Review of CalMHSA (Mental Health Services Act) Innovation Plans[1]

Ninety-one (91) Innovative (INN) work plans were approved for 33 counties by the Mental Health Services and Accountability Commission (MHSOAC) for FYs 2008-2009 & 2009-2010. Of these, 22 projects include a component integrating mental health and physical health services. This report provides a detailed summary of each of these 22 projects. Plans are arranged by county, in alphabetical order.

County	Butte
Plan Name	Homeless Shelter Collaboration
Purpose	Promote Interagency Collaboration
Project Description	Tests a unique collaborative model which uses a mobile medical unit & follow-up services combined with existing shelter services; Provides a support team w/BH, medical, & financial services to shelters; Provides testing & assessment for PH & BH issues, eligibility for financial assistance, & follow-up services at shelters. Dep't of Employment & Social Services assists w/ Medi-Cal applications; DPH provides medical assessment & clinic services; Behavioral Health clinician provides assessments, individual & group services at shelter (CM, MH counseling, preventive health services, health education, assists w/accessing needed primary health or dental services)
Duration	3 yrs
Budget	$180,787 (1 yr) /$418,530 (3 yr est.)
Target Population	Homeless persons w/MI at shelters
Annual # Clients Served	100
Cost per Client 1st Year	$1,807
Description of Integration	New model of service collaboration leads to seamless integrated delivery of multiple services (testing & assessing for PH & BH & financial assistance eligibility through mobile van); Integrated on-site delivery & follow-up
Integration Approach	Linkage w/CBOs
AODS	No AODS integration
Supportive Services	Coordinated Care; Counseling (licensed); CM; Health, MH, psycho-social education &/or skill building; Medi-Cal/Benefits enrollment; Medical &/or MH assessment/screening; Support group; Link to resources
Staff	Team - Public Health Nurse, Behavioral Health Clinician, Social Services Eligibility Worker Shelter Case Manager, DBH Mobile TAY team & Mobile Foster team (youth)
Peers	No use of peers as providers
Training	Will teach behavioral health, public health, & social services staff to work as a team utilizing strength based recovery approaches w/homeless consumers. Staff will be trained in cultural competence.
Partners/Collaborators	Butte County Departments of Public Health, Employment & Social Services, Behavioral Health; Shelters
Expected Outcomes	Homeless individuals w/MI at shelters will increase utilization of services at shelters (PH, MH), experience reduced shelter recidivism, fewer hospitalizations or crisis contacts, increased engagement in their recovery & wellness plans

[1] INN plans for each county can be accessed by visiting the Innovation page of the Mental Health Services Oversight and Accountability Commission website at: http://www.mhsoac.ca.gov/Counties/Innovation/Innovation.aspx. Each County has its own link where its INN plan and INN Plan Summary are posted in pdf format.

County	Contra Costa
Plan Name	Promoting Wellness, Recovery and Self-Management through Peers ***(approval pending)***
Purpose	Increase quality of services, including better outcomes
Project Description	Test whether utilizing peer service providers as health educators & system navigators in PC/MH integration leads to improved health outcomes & enhanced MH recovery & resiliency. Peer Wellness Coaches placed on primary-MH care service integration teams in county-run MH clinics (& Wellness & Recovery Centers) serve as trained wellness, recovery & chronic disease (including SMI) self-management coaches. Warm hand-off.
Duration	1 year
Budget	$281,781 (1 yr)
Target Population	Consumers served in county operated adult MH clinics
Annual # Clients Served	100
Cost per Client 1st Year	$2,818
Description of Integration	Peer Wellness Coaches (as part of PC/MH service integration teams) will be placed in MH clinics to assist consumers w/managing their chronic diseases. Warm hand-off.
Integration Approach	Coordinated Care
AODS	No AODS integration
Supportive Services	Coordinated care; Physical health, MH, psycho-social education &/or skill building; Support groups; System Navigation; Assist consumers w/wellness plans/goals; Peer mentoring/coaching/support; Link to resources; Transportation assistance
Staff	Peer Wellness Coaches (Community Support Workers)
Peers	3 FTE Peer Wellness Coaches (classified as Mental Health Community Support Worker I-Project). Total cost of the Peer Wellness Coaches, including benefits, is $182,359. The Peer Wellness Coaches will provide self-management coaching, wellness & health education, & recovery support to MH consumers. Peer Wellness Coaches will also assist consumers in navigating the health system as well as accessing health & wellness resources.
Training	Train peer providers in advanced wellness, recovery & self-management skills using a modified version of HARP (Health & Recovery Peer Program)
Partners/Collaborators	Training consultant contract w/Recovery Innovations, Inc.
Expected Outcomes	Using Peer Wellness Coaches will improve service navigation, increase # of consumers who participate in health ed &/or wellness activities, improve PC & BH providers understanding of the consumer culture & recovery skills.

County	Kern
Plan Name	Freise HOPE House (Helping Others through Peer Empowerment)
Purpose	Increase quality of services, including better outcomes
Project Description	Development of a consumer/peer-managed Crisis Residential program (12-14 beds) to serve both as a short-term, recovery-oriented, “step-down” program for adults following inpatient hospitalization of an acute psychiatric episode & as a means of crisis stabilization to avoid an acute psych episode warranting need for hospitalization.
Duration of Work Plan	4 yrs
Budget	$2,254,600 (2 yrs) funding from 2 years of allocations, but the amount funds only the 1st year of plan
Target Population	Persons (18+) requiring direct care as a result of acute psych episode/crisis (when medical complications are not present). Persons 18+ at imminent risk of acute psych episode or homelessness

Annual # Clients Served	125
Cost per Client 1st Year	$18,037
Description of Integration	Focus on co-occurring mental illness & substance abuse; RN on staff to provide medical services
Integration Approach	Linkage w/CBOs
AODS	No AODS integration
Supportive Services	Counseling (licensed); Physical health, MH, psycho-social education &/or skill building; Medical &/or MH assessment/screening; Medication assistance; Peer mentoring/coaching/support; Assist consumers w/wellness plans/goals; Link to resources; Housing referral or assistance
Staff	Project Program Director (peer in recovery), Peer Support Specialists, Peer Support Educator, RNs & Psychiatrists (address physical & MH needs), PEC MH staff, LMFTs, Clinical SW or Psychologist, Project Administrator, Office Manager, Food Services Supervisor, Regional VP for Recovery Innovations CA
Peers	Uses trained peers, "Peer Specialists", to manage & run the facility & program. 6 FTE Specialists will work directly w/PEC MH, Psychiatrists, & Psychiatry Interns to assist in crisis stabilization, recovery & discharge planning, & referral for the Freise HOPE House for individuals when indicated. There is intended to be no differentiation between "peer" & "professional" MH providers. Provides for 1 FTE "Peer Support Educator" to coordinate & facilitate recovery education classes.
Training	Recovery Innovations 80-hr Peer Employment Training course (includes a module on co-recovery from MH & SA)
Partners/Collaborators	County MH Dep't Psychiatric Evaluation Center (PEC), Bethany Services (local NP SS agency to assist residents to develop skills to obtain housing, employment & community supports), Other community organizations, Recovery Innovations of California
Expected Outcomes	System-level indicators include improved collaboration between local community supports & Public MH system, reduced MH stigma & discrimination; Person-level indicators include reduced recidivism (crisis center use, jail, hospitalization, homelessness)

County	**Los Angeles**
Plan Name	Integrated Clinic Model
Purpose	Increase quality of services, including better outcomes
Project Description	Combines PH, MH & SU services in a system that includes directly operated & contracted entities (Community-based sites- 4 planned PC or MH clinic sites). Extends scope of clinic-based MH care to include support & treatment for individuals w/SMI (w/in the borders of a PC site), expands staff role of peers. Tests if w/stabilization supports, clients can change their HH to physical health site. Peer involvement assists w/critical enabling services. Includes comprehensive care coordination (medical & social support services), care management. Warm hand-off.
Duration	2 yrs
Budget	$3,640,000/yr
Target Population	Uninsured, Medically Indigent, Homeless, Underrepresented Ethnic Populations (UREP)
Annual # Clients Served	1,600
Cost per Client 1st Year	$2,275
Description of Integration	Co-site model - Imbed PH & SU services in MH sites; Imbed MH & SU in PH sites – Provides a "home" for people seeking integrated care- "no wrong door" approach to services; "warm hand-off" approach
Integration Approach	Co-location of Services
AODS	Integration w/AODS
Supportive Services	Coordinated care; CM; Medi-Cal/benefits enrollment; Medical &/or MH assessment/screening; System navigation;

	Medication assistance; Peer mentoring/coaching/support; Assist consumers w/wellness plans/goals; Link to resources; Transportation assistance
Staff	Multi-disc. team - Peers, Skilled Care Coordinator, Benefits Establishment Coordinator, Licensed providers (PH, MH, SU), Team Case Managers
Peers	Potential for peer involvement assisting clients w/other services such as transportation, CM, & linguistic support. Peers included on multi-disciplinary team. Peers as staff &/or counselors.
Training	Staff training & Team orientation to the model. Service Provider Management Team will train staff/others who will be screening clients & providing referrals.
Partners/Collaborators	MH, Medical, AODS, peers, community agencies w/specialty services, social services, voluntary associations, immigration services, education services, recreation services
Expected Outcomes	System Change: Integrated care, Service levels/access, Quality of care, Community involvement, Stakeholder satisfaction, Cost; Single sites provide integrated services for MH, PH, SA services Integrated care at common site to improve access & create more efficiency in the person-centered system; Community-based resources are integral service providers

County	**Los Angeles**
Plan Name	Integrated Mobile Health Team Model
Purpose	Increase quality of services, including better outcomes
Project Description	Deploy a mobile, enhanced, integrated & multi-disc. team (includes PH, MH, SA care) to serve individuals w/MI & their families who are homeless, in a shelter, or recently in permanent supportive housing (PSH). Test the value of a single point of management & supervision for the multi-disc. mobile team. Client centered, housing first approach. Uses harm reduction strategies across all modalities of MH, PH, SA. Access through multiple points of entry. Provide outreach & on-going services. Additional services (transportation, follow-up). Use of project-based service voucher. Braiding of funding streams
Duration	2 yrs
Budget	$8,714,238 (2 yrs) ($5,220,024 yr 1 + $3,494,214 yr 2)
Target Population	Individuals/families w/a diagnosis of MI who are homeless, in shelters or recently moved into PSH
Annual # Clients Served	900 individuals & their families
Cost per Client 1st Year	$5,800
Description of Integration	Integrated mobile health team model (includes PH,MH, SU professionals & specially-trained peers)
Integration Approach	Coordinated Care; Peer mentoring/coaching/support
AODS	Integration w/AODS
Supportive Services	Counseling (licensed); Medi-Cal/benefits enrollment; Employment/vocational assistance; Peer mentoring/coaching/support; Link to resources; Transportation assistance; Housing referral or assistance
Staff	PH, MH, SA professionals, housing, benefits eligibility specialists, specially trained peer/family/parent advocates
Peers	Specially-trained peers are included on multi-disciplinary team.
Training	Training for housing/employment/benefit establishment specialists & peer/family/parent advocates
Partners/Collaborators	Affordable housing developers, service agencies, FQHCs, LAC-DMH, Dep't of Health Services, DPH, Alcohol & Drug Program Administration
Expected Outcomes	Homeless people w/PH, MH, SA needs receive integrated services w/single point of administrative supervision; Funding is braided

County	Los Angeles
Plan Name	Community-Designed Integrated Service Management Model (ISM)
Purpose	Increase quality of services, including better outcomes
Project Description	Model seeks to bridge divide between ethnic communities & formal care & non-traditional (community-defined healers) providers by giving communities opportunity to direct how MH, PH, & SA services (& other needed care) are integrated. Uses a multi-disc., holistic team approach. ISM teams will integrate formal & informal provider & community-based resources through community-specific, peer-designed 1) outreach & education, 2) enhanced engagement practices, 3) enhanced linkage & advocacy, 4) facilitation of inter-provider communication. Creates distinct models of care defined by each of 5 communities. Point of entry through various sites (schools, places of worship, clinics, community agencies).
Duration	2 yrs
Budget	$15,997,800 (2 yrs) ($7,998,900 Yr 1)
Target Population	UREP- Ethnic communities: African immigrant/AA, American Indian, API, Eastern European/Middle Eastern & Latino; Families/individuals w/history of dropping out of services, linguistically isolated, not accessed due to stigma
Annual # Clients Served	1,400 families
Cost per Client 1st Year	$5,714
Description of Integration	Integrated service management – PH/MH/SU – multi-disc team approach – focuses on community self-direction for integrated service delivery – collaboration & partnerships between non-traditional services & formal services
Integration Approach	Bi-directional
AODS	Integration w/AODS
Supportive Services	Coordinated care; Peer mentoring/coaching/support; Link to resources; Transportation assistance
Staff	Teams of specially-trained, culturally competent “service integrators”, specially trained peers
Peers	Integrate peers into the model’s mix of formal & non-traditional providers
Training	Provide training, education, & coaching to community organizations & leaders. Train peers to provide outreach, engagement, & linkage services. Training of culturally diverse staff in resources, including multiple self-help peer-run resources, team building, reporting methods & safety issues.
Partners/Collaborators	Regulated entities, contract providers, CBOs, schools, places of worship, PC clinics, peers, BH, AODS, PC, Child Welfare
Expected Outcomes	Community-based resources are integral service providers; Care is integrated across the network of formal & non-traditional MH, SA, PH services; Culturally informed peer based outreach, engagement, linkage, education & training to UREP communities; Regulatory interpretations facilitate access to services provided by non-traditional practitioners

County	Madera
Plan Name	Increase Access from Crisis Services
Purpose	Increase access to services
Project Description	Will employ an integrated team of transition age youth (TAY) & adult/family support specialists to engage clients (& families) at initiation of MH crisis services at the Hospital's Emergency Department. The team will provide engagement services at the ER or after the client is released from being hospitalized.
Duration	3 yrs
Budget	$330,943 (1 yr)
Target Population	Clients/family members at Madera Community Hospital Emergency room who themselves or family members received crisis MH services.
Annual # Clients Served	250

Cost per Client 1st Year	$1,324
Description of Integration	Team & hospital staff work w/consumers experiencing a crisis in the hospital ER, or after the consumer has been discharged
Integration Approach	Linkage w/CBOs
AODS	No AODS integration
Supportive Services	Medical &/or MH assessment/screening; Medication assistance; Peer mentoring/coaching/support; Assist consumers w/ wellness plans/goals
Staff	Trained peers/family, hospital medical staff
Peers	Employs peer/family member support staff, including TAY peer support staff to provide outreach & engagement. Integrate peer/family member support services as an adjunct to the clinical services for people seeking emergency or crisis services at the ER.
Training	Peer, clinical, & clerical staff will be trained to understand & effectively address the needs & values of the particular racial/ethnic, cultural &/or linguistic population or community. Purchase training for peer staff on crisis intervention services & how to provide peer engagement & support to individuals & families. Training would also be provided for the ER staff & other hospital staff.
Partners/Collaborators	Madera Community Hospital, Madera Behavioral Health
Expected Outcomes	Clients seen in the ER or who are hospitalized will access & utilize services at higher rates; Youth & TAY seen at the ER or who were hospitalized will access services at higher rates due to outreach & engagement by a TAY peer provider.

County	Madera
Plan Name	Linkage to Physical Health by Pharmacist and Integration from Mental Health to Physical Health
Purpose	Promote interagency collaboration
Project Description	Pharmacist will work w/ PC physicians & MCBHS staff by linking & coordinating the MCBHS client's MH & PH care. Clients who need physical health services would be referred & coordinated w/PH care as necessary by the pharmacist. Pharmacist will be transitioning those MCBHS clients who are stable & receiving only medication services from a MH home to a "medical home."
Duration	3 yrs
Budget	$19,200 (1 yr)
Target Population	Madera County Behavioral Health Services (MCBHS) clients who are seriously and persistently mentally ill or have a serious emotional disturbance.
Annual # Clients Served	50
Cost per Client 1st Year	$384
Description of Integration	Pharmacist coordinated clients' BH & PH care
Integration Approach	Bi-directional
AODS	No AODS integration
Supportive Services	Coordinated care; Medication assistance; Link to resources
Staff	Pharmacist, PCPs, BH practitioners
Peers	No use of peers as providers
Training	Will provide training to the PC staff (not only including medical, but also support staff) on mental illnesses, stigma, Mental Health First Aid, client culture, etc.
Partners/Collaborators	MCBHS, contracted pharmacist & local PC providers

Expected Outcomes	Increase the # of clients able to get physical health care after the linkage by the pharmacist; PC staff will learn more about MH issues & medications & will be more comfortable w/serving the SMI population; Greater interagency collaboration between PH services & MH.

County	Madera
Plan Name	Integrated Peer Support and Clinical Services in a Rural County Mental Health System
Purpose	Increase quality of services, including better outcomes
Project Description	Co- location of Behavioral Health peer/family member staff &Behavioral Health clinical staff at a newly proposed clinic w/ the Madera rural health clinic (RHC). The peer & clinical staff will work together to meet the needs of clients/family members in an integrated MH & PH setting.
Duration	3 yrs
Budget	$330,079 (1 yr)
Target Population	Madera County residents seeking initial behavioral health services.
Annual # Clients Served	300
Cost per Client 1st Year	$1,100
Description of Integration	Establish a new clinic site that co-locates BH services w/the Madera rural health clinic that includes peer/family member staff
Integration Approach	Co-location of Services
AODS	No AODS integration
Supportive Services	Coordinated care; Peer mentoring/coaching/support
Staff	Peer staff, PCPs & staff, Behavioral Health practitioners
Peers	Includes peer/family member staff to provide support for service engagement. Will work w/clinical staff as equal members of the team.
Training	Rural health clinic staff (including professional & support staff) will be trained in Mental Health First Aid. Training would also be purchased for clinical staff on recovery principles, working w/peer staff as equal members of a team, short-term crisis resolution services & other clinical training as appropriate. Training provided to increase their cultural competency.
Partners/Collaborators	Madera rural health clinic (RHC), peers/community, MCBHS
Expected Outcomes	Increase the access to services for clients & families; Decrease recidivism rates in crisis services & stigma about MH services; Increase the retention rates, access, utilization & retention of MH resources/services

County	Modoc
Plan Name	Taking Integration Personally
Purpose	Promote interagency collaboration
Project Description	Promotes interagency collaboration through development, evaluation & implementation of integrated treatment processes. Develops an approach to integrated MH, alcohol & other drug services & public health w/ strong linkages to PC, social services, collaborative treatment courts & other partners. Develops & tests a process to facilitate integrated treatment delivery for consumers w/co-occurring MH & SU disorders &/or serious medical conditions. Develop an integrated assessment tool/process. Identify models for developing a single, integrated treatment team
Duration	3 yrs
Budget	$253,900 (2 yrs)

Target Population	Individuals w/co-occurring MH diagnoses & SU disorders &/or serious medical conditions
Annual # Clients Served	150
Cost per Client 1st Year	$567
Description of Integration	Integrated treatment processes for consumers. Integration of MH, AODS & public health, w/strong linkages to PC, SS, collaborative treatment courts & other partners. Integration of assessment tools & processes. Ffully integrated team treatment provision
Integration Approach	Bi-directional
AODS	Integration w/AODS
Supportive Services	Coordinated care; Medical &/or MH assessment/screening; Assist consumers w/wellness plans/goals
Staff	Integration Team- consumers & family members, clinicians, nurses, case managers, MH, PH, A&D Services, NP from local health clinic, MH Specialist
Peers	No use of peers as providers. However, the Integration Team will include consumers & family members as full Team members to design/adapt the integrated assessment tool.
Training	Identify training needs to address barriers to consumer-level integrated treatment plans. Will provide training on cultural awareness & cultural responsiveness, w/specialized training provided on Latino & Native American cultures. Training provided in recovery & resilience; client & family member centered approach, stigma, & discrimination. Also provides cross training in organizational culture & language. Training also to be provided on use of assessment tool.
Partners/Collaborators	Sun Rays of Hope Center, Strong Family Health Center, Alcohol & Drug Services, Public Health, Collaborative Treatment Courts
Expected Outcomes	Development of a sustainable model of collaboration that supports behavioral health & holistic health care integration. Development of system changes integral to integrated health care service delivery

County	**Monterey**
Plan Name	Alternative Healing and Promotores de Salud
Purpose	Increase access to underserved groups; Increase quality of services, including better outcomes; Increase access to services
Project Description	Seeks an alternative method of service delivery by using a community health based model in which services & education are offered in a non-clinical, culturally acceptable setting. Dev't of effective PIE & intensive treatment strategies that address the needs of Latinos, including a curriculum & cross-training program developed jointly by Promotores & clinical staff. Culturally relevant education, outreach & engagement methods. Model focuses on addressing cultural barriers individuals have in seeking MH care & deals directly w/addressing stigma around MH (a major barrier in Latino culture)
Duration	3 yrs
Budget	$233,066 (1yr)
Target Population	Latino transition age youth, adults & older adults
Annual # Clients Served	800
Cost per Client 1st Year	$291
Description of Integration	Offers alternative treatment methods – use of holistic medicines; Services will incorporate holistic & culturally relevant approaches to clinical treatment of MH issues
Integration Approach	Other
AODS	No AODS integration
Supportive Services	Coordinated care; Physical health, MH, psycho-social education &/or skill building; Medical &/or MH assessment/screening; Link to resources

Staff	LCSW , community based Promotores, Psychiatrist + Steering committee (includes consumers & family members)
Peers	No use of peers as providers
Training	Cross training- Clinical staff train Promotores on holistic approaches; Promotores train clinical staff on traditional approaches/remedies embedded in Latino culture
Partners/Collaborators	Outreach sites – agricultural worksites
Expected Outcomes	Integrating holistic medicine w/traditional MH practices; Increase skills of MH staff in identifying successful outreach methods to Latino community; Increased # of Latino clients seen throughout the continuum of MH services

County	**Monterey**
Plan Name	Mental Health Evaluation Model, Outcome Data, and Reporting Plan
Purpose	Increase quality of services, including better outcomes
Project Description	An evaluation model to measure consumer utilization, service disparities, program fidelity, integration w/community partners, & Children & Adult systems transformations resulting from CalMHSA initiatives. Client, Program & System level analysis- System level to support system of care integration & community partnership
Duration	1.5 yrs
Budget	$92,976 (1 yr)
Target Population	TA to all programs sponsored by BH
Annual # Clients Served	Not applicable (NA)
Cost per Client 1st Year	NA
Description of Integration	Model measures systems linkages – which inter & intra-agency links are most beneficial to achieving positive consumer outcomes. Aims to share information from the EMR
Integration Approach	Bi-directional
AODS	No AODS integration
Supportive Services	NA
Staff	Obtaining input for model from consumers, family members, clinicians, managers, & service partners/staff, Innovations Program Coordinator
Peers	No use of peers as providers
Training	Train behavioral health program & service managers in participatory evaluation methods & reporting
Partners/Collaborators	Obtain input from consumers, family members, clinicians, managers, service partners
Expected Outcomes	Model provides a framework to examine what is working, to what degree, for whom & why. Knowledge gained will be used to sustain & improve access, equity, positive consumer outcomes, collaborations, integrations & efficiencies. Expand cross-dep'tal collaboration to create a system-wide approach to BH, PH, epidemiology & eventually PC clinics

County	**Monterey**
Plan Name	Positive Behavioral Intervention Supports (PBHS)
Purpose	Increase quality of services, including better outcomes
Project Description	Test a new outcome based framework that measures the effectiveness of instructional & BH practices & interventions. Systems-focused approach aimed at reducing problem behaviors while increasing academic achievement. Pilot w/a local school district.
Duration	3 yrs

Budget	$290,176 (1 yr)
Target Population	School age children & youth & their families
Annual # Clients Served	1,000
Cost per Client 1st Year	$290
Description of Integration	Integration of community/public health services w/a systems-focused approach to increase children & youth's MH & school success
Integration Approach	Linkage w/CBOs
AODS	No AODS integration
Supportive Services	Coordinated care
Staff	District wide PBIS Coordinator, Community/PH staff member - Team approach to include family members & school community members
Peers	No use of peers as providers
Training	School administrative team will work to provide training & implementation for teachers, support staff, family members & student community.
Partners/Collaborators	Public health, Local School district
Expected Outcomes	Increased resilience in youth & families. Increased capacity to reduce disparities in access to MH services. Better communication, coordination & collaboration of services between schools & MH & PH systems

County	**Orange**
Plan Name	Integrated Community Services
Purpose	Increase quality of services, including better outcomes
Project Description	Provides two approaches to integrating PH, MH & alcohol/SA treatments. MH care at PC community clinics using trained consumer MH workers, supervised by licensed MH staff. Provide psych consult to PCPs about prescribing. (Consumers) trained to coordinate & monitor PH care of BH clients at BH sites, Medical Care Coordinator supervised by RNs.
Duration	3 yrs
Budget	$4,162,267 (3 yrs)
Target Population	Transitional age youth, adult & OA w/mild to SMI receiving services either in community medical settings or in county BH settings. Medi-Cal or MSI eligible individuals, Consumers of both PH & MH services who have co-occurring disorders
Annual # Clients Served	800
Cost per Client 1st Year	$1,115
Description of Integration	Two approaches to integrating PH, MH & alcohol/SA treatments. MH care at PC community clinics; PC at MH clinics – Integrated PH & MH services at both BH & PH sites for consumers w/MH & PH diagnoses often w/co-occurring alcohol/SA problems
Integration Approach	Bi-directional
AODS	No AODS integration
Supportive Services	Coordinated care; Medical &/or MH assessment/screening; Peer mentoring/coaching/support
Staff	At PC clinics- Trained consumer MH workers as Peer Mentors & Outreach Workers, Licensed MH staff (supervisors); At MH clinics- Medical Care Coordinators (employed consumers- trained to coordinate & monitor PH care, RNs (supervisors), PCPs
Peers	Employ trained consumer MH workers as peer mentors, & medical care coordinators & outreach workers. Peer mentors will be supervised by licensed MH staff.

Training	Intensive training of consumer & family member employees to become MH workers or medical care coordinators.
Partners/Collaborators	Health Care Agency BH Services, Community clinics
Expected Outcomes	Increased access to MH services for persons w/o insurance. Increased # MH clients who regularly visit PCP. Improved prescribing practices for MH conditions by PCPs. Comparison of use & satisfaction w/PH & MH services by clients who receive them in PH vs MH locations

County	**San Bernardino *(pages 55-190 blank in proposal; info provided below is not complete)***
Plan Name	Holistic Campus
Purpose	
Project Description	Creates one location (non-MH setting) that brings together the County's diverse cultures & communities to address a wide range of MH needs including culturally specific healing techniques (acupuncture, sweat lodges, yoga, healing circles, etc). Hub for local & community-based providers & resources – using cross-cultural & cross-generational strategies
Duration	3 yr
Budget	$1,769,180 (3 yrs)
Target Population	
Annual # Clients Served	
Cost per Client 1st Year	
Description of Integration	Establish single site for diverse communities & cultures to provide culture specific healing & to address other needs
Integration Approach	Co-location of Services
AODS	
Supportive Services	Peer mentoring/coaching/support; Link to resources
Staff	Peers, Advisory board including community representatives
Peers	80% peer operated
Training	
Partners/Collaborators	
Expected Outcomes	Discover how people from diverse communities & ethnicities learn from each other & work together

County	**San Diego**
Plan Name	Physical Health Integration Project
Purpose	Increase quality of services, including better outcomes; Promote interagency collaboration
Project Description	Proposes an innovative collaboration or "twinning" between an existing MH clinic & local PC clinic to create a new patient-centered medical home for stable SMI individuals in a PC setting. Transition stable SMI clients in MH system to a PCMH. Includes providing psychotropic MH care monitoring & PH care services in an integrated PC setting
Duration	3 yrs
Budget	$1,600,000 (2 yrs)
Target Population	300 transition age youth, adults & older adults w/SMI who are clients in an outpatient MH clinic; 300 transition age youth, adult & older adult clients w/BH services at a PC clinic site; Refugee & immigrant community
Annual # Clients Served	600
Cost per Client 1st Year	$1,417
Description of Integration	Integration of PH & BH to create a client-centered medical home for individuals with SMI. BH integrated into PC clinic –

	client centered pathway for referrals of MH clients from PC & MH clinic. Incorporation of a BH Consultant into a PC clinic team. Integration of RN Care Coordinator at the MH clinic site. Placement of ADC w/in each team & site to assist w/the integrated treatment of individuals w/co-occurring disorders
Integration Approach	Co-location of Services
AODS	Integration w/AODS
Supportive Services	Coordinated care; Medical &/or MH assessment/screening; Medication assistance
Staff	BH Consultant, Psychiatrist, RN Coordinator, Alcohol/Drug Counselor (ADC), Project Manager, Adm. Support
Peers	No use of peers as providers
Training	Education & training for all staff at PC clinic to reduce stigma, increase cultural competence, etc
Partners/Collaborators	Children's, Adult, & Older Adult System of Care Councils
Expected Outcomes	Outcome measures include: effective treatment & improved outcomes for clients served by PCMH; improved MH outcomes due to integrated treatment & disease management support; # of emergency service visits of referred clients for both MH & PH issues.

County	**San Mateo**
Plan Name	Total Wellness ***(approval pending)***
Purpose	Increase quality of services, including better outcomes
Project Description	Delivering integrated PC/BH care services at behavioral care clinics utilizing trained consumers & family members as Health & Wellness Coaches partnering w/other team members to help participants manage their health conditions. Using MH/SU entry point as entry point for SMI participants into PC. Builds upon & supports the practices of NPs currently located in BHRS clinics. Health & Wellness Coaches play a key role in care management by partnering w/other team members (Nurse Care Managers, Nurse Practitioners) to assist clients w/communication & advocacy w/medical providers, health ed & support.
Duration	3 yrs
Budget	$1,107,640 (1 yr)
Target Population	SMI individuals w/chronic health conditions
Annual # Clients Served	1,200
Cost per Client 1st Year	$923
Description of Integration	Integration of PC & BH care services at BH clinics. Includes regular screening & tracking of health status, nurse care managers who assure preventive clinical screening & engagement in a PCMH & peer Health & Wellness Coaches to assist consumers in the management of their health conditions
Integration Approach	Co-location of Services
AODS	No AODS integration
Supportive Services	Coordinated care; Medical &/or MH assessment/screening; Peer mentoring/coaching/support; Link to resources; Transportation assistance; Self-management
Staff	Project Director-Project Anchor (Community Health Planner), Nurse Practitioners, Supervising Physician, Nurse Care Managers, Patient Services Assistant, Medical Services Assistant, MH Counselor, Pharmacist, Research & Evaluator, Dietician, QI Consultant, Health & Wellness Coaches
Peers	Peers are trained as "Health and Wellness Coaches" to assist consumers in the management of their health conditions & facilitate wellness groups. They will partner w/nurse care managers.
Training	Utilizes trained "Peer Health and Wellness Coaches"

Partners/Collaborators	MHSA Recovery Board, Community & Internal partners
Expected Outcomes	Increase access to & utilization of PC, specialty services & wellness groups among SMI program participants. Improve the health status of SMI individuals who suffer chronic health conditions

County	Santa Barbara
Plan Name	Benefit Acquisition for High-Risk Indigent Individuals
Purpose	Increase quality of services, including better outcomes; Promote interagency collaboration
Project Description	Adapts benefits counseling programs currently practiced in MH & other health & social service systems (including SOAR model) for homeless persons with SMI. Develop & access the use of two benefits acquisition (bilingual/bicultural) teams (in North & South County) in providing comprehensive supportive services to clients in the process of obtaining benefits. Provide benefits access assistance (income & medical insurance benefits), CM, psychiatric care, peer supports, medication support.
Duration	3 yrs
Budget	$2,948,000 (3 yrs)
Target Population	High-risk indigent persons w/severe & persistent MI who are uninsured
Annual # Clients Served	300
Cost per Client 1st Year	$3,053
Description of Integration	Combines benefits counseling w/integrated recovery-oriented supports provided by a multi-disc team, including peer support, CM, medication support & access to wraparound services. Also assists persons w/SMI leaving jail to obtain benefits.
Integration Approach	Bi-directional
AODS	No AODS integration
Supportive Services	Coordinated care; Counseling (licensed); Case management; Medi-Cal/benefits enrollment; Support groups; System navigation; Medication assistance; Peer mentoring/coaching/support; Assist consumers w/wellness plans/goals; Link to resources; Self-management
Staff	Peer Support Specialists, Practitioners/Interns, Psychiatrist, Homeless Discharge Planner at jail.
Peers	1 FTE Peer Specialist at each of the two sites. Will provide peer-to-peer support to keep each client engaged during the benefits acquisition process. Will serve on multi-disc teams.
Training	Team members receive training in SSI/SSDI Outreach, Access & Recovery (SOARS) developed by SAMHSA. Staff will participate in cultural competency training offered annually
Partners/Collaborators	Santa Barbara Co. Dep't of Alcohol, Drug & MH Services, CARES (Crisis & Recovery Emergency Services), Recovery Learning Centers, SSA, MH Cooperative, General Relief, DSS, PH, Jail - Emphasis place on collaboration across all sectors that come in contact w/high risk groups. Also includes housing, law enforcement, immigrant advocacy, workforce development, etc. Coordinate efforts towards a "system without cracks."
Expected Outcomes	High risk indigent persons w/SMI acquire benefits & gain services & supports to assist w/recovery. Greater # of interagency contacts. Better knowledge of workings of other agencies

County	Santa Clara
Plan Name	Early Childhood Universal Screening Project
Purpose	Increase access to services; Promote interagency collaboration
Project Description	Strengthening the screening & referral process for young children w/developmental disabilities & social emotional delays. Provides a new method of pediatric MH screening, parent education & referral. Develop & tests parent administration of electronic MH screening models using kiosks in public pediatric clinic settings. Pilots a Spanish audio component of the ASQ-III to increase use by monolingual & LEP Spanish families. Provides immediate written electronic communication of screening results & linkages to evaluations & services.
Duration	2 yrs
Budget	$170,158 (1 yr) + $235,127 (yr 2) + $97,970 (yr 3) = $503,254 (plan states duration is 2 yrs, but budget requests funds for 3 yrs)
Target Population	Children ages 0-5 & their parents/caregivers – largely from underserved ethnic communities who receive care at County clinics or partner clinics
Annual # Clients Served	700
Cost per Client 1st Year	$243
Description of Integration	Pediatric MH screening linking parents & their children to MH & other indicated services. Improves collaboration between pediatricians & BH professionals.
Integration Approach	Other
AODS	No AODS integration
Supportive Services	Physical health, MH, psycho-social education &/or skill building; Medical &/or MH assessment/screening
Staff	MH Clinician (Care Manager), pediatrician
Peers	No use of peers as providers
Training	“Complete all necessary training.” No further training specified.
Partners/Collaborators	Santa Clara Valley Health & Hospital System, First Five
Expected Outcomes	Design of a sustainable MH screening system (includes parent ed & referral) for pediatric clinic setting. Strengthening the screening & referral process for young children w/developmental disabilities & emotional delays

County	Solano
Plan Name	Community Access to Resources and Education (CARE)
Purpose	Increase access to underserved groups
Project Description	Brings a range of MH services/ interventions (assessment, direct MH services, CM help w/PC/BH integration) to locations where people go for other health & social services (family resource centers, homeless shelters, PC). Taking MH services out of the traditional MH clinic setting & bringing them into the community. Provides a flexible, well-focused model for building the capacity of community providers
Duration	3 yrs
Budget	$1,078,300 (1 yr)
Target Population	Vulnerable populations- geographically distant, underserved ethnic, non-English speaking Latino & Filipino, uninsured & underinsured, LGBTQ, homeless & transitioning people
Annual # Clients Served	520
Cost per Client 1st Year	$2,074
Description of Integration	Bring MH services to agencies where people are already accessing other health & social services (FRCs, homeless

	shelters, PC sites). Key components include education & consultation to providers including PCP on MH treatment options, visits to community locations to provide direct MH services. Implementing community-based MH services. Providing a "one stop shop" will integrate the client MH service experience w/that of health care & basic needs
Integration Approach	Coordinated Care
AODS	No AODS integration
Supportive Services	Coordinated care; Case management; Medical &/or MH assessment/screening; Support groups; Medication assistance; Link to resources; Transportation assistance
Staff	Team- Psychiatrist, MH Nurse, Licensed Clinician, MH Specialist, Eval Consultant
Peers	No use of peers as providers
Training	Provides for education & consultation to providers, including PC doctors, on MH treatment options, & "training in evidence based practices."
Partners/Collaborators	Numerous & varied community partners (not specified)
Expected Outcomes	Partnering w/community providers increases their capacity to provide MH services to underserved groups. Increased awareness of MH symptoms that may present in a community or PC setting. Increased knowledge of intervention & treatment options. Increased # underserved individuals receiving MH services in the community & PC setting

County	**Sonoma**
Plan Name	Three-Pronged Integrated Community Health Model
Purpose	Increase quality of services, including better outcomes
Project Description	Adapts & blends two existing models- 1) PC & BH integration & 2) peer-based community health education (promotores model). Increases the capacity of FQHCs to deliver MH services to adults living with SMI who are homeless &/or who have co-occurring disorders by strengthening the connection of MH consumers to other consumers & to MH staff & practitioners. Expands the roles of people w/lived experience of MI in the design & delivery of integrated BH & PH care. Client-centered, holistic approach that incorporates community health education strategies as a core component of PC & BH service provision. Provides health education services at clinic site & off-site locations (shelters, group homes). Health education curriculum tailored to addressing the unmanaged PH conditions of persons living w/SPMI.
Duration	3 yrs
Budget	$1,861,315 (3 yrs)
Target Population	Individuals w/SMI w/1 or more co-occurring physical health condition
Annual # Clients Served	300
Cost per Client 1st Year	$1,000
Description of Integration	Interface of PC, BH & SU treatment. Goal of team is to address unmanaged physical health conditions that lead to early morbidity for consumers living w/SPMI.
Integration Approach	Coordinated Care
AODS	No AODS integration
Supportive Services	Coordinated care; Physical health, MH, psycho-social education &/or skill building; System navigation; Peer mentoring/coaching/support; Assist consumers w/wellness plans/goals; Link to resources; Self-management
Staff	Integrated, multi-disc team - peer health educators, physicians, psychiatrists, nurses, BH clinicians, & care managers
Peers	Peer health educators to serve on multi-disc team. The health education component will be co-designed & operated by peers w/lived experience of MH issues. Peer staff will meet regularly w/consumers to reinforce health education messages & to support navigation of the full spectrum of integrated services. Integrate peers in the dev't of client-centered, individualized care plans that address the full spectrum of health issues.

Training	Identify/locate or develop training material for integrating a culturally responsive health ed & promotion team. Provide training for consumer & non-consumer staff in developing working relationships. Trainings will be conducted w/ team members & core partners to ensure services are culturally & linguistically appropriate.
Partners/Collaborators	FQHCs & rural health clinics, SA prevention & treatment programs, Orenda Center (detox), Goodwill Industries, West County Community Services
Expected Outcomes	Improved physical health outcomes for consumers living w/SPMI

County	**Tuolumne**
Plan Name	Building a Life at Home Innovation Project
Purpose	Promote interagency collaboration
Project Description	Collaboration between BH Dept, consumers & families, representatives of Spanish-speaking & Native American residents & diverse stakeholders (Public Guardian, APS, law enforcement, etc) who all play a part in the decision to conserve SMI residents in LT residential facilities or who would refer them for more restrictive services. Task Force will address issues related to MI & alternatives to high level placements & oversee the dev't, implementation & assessment of best practice CM (emphasizing peer recovery & resiliency strategies). Service component includes a pilot of intensive CM & peer recovery services
Duration	3 yrs
Budget	$1,049,346 (3 yrs)
Target Population	MI consumers currently living at home but requiring a higher level of care; SMI peers residing in residential facilities that need to return home; SMI peers who have experienced at least 1 hospitalization &/or psych emergency visit
Annual # Clients Served	60
Cost per Client 1st Year	$5,416
Description of Integration	Develop an effective community collaborative partnership that will work together to improve & strengthen coordination & collaboration & reduce stigma between MH & varied stakeholders
Integration Approach	Other
AODS	No AODS integration
Supportive Services	Case management; Physical health, MH, psycho-social education &/or skill building; Support groups; Medication assistance; Peer mentoring/coaching/support; Assist consumers w/wellness plans/goals; Link to resources; Transportation assistance; Housing referral or assistance
Staff	Case Managers, Nurse CM, LPS CM, Clinical Program Manager, Recovery Counselors
Peers	Client-driven peer support services & activities. Hire 3 FT CM staff, including a nurse case manager w/a preference for peers. Refers to consumers/clients being served as "peers."
Training	CM trained in peer recovery, wellness & resiliency model; On-going education & training regarding stigma & mental illness & information about intensive CM & peer recovery services.
Partners/Collaborators	Consumers & families, representatives of Spanish-speaking & Native American residents, & diverse stakeholders (Public Guardian, APS, law enforcement, etc)
Expected Outcomes	Shift/Change cultural attitudes & beliefs in community systems. Create new planning process across range of social service agencies. Reduce high # of permanent conservatorships. Build community capacity to better support MI consumers