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.

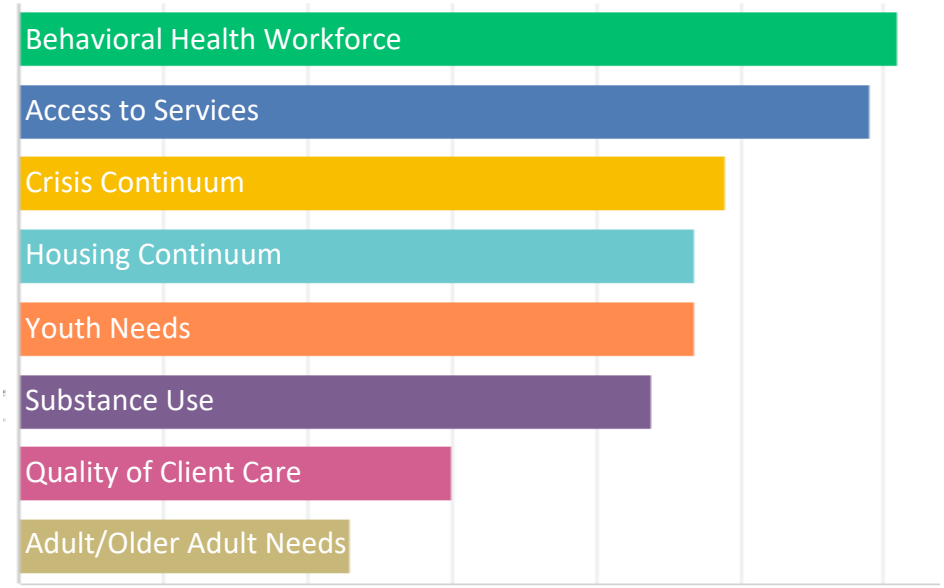
** As part of a simultaneous process to develop the MHSA 3-Year Workforce Education and Training (WET) Plan, 5 additional sessions were conducted to brainstorm around Behavioral Health Workforce strategies with the Diversity and Equity Council, Lived Experience and Education Workgroup, Alcohol and Other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

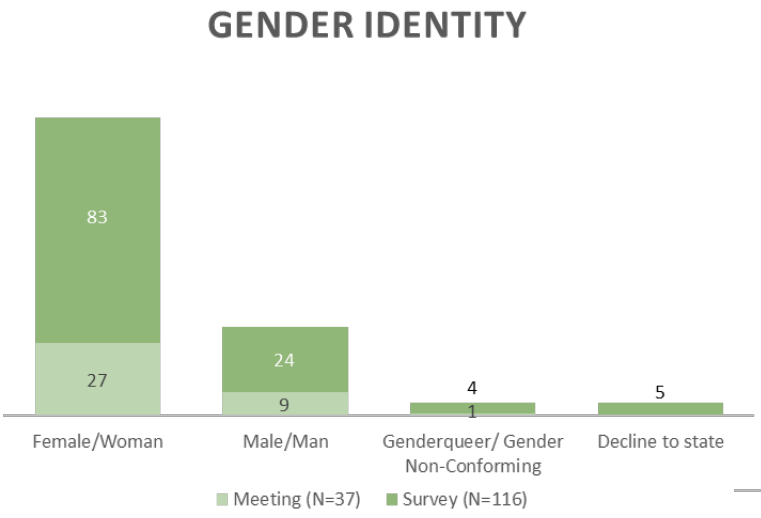
Date	Stakeholder Group	Input Session Topics
	MHSA Steering Committee	
2/2/23	4 Breakout Groups	Access to Services; Behavioral Health Workforce; Housing Continuum; Crisis Continuum
	Health Equity Initiatives	
2/3/23	Chinese Health Initiative	Access to Services
2/7/23	Pacific Islander Initiative	Youth 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

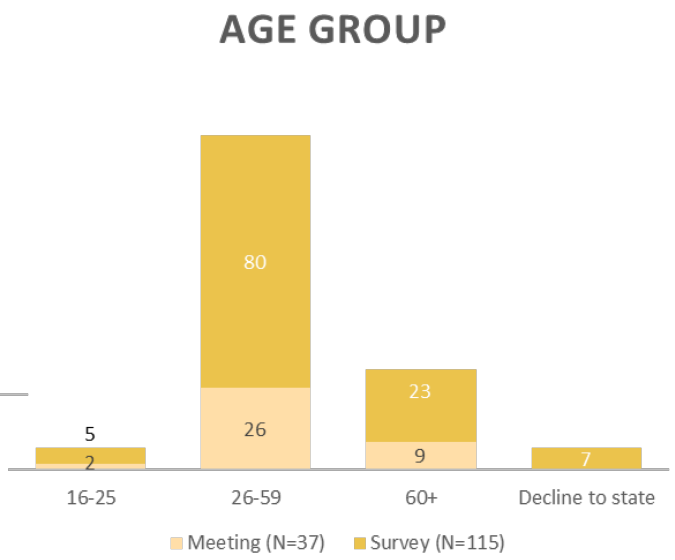
2/15/23	BHC Child and Youth Committee (3 Breakout Groups)	Youth Needs
2/15/23	BHC Adult Committee	Housing Continuum
2/21/23	BHC Alcohol and Other Drugs Committee	Substance Use Challenges
	Other Committees/Groups	
2/9/23	Housing Operations Committee	Housing Continuum
2/7/23	Lived Experience Education 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

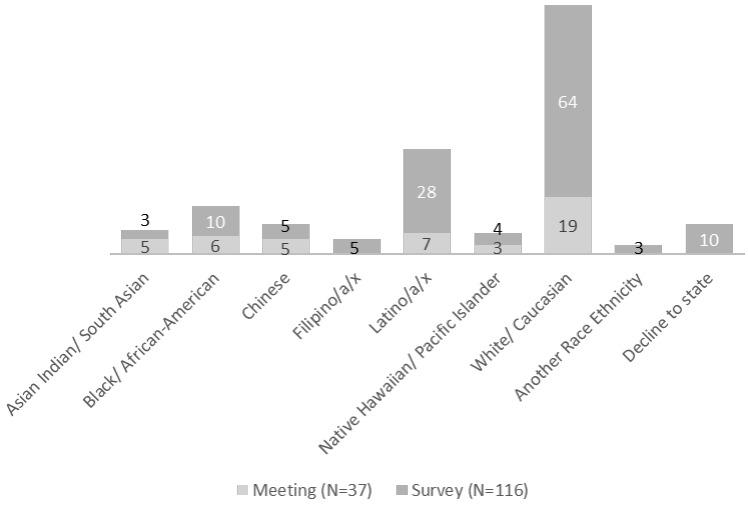
Demographic data was not collected from all 31 Community Input Sessions. 35 client and family members received stipends for participating in these sessions.

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.

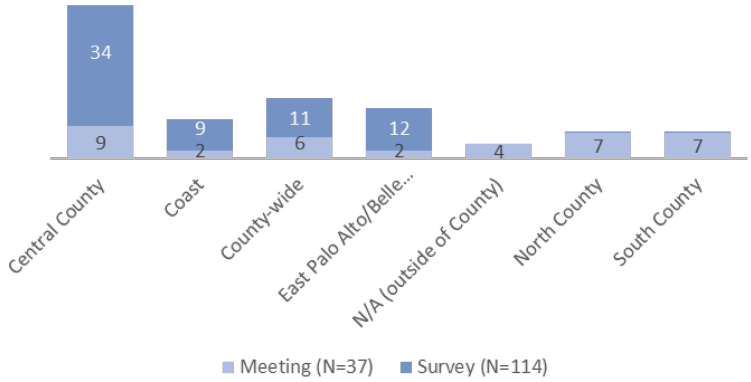




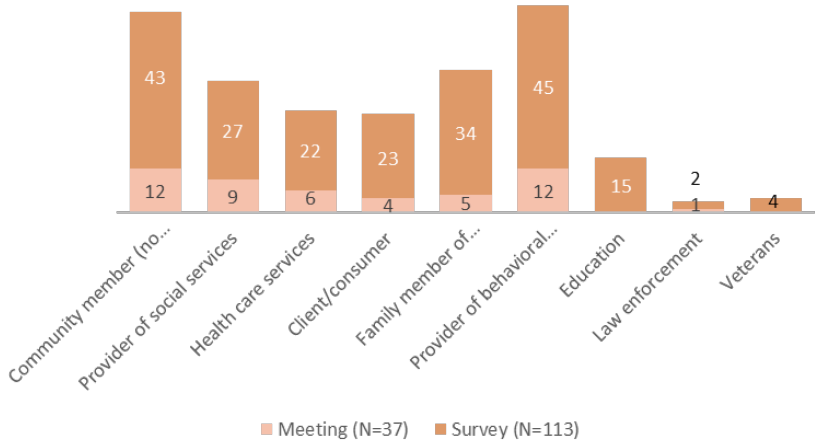
RACE/ETHNICITY



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.