through Fiscal Year (FY) 2023-24. MHSA funded programs and activities are grouped into "Components" as listed below, each one with its own funding allocations.

MHSA Component	Funding Allocation (% of total revenue)
Community Services and Supports (CSS)*	76% *Full Service Partnerships (FSP) at least 51% of CSS allocation*
Prevention and Early Intervention (PEI)	19% *Service for Ages 0-25, at least 51% of PEI allocation*
Innovations (INN)	5%

** Counties can allocate up to 20% of the average 5-year total MHSA funds from CSS to **Workforce Education and Training (WET), Capital Facilities and Information Technology (CFTN)** and a **Prudent Reserve**.*

MHSA legislation requires counties to develop MHSA Three-Year Program and Expenditure Plans (Three-Year Plan) and subsequent Annual Updates in collaboration with diverse stakeholders. MHSA legislation also requires that the local county behavioral health board open a 30-day public comment process, hold a public hearing and vote to recommend the approval of Three-Year Plans, Annual Updates and any Amendments, by the Board of Supervisors.

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Property Purchase Proposal – BHRS South County Adult Clinic

The MHSA Annual Update for FY 2024-25 was approved by the San Mateo County Board of Supervisors on June 11, 2024, and included allocation of one-time unspent funds to renovate County-owned BHRS clinic facilities. A partial re-allocation of the unspent funds is being proposed, in the amount of **$5,000,500 from this current FY 2024-25,** to purchase a property to replace the current BHRS South County Clinic building.

This proposal will require a transfer of funds from Community Services and Supports (CSS) to Capital Facilities and Information Technology (CFTN) component, as per MHSA fiscal guidelines. The Amendment to the Funding Summary can be seen in previous pages 4-6.

The current BHRS South County Clinic is at a leased property at 802 Brewster, Redwood City, CA, 94603. The lease expires March 31, 2026. BHRS anticipates that the upcoming lease renewal rate will be significant and far beyond a reasonable rate for the property and the current state is outdated, has significant safety concerns and pest issues. Purchasing a new property to replace the current location will allow BHRS to address many of the current issues including adequate maintenance and pest mitigation by the County Department of Public Works.

The total purchase cost is estimated between $7-8 million. Renovations and tenant improvements beyond the purchase price will be needed to ensure the property meets clinic requirements such as a medication rooms, sufficient private offices for therapy, compliance with HIPAA standards, Medi-Cal certification requirements, ADA, and any other County requirements. Renovations will run between $1-$2 million.

The Behavioral Health Commission (BHC) voted to open the 30-day public comment period on October 2, 2024 and held a public hearing at closing of the public comment period on November 6, 2024.

- Following is the property purchase proposal in more detail. All public comments received are combined and included on page 245 of this document.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Property Purchase Proposal– BHRS South County Adult Clinic

September 2024

Request: Use MHSA funds in the amount of $5,000,500 to support the purchase of a new building for the San Mateo County Behavioral Health and Recovery Services (BHRS) South County Adult Clinic. The purchase is estimated to be $7M-$8M. Renovations/tenant improvements beyond the purchase price will be needed to most properties to ensure the property meets clinic requirements such as a medication rooms, sufficient private offices for therapy, compliance with HIPAA standards, Medi-Cal certification requirements, ADA, and any other County requirements. Renovations will run $1M-$2M.

Current Location: BHRS currently leases the property at 802 Brewster, Redwood City, CA, 94603. The lease expires March 31, 2026.

Operations: Although building's primary purpose is the mental health clinic, the Conservatorship and Patients' Rights teams are co-located at the site.

Current State: The property is old, many features are unable to be upgraded such as the elevator, and the property has persistent pest problems which are a public health issue.

Safety: The clinic operates on three floors which is not ideal for our clients as the elevator often needs repairs. It is also a safety issue as it cannot be retrofitted for a "lockout" system that prevents it from going to specific floors in the case of an emergency.

The reception area on the first floor is limited to a fully open security desk and a small, reception room that has one door. The reception room has a window to the lobby; however, is in situations with disruptive clients, it is potentially dangerous for the administrative staff to be in a small room that has only one exit into the area where the client is. The walls are cinder block which prevents an additional door from being added to the reception room.

The third floor does not have a reception area which also poses potential threat to staff. Although the entrances to the private treatment and other areas are locked and require a staff escort, there is no effective way to monitor clients in this lobby.

Public Health: Over the past three (3) years, the have been persistent pest issue that are creating public health hazards and affecting the health of staff and clients.

The specific issues and mitigations:

- Rodents in walls and ceilings traps
- Flea infestation; Fall, 2023
    - Full chemical fumigation of building which required closing of clinic for three (3) weeks
    - Several staff filed Worker's Compensation claims related to impacts of fleas
    - Three staff had to get their homes treats for fleas due to cross-contamination from the clinic infestation
- Cockroaches, Summer, 2024
    - Infestation of cockroaches
    - Numerous mitigations were used including bait, traps, spraying, and fogging
    - Some staff filed Worker's Compensation claims for sensitivities/reactions to chemicals used in fogging treatment
- Fly swarms in the spring
    - Treated with zappers or chemicals
- Termites
    - Termites are observed at various times during the year despite continuous treatments
- All chemical treatment poses additional safety hazards for staff and clients due to potential chemical sensitivities

Relationship with Landlord: Although BHRS has leased the property for more than 15 years, is has been extremely difficult work with the landlord. The building is old and run down. Regular maintenance is not generally provided. It is often difficult to get the landlord to respond to facilities requests. Pest mitigation although responsibility of the landlord is being taken over by BHRS so that there is continuity and consistency in response. Termite control will remain the responsibility of the landlord.

Rent escalators: The leases have included annual lease escalators with no additional services or building upgrades. BHRS anticipates that the upcoming lease renewal rate will be significant and far beyond a reasonable rate for the property.

New Property: BHRS is actively looking for a new property to house the South County Adult Clinic and other programs. A new building will address:

- A new, first entrance reception area with multiple stations and entrance/exit points for staff, increasing stagey
- All maintenance will be taken over by the County Department of Public Works. This will ensure:
    - Quick response times to immediate problems
    - Regular maintenance
    - Addition to the County pest control contract which provides regular pest inspections and mitigation
- Reduction in pest problems which will in turn reduce potential public health issues and Worker's Compensation claims
- Long-term reduction in cost as the building will be purchased outright. There will be no lease escalators.
- Improved accessibility for clients and staff

Innovation (INN) Project Plans

Four INN Project Plans are being proposed for approval. The proposed amendment will allow for the use of MHSA INN funds in the amount of **$870,000 in this current FY 2024-25** for BHRS procurement activities and to launch two of the four projects that are launch-ready.

1. *Peer Support for Peer Workers.* Total amount proposed: $580,000 for 4 years ($450K service delivery, $55K BHRS administration, $75K evaluation). The project creates a team of trained peers to provide on-demand peer support services for peers and family members in the workforce. The project supports behavioral health workforce development priorities as peer and family support specialists are supported, stable and well, leading to higher job satisfaction and retention rates, better work-life balance, improvement in services provided, and a decrease in burnout, vicarious trauma, and compassion fatigue.
2. *Animal Fostering and Care for Client Housing Stability and Wellness.* Total amount proposed: $990,000 ($870K service delivery for 3 years, $120K evaluation). The project will provide temporary animal foster care, veterinary and pet support services as needed by adult and older adult clients living with serious mental illness (SMI) and/or substance use disorders (SUD) for whom animal care is an urgent and temporary barrier to receiving a higher level of care treatment or maintaining their housing stability and wellness.
3. *allcove Half Moon Bay.* Total amount proposed: $1,600,000 for 4 years $1.5M service delivery for 3 years, $100K BHRS administration, evaluation to be provided by Stanford as part of the multi-county collaborative). This youth-focused "one-stop-shop" health center for youth ages 12 to 25 living in the coastside region of San Mateo received a grant to support start-up costs. Local INN funding will supplement and support the delivery of mental health support groups, individual therapy and other early intervention treatment services at the center.
4. *Progressive Improvements for Valued Outpatient Treatment (PIVOT) – developing capacity for MediCal billing.* Total amount proposed $5,650,000 for 5 years ($5M service delivery for 5 years, $200K BHRS administration, $450K evaluation). The project will support community-based organizations that are interested become certified providers of specialty mental health services (SMHS) for individuals living with serious mental illness (SMI) or substance use disorders (SUD). The project has the potential to support the sustainability of critical Community-Defined Evidence Practices (CDEPs) by identifying billable components of CDEPs for which counties could leverage Medi-Cal billing.

The Community Program Planning (CPP) process for INN Project Plans begins with the development of the MHSA Three-Year Plan. A comprehensive community needs assessment process determines the gaps, needs and priorities for services, which are used as the basis for the development of INN projects.

In 2022, BHRS conducted a participatory process to gather a broad solicitation of innovation ideas. With the availability of funding for new INN projects to be approved in the current fiscal year, BHRS sought to identify potential INN projects that would meet current needs and align with the priorities of Proposition 1 – Behavioral Health Service Act (BHSA).

- ✓ BHRS staff reviewed the 14 ideas that had been pre-screened in 2022 against new Innovation requirements given Prop. 1 – BHSA changes. Five ideas included the required components of early intervention, treatment, and/or recovery.
- ✓ BHRS conducted an internal feasibility review of the five projects and determined to move forward with two of the INN proposals based on BHRS capacity and priorities for the Prop. 1 – BHSA transition.
- ✓ In addition, BHRS decided to move forward with two multi-county collaborative INN projects

On September 5, 2024, the MHSA Steering Committee met to review the two community-derived INN ideas, and the two multi-county collaborative projects, and provide comment and considerations for the projects through breakout room discussions and online comment forms. The Behavioral Health Commission (BHC) voted to open the 30-day public comment period on October 2, 2024 and held a public hearing at closing of the public comment period on November 6, 2024.

The projects will be presented for approval by the MHSOAC, scheduled for January 23, 2025. Request for Proposal process will follow to support an open procurement process for the relevant projects.

- Following are the 4 INN Project Plans. All public comments received are combined and included on page 245 of this document.

INN Project Proposal #1 - *Peer Support for Peer Workers*

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSOAC
Mental Health Services Oversight & Accountability Commission

INNOVATIVE PROJECT PLAN RECOMMENDED TEMPLATE

COMPLETE APPLICATION CHECKLIST
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:
☑ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors.
☑ Local Mental Health Board approval Approval Date: November 6, 2024
☑ Completed 30 day public comment period Comment Period: November 6, 2024
☐ BOS approval date Approval Date: _____ If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: January 14, 2025 *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*
Desired Presentation Date for Commission: January 23, 2025 ***Note: Date requested above is not guaranteed until MHSOAC staff verifies all requirements have been met.***

Mental Health Services Act (MHSA) Innovation Project Plan

County Name: San Mateo County
Date submitted: TBD
Project Title: Peer Support for Peer Workers
Total amount requested: $580,000 ($450K service delivery for 3 years, $55K BHRS administration, $75K evaluation)
Duration of project: 4 years (3 years of services, 6 months start-up, 6 months post evaluation)

Section 1: Innovations Regulations Requirement Categories

GENERAL REQUIREMENT:

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

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

PRIMARY PURPOSE:

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

- ☐ Increases access to mental health services to underserved groups
- ✓ **Increases the quality of mental health services, including measured outcomes**
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Peer support is an evidence-based practice (EBP) that has been shown to improve outcomes and quality of life for individuals living with mental health and/or substance use challenges. In recent years, many states have expanded the peer workforce to strengthen the capacity of the behavioral health system.[1] With the introduction of peer certification in California, peers are now playing an integral role in the behavioral health workforce. For individuals in recovery who are navigating employment, it is important that they have strategies for integrating work, recovery, and wellness to support their ongoing employment.[2] While the state and counties have put in place resources for training and support for peer workers, the support has largely focused on training peers in their role, developing leadership and career pathways, and guidance on peer certification. There are limited resources to support peers' own mental health and recovery needs that can arise in the context of their role in the behavioral health workforce. It is essential that peers receive support to maintain their own recovery as they work with clients, as the wellbeing of the workforce translates directly to the quality of services for clients.

While the Substance Abuse and Mental Health Services Administration (SAMHSA) National Model Standards for Peer Support Certification encourages organizations to support peer workers through peer supervision and providing training on self-care, the peer workforce has unique needs that are not adequately addressed through existing supports. Stress and triggers can arise in their work that may destabilize their wellness, particularly given the unclear boundaries that peer workers sometimes navigate in providing services to clients who may be experiencing similar challenges as the peer worker has experienced on their journey to recovery.[3] In addition, peer workers experience challenges related to unclear role expectations and regularly report stigma and discrimination in the workplace.[4] There is a further need for support post-pandemic as peer workers continue to recover from the stresses of COVID-19 and adjust to changes in job tasks (e.g., increased reliance on technology, reduction in in-person services).[5]

In a formal capacity, peers do not have someone outside of their supervisors to go to for support in dealing with work-related distress. While BHRS has structured two consultations per month for peer workers, these sessions often focus on training on their role and how to access resources for peer certification. Peers may be unlikely to discuss their own recovery with a supervisor, for fear that it may be seen as cause for concern about their ability to perform their jobs. Peers may also be unlikely to use programs designed for the

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[1] *Issue Brief: Expanding peer support and supporting the peer workforce in mental health*. (2024, June 1). SAMHSA Publications and Digital Products. https://store.samhsa.gov/product/expanding-peer-support-peer-workforce-mental-health/pep24-01-004

[2] Williams, A. E., Fossey, E., Corbière, M., Paluch, T., & Harvey, C. (2016). Work participation for people with severe mental illnesses: An integrative review of factors impacting job tenure. *Australian Occupational Therapy Journal*, *63*(2), 65–85. https://doi.org/10.1111/1440-1630.12237

[3] *Issue Brief: Expanding peer support and supporting the peer workforce in mental health*. (2024, June 1).

[4] *Issue Brief: Expanding peer support and supporting the peer workforce in mental health*. (2024, June 1).

[5] NAMI. (2024, February 7). *When trauma is triggered at work | NAMI: National Alliance on Mental Illness*. NAMI. https://www.nami.org/recovery/when-trauma-is-triggered-at-work/

mainstream workforce, such as Employee Assistance Programs, as they prefer to talk with someone who understands and relates to their experience.

Currently there is no centralized resource or system in San Mateo County for peer workers who experience workplace-related distress to receive non-clinical, recovery-oriented support. Peers in the workforce need a safe and supportive environment to discuss challenges at work that gives them confidentiality and autonomy in decision making regarding their mental health care supports and services. In addition to supervision and meeting with one's own clinical providers, a comprehensive set of workplace benefits for peer workers should include a formal pathway for workplace support from other peers. The idea for an INN project to establish peer support for peer workers was proposed by a peer-run organization in San Mateo County that has witnessed the need for peer support firsthand and has provided this type of support internally in an informal way. San Mateo County Behavioral Health and Recovery Services (BHRS) prioritized the need to address this gap because peer support workers who are well and feel supported are better able to engage in behavioral health system transformation and the delivery of high-quality services that impact positive behavioral health outcomes for clients.

Client Stories

One New Heartbeat, a local peer-run non-profit organization shared several first-person stories from peer support workers who have experienced work-related stressors and found themselves in need of supports within the context of their role in the behavioral health workforce.

As a peer support worker, I often find myself deeply invested in the well-being of those I support, which can sometimes leave me feeling emotionally overwhelmed. The stories I hear and the challenges I witness resonate deeply with my own experiences, and while this connection fuels my passion for the work, it can also take a toll on my emotional resilience. There are days when the weight of others' struggles feels like it merges with my own, creating an emotional heaviness that's hard to shake. In these moments, I don't necessarily need advice or solutions; I just need a safe, nonjudgmental space where I can process and release my feelings.

Having the opportunity to journal out loud—whether by talking to someone who simply listens or by sharing my thoughts openly without fear of judgment—helps me find clarity and regain balance. It's not about finding answers but about feeling heard, validated, and understood. Peer support in these moments offers a kind of connection and grounding that reminds me I'm not alone in navigating the complexities of this work. It creates a space where I can honor my emotions and move forward with renewed strength and focus.

My work as a Peer Supporter is one of the greatest joys of my life. Being there for others in the way I wished someone had been there for me during my own struggles brings a deep sense of purpose and fulfillment. It allows me to transform my lived experiences into something meaningful, offering hope and support to those navigating their own challenges. This role not only empowers others but also gives me the perspective that the difficulties I endured had a purpose—they equipped me to walk alongside others in their healing journey. However, there are times when, after giving so much of myself—listening, holding space, and supporting others—I realize I have unmet needs of my own. I often find myself yearning for someone to extend the same listening ear and safe space that I provide to others. Without it, I can feel emotionally depleted, making it hard to rest, recharge, and show up fully for the work I love. Having a space where I can share my thoughts without fear of judgment, simply to be heard and

supported, is not just a want but a necessity for my well-being and ability to continue showing up with compassion and presence.

As a peer support worker, one of the biggest challenges I faced was being left alone to support a community member going through a difficult time, while my coworkers chose to step away. Having been in a similar position myself, I understood how important it was to be there for this person, even when others were unwilling to help. However, this situation also made me realize how crucial it is for peer support workers to have support themselves. I recognized that we can't effectively support others if we aren't being supported as a team. I shared my concerns with my supervisor, and together we developed a plan to ensure peer support workers had regular check-ins, breaks, and a system for backup when needed. This experience was a turning point for me, reinforcing that the work we do requires mutual support, both for the people we help and for ourselves as caregivers.

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.

The proposed project will fill a gap in workplace support available to peer workers (which include individuals with lived experience and their family members) by creating a peer support team of trained peers to provide on-demand support for peers and family support staff who are in the workforce and experience work-related distress related to their role. Services will include one-on-one, non-clinical support to listen, empathize, and share coping strategies for navigating their wellness needs at work, as well as referrals to additional support within and outside of BHRS as needed. The project will support behavioral health workforce development priorities as peers become more supported, stable and well, leading to higher job satisfaction and retention rates, better work-life balance, improvement in services provided, and a decrease in burnout, vicarious trauma, and compassion fatigue. Through providing education and coping strategies for recovery in a non-judgmental setting, the project also intends to reduce internalized stigma among peer workers.

The project aligns with the county's transition to BHSA by expanding a culturally informed and well trained and supported behavioral health workforce. The project will strengthen the foundation for integrating peers in the workforce, service delivery and behavioral health reform, which will ensure high-quality delivery of new services for the most vulnerable and at-risk individuals. The project will serve as a demonstration project to study and refine a peer support model for peer workers. If successful, it can become a model used throughout the state for supporting peer workers. See the INNOVATION PROJECT SUSTAINABILITY section below for more detail on how the project aligns with the transition to BHSA.

Referral and Enrollment

- The program will be monitored by the BHRS Office of Consumer and Family Affairs (OCFA) and outreach will be conducted to local nonprofits that employ peers and family support workers, as well as the over 19 BHRS OCFA peer workers across the County behavioral health department.

- All referrals will be self-referrals. Anyone who identifies as a peer or family member and is employed as a peer worker (certified or not) can contact the program.

Services

- **On-demand non-clinical support.** A peer support team composed of certified Peer Specialists and Supervisors will provide non-clinical, confidential, recovery-oriented support for work-related distress that may impact a peer worker's wellness. Services will be provided by peers, for peers, via one-on-one sessions held in the moment that a peer worker contacts the service.
    - Services will be offered virtually during and after work hours and on weekends. A phone line and online support referral mechanism will be developed.
    - Services will be available in English and Spanish. The program will develop a plan to support peers that may need another language, e.g., using a language line.
    - Peer support providers will receive training including trauma-informed care, conflict resolution, de-escalation techniques, boundaries, ethics, Mental Health First Aid (MHFA), vicarious trauma, and stress management (many of the trainings that peer workers already receive for their role as a peer specialist will apply to how they support other peer staff).
    - This non-clinical support is to provide respite before a crisis; it is not intended for crisis care nor does it replace the role of clinical counseling. Providers will be trained in crisis intervention and will refer participants to external support if they are in a crisis.
    - There will not be a limit on the number of sessions or duration of services that peer workers can participate in; however, if the peer support team notices that a peer worker is using the team frequently or repeatedly, they will have a conversation with the individual about whether there could be a need for a higher level of support to address the issues that individual is facing.
- **Referrals and resources.** In the event that a peer worker needs more support than the peer support team provides, they will engage peers in a discussion to identify the most appropriate support (e.g., therapist, psychiatrist, Employee Assistance Programs, cultural healing resources, etc.).
    - If an individual does not already have a care team (e.g., psychiatrist, therapist), the peer support team will be able to provide a list of resources for behavioral health support and/or refer individuals to the BHRS system.
    - The peer support team may refer individuals to their employer mediation process and/or a community resources (Peninsula Conflict Resolution) if the participant is experiencing an issue/conflict with a supervisor or staff in the workplace.

Staff and contractors

- **Program Manager**. The program will have a program manager who will:
    - Reach out to BHRS and contracted organizations in the county to make them aware of the resource, which could include making presentations in various workplaces.
    - Create a self-referral form and keeping track of referrals into the program.
    - Monitor the number of sessions held per individual.
    - Train peer support providers.
    - Supervise peer support providers in individual and group settings.
- **Peer Support Providers**. The program will have employ peer support providers who will be paid staff or contractors, and who will come from diverse backgrounds, with at least one bilingual Spanish-speaking provider. They will:
    - Assist with outreach to organizations about the program
    - Monitor phone line and online support request form
    - Conduct intakes for individuals requesting support

- Provide one-on-one support sessions
- Refer participants to supports serving individuals with behavioral health challenges and their families members
- Participate in individual and group supervision

Advisory Group

A small advisory group of peers, clients, family members, and community organizations will be established early in the program start-up. The advisory group will inform all aspects of the program including the program structure and services, outreach strategies, evaluation and dissemination of the findings of the innovation. Stakeholders will continue to play a critical role in the evolution of this project.

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

This project makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population.

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.

The peer support for peer worker approach is appropriate for two main reasons:

1. Peer support is an evidence-based practice that can be extended to the context of peer workers themselves. As SAMHSA and counties have lifted up the importance of peer support, it is only natural that peer workers themselves also receive support from their peers. Several sources report that peer support offerings in the workplace are beneficial for employee mental health (see the "Research on INN Component" section below). In San Mateo County, this type of support is already being provided in informal ways within peer-run behavioral health organizations; this project will allow BHRS to test and formalize the model.
2. There is precedent for the peer support model in the broader workforce. Outside of the common Employee Assistance Program model, some employers offer peer support teams wherein colleagues provide support to one another in the workplace. In these models, a group of colleagues volunteers to serve in a peer support role and receives training to assist colleagues experiencing personal distress through emotional support, coping strategies, and referrals to resources. An impetus for these models is that many employees feel more at ease sharing their concerns with a peer who understands their situation, and may be more likely to trust a coworker who can provide relatable advice.[6]

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

[6] Kratz, R., LCSW. (n.d.). *Peer support: Building up from the inside out | Social Work Today magazine*. https://www.socialworktoday.com/news/pp_070918.shtml

The project will serve an estimated 25-50 peer support workers annually. This number comes from estimating capacity to provide services in a manageable and meaningful way that aligns with the number of peer workers currently in San Mateo County. We estimate it will be reasonable for the program manager to supervise three part-time peer support providers, and for each provider to hold 1-3 support sessions per week, with some sessions being with repeat participants. BHRS currently employs about 20 peer/family support workers.

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

The target population will be peers and family support workers in behavioral health agencies. Peer support will be available to all peer and family support staff working within BHRS and community-based organizations. There is currently no centralized resource for collecting demographics of peer/family support workforce in San Mateo County. Demographics will be collected as part of this project. In a 2023 national survey of peer support specialists, 65.3% of peer support specialists respondents identified as White/Caucasian, 19% identified as Hispanic, 12.4% identified as Black/African American, and 0.8% identified as Native American.[7]

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 project will apply new understandings of how to support and sustain fidelity to peer support practices, values, and ethics that transform the culture of the organization and quality of support provided to people in recovery. The project will do so by applying a peer support model to the peer worker context, which has not been done before. As described below, peer support may be part of a benefits program available to employees in broader workplace settings, and are generally workplace-specific (i.e., within a particular company or organization). This project will build upon the ways that peer workers have been informally supporting one another within peer-run behavioral health organizations, in order to create a centralized peer support team for all peer/family member workers in the county.

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.

BHRS conducted an extensive online search and literature reviews of workplace peer support programs and identified the following gaps in practice and in the literature.

[7] Collier, K.M., Halvorsen, C.J., and Fortuna, K.L. (2023). Assessing Mental Healthcare Worker Experiences of Workplace Fairness and Organizational Value: A National Survey of Peer-Support Specialists, Volume 72, Issue 1. https://doi.org/10.1177/21650799231200

Gaps in Practice

Workplace peer support programs exist in settings outside the behavioral health field (i.e., work that does not pertain to behavioral health) and in the health and behavioral fields (e.g., nurses, social workers).[8] These include workplace peer-support programs, often called Peer Support Teams or Peer Support Programs, as well as peer-run Employee Assistance Programs.

Peer Support Teams are structured programs that train employees who have lived experience with behavioral health challenges to help co-workers who are facing similar issues. The trained peer support employees are people who have empathy for those struggling because they have experienced similar issues in their own lives.[9] After training, peers and coworkers provide education, training, assistance, and referrals. These programs are non-clinical and not meant to replace professional therapy.[10] Most Peer Support Teams are described as being in-house at a specific company or organization. Recently some online resources have been developed, including Togetherall, a peer-to-peer online mental health support community available that workplaces can use for their employees.[11]

Employee Assistance Programs (EAPs) offer an array of services designed to support employee wellbeing, including emotional and mental health, stress management, grief counseling, substance abuse intervention, family and relationship issues, and legal and financial guidance.[12] **Peer-run EAPs** are mentioned by websites related to Human Resources, but our research did not find any examples of peer-run EAPs in the country. In practice, peer-run EAPs appear to be similar to the Peer Support Team model, given that peer-based EAPs do not appear to offer counseling by professionally trained counselors as traditional EAPs do, but rather can serve as a referral pathway to professional EAP services.

Peer Support Teams and EAPs are distinct in several ways. Peer Support Teams are generally available on-site or nearby and offer immediate and short-term support after a critical incident, while EAPs may require an appointment or a referral and may be located on-site or off-site. Peer Support Teams and EAPs also provide different levels and types of support: Peer Support Team can offer immediate and informal support, while EAPs can offer comprehensive and professional support. Peer Support Teams can also help employees access EAPs or other resources.[13]

Gaps in Literature

Research has discussed barriers to peers' work, including role ambiguity to stigma, but there has been limited research on factors that *support* peers' work; in one study, peers emphasized two factors that facilitate their work: healthy personal coping strategies and strong workplace supports. They valued having peer colleagues and peer-led organizations, noting how shared experiences of substance use and recovery

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[8] Pace, E. (2002). The Employee Assistance Program as a model of care for addicted colleagues: Peer Assistance, by nurses for nurses. *Drugs and Alcohol Today*, *2*(3), 41–48. https://doi.org/10.1108/17459265200200025

[9] Prince, J. (n.d.). *DiversityPlus. The power of peer support to improve mental health in the workplace*. DiversityPlus. https://diversityplus.com/web/Article.aspx?id=The-Power-of-Peer-Support-to-Improve-Mental-Health-in-the-Workplace-5161

[10] Goth, G. (2023, December 21). Peer support strengthens mental health offerings. *SHRM*. https://www.shrm.org/topics-tools/news/benefits-compensation/peer-support-strengthens-mental-health-offerings

[11] https://togetherall.com/en-us/faqs/about-togetherall/

[12] *What is an employee assistance program (EAP)? | Global HR glossary | Oyster®*. (n.d.). https://www.oysterhr.com/glossary/employee-assistance-program

[13] *What are the best practices for collaborating with EAP providers when dealing with critical incident stress?* (n.d.). https://www.linkedin.com/advice/0/what-best-practices-collaborating-eap

created a unique support system. For peers who lack such support at work, the authors of the study suggested "peer networks" as an alternative. [14]

There have been studies of the positive benefits of workplace peer support programs for healthcare workers,[15] law enforcement officers,[16] and in general workplace environments, which indicate that workplace peer support programs may improve employees' wellbeing and relationships between employees.[17] In a study of peer support among law enforcement officers, participants found the program helpful in normalizing experiences, increasing hope, and decreasing stigma, and the program also helped connect participants to mental health services.[18] While this literature is promising, there are no studies on how peer support teams would be applied with the peer workforce itself, nor on program outcomes for peer support teams for peer workers.

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 an independent evaluation, this project seeks to learn the following. If the project is successful, it will culminate with a **toolkit** for other jurisdictions that wish to implement this model.

1. Does providing non-clinical peer support for peer/family support workers help to **sustain the peer workforce**?
    a. *Reason:* In order for peers to become embedded in the behavioral health workforce in a sustainable and successful way, it is essential to integrate the unique types of support that the peer workforce needs. This learning goal will explore the outcomes of peer/family support workers and the peer support experience as a result of the program, including but not limited to self-reported outcomes related to wellbeing and recovery and employment-related outcomes such as longevity in their position.
2. Does providing non-clinical peer support for peer/family support workers **strengthen the quality of services** provided by peers?
    a. *Reason:* In addition to learning how peers feel supported by peer support, it will be important

[14] Brady, L. A., Wozniak, M. L., Brimmer, M. J., Terranova, E., Moore, C., Kahn, L., Vest, B. M., & Thomas, M. (2022). Coping Strategies and Workplace Supports for Peers with Substance Use Disorders. *Substance Use & Misuse*, *57*(12), 1772–1778. https://doi.org/10.1080/10826084.2022.2112228

[15] Pace, E. (2002). The Employee Assistance Program as a model of care for addicted colleagues: Peer Assistance, by nurses for nurses. *Drugs and Alcohol Today*, *2*(3), 41–48. https://doi.org/10.1108/17459265200200025

[16] Fallon, P., Jaegers, L. A., Zhang, Y., Dugan, A. G., Cherniack, M., & Ghaziri, M. E. (2023). Peer support programs to reduce organizational stress and Trauma for public safety workers: A scoping review. *Workplace Health & Safety*, *71*(11), 523–535. https://doi.org/10.1177/21650799231194623

[17] Agarwal, B., Brooks, S. K., & Greenberg, N. (2019). The role of Peer support in Managing Occupational stress: A Qualitative study of the Sustaining Resilience at Work intervention. *Workplace Health & Safety*, *68*(2), 57–64. https://doi.org/10.1177/2165079919873934

[18] Fallon, P., Jaegers, L. A., Zhang, Y., Dugan, A. G., Cherniack, M., & Ghaziri, M. E. (2023). Peer support programs to reduce organizational stress and Trauma for public safety workers: A scoping review. *Workplace Health & Safety*, *71*(11), 523–535. https://doi.org/10.1177/21650799231194623

to understand how receiving support has a downstream effect on client services.

3. What are the components of peer support for peer/family support workers that are effective and could be **scaled and replicated,** including possible billable services?
    a. *Reason:* As behavioral health departments statewide and nationally seek to sustain their peer workforce, this project has the potential to offer a model for a centralized, formalized approach for supporting the peer/family support workforce. With the statewide behavioral health reform, there is also an opportunity to determine whether this model could be sustained by enabling Medi-Cal billling.

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

The table below describes the gaps in literature and practice and the new practices that the proposed learning goals will address.

Gaps in the literature and practice	Proposed intervention and opportunities for learning	Learning Goal
• Effectiveness of peer support teams in a peer worker context • Effectiveness of peer/family worker peer support on staff retention • Effectiveness of peer/family worker support on reported wellbeing/recovery indicators	• Develop peer worker peer support team • Train peer support team providers to provide education and coping strategies related to recovery challenges and workplace challenges • Integrate peer support team as an employee benefit across BHRS and community-based organizations that employ peers and family support workers	1. Does providing non-clinical peer support for peer/family support workers help to **sustain the peer workforce**?
• Effectiveness of peer support team in changing knowledge, skills, and behaviors in the workplace	• Train peer support team providers to provide education and coping strategies related to recovery challenges and workplace challenges	2. Does providing non-clinical peer support for peer/family support workers **strengthen the quality of services** provided by peers?
• Peer support teams as a potential for a centralized model to support a county's peer workforce	• Opportunities to define the program model through implementation and outcome evaluation • Toolkit with best practices for implementing the model	3. What are the components of peer support for peer/family support workers that are effective and could be **scaled and replicated,** including possible billable services?

EVALUATION OR LEARNING PLAN

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

An independent evaluation consultant will be contracted and monitored by the MHSA Manager in collaboration with the BHRS program monitor to formally evaluate the innovation project. The following depicts a rough evaluation plan given that the consultant will be hired after the project is approved. A Theory of Change, Appendix 1. was also developed to support the evaluation and learning plan.

Learning Goal	Potential Measures	Potential Data Sources
1. Does providing non-clinical peer support for peer/family support workers help to **sustain the peer workforce**?	✓ Number of participants served ✓ Self-reported outcomes related to wellbeing and recovery, such as: level of stress at work, confidence in coping strategies at work, connection to/use of behavioral health services ✓ Number of referrals made for participants to external resources ✓ Self-reported employment-related outcomes such as: likelihood of remaining in position, likelihood of recommending peer role to others ✓ Pre/post program staff retention rates for organizations that employ peers and family support workers	✓ Baseline burnout and job retention survey for peer support workers ✓ Program data ✓ Participant post-survey ✓ Participant interviews ✓ Peer support provider focus group/interviews ✓ Peer support manager interview ✓ Organization pre/post survey
2. Does providing non-clinical peer support for peer/family support workers **strengthen the quality of services** provided by peers?	✓ Self-reported changes in knowledge, skills, and behaviors (e.g., skills in handling role ambiguity and maintaining boundaries)	✓ Participant post-survey ✓ Participant interviews ✓ Peer support provider focus group/interviews ✓ Peer support manager interview ✓ Organization pre/post survey
3. What are the components of peer support for peer/family support workers that are effective and could be **scaled and replicated,** including possible billable services?	✓ Self-reported most useful components ✓ Identified opportunities for potential system change and Medi-Cal billing	✓ Participant survey ✓ Participant interviews ✓ Peer support provider focus group/interviews

		✓ Peer support manager interview ✓ Interviews with other counties and DHCS

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

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

All BHRS service agreements (contracts, MOUs) are monitored by a BHRS Manager that has the subject matter expertise. Contract monitors check-in at least monthly with service providers to review challenges, successes, troubleshoot and stay up-to-date on the progress of the project. Additionally, reporting deliverables are set in place in the agreements and linked to invoicing. Payments of services are contingent on the reporting. Evaluation contracts are monitored in a similar fashion by the MHSA Manager in collaboration with the assigned BHRS Manager.

COMMUNITY PROGRAM PLANNING

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

In San Mateo, the CPP process for Innovation Projects begins with the development of the MHSA Three-Year Plan. A comprehensive community needs assessment process determines the gaps, needs and priorities for services, which are used as the basis for the development of Innovation projects. One of San Mateo County's current MHSA Three-Year Plan strategies includes to *expand type, flexibility, and access to staff wellness and engagement opportunities (e.g., appreciation, healing activities, mentoring, behavioral health supports)*, which includes peer/family support staff. The Peer Support for Peer Workers addresses this priority. Appendix 2. includes the MHSA Three-Year Plan CPP process and Strategy Recommendations.

Additionally, BHRS conducted a participatory process to gather a broad solicitation of innovation ideas. The proposed project was identified in the 2022 MHSA Innovation (INN) stakeholder submission process and is being brought forward for the current round of INN funding as the County transitions to the BHSA.

<u>Initial INN Idea Solicitation Process in 2022</u>

- ✓ Jan-Feb 2022: BHRS conducted outreach and convened a workgroup with community members and service providers including people with lived experience and family members.
- ✓ Feb-Apr 2022: The workgroup met three times in the beginning of the year to develop the idea stakeholder participation process. BHRS wanted the submission process to be as *inclusive* and as *accessible* as possible so that a broad range of community members would submit project ideas.
- ✓ May-June 2022: Based on ideas from the workgroup, BHRS developed frequently asked questions about INN and requirements for INN projects; created "MythBusters" to demystify the submission

process; and developed an outreach plan to inform community members about this opportunity. The submission form asked submitters to describe how their project addressed the MHSA Core Values as well as San Mateo County's MHSA Three-Year Plan prioritized needs. BHRS created a comprehensive submission packet with this information, a user-friendly submission form, and the scoring criteria.

✓ Jun-July 2022: BHRS opened the submission process and conducted outreach to the community, along with workgroup members and partners. Because of the ongoing COVID pandemic, outreach was largely electronic and word-of-mouth.
  - Announcements at numerous internal and external community meetings;
  - Announcements at program activities engaging diverse families and communities (Parent Project, Health Ambassador Program, Lived Experience Academy, etc.);
  - E-mails disseminating information to over 3,000 stakeholders;
  - Word of mouth on the part of committed staff and active stakeholders,
  - Postings on a dedicated MHSA webpage smchealth.org/bhrs/mhsa, the monthly BHRS Director's Update.

✓ June-July 2022: As part of the outreach strategy, BHRS held an online information session. BHRS also held a session on "online research" to provide submitters with tips for how to search online for data and research for their submission. These were recorded and available on the MHSA website. The submission window was open for six weeks in June and July. Throughout that time, BHRS held technical assistance/support sessions that potential submitters could join to talk through aspects of their idea. Submitters were highly encouraged to attend a support session.

✓ July-August: BHRS received 19 ideas. All submitted ideas were pre-screened against the Innovation requirements, and 14 ideas moved forward to review. BHRS created a selection workgroup of four people, including BHRS staff, nonprofit providers, and people with lived experience, who reviewed proposals and scored them based on the identified criteria. BHRS also conducted an internal feasibility review that included preliminary feedback from the Mental Health Oversight and Accountability Commission (MHSOAC). From there, four INN ideas moved forward to develop into full INN project proposals that were ultimately approved by the MHSOAC and are currently being implemented.

✓ The current project was not selected at that time; BHRS informed proposers that the idea might be revisited in the future if additional funding became available.

<u>2024 INN Idea Selection Process</u>

✓ With the availability of funding for new INN projects to be approved in the current fiscal year, BHRS sought to identify potential INN projects from its 2022 idea submission round that would meet current needs and align with the priorities of the BHSA.

✓ BHRS staff reviewed the 14 ideas that had been pre-screened in 2022 against the Innovation requirements. In order to prioritize INN projects that could be sustained under the BHSA, staff screened the 14 ideas to identify projects that included treatment/recovery and/or early intervention services. Most project ideas were in the area of prevention; five ideas included components of early intervention, treatment, and/or recovery.

✓ BHRS conducted an internal feasibility review of the five projects, and determined to move forward with two of the INN proposals based on BHRS capacity and priorities for the BHSA transition. In addition, BHRS decided to move forward with two multi-county collaborative INN projects.

✓ On September 5, 2024, the MHSA Steering Committee met to review the two community-derived INN ideas, and the two multi-county collaborative projects, and provide comment and considerations for the projects through breakout room discussions and online comment forms.

✓ The Behavioral Health Commission voted to open the 30-day public comment period on October 2, 2024 and reviewed comments during the public hearing and closing of the public comment period on November 3, 2024. All public comments received are summarized in Appendix 3.

MHSA GENERAL STANDARDS

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

A) **Community Collaboration**. The peer support team will collaborate closely with San Mateo County BHRS, the Office of Consumer and Family Affairs (OCFA) and its peer programs, and nonprofit organizations, to share information about the program and to create a seamless experience for peers/family support workers to receive support, and to be linked to additional support services within and outside of BHRS as needed.

B) **Cultural Competency**. The peer support team will provide culturally informed services, with at least one bilingual (English-Spanish) staff member, and capacity to use a language line to serve peers/family support workers who speak other languages. The program will employ predominantly BIPOC staff who have lived experience with substance use, recovery, and mental health issues.

C) **Client/Family-Driven**. An elemental concept in the MHSA is that counties develop a "...Consumer and family-driven system [in which] consumers identify their needs and preferences which lead to the programs and providers that will help them most. Their needs and preferences drive the policy and financing decisions that affect them." This includes the voice of the peers in existing BHRS committees, initiatives, and workgroups and their role as core members of the behavioral health workforce. The peer support team will provide an effective and efficient vehicle to promote this concept in San Mateo County.

D) **Wellness, Recovery, and Resilience-Focused**. The peer support team is built upon the fact that recovery is a journey and there will be times in one's recovery where additional support is needed. As such, the program will be rooted in a peer-led recovery model that promotes wellness, recovery, mental and physical health, self-empowerment, hope, determination, connectedness, self-responsibility, and purpose.

E) **Integrated Service Experience for Clients and Families**. The peer support team will conduct outreach and collaboration with BHRS and community-based providers to ensure that the services are promoted and made available to peer and family employees of these agencies. The peer support team will also make referrals and linkages to BHRS and community-based resources for external 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 evaluation contractor will engage the project advisory group of diverse peers, clients, family members and providers to gather input on the evaluation questions, strategies and on quarterly progress reports. Cultural and language demographics will be collected and analyzed as part of the quarterly reports to ensure equal access to services among racial/ethnic, cultural, and linguistic populations or communities. The quarterly reports will be used to inform and adjust as needed the direction, outreach strategies and activities.

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.

Contracted service providers for this program will be required to develop a sustainability plan that is vetted and informed by the advisory group with the goal of leveraging diversified funding for the ongoing needs of the program including opportunities for Medi-Cal billing. The advisory group will be engaged in sustainability planning for the project at minimum one year in advance of the innovation end date. Individuals with serious mental illness or others requiring ongoing behavioral health supports will be connected with the local BHRS clinic and/or existing local service providers.

If the evaluation indicates that the proposed project is successful and an effective means of supporting peer/family support workers, BHSA funding can be an option for sustainability, a proposal of continuation would be brought to the BHSA Steering Committee and the Behavioral Health Commission for approval and to a 30-day public comment process to secure ongoing BHSA Behavioral Health Services and Supports funding. There is also an opportunity to determine whether this model could be sustained by enabling peer support team services to bill to Medi-Cal.

The following table includes responses to the MHSOAC's questions regarding how new INN proposed projects will align with the transition to BHSA, be sustained, and provide continuity of care.

BHSA Transition Questions	Response
How does the proposal align with the BHSA reform?	As BHSA increases a focus on treatment and housing services, having a strong peer workforce will support the delivery of high-quality services. In this way, the project will aid in transforming the behavioral health system to serve the "most ill, unsheltered, and vulnerable" populations in the county.
Does it provide housing interventions for persons who are chronically homeless or experiencing homelessness or are at risk of homelessness?	Yes, peer support workers are an integral part of the behavioral health workforce supporting unhoused individuals with housing navigation and ongoing housing maintenance. Peer workers that are supported are better able to provide high-quality services for persons who are chronically homeless or experiencing homelessness or are at risk of homelessness.
Does it support early intervention programs or approaches in order to prevent mental illnesses and substance abuse disorders from becoming severe and disabling?	No
Does it support Full-Service Partnership efforts and services for individuals living with serious mental illness?	Yes, FSP staffing models require peer support workers as an integral part of the treatment team. Peer workers that are supported are better able to provide high-quality services for FSP clients and their family members.
How will the County continue the project, or components of the project, after its completion without the ability to utilize certain components of MHSA funding for sustainability?	The pilot project will include a deliverable to develop a sustainability plan that is vetted and informed by an established advisory group for the pilot term. The goal of the plan will be to leverage diversified funding for ongoing sustainability of the program including funding opportunities for behavioral health workforce initiatives, Medi-Cal billing if approved, Behavioral Health Services and Supports, and/or FSP funds (for peer support workers in these programs) can be used. The advisory group will be engaged in sustainability planning for the project at minimum one year in advance of the innovation end date. If the innovation evaluation indicates that the proposed project is successful and an effective means of supporting peer support workers and improving client care, a proposal of continuation would be brought to the BHSA Community Program Planning process.

BHSA Transition Questions	Response
How does the project assist the county's transition to the behavioral health reform?	BHSA prioritizes workforce initiatives that expand culturally informed and well trained and supported behavioral health workforce. The project will strengthen the foundation for integrating peers in service delivery and behavioral health reform, which will ensure high-quality delivery of new services created for the most vulnerable and at-risk individuals.

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?

MHSA implementation is very much a part of BHRS' day-to-day business. Information is shared, and input collected with a diverse group of stakeholders, on an ongoing basis. All MHSA information is made available to stakeholders on the MHSA webpage, www.smchealth.org/bhrs/mhsa. The site includes a subscription feature to receive an email notification when the website is updated with MHSA developments, meetings and opportunities for input. This is currently at over 2,000 subscribers.

The BHRS Director's Update is published the first Wednesday of every month and distributed electronically to county wide partners and stakeholders, and serves as an information dissemination and educational tool, with a standing column written by the County's MHSA Manager. The BHRS Blog also provides a forum for sharing and disseminating information broadly. In addition, presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the quarterly MHSA Steering Committee meeting; at meetings with community partners and advocates; and internally with staff.

Opportunities to present at statewide conferences will also be sought.

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. Peer support worker
2. Peer support team
3. Staff retention
4. Workforce development
5. Peer-to-peer

TIMELINE

A) Specify the expected start date and end date of your INN Project: July 1, 2025 – June 30, 2029

B) Specify the total timeframe (duration) of the INN Project: 4 years (3 years of services, 6 months start-up, 6 months post eval)

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

Quarter	Key Activities, Milestones, and Deliverables
Mar-Jun 2025	• BHRS Administrative startup activities – procurement and contract negotiations
July-Dec 2025	• Hire and train staff • Hire and train peer support team providers • Convene project advisory board • Develop participant intake and follow-up forms • Set up infrastructure for implementation/ evaluation and referral system and resources • Evaluator to meet with contractor and BHRS staff to discuss evaluation plan and tools • Begin outreach to BHRS and community-based organizations that services will start in January
Jan-Mar 2026	• Begin services to participants • Data tracking and collection begins, including qualitative data collection (interviews, focus groups, etc.)
Apr-Jun 2026	• Continue services to participants • Data tracking and collection • First 6 months post-launch evaluation report presented to advisory group for input, adjustments to strategies, tools and resources based on operational learnings to-date and quantitative data available • Make adjustments to the program approach and services as needed
Jul-Sept 2026	• Continue services to participants • Data tracking and collection
Oct-Dec 2026	• Continue services to participants • Data tracking and collection
Jan-Mar 2027	• Continue services to participants • Data tracking and collection • Sustainability planning begins
Apr-Jun 2027	• Continue services to participants • Data tracking and collection • Second evaluation report presented to advisory group for input, adjustments to strategies, tools and resources based on quantitative and qualitative data.
Jul-Sept 2027	• Continue services to participants • Initial sustainability plan presented, begin exploring options for sustainability • Engage the BHSA Steering Committee and the Behavioral Health Commission through MHSA Community Program Planning (CPP) process on continuation of the project with BHSA Behavioral Health Services and Supports funds.
Oct-Dec 2027	• Continue services to participants • Data tracking and collection

Jan-Mar 2028	• Continue services to participants • Data tracking and collection
Apr-Jun 2028	• Continue services to participants • Data tracking and collection • Third evaluation report presented to advisory group for input, adjustments to strategies, tools and resources based on quantitative and qualitative data.
Jun-Dec 2028	• Complete evaluation activities, prepare analysis and final evaluation report due to the MHSOAC December 2028
Jan-Mar 2029	• Finalize replicable best practice model to share statewide and nationally • Disseminate final findings and evaluation report

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

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

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

BUDGET NARRATIVE

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

The total Innovation funding request for 4 years is **$580,000**, which will be allocated as follows:

Service Contract: $450,000	**Evaluation: $75,000**	**BHRS Administration: $55,000**
· $150,000 for FY 25/26 · $150,000 for FY 26/27 · $150,000 for FY 27/28	· $25,000 for FY 25/26 · $20,000 for FY 26/27 · $20,000 for FY 27/28 · $10,000 For FY 28/29 (6mths)	· $10,000 for FY 24/25 (6 mths) · $15,000 for FY 25/26 · $12,000 for FY 26/27 · $12,000 for FY 27/28 · $6,000 FY 28/29 (6 mths)

Direct Costs will total $450,000 over a three-year term and includes all contractor expenses related to delivering the program services (salaries and benefits, program supplies, rent/utilities, mileage, translation services, subcontracts, etc.).

Indirect Costs will total $130,000

- $75,000 for an independent evaluation contract to develop all annual reports and the final report due by December 31, 2029. The evaluation contract includes developing the evaluation plan, supporting data collection, data analysis and preparing the annual and final reports required.

- $55,000 for BHRS county business, procurement processes, contract monitoring, fiscal tracking, IT support, and oversight of the innovation project.

Federal Financial Participation (FFP) there is no initial anticipated FFP. Opportunities for Medi-Cal billing if approved (as a CalAim Community Support or through Housing Interventions) will be pursued.

Other Funding: The County will go through a local bidding process to identify the contractor for direct services; the bidding process will inquire about any in-kind or other revenue sources that can be leveraged.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
	PERSONNEL COSTS (salaries, wages, benefits)	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**TOTAL**
1.	Salaries						
2.	Direct Costs						
3.	Indirect Costs	$10,000	$15,000	$12,000	$12,000	$6,000	**$55,000**
4.	**Total Personnel Costs**	**$10,000**	**$15,000**	**$12,000**	**$12,000**	**$6,000**	**$55,000**
	OPERATING COSTS*						
5.	Direct Costs						
6.	Indirect Costs						
7.	**Total Operating Costs**						**$**
	NON-RECURRING COSTS (equipment, technology)						
8.							
9.							
10.	**Total non-recurring costs**						**$**
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)						
11.	Direct Costs		$150,000	$150,000	$150,000		**$450,000**
12.	Indirect Costs		$25,000	$20,000	$20,000	$10,000	**$75,000**
13.	**Total Consultant Costs**		**$175,000**	**$170,000**	**$170,000**	**$10,000**	**$525,000**
	OTHER EXPENDITURES (please explain in budget narrative)						
14.							
15.							
16.	**Total Other Expenditures**						**$**
	BUDGET TOTALS						
	Personnel (total of line 1)						**$**
	Direct Costs (add lines 2, 5, and 11 from above)		$150,000	$150,000	$150,000		**$450,000**
	Indirect Costs (add lines 3, 6, and 12 from above)	**$10,000**	$40,000	$32,000	$32,000	$16,000	**$130,000**
	Non-recurring costs (total of line 10)						**$**
	Other Expenditures (total of line 16)						**$**
	TOTAL INNOVATION BUDGET	**$10,000**	**$190,000**	**$182,000**	**$182,000**	**$16,000**	**$580,000**

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

BUDGET CONTEXT – EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures <u>for administration</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**TOTAL**
1.	Innovative MHSA Funds	$10,000	$165,000	$162,000	$162,000	$6,000	$505,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	**Total Proposed Administration**						**$505,000**
EVALUATION:							
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**TOTAL**
1.	Innovative MHSA Funds		$25,000	$20,000	$20,000	$10,000	$75,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	**Total Proposed Evaluation**						**$75,000**
TOTALS:							
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 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**TOTAL**
1.	Innovative MHSA Funds*	$10,000	$190,000	$182,000	$182,000	$16,000	**$580,000**
2.	Federal Financial Participation						**$**
3.	1991 Realignment						**$**
4.	Behavioral Health Subaccount						**$**
5.	Other funding**						**$**
6.	**Total Proposed Expenditures**	**$10,000**	**$190,000**	**$182,000**	**$182,000**	**$16,000**	**$580,000**
*** INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting** **** If "other funding" is included, please explain within budget narrative.**							

APPENDIX 1. THEORY OF CHANGE

Theory of Change: Peer Support for Peer Workers

Primary Problem: There is a gap in support for peer workers that impacts workforce sustainability and quality of services

Key Considerations (from the literature)

Integration of Peer Workforce

- Peers play an integral role in the behavioral health workforce with new peer certification opportunities

Challenges for Peer Workers

- Peer workers face stress due to unclear boundaries, unclear role expectations, stigma and discrimination, and changes to job tasks after COVID
- Individuals in recovery who are navigating employment need strategies for integrating work, recovery, and wellness

Support Needs

- Peer workers do not have someone outside of their supervisors to go to for work-related distress
- Peers may be unlikely to discuss their own recovery with their supervisor or use programs designed for the mainstream workforce

Interventions

On-Demand Non-Clinical Support

- Peer support team with certified peer specialists and supervisors will provide one-on-one, immediate non-clinical support for work-related distress
- Centered around principles of recovery
- Services offered virtually during and after work hours and on weekends
- Services available in English and Spanish, with language line to support other languages

Referrals and Resources

- As needed, the team will share referrals for behavioral health services, cultural healing resources, and mediation services for workplace conflicts

System Capacity Building

- Toolkit with best practices for implementing the peer support team model

Outcomes

Workforce Satisfaction and Retention

- Peer workers experience improvement in their level of stress at work, confidence in coping strategies at work, and connection to/use of behavioral health services
- Peer workers are more likely to remain in their role and recommend the role to others
- Retention rates for organizations that employ peer workers are stable or improve

Quality of Services

- Peers improve knowledge and skills in their role (e.g., maintaining boundaries)

System Capacity

- There is increased capacity in BHRS to support peer workers
- Other counties/the state have tools to expand capacity for supporting the peer workforce, including possible billable services

Learning Objectives

Learning Goal #1

Does providing non-clinical peer support for peer/family support workers help to **sustain the peer workforce**?

Learning Goal #2

Does providing non-clinical peer support for peer/family support workers **strengthen the quality of services** provided by peers?

Learning Goal #3

What are the components of peer support for peer/family support workers that are effective and could be **scaled and replicated**, including possible billable services?

MHSA INN Primary Purpose

Increased quality of behavioral health services

APPENDIX 2. MHSA THREE-YEAR PLAN CPP & STRATEGY RECOMMENDATIONS

MHSA Three-Year Plan, 2020-2023
Community Program Planning (CPP) Process

The MHSA Three-Year Program and Expenditure Plan is developed in collaboration with clients and families, community members, staff, community agencies and stakeholders. In November 2022, a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan commenced and engaged over 400 diverse clients, family members, staff and community agencies and leaders representing geographical, ethnic, cultural and social economic status, providers of behavioral health care services, social services and other sectors across various means of providing input (surveys, input sessions, public comments). Planning was led by the MHSA Manager, Behavioral Health Commission MHSA Co-Chairpersons, an MHSA Three-Year Plan Workgroup and the MHSA Steering Committee. A draft CPP process was provided to the Behavioral Health Commission (BHC) and the MHSA Steering Committee in December 2022. Stakeholders provided input and comments on the process and what additional stakeholder groups should be engaged.

CPP FRAMEWORK

MHSA THREE-YEAR PLAN WORKGROUP

Between November and January 2023, a workgroup was convened made up of diverse stakeholders including clients, family members, community members and contracted service providers. The workgroup met monthly with the goal of co-designing an MHSA 3- Year Plan Community Program Planning (CPP) process that is equitable, inclusive and honors and centers the voices of marginalized communities. The objectives of each meeting included the following:

- Review and advise on data needed to support a comprehensive needs assessment
- Advise on the community input process and community engagement best practices, to ensure it is inclusive of all vulnerable communities
- Support opportunities for all San Mateo County community members to provide input

The MHSA Three-Year Plan Workgroup guided and informed the process each step of the way:

1. Needs Assessment
    - Informed Data Collection resources
    - Advised on the Community Survey structure
2. Strategy Development
    - Informed Community Input Sessions strategy
    - Advised on the creation of a Facilitator Training for stakeholders to support input sessions
    - Facilitated Community Input sessions
3. MHSA Three-Year Plan Development
    - Reviewed the Recommended Strategies for accuracy

COMMUNITY PROGRAM PLANNING PROCESS

1. Needs Assessment – this phase of the CPP process included the following two steps:
    - ✓ Data Review: Over 30 local plans, assessments, evaluation reports, and data were reviewed to identify prominent mental health and substance use needs reported across service sectors and the community. All of the concerns identified in the needs assessment review were categorized into the following 8 areas of need.
        i. **Access to Services** - this category captures the needs of diverse cultures and identities (race/ethnicity, LGBTQIA+, veteran status, age) related to accessing mental health and substance use services, including knowledge and education and culturally responsive approaches to engaging communities.
        ii. **Behavioral Health Workforce** - this category captures the needs related to recruiting, developing, supporting and maintaining a sufficient workforce to address the needs and the diversity of the community. This includes supporting individuals with lived experience as clients and/or family members of clients of mental health and substance use services to join the workforce and support all services and programming.

iii. **Crisis Continuum** - this category captures needs related to mental health and substance use crisis response, as well as appropriate community-based supports and stabilization during and after a crisis.

iv. **Housing Continuum** - this category captures the housing needs for individuals living with mental health challenges ranging from assisted living facilities to having access to permanent supportive housing, to early assessment of risk of homelessness and culturally responsive approaches and support with locating and maintaining housing.

v. **Substance Use Challenges** - this category captures the increasing need for substance use services and supports that are accessible, integrated and coordinated with mental health services.

vi. **Quality of Client Care** - this category captures the needs of clients that are in treatment for mental health and/or substance use challenges to have timely access to care when needed, are successfully connected to services after an emergency and receive culturally responsive approaches to their treatment.

vii. **Youth Needs** - this category is age-based and captures mental health and substance use challenges for school to transition-age youth ages 6-25, it includes recent data for adolescent suicides, juvenile justice involvement, school-based and on-campus supports.

viii. **Adult/Older Adult Needs** - this category is age-based and captures mental health and substance use challenges for adults and older adults, it includes recent data related to increasing complexity of needs, general poor mental health outcomes, and suicide prevention needs.

✓ Community Survey: The identified needs from the review of local plans and data were included in an online survey that was distributed broadly to individuals living or working in San Mateo County. The survey asked respondents to share any additional concerns related to mental health and/or substance. Additionally, the survey requested that respondents rank the 8 areas of need in order of importance.

There were 129 survey respondents to the survey, the Needs Assessment summary of results were presented to the MHSA Steering Committee on February 2, 2023, to launch the Strategy Development phase.

2. Strategy Development – this phase of the CPP process included the following two steps:

✓ Community Input: 31 community input sessions and key interviews with diverse groups and vulnerable populations (immigrant families, veterans and transition-age youth) were conducted. Based on advice from the MHSA Three-Year Plan Workgroup, groups were asked to select 1 of the 8 areas of need to brainstorm strategies in the areas of prevention, direct service and workforce supports.* Participants were asked what possible solutions (services, programs, infrastructure, etc.) would they recommend to address the need they selected. See Appendix 2. for the full list of Strategy Recommendations.

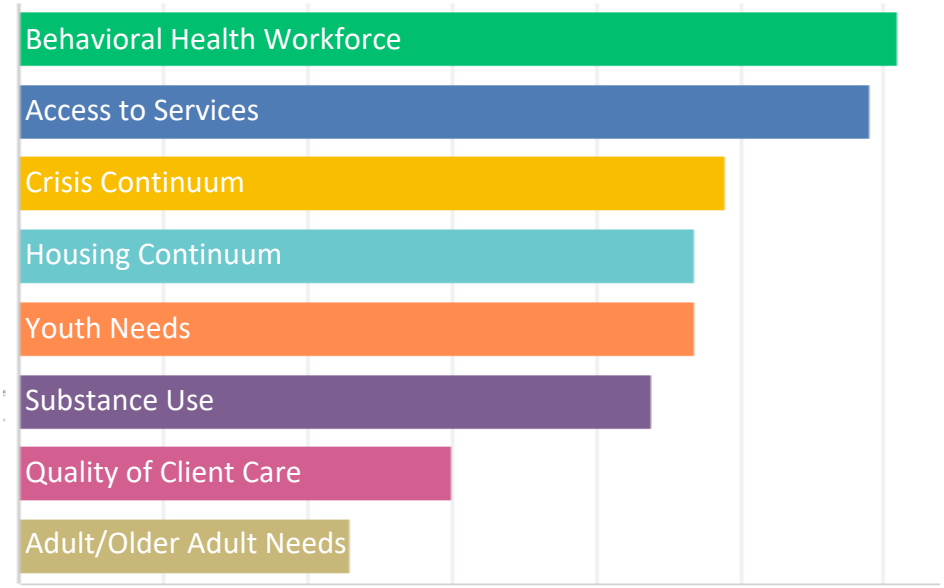
** As part of a simultaneous process to develop the MHSA 3-Year Workforce Education and Training (WET) Plan, 5 additional sessions were conducted to brainstorm around Behavioral Health Workforce strategies with the Diversity and Equity Council, Lived Experience and Education Workgroup, Alcohol and Other Drugs' Contracted Providers and BHRS Adult and Youth Leadership Teams.*

✓ Prioritization: To support the prioritization of strategies, participants were also asked: If you had to select one strategy to focus on over the next 3 years, which would you prioritize? Qualitative data analysis of all input received was conducted to identify the top strategy recommendations and key themes to present to the MHSA Steering Committee on May 4, 2023. Over 1,000 strategy ideas were shared via the Community Input sessions. This was narrowed down to 70 Strategy Recommendations across the 8 areas of need; strategies were included in this list if they were the top prioritized strategy by an input session group, they were repeated across input sessions, and for the areas of need that weren't selected as often by community groups (i.e., crisis continuum, substance use challenges, quality of client care and adult/older adult needs) all strategies that received a prioritization vote during in the input sessions were included.

Additionally, three key themes emerged from the input sessions overall, these strategies were brought up in virtually all input session: 1) Increase community awareness and education about behavioral health topics, resources and services; 2) Embed peer and family supports into all behavioral health services; 3) Implement culturally responsive approaches that are data-driven to address existing inequities. The idea is to incorporate these components into EVERY prioritized strategy moving forward.

The key themes and 70 Strategy Recommendations, Appendix 2., were presented to the MHSA Steering Committee on May 4th along with pre-recorded stakeholder video testimonials for each of the 8 areas of need and with an opportunity for additional public comments from meeting participants. Following the meeting the MHSA Steering Committee members were asked, via an online survey, to rank the 8 areas of need and help narrow down the scope of MHSA resources (both funding and planning) over the next three years. Given this prioritization, the areas of focus for the next three years will include Behavioral Health Workforce, Access to Services and addressing gaps in the Crisis Continuum. The MHSA Steering Committee was then asked in a follow-up survey to select their top Strategy Recommendations for each of the three prioritized areas of focus.

MHSA Steering Committee
Part 1 Survey Results – Areas of Need Prioritization:



3. MHSA Three-Year Plan – this phase of the CPP process includes the development of the plan, the 30-day public comment period and public hearing hosted by the Behavioral Health Commission (BHC) and the subsequent approval by the Board of Supervisors.

   - ✓ 30-Day Public Comment: The BHC voted to open a 30-day public comment period on June 7, 2023 and held a Public Hearing on July 5, 2023.
   - ✓ Board of Supervisor Approval: The BHC also voted to submit the MHSA Three-Year Plan to the Board of Supervisors for approval after the closing of the public comment period on July 7, 2023.

   This MHSA Three-Year Plan includes new funding allocations for the prioritized strategy recommendations, proposed funding allocations for other areas of need and strategy ideas that were identified; if there is an opportunity to leverage other efforts, initiatives, and/or external funding. The MHSA Three-Year Plan also builds on previous priorities. Funding and implementation for recommendations from the FY 20-21 Housing Taskforce and the Full Service Partnership (FSP) Workgroups will continue. See the Housing and FSP Workgroup priorities section.

   Additionally, The MHSA Three-Year Plan includes ongoing funding allocations for existing MHSA-funded programs. These programs are monitored, evaluated and adjusted as needed during the MHSA Three-Year Plan implementation years and recommendations are made annually about continuing, adjusting and/or ending a program. Changes to existing programs and services are included in subsequent Annual Updates, which involve stakeholder input, the MHSA Steering Committee and the BHC 30-day public comment period. Agencies selected to provide MHSA-funded services go through a formal Request for Proposal (RFP) process to ensure an open and competitive process to funding opportunities. The RFPs are posted on the BHRS RFP website, www.smchealth.org/rfps, which includes a subscription option to receive notifications.

MHSA THREE-YEAR PLAN STAKEHOLDER INPUT

Extensive outreach was conducted to promote the MHSA Three-Year Plan Workgroup participation opportunity, the Facilitator Training opportunity, the MHSA Steering Committee meetings, and the Community Input sessions. Flyers were made available in English, Spanish, and Chinese. Stipends to consumers/clients and their family members and language interpretation were offered at every meeting, childcare for families and refreshments were offered for in-person meetings.

Input included perspectives from clients and family members, communities across geographical, ethnic, cultural and social economic status, providers of behavioral health care services, social services and other sectors. The sessions were conducted through 14 existing collaboratives/initiatives, 11 committees/workgroups, 3 geographically-focused collaboratives (Coastside, East Palo Alto and North County) and 3 stakeholder group key interviews of transition-age youth, immigrant families and veterans. The majority of the meetings were conducted online. Over 400 individuals participated across the various means of providing input (surveys, input sessions, public comments).

Input Session conducted

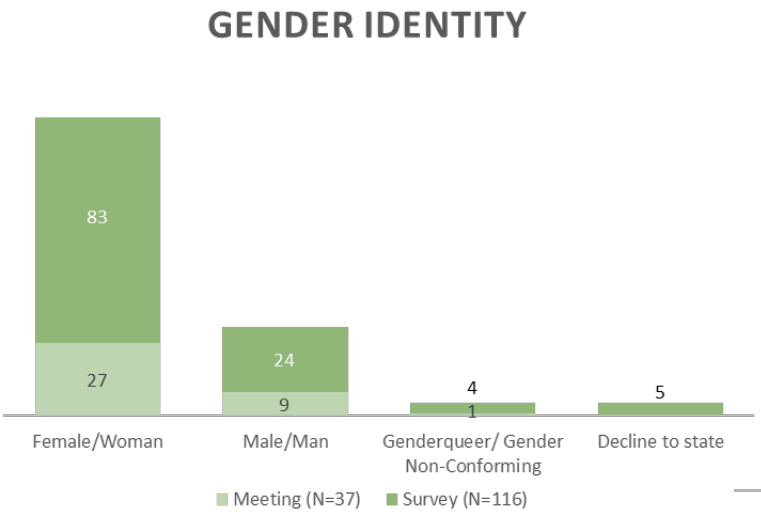
Date	Stakeholder Group	Input Session Topics
	MHSA Steering Committee	
2/2/23	4 Breakout Groups	Access to Services; Behavioral Health Workforce; Housing Continuum; Crisis Continuum
	Health Equity Initiatives	
2/3/23	Chinese Health Initiative	Access to Services
2/7/23	Pacific Islander Initiative	Youth Needs
2/8/23	Pride Initiative	Housing Continuum
2/14/23	African American Community Initiative	Quality of Client Care
2/14/23	Spirituality Initiative	Adult/Older Adult Needs
2/16/23	Native American and Indigenous Peoples Initiative	Quality of Client Care
2/16/23	Filipino Mental Health Initiative	Access to Services
2/28/23	Latino Collaborative	Access to Services
	Community Collaboratives	
2/10/23	North County Outreach Collaborative	Behavioral Health Workforce
2/16/23	East Palo Alto Behavioral Health Advisory	Behavioral Health Workforce
2/22/23	Coastside Collaborative	Access to Services
3/9/23	East Palo Alto Community Collaborative	Access to Services
	Peer Recovery Collaborative	
2/6/23	California Clubhouse/Heart & Soul	Housing Continuum
2/7/23	Voices of Recovery	Substance Use Challenges
	Behavioral Health Commission (BHC)	
2/1/23	BHC Older Adult Committee	Adult/Older Adult Needs

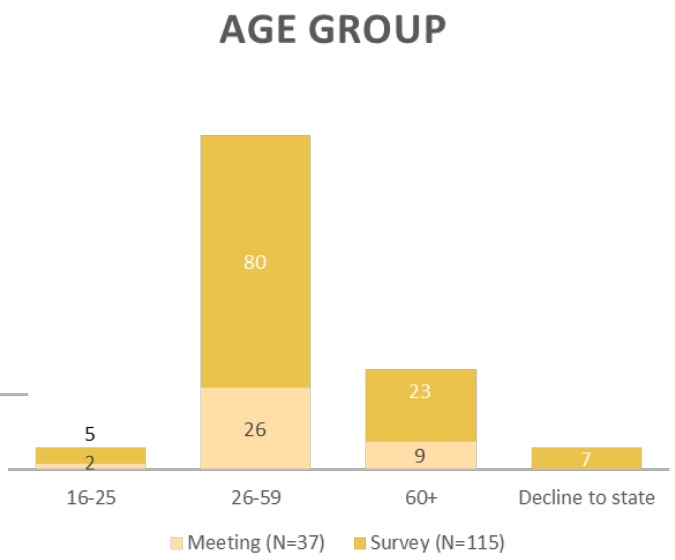
2/15/23	BHC Child and Youth Committee (3 Breakout Groups)	Youth Needs
2/15/23	BHC Adult Committee	Housing Continuum
2/21/23	BHC Alcohol and Other Drugs Committee	Substance Use Challenges
	Other Committees/Groups	
2/9/23	Housing Operations Committee	Housing Continuum
2/7/23	Lived Experience Education Workgroup	Housing Continuum
2/16/23	Contractors Association	Behavioral Health Workforce
2/20/23	Solutions for Supportive Housing	Housing Continuum
2/24/23	School Wellness Counselors	Youth Needs
2/14/23	BHRS Youth Leadership	Crisis Continuum
	Workforce Education & Training 3-Year Plan	
3/3/23	Diversity and Equity Council	Behavioral Health Workforce
3/2/23	Alcohol and Other Drug Providers	Behavioral Health Workforce
3/8/23	BHRS Adult Leadership	Behavioral Health Workforce
2/28/23	BHRS Youth Leadership	Behavioral Health Workforce
3/7/23	Lived Experience Education Workgroup	Behavioral Health Workforce
Key interviews conducted:		
Immigrant Families, Transition Age Youth, Veterans		Youth Needs; Access to Services

Demographics of participants

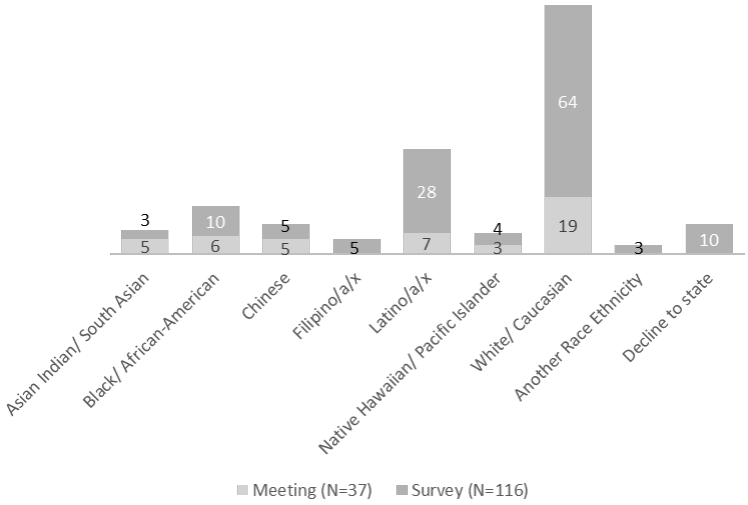
Demographic data was not collected from all 31 Community Input Sessions. 35 client and family members received stipends for participating in these sessions.

Demographics were collected for 129 survey respondents and 37 participants via a Zoom Poll feature during the two MHSA Steering Committee meetings focused on the MHSA Three-Year Plan Community Program Planning process.

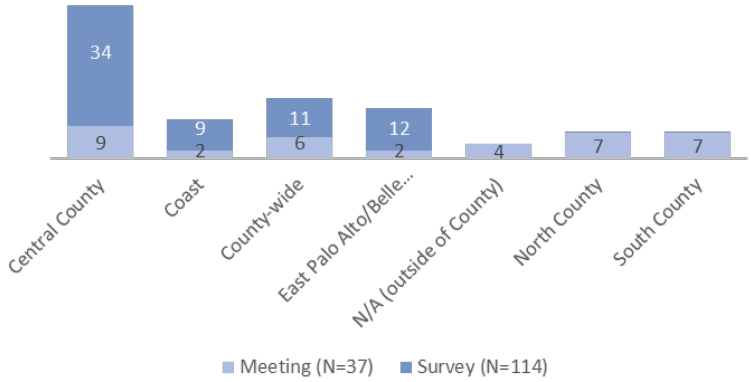




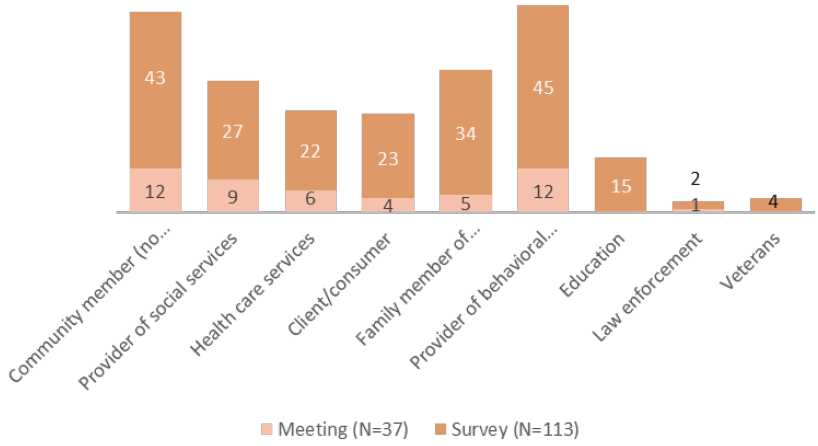
RACE/ETHNICITY



AREA OF COUNTY REPRESENTED



STAKEHOLDER GROUP



SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA Three-Year Plan Strategy Recommendations

FY 23-24 to FY 25-26

30+ community input sessions and key interviews were conducted to brainstorm strategies to address San Mateo County behavioral health needs. The MHSA Steering Committee will be voting to prioritize across the Identified Needs and across the Strategy Recommendations. This prioritization will inform the allocation of resources over the next three-years. Across all community input sessions, three core themes emerged. These components will be incorporated into EVERY prioritized strategy:

1. **Increase community awareness** and education about behavioral health topics, resources and services
2. **Embed peer and family supports** into all behavioral health services
3. **Implement culturally responsive** approaches to address existing inequities that are data-driven

Direct Services & Supports / Prevention Early Intervention

Identified Needs	Strategy Recommendations
Access to Services	1. Coordinate behavioral health services for cultural and ethnic communities (centralize services, outreach and education for the Chinese community, hire bilingual/bicultural peer staff, etc.).
	2. Expand drop-in behavioral health services that includes access to wrap around services for youth.
	3. Provide school-based behavioral health services starting in elementary and middle school; include early diagnosis and assessment at high school grade level.
	4. Co-locate prevention services (support groups, programs, workshops, etc.) in community settings such as faith-based organizations, core-service agencies, community spaces, etc.
	5. Conduct racial equity analysis of BHRS policies and procedures to identify barriers to accessing care; include service utilization and staff capacity data.
	6. Expand services for older adults focused on addressing isolation, peer support, social engagement and intergenerational work.
	7. Expand the Health Ambassador Program to include diverse languages/cultures and subject expertise (substance use, justice involved, unhoused, human trafficking, etc.)
	8. Expand outreach partnerships to include increased mild-to-moderate services, faith-based organizations and veteran engagement.
	9. Promote volunteerism to increase social engagement and community cohesion.

Recruitment & Retention Strategies

Identified Need	Strategy Recommendations
Behavioral Health Workforce	1. Create a pipeline program focused on increasing Asian American and African American behavioral health staff, develop partnerships with local and neighboring academic and non-academic programs.
	2. Create more entry level positions and internships for students of diverse backgrounds; streamline hiring processes (e.g., onboarding and process to hire interns).
	3. Target recruitment activities to reach black, indigenous, people of color (BIPOC) communities (e.g., partner with BIPOC-focused communities and student organizations and networks).
	4. Implement recruitment and retention financial incentives such as retention bonuses, signing bonuses, educational loan repayment for staff and contracted providers.
	5. Examine and adjust caseload size and balance, particularly for bilingual staff.
	6. Expand type, flexibility, and access to staff wellness and engagement opportunities (e.g., appreciation, healing activities, mentoring, behavioral health supports, networking events).
	7. Explore opportunities for alternative and flexible schedules and remote work.
	8. Implement supports for direct service staff, including peers, to advance in their careers, specifically BIPOC staff (e.g., scholarships to pursue licensure/credentials, mentorship).
	9. Invest in support, retention and leadership development of peer and family support workers (training, fair compensation, career ladders, flexible hours, and mentorship).
	10. Address extra help and contracted positions, especially for those that interface with the community.
	11. Research, plan, and implement compensation and benefits that are aligned with competing agencies and neighboring counties (e.g., salaries, cost of living, retirement plans, housing vouchers).

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Crisis Continuum	1. Create stabilization unit(s) and dedicated teams.
	2. Expand step-down from hospitalization facilities, programs and teams (e.g., respite centers).
	3. Create a youth crisis residential in the County.
	4. Expand intensive outpatient services (extended Intensive Outpatient Programs for youth, day treatment programs, detox centers, etc.).
	5. Provide respite care and language-appropriate navigation supports for parents with children who experience a behavioral health crisis (5150, psychiatric emergency services, hospitalization, etc.).
	6. Expand non-armed 24/7 mobile mental health crisis response to serve the entire community.
	7. Expand drop-in centers for individuals that struggle with mental health and/or substance use.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Housing Continuum	1. Expand clinicians available to the Homeless Engagement Assessment Linkage team (a field-based outreach, engagement and intervention services).
	2. Expand supportive housing slots for individuals living with mental health and substance use challenges that do not require homelessness as an eligibility requirement.
	3. Provide housing maintenance and peer supports including case management, wrap around services, hoarding resources, and specialized services for older adults and other vulnerable communities.
	4. Develop a comprehensive housing database that includes real time waitlist times and availability.
	5. Incentivize board and cares (streamline the application process, reduce/subsidize licensing costs, etc.).
	6. Provide housing navigation and locator resources; include re-entry supports, bilingual peer supports, streamlined case management, simplified housing application and subsidized fees.
	7. Provide supports for section 8 housing including funding, vouchers, and training to landlords.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Substance Use Challenges	1. Create integrated services for complex needs including individuals with dual diagnosis or co-occurring mental health and substance use needs.
	2. Create longer-term sober living arrangements.
	3. Expand non-medication supports for individuals with addiction.
	4. Expand recovery-focused drop-in centers.
	5. Expand resources for reunification (support for parents, how to talk/interact with their children, etc.).
	6. Provide access to Narcan for clients and family members.
	7. Provide family-centered recovery supports that includes child care at every stage.
	8. Address intergenerational trauma in recovery and treatment.
	9. Expand early intervention resources for addiction.
	10. Provide education about substance use prevention starting in elementary school (how to say no, healthy boundaries, etc.).

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Quality of Client Care	1. Provide ongoing resource navigation and peer support in crisis situations.
	2. Create client centered services (meet people where they are, provide virtual/in-person, services in their language, flexible hours, etc.).
	3. Implement best practice sharing across BHRS clinics, including integrated services and identification of supports that can be offered across the county.
	4. Develop a streamlined BHRS intake process across the network of care.
	5. Develop partnerships for substance use referrals for clients with Access and Care for Everyone (ACE).
	6. Develop partnerships with indigenous community spaces and cultural healers.
	7. Address Adverse Childhood Experiences, Social Determinants of Health, and intergenerational trauma.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Adult/Older Adult Needs	1. Create internal processes to regularly review utilization and outcome data to inform responsive services for older adults.
	2. Create partnership between the County and Veterans Administration to increase supports for veterans (integration with primary care services, resources for women veterans on sexual assault, suicide prevention for veterans, etc).
	3. Expand capacity for neuropsychological evaluation and diagnosis.
	4. Expand in-home hoarding supports (linkages to services, case management, specialized therapy, decluttering, etc.)
	5. Expand services for individuals with complex needs; develop partnerships with organizations that can support complex client needs.
	6. Expand the OASIS team peer specialist' support for older adults, caregivers and family members.
	7. Develop an outreach and communication strategy on behavioral health and wellness in multiple languages; leverage existing networks (SMC Alert, neighborhood CERTs, etc.).
	8. Expand culturally relevant suicide prevention strategies.
	9. Expand prevention services to older adults prior to complications; develop partnerships with organizations that can provide these services.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Youth Needs	1. Address gaps in the crisis continuum for youth (increase 5150 beds, language capacity, expand non-law enforcement response, stabilization unit, crisis residential, etc.).
	2. Expand school-based behavioral health education and services starting in middle school that includes family therapy and peer support groups for parents, youth, and school staff.
	3. Expand school-based wellness centers.
	4. Expand afterschool-based programming.
	5. Expand availability of diverse wellness counselors and clinicians on all school campuses.
	6. Integrate wraparound services in schools, in partnership with community-based organizations.
	7. Provide Narcan in high schools (used to reverse opioid overdose).
	8. Expand Social Emotional Learning (SEL) curriculum in schools.
	9. Expand the Health Ambassador Program for both Youth and Adults; include case management and increased support for ambassador's families.

APPENDIX 3. ALL PUBLIC COMMENTS RECEIVED

Summary of Public Comments Received

INN Project Plans – Progressive Improvements for Valued Outpatient Treatment (PIVOT)
30-Day Public Comment Process & Public Hearing (10/2/24 – 11/7/24)

Substantive Comments[1]

No substantive comments received.

Public Comments and Q&A

BHC meeting (10/02/24), opening of public comment period

- **Commissioner S. Escobar**. I just wanted to say thank you for your presentation. It was really well done, and these ideas seem really exciting. My question was in regards to the peer support and the peer workers. Where would you find these peer workers, and do you have a plan for this to be more volunteer or something that's more of a contract job base with peers?
    - Doris Estremera: At this point, my understanding of it is that the folks who are going to be providing the peer support are hired peer support workers themselves.
    - Waynette Brock (One New Heartbeat) via email: The peer workers will be Certified Peer Specialists and Supervisors, who are staff members trained in trauma-informed care, conflict resolution, de-escalation techniques, boundaries, and ethics amongst other things

Additional Public Comments

- **MHSOAC Innovations team:** Consider including additional detail on the local need, such as anecdotal data from peer workers to bring in the human element. In addition, consider adding a baseline survey for peer support workers as part of the learning and evaluation section to establish baseline data. Also ensure that the county is connecting with DHCS and other counties on connecting the INN investment to potential system change and possibly Medi-Cal billing.

[1] MHSA legislation requires that the Annual Updates for the MHSA Program and Expenditure Plan include a summary of any "substantive" public comments received (e.g., comments that may require a change to the plan) and if applicable, include the recommended revisions to the plan.

INN Project Proposal #2 - *Animal Fostering and Care for Client Housing Stability and Wellness*

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSOAC
Mental Health Services Oversight & Accountability Commission

INNOVATIVE PROJECT PLAN RECOMMENDED TEMPLATE

COMPLETE APPLICATION CHECKLIST
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:
☑ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors.
☑ Local Mental Health Board approval Approval Date: November 6, 2024
☑ Completed 30 day public comment period Comment Period: November 6, 2024
☐ BOS approval date Approval Date: _____ If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: January 14, 2025 *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*
Desired Presentation Date for Commission: January 23, 2025 ***Note: Date requested above is not guaranteed until MHSOAC staff verifies all requirements have been met.***

Mental Health Services Act (MHSA) Innovation Project Plan

County Name: San Mateo County
Date submitted: TBD
Project Title: Animal Fostering and Care for Client Housing Stability and Wellness
Total amount requested: $990,000 ($870K service delivery for 3 years, $120K evaluation)
Duration of project: 4 years (3 years of services, 6 months start-up, 6 months post evaluation)

Section 1: Innovations Regulations Requirement Categories

GENERAL REQUIREMENT:

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

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

PRIMARY PURPOSE:

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

- ☐ Increases access to mental health services to underserved groups
- ☐ Increases the quality of mental health services, including measured outcomes
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ✓ **Increases access to mental health services, including but not limited to, services provided through permanent supportive housing**

Section 2: Project Overview

PRIMARY PROBLEM

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Animal companionship provides meaningful support for individuals with mental health and/or substance use challenges in ways that align with the four dimensions of recovery outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA): *health, home, purpose*, and *community*.[1] Research shows that 97% of U.S. pet owners consider their pet to be part of their family.[2] Animals provide a sense of purpose, are a source of empathy and emotional support, provide social connectedness, serve as family in the absence of or in addition to human family members, and support individuals' self-efficacy and self-esteem.[3] In these ways, the human-animal relationship is commonly considered a main source of support in recovery.[4] Additionally, some individuals with mental health and/or substance use challenges may use service animals–including psychiatric service animals–that are trained to work, provide assistance, or perform tasks to support them with their disability.[5]

Both the literature and local San Mateo County behavioral health providers indicate that animal companionship is a common source of support for individuals with mental health and/or substance use challenges. Research studies on pet ownership by individuals living with SMI have found that at least one in five study participants were pet owners; in several cases, close to half or more than half of study participants were pet owners.[6] The Mental Health Association of San Mateo County (MHA) estimates that of the 600 individuals they serve in supportive housing and shelters, approximately 400 of whom are BHRS clients, about one-third have animals.

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[1] SAMHSA. (2024, March 26). *Recovery and Recovery Support*. https://www.samhsa.gov/find-help/recovery

[2] Beshay. (2024, April 14). About half of U.S. pet owners say their pets are as much a part of their family as a human member. *Pew Research Center*. https://www.pewresearch.org/short-reads/2023/07/07/about-half-us-of-pet-owners-say-their-pets-are-as-much-a-part-of-their-family-as-a-human-member/

[3] Wisdom, J. P., Saedi, G. A., & Green, C. A. (2009). Another breed of "service" animals: STARS study findings about pet ownership and recovery from serious mental illness. American Journal of Orthopsychiatry, 79(3), 430–436. https://doi.org/10.1037/a0016812; Kosteniuk, B. M., & Dell, C. A. (2020). How Companion Animals Support Recovery from Opioid Use Disorder: An Exploratory Study of Patients in a Methadone Maintenance Treatment Program. In *Vol.12, Numéro 1/Vol.12, Issue 1* [Journal-article]. https://pdfs.semanticscholar.org/3639/ba3c072070662d46729ffd3885609afaf8a7.pdf

[4] Brooks, H., Rushton, K., Walker, S., Lovell, K., & Rogers, A. (2016). Ontological security and connectivity provided by pets: a study in the self-management of the everyday lives of people diagnosed with a long-term mental health condition. BMC Psychiatry, 16(1). https://doi.org/10.1186/s12888-016-1111-3

[5] Animals are classified into three different categories: (1) pets, (2) emotional support animals (ESA), and (3) service animals (SAs). A SA is a dog (or miniature horse) that aids those with a physical or mental disability. An ESA provides emotional, cognitive, or other similar support to an individual with a disability, and does not need to be trained or certified. A pet is a domesticated animal that provides companionship and is not considered a service animal or an emotional support animal. The term "animal" is used throughout this plan to encompass pets, ESAs, and SAs, unless otherwise noted.

[6] Zimolag, U., & Krupa, T. (2009). Pet ownership as a meaningful community occupation for people with serious mental illness. *American Journal of Occupational Therapy*, *63*(2), 126–137. https://doi.org/10.5014/ajot.63.2.126; Wisdom, J. P., Saedi, G. A., & Green, C. A. (2009). Another breed of "service" animals: STARS study findings about pet ownership and recovery from serious mental illness. *American Journal of Orthopsychiatry*, *79*(3), 430–436. https://doi.org/10.1037/a0016812

Given the role of animal relationships in recovery, and the substantial proportion of individuals living with mental health and/or substance use challenges who have animals, there is a need for programs and policies to sustain the human-animal relationship when an individual needs a higher level of care to support their recovery. During such times, lack of animal care can be a barrier to clients' recovery by impacting decisions to seek treatment and/or by impacting housing stability, as described below.

- **Receiving timely treatment**: Service providers have found that a reason clients with animals decline higher levels of care (e.g., residential treatment, hospitalization) is the uncertainty around care for their animal during this time. Because of the strong emotional bond with their animal, clients who cannot bring their animals with them to a higher level of care (either because the animal is not accepted or because the individual is unable to care for the animal) can experience parental concern, separation anxiety, and grief if their animal does not have a safe place to go.[7] A survey conducted by the Johnson County, Kansas Mental Health Center found that more than 70% of County mental health staff members had at least one client decline treatment in the previous six months because they didn't have temporary care for their pet.[8] Similarly, a study exploring pet care of individuals hospitalized for physical health issues found that 63% of participants reported challenges finding pet care during a prior hospitalization, and/or knew someone who encountered similar challenges. Participants also reported that these challenges negatively affected their health, recovery, or their decision to receive medical care.[9]
- **Maintaining stable housing and wellness**: Clients who are in supportive housing settings may experience periods of crisis or unwellness, during which they may not be able to maintain care for their animals. This may result in unhealthy living conditions for both the animal and the client (e.g., not being able to take animals out for walks, animals may urinate/defecate in the home), which may also put a client at risk for eviction. Among clients who are unhoused, having an animal may be a barrier to securing stable housing and/or receiving health or behavioral health services if animals are not accepted in a particular housing or treatment setting, as individuals may choose animal companionship over formal housing and health services.[10] This stark reality has been referred to as "choosing pet over place."[11]

Recognizing the importance of animal companionship in supporting behavioral wellness, San Mateo County has implemented policies and services for individuals who have animals and are seeking housing and behavioral health treatment.

- **For unhoused individuals:** In 2022, San Mateo County made a commitment to achieve "functional zero" homelessness and implemented animal-friendly shelters as a strategy in realizing this goal. The San Mateo County Housing Navigation Center added kennels and allows emotional support

[7] Cleary, M., West, S., Visentin, D., Phipps, M., Westman, M., Vesk, K., & Kornhaber, R. (2020). The Unbreakable Bond: The Mental Health Benefits and Challenges of Pet Ownership for People Experiencing Homelessness. Issues in Mental Health Nursing, 42(8), 741–746. https://doi.org/10.1080/01612840.2020.1843096

[8] *Group cares for pets while owners get mental health, drug treatment*. (2022, November 21). National Association of Counties. https://www.naco.org/articles/group-cares-pets-while-owners-get-mental-health-drug-treatment

[9] Polick, C. S., Applebaum, J. W., Hanna, C., Jackson, D., Tsaras-Schumacher, S., Hawkins, R., Conceicao, A., O'Brien, L. M., Chervin, R. D., & Braley, T. J. (2021). The Impact of Pet Care Needs on Medical Decision-Making among Hospitalized Patients: A Cross-Sectional Analysis of Patient Experience. *Journal of Patient Experience*, *8*, 237437352110460. https://doi.org/10.1177/23743735211046089

[10] Ward, C., Johnson, I., Bamwine, P., & Light, M. (2023). The Pet Paradox: uncovering the role of animal companions during the serious health events of people experiencing homelessness. *Anthrozoös*, *37*(2), 343–359. https://doi.org/10.1080/08927936.2023.2280376

[11] Cleary, M., West, S., Visentin, D., Phipps, M., Westman, M., Vesk, K., & Kornhaber, R. (2020). The Unbreakable Bond: The Mental Health Benefits and Challenges of Pet Ownership for People Experiencing Homelessness. Issues in Mental Health Nursing, 42(8), 741–746. https://doi.org/10.1080/01612840.2020.1843096

animals (ESAs), and San Mateo County Health's Veterinary Preventative and Wellness Care Program (VPWC) provides free veterinary care for pets of clients who are unhoused (preventative and wellness care, equipment, and supply needs will be minimal, limited to vaccines, flea control, antibiotic, anti-inflammatory, and parasiticide medications).

- **For clients enrolled in Full Service Partnership (FSP) and/or in permanent supportive housing (PSH) settings**: Animals are allowed in some cases (see table below). Clients' case managers and/or peers sometimes provide support with short-term, low-effort pet care needs such as dog walking; however, these limited supports are insufficient for clients who need a safe home for their pet while they are receiving medical and/or behavioral health treatment during a period of unwellness.

The table below describes the animal policies in different types of San Mateo County facilities. As is shown in the table, homeless shelters accept animals per the County's policy; PSH sites accept ESAs (per California housing law) and some accept pets (there is a bill currently in the California legislature that may require rental properties to also allow pets as well as ESAs); while residential treatment facilities are mixed in their policies for accepting animals.

Type of Facility	Animal Policies
Congregate and non-congregate shelters	**County shelters** – Accept animals under conditions described in the Service Animal (SA), Emotional Support Animal (ESA), and Pet Policy of March 2024.
Permanent Supportive Housing (PSH)	**Larger PSH sites** – These sites serve a mix of MHSA-funded and non MHSA-funded residents. Four sites accept pets (per California law now requires all multi family communities accept pets. Check out California AB2216). Light Tree in East Palo Alto accepts pets; South San Francisco MidPen allows pets; San Mateo MidPen site allows one pet, with restrictions on breeds; and Mental Health Association sites accept pets. **Smaller PSH sites** – These sites are for MHSA residents and accept ESAs, but not pets.
Crisis Residential Facilities	**Serenity House –** Cannot accept clients with ESAs, per DHCS rules.
Residential Substance Use Treatment Facilities	**Hope House** – No animals are allowed due to allergy issues with staff and potentially with clients. Additionally, animals could only be allowed in the downstairs room, which is the same room that babies would be in, so no animals are allowed in there. **Free at Last** – No official policy, historically no animals allowed. **Latino Commission** – SAs allowed only on a case-by-case basis, subject to denial if posing allergy threat to staff or other clients. **HealthRight 360** – Both ESAs and SAs are allowed upon approval. **Our Common Ground** – Allows documented SAs only.

While the above-mentioned policies and supports are an important step in supporting individuals to maintain their relationships with their animals, animals are not accepted at the county's residential crisis treatment facility, Serenity House, which serves as a barrier for any client needing crisis mental health care. In addition, providers observed that even though certain substance use treatment facilities accept animals in some cases, it can be difficult for clients to receive approval to bring their animals. While clients with financial resources may be able to pay for a pet sitter or board their animals, BHRS clients are likely to have lower income and therefore have no access to this type of support. San Mateo County's contracted Animal Care and Control Vendor is able to hold animals in protective custody for 30 days; however, clients may be hesitant to leave their animals in this type of boarding arrangement, and if animals need a stay longer than 30 there is a gap in service. Thus, there remains a need for temporary foster care and supportive services when an individual either cannot bring their animal to a higher level of care, or is temporarily unable to properly care for their animal.

San Mateo County Behavioral Health and Recovery Services (BHRS) providers and contractors do not formally collect data on the number of clients who face barriers to treatment or housing due to a need for animal care, but providers shared several anecdotal experiences. MHA has had three recent cases where clients' mental health deteriorated because they were unable to access Serenity House without finding suitable care for their pets. At least two BHRS providers reported attempting to receive temporary support from the local SPCA while clients were accessing a higher level of care.

Client Case Studies

MHA of San Mateo County and other county providers shared several experiences with clients who faced barriers to treatment without temporary care for their animals. Names and identifying details have been changed to protect client privacy.

Morgan had struggled with an addiction to alcohol throughout his twenties. In his thirties, he got sober and got a job through [a vocational rehabilitation program]. After two years of successfully remaining sober, he relapsed. He reached out to his case manager for help. Although they were able to find an inpatient treatment center for Morgan, the Center would not take his dog, Luna. Morgan was faced with the impossible choice of getting help or keeping is beloved companion. He ultimately did not enter treatment.

Sandra was experiencing problems with neighbors; her mental health deteriorated, and she would have benefited from going to treatment but there was no one to take her dog. Her mental health continued to decline until we were able to obtain a reasonable accommodation, help her find alternative housing, and move.

Jessica periodically returned to her doctor for [mental health] treatment. She decided she no longer wanted to have that treatment, but her anxiety and depression increased; she started medicating with alcohol resulting in more problems over time. At one point she considered entering the hospital voluntarily, but there was no one to take care of her dog. She never went into the hospital, continues to medicate with alcohol, and as a result has alienated the majority of her support network.

Benjamin, who suffers from major depression, was willing to go to treatment when his mental health declined. Because there was no one to take care of his dog, he ended up isolating. We were able to

increase support for a period of time until his mental health began to improve, but it would have been much better if he hadn't had to have that experience.

S and his dog, Wrex, came by the [San Mateo County Health Veterinary Preventative and Wellness Care Program] monthly vaccine clinic regularly, always keeping on schedule with flea/tick prevention and vaccines. S would tell me about all the commands and tasks Wrex knew, and how he knew to help S through difficult emotional states. With the specific tasks Wrex performed, we were able to issue him a service dog license tag. This helped with their search for permanent housing – it is very difficult to find rentals that will accept large dogs, so the service dog designation was important for keeping these two together. This past spring, Wrex was attacked by another large dog. Around the same time, S had some challenges communicating with the shelter's management and had been asked to leave. He and Wrex ended up moving out and camping on a beach for a period of time. They came to visit our clinic, and we set Wrex up with an appointment at a local vet hospital to work up a recurring lip wound. By the time Wrex visited our clinic [several months later], the two of them had moved in to permanent housing and Wrex's lip was healing. S was able to reconnect with his son, who he had not seen in several years, and host his son for a long weekend visit. S still periodically sends me cute videos of Wrex learning new tricks or walking on the beach – I am very happy that they have found a nice place.

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.

The proposed project will serve individuals who are living with mental health and/or substance use challenges and experience a change in their condition wherein temporary animal care would support wellness and housing stability. In this way, the project will 1) facilitate entry into higher levels of care (e.g., crisis or treatment residentials, hospitalization), and 2) help housed clients maintain housing, all while preserving the crucial human-animal relationship that supports clients' recovery.

The project will provide temporary animal foster care by appropriately trained volunteers during the time their humans are experiencing need for respite care, hospitalization, criminal justice encounter, or higher level of care. Choosing to be separated from their animal, even temporarily, is often the single biggest barrier for an individual who is facing an extended period of time in treatment or hospitalization, so knowing their pet will be cared for in a safe and loving foster home eases any added stress allowing clients to focus their energy on healing.

The project will also provide short-term in-home animal care support (e.g., grooming, dog walking, transportation to veterinary appointments) in cases where temporary support would help clients maintain wellness and housing for themselves and their animal. These services allow clients to focus on their own health while keeping their pets healthy and cared for.

On a system level, the project will work with supportive housing and treatment facilities that do not currently have policies around accepting animals to establish and formalize policies around accepting animals.

As the county prepares to transition to Behavioral Health Services Act (BHSA), this INN project was prioritized as it directly removes a known barrier to care that will enable the most vulnerable clients to engage in needed services including higher levels of treatment as needed, and to remain housed. See the INNOVATION PROJECT SUSTAINABILITY section below for more detail on how the project aligns with the transition to BHSA.

Assessment and Enrollment

- Criteria for referral are individuals living with serious mental illness (SMI) and/or substance use disorders (SUD) with pets, ESAs, or SAs for whom animal care is an **urgent and temporary barrier** to receiving a higher level of care or maintaining their housing stability and wellness.
- BHRS and its network of care providers and community-based organizations will identify individuals who meet this criteria and refer them to the program.
- Program staff will conduct an assessment to determine that the animal care needs are temporary, and that the individual wishes to participate in the program.
- If the individual meets the program criteria and desires to participate, program staff will conduct an intake to understand their specific needs, and complete a consent for and temporary surrender form for their animals to stay in foster care.

Services

The project will provide the following services.

- **Recruitment, training, and support of animal fosterers/caregivers (AFCs).** Training will follow established procedures for animal fostering, including the foster home environment and health status of other animals in the home. AFCs who are renters will be educated about California tenant law as it relates to animals/pets in the home and be provided with support if they face challenges from landlords about fostering an animal.
- **Free, temporary foster care placement for animals**. AFCs will provide care and attention for the animal, keep the animal safe and healthy, and ensure the animals receive necessary veterinary care during the fostering period. AFCs will share video and photo updates with the program, who will pass those updates to the client.
    - *Length of care*: Temporary foster care will typically be for a minimum of 30 days and a maximum of 90 days to account for time in residential treatment. If more time is needed to support a client's long-term recovery, the program will have a process in place to extend foster care for up to six months.
    - *Emergency foster care*: Emergency foster care will be available for when a client is ready to go into treatment but the program has not found a temporary foster. Emergency AFCs will have an open and/or flexible schedule that can take an animal in within 24-48 hours and keep an animal for approximately 1-2 weeks.
    - *Rehoming*: In the rare case that a pet owner makes the challenging decision to rehome their pet or ESA during the program, the program will support them in finding a new home for their animal.
- **In-home animal care support**. For individuals in supportive housing settings who do not need full foster care for their animal, but need temporary support caring for their animal, AFCs will visit

clients in their homes to support dog-walking, grooming, and routine veterinary care. These visits may also include teaching and coaching for clients on housing retention and animal care.

- **Policy development.** Program staff will outreach to and assist supportive housing and treatment facilities that do not currently have policies around accepting animals to establish to support them in developing policies around when and how they will accept animals (i.e., Permanent Supportive Housing, Serenity House, and substance use treatment facilities).

Project Staffing

A Project Coordinator from San Mateo County Health will work in collaboration with a BHRS Manager. A local animal care organization that provides fostering services will be contracted to oversee the program. BHRS will promote opportunities for individuals with lived experience (peers) to serve as AFCs. BHRS will center the importance of peer-to-peer services by 1) including language in the Request for Proposals (RFP) for the contracted foster agency that the agency should value and promote the importance of peer-to-peer services for individuals with mental health and substance use challenges; and 2) working with the contracted agency to promote the opportunity for peers to become fosterers through BHRS's existing network of peer support workers and programs for individuals with lived experience and their family members.

The Project Coordinator will be responsible for contracting with an animal fostering agency and supportive services with the goal of prioritizing the following positions:

- Program Manager (part-time) with expertise in animal care and fostering to:
  - Screen and certify AFCs to provide animal foster care
  - Screen potential clients who have been referred to the program
  - Match AFCs to clients
  - Oversee training of AFCs and Peer Specialists
  - Supervise Peer Specialists
  - Monitor the quality of the fostering relationship
  - Manage urgent situations that arise related to animal care
- Certified Peer Specialists (two part-time) with experience in animal care to:
  - Conduct outreach to BHRS providers about the program
  - Conduct client intakes
  - Be a point of contact for clients who may have questions about their animals during the fostering period
  - Provide training and supervision for AFCs
  - Provide education and coaching to clients on animal care and housing retention
  - Support and liaise with clients' treatment team as needed
  - Provide check-ins, support, and referrals to community resources for clients
- Animal fosterers/caregivers (AFCs):
  - The contracted agency will recruit a pool of AFCs who may choose to be certified to provide animal foster care and/or to provide in-home animal care support. The contracted agency will deliver a thorough training and certification process. We anticipate that a pool of AFCs will be recruited, with not all volunteers actively providing service at any given time but being available as fostering/animal care needs come up.
  - While volunteers will not be paid, they will receive a stipend for participating in the training and certification process, and all animal-care related costs while fostering will be covered.

Advisory Group

A small advisory group of clients, family members, and community organizations will be established early in the program start-up. The advisory group will inform all aspects of the program including the program structure and services, outreach strategies, evaluation and dissemination of the findings of the innovation. Stakeholders will continue to play a critical role in the evolution of this project.

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

This project makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population.

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.

This approach has been demonstrated to meet a need both within and outside the behavioral health field. Temporary animal foster care has been successful with populations including individuals needing medical treatment, individuals in domestic violence situations, individuals experiencing housing insecurity, and individuals seeking behavioral health treatment. One provider of such services, BestyBnb, reports having provided 4,000+ nights of temporary animal care for pets with a 100% reunification rate.[12] Dogs Matter, a nonprofit based in Texas, has helped over 750 clients through temporary foster care for dogs. The approach we have selected for this project combines temporary animal foster care with additional supportive services designed to provide a client-centered and integrated experience for the client. The project idea was proposed by a family member with lived experience who is in a leadership role in MHSA planning, and has observed the need for this service firsthand.

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

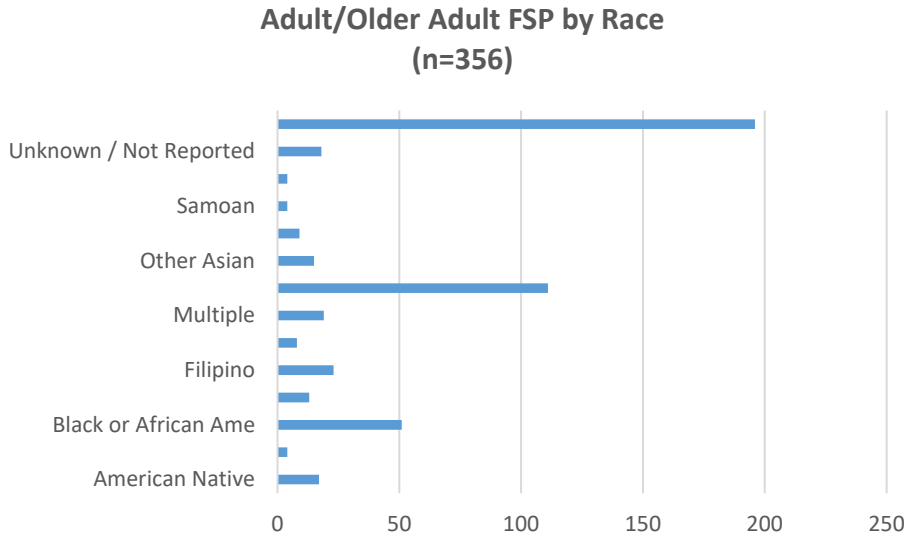
The project will be piloted with a small set of clients who are enrolled in FSP services or living in PSH settings. A pilot will enable the program to oversee a small number of clients, provide close oversight of AFCs, and study implementation and effectiveness before scaling to a larger number of clients. The next phase would open the program to referrals from mental health and substance use residential settings and behavioral health crisis and emergency settings. In the first year of service, it will be crucial to focus on the process of recruiting, training, and supervising AFCs and to more deeply understand the specific animal care needs that clients have.

During the first six months of the service period, AFCs will collectively be able to provide temporary animal foster care for six to nine clients. After the first six months, the project will evaluate what has gone well, what needs improvement, and make any needed changes to the program model or training approach. As the program model is formalized, the number of AFCs will increase and the target population will be expanded to include other BHRS clients outside of FSP or PSH settings.

[12] *Impact & Momentum — BestyBnB*. (2022). https://www.mybestybnb.com/impact-momentum

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

The project will serve adult and older adult clients living with SMI and/or SUD with pets, ESAs, or service animals for whom animal care is an urgent and temporary barrier to receiving a higher level of care treatment or maintaining their housing stability and wellness (the type of animals that will be accepted will be determined by the contracted agency). Clients may be age 18 or older, any gender, race/ethnicity, or sexual orientation, and speak any language. FSP clients are 29% Hispanic or Latino ethnicity and represent diverse races as demonstrated below.



RESEARCH ON INN COMPONENT

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

The proposed project addresses a known barrier to wellness and housing stability through a unique combination of services. There are existing programs throughout the U.S. that provide temporary foster care for pets while their owners are experiencing physical or behavioral health challenges that prevent them from being able to have their animal with them. The innovative components of the project include:

1. **Emphasis on peer-to-peer services**. There is no evidence that existing programs focus on promoting peers with lived experience as the providers of foster care and animal support services.
2. **Inclusion of ESAs and SAs in addition to pets**. Most existing programs are described as providing temporary foster care for pets, but do not clarify if they also serve ESAs and SAs, and how that care might differ for both the animal caregiver and the impacts for the client.
3. **Addition of in-home animal support services for housing retention.** While some programs offer animal support services including dog-walking, grooming, and assistance with vet appointments, these services are not designed specifically with the goal of preventing loss of housing. The proposed INN project will provide animal care support services along with coaching around animal care and housing retention in order to support this goal.

2) 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.

BHRS conducted an extensive online search and literature reviews of temporary animal foster care programs and reached out to various programs. Several programs provide temporary animal foster care for clients seeking behavioral health treatment. Some of these programs are explicitly designed for individuals experiencing behavioral health challenges, while others serve a broader population including individuals experiencing medical needs, homelessness, or who are in domestic violence situations. For example:

- Pause4Paws, Inc. is a Tulsa, OK non-profit that arranges foster homes for pets while their owners experiencing homelessness, mental health challenges, and/or substance use challenges receive urgent medical, mental health, or substance abuse treatment. https://www.pause4pawsok.org/who-we-serve.html
- Dogs Matter is a Dallas, TX based program that provides free, temporary foster care placement and supportive services for dogs of individuals seeking substance abuse treatment and transitioning into recovery https://www.dogsmatter2.org/
- BestyBnB is a Kansas-based program originally created to help survivors of domestic violence that partners with agencies in the areas of domestic violence, mental health, Veteran affairs, homeless services, and other social service agencies to provide temporary homes for pets during their owners' time of crisis. Community members sign up to be animal caregivers, and can offer their services at a cost or for free. https://www.mybestybnb.com/

These programs appear to be successful in meeting the need for temporary animal care, however there have not been formal evaluations of the implementation or outcomes of these programs beyond measuring reunification rates between animals and their owners. Other programs provide temporary animal foster care without a specific focus on behavioral health, including:

- The Bond Between, located in Minnesota, provides temporary foster care for pets due to personal emergencies or unforeseen life circumstances (e.g., medical emergency, survivors of domestic violence, people facing housing insecurity). https://www.thebondbetween.org/respite
- Paws for Hope's No Pet Left Behind crisis foster care program, located in British Columbia, provides temporary safe care for pets of individuals who are in crisis (including escaping violence, needing behavioral health treatment). https://www.pawsforhope.org/what-we-do/no-pet-left-behind/
- PACT for Animals, is a national program that provides temporary animal foster care for Veterans, hospital patients and military personnel. https://pactforanimals.org/
- Pets Are Wonderful Support (PAWS) is a San Francisco, CA based program that provides emergency pet foster care and assistance with pet food, veterinary services, and in-home services to help older adults and adults with illnesses and disabilities care for their animal companions. https://www.shanti.org/programs-services/pets-are-wonderful-support/

Finally, there are programs that provide assistance with veterinary care and, in some cases, temporary animal boarding/fostering, for clients experiencing homelessness who are staying in shelters. For example, Kern County has a pet assistance program for people experiencing homelessness that includes board and care for pets while clients are in shelters (where pets are not allowed) or for brief periods of time such as during the time the client needs to attend a doctor's appointment (personal communication from 2024 CalMHSA conference).

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?

The project's learning goals and the reasons for their prioritization are as follows.

1) Does offering temporary animal fostering and care for individuals with mental health and/or substance use challenges who have assistance animals or companion animals:
    a) **increase engagement in higher levels of care** for individuals who otherwise would not have engaged?
    b) **improve housing retention** for individuals who are at risk of losing housing?
    c) **improve indicators of recovery**, including recovery time, mental wellness indicators, and substance use indicators?

    Reason: This learning goal focuses on program outcomes. While there is a clearly identified need for this project, this project provides an opportunity to examine the changes that individuals who receive this type of service experience in key areas related to behavioral health treatment and housing.

2) Does providing **peer-to-peer services** impact client engagement in the program?

    Reason: It is a hypothesis of this project that having peers as the animal fosterers/caregivers will promote a positive experience for the program clients. To the extent that the project is able to recruit peers as the AFCs, we seek to understand the perspectives of both the project clients and the peer volunteers on the role of peer-to-peer services in how the program engages and supports clients.

3) What are the **essential elements** of the project that could be scaled or replicated?

    Reason: This project is the first of its kind in offering animal care for behavioral health clients that is client-centered, recovery-oriented, integrated, and promotes peers as the service providers. If successful, there is the potential for other counties to implement similar programs. There is ample opportunity to learn from an implementation and outcome evaluation about the elements of the program that must be in place for it to be successful, and the elements of the program that are easier and more challenging to execute. This information can be used to consolidate lessons learned and tips for other jurisdictions.

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

The table below describes the gaps in literature and practice and the new practices that the proposed learning goals will address.

Gaps in the literature and practice	Proposed intervention and opportunities for learning	Learning Goal
• The success rate of client-animal reunification for clients living with serious mental illness • Effects of temporary pet care on engagement in treatment • Effects of temporary pet care on the behavioral wellness of participants • Effects of temporary pet care on housing retention	• Offering temporary animal foster care to clients who need care to support their recovery • Offering temporary in-home animal care support to clients who need care to support their recovery	1. Does offering temporary animal care for individuals with mental health and/or substance use challenges who have assistance animals or companion animals: a) **increase engagement in higher levels of care** for individuals who otherwise would not have engaged? b) **improve housing retention** for individuals who are at risk of losing housing? c) **improve indicators of recovery,** including recovery time, mental wellness indicators, and substance use indicators?
• Using peer services in a way that has not been tried and tested before	• Recruitment and training for peer volunteers to serve as animal foster homes • Provision of peer supervision for peer volunteers • Peer specialist role to support the client during the time their animal is in foster care	2. Does providing **peer-to-peer services** impact client engagement in the program?
• What support services individuals in recovery needs to ensure the health and safety of themselves and their animal in the long term	• Opportunity to pilot program with small number of clients, then expand based on evaluation • Opportunities to define the program model through implementation and outcome evaluation	3. What are the **essential elements** of the project that could be scaled or replicated?

EVALUATION OR LEARNING PLAN

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

An independent evaluation consultant will be contracted and monitored by the MHSA Manager in collaboration with the BHRS program monitor to formally evaluate the innovation project. The following depicts a rough evaluation plan given that the consultant will be hired after the project is approved. A Theory of Change, Appendix 1. was also developed to support the evaluation and learning plan.

Learning Goal	Potential Measures	Potential Data Sources
1. Does offering temporary animal care for individuals with mental health and/or substance use challenges who have assistance animals or companion animals: a) increase engagement in higher levels of care for individuals who otherwise would not have engaged? b) improve housing retention for individuals who are at risk of losing housing? c) improve indicators of recovery, including recovery time, mental wellness indicators, and substance use indicators?	<u>Engagement in treatment</u> ✓ Number of clients who report that lack of animal care is a barrier to participating in treatment ✓ Number of clients with animals who receive a higher level of care and report that they otherwise would not have <u>Housing retention</u> ✓ Number/percent of clients receiving animal foster care who return to their housing after treatment ✓ Number/percent of clients receiving in-home animal care support who maintain their housing <u>Recovery</u> ✓ Number/percent of clients who are reunited with their animal after being in higher level of care ✓ Number/percent of clients who receive a higher level of SUD care ✓ Number/percent of clients who receive a higher level of mental health care	✓ Program data ✓ Data from client's treatment team (FSP/PSH) ✓ Client interviews ✓ Program staff and volunteer interviews ✓ Interviews with members of program clients' treatment teams
2. Does providing peer-to-peer services impact client engagement in the program?	✓ Self-reported client satisfaction with AFCs, and any differences in satisfaction based on whether AFCs are peers with lived experience	✓ Client interviews ✓ Program staff and volunteer interviews

3. What are the essential elements of the project that could be scaled or replicated?	✓ Self-reported most useful components ✓ Documentation of animal acceptance policies for housing and treatment facilities	✓ Client interviews ✓ Program staff and volunteer interviews ✓ Interviews with members of program clients' treatment teams ✓ Program documentation ✓ Interviews with other counties

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

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

All BHRS service agreements (contracts, MOUs) are monitored by a BHRS Manager that has the subject matter expertise. Contract monitors check-in at least monthly with service providers to review challenges, successes, troubleshoot and stay up-to-date on the progress of the project. Additionally, reporting deliverables are set in place in the agreements and linked to invoicing. Payments of services are contingent on the reporting. Evaluation contracts are monitored in a similar fashion by the MHSA Manager in collaboration with the assigned BHRS Manager.

COMMUNITY PROGRAM PLANNING

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

In San Mateo, the CPP process for Innovation Projects begins with the development of the MHSA Three-Year Plan. A comprehensive community needs assessment process determines the gaps, needs and priorities for services, which are used as the basis for the development of Innovation projects. One of San Mateo County's current MHSA Three-Year Plan Strategy Recommendations includes to *provide housing maintenance and peer supports including case management, wraparound services, hoarding resources, and specialized services for older adults and other vulnerable communities*. The Animal Fostering and Care for Client Housing Stability and Wellness addresses this priority. Appendix 2. includes the MHSA Three-Year Plan CPP process and Strategy Recommendations.

Additionally, BHRS conducted a participatory process to gather a broad solicitation of innovation ideas. The proposed project was identified in the 2022 MHSA Innovation (INN) stakeholder submission process and is being brought forward for the current round of INN funding as the County transitions to the BHSA.

<u>Initial INN Idea Solicitation Process in 2022</u>

- ✓ Jan-Feb 2022: BHRS conducted outreach and convened a workgroup with community members and service providers including people with lived experience and family members.
- ✓ Feb-Apr 2022: The workgroup met three times in the beginning of the year to develop the idea stakeholder participation process. BHRS wanted the submission process to be as *inclusive* and as *accessible* as possible so that a broad range of community members would submit project ideas.
- ✓ May-June 2022: Based on ideas from the workgroup, BHRS developed frequently asked questions about INN and requirements for INN projects; created "MythBusters" to demystify the submission process; and developed an outreach plan to inform community members about this opportunity. The submission form asked submitters to describe how their project addressed the MHSA Core Values as well as San Mateo County's MHSA Three-Year Plan prioritized needs. BHRS created a comprehensive submission packet with this information, a user-friendly submission form, and the scoring criteria. The submission packet was translated into Spanish and Vietnamese.
- ✓ Jun-July 2022: BHRS opened the submission process and conducted outreach to the community, along with workgroup members and partners. Because of the ongoing COVID pandemic, outreach was largely electronic and word-of-mouth.
    - Announcements at numerous internal and external community meetings;
    - Announcements at program activities engaging diverse families and communities (Parent Project, Health Ambassador Program, Lived Experience Academy, etc.);
    - E-mails disseminating information to over 3,000 stakeholders;
    - Word of mouth on the part of committed staff and active stakeholders,
    - Postings on a dedicated MHSA webpage www.smchealth.org/MHSA and the monthly BHRS Director's Update.
- ✓ June-July 2022: As part of the outreach strategy, BHRS held an online information session. BHRS also held a session on "online research" to provide submitters with tips for how to search online for data and research for their submission. These were recorded and available on the MHSA website. The submission window was open for six weeks in June and July. Throughout that time, BHRS held technical assistance/support sessions that potential submitters could join to talk through aspects of their idea. Submitters were highly encouraged to attend a support session.
- ✓ July-August: BHRS received 19 ideas. All submitted ideas were pre-screened against the Innovation requirements, and 14 ideas moved forward to review. BHRS created a selection workgroup of four people, including BHRS staff, nonprofit providers, and people with lived experience, who reviewed proposals and scored them based on the identified criteria. BHRS also conducted an internal feasibility review that included preliminary feedback from the Mental Health Oversight and Accountability Commission (MHSOAC). From there, four INN ideas moved forward to develop into full INN project proposals that were ultimately approved by the MHSOAC and are currently being implemented.
- ✓ The current project was not selected at that time; BHRS informed proposers that the idea might be revisited in the future if additional funding became available.

<u>2024 INN Idea Selection Process</u>

- ✓ With the availability of funding for new INN projects to be approved in the current fiscal year, BHRS sought to identify potential INN projects from its 2022 idea submission round that would meet current needs and align with the priorities of the BHSA.
- ✓ BHRS staff reviewed the 14 ideas that had been pre-screened in 2022 against the Innovation requirements. In order to prioritize INN projects that could be sustained under the BHSA, staff screened the 14 ideas to identify projects that included treatment/recovery and/or early

intervention services. Most project ideas were in the area of prevention; five ideas included components of early intervention, treatment, and/or recovery.

- ✓ BHRS conducted an internal feasibility review of the five projects, and determined to move forward with two of the INN proposals based on BHRS capacity and priorities for the BHSA transition. In addition, BHRS decided to move forward with two multi-county collaborative INN projects.
- ✓ On September 5, 2024, the MHSA Steering Committee met to review the two community-derived INN ideas, and the two multi-county collaborative projects, and provide comment and considerations for the projects through breakout room discussions and online comment forms.
- ✓ The Behavioral Health Commission voted to open the 30-day public comment period on October 2, 2024 and reviewed comments during the public hearing and closing of the public comment period on November 6, 2024. All public comment comments received are summarized in Appendix 3.

MHSA GENERAL STANDARDS

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

A) **Community Collaboration**. This project will require collaboration between clients and providers and will include service providers, clients, and families in assessing the need, interest and willingness to receive animal fostering and support services. The program staff will also work collaboratively with BHRS, treatment providers, and community behavioral health and social service providers, to utilize additional and unique supports that will enable clients to support their recovery and maintain their housing in the most successful and independent manner possible.

B) **Cultural Competency**. The program will be sensitive to clients' backgrounds, culture, and language by recruiting and matching AFCs to clients based on race/ethnicity and language as much as possible. If not possible to match the AFC to the language spoken by the client, interpretation services will be provided to support communication. Staff and AFCs will receive orientations and refresher trainings on cultural sensitivity and cultural humility, particularly as it may relate to cultural differences in communication and personal space when a provider is providing in-home services.

C) **Client/Family-Driven**. Client preference will be paramount throughout – clients will determine if they want to enroll in the program, and they will have a voice in choosing the AFC who provides fostering and/or in-home animal care services. The project design prioritizes opportunities for clients to be in contact with a peer specialist during the time they are receiving program services, and the peer specialist will advocate for the client's needs.

D) **Wellness, Recovery, and Resilience-Focused**. Individuals who have animal relationships at the time when they experience instability in their wellness have bonds with their animals. Preserving and sustaining those relationships has an important role in recovery, hope, and resiliency. It is possible that this animal-human relationship is the most important strength for the client, providing a foundation for recovery. The

program is intended to help clients maintain stable housing, which is critically important to recovery and wellness. With less risk and worry about losing housing, the program will support clients' capacity to continue focusing on their recovery and wellness goals.

E) **Integrated Service Experience for Clients and Families.** The program will conduct outreach and collaboration, and referrals and linkages, with existing BHRS and contracted providers in the community to bring clients into the program. Peer specialists will be assigned to each client to help ensure a seamless intake and enrollment process, and will be able to communicate with the client's treatment team to share updates on the services clients are receiving in the program. If needed, the program will also refer clients to other animal care resources outside of the program.

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 evaluation contractor will engage the project advisory group of diverse clients, family members and providers to gather input on the evaluation questions, strategies and on quarterly progress reports. Cultural and language demographics will be collected and analyzed as part of the quarterly reports to ensure equitable access to services among racial/ethnic, cultural, and linguistic populations or communities. The quarterly reports will be used to inform and adjust as needed the direction, outreach strategies and activities.

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.

Contracted service providers for this program will be required to develop a sustainability plan that is vetted and informed by the advisory group with the goal of leveraging diversified funding for the ongoing needs of the program including opportunities for Medi-Cal billing. The advisory group will be engaged in sustainability planning for the project at minimum one year in advance of the innovation end date. Individuals with serious mental illness or others requiring ongoing behavioral health supports will be connected with the local BHRS clinic and/or existing local service providers.

If the evaluation indicates that the proposed project is successful and an effective means of supporting clients living with mental health and/or substance use challenges with maintaining their recovery and their housing, BHSA funding can be an option for sustainability, a proposal of continuation would be brought to the BHSA Steering Committee and the Behavioral Health Commission for approval and to a 30-day public comment process to possibly secure ongoing BHSA Behavioral Health Services and Supports funding.

The following table includes responses to the MHSOAC's questions regarding how new INN proposed projects will align with the transition to BHSA, be sustained, and provide continuity of care.

BHSA Transition Questions	Response
How does the proposal align with the BHSA reform?	The project focuses on housing interventions and recovery supports for the "most ill and vulnerable" population.
Does it provide housing interventions for persons who are chronically homeless or experiencing homelessness or are at risk of homelessness?	Yes, the project will remove barriers to maintaining housing for individuals who are at risk of eviction.
Does it support early intervention programs or approaches in order to prevent mental illnesses and substance abuse disorders from becoming severe and disabling?	No
Does it support Full-Service Partnership efforts and services for individuals living with serious mental illness?	Yes, the project will serve individuals who are enrolled in FSPs that may need added supports during a functional decline in their health or may need a higher level of temporary treatment (e.g., residential setting, hospitalization) but decline due to a lack of animal care.
How will the County continue the project, or components of the project, after its completion without the ability to utilize certain components of MHSA funding for sustainability?	The pilot project will include a deliverable to develop a sustainability plan that is vetted and informed by an established advisory group for the pilot term. The goal of the plan will be to leverage diversified funding for ongoing sustainability of the program including opportunities for Medi-Cal billing if approved, as a CalAim Community Support or through Housing Interventions. If DHCS does not allow pet-related supports as part of Housing Intervention funds, then Behavioral Health Services and Supports funds can be used. The advisory group will be engaged in sustainability planning for the project at minimum one year in advance of the innovation end date. If the innovation evaluation indicates that the proposed project is successful and an effective means of supporting clients living with SMI and/or SUD with their recovery goals, high-level treatment needs and accessing and maintaining their housing, a proposal of continuation would be brought to the BHSA Community Program Planning process.
How does the project assist the county's transition to the behavioral health reform?	BHSA expands and increases the types of support available to the most vulnerable and at-risk individuals. The project removes a barrier to care that will enable the most vulnerable clients to

	engage in needed services including FSPs, higher levels of treatment as needed, and to remain housed.

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?

MHSA implementation is very much a part of BHRS' day-to-day business. Information is shared, and input collected with a diverse group of stakeholders, on an ongoing basis. All MHSA information is made available to stakeholders on the MHSA webpage, www.smchealth.org/bhrs/mhsa. The site includes a subscription feature to receive an email notification when the website is updated with MHSA developments, meetings and opportunities for input. This is currently at over 2,000 subscribers.

The BHRS Director's Update is published the first Wednesday of every month and distributed electronically to county wide partners and stakeholders, and serves as an information dissemination and educational tool, with a standing column written by the County's MHSA Manager. The BHRS Blog also provides a forum for sharing and disseminating information broadly. In addition, presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the quarterly MHSA Steering Committee meeting; at meetings with community partners and advocates; and internally with staff.

Opportunities to present at statewide conferences will also be sought.

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. Animal companionship
2. Animal foster care
3. Pet foster care
4. Pets and behavioral health
5. Pets and housing

TIMELINE

A) Specify the expected start date and end date of your INN Project: July 1, 2025 – June 30, 2029

B) Specify the total timeframe (duration) of the INN Project: 4 years (3 years of services, 6 months start-up, 6 months post eval)

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

Quarter	Key Activities, Milestones, and Deliverables
Mar-Jun 2025	• BHRS Administrative startup activities – procurement and contract negotiations
July-Dec 2025	• Hire and train staff • Hire and train AFCs • Convene project advisory board • Develop client intake and follow-up forms • Set up infrastructure for implementation/ evaluation and referral system and resources • Evaluator to meet with contractor and BHRS staff to discuss evaluation plan and tools • Begin enrolling clients to start in January
Jan-Mar 2026	• Begin services to clients • Data tracking and collection begins, including qualitative data collection (interviews, focus groups, etc.)
Apr-Jun 2026	• Continue services to clients • Data tracking and collection • First 6 months post-launch evaluation report presented to advisory group for input, adjustments to strategies, tools and resources based on operational learnings to-date and quantitative data available • Based on first 6 months evaluation, determine whether and how to expand the program target population and number of clients served
Jul-Sept 2026	• Expand and continue services to clients • Data tracking and collection
Oct-Dec 2026	• Continue services to clients • Data tracking and collection
Jan-Mar 2027	• Continue services to clients • Data tracking and collection • Sustainability planning begins
Apr-Jun 2027	• Continue services to clients • Data tracking and collection • Second evaluation report presented to advisory group for input, adjustments to strategies, tools and resources based on quantitative and qualitative data.
Jul-Sept 2027	• Continue services to clients • Initial sustainability plan presented, begin exploring options for sustainability • Engage BHSA Steering Committee and the Behavioral Health Commission through BHSA Community Program Planning (CPP) process on the possibility of continuation with BHSA Behavioral Health Services and Supports funds.
Oct-Dec 2027	• Continue services to clients • Data tracking and collection
Jan-Mar 2028	• Continue services to clients • Data tracking and collection
Apr-Jun 2028	• Continue services to clients

	• Data tracking and collection • Third evaluation report presented to advisory group for input, adjustments to strategies, tools and resources based on quantitative and qualitative data.
Jun-Dec 2028	• Complete evaluation activities, prepare analysis and final evaluation report due to the MHSOAC December 2028 • Disseminate final findings and evaluation report

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

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

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

BUDGET NARRATIVE

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

The total Innovation funding request for 4 years is **$990,000**, which will be allocated as follows:

Service Contract: $870,000	**Evaluation: $120,000**
· $290,000 for FY 25/26 · $290,000 for FY 26/27 · $290,000 for FY 27/28	· $40,000 for FY 25/26 · $30,000 for FY 26/27 · $30,000 for FY 27/28 · $20,000 For FY 28/29 (6mths)

Direct Costs will total $870,000 over a three-year term and includes all contractor expenses related to delivering the program services (salaries and benefits, program supplies, rent/utilities, mileage, transportation of clients, translation services, subcontracts for outreach, etc.).

Indirect Costs will total $120,000

- $120,000 for an independent evaluation contract to develop all annual reports and the final report due by December 31, 2029. The evaluation contract includes developing the evaluation plan, supporting data collection, data analysis and preparing the annual and final reports required.

Federal Financial Participation (FFP) there is no initial anticipated FFP. Opportunities for Medi-Cal billing if approved (as a CalAim Community Support or through Housing Interventions) will be pursued.

Other Funding: The County will go through a local bidding process to identify the contractor for direct services; the bidding process will inquire about any in-kind or other revenue sources that can be leveraged.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
	PERSONNEL COSTS (salaries, wages, benefits)	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**TOTAL**
1.	Salaries						
2.	Direct Costs						
3.	Indirect Costs						
4.	**Total Personnel Costs**						**$**
	OPERATING COSTS*						
5.	Direct Costs						
6.	Indirect Costs						
7.	**Total Operating Costs**						**$**
	NON-RECURRING COSTS (equipment, technology)						
8.							
9.							
10.	**Total non-recurring costs**						**$**
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)						
11.	Direct Costs		$290,000	$290,000	$290,000		**$870,000**
12.	Indirect Costs		$40,000	$30,000	$30,000	$20,000	**$120,000**
13.	**Total Consultant Costs**		**$330,000**	**$320,000**	**$320,000**	**$20,000**	**$990,000**
	OTHER EXPENDITURES (please explain in budget narrative)						
14.							
15.							
16.	**Total Other Expenditures**						**$**
	BUDGET TOTALS						
	Personnel (total of line 1)						**$**
	Direct Costs (add lines 2, 5, and 11 from above)		$290,000	$290,000	$290,000		**$870,000**
	Indirect Costs (add lines 3, 6, and 12 from above)		$40,000	$30,000	$30,000	$20,000	**$120,000**
	Non-recurring costs (total of line 10)						**$**
	Other Expenditures (total of line 16)						**$**
	TOTAL INNOVATION BUDGET		**$330,000**	**$320,000**	**$320,000**	**$20,000**	**$990,000**

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

BUDGET CONTEXT – EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures <u>for administration</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**TOTAL**
1.	Innovative MHSA Funds		$290,000	$290,000	$290,000		**$870,000**
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	**Total Proposed Administration**		$290,000	$290,000	$290,000		**$870,000**
EVALUATION:							
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**TOTAL**
1.	Innovative MHSA Funds		$40,000	$30,000	$30,000	$20,000	**$120,000**
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	**Total Proposed Evaluation**		$40,000	$30,000	$30,000	$20,000	**$120,000**
TOTALS:							
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 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**TOTAL**
1.	Innovative MHSA Funds*		$330,000	$320,000	$320,000	$20,000	**$990,000**
2.	Federal Financial Participation						**$**
3.	1991 Realignment						**$**
4.	Behavioral Health Subaccount						**$**
5.	Other funding**						**$**
6.	**Total Proposed Expenditures**		**$330,000**	**$320,000**	**$320,000**	**$20,000**	**$990,000**
*** INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting** **** If "other funding" is included, please explain within budget narrative.**							

APPENDIX 1. THEORY OF CHANGE

Theory of Change: Animal Fostering and Care for Client Housing Stability and Wellness

Primary Problem: Clients with animals face barriers to treatment access and housing stability when they lack temporary care for their animals

Key Considerations (from the literature)

Animal Companionship

- Animal companionship is a common source of support for individuals with mental health and/or substance use challenges in line with the four dimensions of recovery outlined by SAMHSA: *health, home, purpose, and community*
- Research estimates at least one in five clients have animals

Barriers to Timely Treatment

- A common reason clients with animals decline higher levels of care (e.g., residential treatment) is uncertainty around care for their animal

Housing Stability and Wellness

- Clients in supportive housing settings may experience periods of crisis or unwellness, which may result in unhealthy living conditions for both the animal and the client, placing the client at risk for eviction

Interventions

Temporary Animal Foster Care

- Animal fostering for approx. 30-90 days while client is in higher level of care, extensions possible
- Emergency foster care for urgent client treatment needs
- Rehoming pets if needed

In-Home Animal Care Support

- In-home visits to support clients with dog walking, grooming, and routine veterinary care
- Coaching for clients on housing retention and animal care

Peer-Based Services

- Emphasis on animal foster care and in-home support providers with lived experience

Linkages to Community Resources

- Integration with mental health, substance use, and recovery services; check-ins, support, and referrals to community resources

System-Level Support

- Policy development for facilities that do not have policies around accepting animals

Outcomes

Access, Utilization, and Linkages

- Individuals who may have otherwise declined higher levels of care (e.g., residential treatment) choose to engage in services
- Clients experience fewer barriers to bringing their animals to treatment facilities due to clear facility policies

Housing Retention

- Participants with animals who experience a period of unwellness maintain their housing and their animal's wellness

Recovery

- Participants increase their length of time in recovery and fewer relapses

County Capacity

- Peers are further integrated into the system of services
- Facilities have clear and sustainable policies to support clients who have animals

Learning Objectives

Learning Goal #1

Does offering temporary animal fostering and care for individuals with mental health and/or substance use challenges who have assistance animals or companion animals: increase **engagement** in higher levels of care, improve **housing retention**, and improve **indicators of recovery**?

Learning Goal #2

Does providing **peer-to-peer services** impact client engagement in the program?

Learning Goal #3

What are the **essential elements** of the project that could be scaled or replicated?

MHSA INN Primary Purpose

Increased access to behavioral health services

APPENDIX 2. MHSA THREE-YEAR PLAN CPP & STRATEGY RECOMMENDATIONS

MHSA Three-Year Plan, 2020-2023
Community Program Planning (CPP) Process

The MHSA Three-Year Program and Expenditure Plan is developed in collaboration with clients and families, community members, staff, community agencies and stakeholders. In November 2022, a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan commenced and engaged over 400 diverse clients, family members, staff and community agencies and leaders representing geographical, ethnic, cultural and social economic status, providers of behavioral health care services, social services and other sectors across various means of providing input (surveys, input sessions, public comments). Planning was led by the MHSA Manager, Behavioral Health Commission MHSA Co-Chairpersons, an MHSA Three-Year Plan Workgroup and the MHSA Steering Committee. A draft CPP process was provided to the Behavioral Health Commission (BHC) and the MHSA Steering Committee in December 2022. Stakeholders provided input and comments on the process and what additional stakeholder groups should be engaged.

CPP FRAMEWORK

MHSA THREE-YEAR PLAN WORKGROUP

Between November and January 2023, a workgroup was convened made up of diverse stakeholders including clients, family members, community members and contracted service providers. The workgroup met monthly with the goal of co-designing an MHSA 3- Year Plan Community Program Planning (CPP) process that is equitable, inclusive and honors and centers the voices of marginalized communities. The objectives of each meeting included the following:

- Review and advise on data needed to support a comprehensive needs assessment
- Advise on the community input process and community engagement best practices, to ensure it is inclusive of all vulnerable communities
- Support opportunities for all San Mateo County community members to provide input

The MHSA Three-Year Plan Workgroup guided and informed the process each step of the way:

1. Needs Assessment
    - Informed Data Collection resources
    - Advised on the Community Survey structure
2. Strategy Development
    - Informed Community Input Sessions strategy
    - Advised on the creation of a Facilitator Training for stakeholders to support input sessions
    - Facilitated Community Input sessions
3. MHSA Three-Year Plan Development
    - Reviewed the Recommended Strategies for accuracy

COMMUNITY PROGRAM PLANNING PROCESS

1. Needs Assessment – this phase of the CPP process included the following two steps:
    - ✓ Data Review: Over 30 local plans, assessments, evaluation reports, and data were reviewed to identify prominent mental health and substance use needs reported across service sectors and the community. All of the concerns identified in the needs assessment review were categorized into the following 8 areas of need.
        i. **Access to Services** - this category captures the needs of diverse cultures and identities (race/ethnicity, LGBTQIA+, veteran status, age) related to accessing mental health and substance use services, including knowledge and education and culturally responsive approaches to engaging communities.
        ii. **Behavioral Health Workforce** - this category captures the needs related to recruiting, developing, supporting and maintaining a sufficient workforce to address the needs and the diversity of the community. This includes supporting individuals with lived experience as clients and/or family members of clients of mental health and substance use services to join the workforce and support all services and programming.

iii. **Crisis Continuum** - this category captures needs related to mental health and substance use crisis response, as well as appropriate community-based supports and stabilization during and after a crisis.

iv. **Housing Continuum** - this category captures the housing needs for individuals living with mental health challenges ranging from assisted living facilities to having access to permanent supportive housing, to early assessment of risk of homelessness and culturally responsive approaches and support with locating and maintaining housing.

v. **Substance Use Challenges** - this category captures the increasing need for substance use services and supports that are accessible, integrated and coordinated with mental health services.

vi. **Quality of Client Care** - this category captures the needs of clients that are in treatment for mental health and/or substance use challenges to have timely access to care when needed, are successfully connected to services after an emergency and receive culturally responsive approaches to their treatment.

vii. **Youth Needs** - this category is age-based and captures mental health and substance use challenges for school to transition-age youth ages 6-25, it includes recent data for adolescent suicides, juvenile justice involvement, school-based and on-campus supports.

viii. **Adult/Older Adult Needs** - this category is age-based and captures mental health and substance use challenges for adults and older adults, it includes recent data related to increasing complexity of needs, general poor mental health outcomes, and suicide prevention needs.

✓ Community Survey: The identified needs from the review of local plans and data were included in an online survey that was distributed broadly to individuals living or working in San Mateo County. The survey asked respondents to share any additional concerns related to mental health and/or substance. Additionally, the survey requested that respondents rank the 8 areas of need in order of importance.

There were 129 survey respondents to the survey, the Needs Assessment summary of results were presented to the MHSA Steering Committee on February 2, 2023, to launch the Strategy Development phase.

2. Strategy Development – this phase of the CPP process included the following two steps:

✓ Community Input: 31 community input sessions and key interviews with diverse groups and vulnerable populations (immigrant families, veterans and transition-age youth) were conducted. Based on advice from the MHSA Three-Year Plan Workgroup, groups were asked to select 1 of the 8 areas of need to brainstorm strategies in the areas of prevention, direct service and workforce supports.* Participants were asked what possible solutions (services, programs, infrastructure, etc.) would they recommend to address the need they selected. See Appendix 2. for the full list of Strategy Recommendations.

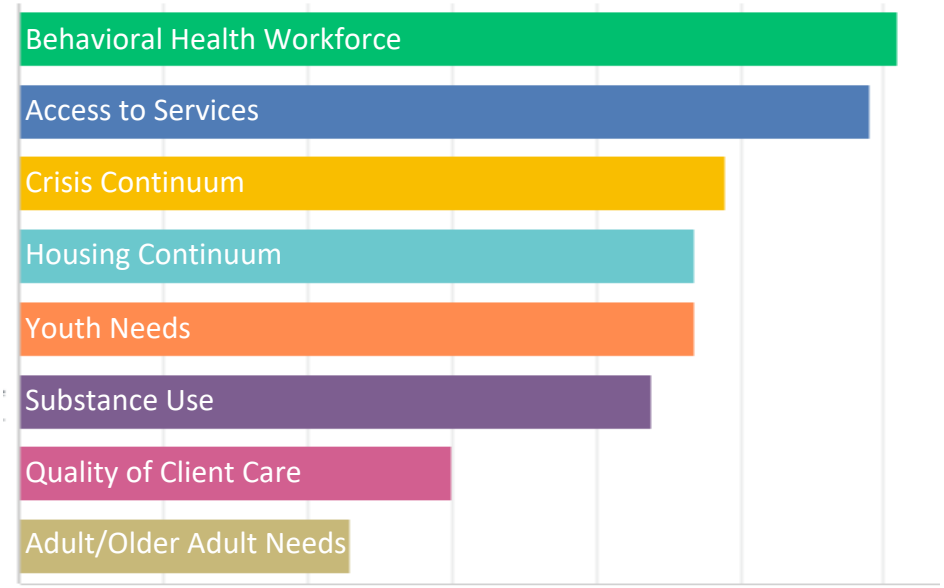
** As part of a simultaneous process to develop the MHSA 3-Year Workforce Education and Training (WET) Plan, 5 additional sessions were conducted to brainstorm around Behavioral Health Workforce strategies with the Diversity and Equity Council, Lived Experience and Education Workgroup, Alcohol and Other Drugs' Contracted Providers and BHRS Adult and Youth Leadership Teams.*

✓ Prioritization: To support the prioritization of strategies, participants were also asked: If you had to select one strategy to focus on over the next 3 years, which would you prioritize? Qualitative data analysis of all input received was conducted to identify the top strategy recommendations and key themes to present to the MHSA Steering Committee on May 4, 2023. Over 1,000 strategy ideas were shared via the Community Input sessions. This was narrowed down to 70 Strategy Recommendations across the 8 areas of need; strategies were included in this list if they were the top prioritized strategy by an input session group, they were repeated across input sessions, and for the areas of need that weren't selected as often by community groups (i.e., crisis continuum, substance use challenges, quality of client care and adult/older adult needs) all strategies that received a prioritization vote during in the input sessions were included.

Additionally, three key themes emerged from the input sessions overall, these strategies were brought up in virtually all input session: 1) Increase community awareness and education about behavioral health topics, resources and services; 2) Embed peer and family supports into all behavioral health services; 3) Implement culturally responsive approaches that are data-driven to address existing inequities. The idea is to incorporate these components into EVERY prioritized strategy moving forward.

The key themes and 70 Strategy Recommendations, Appendix 2., were presented to the MHSA Steering Committee on May 4th along with pre-recorded stakeholder video testimonials for each of the 8 areas of need and with an opportunity for additional public comments from meeting participants. Following the meeting the MHSA Steering Committee members were asked, via an online survey, to rank the 8 areas of need and help narrow down the scope of MHSA resources (both funding and planning) over the next three years. Given this prioritization, the areas of focus for the next three years will include Behavioral Health Workforce, Access to Services and addressing gaps in the Crisis Continuum. The MHSA Steering Committee was then asked in a follow-up survey to select their top Strategy Recommendations for each of the three prioritized areas of focus.

MHSA Steering Committee
Part 1 Survey Results – Areas of Need Prioritization:



3. MHSA Three-Year Plan – this phase of the CPP process includes the development of the plan, the 30-day public comment period and public hearing hosted by the Behavioral Health Commission (BHC) and the subsequent approval by the Board of Supervisors.

   - ✓ 30-Day Public Comment: The BHC voted to open a 30-day public comment period on June 7, 2023 and held a Public Hearing on July 5, 2023.
   - ✓ Board of Supervisor Approval: The BHC also voted to submit the MHSA Three-Year Plan to the Board of Supervisors for approval after the closing of the public comment period on July 7, 2023.

   This MHSA Three-Year Plan includes new funding allocations for the prioritized strategy recommendations, proposed funding allocations for other areas of need and strategy ideas that were identified; if there is an opportunity to leverage other efforts, initiatives, and/or external funding. The MHSA Three-Year Plan also builds on previous priorities. Funding and implementation for recommendations from the FY 20-21 Housing Taskforce and the Full Service Partnership (FSP) Workgroups will continue. See the Housing and FSP Workgroup priorities section.

   Additionally, The MHSA Three-Year Plan includes ongoing funding allocations for existing MHSA-funded programs. These programs are monitored, evaluated and adjusted as needed during the MHSA Three-Year Plan implementation years and recommendations are made annually about continuing, adjusting and/or ending a program. Changes to existing programs and services are included in subsequent Annual Updates, which involve stakeholder input, the MHSA Steering Committee and the BHC 30-day public comment period. Agencies selected to provide MHSA-funded services go through a formal Request for Proposal (RFP) process to ensure an open and competitive process to funding opportunities. The RFPs are posted on the BHRS RFP website, www.smchealth.org/rfps, which includes a subscription option to receive notifications.

MHSA THREE-YEAR PLAN STAKEHOLDER INPUT

Extensive outreach was conducted to promote the MHSA Three-Year Plan Workgroup participation opportunity, the Facilitator Training opportunity, the MHSA Steering Committee meetings, and the Community Input sessions. Flyers were made available in English, Spanish, and Chinese. Stipends to consumers/clients and their family members and language interpretation were offered at every meeting, childcare for families and refreshments were offered for in-person meetings.

Input included perspectives from clients and family members, communities across geographical, ethnic, cultural and social economic status, providers of behavioral health care services, social services and other sectors. The sessions were conducted through 14 existing collaboratives/initiatives, 11 committees/workgroups, 3 geographically-focused collaboratives (Coastside, East Palo Alto and North County) and 3 stakeholder group key interviews of transition-age youth, immigrant families and veterans. The majority of the meetings were conducted online. Over 400 individuals participated across the various means of providing input (surveys, input sessions, public comments).

Input Session conducted

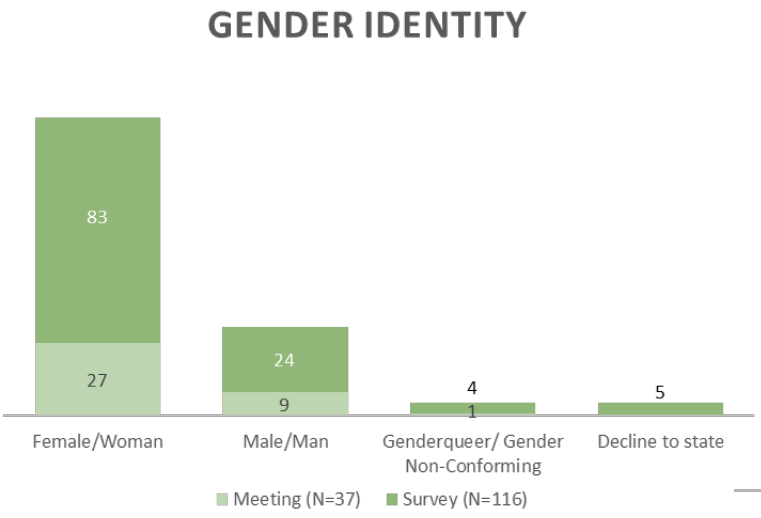
Date	Stakeholder Group	Input Session Topics
	MHSA Steering Committee	
2/2/23	4 Breakout Groups	Access to Services; Behavioral Health Workforce; Housing Continuum; Crisis Continuum
	Health Equity Initiatives	
2/3/23	Chinese Health Initiative	Access to Services
2/7/23	Pacific Islander Initiative	Youth Needs
2/8/23	Pride Initiative	Housing Continuum
2/14/23	African American Community Initiative	Quality of Client Care
2/14/23	Spirituality Initiative	Adult/Older Adult Needs
2/16/23	Native American and Indigenous Peoples Initiative	Quality of Client Care
2/16/23	Filipino Mental Health Initiative	Access to Services
2/28/23	Latino Collaborative	Access to Services
	Community Collaboratives	
2/10/23	North County Outreach Collaborative	Behavioral Health Workforce
2/16/23	East Palo Alto Behavioral Health Advisory	Behavioral Health Workforce
2/22/23	Coastside Collaborative	Access to Services
3/9/23	East Palo Alto Community Collaborative	Access to Services
	Peer Recovery Collaborative	
2/6/23	California Clubhouse/Heart & Soul	Housing Continuum
2/7/23	Voices of Recovery	Substance Use Challenges
	Behavioral Health Commission (BHC)	
2/1/23	BHC Older Adult Committee	Adult/Older Adult Needs

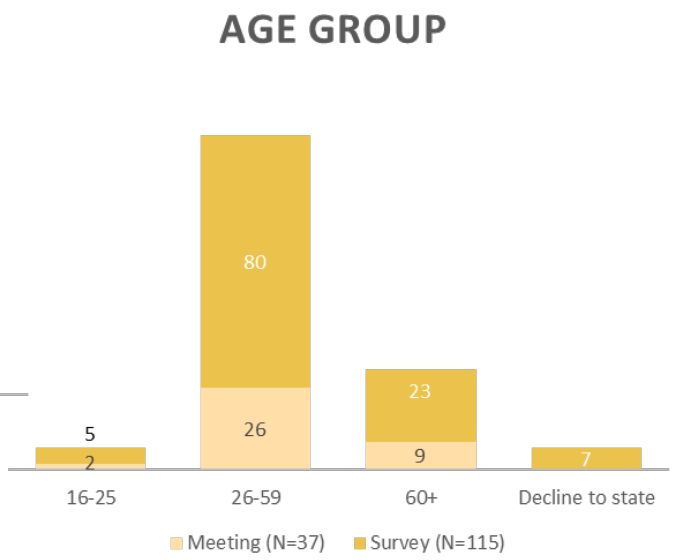
2/15/23	BHC Child and Youth Committee (3 Breakout Groups)	Youth Needs
2/15/23	BHC Adult Committee	Housing Continuum
2/21/23	BHC Alcohol and Other Drugs Committee	Substance Use Challenges
	Other Committees/Groups	
2/9/23	Housing Operations Committee	Housing Continuum
2/7/23	Lived Experience Education Workgroup	Housing Continuum
2/16/23	Contractors Association	Behavioral Health Workforce
2/20/23	Solutions for Supportive Housing	Housing Continuum
2/24/23	School Wellness Counselors	Youth Needs
2/14/23	BHRS Youth Leadership	Crisis Continuum
	Workforce Education & Training 3-Year Plan	
3/3/23	Diversity and Equity Council	Behavioral Health Workforce
3/2/23	Alcohol and Other Drug Providers	Behavioral Health Workforce
3/8/23	BHRS Adult Leadership	Behavioral Health Workforce
2/28/23	BHRS Youth Leadership	Behavioral Health Workforce
3/7/23	Lived Experience Education Workgroup	Behavioral Health Workforce
Key interviews conducted:		
Immigrant Families, Transition Age Youth, Veterans		Youth Needs; Access to Services

Demographics of participants

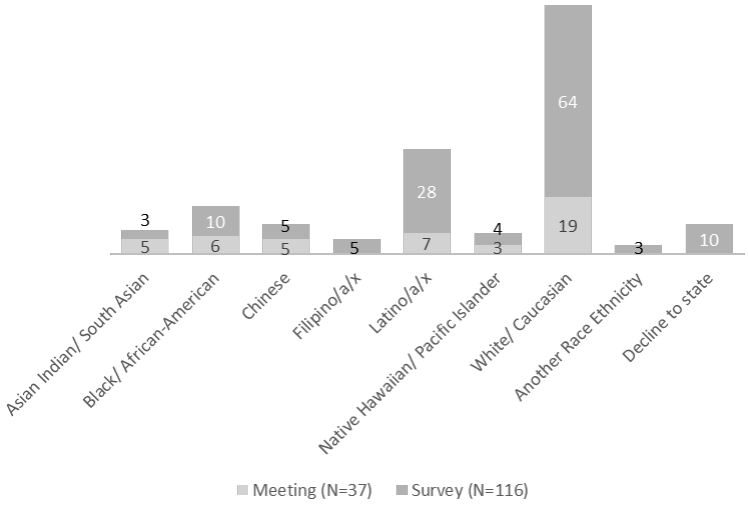
Demographic data was not collected from all 31 Community Input Sessions. 35 client and family members received stipends for participating in these sessions.

Demographics were collected for 129 survey respondents and 37 participants via a Zoom Poll feature during the two MHSA Steering Committee meetings focused on the MHSA Three-Year Plan Community Program Planning process.

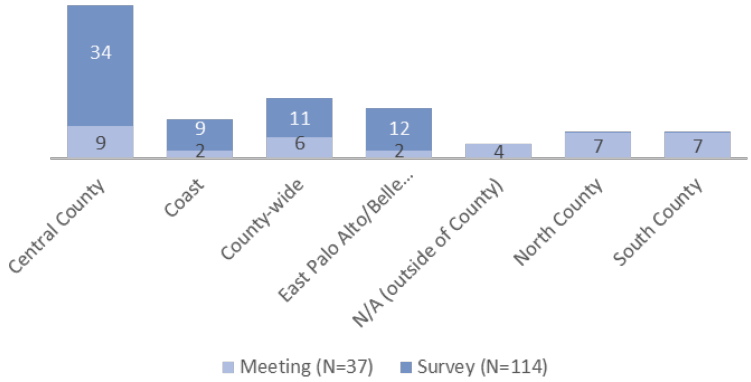




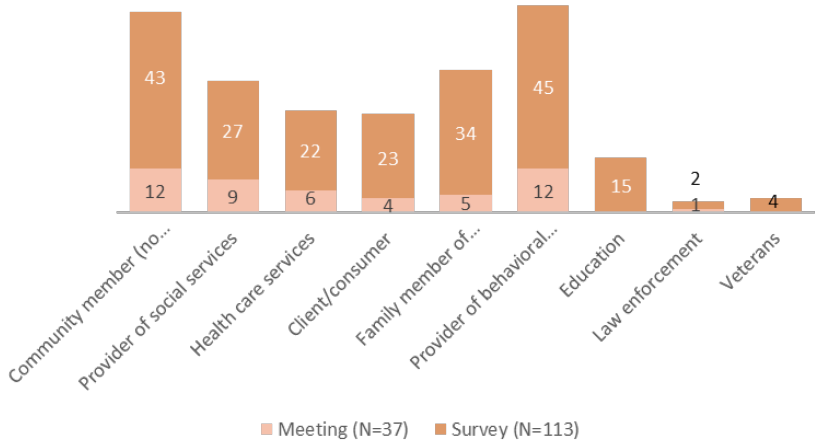
RACE/ETHNICITY



AREA OF COUNTY REPRESENTED



STAKEHOLDER GROUP



SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA Three-Year Plan Strategy Recommendations

FY 23-24 to FY 25-26

30+ community input sessions and key interviews were conducted to brainstorm strategies to address San Mateo County behavioral health needs. The MHSA Steering Committee will be voting to prioritize across the Identified Needs and across the Strategy Recommendations. This prioritization will inform the allocation of resources over the next three-years. Across all community input sessions, three core themes emerged. These components will be incorporated into EVERY prioritized strategy:

1. **Increase community awareness** and education about behavioral health topics, resources and services
2. **Embed peer and family supports** into all behavioral health services
3. **Implement culturally responsive** approaches to address existing inequities that are data-driven

Direct Services & Supports / Prevention Early Intervention

Identified Needs	Strategy Recommendations
Access to Services	1. Coordinate behavioral health services for cultural and ethnic communities (centralize services, outreach and education for the Chinese community, hire bilingual/bicultural peer staff, etc.).
	2. Expand drop-in behavioral health services that includes access to wrap around services for youth.
	3. Provide school-based behavioral health services starting in elementary and middle school; include early diagnosis and assessment at high school grade level.
	4. Co-locate prevention services (support groups, programs, workshops, etc.) in community settings such as faith-based organizations, core-service agencies, community spaces, etc.
	5. Conduct racial equity analysis of BHRS policies and procedures to identify barriers to accessing care; include service utilization and staff capacity data.
	6. Expand services for older adults focused on addressing isolation, peer support, social engagement and intergenerational work.
	7. Expand the Health Ambassador Program to include diverse languages/cultures and subject expertise (substance use, justice involved, unhoused, human trafficking, etc.)
	8. Expand outreach partnerships to include increased mild-to-moderate services, faith-based organizations and veteran engagement.
	9. Promote volunteerism to increase social engagement and community cohesion.

Recruitment & Retention Strategies

Identified Need	Strategy Recommendations
Behavioral Health Workforce	1. Create a pipeline program focused on increasing Asian American and African American behavioral health staff, develop partnerships with local and neighboring academic and non-academic programs.
	2. Create more entry level positions and internships for students of diverse backgrounds; streamline hiring processes (e.g., onboarding and process to hire interns).
	3. Target recruitment activities to reach black, indigenous, people of color (BIPOC) communities (e.g., partner with BIPOC-focused communities and student organizations and networks).
	4. Implement recruitment and retention financial incentives such as retention bonuses, signing bonuses, educational loan repayment for staff and contracted providers.
	5. Examine and adjust caseload size and balance, particularly for bilingual staff.
	6. Expand type, flexibility, and access to staff wellness and engagement opportunities (e.g., appreciation, healing activities, mentoring, behavioral health supports, networking events).
	7. Explore opportunities for alternative and flexible schedules and remote work.
	8. Implement supports for direct service staff, including peers, to advance in their careers, specifically BIPOC staff (e.g., scholarships to pursue licensure/credentials, mentorship).
	9. Invest in support, retention and leadership development of peer and family support workers (training, fair compensation, career ladders, flexible hours, and mentorship).
	10. Address extra help and contracted positions, especially for those that interface with the community.
	11. Research, plan, and implement compensation and benefits that are aligned with competing agencies and neighboring counties (e.g., salaries, cost of living, retirement plans, housing vouchers).

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Crisis Continuum	1. Create stabilization unit(s) and dedicated teams.
	2. Expand step-down from hospitalization facilities, programs and teams (e.g., respite centers).
	3. Create a youth crisis residential in the County.
	4. Expand intensive outpatient services (extended Intensive Outpatient Programs for youth, day treatment programs, detox centers, etc.).
	5. Provide respite care and language-appropriate navigation supports for parents with children who experience a behavioral health crisis (5150, psychiatric emergency services, hospitalization, etc.).
	6. Expand non-armed 24/7 mobile mental health crisis response to serve the entire community.
	7. Expand drop-in centers for individuals that struggle with mental health and/or substance use.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Housing Continuum	1. Expand clinicians available to the Homeless Engagement Assessment Linkage team (a field-based outreach, engagement and intervention services).
	2. Expand supportive housing slots for individuals living with mental health and substance use challenges that do not require homelessness as an eligibility requirement.
	3. Provide housing maintenance and peer supports including case management, wrap around services, hoarding resources, and specialized services for older adults and other vulnerable communities.
	4. Develop a comprehensive housing database that includes real time waitlist times and availability.
	5. Incentivize board and cares (streamline the application process, reduce/subsidize licensing costs, etc.).
	6. Provide housing navigation and locator resources; include re-entry supports, bilingual peer supports, streamlined case management, simplified housing application and subsidized fees.
	7. Provide supports for section 8 housing including funding, vouchers, and training to landlords.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Substance Use Challenges	1. Create integrated services for complex needs including individuals with dual diagnosis or co-occurring mental health and substance use needs.
	2. Create longer-term sober living arrangements.
	3. Expand non-medication supports for individuals with addiction.
	4. Expand recovery-focused drop-in centers.
	5. Expand resources for reunification (support for parents, how to talk/interact with their children, etc.).
	6. Provide access to Narcan for clients and family members.
	7. Provide family-centered recovery supports that includes child care at every stage.
	8. Address intergenerational trauma in recovery and treatment.
	9. Expand early intervention resources for addiction.
	10. Provide education about substance use prevention starting in elementary school (how to say no, healthy boundaries, etc.).

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Quality of Client Care	1. Provide ongoing resource navigation and peer support in crisis situations.
	2. Create client centered services (meet people where they are, provide virtual/in-person, services in their language, flexible hours, etc.).
	3. Implement best practice sharing across BHRS clinics, including integrated services and identification of supports that can be offered across the county.
	4. Develop a streamlined BHRS intake process across the network of care.
	5. Develop partnerships for substance use referrals for clients with Access and Care for Everyone (ACE).
	6. Develop partnerships with indigenous community spaces and cultural healers.
	7. Address Adverse Childhood Experiences, Social Determinants of Health, and intergenerational trauma.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Adult/Older Adult Needs	1. Create internal processes to regularly review utilization and outcome data to inform responsive services for older adults.
	2. Create partnership between the County and Veterans Administration to increase supports for veterans (integration with primary care services, resources for women veterans on sexual assault, suicide prevention for veterans, etc).
	3. Expand capacity for neuropsychological evaluation and diagnosis.
	4. Expand in-home hoarding supports (linkages to services, case management, specialized therapy, decluttering, etc.)
	5. Expand services for individuals with complex needs; develop partnerships with organizations that can support complex client needs.
	6. Expand the OASIS team peer specialist' support for older adults, caregivers and family members.
	7. Develop an outreach and communication strategy on behavioral health and wellness in multiple languages; leverage existing networks (SMC Alert, neighborhood CERTs, etc.).
	8. Expand culturally relevant suicide prevention strategies.
	9. Expand prevention services to older adults prior to complications; develop partnerships with organizations that can provide these services.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Youth Needs	1. Address gaps in the crisis continuum for youth (increase 5150 beds, language capacity, expand non-law enforcement response, stabilization unit, crisis residential, etc.).
	2. Expand school-based behavioral health education and services starting in middle school that includes family therapy and peer support groups for parents, youth, and school staff.
	3. Expand school-based wellness centers.
	4. Expand afterschool-based programming.
	5. Expand availability of diverse wellness counselors and clinicians on all school campuses.
	6. Integrate wraparound services in schools, in partnership with community-based organizations.
	7. Provide Narcan in high schools (used to reverse opioid overdose).
	8. Expand Social Emotional Learning (SEL) curriculum in schools.
	9. Expand the Health Ambassador Program for both Youth and Adults; include case management and increased support for ambassador's families.

APPENDIX 3. ALL PUBLIC COMMENTS RECEIVED

Summary of Public Comments Received

INN Project Plans – Animal Fostering and Care for Housing Stability and Wellness

30-Day Public Comment Process & Public Hearing (10/2/24 – 11/7/24)

Substantive Comments[1]

Comment	Response/Recommended Revision
Lori Morton-Feazell (County of San Mateo Health): How can we work with these residential facilities to change their policy around pets? In our shelter and congregate shelters we have shown that the issues they are stating do not exist. (p5)	BHRS will add a component to the program that will include working with supportive housing and treatment facilities that do not currently have policies to establish and formalize policies around accepting animals (i.e., Permanent Supportive Housing, Serenity House, and substance use treatment facilities).
Lori Morton-Feazell: Given legal issues, client-animal visitation is not feasible. (p7)	BHRS will remove the client-animal visitation component of the program. The program will still include opportunities for clients to receive regular updates about the wellbeing of their animal.
Lori Morton-Feazell: Will [the Program Manager] be a BHRS employee? Or is this person employed by the Animal organization you will be contracting with? (p8)	BHRS will adjust the staffing section of the plan to include a Project Coordinator from San Mateo County Health that will work in collaboration with a BHRS Manager. The Project Coordinator will be responsible for contracting with fostering agency and supportive services.
Lori Morton-Feazell: Have you included in the cost animal food, supplies such as bowls, litter boxes, cages etc? Will BHRS pay for that or will it be the animal organization's responsibility to cover those costs? (p8)	Given this comment and further understanding about the cost of providing the animal foster care and supportive services, BHRS will adjust the budget as follows to increase the funding for contracted services and remove the funding for BHRS administration. In addition, BHRS will increase the funding for evaluation based on field standards of 12-15%. ● **Service Contract**: increase from $750,000 to $870,000 ($290,000 annually for three years) ● **Evaluation**: Increase from $100,000 to $120,000

[1] MHSA legislation requires that the Annual Updates for the MHSA Program and Expenditure Plan include a summary of any "substantive" public comments received (e.g., comments that may require a change to the plan) and if applicable, include the recommended revisions to the plan.

Public Comments and Q&A

BHC meeting (10/02/24), opening of public comment period

- **Jo** [via chat]: So the animal care for housing stability, is it medical care for the animals?
    - Doris Estremera: So there is a component that does provide veterinary care. And this is something that actually we have a good resource in our County. This is something that's already provided at our shelters through our Public Health Department. So yes, veterinary care services would be [part of the project]. But again, the main criteria, as this project has been envisioned, is for that urgent and temporary need where it is going to support somebody to either get housed or maintain their housing, or enter a higher level of care, not as an ongoing support for clients with pets.

Additional Public Comments

- **MHSOAC Innovations team:** Consider including additional detail on the local need, such as local personal stories on the need for and impact of receiving support for animal care.
- **Lori Morton-Feazell (County of San Mateo Health):**
    - I am so glad that BHRS has a way to get the funding for this pilot. It is a large gap for those in need of treatment that have pets to have a foster care program. It is so true that people will not leave their pets unless they know they are being cared for and safe. Is the name of the project final? I am not sure if it can be modified at this point. When the term " Animal Care" is used it includes all aspects of the care for the animal when this proposal covers mainly foster care, and in-home pet care of the animals in need. I don't want the case managers, county staff, or clients to confuse your program with the Veterinarian wellness program that my team provides. Maybe the title can be "Animal Foster Care." Just a suggestion.
    - Will BHRS be asking my vet wellness program for support on vaccines and treatment? If the answer is yes I will need to look for a way to expand my program.
        - Doris Estremera: We do not anticipate a high need for vaccines and treatment, it will be minimal and only available to pets while in foster care.
    - Lori Morton-Feazell: Why would BHRS be recruiting peer support workers [to serve as the animal fosterers]? Wouldn't that fall to the scope of work of the animal organization you will be contracting with? The group recruiting animal foster care volunteers should have the knowledge of what is needed for the care of that animals. They should already be aware of animal issues that can happen, however to handle animal emergencies, etc. Just curious why that would not be a role of the animal group? (p8)
        - Doris Estremera: This is the role of the contracted animal fostering agency. BHRS will center the importance of peer-to-peer services by 1) including language in the Request for Proposals (RFP) for the contracted foster agency that the agency should value and promote the importance of peer-to-peer

services for individuals with mental health and substance use challenges; and 2) working with the contracted agency to promote the opportunity for peers to become fosterers through BHRS's existing network of peer support workers and programs for individuals with lived experience and their family members.

- Who will be developing the training [for the volunteer animal fosters]? I would increase this number [3 fosterers] due to people not being available or on vacation, or sick etc. If you are putting in the effort to train, why not train more people?
    - Doris Estremera: The training, support and recruitment of fosterers will be on the contracted fostering agency, we are looking to contract with an agency that already offers pet fostering during natural disasters or other emergencies and has the infrastructure in place to support volunteers.
- Will the support [through this program] remain with clients with mental health or substance issues or is the plan to expand to those in residential housing /congregate housing that might need a foster home if they are entering the hospital or incarcerated?
    - Doris Estremera: Yes, this would be for BHRS and network of providers' clients only.
- Will the program include all types of animals? Just curious as we do have a resident with chickens. I think it should be for all pets. I am bringing this up so it is on your radar that the client could have a bird, rabbit, fish or reptiles. You will need [animal fosters] that can handle any species of animal.
    - Doris Estremera: This will be on the selected fostering agency to determine based on capacity and their policies; we can request this (but, not require) during the RFP process.
- You could include [in the background Research for the INN Component section] that the Contracted Animal Care and Control Vendor of San Mateo County currently will hold in protective custody animals for 30 days however if they need a longer stay there is a gap in service.

BHC meeting (11/06/24), closing public comment period.

- **Commissioner J. Perry:** I'm concerned of the level of control that BHRS will have over the fosterers. The people that would love to foster would be doing this and they won't be given the right kind of training and support that a peer would already have. They won't have take family-to-family [NAMI training]. They won't know that the pet parent may respond to them in really negative ways in response to you doing a good thing because of where they may be in their illness. And so, I just am concerned that people who are really good at fostering pets will not be given the skill set to be interacting with the pat parent, who is a BHRS client.

INN Project Proposal #3 - *allcove Half Moon Bay*

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSOAC
Mental Health Services
Oversight & Accountability Commission

INNOVATIVE PROJECT PLAN
RECOMMENDED TEMPLATE

COMPLETE APPLICATION CHECKLIST
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:
☑ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors.
☑ Local Mental Health Board approval Approval Date: November 6, 2024
☑ Completed 30 day public comment period Comment Period: November 6, 2024
☐ BOS approval date Approval Date: _____ If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: January 14, 2025 *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*
Desired Presentation Date for Commission: January 23, 2025 ***Note: Date requested above is not guaranteed until MHSOAC staff verifies all requirements have been met.***

Mental Health Services Act (MHSA) Innovation Project Plan

County Name: San Mateo County
Date submitted: TBD
Project Title: allcove Half Moon Bay
Total amount requested: $1,600,000

- $1.5M service delivery for 3 years
- $100K BHRS administration
- Evaluation to be provided by Stanford as part of the multi-county collaborative

Duration of project: 3.5 years

- 3 years of service provision + 6 months of pre/post BHRS administration

In early 2024, CoastPride, a nonprofit based in San Mateo County's coastside community, was awarded two-year start-up funding from the MHSOAC to establish an allcove center in the city of Half Moon Bay (allcove Half Moon Bay) to reach youth and young adults on the coast. This proposal is for local San Mateo County INN funding to supplement the state start-up grant and specifically fund the delivery of early intervention services behavioral health services to youth and their families, including mental health support groups, individual therapy and other treatment services. The funding will also be utilized to implement principles for allcove centers called ACCESS (Anti-racist, Culturally-minded, Community Education, Support, and Services). ACCESS principles will allow allcove Half Moon Bay to prioritize Latine and queer youth community engagement and become truly reflective of the diverse community in the coastside and support access to services that are bicultural, bilingual, queer-affirming, and resonate with our young coastsiders' multiple identities.

This proposal contains specific details on the local context, local community planning process (including local review dates), and budget details for San Mateo County's allcove center in Half Moon Bay (allcoveHMB). The statewide INN Plan is provided as an attachment for context. This proposal will serve as an appendix to the broader INN plan for a Multi-County allcove collaborative, which is attached here for reference.

BACKGROUND

As part of the Prop. 1 behavioral health transformation, the Behavioral Health Services Act (BHSA) prioritizes strategies to increase access to early intervention services for youth and young adults. The California Mental Health Services Oversight and Accountability Commission (MHSOAC) has approved a statewide collaborative that supports counties to use MHSA Innovation (INN) funding to establish youth multi-service centers based on the allcove™ model. The allcove model, inspired by successful international integrated youth mental health models in Australia, Canada, and Ireland, creates stand-alone, "one-stop-shop" health centers for young people ages 12 to 25 to access support for mild to

moderate needs with mental health, physical health, substance use, peer support, supported education and employment, and family support, as well as linkages to community referrals in the continuum of care for more intensive needs.

LOCAL NEED

In San Mateo County, as in the United States as a whole, there are dire concerns about the status of youth mental health. In October 2021, leading children's health organizations declared a National State of Emergency in Children's Mental Health and in December 2021, the U.S. Surgeon General issued a National Advisory on the youth mental health crisis. Youth and young adults are facing an unprecedented level of stress from causes including racism, violence, the climate crisis, cyberbullying, the impacts of the COVID-19 pandemic, and a charged political climate around immigration and LGBTQ+ rights, all of which contribute to increased levels of chronic stress among youth, which in turn can lead to anxiety and depression.

An allcove center in the city of San Mateo was established in the fall of 2023 by Peninsula Health Care District. However, it is well known that San Mateo County's coastside region is physically isolated from the central parts of the county and lacks equitable access to services. The coastside has long struggled with social and economic challenges that have been exacerbated by the COVID-19 pandemic, the climate crisis, and the growing economic disparity in the Bay Area. Despite being situated in one of the richest counties in the nation, the limited resources in this part of the county have limited access to mental health, substance use prevention and treatment, educational and employment opportunities, and other supportive services. Behavioral health inequities flow from this economic disparity, and while it is felt by all coastsiders, it disproportionately impacts residents of color and LGBTQ+ communities.

The mental health of middle school and high school age students points to a need for greater support. The California Healthy Kids Survey for Cabrillo Unified School District (CUSD) in 2022-23 found that one-third of students in grades 7th, 9th and 11th report chronic sadness; among 7th graders, 20% of students reported they considered suicide; among 11th graders, one-third of students reported social and emotional distress; and less than half (45%) of students in all grades reported a sense of optimism.

A 2023 community survey of Latinx youth on the coastside (n=46) also had distressing findings about the behavioral health struggles that youth face.

- **Stress related to school and family.** Four out of five respondents said that they were really stressed out about school/homework. Thirteen percent of respondents reported being bullied. One in four said they were really stressed out about family.
- **Concern and stress about the future**. When asked about their future, over 40% said confused and concerned; 24% scared and not sure what the future may hold; and close to 36% said excited and hopeful. Nearly one-third reported being really stressed out about their future.
- **Life-changing events**. Youth reported experiencing life changing events in the previous year, including grieving the death of a loved one (19%) and having to move (13%).

- **Sadness, depression, self-harm, and thoughts of suicide.** Over 40% of respondents said they felt sad or depressed "a little" or "some of the time" during the past month, and close to 20% said "most of the time." 13% said they self-harmed. 20% said that they considered suicide during the past year.
- **Substance use**. Over 70% said young people got alcohol or marijuana from other teens.
- **Gaps in support.** A little over half of respondents felt they had a friend they could talk to when they were having a hard time. Almost 60% said they didn't think anyone showed concern or maybe just a little or they just didn't know if anyone was concerned with what they were doing. In response to the question, "What do you wish the community would do to support people your age?" the main themes were: 1) more mental health services; 2) alcohol/drug/smoking prevention services; 3) access to rehab services; 4) support in school; and 5) more activities that are fun.

In 2022, CoastPride partnered with Our Voice to engage students from diverse backgrounds across gender, sexual orientation, race, and disability to document positive and challenging aspects of their school and community life. Twenty-three students from local Gender Sexuality Alliance (GSA) and social justice groups collected 137 photos and descriptions to document affirming (positive) and non-affirming (negative) spaces and interactions in their school and community. The records were categorized into eight themes, with mental health being by far the most commonly represented theme: mental health (44), gender (15), race/ethnicity (13), physical activity (14), language (8), religion (7), sexual orientation (7), and something else (47). Challenging and non-affirming results included stressful spaces, run-down buildings, anti-LGBTQ slurs, racial slurs, and the overwhelming need to address youth mental health.

Given the significant need among youth in San Mateo County's coastside, youth-led and community-defined evidence-based practices such as allcove are needed in order to reduce behavioral health disparities and advance behavioral health equity for young coastside residents.

PROPOSED PROJECT

In early 2024, CoastPride, a nonprofit based in San Mateo County's coastside community, was awarded $1,729,590 in two-year start-up funding from the MHSOAC to establish an allcove center in the city of Half Moon Bay (allcove Half Moon Bay) to reach youth and young adults on the coastside. The start-up grant funding will be used during the first two years of operation to support start-up costs including identifying a building, hiring and training staff, and planning for services. Local INN funding will supplement and support the delivery of early intervention services and behavioral health services to youth and their families at the allcove Half Moon Bay center, including mental health support groups, individual therapy and other treatment services. The funding will also be utilized to implement a cultural safety framework that is being developed by Stanford with youth advisor input for allcove centers. This approach will allow allcove Half Moon Bay to prioritize Latine and queer youth community engagement and become truly reflective of the diverse community in the coastside and support access to services that are bicultural, bilingual, queer-affirming, and resonate with our young coastsiders' multiple identities.

The allcove Half Moon Bay center will provide:

- Holistic and coordinated services including mental health, substance use, physical health, supported education and employment, peer support, family support, and social and arts activities.
- Upstream, early intervention services that aim to positively alter even the most serious forms of mental illness through early detection and intervention.
- Youth-centered approaches that focus on resilience and identity, and a youth-friendly physical space with accessible hours of operation.
- Connections to community-based partners, including Ayudando Latinos a Soñar (ALAS) and Youth Leadership Institute (YLI).

Specific services will depend on youth priorities and needs for culturally informed services. CoastPride has identified youth interests in the following mental health supports: tools for anxiety, harm reduction and trauma-informed tips, neurodiversity versus neurodivergent exploration, disordered eating and mindful eating, and music, art, games, and martial arts.

Numbers Of Youth Served with INN Funding

allcove Half Moon Bay will begin serving youth in Year 1 with a soft launch, which will include implementation of the allcove cultural safety framework and mental health supports to youth and their families. The full launch will occur in Year 2, and by Year 3 will operate at full capacity. The estimated numbers of youth receiving direct services using INN funding are as follows:

- Year 1: 50 youth and families
- Year 2: 100-125 youth and families
- Years 3-5: (Full capacity) 10% of target population living on the coastside ages 12-25, or approximately 200-800 youth annually

The allcove Half Moon Bay center estimates it will serve approximately 10% of the target population of youth ages 12-25 in the region. The large range in the estimated number of youth served, 200-800, rests with the discrepancy in the numbers between public school data and Census data for the target population. Because the coastside has families who are very wealthy and those that are very economically disadvantaged, many families likely send their children to local private schools.

Public School Data - Total: 1,550

- Public Middle School: 550
- Public High School: 1,000

Census Data (12-25 years old) - Total: 8,202

- Under age 18: 5,795
- Age 18 to 24: 2,407

Population Served

The target population will be underserved youth ages 12 to 25 living on the San Mateo County coastside from Pacifica to Pescadero (zip codes 94018 and 94019, 94038, 94037), including vulnerable youth

populations such as those who identify as Black, Indigenous, and people of color (BIPOC), LGBTQ+, and young people experiencing homelessness.

<table>
<tr><th colspan="2">San Mateo County - Coastside Profile</th></tr>
<tr><td>Race/Ethnicity of Youth in CUSD

• Hispanic/Latinx: 53.1%
• White: 39.5
• Asian: 1.3%
• Filipino: .7%
• Two or more Races: .5%
• Black/African American: .3%
• Pacific Islander: .0%

Source: CUSD</td><td>Language Spoken by CUSD Students

In CUSD public schools, close to half of the children speak a language, other than English at home. The vast majority of those speak Spanish at home as their first language, with a small percentage speaking an Asian language.

Source: CUSD</td></tr>
<tr><td>Immigrant Population

As of 2020, 22.6% of residents were born outside of the United States, which is higher than the national average of 13.5%. In Half Moon Bay, 55.7% are from Mexico, 6.3% from Vietnam, 4.7% from China (excluding Hong Kong and Taiwan), 2.9% from Canada, 2.6% from El Salvador, 2.4% from Iran, 2.2% from Philippines, 2.% from England, 1.7% from Brazil, 1.7% from Serbia, and 1.6% from Lebanon (all other countries of origin are 1.5% or less). It is estimated that in several areas of the coastside, half or more of immigrants are undocumented.

Source: Census and Towncharts citing census</td><td>Income and Housing

Poverty: Nearly half (45.1) of students in CUSD are low income/socioeconomically disadvantaged.

Food Insecurity: 1,642 households received basic safety net services from Coastside Hope, 35% of which have children.

Housing Insecurity or Homelessness: 120 community members are served at Abundant Grace and 52 community members are served at Coast House through interim housing and support services to families, couples, and individuals experiencing homelessness in Half Moon Bay.

Sources: CUSD, Coastside Hope, Abundant Grace, Coast House</td></tr>
</table>

CONTRACTING

All BHRS service agreements (contracts, MOUs) are monitored by a BHRS Manager that has the subject matter expertise. Contract monitors check-in at least monthly with service providers to review challenges, successes, troubleshoot and stay up-to-date on the progress of the project. Additionally, reporting deliverables are set in place in the agreements and linked to invoicing. Payments of services are contingent on the reporting. Evaluation contracts are monitored in a similar fashion by the MHSA Manager in collaboration with the assigned BHRS Manager.

COMMUNITY PROGRAM PLANNING

The allcove Half Moon Bay was approved for start-up funding through CoastPride's planning and application process with the MHSOAC. In San Mateo, the CPP process for Innovation Projects supported the local implementation and begins with the development of the MHSA Three-Year Plan. A comprehensive community needs assessment process determines the gaps, needs and priorities for services, which are used as the basis for the development of Innovation projects. One of San Mateo County's current MHSA Three-Year Plan strategies includes to *expand drop-in behavioral health services that includes access to wrap around services for youth*. allcove Half Moon Bay addresses this priority. Appendix 1 includes the MHSA Three-Year Plan CPP process and Strategy Recommendations.

<u>INN Idea Selection Process</u>

- ✓ With the availability of funding for new INN projects to be approved in the current fiscal year, BHRS sought to identify potential INN projects from its 2022 idea submission round that would meet current needs and align with the priorities of the BHSA.
- ✓ BHRS staff reviewed the 14 ideas that had been pre-screened in 2022 against the Innovation requirements. In order to prioritize INN projects that could be sustained under the BHSA, staff screened the 14 ideas to identify projects that included treatment/recovery and/or early intervention services. Most project ideas were in the area of prevention; five ideas included components of early intervention, treatment, and/or recovery.
- ✓ BHRS conducted an internal feasibility review of the five projects and determined to move forward with two of the INN proposals based on BHRS capacity and priorities for the BHSA transition. In addition, BHRS decided to move forward with two multi-county collaborative INN projects.
- ✓ On September 5, 2024, the MHSA Steering Committee met to review the two community-derived INN ideas, and the two multi-county collaborative projects, and provide comment and considerations for the projects through breakout room discussions and online comment forms.
- ✓ The Behavioral Health Commission voted to open the 30-day public comment period on October 2, 2024 and reviewed comments during the public hearing and closing of the public comment period on November 6, 2024. All public comments received are summarized in Appendix 2.

MHSA GENERAL STANDARDS

A) Community Collaboration

allcove centers are led by two strong local community advisory bodies: the Youth Advisory Group, which ensures that local youth voice informs service design at an individual, service and governance level, and the Community Consortium, which ensures that the center is embedded in the local youth service system. Together they provide a collaborative platform for service system reform and uplift the voice of young people and families with living or lived experience. Along with direct service delivery, another main activity of the center will be outreach in the community to raise awareness of services, increase mental health literacy and initiate conversations about mental health early to decrease stigma. These activities will be planned and carried out through formal and informal community collaboration arrangements.

CoastPride has strong partnerships with Ayudando Latinos A Soñar, Puente de la Costa Sur, Pacifica Collaborative (ALAS and Puente are the LatinX-centered nonprofits serving the midpeninsula and south coast respectively and the Pacifica Collaborative membership includes all of the nonprofit safety net

organizations serving Pacifica), Adolescent Counseling Services, Outlet and the San Mateo County Pride Center (these are LGBTQ+ centered service providers on the peninsula), On the Margins (a San Francisco network of clinicians providing consulting services in pursuit of transformative, antiracist, affirming, and innovative work), and Peninsula Family Service. The center will also employ a Community Engagement Manager to maintain strong relationships with community partners and families.

B) Cultural Competency

One of the key principles for the allcove model is that youth-centered care must be socially and culturally inclusive. allcove centers are intended to reflect a community's culture and be flexible enough to adapt to the needs and unique characteristics of a given community, whether large or small. Each center is led by a coalition of service providers and community-based agencies joining together in an integrated approach to serving young people. Beyond the Youth Advisory Group and Community Consortium, which reflect the local community, centers will also build additional partnerships, especially those of hard to reach and vulnerable groups. Lead agencies and service partners are encouraged to staff their allcove center with young adults and adults who look like the young people in the community who will be seeking services, and each center identifies staffing needs, including building more culturally responsive services, on an ongoing basis. Stanford's Central allcove Team and youth advisors co-developed a set of principles and recommended actions for promoting inclusion, belonging and anti-racist practices in allcove centers. These principles and actions will be encouraged through the allcove Learning Community and upheld through model integrity process.

allcove Half Moon Bay will use the allcove cultural safety framework to strengthen Latinx/Latine and queer youth engagement to be truly reflective of the diverse community in the coast. The center will ensure young people have access to culturally informed services based on cultural/ethnic background, gender, and sexual orientation, such as providing access to therapists who specialize in gender expansive youth, referrals to hormone therapy, access to bicultural providers, and cultural healing practices such as traditional Mexican dance, art, or mariachi.

C) Client-Driven

Through the mechanisms of shared decision making, Youth Advisory Group and Community Consortium representation, a foundational characteristic of the allcove model is the central and ongoing involvement of young people in their individual care, the center's service design and governance. These community-based groups ensure that allcove services and activities are client-driven.

CoastPride has deep experience centering youth voice in the design and implementation of services. In response to hate crimes on the coastside, CoastPride established an equity project entirely youth led. Approximately 30 youth served as citizen scientists, reflecting on their experiences in school in real time-discerning whether they felt affirmed or undermined in their multiple identities (race/ethnicity, sexual orientation, gender identity). The experiences of these LGBTQ+ and BIPOC youth were amplified through the use of a Stanford University phone application called, Our Voice. The data they collected were brought forward to School and Civic leaders for immediate collective action in their schools. CoastPide's approach to working with youth and young adults is to empower them by uplifting their strengths to achieve their desired goals, helping them explore and understand their multiple and intersecting identities, and uncovering the impact of how others are treating them may be shaping their sense of wellness and belonging.

D) Family-Driven

While the focus of the allcove model is young people, the program acknowledges the importance of families as a critical support network. When clinically indicated and acceptable to the young person, families and other adults providing care are guided in supporting their young people with a variety of service options including brief interventions, psychoeducation and group programs. CoastPride also offers a monthly family support group to engage families.

E) Wellness, Recovery, and Resilience-Focused

While supporting young people to address health and wellbeing challenges as they arise, the allcove center will provide group wellbeing, health education and recreational programs that support wellbeing and develop protective factors. Services will be youth centered, hope inspired and strengths based. Every allcove center is active in the community to raise mental health literacy, increase help seeking and reduce mental health stigma.

F) Integrated Service Experience for Clients and Families

The heart of the allcove model is providing a core set of co-located, integrated, clinical and youth development services, with referral pathways to other services that provide a continuum of care, that address bio-psycho-social determinants of health in achievement of young people's aspirational health and wellbeing goals.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Statewide, to date, allcove centers have spent up to several million dollars on start-up costs. These costs vary widely by geography, type of lead agency, facility access, payer mix, etc. These are also the costs without any reimbursement plan to this point, which will allow for lower annual costs. Stanford's Central allcove Team is working in partnership with Commission in developing further sustainability, including through collaborating to facilitate regular meetings with leadership from across the allcove network to create more pathways for billable reimbursement opportunities and funding for non-billable services. The allcove center will have a focus on prevention and early intervention supporting youth and their families in addressing mild to moderate mental health needs. As this model provides a "no wrong door" point of entry, each allcove center will facilitate supported referrals to more specialized services for young people presenting with serious mental illness. These referrals will also be in place so as not to disrupt continuity of care should the center cease to operate. These "warm hand-off" referrals include direct linkages to early psychosis programs and mental health services for needs greater than mild to moderate.

In addition to the two-year MHSOAC start-up grant for allcove Half Moon Bay, CoastPride receives funding from individual donors and the following grants: San Mateo County Measure K funds, Half Moon Bay City Community Services and Financial Assistance grant, Chan Zuckerberg grant, San Francisco Community Foundation grant, and Wells Fargo social impact grant.

The project aligns with the county's transition to BHSA by by expanding and increasing the types of early intervention strategies available to to children, youth and young adults through the prioritization of Early Intervention strategies. The project removes a barrier to accessing culturally informed, collaborative, and youth and family friendly services.

BHSA Transition Questions	Response
How does the proposal align with the BHSA reform?	The project focuses on holistic early-life investments and strategies for youth and young adults 12 to 25 years old and their families to intervene in the early signs of mental illness or substance use, through an integrated services approach that reduces silos for planning and service delivery. This network of centers around California are poised to expand the behavioral health workforce through community- and youth-led efforts.
Does it provide housing interventions for persons who are chronically homeless or experiencing homelessness or are at risk of homelessness?	No. An allcove center may have supports for young people who are unhoused, including referrals to community partners that offer this service, if there is a need in the community as identified by youth advisors and if the young person requests this service.
Does it support early intervention programs or approaches in order to prevent mental illnesses and substance abuse disorders from becoming severe and disabling?	Yes, the project provides early behavioral health services for youth and young adults, ages 12 to 25 years old. allcove centers support young people with a range of needs through these prevention and early intervention services, such as brief therapy or psychoeducation on substance use, and also connects young people to other providers in the community for other services, like early psychosis. Additionally, through each center's Youth Advisory Group and Community Consortium, centers engage in activities designed to destigmatize behavioral health issues, increase awareness of services and resources offered at allcove centers, provide a focus on wellness activities and prevent behavioral health problems before they start.
Does it support Full-Service Partnership efforts and services for individuals living with serious mental illness?	No. Depending on each community's needs, allcove centers may have partners who provide Full-Service Partnership services and could provide a warm hand-off to these organizations for services outside of allcove's mild to moderate focus.
How will the County continue the project, or components of the project, after its completion without the ability to utilize certain components of MHSA funding for sustainability?	allcove Half Moon Bay will develop a sustainability plan that is vetted and informed by an established youth advisory group. The goal would be to leverage diversified funding for ongoing sustainability of the program including opportunities for Medi-Cal billing of approved services. Additionally, a proposal of continuation will be brought to the BHSA Community Program Planning (CPP) process for Behavioral Health Services and Supports - Early Intervention funding.
How does the project assist the county's transition to the behavioral health reform?	BHSA expands and increases the types of support available to children, youth and young adults through the prioritization of Early Intervention strategies. The project provides access to culturally informed, collaborative, and youth and family led services.

COMMUNICATION AND DISSEMINATION PLAN

MHSA implementation is very much a part of BHRS' day-to-day business. Information is shared, and input collected with a diverse group of stakeholders, on an ongoing basis. All MHSA information is made available to stakeholders on the MHSA webpage, www.smchealth.org/bhrs/mhsa. The site includes a subscription feature to receive an email notification when the website is updated with MHSA developments, meetings and opportunities for input. This is currently at over 2,000 subscribers.

The BHRS Director's Update is published the first Wednesday of every month and distributed electronically to county wide partners and stakeholders, and serves as an information dissemination and educational tool, with a standing column written by the County's MHSA Manager. The BHRS Blog also provides a forum for sharing and disseminating information broadly. In addition, presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the quarterly MHSA Steering Committee meeting; at meetings with community partners and advocates; and internally with staff.

Opportunities to present at statewide conferences will also be sought.

TIMELINE

allcove Half Moon Bay is currently in the first year of its start-up phase. INN funding will begin in Year 1 of the start-up period when allcove Half Moon Bay will have a soft opening, and will continue for three years. The following timeline outlines milestones that will occur each year of project implementation.

Establishment Phase (Year 1)
Project team from community assembled
Lead agency begins by completing the establishment work plan (template) and set timelines for milestones Attend monthly implementation meetings with Central allcove Team and the MHSOAC Youth outreach specialist hired
Youth Advisory Group established and continue regular meetings
Facility secured, space fit out and permits completed
Community Consortium established and continue monthly meetings
Lead agency staff attend and participate in Learning Community activities
Center design completed (furniture, branding, etc.)
Center manager and clinical lead hired
Partnership agreements completed

Establishment Phase continues with Model Integrity (Year 1 or Year 2)
Continue attending monthly implementation meetings with Central allcove Team and the MHSOAC
Data requirements completed
Center staff (clinical, youth development, administrative) hired
Lead agency and service partner staff attend and participate in Learning Community activities
Model integrity review completed (at least 8 weeks before soft opening)
Lead agency and service partners prepare for visit from Central allcove Team (at least 1 – 2 weeks prior to soft opening)

Local INN Funds: Cultural safety framework implementation (Year 1 and Year 2)
Translate all materials to Spanish and provide interpretation services at relevant events
Creating Cultural Safety Dialogues with Community Consortium and Youth Advisory Group, including introductory equity trainings to develop shared language
Piloting Cultural Safety concepts and adapting them to Community Consortium Member organizations
Align Cultural Safety Principles with a curriculum that will be taught to staff and core service providers
Process Evaluation

Establishment Phase continues with Soft Opening (Year 1 or Year 2)
Continue attending monthly implementation meetings with Central allcove Team and the MHSOAC
Lead agency staff attend and participate in Learning Community activities
allcove center soft opening (at least 4 weeks before public opening)
Begin collecting evaluation data through the use of datacove
Lead agency and service partners prepare for visit from Central allcove Team (at least 1 – 2 weeks prior to official launch)

Local INN Funds: Soft opening mental health services (Year 1 and Year 2)
Begin provision of mental health support groups, individual therapy and other early intervention treatment services
Facilitate focus groups with families to understand familial needs as the youth support system

Establishment Phase continues with Official Launch (Year 1 or Year 2)
Move to attending quarterly implementation meetings with Central allcove Team and the MHSOAC
Lead agency staff attend and participate in Learning Community activities
allcove center public opening (after completion of all model integrity review outstanding items)
Continue collecting evaluation data through the use of datacove

Center Operational Phase (Year 2 or Year 3 through Year 5)
Attend quarterly implementation meetings with Central allcove Team and the MHSOAC
Complete annual model integrity review every 12 months after official launch
allcove staff attend and participate in Learning Community activities
Continue collecting data through the use of datacove
Participate in other evaluation activities, including focus groups and interviews, about the development of the allcove center

Local INN Funds: Cultural safety framework implementation (Year 3)
Translate all materials to Spanish and provide interpretation services at relevant events + plus providing interpretation for services provided at allcove
Continue providing trainings and workshops for all service stream providers and staff
Piloting Cultural Safety concepts and adapting them to Community Consortium Member organizations
Align Cultural Safety Principles with a curriculum that will be taught to staff and core service providers
Process Evaluation

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

Note: As long as allcove Half Moon Bay is designated by the MHSOAC as a site to receive ongoing technical assistance from Stanford's Center for Youth Mental Health and Wellbeing, no additional costs for ongoing technical assistance and evaluation are required.

The total Innovation funding request for 3.5 years is **$1,600,000**, which will be allocated as follows:

Service Contract: $1,500,000 · $250,000 for FY 24/25 (6 months) · $500,000 for FY 25/26 · $500,000 for FY 26/27 · $250,000 for FY 27/28 (6 months)	**BHRS Administration: $100,000** · $20,000 for FY 24/25 (9 mths) · $30,000 for FY 25/26 · $30,000 for FY 26/27 · $20,000 for FY 27/28 (9 mths)

Direct Costs will total $1,500,000 over a three-year term and includes all contractor expenses related to delivering the program services (salaries and benefits, program supplies, rent/utilities, mileage, translation services, subcontracts, etc.).

Indirect Costs will total $100,000

- $100,000 is for BHRS county business, procurement processes, contract monitoring, fiscal tracking, IT support, and oversight of the innovation project.
- As long as allcove Half Moon Bay is designated by the MHSOAC as a site to receive ongoing technical assistance from Stanford's Center for Youth Mental Health and Wellbeing, no additional costs for ongoing technical assistance and evaluation are required.

Federal Financial Participation (FFP) there is no initial anticipated FFP. Opportunities for developing Medi-Cal billing capacity for BHSA early intervention providers will be pursued.

Other Funding: The County will go through a local bidding process to identify the contractor for direct services; the bidding process will inquire about any in-kind or other revenue sources that can be leveraged.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
	PERSONNEL COSTS (salaries, wages, benefits)	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**TOTAL**
1.	Salaries						
2.	Direct Costs						
3.	Indirect Costs	$20,000	$30,000	$30,000	$20,000		**$100,000**
4.	**Total Personnel Costs**	**$20,000**	**$30,000**	**$30,000**	**$20,000**		**$100,000**
	OPERATING COSTS*						
5.	Direct Costs						
6.	Indirect Costs						
7.	**Total Operating Costs**						**$**
	NON-RECURRING COSTS (equipment, technology)						
8.							
9.							
10.	**Total non-recurring costs**						**$**
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)						
11.	Direct Costs	$250,000	$500,000	$500,000	$250,000		**$1,500,000**
12.	Indirect Costs						
13.	**Total Consultant Costs**	**$250,000**	**$500,000**	**$500,000**	**$250,000**		**$1,500,000**
	OTHER EXPENDITURES (please explain in budget narrative)						
14.							
15.							
16.	**Total Other Expenditures**						**$**
	BUDGET TOTALS						
	Personnel (total of line 1)						**$**
	Direct Costs (add lines 2, 5, and 11 from above)	$250,000	$500,000	$500,000	$250,000		**$1,500,000**
	Indirect Costs (add lines 3, 6, and 12 from above)	$20,000	$30,000	$30,000	$20,000		**$100,000**
	Non-recurring costs (total of line 10)						**$**
	Other Expenditures (total of line 16)						**$**
	TOTAL INNOVATION BUDGET	**$270,000**	**$530,000**	**$530,000**	**$270,000**		**$1,600,000**

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

BUDGET CONTEXT – EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures <u>for administration</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**TOTAL**
1.	Innovative MHSA Funds	$270,000	$530,000	$530,000	$270,000		$1,600,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	**Total Proposed Administration**	**$270,000**	**$530,000**	**$530,000**	**$270,000**		**$1,600,000**
EVALUATION:							
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**TOTAL**
1.	Innovative MHSA Funds						
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	**Total Proposed Evaluation**						
TOTALS:							
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 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**TOTAL**
1.	Innovative MHSA Funds*	**$270,000**	**$530,000**	**$530,000**	**$270,000**		**$1,600,000**
2.	Federal Financial Participation						**$**
3.	1991 Realignment						**$**
4.	Behavioral Health Subaccount						**$**
5.	Other funding**						**$**
6.	**Total Proposed Expenditures**	**$270,000**	**$530,000**	**$530,000**	**$270,000**		**$1,600,000**
*** INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting** **** If "other funding" is included, please explain within budget narrative.**							

APPENDIX 1. MHSA THREE-YEAR PLAN CPP & STRATEGY RECOMMENDATIONS

MHSA Three-Year Plan, 2020-2023
Community Program Planning (CPP) Process

The MHSA Three-Year Program and Expenditure Plan is developed in collaboration with clients and families, community members, staff, community agencies and stakeholders. In November 2022, a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan commenced and engaged over 400 diverse clients, family members, staff and community agencies and leaders representing geographical, ethnic, cultural and social economic status, providers of behavioral health care services, social services and other sectors across various means of providing input (surveys, input sessions, public comments). Planning was led by the MHSA Manager, Behavioral Health Commission MHSA Co-Chairpersons, an MHSA Three-Year Plan Workgroup and the MHSA Steering Committee. A draft CPP process was provided to the Behavioral Health Commission (BHC) and the MHSA Steering Committee in December 2022. Stakeholders provided input and comments on the process and what additional stakeholder groups should be engaged.

CPP FRAMEWORK

MHSA THREE-YEAR PLAN WORKGROUP

Between November and January 2023, a workgroup was convened made up of diverse stakeholders including clients, family members, community members and contracted service providers. The workgroup met monthly with the goal of co-designing an MHSA 3- Year Plan Community Program Planning (CPP) process that is equitable, inclusive and honors and centers the voices of marginalized communities. The objectives of each meeting included the following:

- Review and advise on data needed to support a comprehensive needs assessment
- Advise on the community input process and community engagement best practices, to ensure it is inclusive of all vulnerable communities
- Support opportunities for all San Mateo County community members to provide input

The MHSA Three-Year Plan Workgroup guided and informed the process each step of the way:

1. Needs Assessment
    - Informed Data Collection resources
    - Advised on the Community Survey structure
2. Strategy Development
    - Informed Community Input Sessions strategy
    - Advised on the creation of a Facilitator Training for stakeholders to support input sessions
    - Facilitated Community Input sessions
3. MHSA Three-Year Plan Development
    - Reviewed the Recommended Strategies for accuracy

COMMUNITY PROGRAM PLANNING PROCESS

1. Needs Assessment – this phase of the CPP process included the following two steps:
    - ✓ Data Review: Over 30 local plans, assessments, evaluation reports, and data were reviewed to identify prominent mental health and substance use needs reported across service sectors and the community. All of the concerns identified in the needs assessment review were categorized into the following 8 areas of need.
        i. **Access to Services** - this category captures the needs of diverse cultures and identities (race/ethnicity, LGBTQIA+, veteran status, age) related to accessing mental health and substance use services, including knowledge and education and culturally responsive approaches to engaging communities.
        ii. **Behavioral Health Workforce** - this category captures the needs related to recruiting, developing, supporting and maintaining a sufficient workforce to address the needs and the diversity of the community. This includes supporting individuals with lived experience as clients and/or family members of clients of mental health and substance use services to join the workforce and support all services and programming.

iii. **Crisis Continuum** - this category captures needs related to mental health and substance use crisis response, as well as appropriate community-based supports and stabilization during and after a crisis.

iv. **Housing Continuum** - this category captures the housing needs for individuals living with mental health challenges ranging from assisted living facilities to having access to permanent supportive housing, to early assessment of risk of homelessness and culturally responsive approaches and support with locating and maintaining housing.

v. **Substance Use Challenges** - this category captures the increasing need for substance use services and supports that are accessible, integrated and coordinated with mental health services.

vi. **Quality of Client Care** - this category captures the needs of clients that are in treatment for mental health and/or substance use challenges to have timely access to care when needed, are successfully connected to services after an emergency and receive culturally responsive approaches to their treatment.

vii. **Youth Needs** - this category is age-based and captures mental health and substance use challenges for school to transition-age youth ages 6-25, it includes recent data for adolescent suicides, juvenile justice involvement, school-based and on-campus supports.

viii. **Adult/Older Adult Needs** - this category is age-based and captures mental health and substance use challenges for adults and older adults, it includes recent data related to increasing complexity of needs, general poor mental health outcomes, and suicide prevention needs.

✓ Community Survey: The identified needs from the review of local plans and data were included in an online survey that was distributed broadly to individuals living or working in San Mateo County. The survey asked respondents to share any additional concerns related to mental health and/or substance. Additionally, the survey requested that respondents rank the 8 areas of need in order of importance.

There were 129 survey respondents to the survey, the Needs Assessment summary of results were presented to the MHSA Steering Committee on February 2, 2023, to launch the Strategy Development phase.

2. Strategy Development – this phase of the CPP process included the following two steps:

✓ Community Input: 31 community input sessions and key interviews with diverse groups and vulnerable populations (immigrant families, veterans and transition-age youth) were conducted. Based on advice from the MHSA Three-Year Plan Workgroup, groups were asked to select 1 of the 8 areas of need to brainstorm strategies in the areas of prevention, direct service and workforce supports.* Participants were asked what possible solutions (services, programs, infrastructure, etc.) would they recommend to address the need they selected. See Appendix 2. for the full list of Strategy Recommendations.

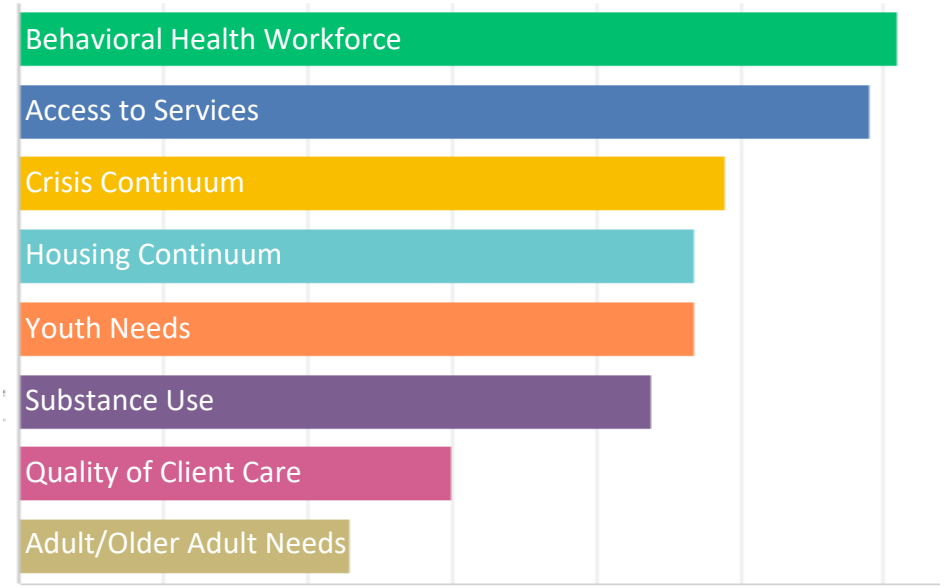
** As part of a simultaneous process to develop the MHSA 3-Year Workforce Education and Training (WET) Plan, 5 additional sessions were conducted to brainstorm around Behavioral Health Workforce strategies with the Diversity and Equity Council, Lived Experience and Education Workgroup, Alcohol and Other Drugs' Contracted Providers and BHRS Adult and Youth Leadership Teams.*

✓ Prioritization: To support the prioritization of strategies, participants were also asked: If you had to select one strategy to focus on over the next 3 years, which would you prioritize? Qualitative data analysis of all input received was conducted to identify the top strategy recommendations and key themes to present to the MHSA Steering Committee on May 4, 2023. Over 1,000 strategy ideas were shared via the Community Input sessions. This was narrowed down to 70 Strategy Recommendations across the 8 areas of need; strategies were included in this list if they were the top prioritized strategy by an input session group, they were repeated across input sessions, and for the areas of need that weren't selected as often by community groups (i.e., crisis continuum, substance use challenges, quality of client care and adult/older adult needs) all strategies that received a prioritization vote during in the input sessions were included.

Additionally, three key themes emerged from the input sessions overall, these strategies were brought up in virtually all input session: 1) Increase community awareness and education about behavioral health topics, resources and services; 2) Embed peer and family supports into all behavioral health services; 3) Implement culturally responsive approaches that are data-driven to address existing inequities. The idea is to incorporate these components into EVERY prioritized strategy moving forward.

The key themes and 70 Strategy Recommendations, Appendix 2., were presented to the MHSA Steering Committee on May 4th along with pre-recorded stakeholder video testimonials for each of the 8 areas of need and with an opportunity for additional public comments from meeting participants. Following the meeting the MHSA Steering Committee members were asked, via an online survey, to rank the 8 areas of need and help narrow down the scope of MHSA resources (both funding and planning) over the next three years. Given this prioritization, the areas of focus for the next three years will include Behavioral Health Workforce, Access to Services and addressing gaps in the Crisis Continuum. The MHSA Steering Committee was then asked in a follow-up survey to select their top Strategy Recommendations for each of the three prioritized areas of focus.

MHSA Steering Committee
Part 1 Survey Results – Areas of Need Prioritization:



3. MHSA Three-Year Plan – this phase of the CPP process includes the development of the plan, the 30-day public comment period and public hearing hosted by the Behavioral Health Commission (BHC) and the subsequent approval by the Board of Supervisors.

   - ✓ 30-Day Public Comment: The BHC voted to open a 30-day public comment period on June 7, 2023 and held a Public Hearing on July 5, 2023.
   - ✓ Board of Supervisor Approval: The BHC also voted to submit the MHSA Three-Year Plan to the Board of Supervisors for approval after the closing of the public comment period on July 7, 2023.

   This MHSA Three-Year Plan includes new funding allocations for the prioritized strategy recommendations, proposed funding allocations for other areas of need and strategy ideas that were identified; if there is an opportunity to leverage other efforts, initiatives, and/or external funding. The MHSA Three-Year Plan also builds on previous priorities. Funding and implementation for recommendations from the FY 20-21 Housing Taskforce and the Full Service Partnership (FSP) Workgroups will continue. See the Housing and FSP Workgroup priorities section.

   Additionally, The MHSA Three-Year Plan includes ongoing funding allocations for existing MHSA-funded programs. These programs are monitored, evaluated and adjusted as needed during the MHSA Three-Year Plan implementation years and recommendations are made annually about continuing, adjusting and/or ending a program. Changes to existing programs and services are included in subsequent Annual Updates, which involve stakeholder input, the MHSA Steering Committee and the BHC 30-day public comment period. Agencies selected to provide MHSA-funded services go through a formal Request for Proposal (RFP) process to ensure an open and competitive process to funding opportunities. The RFPs are posted on the BHRS RFP website, www.smchealth.org/rfps, which includes a subscription option to receive notifications.

MHSA THREE-YEAR PLAN STAKEHOLDER INPUT

Extensive outreach was conducted to promote the MHSA Three-Year Plan Workgroup participation opportunity, the Facilitator Training opportunity, the MHSA Steering Committee meetings, and the Community Input sessions. Flyers were made available in English, Spanish, and Chinese. Stipends to consumers/clients and their family members and language interpretation were offered at every meeting, childcare for families and refreshments were offered for in-person meetings.

Input included perspectives from clients and family members, communities across geographical, ethnic, cultural and social economic status, providers of behavioral health care services, social services and other sectors. The sessions were conducted through 14 existing collaboratives/initiatives, 11 committees/workgroups, 3 geographically-focused collaboratives (Coastside, East Palo Alto and North County) and 3 stakeholder group key interviews of transition-age youth, immigrant families and veterans. The majority of the meetings were conducted online. Over 400 individuals participated across the various means of providing input (surveys, input sessions, public comments).

Input Session conducted

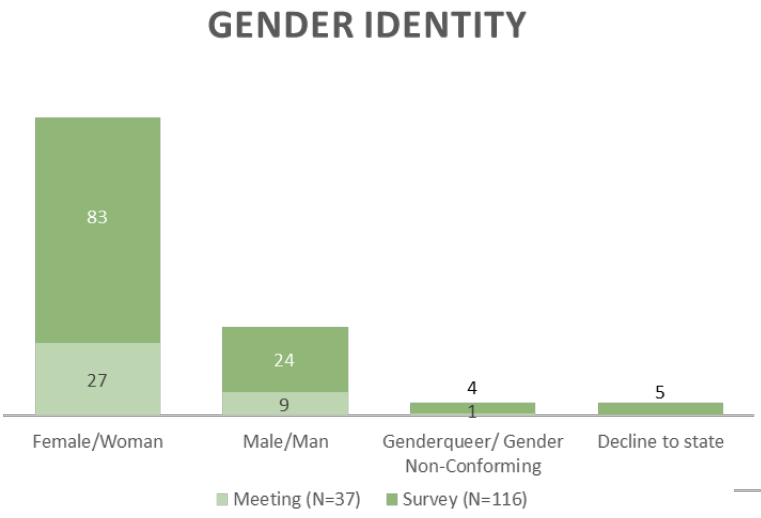
Date	Stakeholder Group	Input Session Topics
	MHSA Steering Committee	
2/2/23	4 Breakout Groups	Access to Services; Behavioral Health Workforce; Housing Continuum; Crisis Continuum
	Health Equity Initiatives	
2/3/23	Chinese Health Initiative	Access to Services
2/7/23	Pacific Islander Initiative	Youth Needs
2/8/23	Pride Initiative	Housing Continuum
2/14/23	African American Community Initiative	Quality of Client Care
2/14/23	Spirituality Initiative	Adult/Older Adult Needs
2/16/23	Native American and Indigenous Peoples Initiative	Quality of Client Care
2/16/23	Filipino Mental Health Initiative	Access to Services
2/28/23	Latino Collaborative	Access to Services
	Community Collaboratives	
2/10/23	North County Outreach Collaborative	Behavioral Health Workforce
2/16/23	East Palo Alto Behavioral Health Advisory	Behavioral Health Workforce
2/22/23	Coastside Collaborative	Access to Services
3/9/23	East Palo Alto Community Collaborative	Access to Services
	Peer Recovery Collaborative	
2/6/23	California Clubhouse/Heart & Soul	Housing Continuum
2/7/23	Voices of Recovery	Substance Use Challenges
	Behavioral Health Commission (BHC)	
2/1/23	BHC Older Adult Committee	Adult/Older Adult Needs

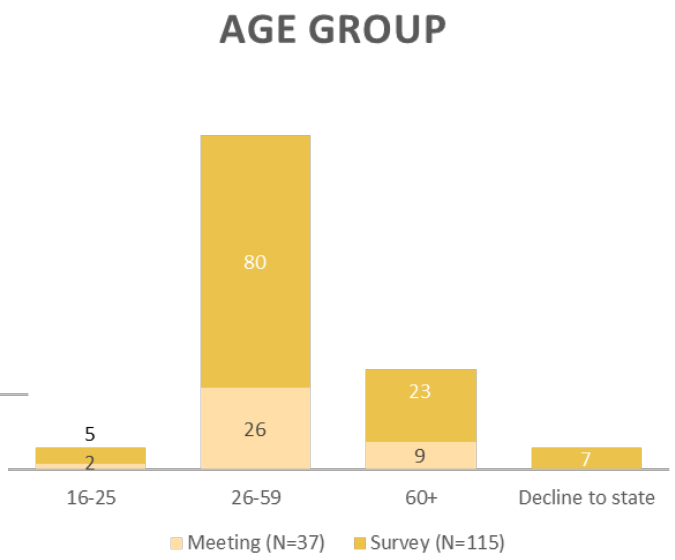
2/15/23	BHC Child and Youth Committee (3 Breakout Groups)	Youth Needs
2/15/23	BHC Adult Committee	Housing Continuum
2/21/23	BHC Alcohol and Other Drugs Committee	Substance Use Challenges
	Other Committees/Groups	
2/9/23	Housing Operations Committee	Housing Continuum
2/7/23	Lived Experience Education Workgroup	Housing Continuum
2/16/23	Contractors Association	Behavioral Health Workforce
2/20/23	Solutions for Supportive Housing	Housing Continuum
2/24/23	School Wellness Counselors	Youth Needs
2/14/23	BHRS Youth Leadership	Crisis Continuum
	Workforce Education & Training 3-Year Plan	
3/3/23	Diversity and Equity Council	Behavioral Health Workforce
3/2/23	Alcohol and Other Drug Providers	Behavioral Health Workforce
3/8/23	BHRS Adult Leadership	Behavioral Health Workforce
2/28/23	BHRS Youth Leadership	Behavioral Health Workforce
3/7/23	Lived Experience Education Workgroup	Behavioral Health Workforce
Key interviews conducted:		
Immigrant Families, Transition Age Youth, Veterans		Youth Needs; Access to Services

Demographics of participants

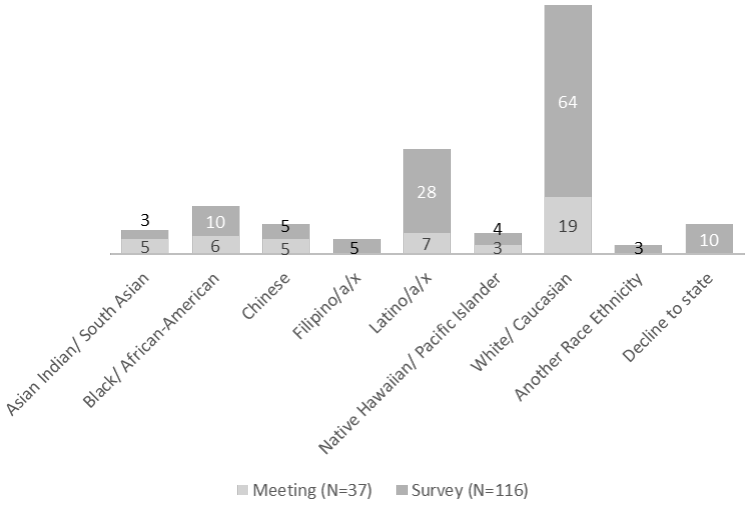
Demographic data was not collected from all 31 Community Input Sessions. 35 client and family members received stipends for participating in these sessions.

Demographics were collected for 129 survey respondents and 37 participants via a Zoom Poll feature during the two MHSA Steering Committee meetings focused on the MHSA Three-Year Plan Community Program Planning process.

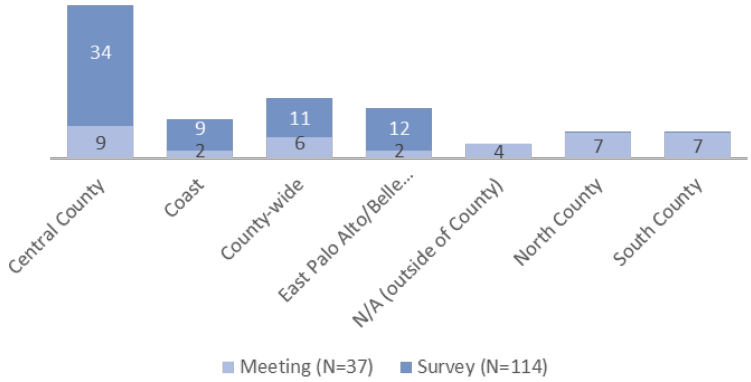




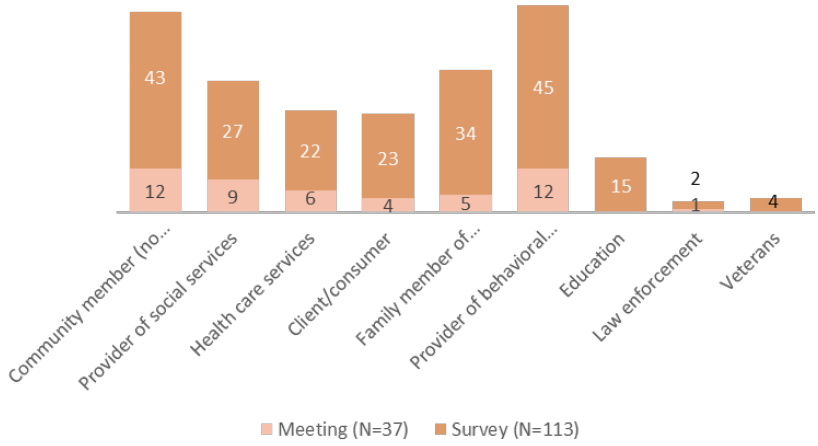
RACE/ETHNICITY



AREA OF COUNTY REPRESENTED



STAKEHOLDER GROUP



SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA Three-Year Plan Strategy Recommendations

FY 23-24 to FY 25-26

30+ community input sessions and key interviews were conducted to brainstorm strategies to address San Mateo County behavioral health needs. The MHSA Steering Committee will be voting to prioritize across the Identified Needs and across the Strategy Recommendations. This prioritization will inform the allocation of resources over the next three-years. Across all community input sessions, three core themes emerged. These components will be incorporated into EVERY prioritized strategy:

1. **Increase community awareness** and education about behavioral health topics, resources and services
2. **Embed peer and family supports** into all behavioral health services
3. **Implement culturally responsive** approaches to address existing inequities that are data-driven

Direct Services & Supports / Prevention Early Intervention

Identified Needs	Strategy Recommendations
Access to Services	1. Coordinate behavioral health services for cultural and ethnic communities (centralize services, outreach and education for the Chinese community, hire bilingual/bicultural peer staff, etc.).
	2. Expand drop-in behavioral health services that includes access to wrap around services for youth.
	3. Provide school-based behavioral health services starting in elementary and middle school; include early diagnosis and assessment at high school grade level.
	4. Co-locate prevention services (support groups, programs, workshops, etc.) in community settings such as faith-based organizations, core-service agencies, community spaces, etc.
	5. Conduct racial equity analysis of BHRS policies and procedures to identify barriers to accessing care; include service utilization and staff capacity data.
	6. Expand services for older adults focused on addressing isolation, peer support, social engagement and intergenerational work.
	7. Expand the Health Ambassador Program to include diverse languages/cultures and subject expertise (substance use, justice involved, unhoused, human trafficking, etc.)
	8. Expand outreach partnerships to include increased mild-to-moderate services, faith-based organizations and veteran engagement.
	9. Promote volunteerism to increase social engagement and community cohesion.

Recruitment & Retention Strategies

Identified Need	Strategy Recommendations
Behavioral Health Workforce	1. Create a pipeline program focused on increasing Asian American and African American behavioral health staff, develop partnerships with local and neighboring academic and non-academic programs.
	2. Create more entry level positions and internships for students of diverse backgrounds; streamline hiring processes (e.g., onboarding and process to hire interns).
	3. Target recruitment activities to reach black, indigenous, people of color (BIPOC) communities (e.g., partner with BIPOC-focused communities and student organizations and networks).
	4. Implement recruitment and retention financial incentives such as retention bonuses, signing bonuses, educational loan repayment for staff and contracted providers.
	5. Examine and adjust caseload size and balance, particularly for bilingual staff.
	6. Expand type, flexibility, and access to staff wellness and engagement opportunities (e.g., appreciation, healing activities, mentoring, behavioral health supports, networking events).
	7. Explore opportunities for alternative and flexible schedules and remote work.
	8. Implement supports for direct service staff, including peers, to advance in their careers, specifically BIPOC staff (e.g., scholarships to pursue licensure/credentials, mentorship).
	9. Invest in support, retention and leadership development of peer and family support workers (training, fair compensation, career ladders, flexible hours, and mentorship).
	10. Address extra help and contracted positions, especially for those that interface with the community.
	11. Research, plan, and implement compensation and benefits that are aligned with competing agencies and neighboring counties (e.g., salaries, cost of living, retirement plans, housing vouchers).

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Crisis Continuum	1. Create stabilization unit(s) and dedicated teams.
	2. Expand step-down from hospitalization facilities, programs and teams (e.g., respite centers).
	3. Create a youth crisis residential in the County.
	4. Expand intensive outpatient services (extended Intensive Outpatient Programs for youth, day treatment programs, detox centers, etc.).
	5. Provide respite care and language-appropriate navigation supports for parents with children who experience a behavioral health crisis (5150, psychiatric emergency services, hospitalization, etc.).
	6. Expand non-armed 24/7 mobile mental health crisis response to serve the entire community.
	7. Expand drop-in centers for individuals that struggle with mental health and/or substance use.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Housing Continuum	1. Expand clinicians available to the Homeless Engagement Assessment Linkage team (a field-based outreach, engagement and intervention services).
	2. Expand supportive housing slots for individuals living with mental health and substance use challenges that do not require homelessness as an eligibility requirement.
	3. Provide housing maintenance and peer supports including case management, wrap around services, hoarding resources, and specialized services for older adults and other vulnerable communities.
	4. Develop a comprehensive housing database that includes real time waitlist times and availability.
	5. Incentivize board and cares (streamline the application process, reduce/subsidize licensing costs, etc.).
	6. Provide housing navigation and locator resources; include re-entry supports, bilingual peer supports, streamlined case management, simplified housing application and subsidized fees.
	7. Provide supports for section 8 housing including funding, vouchers, and training to landlords.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Substance Use Challenges	1. Create integrated services for complex needs including individuals with dual diagnosis or co-occurring mental health and substance use needs.
	2. Create longer-term sober living arrangements.
	3. Expand non-medication supports for individuals with addiction.
	4. Expand recovery-focused drop-in centers.
	5. Expand resources for reunification (support for parents, how to talk/interact with their children, etc.).
	6. Provide access to Narcan for clients and family members.
	7. Provide family-centered recovery supports that includes child care at every stage.
	8. Address intergenerational trauma in recovery and treatment.
	9. Expand early intervention resources for addiction.
	10. Provide education about substance use prevention starting in elementary school (how to say no, healthy boundaries, etc.).

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Quality of Client Care	1. Provide ongoing resource navigation and peer support in crisis situations.
	2. Create client centered services (meet people where they are, provide virtual/in-person, services in their language, flexible hours, etc.).
	3. Implement best practice sharing across BHRS clinics, including integrated services and identification of supports that can be offered across the county.
	4. Develop a streamlined BHRS intake process across the network of care.
	5. Develop partnerships for substance use referrals for clients with Access and Care for Everyone (ACE).
	6. Develop partnerships with indigenous community spaces and cultural healers.
	7. Address Adverse Childhood Experiences, Social Determinants of Health, and intergenerational trauma.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Adult/Older Adult Needs	1. Create internal processes to regularly review utilization and outcome data to inform responsive services for older adults.
	2. Create partnership between the County and Veterans Administration to increase supports for veterans (integration with primary care services, resources for women veterans on sexual assault, suicide prevention for veterans, etc).
	3. Expand capacity for neuropsychological evaluation and diagnosis.
	4. Expand in-home hoarding supports (linkages to services, case management, specialized therapy, decluttering, etc.)
	5. Expand services for individuals with complex needs; develop partnerships with organizations that can support complex client needs.
	6. Expand the OASIS team peer specialist' support for older adults, caregivers and family members.
	7. Develop an outreach and communication strategy on behavioral health and wellness in multiple languages; leverage existing networks (SMC Alert, neighborhood CERTs, etc.).
	8. Expand culturally relevant suicide prevention strategies.
	9. Expand prevention services to older adults prior to complications; develop partnerships with organizations that can provide these services.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Youth Needs	1. Address gaps in the crisis continuum for youth (increase 5150 beds, language capacity, expand non-law enforcement response, stabilization unit, crisis residential, etc.).
	2. Expand school-based behavioral health education and services starting in middle school that includes family therapy and peer support groups for parents, youth, and school staff.
	3. Expand school-based wellness centers.
	4. Expand afterschool-based programming.
	5. Expand availability of diverse wellness counselors and clinicians on all school campuses.
	6. Integrate wraparound services in schools, in partnership with community-based organizations.
	7. Provide Narcan in high schools (used to reverse opioid overdose).
	8. Expand Social Emotional Learning (SEL) curriculum in schools.
	9. Expand the Health Ambassador Program for both Youth and Adults; include case management and increased support for ambassador's families.

APPENDIX 2. ALL PUBLIC COMMENTS RECEIVED

Summary of Public Comments Received

INN Project Plans – allcove Half Moon Bay

30-Day Public Comment Process & Public Hearing (10/2/24 – 11/7/24)

Public Comments and Q&A

BHC meeting (10/02/24), opening of public comment period

- **Commissioner F. Edgette**: And with allcove Half Moon Bay do they have a site identified, and how far along are they in terms of their reorganizing?
    - Cameron Zeller (Coast Pride) via email: We signed our contract with the state for developing allcove Half Moon Bay on October 2nd so we are just getting started. We have a kick-off meeting with the Stanford TTA team scheduled for Monday, 10/21/2024. We have identified some potential locations for allcoveHalfMoonBay and will vet them with the Youth Advisory Group once that group has been formed.
- **Commissioner F. Edgette**: We were very involved and I'm on the community consortium for allcove San Mateo, so I'm very familiar with the process; we're very excited, the community, in terms of another allcove, it's such an effective, proven model, and it's wonderful seeing California and the Bay Area taking a leadership role in bringing this model here, so I'm enthusiastically eager to support bringing this model here.

Additional Public Comments

- **MHSOAC Innovations team:** Consider including the dollar amount of the original OAC start-up grant to CoastPride. Ensure the proposal contains the items specific to San Mateo County as an appendix to the multi-county collaborative plan.
- **Sarah Kremer (allcove Implementation Manager, Stanford University):**
    - allcove Half Moon Bay is written out completely without abbreviations.
    - Instead of saying, "The funding will also be utilized to implement principles for allcove centers called ACCESS (Anti-racist, Culturally-minded, Community Education, Support, and Services)," change to: "The funding will also be used to implement a cultural safety approach that is being developed by Stanford with youth advisor input for allcove centers." Throughout the document, use "the allcove cultural safety framework" instead of "ACCESS principles." (p4)
    - Add "physical health, supported education and employment, peer support, family support" to the list of services that allcove will provide. (p5)
    - Suggestion to expand the BHSA transition responses (p11) as follows:
        - *How does this proposal align with the BHSA reform?* The project focuses on holistic early-life investments and strategies for youth and young adults 12 to 25 years old and their families to intervene in the early signs of mental illness or

substance use, through an integrated services approach that reduces silos for planning and service delivery. Through allcove's "no wrong door" approach, young people are welcomed in to a center and through a shared decision process, can have rapid and easy access to a range of services. While allcove's focus is mild to moderate behavioral health issues, no young person is turned away. A robust community-led referral network supports youth with greater needs, advancing equity and reducing disparities for individuals with behavioral health needs. Every allcove center also provides culturally safe and supported services that are identified by youth through their Youth Advisory Group in collaboration with a Community Consortium. These advisory groups continue to ensure that all young people in the community, especially the most underserved populations, such as those who identify as Black, Indigenous, and people of color (BIPOC), LGBTQ+, and young people experiencing homelessness, are aware of the center. Both groups also work to ensure that allcove is meeting the needs of all young people through its services provided by community partners. Additionally, by providing the range of staff positions from peer support specialists to youth outreach specialists, from clinicians earning hours toward licensure to those providing supervision, allcove centers offer a path for young people interested in behavioral health careers. A young person may seek services at an allcove center, become a youth advisor, then move into a peer support specialist role while attending college. They may decide to pursue a degree that provides a pathway to clinical services, while still working at an allcove center. This network of centers around California are poised to expand the behavioral health workforce through community- and youth-led efforts.

- *Does it provide housing interventions for persons who are chronically homeless or experiencing homelessness or are at risk of homelessness?* No. An allcove center may have supports for young people who are unhoused, including referrals to community partners that offer this service, if there is a need in the community as identified by youth advisors and if the young person requests this service.

- *Does it support early intervention programs or approaches in order to prevent mental illnesses and substance abuse disorders from becoming severe and disabling?* Yes, the project provides early behavioral health services for youth and young adults, ages 12 to 25 years old. allcove centers support young people with a range of needs through these prevention and early intervention services, such as brief therapy or psychoeducation on substance use, and also connects young people to other providers in the community for other services, like early psychosis. allcove center staff understand the need to integrate traditional mental health services and substance use services to ensure young people are treated with a unified approach as a whole person. Additionally, through each center's Youth Advisory Group and Community Consortium, centers engage in activities designed to destigmatize behavioral health issues, increase awareness

of services and resources offered at allcove centers, provide a focus on wellness activities and prevent behavioral health problems before they start.

- *Does it support Full-Service Partnership efforts and services for individuals living with serious mental illness?* No. Depending on each community's needs, allcove centers may have partners who provide Full-Service Partnership effort, and could provide a warm hand-off to these organizations for services outside of allcove's mild to moderate focus.

- **Cameron Zeller (CoastPride):** Under Numbers of Youth Served with INN Funding, change "youth" to "youth and families." (p5)

ATTACHMENT: MULTI-COUNTY ALLCOVE COLLABORATIVE

ATTACHMENT: Multi-County allcove Collaborative

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT:

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

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

CHOOSE A PRIMARY PURPOSE:

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

- ☒ Increases access to mental health services to underserved groups
- ☐ Increases the quality of mental health services, including measured outcomes
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

The allcove™ model, inspired by successful international integrated youth mental health models in Australia, Canada, and Ireland, creates stand-alone, "one-stop-shop" health centers for young people ages 12 to 25 to access support for mild to moderate needs with mental health, physical health, substance use, peer support, supported education and employment, and family support, as well as linkages to community referrals in the continuum of care for more intensive needs. allcove approaches youth wellness in a comprehensive and youth-friendly way, led by members of an active local Youth Advisory Group, who help design the services and environment they most want to see in their community, and a Community Consortium. Through innovative, evidence-based approaches, allcove centers have the flexibility to reflect the unique youth culture of each community being served and fill a critical gap in the spectrum of youth mental health and wellness services.

Increasing need: A mental health crisis facing American youth
Data show American youth are suffering and have been struggling even prior to the onset of the COVID-19 pandemic. According to the National Center for Health Statistics (Curtin & Heron, 2019), the rate of youth suicide:

- Increased nearly 60% among 10- to 24-year-olds between 2007 and 2017.
- Grew at an average rate of 3% per year between 2007 and 2013.
- Rapidly rose to 7% per year between 2013 and 2017.
- Tripled for children aged 10 to 14 between 2007 and 2017, after years of decline.

After the start of the COVID-19 pandemic, there was a greater than 50% increase in suspected suicide attempt emergency department visits among girls ages 12 to 17 in the beginning of 2021, as compared to the same period in 2019 (Yard et al., 2021). Suicide is now the second-leading cause of death for people ages 10 to 24 (The American Association of Suicidology, 2021).

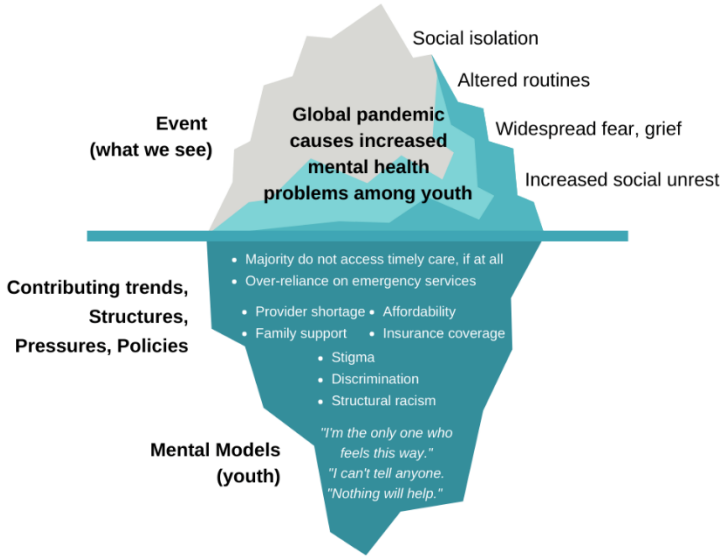
According to the Centers for Disease Control and Prevention (2023), more students experienced persistent feelings of sadness or hopelessness from 2009 through 2019, regardless of race/ethnicity; more than 1 in 3 and almost half of female students reported persistent feelings of sadness or hopelessness in 2019. Roughly half (49.5%) of adolescents in the U.S. meet the criteria for a mental disorder at some point, with anxiety disorders being the most common (31.9%), followed by mood (14.3%), behavior (19.6%), and substance use (11.4%). According to the Substance Abuse and Mental Health Services Administration's 2019 Behavioral Health Barometer, 57% of youth aged 12 to 17 with a major depressive episode did not receive treatment in the past year. The Mental Health in America 2022 report notes an increase in the number of youth who experienced a major depression episode (15%, up 1% from the previous year) and that only 27% of

youth with severe depression received consistent treatment while 60% do not receive any treatment at all.

Figure 1. Mental health factors for youth iceberg

The status of youth mental health appears to be approaching a breaking point. In October 2021, three leading children's health organizations declared a National State of Emergency in Children's Mental Health and in December 2021, U.S. Surgeon General Vivek Murthy issued a National Advisory on the youth mental health crisis. This alarming increase in distress does not point to any one stressor. Rather, climate change, racism, gun violence, income inequality, and charged political discussions (i.e., immigration, LGBTQ+ topics) that have a direct impact on an individual's future are among factors that contribute to increased levels of chronic stress among youth, which in turn can lead to anxiety and depression. Income inequality alone is linked to higher rates of mental health difficulties (Pickett & Wilkinson, 2015). In addition, LGBTQ+, maltreated, runaway, and unhoused youth are at a disproportionately high risk for depression, suicidal ideation, self-harming behaviors, and suicide (Stillman Cohen & Bosk, 2020). Successfully identifying and treating mental health issues that youth and young adults are facing is key to ensuring their lifelong emotional and mental wellbeing.

Garrett, 2022



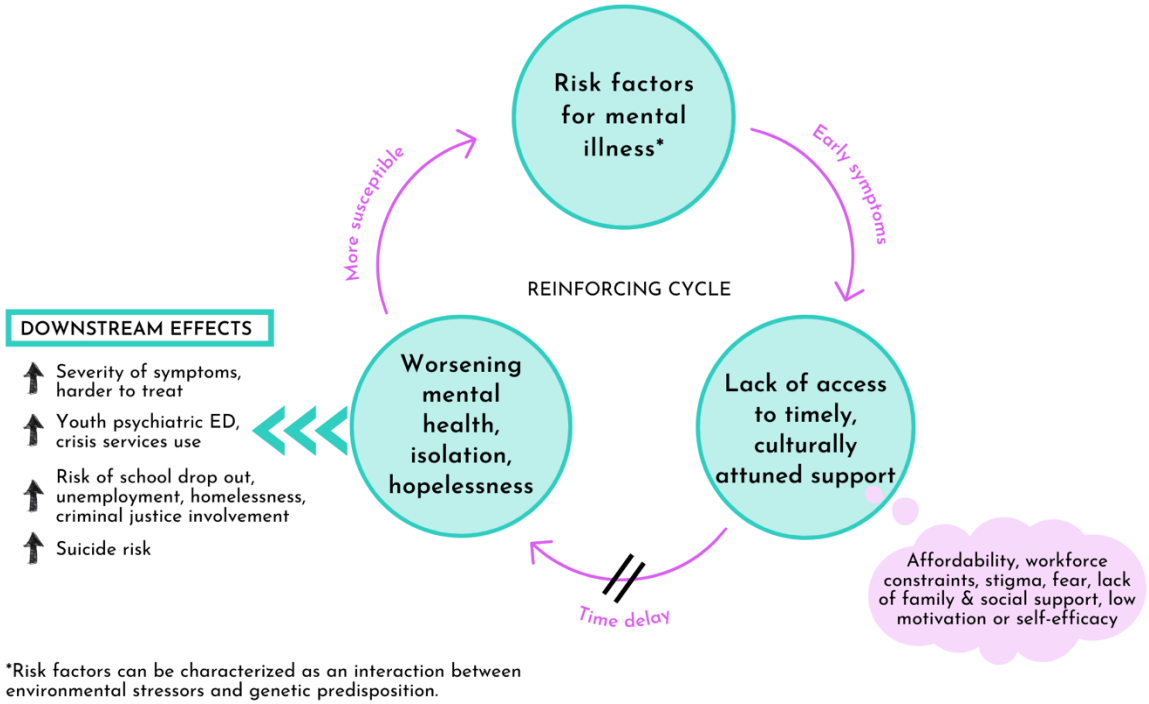
The COVID-19 pandemic has exacerbated the mental health crisis among young people. Feelings of isolation and hopelessness, reduced access to friends, disruptions to school, economic instability, lack of access to resources, stigma, and hopelessness are all factors that fuel the current youth mental health crisis. Many young people have also grieved the loss of connection, key life milestones, and friends and family during the pandemic. For some youth, home can be isolating and for others, dangerous. Adverse childhood experiences, including physical abuse, sexual abuse, and neglect are commonplace, with an estimated 656,000 children and adolescents experiencing maltreatment in 2019 (U.S. Department of Health & Human Services, 2021). Stay-at-home pandemic measures limited access to mandated reporters and maltreatment experienced by youth can go unnoticed (Stillman Cohen & Bosk, 2020). The pandemic has been especially challenging for marginalized communities, such as LGBTQ+ youth. In a survey from the Trevor Project (2021), 70% of LGBTQ+ youth stated that during COVID-19, their mental health was "poor" most of the time or always, and 42% of LGBTQ+ youth, including more than half of transgender and nonbinary youth, reported that they seriously considered attempting suicide in the past year.

Throughout the pandemic, anxiety, depression, sleep disruptions, and thoughts of suicide have increased for many young adults. In a Kaiser Family Foundation study (2021), results suggested that

approximately 56% of young adults ages 18 to 24 reported symptoms of anxiety and/or depressive disorder. These factors, along with the already challenging transition from adolescence to adulthood, can be even more difficult for youth with pre-existing mental health risks.

A statement released by the White House on the date of President Biden's first State of the Union address highlighted the dire state of mental health in the nation and proposed priority areas, such as connecting Americans to care through the integration of mental health and substance use services in community-based settings and developing the peer workforce. While half of all lifetime cases of mental illness begin by the age of 14 (Kessler et al., 2005), this country has never committed to creating a public mental health system that children and families need. While successfully identifying and treating mental health issues that youth and young adults are facing is key to fostering their lifelong emotional and mental wellbeing, current U.S. health systems pose many barriers for youth to access the help, as illustrated in Figure 2. Spaces that encourage youth voice, establish a safe environment which respects gender identity and sexual orientation, and ultimately increase youth's accessibility to clinical services and support are essential for this vulnerable population.

Figure 2. Reinforcing cycle of mental health issues for youth



Garrett, 2022

Fragmented services and barriers to access

Because of its whole-person approach, the allcove model may have a significant positive impact on young people's mental health and wellbeing. As an integrated service, allcove addresses the overlapping needs of young people, whether through providing vocational support, reducing mental health distress, or starting conversations with a peer support specialist that may lead to an appointment with a substance use specialist or primary care staff. allcove's model structure is aligned with many of the key principles outlined in the California Department of Health Care

Services' Framework for a Core Continuum of Care (2022), including offering locally tailored, culturally responsive prevention and early intervention-focused, community-based, whole person care. This "no wrong door" approach supports the realities of young people's lives and encircles them with broad support in one setting.

The Institute of Medicine, National Institute of Mental Health, and others call for a comprehensive developmental approach towards mental health treatment. National mental health leaders express the need for programs that provide broad-based outreach and education, anti-stigma efforts, reduction of known risks such as poverty, and comprehensive early identification and intervention of the spectrum of mental health problems. California's existing mental health care system does not operate holistically; centers that link primary care and mental health care for youth using an integrated approach are rare. While valuable for providing care to many school-age children and youth, schools have struggled to establish the infrastructure and resources needed to recognize and provide early treatment for children with mental health issues, and youth and young adults not attending schools do not receive these services.

For both publicly and privately insured youth, California lacks a systematic early intervention approach for youth mental health at a public health level. Instead, the system is highly fragmented and unequal, organized around numerous eligibility requirements such as age, diagnosis, severity, county of residence, insurance coverage, and income. Medi-Cal and private insurance requirements for financial pre-authorization and reimbursement present additional challenges to the sustainability of an integrated program. The potential for realigning payment structures, currently under consideration with California Advancing and Innovating Medi-Cal (CalAIM) and other systems, would better support more holistic, integrated care models such as allcove. This shift creates changes within our systems of care and the ability to meet the healthcare needs of young people. As allcove centers achieve financial sustainability and the model begins to fill this critical gap, linkages to more intensive services when needs are identified will also be more rapidly and easily available.

Complicating the crisis related to a lack of access to mental health services is the reality that many you hesitate to seek help, for reasons such as:

- A lack of awareness and understanding of mental illness.
- Stigma associated with mental illness.
- A lack of age-appropriate, youth-friendly mental health services.
- Concerns about confidentiality and embarrassment in disclosing health concerns.
- Doubts about the effectiveness of the treatment available.
- A lack of affordable services and inadequate transportation to service locations.

The crisis impacts every community as well as individuals. In 2013, the estimated cost of mental disorders among persons under 24 years of age in the U.S. (including health care, use of services such as special education and juvenile justice and decreased productivity of those with mental health challenges) was $247 billion annually (Perou et al., 2013). Due to young people not receiving adequate support during this vulnerable time, quality of life and academic and professional successes are negatively impacted, and the risk for mental illness, substance abuse, suicide, teen pregnancy and many other adverse health and achievement outcomes that follow them into

adulthood increases. This current state is a cause for alarm and calls for a cultural paradigm shift in approaching youth health across the U.S. (Center for Youth Mental Health and Wellbeing, 2016).

A new model to meet the moment: allcove

The first of its kind in the U.S., the allcove model is a network of integrated youth mental health centers designed with, by, and for youth that reduce stigma, embrace mental wellness, increase community connection, and provide access to culturally-responsive services. Based on successful international models and co-designed with local California youth, allcove centers are embedded within the communities they serve and reflect the unique needs of local youth. allcove services include mental and physical health, substance use, peer support, supported education and employment, and family support.

allcove centers engage youth ages 12-25 to help detect, prevent, and treat mild to moderate mental health needs and connect young people to their local community behavioral health system for more intensive interventions. Developed by the Center for Youth Mental Health and Wellbeing within the Department of Psychiatry and Behavioral Sciences at the Stanford University School of Medicine, allcove is guided by a vision where every youth belongs, chooses the support they need and thrives. allcove focuses on early intervention services that are easily accessible, welcoming, and culturally responsive through a network of youth integrated mental health centers.

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.

"allcove offers support in every sense of the word, all forms of support (physical, mental, etc.) are connected to allcove's core mission." ~ Quote from a Central allcove Team youth advisor

allcove is a model of care that considers the holistic needs of young people. The model blends best practices to create a strong, youth-directed set of services that are well-positioned to meet the needs of youth. allcove's focus on early intervention works to counter mental health care that is usually only available to those who are in crisis. Through its robust integrated care model, allcove is creating a culture and space that encourages youth to feel comfortable accessing an array of early supports, get help before reaching a point of crisis, and gain both the skills and a community in which to thrive, both as young people and into their adult lives.

A fully staffed and operational allcove center that meets the allcove model integrity standards is anticipated to serve 1,000 youth annually, based on the headspace U.S. feasibility report, 2015. The projected number of youth served may be adjusted for locations based on youth demographics (for example, a rural community versus an urban community), local needs analysis, and relevant service projections. Factors impacting a center's operations include, but are not limited to, workforce

challenges, partnership agreements and changes, and related community conditions, including access to public transportation and availability of support.

Fundamental best practices that are part of the allcove model include:

- Integrated care that provides a holistic approach that promotes better coordination across services, access to services focused mild to moderate mental health issues, a youth-friendly physical space, and connections with community-based partners.
- Upstream, early intervention services that aim to positively alter even the most serious forms of mental illness through early detection and intervention.
- Youth-centered approaches and activities that include focusing on resilience; flexibility in eligible age groups, accessible hours of operation, and mandatory requirements of youth; empowering young people around issues relevant to them; supporting them with education, job training, skill development and mentorship.
- Centers being embedded in and responsive to the local community through the Youth Advisory Group and Community Consortium that guide the development of each allcove center.

Each allcove center is made up of a coalition of service providers and community-based agencies joining together under one unified allcove brand identity in an integrated approach to serve young people. Young people will see the center as a front door to the local continuum of care streamlining the fractured service system, removing barriers to access for youth and their families. To increase the capacity of young people, their families, and communities to build protective factors and seek help earlier, each allcove center works proactively within their community to decrease the stigma surrounding youth mental health, encourage early help-seeking, and increase knowledge and mental health literacy surrounding youth mental health and wellbeing.

allcove centers complement existing community services rather than compete with them, specifically with school-based mental health and early psychosis services. allcove centers become potential partners to link young people who may want to have conversations outside of schools; allcove staff can also support school communities with suicide prevention, intervention and post-vention activities, and receive referrals for higher needs services while staying connected within confidentiality limits. The supported education and employment services provide a compliment for school-based efforts to learn about careers and future planning. allcove centers also become comfortable places for youth who may be developing clinical high risk or early psychosis to feel welcomed and get support, especially if they may not want to access a community mental health center. By getting help early, allcove centers become an important partner in prevention and early intervention approaches, as well as provide “warm hand-offs" that directly connect young people and their families to higher needs service providers, while continuing to serve as a welcoming space for other needs.

Centers will be part of a multi-county initiative to create a network of centers that test and develop the model together, benefiting from the combined efforts of cross-county experience and technical assistance from the Central allcove Team at the Stanford’s Center for Youth Mental Health and Wellbeing.

Each allcove center will have access to the following infrastructure from the Central allcove Team:

- Intensive training, technical assistance, and resources in the establishment phase and ongoing model integrity support.
- Participation in the Learning Community, a forum for networking, knowledge sharing, collaboration, training and education for all allcove center providers and their service partners in building communities of practice and bi-annual conferences bringing together local and international partners.
- Use of a centralized website, allcove.org, with individual center webpages.
- Participation in the common evaluation of the program (see research section) and use of datacove, allcove's centralized data collection system.

Having a network of allcove centers supports each center contributing to a widely recognized and unified brand that young people will associate with high quality, youth-designed services across communities. Supported by the California Mental Health Services Oversight and Accountability Commission's youth drop-in center grant, three communities are currently establishing allcove centers in San Mateo, Sacramento, and South Orange County. Two centers are open: Redondo Beach (Beach Cities) and Palo Alto; the County of Santa Clara is also in process of relocating a second center in the San José community to a setting that will be more conducive for youth access, using funding streams other than Innovation funding.

The Central allcove Team collaborates with international partners who represent networks of integrated youth mental health services worldwide. Projects include developing a common minimum data set and data collection system with Foundry in British Columbia and other Canadian partners; planning opportunities to share knowledge with providers in low- to medium-resource countries through the World Economic Forum and Orygen Global's Framework for Youth Mental Health pilot initiative; and interfacing with other established networks of providers, such as headspace in Australia and Jigsaw in Ireland, to share expertise and leverage existing models and approaches.

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

The allcove model introduces a new practice or approach to the overall mental health system, including, but not limited to, integrated health services and prevention and early intervention services aimed at increasing access to mental health services to underserved groups including youth 12 to 25 years of age and vulnerable youth populations such as those who identify as Black, Indigenous, and people of color (BIPOC), LGBTQ+, and young people experiencing homelessness.

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.

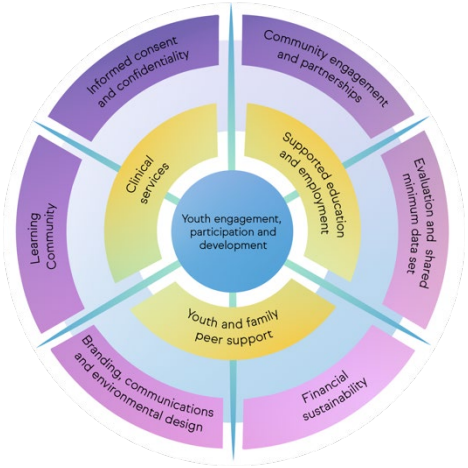
The allcove model proposes a new approach to prevention and early intervention health and wellbeing services that are open, accessible, and acceptable to young people and their families. The model aims to remove historical barriers that have traditionally stopped youth from accessing prevention and early intervention services by implementing an integrated youth mental health

program that has been successful in other countries and is being adapted to local communities in the U.S.

An allcove center implements a consistent set of model components and applies innovative practice principles. The model components, represented in Figure 3, are:

- Youth engagement, participation and development
- Clinical services, including mental health, physical health, and substance use
- Supported education and employment
- Youth and family peer support
- Branding, communications and environmental design
- Evaluation and shared minimum data set
- Community engagement and partnerships
- Financial sustainability
- Informed consent and confidentiality
- Learning Community

Figure 3: Model components of the allcove model.



allcove's practice principles and how they have historically been applied are:

<u>Youth-centered care</u>

"The ability to have both physical including sexual health and mental health services at allcove support young people navigating two services that are both highly stigmatized in one inclusive space allows for confidentiality, support, and youth focused care." ~ Quote from a Central allcove Team youth advisor

Historically, adult experts develop services with business-as-usual practice, current funding streams and reimbursement mechanisms, with eligibility criteria that may be exclusive, rather than the actual needs of youth. Young people have expressed that the current service system in place for mental health does not work for them; the result is low levels of seeking help and poor youth health and wellbeing outcomes. At each allcove center, young people will be seen as experts in their own care and services are designed with, by and for youth. Each center's Youth Advisory

Group, made up of diverse young people who represent the local community, ensures the ongoing and integral involvement of young people in all aspects of allcove. Because these local youth are instrumental in co-creating and co-designing the center, services are socially and culturally inclusive, strengths based, hope inspired, and relevant to youth and their community.

Through the core principles of shared decision-making and informed consent and confidentiality, young people are supported to have agency in their own care, motivating them to engage with adult allies that are ready to meet them wherever they are, on their own terms. At allcove, any youth can come in for services or for a moment of pause, rather than only when they meet criteria for services during a crisis.

Staff includes clinical and youth development professionals with expertise and passion for working with youth. Young people will be welcomed at the door by youth peer support specialists who provide a relatable, lived-experience which is both engaging and therapeutic. All staff, together, deliver developmentally-appropriate interventions and team-based care, bringing together evidence-based and youth-friendly practices.

Offering holistic services within one location that are youth friendly and support referral pathways along the continuum of care ensure that services meet the multiple needs of young people sooner. The allcove approach helps prevent vulnerable youth from falling through the cracks as they try to navigate multiple service locations and systems that do not provide streamlined and integrated level of care.

<u>Prevention, screening and early intervention</u>
"I did not feel that my concerns deserved support, I thought that I needed to be in crisis in order to talk to someone." ~ Quote from a Central allcove Team youth advisor

Historically, health education and community engagement activities focus on services for crisis rather than prevention. Along with direct service delivery, each allcove center actively works in the community to build youth resilience, increase early help seeking, reduce stigma and increase mental health literacy through community engagement activities.

Services and service providers have typically relied on separate electronic health records with little to no sharing of a young person's risk factors, service journey, and experience. This situation results in low levels of collaboration and service integration with other providers in the young person's care team and a disjointed experience for young people and their families as they are required to tell their story repeatedly to each individual provider while it is held in siloed systems. Universal screening of youth at the allcove center through the *youth wellbeing survey* in the allcove data collection system (datacove) supports identification of risk factors that may initiate a cross-team response on a first visit. This process enables the care team to offer tailored and coordinated response to young people, addressing their areas of concern and supporting social determinants of health through allcove's service offerings.

Connecting with young people only when their health and wellbeing is low or in crisis is a deficit approach to care, rather than being proactive when there is an opportunity to engage with activities to improve and maintain health and wellbeing. Along with individual services, allcove

centers provide group wellness, health education, and recreational programs and events that support youth to develop protective factors during a developmentally complex part of their lives. These soft entry service options connect youth with the center and allcove brand, which in turn builds trust needed when, and if, challenges present themselves in that young person's life.

Rapid, easy and affordable access

"allcove is a comfortable place to come in, rather than having to navigate through a whole different system which may be overwhelming." ~ Quote from a Central allcove Team youth advisor

Historically, young people have experienced multiple barriers when accessing health and wellbeing services, leading to a delay in seeking help and poor health outcomes. Costs, tied to insurance status and financial circumstances, are one significant barrier. allcove centers seek to introduce an innovative, universal access approach to care by providing free or low-cost mental health, physical health, substance use, peer support, family support and supported education and employment services to all youth between the ages of 12 to 25 and their families. Young people will be able to access services regardless of their circumstances and, where specified by California laws on consent and confidentiality, without parental notification.

Through funding provided by the Innovation project, allcove centers will provide easy and affordable access to youth while a sustainable financial model is developed both at the local level and within the growing allcove center network of partners. Learnings on financial modelling and braiding funding streams will be shared across the multi-county initiative through the allcove Learning Community, relying on the expertise of many partners implementing the program across California together with other relevant experts.

Along with financial barriers, youth and their families often experience confusion as they navigate services with different eligibility requirements and multiple providers. allcove centers remove this barrier by offering the core services in a location where youth naturally congregate that is accessible by public transportation, and providing a youth-friendly, low stigma environment that supports taking a moment of pause.

Youth need services when the window of seeking help is open and typically disengage with appointment-based services that often have long waiting lists. The service modalities of allcove centers adapt to the needs of local youth and include low-threshold drop-in services of brief interventions which have proven to be successful with young people achieving short-term goals within their desired timelines. Brief interventions often provide a low-barrier entry point to accessing longer interventions in the future.

To decrease disengagement that often happens when being referred from one service to another, allcove centers establish strong and formal linkages to referral sources, such as schools and other educational settings, as well as to specific entities for a higher level of care, such as early psychosis or eating disorder services, as needed. Centers support these transitions while keeping the young person engaged in parallel services, such as peer support, to stay connected and prevent disengagement.

Holistic and integrated care

"Housing services in the same center makes them more accessible, as transportation is less of an issue." ~ Quote from a Central allcove Team youth advisor

allcove centers offer onsite mental health, physical health, substance use, peer support, family support and supported education and employment services, all housed together within one location. Young people will only have to tell their story once and can move in and out of clinical and youth development services as they approach achieving their goals.

Services will have a high degree of internal integration providing multidisciplinary team-based, coordinated care, and be connected with the local community and other local providers. Service partnerships are built with young people's input and goals in mind.

Formal structures, such as the Community Consortium, ensure that a strong and consolidated collaborative platform provides the infrastructure and mechanism for local service system reform and direct connections to the community.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.
This information is county specific and can be discussed in the appendix from each County

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

This information can be discussed from each County as part of the Appendix

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?

While the allcove model is supported by international best practices and shares the characteristics of integrated youth mental health centers worldwide, this innovation project aims to pilot a new model adapted to the U.S. and California, and the needs of local youth in diverse communities.

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.

Within each of the international models, centers become embedded within the communities they serve and reflect the unique needs of local youth.

Established in 2006, the headspace program serves a unique and vital role in the provision of early and integrated mental health supports for adolescents and young adults that does not currently exist in the US. This model has been so successful in providing critical services to an underserved

population (Rickwood, et al., 2019) that the Australian federal government continues to expand both funding and services to sites on an annual basis, regardless of the legislative party in power. Legislators across the country compete to have headspace sites in their communities as sites are incredibly popular with young people and families. In fact, most young people coming to headspace sites come on their own or with a friend. The expansion of this model in Denmark, Israel, and Canada point to the potential for replication (McGorry, et al., 2022).

The success of headspace in Australia shows the overwhelming interest and need young people have in accessing early mental health in a setting that is uniquely tailored to their needs. Recent data (Rickwood, et al., 2015) points to the ability of the headspace model to successfully engage and support youth at an early and critical juncture: Sixty percent of headspace clients experienced improved psychosocial functioning and/or improvement in psychological distress. The most common reasons for seeking headspace services include symptoms of depression and anxiety, accounting for two-thirds of all initial services. Most headspace clients receive an appointment within two weeks, reducing long wait times that lead to missed opportunities for support. These outcomes demonstrate that headspace is succeeding in its hallmark efforts to reduce barriers to help-seeking, while also facilitating early access to quality mental health services with positive outcomes for young people

Similarly, the Foundry model was founded in British Columbia in 2015. Data collected from nearly 5,000 young people across six centers showed that the majority of visits were for mental health/ substance use and that most young people (58%) who accessed Foundry would not have gone anywhere for help had Foundry not been an option. These results show that Foundry is an integrated service model that is addressing an urgent health priority by increasing service access within the province (Mathias, et al., 2022).

In addition to Australia and Canada, similar youth integrated service models have opened in Ireland, Denmark, France, Israel, and other countries (McGorry, et al., 2022). The allcove model represents a version of this integrated youth-service approach that has been adapted for the U.S. context. In addition to being a more diverse and populous country, the U.S. health care delivery system is complex and fragmented. The allcove centers present an opportunity to braid reimbursement mechanism together and find new strategies for making early intervention programs financially sustainable.

Staff from Stanford's Center for Youth Mental Health and Wellbeing represented the allcove model at the International Association for Youth Mental Health (IAYMH) conference in Copenhagen, Denmark in fall 2022 and in prior IAYMH conferences. The opportunity brought together international programs for a two-day conference, sharing research and resources. allcove centers, through Stanford's Center for Youth Mental Health and Wellbeing, will continue to connect with international partners and provide research on the integrated service model.

Santa Clara County's allcove Palo Alto, opened with Mental Health Services Act (MHSA) Innovation (INN) funding, recently released their first evaluation report (Resource Development Associates, 2022) for the center that has been open since July 2021. Their evaluators used a mixed-methods and analytic approach to amplify the voices of youth and provide an assessment of how allcove has met their needs. Among the findings:

- There is strong support for allcove, the services that are provided and for allcove staff.
- Across surveys and focus groups, youth reported satisfaction with the services they have received at allcove. Aspects they enjoyed most were the staff and quality of services. Additionally, youth reported feeling safe and comfortable:
    - 88% were satisfied with the services they received at allcove.
    - 96% indicated that staff at allcove have been supportive.
    - 76% indicated they would be comfortable reaching out to allcove staff in the future.
- Youth also reported their appreciation for how accessible services at allcove are, stating that flexible and quick scheduling allowed youth to receive immediate support. The ability to respond to acute needs is an important and significant achievement. Youth that are undocumented mentioned that allcove does not have structural barriers that slow, limit, or prevent their ability to access care. From the client survey respondents, 88% of youth indicated agreement that provider respect for youth is an area of strength at allcove, and that they feel respected by allcove staff. Receiving services in youths' preferred language also appears to be a strength at allcove.
- Youth emphasized several characteristics that promote accessibility of services, such as adherence to confidentiality, as well as flexible and quick scheduling that allow youth to receive immediate support. Youth also expressed that, without allcove, they would not have otherwise been able to access services.
- Youth advisors reported that the work of allcove is making a difference in destigmatizing mental health and creating a place where youth can come to learn about mental health or seek services. Youth advisors also shared that they can see their input implemented into the work being done at allcove.
- allcove San Jose also opened in June of 2021 but closed after six months with a plan to relocate. Issues related to the closure were primarily related to the choice of location: within a supportive housing unit in a portion of the city already facing high levels of high-risk activity and police presence. Lessons learned from allcove San Jose include the need to ensure the stability of the community where the allcove center is located, the ongoing involvement of all community partners in committing to the safety of the center itself and the assurance that young people from across the local community are comfortable with using the allcove center location.
- Every community is a good fit for an allcove center, as rates of youth mental health challenges are high across all socio-economic levels. It is essential for every allcove center to have the commitment of local partners and existing organizations to make each site successful. Regardless of the socio-economic or resource status of the community where the allcove center is located, it is essential that allcove center services reflect the values, needs and culture of the youth, families and community members that will engage in services.
- As the allcove model evolves, Stanford's Central allcove Team is also evolving its support for diverse communities, recognizing that the technical assistance approach must meet the community culture to ensure local partner commitments. However, each allcove center will include the six core service streams and complete model components while being delivered with an understanding of and sensitivity to diverse needs of each community.

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?

As part of a multi-county initiative, allcove centers will have common learning goals:

1. To learn about the efficacy of the allcove integrated youth mental health model in a local context, evaluating how:
    a. allcove engages with young people and supports them in connecting to services when they want them, before a crisis, leading to better outcomes for youth and cost savings for communities.
    b. allcove destigmatizes mental health and normalizes wellness and prevention and early intervention as important to everyone.
    c. allcove reimagines mental health and wellbeing for young people.
2. To learn the benefits for youth and their families in accessing services from a network of centers who work collaboratively to adapt and test a new model within a multi-county and state initiative.

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

As part of the multi-county initiative, all allcove centers will participate in the allcove common evaluation to evaluate the efficacy of the program model and its adaptation to the local environment.

Goal 1: Learning how allcove engages with young people and supports them in connecting to services when they want them, before a crisis, leading to better outcomes for youth and cost savings for communities, relates to these key allcove approaches:

- *Providing youth-centered care*: To be sure that the center environment, service design, and ethos provide an experience that meets the needs of young people and their families and drives reform in the service system, each center's Youth Advisory Group is involved at the governance, service and individual level.
- *Providing prevention, screening and early intervention services:* Intentional, youth-driven, and targeted outreach to the community and service system aims to increase early help-seeking and mental health literacy, as well as to start health and wellbeing conversations early. Additionally, universal screening identifies risks and protective factors early to address mild to moderate concerns before they become a problem in young people's trajectory and cause higher costs to the health system and community.
- *Providing rapid, easy and affordable access to services*: Removing cost and administrative barriers and providing easy-to-access, free or low cost, set of core services to all youth 12 to 25 years of age delivered in service modalities that are acceptable to young people and their families.

- *Providing holistic and integrated care*: A model of care that is co-located, integrated, and provides clinical and youth development services, along with solid referral pathways to address bio-psycho-social determinants of health and young people's aspirational health and wellbeing goals.

Goal 2: Learning what the benefits are for youth and their families in accessing services from a network of centers working together to test a new model within a multi-county and state initiative relates to these components of the model:

- Participating in knowledge sharing activities of the Learning Community
- Uplifting local and international best-practices by building a community of practice across centers
- Braiding together various insurance reimbursement, state and federal funding for services, and local fundraising efforts to support non-billable services for the overall financial sustainability of the model
- Refining how informed consent and confidentiality, as set by California and federal law, apply to diverse services within the allcove model
- Understanding how model integrity review processes support local allcove center development

EVALUATION OR LEARNING PLAN

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

The first learning goal will be measured in the allcove cross-center evaluation, designed to assess the efficacy of the program at the center level and of the adaptation of the model at the network level. Using datacove, allcove's centralized data collection system, the evaluation and the model integrity review process, the center will collect data:

- To evaluate if access is being increased to the priority groups.
- To evaluate if young people are reaching their health and wellbeing goals.
- To understand the level of youth engagement as reported by young people.
- To evaluate if the services are acceptable to young people and their families.
- About young people's presenting concerns.
- About the nature of services received to evaluate if they are engaging early or accessing services they otherwise may not have accessed.
- About the level of collaboration and integration of services.
- About community engagement objectives and activities.

Tools in the allcove minimum data set consist of:

- Socio-demographic information, including the MHSA data set.
- Key life events to measure significant changes in youth's life (e.g., housing, education, employment, juvenile justice system involvement).

- Clinical symptoms measures, including the Patient Health Questionnaire, the General Anxiety Disorder scale, questionnaires to assess early psychosis risk, and the Columbia Suicide Severity Rating Scale.
- Mental health symptoms and wellbeing measures including the Clinical Outcomes in Routine Evaluation to assess psychological distress, and a Flourishing Measure.
- Measures to assess eating disorders and substance use risks.
- Goal-based outcomes to evaluate progress towards a young person's goals over the course of the brief intervention.
- Youth end-of-visit satisfaction survey to assess shared decision making, ease of access, provider relationship, and sense of utility.

Additionally, service delivery information will be collected by center providers after every visit to describe types of services youth receive (e.g., mental health, physical health, supported education and employment).

The allcove cross-center evaluation includes measuring consistent program and organizational information to understand characteristics of the allcove model, including youth partnership, mental health stigma, integrated care, and community collaboration. This focus area will be captured through validated or research informed survey instruments to be completed semi- annually, timed to coincide with the model integrity review that includes measuring:

- Youth-adult partnership, youth voice in decision making and supportive adult relationships.
- Stigma among healthcare providers.
- Integrated practice and care integration.
- Collaboration at the multi-agency organizational level.

The second learning goal will be measured through the evaluation of:

- the allcove model integrity review process outcomes that highlight barriers and enablers to the implementation of the model in the U.S. and California.
- The allcove Learning Community outcomes related to knowledge sharing and translation between a network of centers.

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?
Each allcove center will work in close coordination with the Central allcove Team at Stanford's Center for Youth Mental Health and Wellbeing on all aspects of project evaluation. The Central allcove Team works internally and with contractors, including Dacima and Apex Evaluation, to provide technical support for the common evaluation and coordinated data collection.

COMMUNITY PROGRAM PLANNING

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

Stanford's Center for Youth Mental Health and Wellbeing has in the past and will continue to be available to present or co-present with an allcove center or interested community to county MHSA committees about allcove and the viability of establishing center(s) in that county. In general, Stanford's Center for Youth Mental Health and Wellbeing will provide an overview of the allcove model as well as current information about the progress of developing centers and the impact of open centers. Anyone connected with a community interested in bringing allcove to their area is invited to sign up for access to the Exploring allcove folder. This online resource contains written information about the model, its components, and considerations for developing an allcove center.

As allcove centers are open to anyone between the ages of 12 and 25 years old and is designed to reflect the culture of each community, the model is appropriate for every community.

Potential prompts for local counties/ communities to use in focus groups with local youth to enhance their applications:

- *Based on your/ your peers' experience in accessing mental health, what changes need to be made to empower youth to seek or continue with services?*
- *What would being involved in your own mental health journey feel like? Do you think more youth would feel empowered to access allcove/mental health services if their voices led their care?*
- *Tell us about the power of lived experience and supporting a young person's experience into accessing mental health services and allcove. Why is this a core service at allcove?*
- *What would it mean to have one space that allows you to receive multiple services?*
- *What do you think allcove needs to do so that young people feel comfortable in seeking out services? What is the message that they need to hear?*
- *Why is it important to make sure that allcove services are easy to access for youth?*
- *How important is transparency and confidentiality to young people? As a young person, what do you want to see when it comes to how you access services?*
- *In thinking about allcove and all of its services located in one place, where would you go if you weren't going to allcove? How many places would you have to go to receive care?*
- *What would it feel like to go to a center specifically created for young people?*

MHSA GENERAL STANDARDS

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

A) Community Collaboration

allcove centers are led by two strong local community advisory bodies: the Youth Advisory Group, which ensures that local youth voice informs service design at an individual, service and governance level, and the Community Consortium, which ensures that the center is embedded in the local youth service system. Together they provide a collaborative platform for service system reform and uplift the voice of young people and families with living or lived experience. Along with direct service delivery, another main activity of the center will be outreach in the community to raise awareness of services, increase mental health literacy and initiate conversations about mental health early to decrease stigma. These activities will be planned and carried out through formal and informal community collaboration arrangements.

B) Cultural Competency

One of the key principles for the allcove model is that youth-centered care must be socially and culturally inclusive. allcove centers are intended to reflect a community's culture and be flexible enough to adapt to the needs and unique characteristics of a given community, whether large or small. Each center is led by a coalition of service providers and community-based agencies joining together in an integrated approach to serving young people. Beyond the Youth Advisory Group and Community Consortium, which reflect the local community, centers will also build additional partnerships, especially those of hard to reach and vulnerable groups. Lead agencies and service partners are encouraged to staff their allcove center with young adults and adults who look like the young people in the community who will be seeking services, and each center identifies staffing needs, including building more culturally responsive services, on an ongoing basis.

Stanford's Central allcove Team and youth advisors co-developed a set of principles and recommended actions for promoting inclusion, belonging and anti-racist practices in allcove centers. These principles and actions will be encouraged through the allcove Learning Community and upheld through model integrity process.

C) Client-Driven

Though the mechanisms of shared decision making, Youth Advisory Group and Community Consortium representation, a foundational characteristic of the allcove model is the central and ongoing involvement of young people in their individual care, the center's service design and governance. These community-based groups ensure that allcove services and activities are client-driven.

D) Family-Driven

While the focus of the allcove model is young people, the program acknowledges the importance of families as a critical support network. When clinically indicated and acceptable to the young person, families and other adults providing care are guided in supporting their young people with a variety of service options including brief interventions, psychoeducation and group programs.

E) Wellness, Recovery, and Resilience-Focused

While supporting young people to address health and wellbeing challenges as they arise, the allcove center will provide group wellbeing, health education and recreational programs that support wellbeing and develop protective factors. Services will be youth centered, hope inspired and strengths based. Every allcove center is active in the community to raise mental health literacy, increase help seeking and reduce mental health stigma.

F) Integrated Service Experience for Clients and Families

The heart of the allcove model is providing a core set of co-located, integrated, clinical and youth development services, with referral pathways to other services that provide a continuum of care, that address bio-psycho-social determinants of health in achievement of young people's aspirational health and wellbeing goals.

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 allcove evaluation project was initially co-designed with and informed by young people's perspectives. A core number of the Central allcove Team Youth Advisory Group, the eval squad, worked with evaluation planners in creating the evaluation project. As the evaluation plan evolves, it continues to be assessed with feedback from the Central allcove Team Youth Advisory Group and will include involvement from open allcove centers.

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.

To date, allcove centers have spent up to several million dollars on start-up costs. These costs vary widely by geography, type of lead agency, facility access, payer mix, etc. These are also the costs without any reimbursement plan to this point, which will allow for lower annual costs. Stanford's Central allcove Team is working in partnership with Commission in developing further sustainability, including through collaborating to facilitate regular meetings with leadership from across the allcove network to create more pathways for billable reimbursement opportunities and funding for non-billable services.

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.
The allcove center will have a focus on prevention and early intervention supporting youth and their families in addressing mild to moderate mental health needs. As this model provides a "no wrong door" point of entry, each allcove center will facilitate supported referrals to more

specialized services for young people presenting with serious mental illness. These referrals will also be in place so as not to disrupt continuity of care should the center cease to operate. These “warm hand-off" referrals include direct linkages to early psychosis programs and mental health services for needs greater than mild to moderate.

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?

The allcove Learning Community provides the network of centers with a way to communicate, share best practices, resources, learnings, address challenges to implementation, to network, and to build communities of practice. The sharing of knowledge through this structured component will build continuous improvement across the center network and provide a forum for sharing international best practices in the implementation of integrated youth mental health services.

The Central allcove Team Youth Advisory Group, with representation across the state, will work with local Youth Advisory Groups from each center to build statewide youth engagement, amplify youth voice and enhance optimal youth participation.

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.

allcove – Youth Advisory Group – career – therapy or counseling – peer

TIMELINE

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

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

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

A complete timeline of aspects for this Innovation Project is in Table 1. The development of an allcove center can be up to a five-year project, depending on timing at the local level, though the aim to is open within 18 months of contract signing or funding award, with funding from the remaining years applied to sustaining the center.

Counties that have received grant funding are eligible to leverage the use of innovation funding to join the multi-county collaborative. Counties may elect to join the collaborative at various times; therefore, every County may be in different stages of implementation within this multi-county

collaborative. If a County uses innovation funding to join the multi-county collaborative, all of the local process steps must be completed by the County in accordance with innovation regulations.

Implementation activities over the five years include:

- An establishment phase, where the lead agency and community partners begin to form an allcove center and begin to receive training and technical assistance from the Central allcove Team. The establishment phase includes:
    - A model integrity phase, where the lead agency and partners are several months away from opening (pre-service) and focused on providing evidence of meeting benchmarks, with support from the Central allcove Team, to ensure model integrity standards are being met.
    - An opening phase, where the allcove center has a soft launch after model integrity standards have been met and approved by the Central allcove Team and the MHSOAC.
    - A launch phase, where the allcove center has a grand opening, after time to test and adjust processes and services to meet community needs.
- An annual review phase, when the allcove center is fully operational and the Central allcove Team reviews model integrity standards and supports service improvement activities

While the process follows the steps outlined below in Table 1, timing is specific to each center's context. Each aspect is built on the successful completion of the previous aspects; exact timing may occur in a later year if the previous aspects are not completed first.

Establishment Phase (Year 1)	
Local county/ community allcove	***Stanford's Central allcove Team***
Project team from community assembled	Provide presentations and information meetings to interested community partners (*may have begun pre-application and may continue*)
Lead agency begins by completing the establishment work plan (template) and set timelines for milestones Attend monthly implementation meetings with Central allcove Team and the MHSOAC Youth outreach specialist hired	Provide model induction presentations, including an introduction to the establishment work plan Begin and facilitate monthly implementation meetings with lead agency and MHSOAC Provide feedback report on the finalized establishment work plan, addressing outstanding items during monthly implementation meetings Provide training and technical assistance to lead agency in recruiting and forming Youth Advisory Group

	Provide training and technical assistance to lead agency on branding, communications, and environmental design as they begin exploring potential sites
Youth Advisory Group established and continue regular meetings	Provide training and technical assistance to youth outreach specialist to recruit and form Youth Advisory Group
Facility secured, space fit out and permits completed	Provide feedback on proposed center design to help ensure minimum requirements are met
Community Consortium established and continue monthly meetings	Provide training and technical assistance to allcove lead agency to recruit and form Community Consortium
Lead agency staff attend and participate in Learning Community activities	Provide Learning Community activities, including quarterly network meetings, monthly cross-site communities of practice meetings, and recorded/ written modules relating to the allcove model
Center design completed (furniture, branding, etc.)	Provide training and technical assistance youth outreach specialist to support Youth Advisory Group completing center design
Center manager and clinical lead hired	Provide training and technical assistance through reviewing job descriptions and supporting recruitment efforts
Partnership agreements completed	Offer review of Request for Applications and service level agreements (contracts) to lead agency

Establishment Phase continues with Model Integrity (Year 1 or Year 2)	
Local county/ community allcove	***Stanford's Central allcove Team***
Continue attending monthly implementation meetings with Central allcove Team and the MHSOAC	Facilitate monthly implementation meetings with lead agency and MHSOAC, , addressing outstanding items during monthly implementation meetings Provide training and technical assistance to allcove lead agency on center development

Data requirements completed	Provide training and technical assistance to allcove lead agency and service partners on data collection requirements and protocols
Center staff (clinical, youth development, administrative) hired	Provide training and technical assistance to allcove lead agency and service partners on core service streams and integrated services approaches
Lead agency and service partner staff attend and participate in Learning Community activities	Provide Learning Community activities, including quarterly network meetings, monthly cross-site communities of practice meetings, and recorded/ written modules relating to the allcove model
Model integrity review completed (at least 8 weeks before soft opening)	Provide training to allcove lead agency and service partners, if applicable, and carry out the model integrity review process Provide feedback report on model integrity review, addressing challenges to implementation and celebrating achievements
Lead agency and service partners prepare for visit from Central allcove Team (at least 1 – 2 weeks prior to soft opening)	Complete a readiness visit prior to soft opening and provide feedback on soft opening plans

Establishment Phase continues with Soft Opening (Year 1 or Year 2)	
Local county/ community allcove	***Stanford's Central allcove Team***
Continue attending monthly implementation meetings with Central allcove Team and the MHSOAC	Facilitate monthly implementation meetings with lead agency and MHSOAC Provide training and technical assistance to allcove lead agency on center development
Lead agency staff attend and participate in Learning Community activities	Provide Learning Community activities, including quarterly network meetings, monthly cross-site communities of practice meetings, and recorded/ written modules relating to the allcove model
allcove center soft opening (at least 4 weeks before public opening)	Tour center prior to soft opening to provide recommendations for any remaining outstanding model integrity standards
Begin collecting evaluation data through the use of datacove	Provide ongoing technical assistance to ensure datacove protocols are being delivered

	Begin providing data to external evaluator contractor
Lead agency and service partners prepare for visit from Central allcove Team (at least 1 – 2 weeks prior to official launch)	Complete a readiness visit prior to official launch and provide feedback on official launch plans

Establishment Phase continues with Official Launch (Year 1 or Year 2)	
Local county/ community allcove	***Stanford's Central allcove Team***
Move to attending quarterly implementation meetings with Central allcove Team and the MHSOAC	Facilitate quarterly implementation meetings with lead agency and MHSOAC Provide training and technical assistance to allcove lead agency on center development
Lead agency staff attend and participate in Learning Community activities	Provide Learning Community activities, including quarterly network meetings, monthly cross-site communities of practice meetings, and recorded/ written modules relating to the allcove model
allcove center public opening (after completion of all model integrity review outstanding items)	Tour center prior to public opening to provide recommendations for any remaining outstanding model integrity items
Continue collecting evaluation data through the use of datacove	Provide ongoing technical assistance to ensure datacove protocols are being delivered Continue providing data to external evaluator contractor

Center Operational Phase (Year 2 or Year 3 through Year 5)	
Local county/ community allcove	***Stanford's Central allcove Team***
Attend quarterly implementation meetings with Central allcove Team and the MHSOAC	Facilitate quarterly implementation meetings with lead agency and MHSOAC Provide training and technical assistance to allcove lead agency on center development
Complete annual model integrity review every 12 months after official launch	Provide feedback report on annual review, addressing challenges to implementation and celebrating achievements
allcove staff attend and participate in Learning Community activities	Provide Learning Community activities, including quarterly network meetings, monthly cross-site

	communities of practice meetings, and recorded/ written modules relating to the allcove model
Continue collecting data through the use of datacove	Provide ongoing technical assistance to ensure datacove protocols are being delivered Continue providing data to external evaluator contractor
Participate in other evaluation activities, including focus groups and interviews, about the development of the allcove center	Provide ongoing technical assistance and support of external evaluator activities

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INN Project Proposal #4 - *PIVOT – developing capacity for MediCal billing*

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSOAC
Mental Health Services
Oversight & Accountability Commission

INNOVATIVE PROJECT PLAN
RECOMMENDED TEMPLATE

COMPLETE APPLICATION CHECKLIST
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:
☑ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors.
☑ Local Mental Health Board approval Approval Date: November 6, 2024
☑ Completed 30 day public comment period Comment Period: November 6, 2024
☐ BOS approval date Approval Date: _____ If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: January 14, 2025 *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*
Desired Presentation Date for Commission: January 23, 2025 ***Note: Date requested above is not guaranteed until MHSOAC staff verifies all requirements have been met.***

Mental Health Services Act (MHSA) Innovation Project Plan

County Name: San Mateo County

Date submitted: TBD

Project Title: Progressive Improvements for Valued Outpatient Treatment (PIVOT)

Total amount requested: $5,650,000 ($5M service delivery for 5 years, $200K BHRS administration, $450K evaluation)

Duration of project: 5 years

PIVOT is a multi-county system redesign Innovation (INN) project, initially developed by Orange County, that supports counties in preparing for behavioral health transformation and the transition to the Behavioral Health Services Act (BHSA). Given that counties face similar system-level challenges, the project promotes cross-county learning and capacity building as counties redesign their behavioral health systems. San Mateo County BHRS is opting into one of the five components of the PIVOT concept. The Orange County plan, which offers full background on the need and design of the project, is attached. Approval of the project in San Mateo County is contingent upon Mental Health Oversight and Accountability Commission (MHSOAC) approval of the Orange County project.

Proposed PIVOT Component(s) to Implement in San Mateo County:

☐ Full-Service Partnership Reboot
☐ Integrated Complex Care Management for Older Adults
✓ **Developing Capacity for Specialty MH Plan Services with Diverse Communities**
☐ Innovating Countywide Workforce Initiatives
☐ Innovative Approaches to Delivery of Care

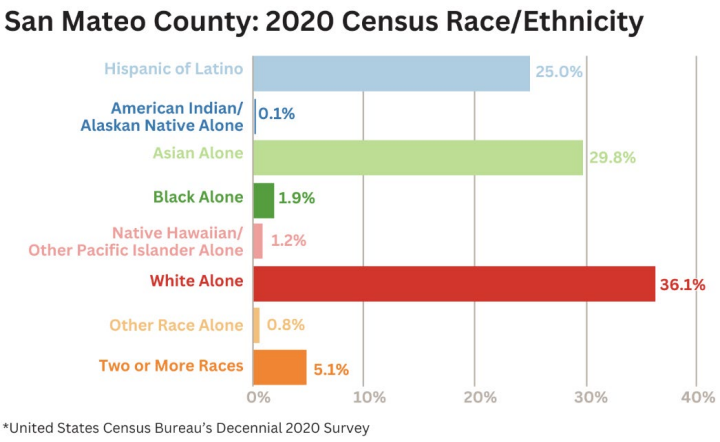
LOCAL NEED

In San Mateo County, as in other counties, mental health services are split into services for individuals with *mild to moderate* behavioral health conditions and specialty mental health services (SMHS) for individuals living with *serious mental illness* (SMI) or *substance use disorders* (SUD). In San Mateo County, community-based mental health providers typically provide MHSA-funded early intervention and peer support services. Additionally, community-based organizations (CBOs) are often the best equipped to provide culturally informed strategies in diverse communities–or what the California Reducing Disparities Project (CRDP) calls *community-defined evidence practices* (CDEPs)—alternatives or complements to standard evidence-based practices that "offer culturally anchored interventions that reflect the values, practices, histories, and lived-experiences of the communities they serve." As counties transition to BHSA and prioritize billable services, it will be critical to develop the community infrastructure and network of providers eligible to bill Medi-Cal for both specialty mental health, peer supports, and early intervention services.

County Demographics

San Mateo County is a diverse county in terms of race/ethnicity, country of origin, and language. As such, there is a great need to ensure that culturally informed CDEPs are integrated in the behavioral health system as the statewide behavioral health reform moves forward.

Race/ethnicity. San Mateo County has a total estimated population of 754,250. In 2020, 36.1% of residents identified as White (non-Hispanic), followed by 29.8% of individuals who identified as Asian, and 25.0% who identified as Hispanic/Latinx. Black/African American individuals made up 1.9% of the population, Native Hawaiian/Pacific Islander individuals made up 1.2%, and American Indian/Alaskan Native made up 0.1% of the population. Individuals who identified as two or more races made up 5.1% of the population, and individuals who identified as another race made up 0.8%.[1]



Country of origin. An estimated 35.9% of San Mateo County residents were born outside of the United States.[2] The regions of birth included Mexico and Central America, South America, Europe/Canada/Oceana, and Asia (60%, 6%, 5%, 29% respectively).[3] In 2019, according to the Migration Policy Institute, San Mateo County had 55,000 undocumented residents.[4]

Languages spoken. Nearly half (45.2%) of San Mateo County residents speak a language other than English at home. The most common foreign languages spoken in San Mateo County are Spanish (17.2%), Chinese which includes Cantonese and Mandarin (9.3%) and Tagalog (6.2%).[5]

[1] San Mateo County, County Executive's Office, using 2020 United States Census. https://www.smcgov.org/ceo/san-mateo-county-demographics-0

[2] San Mateo County, County Executive's Office, using American Community Survey, 2018-2022, 5-Year Estimates.

[3] San Mateo County 2020-2021 Cultural Competence Plan. https://www.smchealth.org/sites/main/files/file-attachments/final_smc_bhrs_ode_cultural_competency_plan_20_21_0.pdf?1642194682

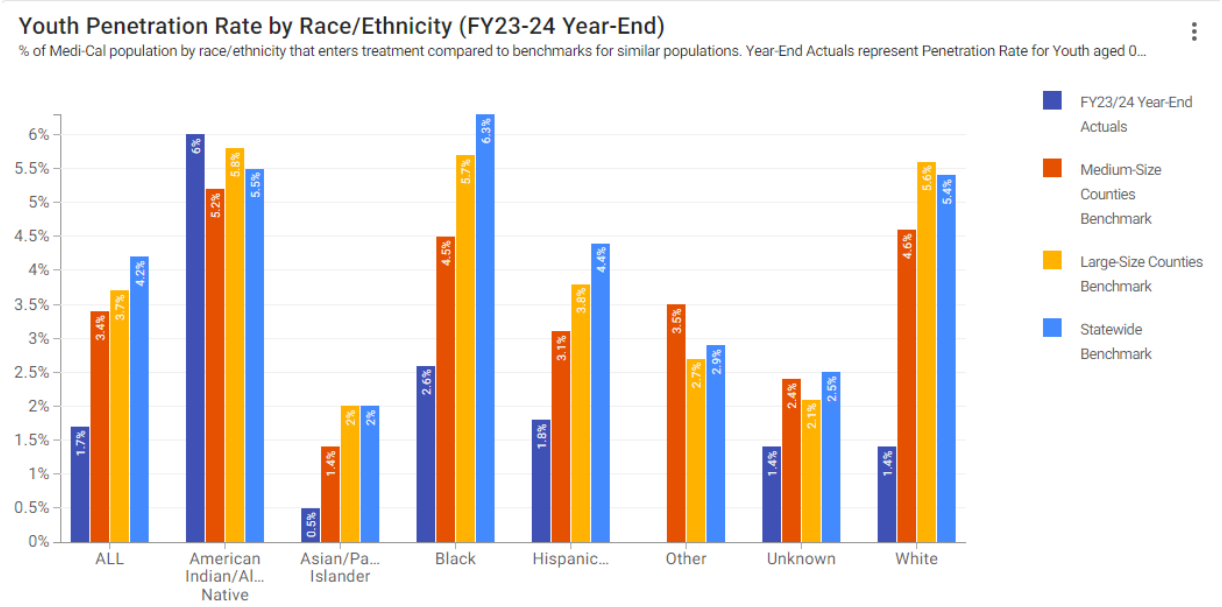
[4] San Mateo County 2020-2021 Cultural Competence Plan.

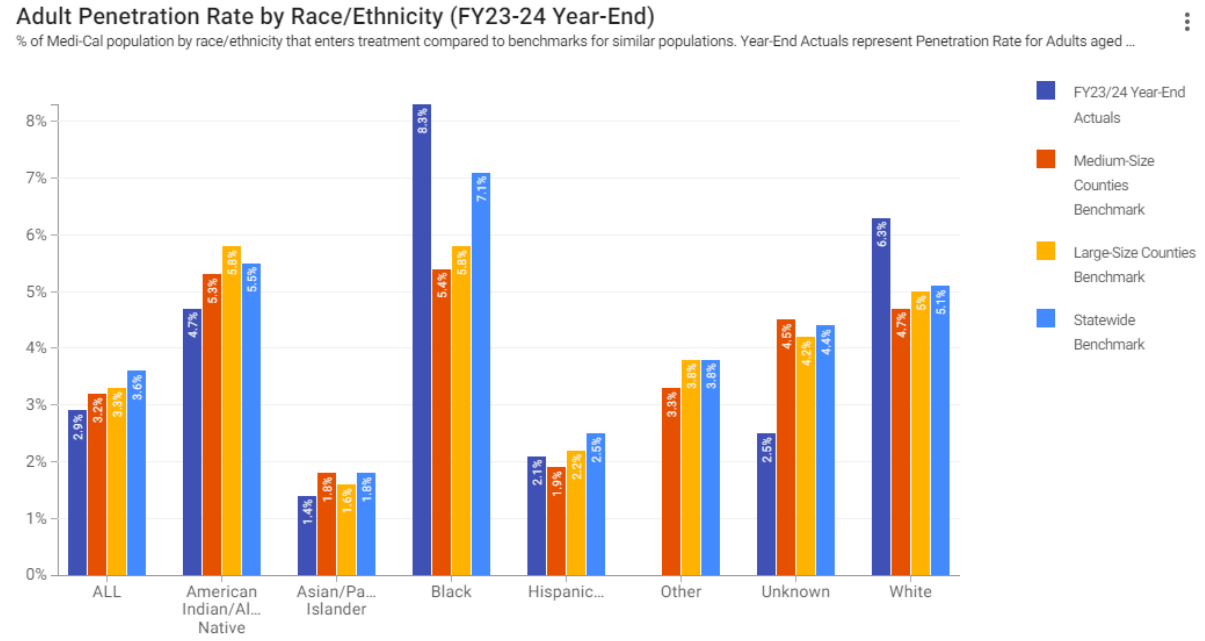
[5] Source: San Mateo County, County Executive's Office, using American Community Survey, 2018-2022, 5-Year Estimates

Underrepresented Groups in the Behavioral Health System

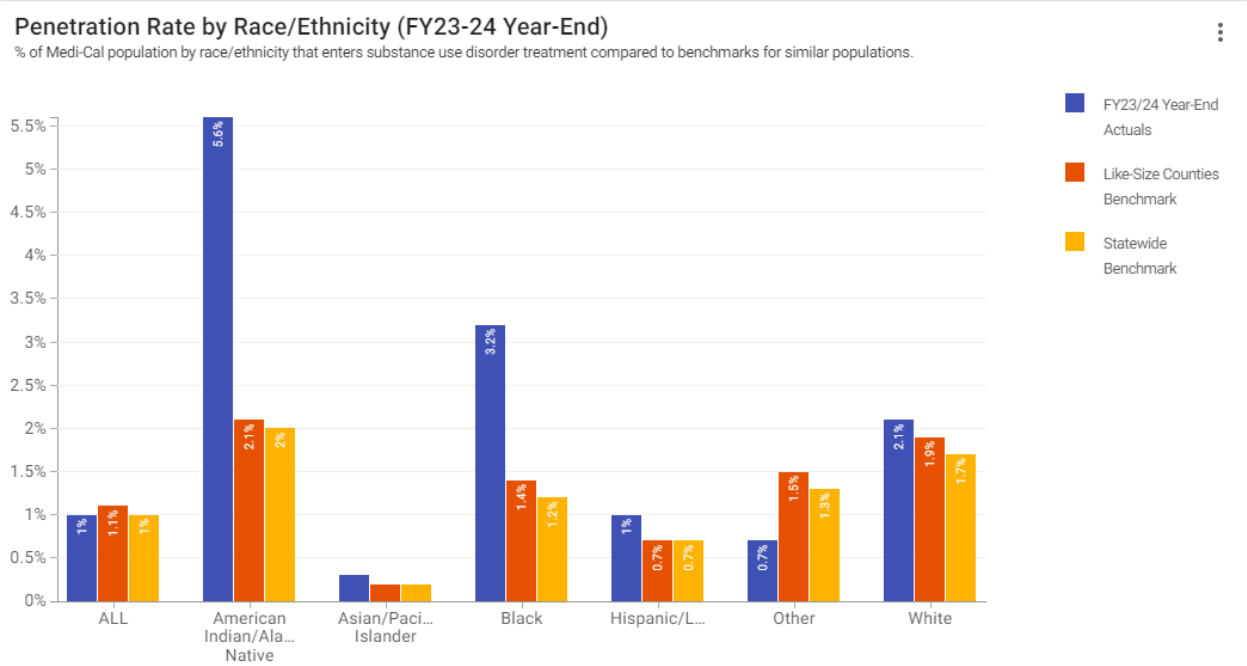
Penetration rates for specialty mental health and substance use services represent the percent of Medi-Cal eligible individuals who are served by the county behavioral health system. Looking at penetration rates for mental health and substance use services by race/ethnicity helps to identify communities that are underrepresented in the BHRS system of care. Mental health penetration rates for youth in San Mateo County are low across all race/ethnicity categories. For adults, overall rates are lower compared to similar-size counties and the state and more specifically underrepresentation of American Indian/Alaskan Native and Asian/Pacific Islander.

FY 23/24 Year-end penetration rates of youth and adults for mental health treatment by race/ethnicity category.





FY 23/24 Year-end penetration rates for substance use disorder treatment by race/ethnicity



Gaps in Medi-Cal Billing

In San Mateo County, larger and established community-based providers are certified to bill for Medi-Cal reimbursement for their culturally informed early intervention mild-to-moderate and SMHS (e.g., StarVista's San Mateo County Pride Center). Yet, there are challenges for smaller CBOs that do not have the infrastructure or capacity needed to become a SMHS provider and/or certified bill Medi-Cal for eligible peer support and early intervention services.

In San Mateo County, there are at least 15 MHSA-funded peer support and early intervention providers that could potentially bill to Medi-Cal if support were available to help them be certified and train them in billing procedures. These programs range from $75,000 to $650,000.

The PIVOT project creates an opportunity to sustain effective and culturally informed early intervention and peer support services funded by San Mateo County MHSA (e.g., The Cariño Project, Farmworker Equity Express, Kapwa Kultural Center, Recovery Connection, California Clubhouse, Helping Our Peers Emerge: From Hospitalization to Healthy Community Integration; Joven Noble, Mindfulness-Based Substance Abuse Treatment, INSPIRE Brief Intervention, Promotores Model - Outreach Collaboratives, Music Therapy for Asian Americans, etc.) and enhance the volume and quality of culturally informed SMHS by assisting CBOs to become SMHS providers, certify to bill Medi-Cal, and help them identify components of successful CDEPs that can be billable. Recently, an organization that has been a longtime provider of specialty mental health services announced the closure of many of their programs in San Mateo County, including Full Service Partnership services. This speaks to the local need to increase the pool of viable SMHS providers. The project will determine steps to help CBOs that are interested become SMHS providers and/or certified to bill for their early intervention CDEPs and peer support services. It will test the model of billing that health care providers use and identify components of CDEPs for which counties could leverage Medi-Cal billing.

LEARNING OBJECTIVES

The table below lists the learning objectives designed for the Orange County project along with additional learning objectives for San Mateo County.

PIVOT Learning Objectives (Orange County)	Additional Local Learning Objectives
1. What are the minimum requirements for a CBO to become a Medi-Cal/DMC-ODS provider? 2. What type and level of technical assistance is needed to support CBOs? 3. In what ways does a hub and spoke model effectively support capacity building? 4. Does embedding culturally based approaches for specialty mental health care improve penetration rates and client outcomes? 5. Which CDEPs are most effective? 6. How can CDEPs be utilized to generate revenue?	1. To what extent and how does the process of billing Medi-Cal change CBOs' service delivery practices (e.g., structure of services, time spent on administration)? 2. What adjustments do CBOs need to make to their practices in order to incorporate Medi-Cal billing into their practice?

LOCAL COMMUNITY PLANNING PROCESS

PIVOT is pending approval from the MHSOAC and is scheduled for review on October 24, 2024 MHSOAC meeting. In San Mateo, the CPP process for Innovation Projects begins with the development of the MHSA Three-Year Plan. A comprehensive community needs assessment process determines the gaps, needs and priorities for services, which are used as the basis for the development of Innovation projects. San Mateo County's current MHSA Three-Year Plan strategies all embed three core components: *1) embed peer and family supports into all behavioral health services; 2) Implement culturally responsive approaches to address existing inequities; and 3) increase community awareness and education about behavioral health topics, resources and services.*

Appendix 1 includes the MHSA Three-Year Plan CPP process and Strategy Recommendations. Implementing this PIVOT component – to develop the community infrastructure and network of providers eligible to bill Medi-Cal for both specialty mental health, peer supports, and early intervention services – not only supports core BHSA priorities but also addresses San Mateo County local priorities. To further explore the support for this project with community stakeholders, an MHSA quarterly meeting was dedicated to exploring options for multi-county projects and hear directly from the community regarding their interests and needs. Participants expressed concern with sustainability of programs currently funded under Prevention and Early Intervention component - there are early intervention providers providing billable services that are not billing Medi-Cal. Participants described

barriers such as infrastructure, capacity, the impact on the community-defined practices if specific criteria are required for billable services.

INN Idea Selection Process

- ✓ With the availability of funding for new INN projects to be approved in the current fiscal year, BHRS sought to identify potential INN projects from its 2022 idea submission round that would meet current needs and align with the priorities of the BHSA.
- ✓ BHRS staff reviewed the 14 ideas that had been pre-screened in 2022 against the Innovation requirements. In order to prioritize INN projects that could be sustained under the BHSA, staff screened the 14 ideas to identify projects that included treatment/recovery and/or early intervention services. Most project ideas were in the area of prevention; five ideas included components of early intervention, treatment, and/or recovery.
- ✓ BHRS conducted an internal feasibility review of the five projects, and determined to move forward with two of the INN proposals based on BHRS capacity and priorities for the BHSA transition. In addition, BHRS decided to move forward with two multi-county collaborative INN projects.
- ✓ On September 5, 2024, the MHSA Steering Committee met to review the two community-derived INN ideas, and the two multi-county collaborative projects, and provide comment and considerations for the projects through breakout room discussions and online comment forms.
- ✓ The Behavioral Health Commission voted to open the 30-day public comment period on October 2, 2024 and reviewed comments during the public hearing and closing of the public comment period on November 6, 2024. All public comments received are summarized in Appendix 2.

SUSTAINABILITY

The project is self-sustaining as BHRS will develop the infrastructure to support community-based network of providers. Currently, BHRS has hired a consultant who is going to help with project management across various infrastructures needed for the BHSA transition, including this project. Ongoing staffing needs will leverage the additional BHSA 2% administration allocation available to counties to implement BHSA priorities where appropriate. San Mateo County BHRS is pursuing a Mental Health Program Specialist position to support the new BHSA Early Intervention component including contract monitoring of all Early Intervention programs, coordination with Managed Care Plans and working closely with the BHRS Quality Management team and administrative staff as it relates to Medi-Cal billing for early intervention contracted providers who currently do not bill Medi-Cal. SMHS providers will continue to work with our current BHRS QM and billing supports. This project is likely to increase the need to have additional in-house infrastructure and ongoing supports and can be funded through the Early Intervention component of BHSA and/or the BHSA 2% administration allocation.

ALIGNMENT WITH BHSA

The PIVOT project supports the county's transition to BHSA by identifying system-level changes that will expand culturally informed billable services and a well-trained and supported behavioral health workforce. These changes will create a sustainable foundation for the delivery of high-quality services for the most vulnerable and at-risk individuals.

The following table includes responses to the MHSOAC's questions regarding how new INN proposed projects will align with the transition to BHSA, be sustained, and provide continuity of care.

BHSA Transition Questions	Response
How does the proposal align with the BHSA reform?	The project focuses on expanding accessible, culturally informed billable services for the "most ill and vulnerable" population and to be able to intervene in the "early signs of mental illness or substance use".
Does it provide housing interventions for persons who are chronically homeless or experiencing homelessness or are at risk of homelessness?	No
Does it support early intervention programs or approaches in order to prevent mental illnesses and substance abuse disorders from becoming severe and disabling?	Yes, the project focuses on developing internal BHRS infrastructure to be able to support community-based mental health providers who typically provide early intervention services, to develop their capacity to provide billable specialty mental health services and early intervention services.
Does it support Full-Service Partnership efforts and services for individuals living with serious mental illness?	No
How will the County continue the project, or components of the project, after its completion without the ability to utilize certain components of MHSA funding for sustainability?	The project is self-sustaining as BHRS will develop the infrastructure to support community-based network of providers. Ongoing staffing needs will leverage the additional BHSA 2% administration allocation available to counties to implement BHSA priorities.
How does the project assist the county's transition to the behavioral health reform?	BHSA expands and increases the types of support available to the most vulnerable and at-risk individuals, which includes peer support services and early intervention strategies. The project develops the infrastructure necessary to provide these services in a culturally informed manner.

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The total Innovation funding request for 5 years is **$5,650,000**, which will be allocated as follows:

Service Contract + Infrastructure: $5,000,000	**Evaluation: $450,000**	**BHRS Administration: $200,000**
· $500,000 for FY 24/25 · $1,000,000 for FY 25/26 · $1,000,000 for FY 26/27 · $1,000,000 for FY 27/28 · $1,000,000 for FY 28/29 · $500,000 for FY 29/30	· $60,000 for FY 24/25 · $85,000 for FY 25/26 · $85,000 for FY 26/27 · $85,000 for FY 27/28 · $85,000 for FY 28/29 · $50,000 for FY 29/30	· $30,000 for FY 24/25 · $40,000 for FY 25/26 · $40,000 for FY 26/27 · $40,000 for FY 27/28 · $40,000 for FY 28/29 · $10,000 for FY 29/30

Direct Costs will total $1,500,000 over a five-year term and includes all contractor expenses related to delivering the program services (salaries and benefits, training costs, program supplies, rent/utilities, mileage, translation services, subcontracts, etc.). Direct costs will also include provider infrastructure incentives in an amount of up to $200,000 to support capacity building for MediCal billing of up to 15 BHRS contracted providers. BHRS has a model for incentivizing contracted providers that has worked well for CalAim implementation activities.

Indirect Costs will total $650,000

- $450,000 for an independent evaluation contract to develop all annual reports and the final report due by December 31, 2030. The evaluation contract includes developing the evaluation plan, supporting data collection throughout the five years of implementation, data analysis and preparing the annual and final reports required.
- $200,000 is for BHRS county business, procurement processes, contract monitoring, fiscal tracking, IT support, and oversight of the innovation project.

Federal Financial Participation (FFP) there is no initial anticipated FFP. Opportunities for developing Medi-Cal billing capacity for BHSA early intervention providers will be pursued.

Other Funding: The County will go through a local bidding process to identify the contractor for direct services; the bidding process will inquire about any in-kind or other revenue sources that can be leveraged.

	BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
	EXPENDITURES							
	PERSONNEL COSTS (salaries, wages, benefits)	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**FY 29/30**	**TOTAL**
1.	Salaries							
2.	Direct Costs							
3.	Indirect Costs	$30,000	$40,000	$40,000	$40,000	$40,000	$10,000	**$200,000**
4.	**Total Personnel Costs**	**$30,000**	**$40,000**	**$40,000**	**$40,000**	**$40,000**	**$10,000**	**$ 200,000**
	OPERATING COSTS*							
5.	Direct Costs							
6.	Indirect Costs							
7.	**Total Operating Costs**							**$**
	NON-RECURRING COSTS (equipment, technology)							
8.								
9.								
10.	**Total non-recurring cost**							**$**
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)							
11.	Direct Costs	$500,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$500,000	**$5,000,000**
12.	Indirect Costs	$60,000	$85,000	$85,000	$85,000	$85,000	$50,000	**$450,000**
13.	**Total Consultant Costs**	$560,000	$1,085,000	$1,085,000	$1,085,000	$1,085,000	$550,000	**$5,450,000**
	OTHER EXPENDITURES (please explain in budget narrative)							
14.								
15.								
16.	**Total Other Expenditure**							**$**
	BUDGET TOTALS							
	Personnel (total of line 1)							**$**
	Direct Costs (add lines 2, 5, and 11 from above)	$500,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$500,000	**$5,000,000**
	Indirect Costs (add lines 3, 6, and 12 from above)	$90,000	$125,000	$125,000	$125,000	$125,000	$60,000	**$650,000**
	Non-recurring costs (total of line 10)							**$**
	Other Expenditures (total of line 16)							**$**
	TOTAL INNOVATION BUDGET	$590,000	$1,125,000	$1,125,000	$1,125,000	$1,125,000	$560,000	**$5,650,000**

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

	BUDGET CONTEXT – EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
	ADMINISTRATION:							
A.	**Estimated total mental health expenditures <u>for administration</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**FY 29/30**	**TOTAL**
1.	Innovative MHSA Funds	$530,000	$1,040,000	$1,040,000	$1,040,000	$1,040,000	$510,000	**$5,200,000**
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other funding							
6.	**Total Proposed Administration**	$530,000	$1,040,000	$1,040,000	$1,040,000	$1,040,000	$510,000	**$5,200,000**
	EVALUATION:							
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**FY 29/30**	**TOTAL**
1.	Innovative MHSA Funds	$60,000	$85,000	$85,000	$85,000	$85,000	$50,000	**$450,000**
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other funding							
6.	**Total Proposed Evaluation**	$60,000	$85,000	$85,000	$85,000	$85,000	$50,000	**$450,000**
	TOTALS:							
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 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**FY 29/30**	**TOTAL**
1.	Innovative MHSA Funds*	$590,000	$1,125,000	$1,125,000	$1,125,000	$1,125,000	$560,000	**$5,650,000**
2.	Federal Financial Participation							**$**
3.	1991 Realignment							**$**
4.	Behavioral Health Subaccount							**$**
5.	Other funding**							**$**
6.	**Total Proposed Expenditures**	$590,000	$1,125,000	$1,125,000	$1,125,000	$1,125,000	$560,000	**$5,650,000**
	*** INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting** **** If "other funding" is included, please explain within budget narrative.**							

APPENDIX 1. MHSA THREE-YEAR PLAN CPP & STRATEGY RECOMMENDATIONS

MHSA Three-Year Plan, 2020-2023
Community Program Planning (CPP) Process

The MHSA Three-Year Program and Expenditure Plan is developed in collaboration with clients and families, community members, staff, community agencies and stakeholders. In November 2022, a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan commenced and engaged over 400 diverse clients, family members, staff and community agencies and leaders representing geographical, ethnic, cultural and social economic status, providers of behavioral health care services, social services and other sectors across various means of providing input (surveys, input sessions, public comments). Planning was led by the MHSA Manager, Behavioral Health Commission MHSA Co-Chairpersons, an MHSA Three-Year Plan Workgroup and the MHSA Steering Committee. A draft CPP process was provided to the Behavioral Health Commission (BHC) and the MHSA Steering Committee in December 2022. Stakeholders provided input and comments on the process and what additional stakeholder groups should be engaged.

CPP FRAMEWORK

MHSA THREE-YEAR PLAN WORKGROUP

Between November and January 2023, a workgroup was convened made up of diverse stakeholders including clients, family members, community members and contracted service providers. The workgroup met monthly with the goal of co-designing an MHSA 3- Year Plan Community Program Planning (CPP) process that is equitable, inclusive and honors and centers the voices of marginalized communities. The objectives of each meeting included the following:

- Review and advise on data needed to support a comprehensive needs assessment
- Advise on the community input process and community engagement best practices, to ensure it is inclusive of all vulnerable communities
- Support opportunities for all San Mateo County community members to provide input

The MHSA Three-Year Plan Workgroup guided and informed the process each step of the way:

1. Needs Assessment
    - Informed Data Collection resources
    - Advised on the Community Survey structure
2. Strategy Development
    - Informed Community Input Sessions strategy
    - Advised on the creation of a Facilitator Training for stakeholders to support input sessions
    - Facilitated Community Input sessions
3. MHSA Three-Year Plan Development
    - Reviewed the Recommended Strategies for accuracy

COMMUNITY PROGRAM PLANNING PROCESS

1. Needs Assessment – this phase of the CPP process included the following two steps:
    - ✓ Data Review: Over 30 local plans, assessments, evaluation reports, and data were reviewed to identify prominent mental health and substance use needs reported across service sectors and the community. All of the concerns identified in the needs assessment review were categorized into the following 8 areas of need.
        i. **Access to Services** - this category captures the needs of diverse cultures and identities (race/ethnicity, LGBTQIA+, veteran status, age) related to accessing mental health and substance use services, including knowledge and education and culturally responsive approaches to engaging communities.
        ii. **Behavioral Health Workforce** - this category captures the needs related to recruiting, developing, supporting and maintaining a sufficient workforce to address the needs and the diversity of the community. This includes supporting individuals with lived experience as clients and/or family members of clients of mental health and substance use services to join the workforce and support all services and programming.

iii. **Crisis Continuum** - this category captures needs related to mental health and substance use crisis response, as well as appropriate community-based supports and stabilization during and after a crisis.

iv. **Housing Continuum** - this category captures the housing needs for individuals living with mental health challenges ranging from assisted living facilities to having access to permanent supportive housing, to early assessment of risk of homelessness and culturally responsive approaches and support with locating and maintaining housing.

v. **Substance Use Challenges** - this category captures the increasing need for substance use services and supports that are accessible, integrated and coordinated with mental health services.

vi. **Quality of Client Care** - this category captures the needs of clients that are in treatment for mental health and/or substance use challenges to have timely access to care when needed, are successfully connected to services after an emergency and receive culturally responsive approaches to their treatment.

vii. **Youth Needs** - this category is age-based and captures mental health and substance use challenges for school to transition-age youth ages 6-25, it includes recent data for adolescent suicides, juvenile justice involvement, school-based and on-campus supports.

viii. **Adult/Older Adult Needs** - this category is age-based and captures mental health and substance use challenges for adults and older adults, it includes recent data related to increasing complexity of needs, general poor mental health outcomes, and suicide prevention needs.

✓ Community Survey: The identified needs from the review of local plans and data were included in an online survey that was distributed broadly to individuals living or working in San Mateo County. The survey asked respondents to share any additional concerns related to mental health and/or substance. Additionally, the survey requested that respondents rank the 8 areas of need in order of importance.

There were 129 survey respondents to the survey, the Needs Assessment summary of results were presented to the MHSA Steering Committee on February 2, 2023, to launch the Strategy Development phase.

2. Strategy Development – this phase of the CPP process included the following two steps:

✓ Community Input: 31 community input sessions and key interviews with diverse groups and vulnerable populations (immigrant families, veterans and transition-age youth) were conducted. Based on advice from the MHSA Three-Year Plan Workgroup, groups were asked to select 1 of the 8 areas of need to brainstorm strategies in the areas of prevention, direct service and workforce supports.* Participants were asked what possible solutions (services, programs, infrastructure, etc.) would they recommend to address the need they selected. See Appendix 2. for the full list of Strategy Recommendations.

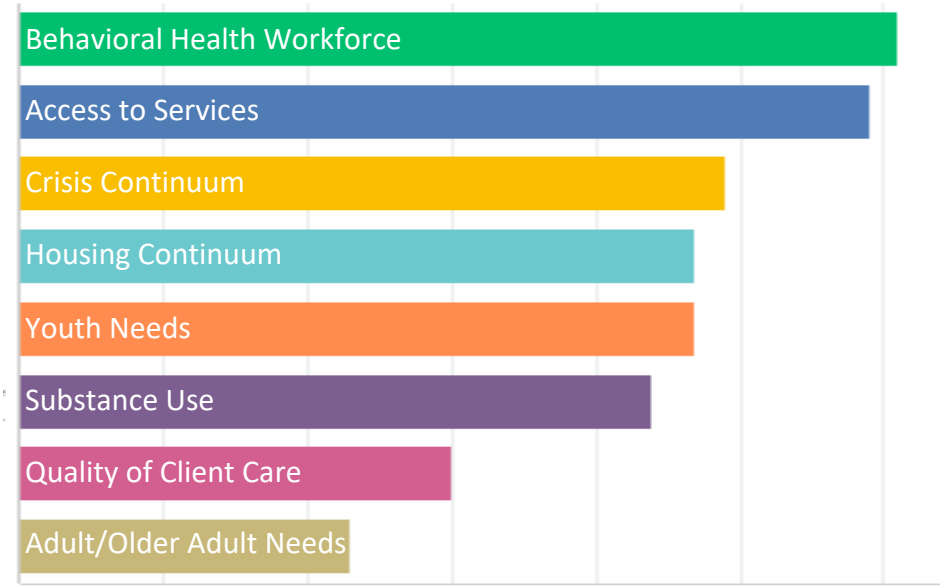
** As part of a simultaneous process to develop the MHSA 3-Year Workforce Education and Training (WET) Plan, 5 additional sessions were conducted to brainstorm around Behavioral Health Workforce strategies with the Diversity and Equity Council, Lived Experience and Education Workgroup, Alcohol and Other Drugs' Contracted Providers and BHRS Adult and Youth Leadership Teams.*

✓ Prioritization: To support the prioritization of strategies, participants were also asked: If you had to select one strategy to focus on over the next 3 years, which would you prioritize? Qualitative data analysis of all input received was conducted to identify the top strategy recommendations and key themes to present to the MHSA Steering Committee on May 4, 2023. Over 1,000 strategy ideas were shared via the Community Input sessions. This was narrowed down to 70 Strategy Recommendations across the 8 areas of need; strategies were included in this list if they were the top prioritized strategy by an input session group, they were repeated across input sessions, and for the areas of need that weren't selected as often by community groups (i.e., crisis continuum, substance use challenges, quality of client care and adult/older adult needs) all strategies that received a prioritization vote during in the input sessions were included.

Additionally, three key themes emerged from the input sessions overall, these strategies were brought up in virtually all input session: 1) Increase community awareness and education about behavioral health topics, resources and services; 2) Embed peer and family supports into all behavioral health services; 3) Implement culturally responsive approaches that are data-driven to address existing inequities. The idea is to incorporate these components into EVERY prioritized strategy moving forward.

The key themes and 70 Strategy Recommendations, Appendix 2., were presented to the MHSA Steering Committee on May 4th along with pre-recorded stakeholder video testimonials for each of the 8 areas of need and with an opportunity for additional public comments from meeting participants. Following the meeting the MHSA Steering Committee members were asked, via an online survey, to rank the 8 areas of need and help narrow down the scope of MHSA resources (both funding and planning) over the next three years. Given this prioritization, the areas of focus for the next three years will include Behavioral Health Workforce, Access to Services and addressing gaps in the Crisis Continuum. The MHSA Steering Committee was then asked in a follow-up survey to select their top Strategy Recommendations for each of the three prioritized areas of focus.

MHSA Steering Committee
Part 1 Survey Results – Areas of Need Prioritization:



3. MHSA Three-Year Plan – this phase of the CPP process includes the development of the plan, the 30-day public comment period and public hearing hosted by the Behavioral Health Commission (BHC) and the subsequent approval by the Board of Supervisors.

   - ✓ 30-Day Public Comment: The BHC voted to open a 30-day public comment period on June 7, 2023 and held a Public Hearing on July 5, 2023.
   - ✓ Board of Supervisor Approval: The BHC also voted to submit the MHSA Three-Year Plan to the Board of Supervisors for approval after the closing of the public comment period on July 7, 2023.

   This MHSA Three-Year Plan includes new funding allocations for the prioritized strategy recommendations, proposed funding allocations for other areas of need and strategy ideas that were identified; if there is an opportunity to leverage other efforts, initiatives, and/or external funding. The MHSA Three-Year Plan also builds on previous priorities. Funding and implementation for recommendations from the FY 20-21 Housing Taskforce and the Full Service Partnership (FSP) Workgroups will continue. See the Housing and FSP Workgroup priorities section.

   Additionally, The MHSA Three-Year Plan includes ongoing funding allocations for existing MHSA-funded programs. These programs are monitored, evaluated and adjusted as needed during the MHSA Three-Year Plan implementation years and recommendations are made annually about continuing, adjusting and/or ending a program. Changes to existing programs and services are included in subsequent Annual Updates, which involve stakeholder input, the MHSA Steering Committee and the BHC 30-day public comment period. Agencies selected to provide MHSA-funded services go through a formal Request for Proposal (RFP) process to ensure an open and competitive process to funding opportunities. The RFPs are posted on the BHRS RFP website, www.smchealth.org/rfps, which includes a subscription option to receive notifications.

MHSA THREE-YEAR PLAN STAKEHOLDER INPUT

Extensive outreach was conducted to promote the MHSA Three-Year Plan Workgroup participation opportunity, the Facilitator Training opportunity, the MHSA Steering Committee meetings, and the Community Input sessions. Flyers were made available in English, Spanish, and Chinese. Stipends to consumers/clients and their family members and language interpretation were offered at every meeting, childcare for families and refreshments were offered for in-person meetings.

Input included perspectives from clients and family members, communities across geographical, ethnic, cultural and social economic status, providers of behavioral health care services, social services and other sectors. The sessions were conducted through 14 existing collaboratives/initiatives, 11 committees/workgroups, 3 geographically-focused collaboratives (Coastside, East Palo Alto and North County) and 3 stakeholder group key interviews of transition-age youth, immigrant families and veterans. The majority of the meetings were conducted online. Over 400 individuals participated across the various means of providing input (surveys, input sessions, public comments).

Input Session conducted

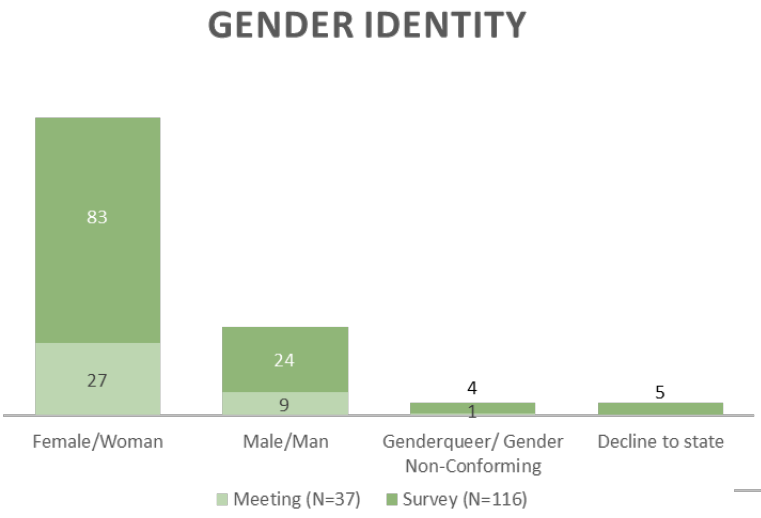
Date	Stakeholder Group	Input Session Topics
	MHSA Steering Committee	
2/2/23	4 Breakout Groups	Access to Services; Behavioral Health Workforce; Housing Continuum; Crisis Continuum
	Health Equity Initiatives	
2/3/23	Chinese Health Initiative	Access to Services
2/7/23	Pacific Islander Initiative	Youth Needs
2/8/23	Pride Initiative	Housing Continuum
2/14/23	African American Community Initiative	Quality of Client Care
2/14/23	Spirituality Initiative	Adult/Older Adult Needs
2/16/23	Native American and Indigenous Peoples Initiative	Quality of Client Care
2/16/23	Filipino Mental Health Initiative	Access to Services
2/28/23	Latino Collaborative	Access to Services
	Community Collaboratives	
2/10/23	North County Outreach Collaborative	Behavioral Health Workforce
2/16/23	East Palo Alto Behavioral Health Advisory	Behavioral Health Workforce
2/22/23	Coastside Collaborative	Access to Services
3/9/23	East Palo Alto Community Collaborative	Access to Services
	Peer Recovery Collaborative	
2/6/23	California Clubhouse/Heart & Soul	Housing Continuum
2/7/23	Voices of Recovery	Substance Use Challenges
	Behavioral Health Commission (BHC)	
2/1/23	BHC Older Adult Committee	Adult/Older Adult Needs

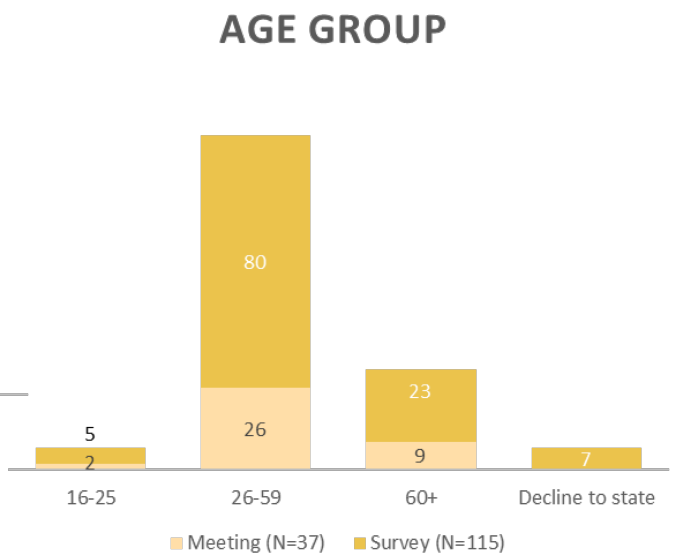
2/15/23	BHC Child and Youth Committee (3 Breakout Groups)	Youth Needs
2/15/23	BHC Adult Committee	Housing Continuum
2/21/23	BHC Alcohol and Other Drugs Committee	Substance Use Challenges
	Other Committees/Groups	
2/9/23	Housing Operations Committee	Housing Continuum
2/7/23	Lived Experience Education Workgroup	Housing Continuum
2/16/23	Contractors Association	Behavioral Health Workforce
2/20/23	Solutions for Supportive Housing	Housing Continuum
2/24/23	School Wellness Counselors	Youth Needs
2/14/23	BHRS Youth Leadership	Crisis Continuum
	Workforce Education & Training 3-Year Plan	
3/3/23	Diversity and Equity Council	Behavioral Health Workforce
3/2/23	Alcohol and Other Drug Providers	Behavioral Health Workforce
3/8/23	BHRS Adult Leadership	Behavioral Health Workforce
2/28/23	BHRS Youth Leadership	Behavioral Health Workforce
3/7/23	Lived Experience Education Workgroup	Behavioral Health Workforce
Key interviews conducted:		
Immigrant Families, Transition Age Youth, Veterans		Youth Needs; Access to Services

Demographics of participants

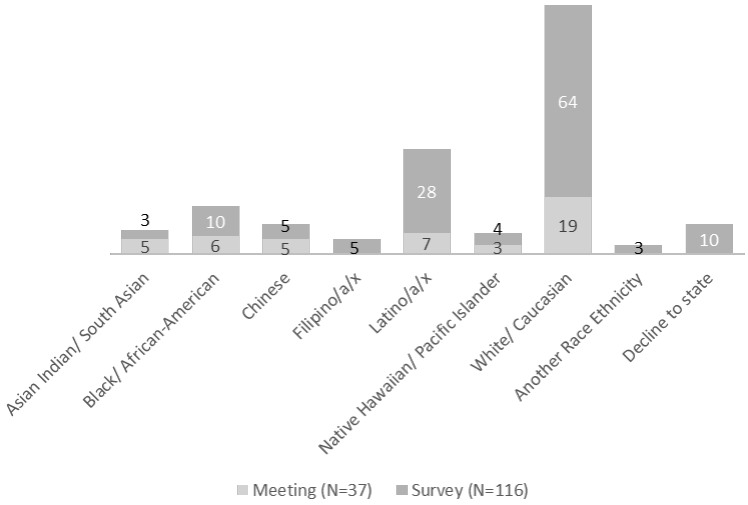
Demographic data was not collected from all 31 Community Input Sessions. 35 client and family members received stipends for participating in these sessions.

Demographics were collected for 129 survey respondents and 37 participants via a Zoom Poll feature during the two MHSA Steering Committee meetings focused on the MHSA Three-Year Plan Community Program Planning process.

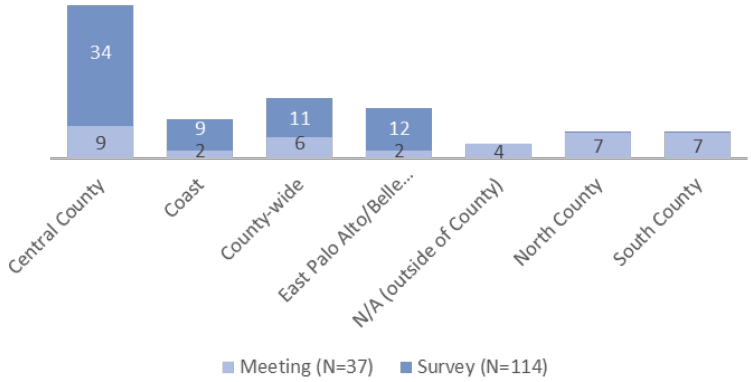




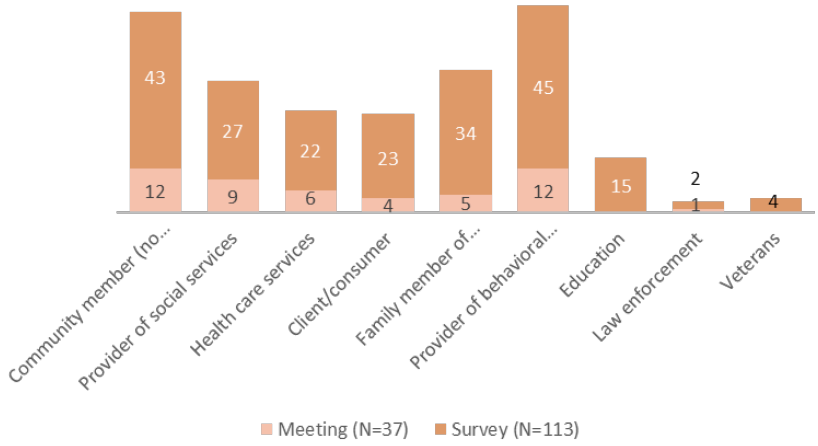
RACE/ETHNICITY



AREA OF COUNTY REPRESENTED



STAKEHOLDER GROUP



SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA Three-Year Plan Strategy Recommendations

FY 23-24 to FY 25-26

30+ community input sessions and key interviews were conducted to brainstorm strategies to address San Mateo County behavioral health needs. The MHSA Steering Committee will be voting to prioritize across the Identified Needs and across the Strategy Recommendations. This prioritization will inform the allocation of resources over the next three-years. Across all community input sessions, three core themes emerged. These components will be incorporated into EVERY prioritized strategy:

1. **Increase community awareness** and education about behavioral health topics, resources and services
2. **Embed peer and family supports** into all behavioral health services
3. **Implement culturally responsive** approaches to address existing inequities that are data-driven

Direct Services & Supports / Prevention Early Intervention

Identified Needs	Strategy Recommendations
Access to Services	1. Coordinate behavioral health services for cultural and ethnic communities (centralize services, outreach and education for the Chinese community, hire bilingual/bicultural peer staff, etc.).
	2. Expand drop-in behavioral health services that includes access to wrap around services for youth.
	3. Provide school-based behavioral health services starting in elementary and middle school; include early diagnosis and assessment at high school grade level.
	4. Co-locate prevention services (support groups, programs, workshops, etc.) in community settings such as faith-based organizations, core-service agencies, community spaces, etc.
	5. Conduct racial equity analysis of BHRS policies and procedures to identify barriers to accessing care; include service utilization and staff capacity data.
	6. Expand services for older adults focused on addressing isolation, peer support, social engagement and intergenerational work.
	7. Expand the Health Ambassador Program to include diverse languages/cultures and subject expertise (substance use, justice involved, unhoused, human trafficking, etc.)
	8. Expand outreach partnerships to include increased mild-to-moderate services, faith-based organizations and veteran engagement.
	9. Promote volunteerism to increase social engagement and community cohesion.

Recruitment & Retention Strategies

Identified Need	Strategy Recommendations
Behavioral Health Workforce	1. Create a pipeline program focused on increasing Asian American and African American behavioral health staff, develop partnerships with local and neighboring academic and non-academic programs.
	2. Create more entry level positions and internships for students of diverse backgrounds; streamline hiring processes (e.g., onboarding and process to hire interns).
	3. Target recruitment activities to reach black, indigenous, people of color (BIPOC) communities (e.g., partner with BIPOC-focused communities and student organizations and networks).
	4. Implement recruitment and retention financial incentives such as retention bonuses, signing bonuses, educational loan repayment for staff and contracted providers.
	5. Examine and adjust caseload size and balance, particularly for bilingual staff.
	6. Expand type, flexibility, and access to staff wellness and engagement opportunities (e.g., appreciation, healing activities, mentoring, behavioral health supports, networking events).
	7. Explore opportunities for alternative and flexible schedules and remote work.
	8. Implement supports for direct service staff, including peers, to advance in their careers, specifically BIPOC staff (e.g., scholarships to pursue licensure/credentials, mentorship).
	9. Invest in support, retention and leadership development of peer and family support workers (training, fair compensation, career ladders, flexible hours, and mentorship).
	10. Address extra help and contracted positions, especially for those that interface with the community.
	11. Research, plan, and implement compensation and benefits that are aligned with competing agencies and neighboring counties (e.g., salaries, cost of living, retirement plans, housing vouchers).

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Crisis Continuum	1. Create stabilization unit(s) and dedicated teams.
	2. Expand step-down from hospitalization facilities, programs and teams (e.g., respite centers).
	3. Create a youth crisis residential in the County.
	4. Expand intensive outpatient services (extended Intensive Outpatient Programs for youth, day treatment programs, detox centers, etc.).
	5. Provide respite care and language-appropriate navigation supports for parents with children who experience a behavioral health crisis (5150, psychiatric emergency services, hospitalization, etc.).
	6. Expand non-armed 24/7 mobile mental health crisis response to serve the entire community.
	7. Expand drop-in centers for individuals that struggle with mental health and/or substance use.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Housing Continuum	1. Expand clinicians available to the Homeless Engagement Assessment Linkage team (a field-based outreach, engagement and intervention services).
	2. Expand supportive housing slots for individuals living with mental health and substance use challenges that do not require homelessness as an eligibility requirement.
	3. Provide housing maintenance and peer supports including case management, wrap around services, hoarding resources, and specialized services for older adults and other vulnerable communities.
	4. Develop a comprehensive housing database that includes real time waitlist times and availability.
	5. Incentivize board and cares (streamline the application process, reduce/subsidize licensing costs, etc.).
	6. Provide housing navigation and locator resources; include re-entry supports, bilingual peer supports, streamlined case management, simplified housing application and subsidized fees.
	7. Provide supports for section 8 housing including funding, vouchers, and training to landlords.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Substance Use Challenges	1. Create integrated services for complex needs including individuals with dual diagnosis or co-occurring mental health and substance use needs.
	2. Create longer-term sober living arrangements.
	3. Expand non-medication supports for individuals with addiction.
	4. Expand recovery-focused drop-in centers.
	5. Expand resources for reunification (support for parents, how to talk/interact with their children, etc.).
	6. Provide access to Narcan for clients and family members.
	7. Provide family-centered recovery supports that includes child care at every stage.
	8. Address intergenerational trauma in recovery and treatment.
	9. Expand early intervention resources for addiction.
	10. Provide education about substance use prevention starting in elementary school (how to say no, healthy boundaries, etc.).

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Quality of Client Care	1. Provide ongoing resource navigation and peer support in crisis situations.
	2. Create client centered services (meet people where they are, provide virtual/in-person, services in their language, flexible hours, etc.).
	3. Implement best practice sharing across BHRS clinics, including integrated services and identification of supports that can be offered across the county.
	4. Develop a streamlined BHRS intake process across the network of care.
	5. Develop partnerships for substance use referrals for clients with Access and Care for Everyone (ACE).
	6. Develop partnerships with indigenous community spaces and cultural healers.
	7. Address Adverse Childhood Experiences, Social Determinants of Health, and intergenerational trauma.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Adult/Older Adult Needs	1. Create internal processes to regularly review utilization and outcome data to inform responsive services for older adults.
	2. Create partnership between the County and Veterans Administration to increase supports for veterans (integration with primary care services, resources for women veterans on sexual assault, suicide prevention for veterans, etc).
	3. Expand capacity for neuropsychological evaluation and diagnosis.
	4. Expand in-home hoarding supports (linkages to services, case management, specialized therapy, decluttering, etc.)
	5. Expand services for individuals with complex needs; develop partnerships with organizations that can support complex client needs.
	6. Expand the OASIS team peer specialist' support for older adults, caregivers and family members.
	7. Develop an outreach and communication strategy on behavioral health and wellness in multiple languages; leverage existing networks (SMC Alert, neighborhood CERTs, etc.).
	8. Expand culturally relevant suicide prevention strategies.
	9. Expand prevention services to older adults prior to complications; develop partnerships with organizations that can provide these services.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Youth Needs	1. Address gaps in the crisis continuum for youth (increase 5150 beds, language capacity, expand non-law enforcement response, stabilization unit, crisis residential, etc.).
	2. Expand school-based behavioral health education and services starting in middle school that includes family therapy and peer support groups for parents, youth, and school staff.
	3. Expand school-based wellness centers.
	4. Expand afterschool-based programming.
	5. Expand availability of diverse wellness counselors and clinicians on all school campuses.
	6. Integrate wraparound services in schools, in partnership with community-based organizations.
	7. Provide Narcan in high schools (used to reverse opioid overdose).
	8. Expand Social Emotional Learning (SEL) curriculum in schools.
	9. Expand the Health Ambassador Program for both Youth and Adults; include case management and increased support for ambassador's families.

APPENDIX 2. ALL PUBLIC COMMENTS RECEIVED

Summary of Public Comments Received

INN Project Plans – Progressive Improvements for Valued Outpatient Treatment (PIVOT)
30-Day Public Comment Process & Public Hearing (10/2/24 – 11/7/24)

Substantive Comments[1]

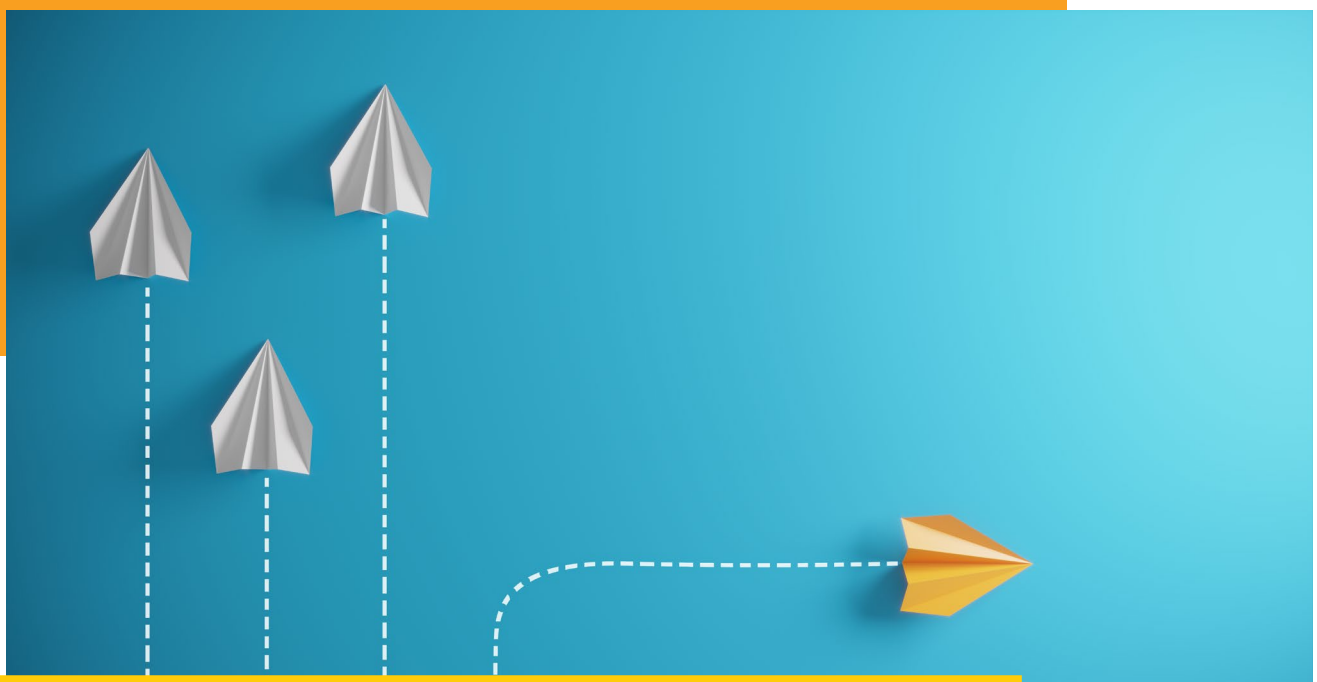
No substantive comments received.

Public Comments and Q&A

- **MHSOAC Innovations team:** Include additional detail about the Community Planning Process (CPP) in terms of how this idea was brought to the community outside of the 30-day public comment period. Add detail about local capacity in San Mateo County to implement PIVOT, in the context of learnings we have had as a state around this effort and system transformation work. Consider connecting with other counties that are working on supporting early intervention programs around Medi-Cal billing, particularly Fresno County and Nevada County.

[1] MHSA legislation requires that the Annual Updates for the MHSA Program and Expenditure Plan include a summary of any "substantive" public comments received (e.g., comments that may require a change to the plan) and if applicable, include the recommended revisions to the plan.

ATTACHMENT: MULTI-COUNTY PIVOT INN PROJECT



Program Improvements for Valued Outpatient Treatment (PIVOT)

MHSA INNOVATION Project

Orange County
2024

ochealth CARE AGENCY

TABLE OF CONTENTS

BACKGROUND

Proposition 1

In March 2024, California voters passed Proposition 1, resulting in significant changes to the Mental Health Services Act (MHSA). The proposition repurposes MHSA–changing the name to the Behavioral Health Services Act (BHSA), re-structuring the use of funding, and expanding on existing requirements.

One of the most significant changes under BHSA involves the funding components. The BHSA eliminates the MHSA components for Community Services and Supports (CSS; 76%), which also includes the ability to set aside funds for Workforce Education and Training (WET) and Capital Facilities and Technological Needs (CFTN); Prevention and Early Intervention (PEI; 19%); and Innovation (INN; 5%). Instead, BHSA requires 35% of funds to be directed toward Full-Service Partnership (FSP) programs to provide comprehensive care for individuals with the most complex needs; 35% for Behavioral Health Services and Supports (BHSS); and 30% toward Housing Interventions, including rental subsidies, operating subsidies, shared housing, family housing for eligible children and youth, and the non-federal share of certain transitional rent[7]. These changes result in a transition from five MHSA components to three, under BHSA (Figure 1).

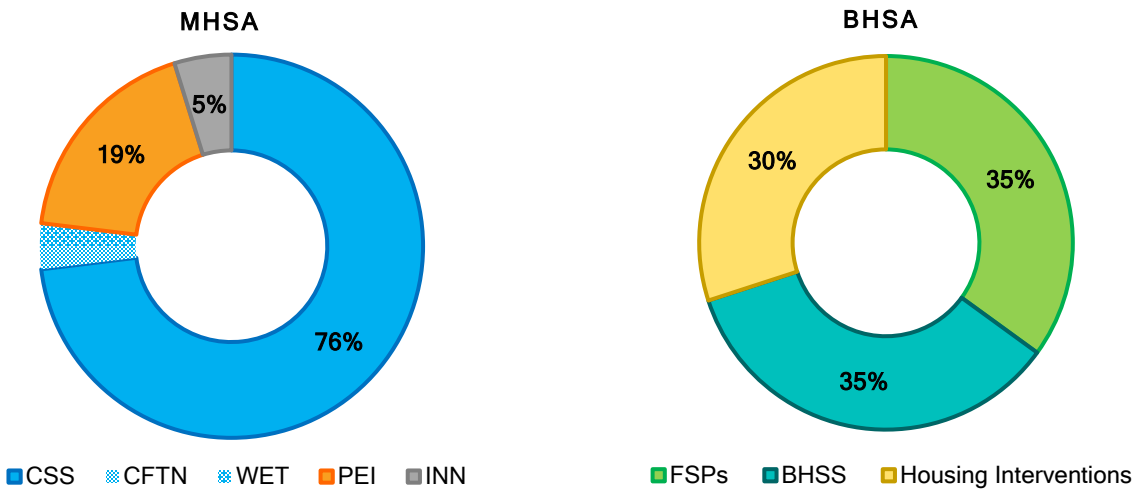


Figure 1. Restructuring of MHSA to BHSA funding components.

The Housing and BHSS component include additional funding requirements. Under the 30% Housing component, half of this amount (50%) is prioritized for housing interventions for the chronically homeless, and up to 25 percent may be used for capital development. Of the 35% of funds dedicated to BHSS, half of these component funds may be used toward behavioral health supports, such as outreach and engagement; workforce; education and training; capital facilities and technological needs; and innovative pilots and projects. The remaining 50% of BHSS funds must be used for Early Intervention programs to address the early signs of mental illness or substance use disorders, 51% of which must further be directed to children and youth ages 25 and younger (Figure 2).

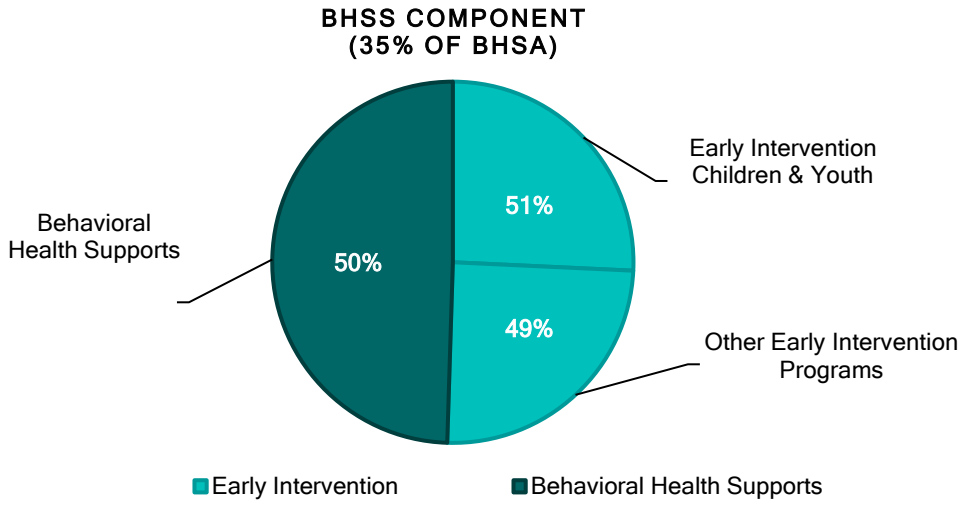


Figure 2. BHSS funding component details.

Between these funding requirements, counties have the flexibility to move up to seven percent from one category to another, for a maximum of 14% added into any one category. Finally, 10% of the total BHSA funds will be allocated to state administrative efforts to create new state-wide, state-led investments. These include population-based prevention (4%), workforce infrastructure (3%) and statewide oversight and monitoring (3%).

In addition to restructuring the funding components, the BHSA also expands the priority populations by including individuals with substance use disorders, and prioritizes individuals at risk of or experiencing homelessness, justice involvement, child welfare involvement, and/or institutionalization/conservatorship.

Finally, BHSA significantly expands the reporting process, requiring the development of a comprehensive Integrated Plan that is inclusive of all behavioral health programs and funding streams.

BHSA will be effective January 1, 2025, and must be implemented by July 1, 2026.

Primary Problem

The BHSA will have several significant impacts to Orange County's behavioral health system of care. The expansion of priority populations to include individuals living with SUD will change the way in which the County conducts business and delivers services. In addition, the new categories eliminate prevention and innovation programs, and combines Early Intervention, CSS General System Development, workforce development, and CFTN into one bucket under BHSS. As a result, existing MHSA programs will need to be modified or eliminated to fit within the three BHSA funding components. In Orange County, these changes will result in a loss of $150 million in funding for currently funded programs that could only be funded under the behavioral health services and supports component. The County will need to identify strategies and solutions to support individuals who would no longer qualify for services under these new funding components.

Proposition 1 and the larger Behavioral Health Transformation initiative makes it clear that the state is envisioning an updated paradigm for public behavioral health services, especially those services provided through the specialty mental health plan (MHP). County specialty MHPs need to respond and reimagine their systems of care to meet the requirements. However, the existing system of care is not currently designed to easily integrate these changes. Furthermore, many of these changes will be effective January 1, 2025, and must be implemented by July 1, 2026, leaving Orange County with approximately 18 months to redesign its behavioral health system to meet the new requirements.

Response to Local Need

The BHSA will require a systemwide transformation of Orange County's behavioral health services. The MHSA INN component was designed to evaluate the impact of new or changed practices in mental health, with transformational change as its primary goal. Although the BHSA does not include a specific component for INN, current language included in Senate Bill 326 notes that approved INN projects can continue to be implemented past the July 1, 2026, start date. This opens the opportunity to utilize INN dollars to evaluate/identify successful strategies and administrative changes needed to prepare for the transition to BHSA and share lessons learned. The "re-imagining" of the overall system, along with the testing of new processes is proposed under the PIVOT INN project.

PROPOSED PROJECT

PIVOT Project Description

PIVOT is a comprehensive proposal with five components, each with its own activities and learning objectives. These components include:

1. Full-Service Partnership Reboot
2. Integrated Complex Care Management for Older Adults
3. Developing Capacity for Specialty MH Plan Services with Diverse Communities
4. Innovating Countywide Workforce Initiatives
5. Innovative Approaches to Delivery of Care

Each component was identified as a need through ongoing stakeholder feedback on Orange County's behavioral health system of care. In addition, each component aligns with and supports the county's transition to BHSA. The underlying goal connecting all components involves redesigning the system of care to prepare for BHSA.

Many counties across the state are facing similar challenges in their system of care. To support statewide learning, the PIVOT INN Project also proposes the opportunity for counties to participate in any of the components that align with their local planning efforts, system needs and INN funding availability. Collectively, this partnership can create a learning collaborative, as counties solve for similar problems in their local systems and navigate the transition to BHSA together.

PIVOT Components

Full-Service Partnership Reboot

The MHSA currently requires the majority of CSS funding be directed toward FSP Programs. Orange County currently funds FSP programs for all age groups that are implemented through a combination of contracted provider agencies and County clinics. FSP programs provide intensive outpatient services and case management for individuals living with serious behavioral health conditions. The FSP framework is based on a "no fail" philosophy and does "whatever it takes" to meet the needs of its members, and when appropriate their families, including providing supportive services. This framework builds

strong connections to community resources, and provides 24 hours per day, 7 days per week (24/7) field-based treatment and recovery services. The primary goal of FSP programs is to improve quality of life by implementing practices that consistently promote good outcomes for the member.

FSP programs will continue to remain a priority under BHSA, as the new legislation requires 35% of the total budget be directed toward FSP programs. Additional guidelines include[2]:

- Implementation of select evidence-based practices, including Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Individual Placement and Support (IPS) model of supported employment and high-fidelity wraparound.
- New established standards of care with levels based on an individual's acuity and criteria for step down into the least intensive level of care.
- Outpatient behavioral health services, either clinic or field-based, necessary for ongoing evaluation and stabilization of an enrolled individual.
- Ongoing engagement services necessary to maintain enrolled individuals in their treatment plan inclusive of clinical and non-clinical services, including services to support maintaining housing.
- Integration of Substance Use Disorder (SUD) services.

Under these new guidelines, the County must examine its FSP programs and services to identify levels of care and determine the appropriate criteria for step down services. Administrative changes and modifications to program workflows and operations will be required to prepare FSP programs for this transition. The purpose of this PIVOT component is to prepare the County for the transition to BHSA by supporting activities within two main categories: 1) Technical and Data Infrastructure and 2) Administrative Processes. Component activities and objectives include:

- Technical and Data Infrastructure
    - Gather technical requirements for the new local data infrastructure needed for county and county-contractors to align with the new FSP standards while maintaining data collection and reporting standards.

    - Design, test, and implement applications that allow real-time access to view an FSP member's current level of care and functioning, with the goal of identifying when it's appropriate to transition to a different level of care.
    - Ensure data system follows all federal and state Information Technology security requirements.
    - Thorough cleaning of local data to prepare for the new path forward.
- Administrative Processes
    - Determine the FSP levels of care and identify criteria for step down to lower levels of care.
    - Determine administrative processes to ensure seamless transition between FSP levels, with minimal disruption to service delivery.
    - Identify process for tracking and reporting how members transition through levels of care.
    - For contracted programs, identify changes needed in the contract language to align with the different levels of care.
    - Strengthen ability to provide SUD or co-occurring services, with an emphasis on co-location of services and dual certification for Drug Medi-Cal Organized Delivery System (DMC-ODS) services.

Recent discussions around FSPs have focused on performance and value-based contracting. To prepare its system for a shift toward this social financing model, Orange County must first address the necessary prerequisites that inform value-based and performance contracting. Without the necessary data infrastructure in place to allow easy access to accurate data, the County runs the risk of drawing erroneous conclusions. Depending on Orange County's readiness and ability to adequately set up data infrastructure and administrative processes, additional component activities may include the following:

- Determine infrastructure needed to move forward in value-based contracting, which includes access and review of the data needed to determine metrics.
- Technical assistance and planning to identify individualized member values, operationalize data collection, and identify strategies to incentivize contracted providers.

- Identify how to set a contracting standard that can be monitored and reimbursed consistent with the state's standard.
- Explore and identify the process for fidelity monitoring.

With the upcoming changes in BHSA and the new requirements for FSP programs, counties must assess their systems' readiness to implement these changes. Orange County has recognized the need to address its data infrastructure and administrative processes to ensure a successful transition. This PIVOT component allows the county to address these primary needs.

Integrated Complex Care Management for Older Adults

Older adults are the fastest growing population in Orange County, and often face unique and multifaceted challenges that require specialized care and support. As individuals age, they may encounter a range of health concerns such as depression, anxiety, and neurocognitive disorders. Neurocognitive disorders—a term used interchangeably with dementia—is a general term that describes decreased mental function due to a medical disease.[12] It refers to a wide range of disorders that affect the brain, involving problems with thinking, reasoning, memory, and problem solving. The prevalence of neurocognitive disorders tends to increase significantly among older adults.

Research evidence and clinical observations suggest that many older adults living with dementia also experience concurrent mental health challenges. Mo et al. (2023) investigated the temporal relationship between psychiatric disorders and dementia diagnosis. Their study revealed a consistently heightened risk of psychiatric comorbidities in patients with dementia, beginning several years before diagnosis, peaking around the time of diagnosis, and persisting post-diagnosis. This finding underscores the necessity of integrating psychiatric interventions across the dementia care continuum. Asmer et al. (2018) explored the prevalence of major depressive disorder (MDD) among older adults with dementia and indicated a significant burden of depression within this population. Variations in MDD prevalence across dementia subtypes underscore the need for nuanced diagnostic and therapeutic strategies. Further investigations by Lai et al. (2018) and Choi et al. (2021) addressed the alarming rates of psychiatric disorders and suicide risk among different dementia subtypes. These studies emphasized the necessity of

tailored interventions and vigilant screening for suicide risk, especially following a dementia diagnosis. Schmutte et al. (2022) emphasized the heightened suicide risk in the year post-dementia diagnosis, especially among specific demographic and clinical subgroups. Early identification and support for individuals at risk are essential to mitigate adverse outcomes. Lastly, Stott et al. (2023) highlighted a potential protective effect of psychological interventions for anxiety disorders against future dementia incidence. Reliable improvement in anxiety symptoms following therapy was associated with reduced dementia risk, emphasizing the mitigation of certain risk factors through targeted interventions. Dementia risk is also reduced by aggressively treating depression with both medications and psychotherapy.

The co-occurrence of mental health conditions alongside neurocognitive disorders presents numerous challenges. The existing support systems often prove limited in terms of accessibility, adequacy, or availability. Long-term stable housing, treatment and services are often inaccessible, inadequate, or unavailable to older adults who are homeless or at risk of homelessness and living with dual mental health conditions and dementia.

This target population also presents a complex clinical landscape that demands a comprehensive approach to care. However, treatment is currently split between the managed care system and specialty mental health plan, with each responsible for specific portions of care. Each system utilizes different screening and assessment tools and views the treatment of the co-morbid condition through the lens of their system. Diagnostic hurdles emerge, as distinguishing between cognitive decline associated with neurocognitive disorders and symptoms of mental health disorders necessitates specialized training and careful assessment (Ording & Sørensen, 2013; Poblador-Plou et al., 2014). The diagnostic process is further complicated by the presence of overlapping symptoms, cognitive impairment, and potential stigma associated with psychiatric conditions. Consequently, delays in diagnosis and intervention may occur, hindering the timely provision of appropriate care and support (Fox et al., 2014).

Even after an individual is linked to services, the siloed system creates challenges in receiving quality care. Multiple medical problems and medications including over the

counter and herbal supplements make it difficult to treat individuals in a non-integrated setting. Addressing comorbid mental health conditions in the context of dementia requires a multifaceted approach. Cognitive impairment, communication difficulties, and potential medication interactions necessitate careful consideration when designing treatment plans (Subramaniam, 2019). Currently, Orange County's Behavioral Health Services division meets with local managed care providers to determine the best course of treatment for individual cases because an integrated system to effectively manage these cases does not currently exist. Outcomes to these cases tend to be highly individualized because of an inconsistent approach to cases, predicated by no clear funding stream or reporting structure, forcing providers to piece meal individualized treatment plans.

Alongside these clinical challenges, societal factors such as stigma and reluctance to seek help further compound the issue. Individuals and families may be hesitant to seek assistance due to fears of judgment or discrimination, leading to delays in accessing necessary support and treatment (Evans-Lacko et al., 2019). Ultimately, increasing awareness and understanding of comorbid mental health conditions in individuals with dementia among caregivers, healthcare professionals, and the public is critical. Educating communities about the complex relationship between dementia, mental health, and stigma can help reduce barriers to care and improve access to appropriate resources (Riley, Burgener, & Buckwalter, 2014). In addition, it is equally critical to highlight the value of a healthy lifestyle in curbing both psychiatric and neurocognitive disorders. as well as for positive general physical health.

Given the significant prevalence of dementia and the likely co-occurrence of mental health conditions among older adults, alongside the challenges within the existing system of care, there is a clear and pressing need for a targeted approach to support this vulnerable population. This PIVOT component seeks to address this critical gap by beginning to develop and plan a system of care for older adults living with both behavioral health and physical/neurocognitive conditions, which may include individuals who are homeless or at risk of homelessness.

Component objectives and activities will include but not be limited to the following:

- Multidisciplinary Approach: Identify and engage a team of experts who serve older adults across the continuum of care to inform the development of a holistic and comprehensive system of care for this target population.
- Outreach and Engagement: To create a process for identifying older adults considering the challenges and barriers reaching and engaging this unserved/underserved population.
- Training: To inform and educate providers on best practices in serving older adults living with co-occurring mental health conditions and neurocognitive disorders.
- Assessment: Engage experts in the field to create a different model for assessment that is recognized across the various systems.
- Complex Care Management/Navigation Plan: The multi-disciplinary team will collaborate on funding structures and care strategies to meet the comprehensive needs of older adults. This will involve a multidisciplinary complex care/navigation approach exploring blended funding and housing options.

As the population of older adults in Orange County continues to rapidly increase, a concerning trend emerges: a growing number of older adults face the dual challenges of managing neurocognitive disorders and mental health issues. The literature shows that addressing mental health concerns in individuals with or at risk of dementia is crucial for improving overall outcomes and quality of life in this vulnerable population. Addressing the mental health needs of older adults requires a holistic and interdisciplinary approach that considers the complexities of aging and mental health. This approach should involve collaboration among healthcare providers, social workers, caregivers, and community organizations to develop client-centered care plans that promote mental well-being, independence, and quality of life for older adults. This component recognizes the unique needs of older adults experiencing dual diagnoses and strives to create a system that fosters collaboration among stakeholders and promotes integrated care approaches. Through strategic partnerships and targeted interventions, this component seeks to create a more inclusive and supportive community environment, providing comprehensive care tailored to the unique needs of this vulnerable population.

Developing Capacity for Specialty MHP Services with Diverse Communities

Orange County is home to about 3.2 million people, making it the third most populous County in California, and the second most densely populated County in the state. It is also home to diverse populations, with six threshold languages other than English, including Arabic, Chinese, Farsi, Korean, Spanish, and Vietnamese. The image below shows County demographics at a glance:

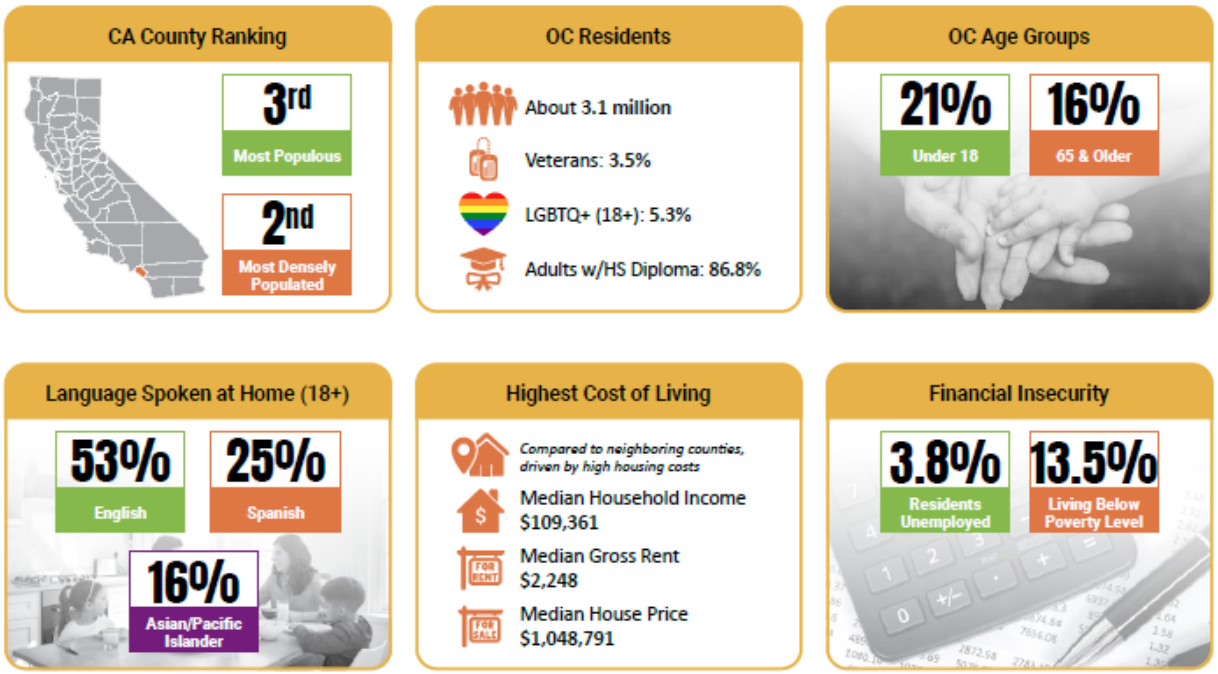


Figure 3. Orange County demographics as presented in the MHSA Annual Update for FY 2024–2025.

The County Behavioral Health Services operates as both the Specialty Mental Health Plan (MHP) and as a provider of specialty mental health plan services, coordinating and providing specialized behavioral health services for Medi-Cal members and uninsured individuals who meet the criteria for medically necessary care under the MHP. SUD services are delivered by both county-operated and contractor-operated providers in the DMC-ODS.

A review of Medi-Cal beneficiary demographics and penetration rates can help identify underserved and unserved populations. Penetration rate is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. In Orange County, the data revealed that

while the number of total eligible residents in the county increased in Calendar Year (CY) 2021, the number of beneficiaries served and overall penetration rates decreased from prior years (Table 1)[15].

Table 1. MHP Annual Beneficiaries Served

Year	Total Eligibles	Beneficiaries Served	Penetration Rate
CY 2021	954,392	23,310	2.44%
CY 2020	863,342	23,739	2.75%
CY 2019	852,008	25,321	2.97%

Overall, Orange County penetration rates were lower than those seen in comparable-sized MHPs and statewide across all age groups (Table 2) and all racial/ethnic groups (Table 3).

Table 2. Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	84,542	543	0.64%	1.29%	1.59%
Ages 6-17	216,756	9,648	4.45%	4.65%	5.20%
Ages 18-20	52,823	1,698	3.21%	3.66%	4.02%
Ages 21-64	490,980	10,922	2.22%	3.73%	4.07%
Ages 65+	109,293	499	0.46%	1.52%	1.77%
TOTAL	**954,392**	**23,310**	**2.44%**	**3.47%**	**3.85%**

Table 3. Penetration Rates (PR) of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	# MHP Served	# MHP Eligibles	MHP PR	Statewide PR
African-American	837	15,436	5.42%	6.83%
Asian/Pacific Islander	1,891	177,504	1.07%	1.90%
Hispanic/Latino	10,834	429,250	2.52%	3.29%
Native American	72	1,376	5.23%	5.58%
Other	4,363	180,793	2.41%	3.72%
White	5,313	150,035	3.54%	5.32%
Total	**23,310**	**954,394**	**2.44%**	**3.85%**

Based on the number of Medi-Cal eligible residents in CY 2021, and beneficiaries with an approved service, the following groups were identified as underrepresented:

- Asian or Pacific Islanders (API)

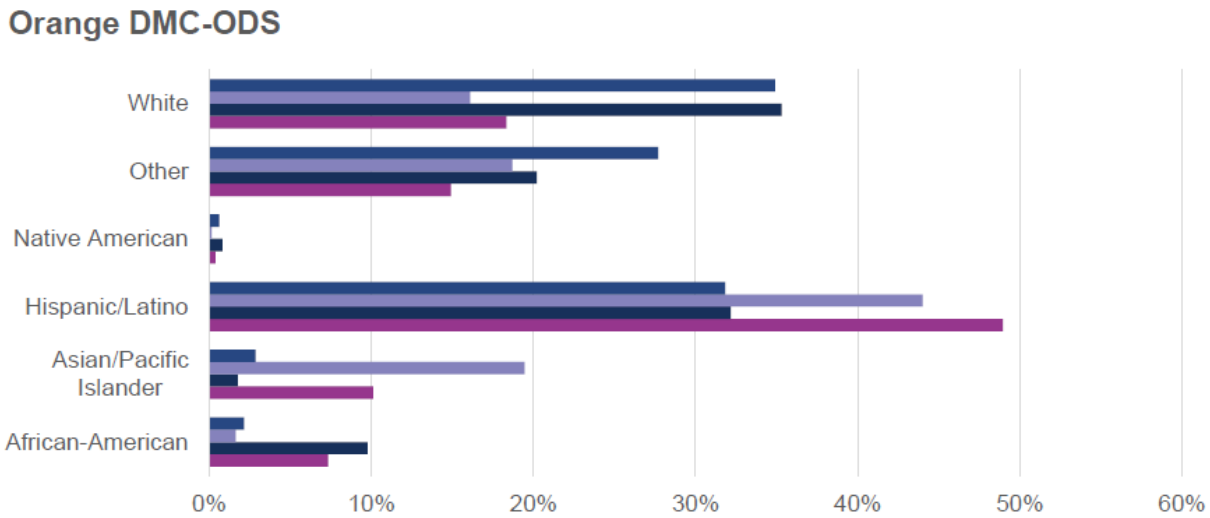
- Black or African Americans
- Youth 5 years of age and under
- Adults over the age of 60
- Native Americans
- Residents who spoke a language other than English

Among these groups, API beneficiaries were the most disproportionately underrepresented. The data available through the state is limited and does not further delineate nuances between the multitude of cultural differences between API, South Asia, Middle Eastern, North African (SAMENA), etc. populations. In addition, there is a lack of data concerning the delivery of behavioral health services for deaf and hard of hearing populations. However, there are existing non-Medi-Cal service providers that provide behavioral health services to these underserved populations.

One of the challenges in reaching these underserved groups may include limitations in the county workforce in providing culturally and linguistically appropriate services. Individuals are likely to seek support from Community-Based Organizations (CBOs) that serve their ethnic groups. CBOs are also more likely to integrate community-defined evidence practices (CDEPs) into their services that look beyond traditional empirical based models to emphasize behavioral health practices that a community considers healing. The MHSA Prevention and Early Intervention (PEI) component played a pivotal role in supporting the delivery of non- Medi-Cal based behavioral health services and supports through a CBO network. With the upcoming changes, CBOs will need to shift the types of services and supports being offered to these diverse populations.

Further, MHSA has not funded SUD services. SUD services are delivered by both county-operated and contractor-operated providers in the DMC-ODS. Across all payment sources, Orange County reported that approximately 32% of services were delivered by county-operated/staffed clinics and sites, and about 67% were delivered by contractor-operated/staffed clinics and sites[14]. Overall, Orange County reported that about 43% of services provided were claimed to Medi-Cal. A review of penetration rates for access to

SUD services through the DMC-ODS showed similar underrepresentation of racial/ethnic groups.



	African-American	Asian/Pacific Islander	Hispanic/Latino	Native American	Other	White
County % Served	2%	3%	32%	1%	28%	35%
County % Eligibles	2%	19%	44%	0%	19%	16%
State % Served	10%	2%	32%	1%	20%	35%
State % Eligibles	7%	10%	49%	0%	15%	18%

Figure 4. Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity CY 2021.

Hispanic/Latino and Asian/Pacific Islander DMC eligible residents were notably under-represented among those receiving SUD treatment. The under-representation of Asian/Pacific Islander DMC eligible residents among those receiving SUD treatment in Orange was substantially more pronounced than statewide.

To address challenges in reaching its diverse communities, Orange County needs to consider larger system changes to ensure the ongoing needs of the unserved and underserved populations living with serious behavioral health conditions and SUD are met. One potential solution is to build on the relationships between CBOs and the communities they serve by helping them develop their capacity for serving individuals living with serious mental health and/or substance use disorders. This PIVOT component seeks to identify the minimum capacity of a community-based organization to be able to become a specialty mental health plan/DMC-ODS contracted provider.

Component activities and objectives will include but not be limited to:

- Assessing what it takes for a CBO to become a Medi-Cal/Drug Medi-Cal provider.
- Identifying the type of technical assistance needed to support.
- Determining if embedding culturally based approaches for specialty mental health care improve penetration rates and outcomes.
- Identifying CDEPs that can generate revenue and be recognized by the state.
- Evaluating the use of a hub and spoke model to support capacity building.

The ability to determine the necessary steps for CBOs to become specialty mental health providers will have lasting benefits in the county's behavioral health system of care. It will improve access for Orange County's most unserved and underserved populations and help close the gap in penetration rates. It will also help identify CDEPs that can generate revenue for the County and CBOs serving these populations, creating a sustainable system of care. Lastly, this component will help build the capacity for CBOs to provide a broader range of services, strengthening their role in the system of care. This is especially critical as BHSA will have significant impacts on the funding of County's behavioral health programs. Many MHSA CSS programs leverage Medi-Cal in the delivery of services; however, these services will be impacted as the funding components transition from MHSA to BHSA, eliminating CSS as a component and folding its services under BHSS. Supporting CBOs in becoming specialty mental health providers will bridge the potential gaps in services as a result of changes in funding under BHSA.

Innovative Countywide Workforce Initiatives

Historically, California's public behavioral health system has experienced a shortage of behavioral health workers, changes in mental health occupational classifications, and underrepresentation of diversity of professionals with consumer and family member experience. To address challenges faced by the public behavioral health workforce, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs. WET is a program that provides training opportunities to the County's Behavioral Health Services (BHS) and contract agency staff, promotes the recruitment and hiring of a culturally diverse workforce, offers financial incentives, facilitates clinical

intern programs, supports the inclusion and incorporation of consumers and their family members into the behavioral health workforce, and is committed to addressing the workforce shortage within Orange County through utilization of various strategies to recruit and retain qualified behavioral health employees. WET carries forth the vision of the MHSA to create a transformed, culturally competent system that promotes wellness, recovery, and resilience across the lifespan of all age groups and all cultural backgrounds.

The Orange County WET component programs have experienced much success over the years, contributing to the development of a highly skilled workforce. However, some institutional barriers still exist, creating roadblocks for establishing integrated pathways to BHS employment. Orange County's vacancy rate showed that while there has been a slight improvement in the rate reported by the department, from approximately 18% in August 2023[5] to 13% currently, the County continues to face staff shortages in all positions, especially clinicians. Several factors contribute to these vacancies, including limited flexibility in work schedule; non-competitive and low pay; minimal pay differential for specialty skills (e.g., language competency); and slow hiring and human resources processes for potential candidates. These factors are extremely difficult to change within the existing County system, and many involve established processes that would take extensive resources and time to change.

A potential strategy to expand the workforce is through clinical internship programs. In the most recent MHSA 3-Year Plan, BHS identified the need to establish a centralized internship program that included paid internship positions; an employee 20/20 program that would enable an employee time to complete training and/or educational requirements for a degree or certification; and streamlining the path from internship to employment. Despite these efforts, barriers exist that limit the success of the existing program, including but not limited to:

- Competition amongst systems. For example, hospitals, education, criminal justice, and managed care plans all compete for the same qualified staff and interns.
- Limited ability to update minimum qualifications for entry level Behavioral Health Clinicians, including necessitating that applicants possess a Board of Behavioral Sciences (BBS) registration number prior to start date.

- Delays between graduation, hiring, and ability to start in BHS.
- Inability to establish the 20/20 program.

In addition, there is not an established coordinated, countywide behavioral health pipeline and pathway to support the development of the larger provider network. These challenges result in workforce shortages that impact an individual's access to care.

These challenges are not limited to the County, as the State continues to seek solutions to address this challenge with its recent behavioral health reform efforts. One of the tenets of BHSA is increasing access by building workforce infrastructure. BHSA will utilize 3% of its administrative funds on workforce investments to expand a culturally competent and well-trained behavioral health workforce to address behavioral health capacity shortages and expand access to services[7].

Similarly, Orange County is striving to build its workforce infrastructure and overcome a portion of these barriers by utilizing an approach that has been proven successful in non-mental health settings—apprenticeship programs. Apprenticeships combine paid on-the-job training with classroom instruction to prepare workers for highly skilled careers. Workers benefit from apprenticeships by receiving a skills-based education that prepares them for good-paying jobs. In addition, apprenticeship programs help employers recruit, build, and retain a highly skilled workforce.

This PIVOT component will take successful strategies from both internship and apprenticeship programs and utilize a third-party vendor as the "employer of record" to support payment of incentives for participating in the internship program. Because apprenticeships are longer than a typical internship, individuals participating in BHS internships will have the option to extend their paid learning opportunity beyond their educational requirement. A standard pay scale will be developed that incentives longevity and continues to provide incentives during the period between graduation and the receipt of a BBS registration number that is required to qualify for regular county positions.

Component activities and objectives include:

- Establish a multi-partner, countywide behavioral health workforce pipeline and pathway.
- Utilize third-party vendor to test alternative pathways to employment (e.g., apprenticeship program).
- Develop pathways that extend beyond traditional mental health clinician roles, including but not limited to substance use disorder counselors, all levels of peer specialists, community health workers, health and wellness coaches, and others.
- Provide option to extend paid learning beyond educational requirements.
- Develop a standard pay scale that incentivizes longevity.
- Provide incentives during period between graduation and receipt of a clinical registration number that is required to qualify for county clinical positions.

Through this PIVOT component, Orange County seeks to create a seamless pathway from paid internship to employment for diverse professionals and paraprofessionals.

Innovative Approaches for Delivery of Care

In the current system, primary care (physical health), SUD, and mental health systems operate according to each systems charting, billing, and regulatory requirements. Despite state movement toward a more integrated model, the simultaneous changes and initiatives have not allowed time for County systems to respond and think through the ways the systems need to be redesigned.

The current structure limits access to wholistic, integrated services forcing clients to navigate bifurcated systems to meet their healthcare needs. Even clinical space is often set up according to the system that primarily funds the clinic, limiting access to person-centered approaches to care.

In 2021, Orange County embarked on an effort to redesign its clinic spaces to be more culturally responsive and improve service delivery. This effort was based on feedback from community engagement meetings conducted in Fiscal Year (FY) 2020-2021, where participants shared that creating more welcoming spaces in clinic common areas would contribute to improved access to behavioral health services. County staff facilitated a series of focus groups with its Wellness Center participants to gather direct consumer feedback on creating a more culturally responsive, calming, inspirational, and a welcoming feel within the County outpatient clinic lobbies and clinic common areas. The original goal was to redesign 12 of the County's outpatient clinics, but due to challenges in cost, clinic relocations, lease terms, and county procurement processes, County staff were only able to redesign one clinic.

While the county is limited in its ability to physically change the external appearance of its clinics, this PIVOT component shifts the focus on changing the internal processes, such as reimagining the flow of clinic operations and providing a more integrated service experience for clients. This PIVOT component will utilize a User Experience model to collaborate with providers, consumers, and their family members to identify more culturally responsive, inclusive, and efficient delivery of care. The User Experience (UX) model or practice is typically utilized in the development of products, services or within the field of technology. It involves the process of understanding a user's expectations and satisfaction when interacting with a product or service to ensure that the products or services created reflect meaningful and relevant experiences to users. Orange County proposes to apply this UX model to improve its approaches to delivery of care.

Component activities and objectives could include:

- Redesign the flow of clinical operations, including specialized services for whole-person care approaches.
- Explore staffing patterns and credentialing that can support a broader range of healthcare services.
- Reimagine service delivery.
- Integrate services.
- Evaluate the impact of using a UX design on client outcomes.

Summary

PIVOT proposes to create and test service models where the delivery, care coordination, systemwide collaborations and payment for care is aligned to make a seamless and integrated experience for behavioral health clients, resulting in improved client outcomes. The project also intends to test innovative approaches to workforce recruitment and retention that have worked in other systems to strengthen the pathways to becoming a clinical service provider and incentivize retention of highly qualified staff.

This multi-component project will result in an overall system redesign while simultaneously addressing key areas of need in the current behavioral health system of care. Each component seeks to identify and develop successful behavioral health approaches that can be integrated across the system of care.

Request for Approval

With this comprehensive proposal, Orange County is requesting approval to utilize its INN funds to further develop the activities and evaluation plan and implement each PIVOT component.

In addition, because many counties face similar challenges in their system of care, Orange County is requesting the Commission's approval to make PIVOT a multi-county project, which would allow other counties the opportunity to join components that best align with their local needs and support their transition to BHSA. If approved, each

interested county would still undergo their local community planning process and provide a brief proposal of their county-specific plan, including their project budget (Appendix A).

EVALUATION

The PIVOT INN Project proposal identifies general learning objectives under each component. Each component will require its own evaluation plan and research team to track lessons learned. Upon approval of the PIVOT INN Project, Orange County, plans to contract with evaluators to support this effort.

If additional counties are approved to join, the overall objectives and evaluation plan will remain consistent among participating counties. However, because counties have their own unique needs and challenges, additional learning questions may be explored that add to and align with the common goal or mission of the PIVOT component(s). Research evaluators would work with all participating counties, gathering data and information to tell a cohesive story of successes and lessons learned.

Based on the activities and objectives of each PIVOT component, Orange County has drafted the following preliminary learning questions that will be further refined by research evaluators:

Full-Service Partnership Reboot

- How can the different FSP levels be operationalized to support timely and appropriate transitions in level of care?
- What administrative processes and program operations ensure that members experience seamless continuity of care during transitions between FSP levels?
- How can BHSA dollars be used to bill for SUD as a primary service?
- For contracted programs, what changes are needed in the contract language to incorporate the different levels of care?
- What are the standards for fidelity monitoring?
- What Quality Assurance and Quality Improvement practices need to be implemented to ensure fidelity?

Integrated Complex Care Management for Older Adults

- What are the most successful strategies for identifying this target population?
- What are the most effective assessments and interventions for this target population?
- What are the viable funding structures that can support this integrated model of care?
- What housing models would best support the needs of this target population?

Developing Capacity for Specialty MH Plan Services with Diverse Communities

- What are the minimum requirements for a CBO to become a Medi-Cal/DMC-ODS provider?
- What type and level of technical assistance is needed to support CBOs?
- In what ways does a hub and spoke model effectively support capacity building?
- Does embedding culturally based approaches for specialty mental health care improve penetration rates and client outcomes?
- Which CDEPs are most effective?
- How can CDEPs be utilized to generate revenue?

Innovative Countywide Workforce Initiatives

- Did the use of an alternative pathway, such as an apprenticeship program model, lead to increased employment engagement and/or retention?
- Which incentives contributed most to increased likelihood of employment engagement and retention?
- Does the development of a countywide initiative place the County in a better position to apply and qualify for grants to sustain/expand workforce initiatives?

Innovative approaches to delivery of care

- What clinic design or set-up elements are most impactful in supporting quality care and/or client engagement?
- Is there an optimal flow to the delivery of care?
- How does utilizing a user experience design impact client outcomes?

ALIGNMENT WITH INITIATIVES

For the purposes of this section, the PIVOT components will be referenced by their respective numbers:

1. Full-Service Partnership Reboot
2. Integrated Complex Care Management for Older Adults
3. Developing Capacity for Specialty MH Plan Services with Diverse Communities
4. Innovating Countywide Workforce Initiatives
5. Innovative Approaches to Delivery of Care

BHSA

The overarching goal of the PIVOT INN Project is to help Orange County, and other counties, prepare for the upcoming changes under the new legislation. As such, each PIVOT component aligns with the tenets of BHSA.

Full-Service Partnership Reboot

BHSA requires 35% of funds to be directed toward FSP programs. The new legislation also provides additional guidelines for FSP programs, including the establishment of levels of care. The FSP Reboot focuses on changing its administrative processes and building the data/technical infrastructure necessary to align with the new requirements under BHSA.

Innovative Countywide Workforce Initiatives

BHSA will utilize 3% of the total administrative funds to create a workforce infrastructure that seeks to expand a culturally competent and well-trained behavioral health workforce. Orange County is aligned with this effort, as this PIVOT component proposes to utilize an apprenticeship program approach to address its behavioral health workforce shortage and increase access to services.

The remaining PIVOT components each align with BHSA's emphasis on equitable care and reducing disparities. BHSA strives to create pathways to ensure equitable access to care by advancing equity and reducing disparities for individuals with behavioral health needs[4]. BHSA builds on many strategies to meet communities' needs for culturally

responsive services that improve health and reduce health disparities for all, including clearly advancing community-defined practices as a key strategy for reducing health disparities and increasing diverse community representation[4].

Developing Capacity for Specialty MH Plan Services with Diverse Communities

This component strives to ensure equitable access and reduce disparities by developing the capacity of CBOs that serve the County's diverse communities to become specialty mental heath providers. If successful, this will increase access to care for individuals who are otherwise unserved or underserved in the county system of care. This component also seeks to advance community-defined practices by identifying the most effective CDEPs and exploring opportunities to generate revenue for utilizing these approaches.

Integrated Complex Care Management for Older Adults

This component also strives to create pathways to ensure equitable access to housing and care to reduce disparities. It proposes the development of an integrated and comprehensive system of care that does not currently exist for older adults living with mental health conditions and neurocognitive disorders. If successful, the newly established system would provide older adults with access to a continuum of services that are currently operating in silos. This component also seeks to provide culturally responsive care as the treatment for this vulnerable population requires specialized training and individualized care plans.

Innovative Approaches to Delivery of Care

This component aligns with BHSA's goal of providing culturally responsive services. It seeks to change the current clinic space and approach to service to create a more seamless and efficient clinic experience for clients, and provide access to wholistic, integrated services.

MHSOAC Strategic Priorities

The PIVOT components also align with the following MHSOAC Strategic Priorities[11]:

	PIVOT COMPONENT				
MHSOAC STRATEGIC PRIORITIES	**1**	**2**	**3**	**4**	**5**
Goal 1: Champion Vision into Action					
1.1: Elevate the perspectives of diverse communities.		X	X		X
1.2: Assess and advocate for system improvements.	X	X	X	X	X
1.3: Connect federally and globally to learn and apply.	X	X	X	X	X
Goal 2: Catalyze Best Practice Networks					
2.1: Support organizational capacity building.	X	X	X	X	
2.2: Fortify professional development programs and resilient workforce strategies.			X	X	
2.3: Develop adequate and reliable funding models.	X	X	X	X	
2.4: Support system-level analysis to ensure the tailored care and universal access required to reduce disparities	X	X	X		
Goal 3: Inspire Innovation and Learning					
3.1: Curate an analytical-based narrative on the potential for innovation to improve behavioral health outcomes.	X	X	X	X	X
3.2: Establish an innovation fund to link and leverage public and private investments.	X	X	X		
3.3: Accelerate learning and adaptation in public policies and programs.	X	X	X	X	X
Goal 4: Relentlessly Drive Expectations					
4.1: Launch a public awareness strategy to reduce stigma, promote access to care, and communicate the potential for recovery.			X		
4.2: Develop a behavioral health index.					
4.3: Promote understanding of the progress that is being made and the advocacy that will result in further improvements.			X		

REGULATION REQUIREMENTS

Within this section, PIVOT components may be referenced by their respective numbers:

1. Full-Service Partnership Reboot
2. Integrated Complex Care Management for Older Adults
3. Developing Capacity for Specialty MH Plan Services with Diverse Communities
4. Innovating Countywide Workforce Initiatives
5. Innovative Approaches to Delivery of Care

General Requirement

According to the INN Regulations, an Innovation Project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solve persistent mental health challenges, including but not limited to, administrative, governance, and organizational practices, processes, or procedures; advocacy; education and training for services providers, including nontraditional mental health practitioners; outreach, capacity building, and community development; system development; public education efforts; research; services and interventions[12].

The PIVOT INN Project includes the following general requirements:

	PIVOT COMPONENT				
GENERAL REQUIREMENTS	1	2	3	4	5
Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention				X	X
Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population		X		X	
Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system			X		X
Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite		X			
Assesses a new or changed administrative, governance, and organizational practice, process, or procedure[2]	X	X	X		X

Primary Purpose

The PIVOT INN Project addresses the following primary purposes:

	PIVOT COMPONENT				
PRIMARY PURPOSE	1	2	3	4	5
Increases access to mental health services to underserved groups.	X	X	X	X	X
Increases the quality of mental health services, including measured outcomes.	X	X	X	X	X
Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes.		X	X	X	
Increases access to mental health services, including but not limited to, services provided through permanent supportive housing.	X	X	X	X	

Innovative Component

Although the overarching goal of the PIVOT INN Project focuses on preparing the county for the transition to BHSA, each component also has its own innovative aspect:

	PIVOT COMPONENT	INNOVATIVE COMPONENT
1	Full-Service Partnership Reboot	Establish new FSP levels of care and change existing data infrastructure.
2	Integrated Complex Care Management for Older Adults	Develop a new, comprehensive, and integrated system of care for older adults living with co-occurring mental health conditions and neurocognitive disorders.
3	Developing Capacity for Specialty MH Plan Services with Diverse Communities	Determine minimum necessary steps needed for community-based organizations to become specialist MH Plan providers.
4	Innovating Countywide Workforce Initiatives	Utilize an apprenticeship model and incentives to create a seamless pathway from education and training to employment for diverse professionals and paraprofessionals
5	Innovative Approaches to Delivery of Care	Re-imagine the clinic flow of operations to promote quality care and improve client outcomes.

Community Planning Process

To kick off the local community planning process (CPP), Orange County included PIVOT as part of its MHSA Annual Plan update for FY 2024-25. The Plan was posted on County's website for stakeholder review and comment from March 11, 2024, through April 15, 2024. During this time, the MHSA Office facilitated 12 community engagement meetings with local stakeholders to review updates to the MHSA Annual Plan, including a description of the PIVOT INN concept and each component. On April 24, 2024, the Behavioral Health Advisory Board (BHAB) held a Public Hearing, where a summary of the community planning process was provided and the BHAB affirmed the stakeholder process took place. Subsequently, on June 4, 2024, the Orange County Board of Supervisors approved the MHSA Annual Plan update for FY 2024-25, which included the County's plan to seek MHSOAC approval for the PIVOT INN Project.

Following the approval of the MHSA Annual Plan, INN Staff facilitated a follow up community planning meeting on May 16, 2024, where stakeholders participated in a World Café activity to provide feedback on several PIVOT components. This feedback was summarized into themes and reported to the stakeholders at the June 20, 2024, community planning meeting.

In addition to engaging local stakeholders, Orange County also shared the PIVOT concept with other counties, creating the opportunity for interested counties to join the project. Orange County met with other counties on July 7, 2024, at the CBHDA meeting to introduce the concept, and facilitated several follow up meetings with individual counties to further discuss the proposal concept and opportunity for partnership.

Cultural Competence and Stakeholder Involvement in Evaluation

Each PIVOT component activities will be informed by subject matter experts with experience and knowledge in that specific area of behavioral health. Each component will also be staffed with Peer Specialists to integrate the perspective of consumers and family members with lived experience in mental health and recovery.

To ensure each PIVOT component is inclusive of Orange County's diverse communities, this project will include translation services in the budget. These dedicated funds will enable the county to provide materials in its threshold languages and offer interpretation services during virtual and in-person meetings.

MHSA General Standards

The PIVOT INN Projects meets the MHSA General Standards through its various components. Each area is summarized and described in detail below.

	PIVOT COMPONENT				
MHSA GENERAL STANDARDS	1	2	3	4	5
Community Collaboration	X	X	X		
Cultural Competence	X	X	X	X	X
Client Driven	X		X		X
Family Driven					X
Wellness, Recovery, and Resilience Focused	X	X	X	X	X
Integrated Service Experience	X	X	X		

<u>Community Collaborations</u>

Full-Service Partnership Reboot: The process for determining the FSP levels of care and criteria will involve extensive collaboration and discussions with various stakeholders, including but not limited to county-contractors, Department of Health Care Services, and the MHSOAC to ensure alignment.

Integrated Complex Care Management for Older Adults: This component will require the development of a multi-disciplinary team who will work together to create a system of care for older adults living with co-occurring mental health conditions and neurocognitive disorders. It will also require collaboration between numerous community partners and organizations to develop a multidisciplinary complex care/navigation approach exploring blended funding and housing options.

Developing Capacity for Specialty MH Plan Services with Diverse Communities: This component requires a collaboration and close partnership between the County and various CBOs interested in becoming specialty mental health providers.
Innovating Countywide Workforce Initiatives: This component will include partnerships with community agencies to establish employment pipelines and pathways. Through these collaborations the County has an opportunity to expand employment opportunities for professionals and paraprofessionals.

Cultural Competency

Full-Service Partnership Reboot: This component focuses on increasing access and providing treatment interventions that are tailored to the unique and comprehensive needs of program participants.

Integrated Complex Care Management for Older Adults: This component focuses on increasing access, reducing disparities, and providing treatment interventions that are tailored to the unique needs of this vulnerable population.

Developing Capacity for Specialty MH Plan Services with Diverse Communities: Cultural competency is an essential element of this PIVOT component and directly covers key areas within this standard, including equal access to services; an understanding of the diverse belief systems concerning mental illness, health, healing and wellness that exist among different racial/ethnic, cultural, and linguistic groups; and services that utilize the strengths and forms of healing that are unique to an individual's racial/ethnic, cultural, and linguistic population or community.

Innovating Countywide Workforce Initiatives: This component focuses on expanding the diverse behavioral health workforce to help increase clients' access to services, reduce disparities and provide more culturally and linguistically appropriate services.

Innovative Approaches to Delivery of Care: The purpose of this component is to deliver services in way that fosters cultural awareness, safety, and inclusion for all clients receiving services.

Client Driven

Full-Service Partnership Reboot: The process for determining the FSP levels of care and criteria will involve discussions with clients and family members receiving services to ensure the newly identified levels of care and criteria are appropriate and meet the needs of program participants.

Developing Capacity for Specialty MH Plan Services with Diverse Communities: Clients and family members will play a critical role in supporting the identification of CDEPs that are most effective for their community.

Innovative Approaches to Delivery of Care: This component will rely directly on client feedback, utilizing a user experience model to determine the most successful approaches to delivery of care.

Innovating Countywide Workforce Initiatives: This component aims to expand the behavioral health workforce, potentially creating employment pathways for clients interested in providing peer support services or seeking Peer Specialist Certification. This would provide the County with an opportunity to create an integrated and diverse workforce that utilizes an individual's lived experience in mental health and recovery to support the clients and families they serve.

Family Driven

Full-Service Partnership Reboot: FSP programs provide services to family members to help support their own needs, as well as to enable them to assist their loved one's recovery. Family involvement in treatment and services can be critical to supporting and maintaining an individual's recovery and will remain a critical element of this component as clients move through the newly established levels of care.

Integrated Complex Care Management for Older Adults: Family members often play a key role as caregivers for their elderly loved ones. This component will be family driven as the perspectives of children, parents, spouses and loved ones will be considered when creating this comprehensive system of care for older adults.

Developing Capacity for Specialty MH Plan Services with Diverse Communities: This component is family driven, as many culturally specific approaches include family members in their treatment plans and services.

Innovative Approaches to Delivery of Care: This component will rely directly on client and family member feedback, utilizing a user experience model to determine the most successful approaches to delivery of care.

Wellness, Recovery and Resiliency Focused

Full-Service Partnership Reboot: This component focuses on determining and establishing levels of care for clients, which are recovery focused and tailored to their individual needs.

Integrated Complex Care Management for Older Adults: This component will require the development of a multi-disciplinary team who will work together to create a system of care for older adults living with co-occurring mental health conditions and neurocognitive disorders. The treatment for this target population is highly individualized and must be tailored to each person's unique wellness and recovery needs.

Developing Capacity for Specialty MH Plan Services with Diverse Communities: This component ensures that services will reflect the cultural, ethnic, and racial diversity of mental health consumers, utilizing cultural practices to promote wellness and recovery.

Innovating Countywide Workforce Initiatives: This component focuses on expanding the behavioral health workforce, including the development of employment pathways for paraprofessionals. Expanding the Peer workforce promotes wellness, recovery and resilience for the individual and the clients and families they serve.

Innovative Approaches to Delivery of Care: The purpose of this component is to deliver services in way that fosters cultural awareness, safety, and inclusion for all clients receiving services. The goal is to create a space that promotes hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

Integrated Service Experience for Clients and Families

Full-Service Partnership Reboot: This component focuses on providing access to a range of comprehensive, wraparound services tailored to the unique and comprehensive needs of program participants.

Integrated Complex Care Management for Older Adults: This component focuses on establishing comprehensive and coordinated care for older adults that will require collaboration and integration of services between various systems of care. It will also explore blended funding and housing options to provide an integrated service experience for older adults and their families.

Developing Capacity for Specialty MH Plan Services with Diverse Communities: Through this component, the County and CBOs will partner to determine the necessary steps to becoming specialty mental health providers. CBOs that are eligible to become specialty mental health providers will have the ability to provide clients and family members with a range of integrated counseling services and community-defined cultural practices.

Innovating Countywide Workforce Initiatives: This component seeks to expand the behavioral health workforce, creating an employment pipeline for a diverse group of professionals and paraprofessionals. This would provide the County with an opportunity to create an integrated and diverse workforce that culturally and linguistically represents the clients and families they serve.

Timeline

This PIVOT INN proposal is a five-year project. Although there are five separate and distinct components, the project timeline will begin for all components once the first INN dollar is spent. If the MHSOAC approves the opportunity for interested counties to join this project, their five-year timeline will begin when their first INN dollar is spent.

Orange County plans to start this project immediately upon MHSOAC approval. Activities in the first year will focus on setting up the capacity and infrastructure to support each component. This includes:

- Identifying and contracting with project managers, subject matter experts and evaluators for each component.
- Engaging in ongoing community planning to further refine component activities.
- Determining staffing resources necessary to successfully execute activities.
- Drafting an evaluation plan.

This 12-month estimated timeline is based on the average length of time Orange County would need to complete its procurement process to contract with project managers and evaluators. In addition, if additional counties are approved to join this project, this adds further complexity to the contracting process, as each county must still comply with their own procurement processes and come to an agreement on a standard contract for shared project managers and evaluators supporting each component. This timeframe is also based on lessons learned from Orange County's participation in other multi-county INN collaborative projects, where the average length of time to set up the necessary administrative processes and develop a standard contract with vendors has taken up to 12 months.

The remaining time in this project (Years 2-5) will focus on the implementation of component activities outlined under the project description section of this proposal. During the last year of this project, discussions will focus on sustainability efforts identified under each component to ensure the appropriate termination of activities under MHSA INN funding and a seamless transition into BHSA. The figure below illustrates the five-year timeline.

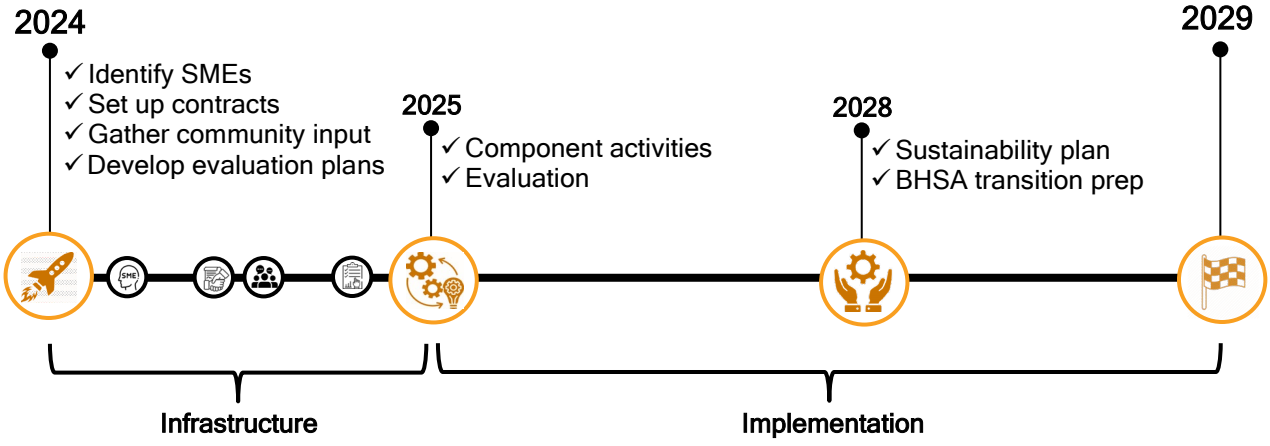


Figure 3. Five-year PIVOT INN Project timeline.

Contracting

The PIVOT INN Project will contract with various consultants and subject matter experts to support activities with each component. Orange County will follow its procurement process to identify qualified consultants, which may include releasing Request for Proposals, as appropriate.

Project Managers

Each PIVOT component will have its own project manager to direct tasks; monitor activities; coordinate meetings between the County, community members and stakeholders involved; and prepare regular status reports. If additional counties are approved to join this project, the project manager will also be tasked with coordinating between all counties; making sure activities remain consistent with the overall vision and goals of the PIVOT proposal; and creating reports that reflect a shared narrative and lessons learned across all participating counties.

Evaluators

Each PIVOT component will also have its own evaluator. The evaluator will be tasked with developing an evaluation plan; gathering information to track progress; providing recommendations to improve implementation efforts; and preparing reports that highlight successful approaches/strategies, barriers/challenges and lessons learned. These reports will be shared with the project manager to provide a comprehensive narrative of the component. If additional counties are approved to join, the evaluator will also be tasked with coordinating between all counties; making sure evaluation activities remain consistent with the overall objectives of PIVOT proposal and evaluation plan; and creating reports that reflect a shared narrative of successes, challenges and lessons learned across all participating counties.

Subject Matter Experts

Each PIVOT component will include various subject matter experts with extensive knowledge and experience in behavioral health services, peer and recovery services, and the specific target population and/or primary focus of the component. These subject

matter experts will inform component activities throughout the duration of the project, as appropriate.

Sustainability

While the PIVOT INN project and each of its components focus on local needs, it is also designed to help the county transition from MHSA funding requirements into the new requirements under BHSA. With this project, Orange County is seeking strategies to prepare its system and continue to make behavioral health services and supports available to unserved and underserved communities. Each component is designed with the intention of sustainability under BHSA.

Full-Service Partnership Reboot

The BHSA will allocate 35% of funds toward FSP programs. However, these funds are intended for service delivery rather than administrative support. The activities in this component are focused on determining the administrative changes and data infrastructure needed to successfully meet the new program requirements. Orange County is proposing to leverage its remaining MHSA INN dollars to help implement new changes into its FSP programs to support ongoing program operations and sustain service delivery under BHSA.

Integrated Complex Care Management for Older Adults

The collaboration between partners in this new system is essential to creating a funding structure that can support service delivery between the different disciplines. The INN funding will support the development of this system of care, and the funding structure created as a result of this collaboration will sustain the system and services beyond the PIVOT INN project.

Developing Capacity for Specialty MH Plan Services with Diverse Communities

The purpose of this component is to identify the minimum necessary requirements for CBOs to become Medi-Cal certified to provide specialty mental health plan services. Determining this process will allow other CBOs to assess their readiness and prepare

their systems. The ability to bill for Medi-Cal services will sustain this component beyond this INN project and bridge the gap in services for diverse communities.

Innovative Countywide Workforce Initiatives

At the end of this INN project component, the County will identify the most successful strategies for employee engagement and retention, and where possible, work with its Human Resource department to embed those approaches into its administrative policies. Furthermore, the development of a baseline infrastructure will enable the County to potentially apply for additional workforce development grants and opportunities with partners, resulting in sustain initiatives without relying solely on BHSA funding. Finally, the County will also explore the ability to maintain ongoing contracts with third party vendors through the BHSS component to sustain the successful approaches that are not possible within the county system.

Innovative Approaches to Delivery of Care

This component will integrate successful approaches into daily program operations, where possible.

Communication and Dissemination Plan

Orange County plans to share status updates about the PIVOT INN Project through:

- Presentations at local community planning meetings.
- Ongoing updates at BHAB meetings, with specific presentations upon request.
- Presentations at the California Behavioral Health Directors Association
- Annual project reports to the MHSOAC/BHSOAC.
- MHSA Annual Plan Update for FY 24-25.
- Future BHSA Integrated Plans.
- Orange County Health Care Agency Website
- Potential publication of research and evaluation results in peer-reviewed academic journals or presented at conferences to share our findings with the larger community.

BUDGET

Budget Narrative

Orange County is requesting approval to utilize $34,950,000 in MHSA INN funds to implement this five-year project. A detailed budget for each component will be developed through ongoing planning meetings that will further define component needs. A description of the expense categories and Full-Time Equivalent (FTE) positions are described below.

Consultant Contracts

- Project Managers for each PIVOT component (5 FTE) to ensure coordination and alignment of activities throughout the duration of this project.
    - The budget includes costs for travel, program supplies and equipment for each project manager to conduct activities and/or prepare reports.
- Subject Matter Experts (SMEs) for each PIVOT component (up to 25 FTE) to facilitate ongoing community planning discussions and inform component activities throughout the duration of this project.
    - The number of consultants and length of their contracts may vary depending on the needs of each component. As a result, the estimated budget accounts for annual contracts with up to 5 SMEs per component to allow flexibility, as needed.
- Evaluators for each PIVOT component (5 FTE) to support data tracking and consistency in reporting and lessons learned throughout the duration of this project.
    - The budget accounts for a principal investigator, research assistants, and supplies needed to conduct research activities and prepare reports.

Staffing Costs

- Staffing for each PIVOT component, which will include County staff time to monitor each component; internal County champions to support integration of component strategies or processes into the county system; and the ability to hire Peer Support Specialists (10 FTE), to include the peer perspective into each component.

Program Costs

- Program supplies to support PIVOT component activities, which may include but not be limited to the development and print of brochures, flyers, announcements and/or marketing materials; equipment such as phones, laptops or computers; costs for renting large meeting spaces or venues as needed and appropriate; and costs to provide incentives such as gift card, food, and transportation support for consumers and family members to participate in planning meetings.
- Translation support to ensure marketing materials, announcements, surveys and virtual and/or in-person meetings are available in Orange County's threshold languages (Arabic, Chinese, Farsi, Korean, Spanish, and Vietnamese)
- Travel for local and/or statewide activities related to each PIVOT component. Costs may include but not be limited to mileage, airfare, lodging, and food expenses.

Indirect Costs

- Orange County will apply a 5% indirect rate to support administrative activities, which was calculated based on the total program costs.

If additional counties are approved to join, each county will be responsible for funding their chosen PIVOT component and local activities. However, a portion of each county INN funds must go toward supporting a shared project manager and evaluator for their chosen component(s) to ensure coordination and aligned of component activities across participation counties, consistent evaluation, and shared learnings. A county's contribution to the project manager and evaluation will vary depending on their available INN funds.

Budget Grid

	Fiscal Year 2024-25	Fiscal Year 2025-26	Fiscal Year 2026-27	Fiscal Year 2027-28	Fiscal Year 2028-29	Total
Consultants						
Proj. Managers	$750,000	$750,000	$750,000	$750,000	$750,000	$3,750,000
SMEs	$3,750,000	$3,750,000	$3,750,000	$3,750,000	$3,750,000	$18,750,000
Evaluators	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$5,000,000
Staffing						
Staffing	$965,000	$965,000	$965,000	$965,000	$965,000	$4,825,000
Program						
Supplies	$275,000	$275,000	$275,000	$275,000	$275,000	$1,375,000
Translation	$100,000	$100,000	$100,000	$100,000	$100,000	$500,000
Travel	$125,000	$125,000	$125,000	$125,000	$125,000	$625,000
Indirect						
5% Admin.	$25,000	$25,000	$25,000	$25,000	$25,000	$125,000

Total Requested Budget: $34,950,000

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APPENDIX A. County INN Template

(Name) County

County Contact and Specific Dates:

- Primary County Contact:
- Date Proposal posted for 30-day Public Review:
- Date of Local MH Board hearing:
- Date of BOS approval or calendared date to appear before BOS:

PIVOT Components:

☐ Full-Service Partnership Reboot

☐ Integrated Complex Care Management for Older Adults

☐ Developing Capacity for Specialty MH Plan Services with Diverse Communities

☐ Innovating Countywide Workforce Initiatives

☐ Innovative Approaches to Delivery of Care

Local Need:

Additional Learning Objectives (if applicable):

Local Community Planning Process:

Alignment with BHSA:

Sustainability:

Budget Narrative:

- Total proposed budget
    - County Costs
    - Contractor Costs
- Budget by Fiscal Year and Specific Budget Category for County Specific Needs

APPENDIX B. Clinic Improvements

The images below reflect the vision of Orange County's stakeholders in creating a more culturally responsive and welcoming clinic space. After multiple rounds of community engagement, general themes emerged for a space that includes calming open-air landscapes, natural wonders, hope, peace, serenity, the use of animal, the use of multiple bright colors, a cultural reflection of the local community, and images that will last the test of time. With this feedback, the County consulted with a professional muralist to develop the murals.

A total of nine murals were created to reflect the visual concept of the natural wonders that are iconic to the clinic's surrounding area – coastal, wetlands, and mountainous landscapes, as well as their recognizable flora and fauna. The goal of this concept was to capture a sense of stillness, calm, peace, and serenity found in nature, that is recognizable and relatable to community stakeholders.

The images also incorporate symbols of hope, peace, and optimism - such as Lotus, Egret, and oranges - to give subtle recognition to the clinic's primarily Vietnamese demographic, while also considering the universal appeal of these symbols across cultures. For example, the Egret is a mythical creature in Vietnamese culture and a national bird of Vietnam. This figure was used in the wetlands mural inside the Adult and Older Adult outpatient clinic lobby.

In another example, the Lotus Flower is a profound symbol of resilience and enlightenment within the culture and daily life of the Vietnamese culture. This image was used in the mural located in the SUD outpatient clinic lobby.

The Children's lobby reflects the local parks and the orange trees that represent the County. To create an immersive experience, the different floors represent various natural and calming environments. The goal for these murals was to create a welcoming and calm space in the clinics and instill a sense of care for the quality of the client's experience.

All Public Comments Received

Summary of Public Comments Received

Amendment to the MHSA FY 2024-25 Annual Update

30-Day Public Comment Process

Substantive Comments[1]

Received during public comment period

Comment	Response/Recommended Revision
Regarding Innovation Proposal: Animal Care for Client Housing Stability and Wellness	
Lori Morton-Feazell (County of San Mateo Health): How can we work with these residential facilities to change their policy around pets? In our shelter and congregate shelters we have shown that the issues they are stating do not exist. (p5)	BHRS will add a component to the program that will include working with supportive housing and treatment facilities that do not currently have policies to establish and formalize policies around accepting animals (i.e., Permanent Supportive Housing, Serenity House, and substance use treatment facilities).
Lori Morton-Feazell: Given legal issues, client-animal visitation is not feasible. (p7)	BHRS will remove the client-animal visitation component of the program. The program will still include opportunities for clients to receive regular updates about the wellbeing of their animal.
Lori Morton-Feazell: Will [the Program Manager] be a BHRS employee? Or is this person employed by the Animal organization you will be contracting with? (p8)	BHRS will adjust the staffing section of the plan to include a Project Coordinator from San Mateo County Health that will work in collaboration with a BHRS Manager. The Project Coordinator will be responsible for contracting with fostering agency and supportive services.
Lori Morton-Feazell: Have you included in the cost animal food, supplies such as bowls, litter boxes, cages etc? Will BHRS pay for that or will it be the animal organization's responsibility to cover those costs? (p8)	Given this comment and further understanding about the cost of providing the animal foster care and supportive services, BHRS will adjust the budget as follows to increase the funding for contracted services and remove the funding for BHRS administration. In addition, BHRS will increase the funding for evaluation based on field standards of 12-15%. ● **Service Contract**: increase from $750,000 to $870,000 ($290,000 annually for three years) ● **Evaluation**: Increase from $100,000 to $120,000

[1] MHSA legislation requires that the Annual Updates for the MHSA Program and Expenditure Plan include a summary of any "substantive" public comments received (e.g., comments that may require a change to the plan) and if applicable, include the recommended revisions to the plan.

Public Comments and Q&A

BHC meeting (10/02/24), opening of public comment period

- **Commissioner F. Edgette**: Following the 30-day public comment period and assuming projects are approved here, what's the time horizon in terms of steps essentially, when's the earliest that projects would be "shovel ready"? I know they're not all infrastructurally, but…
    - Doris Estremera: Great question, Frieda. And actually, it's why I'm proposing it as an amendment to our current fiscal year. Typically, we would wait until the next fiscal year to be able to implement new [projects]. But at least allcove and PIVOT can hit the ground running probably by January [2025], where the other two [projects] will have to go out to RFP and a process, and that take a little longer, so those two projects may have a more of a July 1, 2025 start date.
- **Commissioner F. Edgette**: And with allcove Half Moon Bay do they have a site identified, and how far along are they in terms of their reorganizing?
    - Cameron Zeller (Coast Pride) via email: We signed our contract with the state for developing allcove Half Moon Bay on October 2nd so we are just getting started. We have a kick-off meeting with the Stanford TTA team scheduled for Monday, 10/21/2024. We have identified some potential locations for allcoveHalfMoonBay and will vet them with the Youth Advisory Group once that group has been formed.
- **Commissioner F. Edgette**: We were very involved and I'm on the community consortium for allcove San Mateo, so I'm very familiar with the process; we're very excited, the community, in terms of another allcove, it's such an effective, proven model, and it's wonderful seeing California and the Bay Area taking a leadership role in bringing this model here, so I'm enthusiastically eager to support bringing this model here.
- **Commissioner L. Poreddy:** I'm looking at the four selected ideas, and I believe they are from 2022, and we're going to be in 2025 by the time we implement this. Is there a plan to revisit how relevant these ideas would be in 2025?
    - Doris Estremera: That's an excellent question. That was part of the feasibility review. It [included] reaching out and looking at, is this feasible, does it still make sense? Is it still considered innovative? So we did the research. We reached out to the initial folks that had proposed it. We reached out to potential bidders. So we did a lot of that work to make sure that it was still relevant. And so the two [projects] that moved forward did meet those feasibility review criteria.
- **Commissioner L. Poreddy:** The reason I'm asking that question is, probably these ideas came in even before Chatgpt was out there, right, from an innovation standpoint. Because I'm on the board of a technology company which is working in a similar space. And they're working with the states of North Dakota and Missouri and working with the research institutes there to work for elderly people and troubled young adults, especially in mental health space, looking at cognitive decline and stuff like that. So that idea seemed extremely innovative, and a lot of

universities, including USC, UCLA are interested in that product. And I don't see a lot of - and maybe I'm a little bit biased - but that's what we bring to the table is diversity right? I'm looking at, can we bring some technology innovative ideas to the table and see how our county can benefit, given we are in the Silicon Valley?

    - Doris Estremera: Thank you. Typically the way that Innovation proposals work is that there is a process where projects get proposed. The last process we ran was in 2022. At this point in time and given that we're moving into kicking off the transition to Prop 1 in January 2025, we do not have the capacity to run another comprehensive INN proposal idea process. It is typically about an eight month process - because you have to open it up to the public and make sure that everybody has access to it and ideas can get proposed, make sure [the process] feels supported so that ideas can come from not just agencies that are very well resourced, but that a client, a community member can also propose ideas. You're right, we are in Silicon Valley - and actually, technology innovations has been in the past an idea that came through for funding. We were able to allocate monies through our Help@Hand project that looked at different apps and bringing apps to our older community and our youth. So we have been able to do some work in technology.

    - Commissioner Jean Perry: Thank you, Lavanya, and and I've got to say, there were a bunch of really good ideas left over after the ones were selected in 2022, so I really am happy about the way we modified the process so it was accessible to literally anyone - you could send an idea and it didn't have to be [fully] developed - you didn't have to prove its feasibility, and then there was a process to develop it. And also it's going to be a little different going forward with BHSA because there are not allocated funds for Innovation, so it's going to happen in a different way - it will need to happen. There is a need for this.

- **Commissioner S. Escobar**. I just wanted to say thank you for your presentation. It was really well done, and these ideas seem really exciting. My question was in regards to the peer support and the peer workers. Where would you find these peer workers, and do you have a plan for this to be more volunteer or something that's more of a contract job base with peers?

    - Doris Estremera: At this point, my understanding of it is that the folks who are going to be providing the peer support are hired peer support workers themselves.

    - Waynette Brock (One New Heartbeat) via email: The peer workers will be Certified Peer Specialists and Supervisors, who are staff members trained in trauma-informed care, conflict resolution, de-escalation techniques, boundaries, and ethics amongst other things

- Doris Estremera: I do want to say to folks, like Sophia and Frieda, where you had specific questions about how [the project] was envisioned, this is also our opportunity to provide our feedback, what *we* would want this to look like. This is our opportunity to give considerations, and we can take a look at that.

- Commissioner Jean Perry: I would encourage everyone to go and read what's on the website and submit your questions and ideas. It's not written in stone and further development can happen until November 6.

- **Jo** [via chat]: So the animal care for housing stability, is it medical care for the animals?
    - Doris Estremera: So there is a component that does provide veterinary care. And this is something that actually we have a good resource in our County. This is something that's already provided at our shelters through our Public Health Department. So yes, veterinary care services would be [part of the project]. But again, the main criteria, as this project has been envisioned, is for that urgent and temporary need where it is going to support somebody to either get housed or maintain their housing, or enter a higher level of care, not as an ongoing support for clients with pets.

- **Commissioner R. Garcia**: First of all, Doris, thank you for all the hard work you've been putting into this, to you and to the entire team, and everyone who's been super involved, because I know it's been ongoing since 2022, and so much more to come. It's a long process, and it's for me a fairly new process that I'm learning. So I do want to ask, if there were initially 19 ideas that got pushed out and accepted, now that these four have been prioritized, what does that look like? Are all four going to for sure receive funding? Is it one of the four, two of the four?
    - Doris Estremera: I apologize if that wasn't clear. Out of the 19 original ideas, four are up and running, and now we are proposing two more from the list to move forward. And again, we had to review new criteria with Prop 1, it did limit us. We had a lot of prevention focused ideas that we just won't be able to move forward. And also, looking at all of the things I talked about with regards to feasibility. All new projects will need to be approved by the State Mental Health Oversight and Accountability before we can for sure allocate funding

- **Commissioner R. Garcia**: So two of the four would move forward?
    - Doris Estremera: We have four that moved forward in 2022. We went back and looked at the list of leftover 15 projects, looked at the new criteria and the feasibility review and were able to select two more to move forward two years later - so a total of six out of the original 19.

Public Comments submitted via public comment form

Regarding purchase of new building and Innovation projects:

- **Ligia Andrade Zúñiga (San Mateo County Suicide Prevention Committee):** I am writing to express my full support for the two amendments to the Mental Health Services Act. As a San Mateo County Suicide Prevention Committee Member, Interim Executive Director of the Center for Independence of Individuals With Disabilities, and current Board President for the San Mateo Union High School District both of the amendments are extremely important in being able to provide safe, healthy, and evidence-based practices to best serve our community members in San Mateo County. These amendments will also provide support to our staff members who are dedicated to providing the best service and support that they can, but cannot if they do not have adequate tools and support for them as well. Burnout and working conditions impact our service providers by affecting their quality of work life, their own mental health, job satisfaction, and retention. Ultimately though, the community is affected when we do not provide adequate working conditions and appropriate evidence-based practices when providing services.

Regarding purchase of new building:

- **Claudia Saggese (BHRS):** Purchase of New Building for South County MH Clinic. I fully agree with the proposal - It will better serve our clients/consumers & family members. I also think it is a good investment for the county to own the building because this would reduce rental escalation price.

Additional Public Comments

Regarding Innovation Proposal: Animal Care for Client Housing Stability and Wellness

- **MHSOAC Innovations team:** Consider including additional detail on the local need, such as local personal stories on the need for and impact of receiving support for animal care.
- **Lori Morton-Feazell (County of San Mateo Health):**
    - I am so glad that BHRS has a way to get the funding for this pilot. It is a large gap for those in need of treatment that have pets to have a foster care program. It is so true that people will not leave their pets unless they know they are being cared for and safe. Is the name of the project final? I am not sure if it can be modified at this point. When the term " Animal Care" is used it includes all aspects of the care for the animal when this proposal covers mainly foster care, and in-home pet care of the animals in need. I don't want the case managers, county staff, or clients to confuse your program with the Veterinarian wellness program that my team provides. Maybe the title can be "Animal Foster Care." Just a suggestion.
    - Will BHRS be asking my vet wellness program for support on vaccines and treatment? If the answer is yes I will need to look for a way to expand my program.
        - Doris Estremera: We do not anticipate a high need for vaccines and treatment, it will be minimal and only available to pets while in foster care.

- Lori Morton-Feazell: Why would BHRS be recruiting peer support workers [to serve as the animal fosterers]? Wouldn't that fall to the scope of work of the animal organization you will be contracting with? The group recruiting animal foster care volunteers should have the knowledge of what is needed for the care of that animals. They should already be aware of animal issues that can happen, however to handle animal emergencies, etc. Just curious why that would not be a role of the animal group? (p8)
    - Doris Estremera: This is the role of the contracted animal fostering agency. BHRS will center the importance of peer-to-peer services by 1) including language in the Request for Proposals (RFP) for the contracted foster agency that the agency should value and promote the importance of peer-to-peer services for individuals with mental health and substance use challenges; and 2) working with the contracted agency to promote the opportunity for peers to become fosterers through BHRS's existing network of peer support workers and programs for individuals with lived experience and their family members.
- Who will be developing the training [for the volunteer animal fosters]? I would increase this number [3 fosterers] due to people not being available or on vacation, or sick etc. If you are putting in the effort to train, why not train more people?
    - Doris Estremera: The training, support and recruitment of fosterers will be on the contracted fostering agency, we are looking to contract with an agency that already offers pet fostering during natural disasters or other emergencies and has the infrastructure in place to support volunteers.
- Will the support [through this program] remain with clients with mental health or substance issues or is the plan to expand to those in residential housing /congregate housing that might need a foster home if they are entering the hospital or incarcerated?
    - Doris Estremera: Yes, this would be for BHRS and network of providers' clients only.
- Will the program include all types of animals? Just curious as we do have a resident with chickens. I think it should be for all pets. I am bringing this up so it is on your radar that the client could have a bird, rabbit, fish or reptiles. You will need [animal fosters] that can handle any species of animal.
    - Doris Estremera: This will be on the selected fostering agency to determine based on capacity and their policies; we can request this (but, not require) during the RFP process.
- You could include [in the background Research for the INN Component section] that the Contracted Animal Care and Control Vendor of San Mateo County currently will hold in protective custody animals for 30 days however if they need a longer stay there is a gap in service.

Regarding Innovation Proposal: Peer Support for Peer Workers

- **MHSOAC Innovations team:** Consider including additional detail on the local need, such as anecdotal data from peer workers to bring in the human element. In addition, consider adding a baseline survey for peer support workers as part of the learning and evaluation section to establish baseline data. Also ensure that the county is connecting with DHCS and other counties on connecting the INN investment to potential system change and possibly Medi-Cal billing.

Regarding Innovation Proposal: allcove Half Moon Bay

- **MHSOAC Innovations team:** Consider including the dollar amount of the original OAC start-up grant to CoastPride. Ensure the proposal contains the items specific to San Mateo County as an appendix to the multi-county collaborative plan.

- **Sarah Kremer (allcove Implementation Manager, Stanford University):**

    - allcove Half Moon Bay is written out completely without abbreviations.

    - Instead of saying, "The funding will also be utilized to implement principles for allcove centers called ACCESS (Anti-racist, Culturally-minded, Community Education, Support, and Services)," change to: "The funding will also be used to implement a cultural safety approach that is being developed by Stanford with youth advisor input for allcove centers." Throughout the document, use "the allcove cultural safety framework" instead of "ACCESS principles." (p4)

    - Add "physical health, supported education and employment, peer support, family support" to the list of services that allcove will provide. (p5)

    - Suggestion to expand the BHSA transition responses (p11) as follows:

        - *How does this proposal align with the BHSA reform?* The project focuses on holistic early-life investments and strategies for youth and young adults 12 to 25 years old and their families to intervene in the early signs of mental illness or substance use, through an integrated services approach that reduces silos for planning and service delivery. Through allcove's "no wrong door" approach, young people are welcomed in to a center and through a shared decision process, can have rapid and easy access to a range of services. While allcove's focus is mild to moderate behavioral health issues, no young person is turned away. A robust community-led referral network supports youth with greater needs, advancing equity and reducing disparities for individuals with behavioral health needs. Every allcove center also provides culturally safe and supported services that are identified by youth through their Youth Advisory Group in collaboration with a Community Consortium. These advisory groups continue to ensure that all young people in the community, especially the most underserved populations, such as those who identify as Black, Indigenous, and people of color (BIPOC), LGBTQ+, and young people experiencing homelessness, are aware of the center. Both groups also work to ensure that allcove is meeting the needs of all young people through its services provided by community partners. Additionally, by providing the range of staff positions from peer support

specialists to youth outreach specialists, from clinicians earning hours toward licensure to those providing supervision, allcove centers offer a path for young people interested in behavioral health careers. A young person may seek services at an allcove center, become a youth advisor, then move into a peer support specialist role while attending college. They may decide to pursue a degree that provides a pathway to clinical services, while still working at an allcove center. This network of centers around California are poised to expand the behavioral health workforce through community- and youth-led efforts.

- *Does it provide housing interventions for persons who are chronically homeless or experiencing homelessness or are at risk of homelessness?* No. An allcove center may have supports for young people who are unhoused, including referrals to community partners that offer this service, if there is a need in the community as identified by youth advisors and if the young person requests this service.

- *Does it support early intervention programs or approaches in order to prevent mental illnesses and substance abuse disorders from becoming severe and disabling?* Yes, the project provides early behavioral health services for youth and young adults, ages 12 to 25 years old. allcove centers support young people with a range of needs through these prevention and early intervention services, such as brief therapy or psychoeducation on substance use, and also connects young people to other providers in the community for other services, like early psychosis. allcove center staff understand the need to integrate traditional mental health services and substance use services to ensure young people are treated with a unified approach as a whole person. Additionally, through each center's Youth Advisory Group and Community Consortium, centers engage in activities designed to destigmatize behavioral health issues, increase awareness of services and resources offered at allcove centers, provide a focus on wellness activities and prevent behavioral health problems before they start.

- *Does it support Full-Service Partnership efforts and services for individuals living with serious mental illness?* No. Depending on each community's needs, allcove centers may have partners who provide Full-Service Partnership effort, and could provide a warm hand-off to these organizations for services outside of allcove's mild to moderate focus.

- **Cameron Zeller (CoastPride):** Under Numbers of Youth Served with INN Funding, change "youth" to "youth and families." (p5)

Regarding Innovation Proposal: PIVOT

- **MHSOAC Innovations team:** Include additional detail about the Community Planning Process (CPP) in terms of how this idea was brought to the community outside of the 30-day public comment period. Add detail about local capacity in San Mateo County to implement PIVOT, in the context of learnings we have had as a state around this effort and system transformation

work. Consider connecting with other counties that are working on supporting early intervention programs around Medi-Cal billing, particularly Fresno County and Nevada County.

BHC meeting (11/06/24), closing public comment period.

- **Commissioner J. Perry:** I'm concerned of the level of control that BHRS will have over the fosterers. The people that would love to foster would be doing this and they won't be given the right kind of training and support that a peer would already have. They won't have take family-to-family [NAMI training]. They won't know that the pet parent may respond to them in really negative ways in response to you doing a good thing because of where they may be in their illness. And so, I just am concerned that people who are really good at fostering pets will not be given the skill set to be interacting with the pat parent, who is a BHRS client.

MHSA Funding Summary Amendment

FY 2024-25 Mental Health Services Act Annual Update
Funding Summary - Amendments (in red)

County: San Mateo

Date: 11/14/24

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2024/25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	38,829,190	11,042,302	10,190,041	1,427,005	5,289,400	5,355,145
2. Estimated New FY 2024/25 Funding	37,984,264	9,496,066	2,498,965	0	0	0
3. Transfer in FY 2024/25[a/]	0	0	0	2,580,000	4,840,600	2,593,783
4. Access Local Prudent Reserve in FY 2024/25	0	0	0	0	0	0
5. Estimated Available Funding for FY 2024/25	76,813,454	20,538,368	12,689,006	4,007,005	10,130,000	7,948,928
B. Estimated FY 2024/25 MHSA Expenditures	68,010,885	12,478,838	3,734,502	2,580,000	10,130,000	0
G. Estimated FY 2024/25 Unspent Fund Balance	8,802,569	8,059,530	8,954,504	1,427,005	0	7,948,928

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2023	5,355,145
2. Contributions to the Local Prudent Reserve in FY 2024/25	3,872,204
3. Distributions from the Local Prudent Reserve in FY 2024/25	0
4. Estimated Local Prudent Reserve Balance on June 30, 2024	9,227,349

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2024/25 Mental Health Services Act Annual Update
Innovations (INN) Funding - Amendments (in red)

County: San Mateo

Date: 11/14/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Social Enterprise	523,755	523,755				
2. PIONEERS	297,345	297,345				
3. Adult Residential In-home Support Element	330,000	330,000				
4. Mobile Behavioral Health - Farmworkers	485,000	485,000				
5. Music Theray for Asian/Asian Americans	236,223	236,223				
6. Recver Connection Drop-In Center	573,530	573,530				
7. INN Evaluation	278,649	278,649				
8. Peer Support for Peer Workers	0	0				
9. Animal Care for Housing Stability	0	0				
10. allcove Half Moon Bay	250,000	250,000				
11. PIVOT - MediCal billing	500,000	500,000				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	260,000	260,000				
Total INN Program Estimated Expenditures	3,734,502	3,734,502	0	0	0	0

FY 2024/25 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding - Amendments (in red)

County: San Mateo

Date: 11/14/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects (One-Time)						
1. Rennovations	1,800,000	1,800,000				
2. Methadone Clinic	1,800,000	1,800,000				
3. South County Clinic Property Purchase	5,500,000	5,500,000				
	0					
	0					
	0					
	0					
	0					
	0					
	0					
CFTN Programs - Technological Needs Projects						
1. Client Devices	630,000	630,000				
	0					
CFTN Programs - Technological Needs Projects (One-Time)						
1. Network Adequacy Compliance	400,000	400,000				
	0					
	0					
	0					
	0					
	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	10,130,000	10,130,000	0	0	0	0