



SAN MATEO COUNTY HEALTH

## BEHAVIORAL HEALTH & RECOVERY SERVICES

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# Mental Health Services Act (MHSA) Innovation Project Plan

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**County Name:** San Mateo

**Date submitted:**

**Project Title:** Addiction Medicine Fellowship in a Community Hospital

**Total amount requested:** \$591,650 (\$471,000 services; \$70,650 admin; \$50,000 eval)

**Duration of project:** 3.9 years

### Section 1: Innovations Regulations Requirement Categories

#### GENERAL REQUIREMENT:

*An Innovative Project must be defined by one of the following general criteria:*

- 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.*

- 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.*

#### **Addiction Related Co-Occurring Conditions**

Addiction to drugs and alcohol affects more than 23 million Americans and continues to rise.<sup>1</sup> Although addiction is the leading cause of preventable illness and death in the United States and contributes significantly to healthcare costs, only 10% of people with addiction receive any type of treatment, and far fewer receive life-saving medications. In San Mateo County, it is estimated that 30% (12,164) of emergency and psychiatric emergency visits and 18% (449) of hospital admission where by people with substance use disorders (SUD). According to the National Institute of Health, “multiple national population surveys have found that about half of those who experience a mental illness during their lives will also experience a substance use disorder and vice versa.” Co-occurring substance use disorders are present in 40-50% of clients seen in our San Mateo County Edison Clinic for complex behavioral health and medical health related to HIV, as well as 95% of youth detained at the Youth Services Center. Addiction is highly prevalent in behavioral health and recovery clinics, correctional health and primary care and specialty clinics that treat behavioral health related conditions.

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***Primary Problem: Workforce Capacity to Address  
the Rising Addiction-Related Conditions***

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#### **Addiction Medicine Workforce in the Public Sector**

Now more than ever, with the opioid crisis, having addiction treatment is critical. The current addiction treatment workforce is severely under-equipped to meet the needs of the millions of Americans living with SUD. While San Mateo Health has made great strides in expanding treatment for addiction, many local providers have inadequate training in addiction medicine, and treatment sites are often siloed and in need of broader coordination and integration. In the entire San Mateo Health, including Behavioral Health and Recovery Services (BHRS), there are fewer than ten providers who prescribe medications for opioid use disorder, even though these medications cut the mortality rate in half. Our pain clinic had hopes of hiring an addiction specialist, but due to the inadequate number of such specialists, the position has remained unfilled for three years. It is hoped that an addiction medicine fellowship focused on co-occurring mental health and substance use disorders in a county/community setting would advance us towards the goal of providing high quality, coordinated treatment of addiction.

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<sup>1</sup> Defining the Addiction Treatment Gap, Open Society Foundations (2010).



In San Mateo County, the largest need for addiction medicine expertise is in primary care where providers need to take on a greater share of treating people with co-occurring behavioral health and substance use conditions. Behavioral health and recovery staff and contractors work closely with primary care to support clients in their treatment. Ideally, once a primary care client is stabilized, they should be able to transition treatment back to their primary care providers, so that BHRS staff and contractors can continue to have the capacity for assessing and stabilizing new clients, as well as resuming care for destabilized clients; however, most primary care providers are not comfortable treating even our stable clients.

*“Your [proposed] program is breaking new ground and demonstrating that all stakeholders are needed to address our state and national addiction medicine workforce needs.”*

- Executive VP at American College of Academic Addiction Medicine (ACAAM)

Addiction Medicine Fellowships prepare medical providers with the training they need to recognize and treat patients with substance use disorders. There are currently over 60 accredited addiction fellowships; all sponsored by academic centers, the Veterans Administration, and nonprofit organizations such as Kaiser Permanente. The very first 11 Addiction Medicine Fellowships in academic centers were the model for the rest. Having an Addiction Medicine Fellowship housed within a county government entity can be a model for all of California's 58 counties to train their respective workforce in addiction medicine specific for their populations.

## PROPOSED PROJECT

*Describe the INN Project you are proposing.*

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

The proposed project is an accredited Addiction Medicine Fellowship sponsored by San Mateo County that is tailored to addressing the needs and priorities of the public sector including treating the most vulnerable communities with co-occurring substance use disorders, advancing equity on multiple levels and contributing to educational projects in clinical and community settings.

#### *Addiction Medicine Fellowship*

Addiction Medicine Fellowships are a promising approach for addiction treatment workforce development.<sup>2,3</sup> These fellowships are multispecialty training programs that focus on the provision of care for persons with unhealthy substance use, SUD and other addictive disorders. An Addiction Medicine Fellowship targets candidates from all the major medical fields, such as internal medicine, family medicine, emergency medicine, and psychiatry, which can provide Counties the flexibility to choose candidates depending on where the need is greatest at a given time. For example, one

<sup>2</sup> Rasyidi E, Wilkins JN, Danovitch I. Training the next generation of providers in addiction medicine. *Psychiatr Clin North Am.* 2012;35(2):461-80.

<sup>3</sup> Ayu AP, Schellekens AF, Iskandar S, Pinxten L, De jong CA. Effectiveness and Organization of Addiction Medicine Training Across the Globe. *Eur Addict Res.* 2015;21(5):223-39.



year a physician from family medicine may be accepted, and another year a physician from psychiatry. Fellowship graduates would add to the county and state workforce in addiction medicine, providing expert addiction care to our co-occurring clients and valuable consultation to colleagues.

It is estimated that the minimum number of addiction medicine fellowships needed to meet the projected need of addiction physicians in the U.S. is 125. Even this is small compared to other specialties--sports medicine, for example, has 235 fellowships. They were created out of recognition of addiction as a disease and that people with addiction are vastly underserved. There are Addiction Medicine Fellowships in the Bay Area offered through Stanford, Kaiser Permanente, and UC San Francisco area yet, the experience of a public sector sponsored fellowship will be fundamentally unique because of the larger system of care context. One of the core competencies of Addiction Medicine is Systems Based Practice<sup>4</sup>, which includes recognizing the multi-dimensional components of the systems required to reduce the incidence and impact of addiction and substance-related health conditions, among others. A public sector sponsored fellowship will immerse fellows in a unique system to which few if any fellows will get similar exposure. If Addiction Medicine is to impact public health, a fellowship in a public health system will provide significant impact.

#### *Community-level opportunities and training*

San Mateo County Health serves safety net populations and while other academic center-run fellowships have components that serve safety net populations, no other program would include on the ground, community services like a public health entity. In San Mateo County, one particular element, that is an example of this, is the elective "street medicine" experience with the homeless and farmworkers. Fellows will also be assigned to engage in at least one advocacy activity outside their usual work responsibilities that focuses on building opportunities for community change; examples include becoming a board member of a local substance use organization or speaking at a school-based mental health conference. This could be a training experience that could serve as a model for others.

#### *Health Equity and Cultural Humility*

The addiction medicine fellow would participate in structural humility and advocacy trainings including Cultural Humility 101, Sexual Orientation and Gender Identity (SOGI), and Working with Interpreters. The psychiatry residency program under which the fellowship would be housed is cutting-edge in its active teaching of structural humility and promotion of physician work to advance health equity on multiple levels. In addition to their clinical work with a diverse population, residents engage in learning sessions across disciplines (health providers, community workers, policy advocates) to review health disparities in our communities and find opportunities for intervention at the individual, institutional, and policy levels. These include a session on health disparities in San Mateo and Culturally and Linguistically Accessible Services (CLAS) standards, two sessions on health policy and advocacy and one session on NAMI with a consumer panel and then an experiential community engagement session.

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<sup>4</sup> <https://www.abam.net/become-certified/core-competencies/>



### Project implementation activities:

- Establish program infrastructure - letters of agreement with rotational sites for fellowship and schedules, faculty supervision, clinical competency committee, program evaluation committee, policies and procedures, etc.
- Startup activities - hire program coordinator, develop training materials, identify professional development opportunities, develop website content, secure office space and supplies, etc.
- Promote fellowship, review applications, interview and hire an Addiction Medicine fellow.
- The Addiction Medicine Fellow, will:
  - Provide a new Medication Assisted Treatment (MAT) consultation service in the hospital. This service will coordinate care with the Psychiatry consultation service. Engaging patients in the hospital will provide an early start to treatment and increase subsequent outpatient engagement.
  - Add to the workforce of the team providing integrated treatment of co-occurring addiction and mental health disorders within the primary care setting. This team has received over 3000 referrals since 2015.
  - Provide psychiatric and substance use disorder evaluations and treatment in the HIV Clinic and Pain Clinic, both of which have a high percentage of patients with co-occurring disorders. Currently these clinics offer mental health treatment but lack expertise in treating co-occurring addiction.
  - Provide psychiatric and substance use disorder evaluations and treatment on the Street Medicine team, which treats both the homeless and farmworkers.
  - As an elective, assist with implementation of MAT in Correctional Health, where many inmates have co-occurring disorders.
  - Provide training in substance use disorders and co-occurring disorders to other providers and clinicians.

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

- Increases the quality of mental health services, including measured outcomes**



**C) Briefly explain how you have determined that your selected approach is appropriate.**

Based on a comprehensive review of the needs in addiction-related conditions and treatment, the following key considerations were identified:

1. *Workforce capacity:* considering the current opioid crisis and the prevalence of co-occurring mental health and substance use conditions amongst behavioral health care clients, the current addiction treatment workforce is severely under capacity to meet the needs of co-occurring clients.
2. *County government context:* County services are on the ground in the community providing safety net services and early intervention. An addiction fellowship sponsored by the County should be developed to leverage these learning opportunities for fellows.
3. *Behavioral health equity and cultural humility:* core principles for behavioral health include cultural humility and advancing behavioral health equity. An addiction fellowship sponsored by the County will need to be integrated into the active teaching of structural humility and reducing health disparities.

These considerations are the supporting evidence for the proposed intervention and selected approaches for this project. Appendix 1. Theory of Change illustrates the pathways between these three key considerations, the interventions or activities, expected outcomes, and learning objectives.

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

As mentioned earlier, in FY 2017-18, 30% (12,164) of emergency and psychiatric emergency visits and 18% (449) hospital admissions were by people with SUD. Additionally, 33% (4,950) of behavioral health clients were identified co-occurring but it is believed that it is more likely 60-80% of behavioral health clients (15,000) are co-occurring. Based on current San Mateo County outpatient visits and consultation with other Bay Area fellowship directors, the expected impact is as follows:

- 1,400 combined initial evaluations and follow-up visits per year
- Increase engagement with outpatient care after hospital discharge
- Decrease visits to Emergency Department and Psychiatric Emergency Services
- Decrease hospital admissions
- Decrease alcohol, tobacco, and illicit drug use (measured by self-report and urine drug screens)
- Improved mental health (measured by mood and anxiety scales)





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

BHRS offers services primarily for individuals who are eligible for Medi-Cal or Medicare, as well as to those individuals of the safety net population who are not eligible for Medi-Cal or Medicare. BHRS provides services to approximately 15,000 individuals annually. Of those individuals referred to our Integrated Medication Assisted Treatment program in 2016-2017, 77% identified as male, 23% as female; 50% were White, 38% Hispanic, 6% Black, 2% Asian, and 4% Other; Primary language was 80% English, 17% Spanish, 3% Other; 25% were homeless. At the integrated primary care outpatient clinic where the fellow will practice, 85% are Hispanic.

## 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?**

This Addiction Medicine Fellowship would be the first to be sponsored by a County entity. The key differences with the proposed project are as follows:

- Sponsored and fully implemented within a County government entity to develop specific workforce capacity and skills, increasing access to treatment.
- Experiences and expectations of the fellows are integrated within the context and priorities of behavioral health. For example, fellows can collaborate with street medicine to provide treatment to farmworkers, fellows will be expected to participate in one advocacy activity and health disparity learning sessions.

**B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.**

The literature review identified research gaps on these subjects and areas of focus for this project.



Gaps in the literature and practice	Proposed intervention
<p>A review of the list of accredited addiction medicine fellowships in the US reveals none housed in a county entity. Correspondence with Executive Vice President of Academic College of Academic Addiction Medicine (ACAAM) ,(formerly The Addiction Medicine Foundation (TAMF), confirmed we would be the first addiction medicine fellowship housed in a county entity.</p>	<p>The proposed project would create an addiction medicine fellowship in our county health system, housed under our community psychiatry residency program.</p>
<p>A more in-depth review of the fellowship rotations reveals a lack of on the ground community services and health equity intervention experiences.</p> <ul style="list-style-type: none"> <li>• Stanford Psychiatry outpatient clinics do not accept Medi-Cal or our locally funded health care program for low-income adults.</li> <li>• The UCSF fellowship serves safety net patients but accepts candidates only from Internal Medicine and Family Practice, not Psychiatry.</li> <li>• Kaiser rotations are within the Kaiser hospital and clinics.</li> <li>• The VA fellowship accepts only Psychiatry candidates and the rotations are within the Veterans Administration system, Kaiser, and Alta Mira (a private treatment center).</li> </ul>	<p>The proposed project will provide the fellows with the context and priorities of community behavioral health. For example:</p> <ul style="list-style-type: none"> <li>• Elective "street medicine" experience with the homeless and farmworkers</li> <li>• advocacy activity such as becoming a board member of a local substance use organization or speaking at a school-based mental health conference</li> <li>• review of local health disparities and identify opportunities for intervention</li> </ul>

Links used to gather information:

- <https://www.abam.net/>
- <https://www.asam.org/>
- <https://www.acgme.org>
- <https://www.abam.net/become-certified/core-competencies/>
- <https://www.acaam.org/wp-content/uploads/2019/08/Fellowship-Directory-8-2-19.pdf>





## 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?**

#### Learning Goal #1

- Does an addiction medicine fellowship sponsored by a County government entity improve workforce capacity and skills in terms of coordination and integration of addiction treatment?

#### Learning Goal #2

- Does an addiction medicine fellowship sponsored by a County government entity engage fellows in community and/or advocacy opportunities?

#### Learning Goal #3

- Does an addiction medicine fellowship within a cultural humility structure increase access to diverse minority clients?

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

As stated prior, the two key differences with the proposed project include:

- Sponsored and fully implemented within a County government entity to develop specific workforce capacity and skills. (*Learning Goal #1*)
- Experiences and expectations of the fellows are integrated within the context and priorities of behavioral health. (*Learning Goal #2 and #3*)

The learning goals are directly connected to the needs, strategies (including the approaches that are new in the proposed project) and outputs as depicted in Appendix 1. Theory of Change.



## 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 coordinator 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.

### Learning Goal #1

- Does an addiction medicine fellowship sponsored by a County government entity improve workforce capacity and skills in terms of coordination and integration of addiction treatment?

The outputs for Learning Goal #1 could include:

- Number co-occurring clients served
- Number of co-occurring client visits per month
- Percent improvement as measured by\
  - Decreased hospitalizations
  - Decreased ED/PES visits
  - Increased engagement in outpatient care (# visits)
  - Decreased alcohol, tobacco, and drug use (self-report and drug screens)
  - Improved mental health (mood and anxiety scales)
  - Qualitative survey of other providers in contact with fellow

Additionally, demographics of participants and quality of life indicators can be collected at intake. Key interviews with addiction treatment providers and staff that typically support the providers with substance use treatment

### Learning Goal #2

- Does an addiction medicine fellowship sponsored by a County government entity engage fellows in community and/or advocacy opportunities?

The outputs for Learning Goal #2 could include:

- Number of community opportunities and types that fellows participate in

Additionally, interviews with fellows can help us determine the level of engagement, the level of confidence in impacting community, policy, etc. and satisfaction with the fellowship.



### Learning Goal #3

- Does an addiction medicine fellowship within a cultural humility structure increase access to diverse minority clients?

The outputs for Learning Goal #3 could include:

- Number of completed trainings by fellows and titles
- Number of learning sessions attended by fellows
- Pre/post knowledge, attitude, behavior questionnaire for fellows
- Demographics of clients served
- Client satisfaction

Additionally, the interviews with the fellows can also include questions related to training (learnings, satisfaction, etc).

## 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?*

Services will be provided in-house except for evaluation. All BHRS service agreements/contracts are monitored by a BHRS Manager. Evaluation contracts are monitored in a similar fashion by the MHSA Manager in collaboration with the assigned BHRS Manager.

### COMMUNITY PROGRAM PLANNING

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

In San Mateo, the CPP process for Innovation Projects begins with the development of the MHSA Three -Year Plan. A comprehensive community needs assessment process determines the gaps, needs and priorities for services, which are used as the basis for the development of Innovation projects. Appendix 2 illustrates and describes the Three-Year Plan CPP process for San Mateo County.



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Between February and March 2019, a broad solicitation of innovation ideas was launched. Both a flyer and an MHSAs Innovation Idea Form were circulated through various means:

- Flyers are sent to/placed at County facilities, as well as other venues like family resource centers and community-based organizations;
- 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 1,500 community members and partners;
- Word of mouth on the part of committed staff and active stakeholders,
- Postings on a dedicated MHSAs webpage [smchealth.org/bhrs/mhsa](http://smchealth.org/bhrs/mhsa), the BHRS Wellness Matters bi-monthly e-journal and the BHRS Blog [www.smcbhersblog.org](http://www.smcbhersblog.org)
- MHSAs Innovation brainstorming sessions held with groups that requested it (Lived Experience Workgroup, MHSARC Older Adult Committee).

The MHSAs Innovation Idea Form requested narrative on the proposed idea/project and information to ensure the idea meets the requirements for Innovation funding. Additionally, in San Mateo County we had the requirement that the idea address the MHSAs Three-Year Plan prioritized needs:

- Engagement and integration of older adults across services and prevention activities
- Culturally relevant outreach and service delivery
- Integration of peer/family supports across services and prevention activities
- Integration of co-occurring practices across services and prevention activities
- Engagement services for transition-age youth (mentoring, education, peer support)
- Broader housing options to support individuals across the continuum of care

We received 35 MHSAs Innovation Idea Forms, which speaks to the need for innovation in serving some of our most vulnerable communities' needs. All submitted ideas were pre-screened against the Innovation requirements, twenty-one were moved forward to an MHSAs Innovation Selection Committee. The committee was made up of diverse clients, family members, community service providers and staff. All projects were reviewed and prioritized by the committee and included an Impact/Effort assessment and scoring. Five proposed Innovation ideas moved forward to develop into full Innovation project proposals for approval by the Mental Health Oversight and Accountability Commission (MHSOAC).

On October 2, 2019, the MHSAs Steering Committee met to review the 5 project ideas and provide comment and considerations for the projects. The MHSARC voted to open the 30-day public comment period, all comments will be included in Appendix 3. [This section to be updated following the 30-day public comment process].

## MHSAs GENERAL STANDARDS

*Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSAs 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 planning and implementation of the fellowship would bring together stakeholders from all parts of the system in order to provide both state of the art training for the fellow and addiction treatment for our clients.

### **B) Cultural Competency**

The training context for fellows will include cultural humility and health equity concepts. This will support culturally responsive services for some of the most vulnerable clients.

### **C) Client/Family-Driven**

Client recipients of services will be driving the services provided. Clients and family members will be engaged in an advisory capacity. The evaluation contractor will gather input on the evaluation questions and strategies, develop quarterly progress reports to share preliminary findings and gather input from an advisory group made up of clients and family members. The Mental Health Substance Abuse and Recovery Commission Adult Committee, which is made up of clients, family members and providers will be an ideal resource for this role.

### **D) Wellness, Recovery, and Resilience-Focused**

Supporting wellness, recovery and resilience is accomplished through relationships and social networks, flexibility, respect and responsiveness, and taking a wholistic approach that considers overall health, stable housing, independence, etc. These principles are key to the strategies of the proposed project, addiction medicine believes that people can recover and supports individuals through their recovery.

### **E) Integrated Service Experience for Clients and Families**

Pre-launch planning will be critical to offering an integrated service experience for recipients. Fellows will need to be well-informed on the full range of services at BHRS and the community and build relationships with gatekeepers to ensure a coordinated referral and warm hand-off process.

## **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.*

As mentioned earlier, the evaluation contractor will engage an advisory group of diverse clients, family members and providers to gather input on the evaluation questions, strategies and on quarterly progress reports. Cultural and language demographics will be collected and analyzed as part of the quarterly reports to ensure 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.*

The advisory group will be engaged in the evaluation and adjustments of the project. In addition, the MHSA Steering Committee will be a venue for vetting next steps with diverse stakeholders. If the evaluation indicates that the proposed project is an effective means of improving the quality of services for individual with co-occurring conditions, and there is availability of MHSA Community Services and Supports, General Systems Development funding, a proposal of continuation would be brought to the MHSA Steering Committee and the Mental Health and Substance Abuse Recovery Commission for approval and to a 30-day public comment process to secure ongoing MHSA funding. A sustainability plan will be developed.

## 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](http://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 1,500 subscribers.

The BHRS's e-journal, Wellness Matters is published the first Wednesday of every other 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 monthly Mental Health and Substance Abuse and Recovery Commission meeting at the 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.**

- Addiction Medicine
- Addiction Medicine Fellowship
- County Addiction Medicine Fellowship

## TIMELINE

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

February 1, 2020 – December 31, 2023

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

3.9 years;

- 5 months of BHRS administrative project start-up through June 30, 2020
- 3 years of project implementation through June 30, 2023
- 6 months for final evaluation report due December 31, 2023

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

The timeline will be negotiated and finalized with the contracted partner agency and may change during implementation:

February 1, 2020 – June 30, 2020

- BHRS Administrative startup activities – establish letters of agreement with rotation sites, finalize schedules, identify faculty supervision, clinical competency committee, program evaluation committee, policies and procedures, etc.

July 1, 2020 – September 30, 2020

- Hire Program Coordinator to oversee the program
- Startup activities - developing training materials, identifying professional development opportunities, developing website content, securing office space and supplies, etc.
- Promote fellowship, review applications, interview and hire an Addiction Medicine fellow.
- Evaluator to meet with advisory group, evaluation committee and BHRS staff to discuss evaluation plan and tools

October 1, 2020 – December 31, 2020

- Evaluation plan finalized including data collection and input tools



January 1, 2021 – March 31, 2021

- Onboarding of Fellow #1- orientation, pre-training assessment, training, etc.
- Rotations for Fellow #1 begin
- Data tracking and collection begins
- First evaluation quarterly report January 1, 2021 – March 31, 2021 presented to evaluation committee for input, adjustments to strategies, tools and resources, based on operational learnings to-date and quantitative data available.

April 1, 2021 – June 30, 2021

- Recruitment of Fellow #2
- Ongoing tracking Fellow #1 performance, faculty development, achievement of program objectives by Program Evaluation Committee
- 6-month review of Fellow #1 by Clinical Competence Committee

July 1, 2021 – September 30, 2021

- Qualitative data collection begins (interviews, focus groups, etc.)
- Onboarding of Fellow #2 - orientation, pre-training assessment, training
- Rotations for Fellow #2 begin
- Ongoing tracking Fellow #1 and Fellow #2 performance, faculty development, achievement of program objectives by Program Evaluation Committee
- Continue data collection, evaluation quarterly reports to request input and determine adjustments, as needed

October 1, 2021 – December 31, 2021

- 6-month review of Fellow #2 by Clinical Competence Committee end of Nov
- Annual review of Fellow #1 by Clinical Competence Committee in December
- Graduation of Fellow #1 in December
- Continue data collection, evaluation quarterly reports to request input and determine adjustments, as needed
- Sustainability planning begins

January 1, 2022 – June 30, 2022

- Continue sustainability planning
- Ongoing tracking Fellow #2 performance, faculty development, achievement of program objectives by Program Evaluation Committee
- Annual review of Fellow #2 by Clinical Competence Committee in June
- Graduation of Fellow #2 in June
- Recruitment of Fellow #3
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2022 – December 31, 2022

- Initial sustainability plan presented
- Engage MHSA Steering Committee and MHSARC on issue of continuation of the project with non-INN funds



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- Onboarding of Fellow #3 in July with orientation, pre-training assessment, training
- Rotations for Fellow #3 begin
- Ongoing tracking Fellow #3 performance, faculty development, achievement of program objectives by Program Evaluation Committee
- 6-month review of Fellow #3 by Clinical Competence Committee end of Nov
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

January 1, 2023 – June 30, 2023

- Sustainability plan finalized
- Ongoing tracking Fellow #3 performance, faculty development, achievement of program objectives by Program Evaluation Committee
- Annual review of Fellow #3 by Clinical Competence Committee in June
- Graduation of Fellow #3 in June
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2023 – December 31, 2023

- Complete evaluation analysis and report
- 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 total Innovation funding request for 3.9 years is \$663,125.

**Personnel Costs** will total \$480,000

- Fellow - \$85,000
- Program Director - \$60,000
- Supervisor - \$18,000
- Program Coordinator - \$14,000

**Direct Costs** will total \$46,500 over 3 years and includes insurance, conferences, supplies, equipment, and travel/mileage. \$10,000 per year is also included as faculty support compensation.

**Indirect Costs** will total \$136,625

- \$50,000 for the evaluation contract for 3.5 years given the final report will be due by December 31, 2023. The evaluation contract includes developing a plan, supporting data collection, data analysis and submitting annual reports to the MHSOAC.
- \$86,625 for BHRS county business, contract monitoring, fiscal tracking, IT support, and oversight of the innovation project.

**Federal Financial Participation (FFP)** anticipated FFFP will total \$51,000.

**Other Funding** N/A



<b>BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*</b>							
<b>EXPENDITURES</b>							
<b>PERSONNEL COSTS (salaries, wages, benefits)</b>		<b>FY 19/20</b>	<b>FY 20/21</b>	<b>FY 21/22</b>	<b>FY 22/23</b>	<b>FY 23/24</b>	<b>TOTAL</b>
1.	Salaries		\$126,000	\$194,000	\$160,000		\$480,000
2.	Direct Costs						
3.	Indirect Costs						
4.	<b>Total Personnel Costs</b>		<b>\$126,000</b>	<b>\$194,000</b>	<b>\$160,000</b>		<b>\$480,000</b>
<b>OPERATING COSTS</b>		<b>FY xx/xx</b>	<b>FY xx/xx</b>	<b>FY xx/xx</b>	<b>FY xx/xx</b>	<b>FY xx/xx</b>	<b>TOTAL</b>
5.	Direct Costs		\$15,500	\$15,500	\$15,500		\$46,500
6.	Indirect Costs (15% Direct Costs)	\$14,438	\$28,875	\$28,875	\$14,437		\$86,625
7.	<b>Total Operating Costs</b>	<b>\$14,438</b>	<b>\$44,375</b>	<b>\$44,375</b>	<b>\$29,937</b>		<b>\$133,125</b>
<b>NON-RECURRING COSTS (equipment, technology)</b>		<b>FY 19/20</b>	<b>FY 20/21</b>	<b>FY 21/22</b>	<b>FY 22/23</b>	<b>FY 23/24</b>	<b>TOTAL</b>
8.							
9.							
10.	<b>Total Non-recurring costs</b>						
<b>CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)</b>		<b>FY 19/20</b>	<b>FY 20/21</b>	<b>FY 21/22</b>	<b>FY 22/23</b>	<b>FY 23/24</b>	<b>TOTAL</b>
11.	Direct Costs						
12.	Indirect Costs		\$15,000	\$15,000	\$15,000	\$5,000	\$50,000
13.	<b>Total Consultant Costs</b>		<b>\$15,000</b>	<b>\$15,000</b>	<b>\$15,000</b>	<b>\$5,000</b>	<b>\$50,000</b>
<b>OTHER EXPENDITURES (please explain in budget narrative)</b>		<b>FY 19/20</b>	<b>FY 20/21</b>	<b>FY 21/22</b>	<b>FY 22/23</b>	<b>FY 23/24</b>	<b>TOTAL</b>
14.							
15.							
16.	Total Other Expenditures						
<b>BUDGET TOTALS</b>							
Personnel (line 1)			\$126,000	\$194,000	\$160,000		\$480,000
Direct Costs (add lines 2, 5 and 11 from above)			\$15,500	\$15,500	\$15,500		\$46,500
Indirect Costs (add lines 3, 6 and 12 from above)		\$14,438	\$43,875	\$43,875	\$29,437	\$5,000	\$136,625
Non-recurring costs (line 10)							
Other Expenditures (line 16)							
<b>TOTAL INNOVATION BUDGET</b>		<b>\$14,438</b>	<b>\$185,375</b>	<b>\$253,375</b>	<b>\$204,937</b>	<b>\$5,000</b>	<b>\$663,125</b>

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

**BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)**

**ADMINISTRATION:**

A.	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
		1.	Innovative	\$14,438	\$170,375	\$238,375	\$189,937
2.	Federal Financial Participation		\$8,500	\$25,500	\$17,000		\$51,000
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	<b>Total Proposed Administration</b>	<b>\$14,438</b>	<b>\$178,875</b>	<b>\$263,875</b>	<b>\$206,937</b>		<b>\$664,125</b>

**EVALUATION:**

B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
		1.	Innovative MHSA Funds		\$15,000	\$15,000	\$15,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	<b>Total Proposed Evaluation</b>		<b>\$15,000</b>	<b>\$15,000</b>	<b>\$15,000</b>	<b>\$5,000</b>	<b>\$50,000</b>

**TOTAL:**

C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
		1.	Innovative MHSA Funds	\$14,438	\$185,375	\$253,375	\$204,937
2.	Federal Financial Participation		\$8,500	\$25,500	\$17,000		\$51,000
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	<b>Total Proposed Expenditures</b>	<b>\$14,438</b>	<b>\$193,875</b>	<b>\$278,875</b>	<b>\$221,937</b>	<b>\$5,000</b>	<b>\$714,125</b>

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



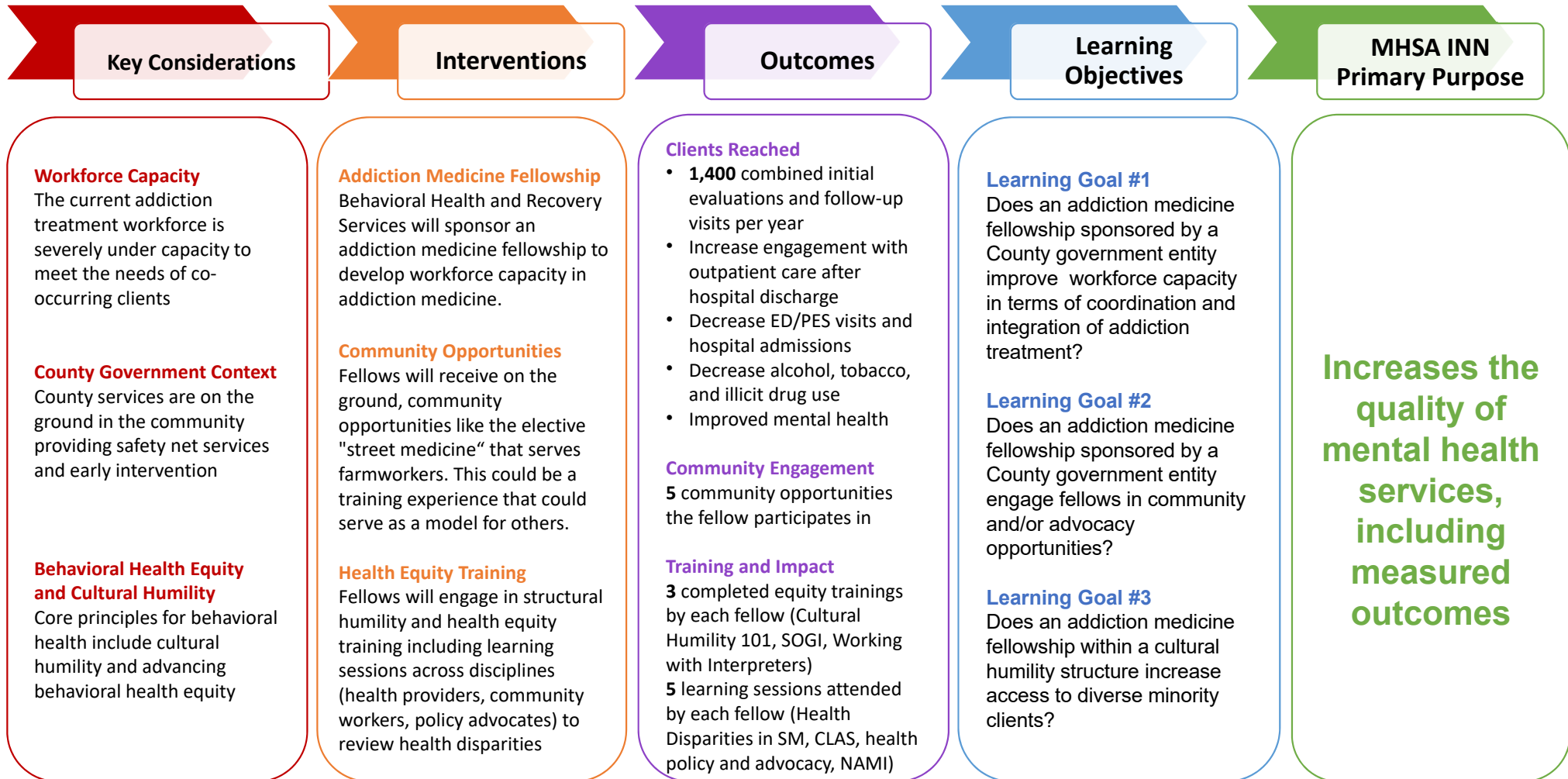
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## **Appendix 1. Theory of Change**

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# Theory of Change

## Primary Problem: Workforce Capacity for Rising Co-Occurring Addiction-Related Conditions



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**Appendix 2. Community Planning Process  
for MHSA Three-Year Plan**

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# San Mateo County Mental Health Services Act

Three-Year Plan FY 2017-2020

## Community Program planning (CPP) process

In December 2016, a comprehensive Community Program Planning (CPP) process to develop the MHSa Three-Year Plan was kicked off by our local mental health board, the Mental Health and Substance Use Recovery Commission (MHSARC). Planning was led by the MHSa Manager and the Director of BHRS along with the MHSARC and the MHSa Steering Committee.



A draft CPP process was presented to and vetted by the MHSARC. The MHSARC was asked for their input and comments on the process and what other stakeholder groups should we be reaching out to in each of the CPP Phases.

## STAKEHOLDERS INVOLVED

Input was sought from twenty nine diverse groups and vulnerable populations to include perspectives of different backgrounds and interests including geographical, ethnic, cultural and

*From the San Mateo County Mental Health Services Act Three-Year Program and Expenditure Plan FY 17-18 through FY 19-20 & Annual Update FY 17-18*

social economic, providers and recipients of behavioral health care services and other sectors, clients and their family members. See the full list of input sessions below.

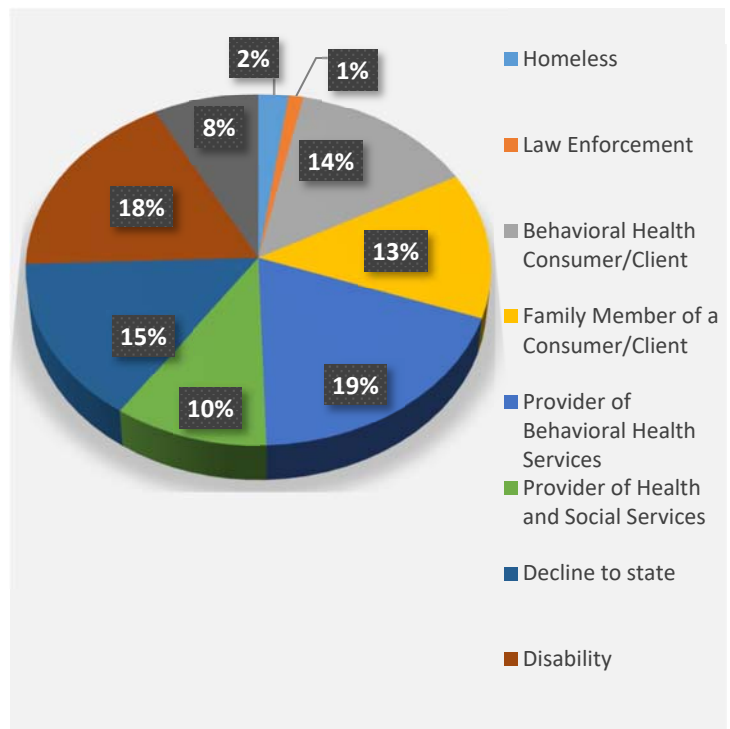
Additionally, a Pre-Launch session was held with clients/consumers hosted by the Peer Recovery Collaborative, a collaborative of peer-run agencies including California Clubhouse, Heart and Soul and Voice of Recovery. At this session information was presented and shared to help prepare clients/consumers for the CPP Launch session where they would be providing input and public comment. Discussion items included, 1) Background on MHSA; 2) What to expect at the CPP Launch session; and 2) How to prepare a public comment.

Extensive outreach was conducted to promote two key public meetings, the CPP Launch Session on March 13, 2017 and the CPP Prioritization Session on April 26, 2017. Flyers were made available in English, Spanish, Chinese, Tagalog, Tongan and Samoan. Stipends to consumers/clients and their family members, language interpretation, child care for families and refreshments were provided at each of these sessions.

Over 270 participated in the sessions, 156 demographic sheets were collected and of these 37% identified as clients/consumers and family members and 36 stipends were provided.

The majority of participants at these two public meetings (64%) represented central and south geographical areas of the county. There are institutional barriers to accessing and attending centrally located public meetings (trust, transportation, cultural and language, etc.). In an effort to account for this, two additional Community Prioritization Sessions were conducted in East Palo Alto and the Coastside. In the future, we will add a community session in the north part of the county as well.

### Represented Groups



## Input Sessions

Date	Stakeholder Group
<b>12/7/16</b>	<b>MHSARC and MHSA Steering Committee (Input on CPP Process)</b>
<b>2/15/17</b>	MHSARC Adult Committee
<b>2/15/17</b>	NAMI Board Meeting
<b>2/16/17</b>	Filipino Mental Health Initiative
<b>2/21/17</b>	Coastside Community Service Area
<b>2/21/17</b>	Northwest Community Service Area
<b>3/1/17</b>	MHSARC Older Adult Committee
<b>3/2/17</b>	Central Community Service Area
<b>3/2/17</b>	Peer Recovery Collaborative
<b>3/3/17</b>	Diversity and Equity Council
<b>3/3/17</b>	Northwest School-Based Mental Health Collaborative
<b>3/7/17</b>	Pacific Islander Initiative
<b>3/7/17</b>	Coastside School-Based Mental Health Collaborative
<b>3/8/17</b>	AOD Change Agents/CARE Committee
<b>3/9/17</b>	<b>Peer Recovery Collaborative (Pre-Launch Session)</b>
<b>3/9/17</b>	East Palo Alto Community Service Area
<b>3/9/17</b>	Central School Collaborative
<b>3/13/17</b>	<b>MHSA Steering Committee (CPP Launch)</b>
<b>3/14/17</b>	African American Community Initiative
<b>3/16/17</b>	Ravenswood School-Based Mental Health Collaborative
<b>3/17/17</b>	South Community Service Area and Child/Youth Committee
<b>3/23/17</b>	Chinese Health Initiative
<b>3/23/17</b>	Northeast School-Based Mental Health Collaborative
<b>3/28/17</b>	Latino Collaborative
<b>4/10/17</b>	Coastside Youth Advisory Committee
<b>4/11/17</b>	Spirituality Initiative
<b>4/13/17</b>	<b>East Palo Alto (Community Prioritization Session)</b>
<b>4/18/17</b>	<b>Coastside (Community Prioritization Session)</b>
<b>4/19/17</b>	MHSARC Child and Youth Committee
<b>4/20/17</b>	Native American Initiative
<b>4/20/17</b>	Contractor's Association
<b>4/21/17</b>	Latino Immigrant Parent Group
<b>4/24/17</b>	Veterans
<b>4/25/17</b>	TAY recipients of services
<b>4/26/17</b>	<b>MHSA Steering Committee (CPP Prioritization)</b>



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## PHASE 1. NEEDS ANALYSIS

To build off of the previous Community Program Planning (CPP) process in FY 2014/15, stakeholders including clients, family members, community partners and organizations were asked to think about current services as they relate to the gaps in services identified in FY 2014/15 (listed below), specific service categories and populations served to identify any additional gaps in services:

- Cultural humility and stigma
- Timely access
- Services for peers and families
- Services for adults and older adults
- Early intervention
- Services for children and TAY
- Co-occurring services
- Criminal justice involvement

For Phase I and the initial input sessions, stakeholders were asked the following questions, based on the priority gaps identified in previous years for continuity:

- From your perspective, do these MHSAs effectively [e.g. serve the cultural and linguistic needs of your target communities, address timely access for your target communities, serve the behavioral healthcare needs of clients and families, etc. ]? What's working well? What improvements are needed?  
Probes: Do these services address principles of wellness and recovery? stigma?
- Are current collaborations effective in reaching and serving target communities? What is working well? What's missing?

All comments received up to the date of the CPP Launch Session on March 13<sup>th</sup> were grouped into themes and presented at the CPP Launch. Additional input was sought regarding both the needs/service gaps and whether there were any voices (or communities) missing from the Needs Analysis phase. See Appendix 3, Needs Analysis Summary of Input, for the complete list of themes and comments received. The CPP Launch Session was a joint MHSARC and MHSAs Steering Committee meeting and included a facilitated community input. Agenda items included 1) an MHSAs Housing proposal for use of unencumbered housing funds 2) public comment from clients, families and community members on priority needs and gaps in mental health services, and 3) breakout groups to begin developing strategies to address the key needs/service gaps identified. About 120 clients, families, community members and stakeholders attended the CPP Launch Session. See Appendix 4 for all CPP Launch Session materials, handouts, minutes and attendance.

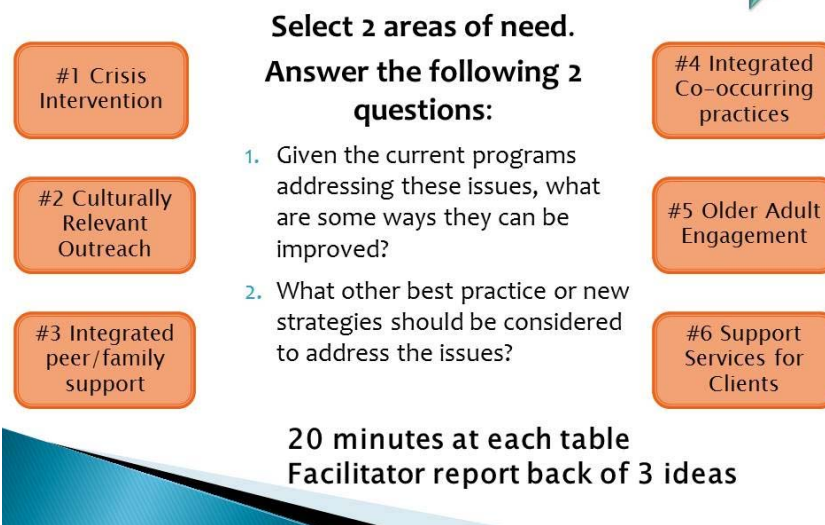
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## PHASE 2. STRATEGY DEVELOPMENT

The Strategy Development Phase was kicked off at the CPP Launch Session on March 13, 2017. Findings from the initial input sessions were shared at the CPP Launch Session including relevant strategy ideas.

*From the San Mateo County Mental Health Services Act Three-Year Program and Expenditure Plan FY 17-18 through FY 19-20 & Annual Update FY 17-18*

## Phase 2. Strategy Development



While the above six need/gaps in services were identified, there was also an overarching theme that arose from the input sessions, which brought to surface common questions in MHSA planning: do we build upon existing MHSA-funded programs or do we create new programs? Input session participants identified the need to consider both. It has been 10 years since the inception of MHSA and most programs have not received additional resources (aside from Cost of Living increases to the contracts) to expand services and/or clients served, especially for those programs that are resulting in positive behavioral health outcomes.

### **Three key next steps for the CPP process were identified at the CPP Launch Session:**

- Additional input sessions with vulnerable populations and key stakeholders identified.
- Additional strategy development sessions in isolated and higher need communities, in particular East Palo Alto and the Coastside/South Coast region.
- Follow up meetings with all MHSA-funded programs to identify priority program challenges, needs and possible strategies to address these.

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## **PHASE 3. PLAN DEVELOPMENT**

The final Phase of the CPP Process was kicked off at the CPP Prioritization Session on April 26, 2017. The meeting goals were three-fold:

1. Present strategy recommendations, results from the Community Input Sessions and prepared public comments in support of each recommendation.
2. Provide meeting participants the opportunity to bring forward any additional strategy recommendations and to prioritize the additional recommendations.
3. Prioritize across all strategies proposed (MHSA Steering Committee only) to help identify the recommendations to include in the MHSA Three-Year Plan.

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## **Appendix 3. Public Comments**

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[To be updated following the 30-day public comment process]