



SAN MATEO COUNTY HEALTH

BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Innovation Project Plan

County Name: San Mateo

Date submitted: 2/24/20

Project Title: Addiction Medicine Fellowship in a Community Hospital

Total amount requested: \$663,125 (\$526,500 services; \$86,625 admin; \$50,000 eval)

Duration of project: 4 years (start-up, 3 full years of project implementation and final evaluation)

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.¹ 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 in 2016, 2.9% (1,112) of emergency department (ED) visits and 21.3% (505) psychiatric emergency services (PES) visits and 18% (449) of hospital admission were by people with substance use disorders (SUD). By 2018, ED and PES visits had increased to 1,560 (4.1%) and 1,018 (47.1%) respectively.

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.” In fiscal year 2017-2018, co-occurring substance use disorders were present in 40-50% of the 400 clients served at our San Mateo County Edison Clinic for complex behavioral health and medical health related to HIV, as well as 95% of the 180 youth detained at the Youth Services Center.

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

Addiction Medicine Workforce in the Public Sector

Now more than ever, with the opioid crisis, providing 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.² In addition, many individuals who seek treatment in the public sector face a variety of barriers to care and are subject to social determinants of health. While San Mateo Health has expanded 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. An Addiction Medicine Fellowship would develop a workforce with expertise to make a significant impact on the lives of those individuals suffering from substance use disorders in our most underserved communities.

¹ Defining the Addiction Treatment Gap, Open Society Foundations (2010).

² Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health (2016)



In the entire San Mateo County Health, including Behavioral Health and Recovery Services (BHRS), fewer than ten primary care and psychiatry providers prescribe medications for opioid use disorder, even though these medications cut the mortality rate in half. In February 2019, our ED providers began participating in the California Bridge Program (<https://www.bridgetotreatment.org/>) and administering buprenorphine. While this has been a step forward, we are now in a position where we lack sufficient outpatient providers who can continue the treatment and our contracted community Medication Assisted Treatment (MAT) clinic has reached capacity. In this crisis, we have an opportunity to train additional physicians especially in primary care and psychiatry, to provide this care. 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 where it is needed the most.

“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. It is estimated that the minimum number of addiction medicine fellowships needed to meet the projected need for addiction physicians in the U.S. is 125 but there are currently only 75; all sponsored by academic centers, the Veterans Administration, and nonprofit organizations such as Kaiser Permanente. The first 11 Addiction Medicine Fellowships in academic centers were the model for the rest. However, many individuals with substance use disorders do not have access to care at such sites. Having an Addiction Medicine Fellowship housed within a county government entity would train a workforce to treat individuals in the most underserved communities where the toll is the highest. Our fellowship would then be a model for all of California's 58 counties to train their respective workforce in addiction medicine specific for their populations, an opportunity to support retention of addiction specialists across counties.

PROPOSED PROJECT

Describe the INN Project you are proposing.

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

This Addiction Medicine Fellowship would be the first to be sponsored by a County health agency.

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; 1) treating the most vulnerable communities with co-occurring substance use disorders, 2) working with peer substance use counselors, and 3) advancing equity on multiple levels including contributing to equity projects in clinical and community settings.



Addiction Medicine Fellowship

The field of Addiction Medicine recognizes addiction as a disease and that impacted individuals are vastly underserved. Addiction Medicine Fellowships are a promising approach to develop a workforce with expertise in addiction treatment.^{3,4} 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 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.

Many individuals seeking treatment in San Mateo County do not have access to addiction medicine specialists through the HMO Kaiser Permanente, the VA, or academic centers at Stanford and UCSF. Our public sector-sponsored fellowship would train physicians to provide addiction treatment to our safety net population, thereby directly addressing health inequities in our county. Few fellows in existing fellowship programs get similar training. If Addiction Medicine is to impact public health, a fellowship in a public health system is essential.

This project will select applicants who are dedicated to working with the safety net population and have demonstrated this in their previous training and activities. Our current Psychiatry Residency program follows this selection process and has been successful in bringing on 50% of program graduates per year to our workforce. While there is no guarantee a graduate will choose to become our employee, we expect that by training fellows dedicated to working with the public sector, they will choose to work with this population somewhere in California.

Recruitment of fellows will be facilitated by our Psychiatry Residency Program as well as by the American College of Academic Addiction Medicine (ACAAM), which provides a website listing fellowship programs and assists with referrals (<https://www.acaam.org/fellowship-resource-center/career-center/fellowship-program-openings/>). The Psychiatry Residency Program also serves as a potential “feeder program” of qualified and highly interested applicants.

The project will select “faculty” from our county physicians and contracted physicians who are experienced in treating addiction to support the learning of the fellows. This will include at least one psychiatrist and one emergency department physician who are

³ Rasyidi E, Wilkins JN, Danovitch I. Training the next generation of providers in addiction medicine. *Psychiatr Clin North Am.* 2012;35(2):461-80.

⁴ 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.



board-certified in Addiction Medicine. Additionally, the fellowship Program Director is a psychiatrist and addiction medicine specialist. We will also participate in a consortium of Bay Area Addiction Medicine fellowships for educational activities, such as case conferences and a journal club, to critically evaluate recent articles in the academic literature. The fellow will also attend the California Society of Addiction Medicine (CSAM) and American Society of Addiction Medicine (ASAM) conferences.

In addition to standard training opportunities in hospital and outpatient settings, an Addiction Medicine Fellowship at San Mateo would offer additional unique public health training opportunities. One example is the Street Medicine elective with training opportunities on a field-based medical and psychiatric service caring for individuals experiencing homelessness as well as farmworkers with little access to care at our clinics. Another possible opportunity would be providing Medication-Assisted Treatment (MAT) in our jails, where our incarcerated population is only beginning to be offered treatment for addiction.

Peer Supports

The addiction fellows will work closely with peer case managers, through our existing BHRS Integrated Medication-Assisted Treatment (IMAT) program. IMAT case managers hire individuals with lived experience and are the first point of contact for referrals made through the medical center, emergency department, mental health clinics and other primary care settings. IMAT case managers provide counseling and assist with linkage to a broad array of services, such as residential programs, mutual support groups, food banks, and housing programs and other support services for clients in need of or receiving substance abuse treatment. To ensure support at all stages of the recovery spectrum, clients will also be linked to our current MHSA-funded Wellness Recovery Action Plan (WRAP) services and peer supports offered by Voices of Recovery, <http://www.vorsmc.org/wellness-recovery-action-plan.html>.

Health Equity and Cultural Humility

The mission of San Mateo County Health is to serve safety net populations. While academic center-run fellowships may expose trainees to some components of public sector work, no other program would include the depth of training we would offer. Fellows in our Addiction Medicine program would receive foundational training in social determinants of health, barriers to accessing care, and cultural humility.

The addiction medicine fellow would participate in employee-wide trainings including Cultural Humility 101, Becoming Visible: Using Cultural Humility in Asking Sexual Orientation and Gender Identity (SOGI) questions, 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, such as Culturally and Linguistically Accessible Services (CLAS) standards.



Fellows would be required to participate in this classroom learning as well as to engage in a community advocacy activity outside their usual work responsibilities. The advocacy activity aims to emphasize physician responsibility to understand and address health inequities and to provide an opportunity for collaboration with community leaders. Examples include becoming a board member of a local substance use organization or speaking at a school-based mental health conference. This unique San Mateo training experience already serves as a model for other psychiatry residency programs and would no doubt serve as a model for future Addiction Medicine Fellowships as well.

Sample Week Schedule for Fellow

Monday

Morning: Consultation service in hospital and ED

Afternoon: Continuity clinic, providing addiction medicine treatment integrated in a primary care clinic

Tuesday

Morning: Consultation service in hospital and ED

Afternoon: Edison HIV Clinic alternating with Pain Clinic, providing co-occurring consultations and treatment

Wednesday

Morning: Consultation service in hospital and ED

Afternoon: Continuity clinic, providing addiction medicine treatment integrated in primary care clinic

Every 2nd Wed 3:30 - 5:00 attend Drug Use Research Group seminar at UCSF

Thursday

All Day: Street Medicine and Farm Workers (6 months)

Morning: Jail, providing addiction medicine treatment

Afternoon: Advocacy Project

Friday

Morning: Consultation service in hospital and ED

Afternoon: Learning experiences: For example, 1st Fri of month, UCSF Buprenorphine Case Conference (Web or in person). 2nd Fri, UCSF Journal Club (Web or in person), 3rd Fri, UCSF Addiction Medicine Fellows Seminar Series (web or in person), other Fridays join Psychiatry residents for didactics, complete online learning assignments



Project implementation activities:

- Startup Activities:
 - Establish letters of agreement with rotational sites and schedules, identify professional development opportunities, develop training materials, policies and procedures, secure office space and supplies.
 - Hire program coordinator, identify faculty supervision, clinical competency committee and program evaluation committee.
 - Develop website content, promote fellowship review applications, interview and hire fellow.
- The Addiction Medicine Fellow will receive a 2-week clinical and organizational orientation and with clinical supervision 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 close to 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.
 - In all clinical settings, will work closely with peer case managers who will provide counseling and assist with linkage to a broad array of services, such as residential programs, mutual support groups, food banks, and housing programs.
- Develop sustainability and retention strategies - work closely with the San Mateo County Workforce Education and Training team to inform strategies that resonate with fellows



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.

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 health agency. 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 community behavioral health. For example, fellows can provide treatment to farmworkers and the homeless, 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"> • Stanford Psychiatry outpatient clinics do not accept Medi-Cal or our locally funded health care program for low-income adults. • The UCSF fellowship serves safety net patients but accepts candidates only from Internal Medicine and Family Practice, not Psychiatry. • Kaiser rotations are within the Kaiser hospital and clinics. • The VA fellowship accepts only Psychiatry candidates and the rotations are within the Veterans Administration system, Kaiser, and Alta Mira (a private treatment center). 	<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"> • Elective Street Medicine experience with the homeless and farmworkers • advocacy activity such as becoming a board member of a local substance use organization or speaking at a school-based mental health conference • review of local health disparities and identification of opportunities for intervention

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?

This project will allow us to pilot a new approach to having an Addiction Medicine Fellowship sponsored by a county government entity. Given that substance use disorders and mental health disorders have very high rate of co-occurrence (at least 50% in both directions), this can be a model for all of California's 58 counties to train their respective workforce in addiction medicine specific for their populations. The specific learning goals to this project are as follows:

Learning Goal #1

- Does an addiction medicine fellowship sponsored by a County government entity improve workforce capacity to serve diverse co-occurring clients?

Learning Goal #2

- Does an addiction medicine fellowship sponsored by a County government increase capacity for fellows to engage in meaningful community advocacy?

Learning Goal #3

- Does an addiction medicine fellowship improve coordination and integration of addiction treatment?

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

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 county 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 to serve diverse co-occurring clients?

The outputs for Learning Goal #1 could include:

- Number co-occurring clients served
- Number of co-occurring client visits per month

Some baseline data exists, while other indicators will be collected as a baseline and tracked throughout the project to inform Learning Goal #1. Measures and methods could include:

- Percent improvement as measured by:
 - Decreased hospitalizations (baseline available)
 - Decreased ED/PES visits (baseline available)
 - Increased engagement in outpatient care (# visits)
 - Decreased alcohol, tobacco, and drug use (self-report and drug screens)
 - Improved mental health (mood and anxiety scales)

Additionally, **demographics** and **quality of life indicators** can be collected at intake.

Learning Goal #2

- Does an addiction medicine fellowship sponsored by a County government increase capacity for fellows to engage in meaningful community advocacy?

The outputs for Learning Goal #2 could include:

- Number of community opportunities and types that fellows participate in. Fellows will be assigned to engage in at least one advocacy activity outside their usual work responsibilities that focuses on building opportunities for community change.

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. These indicators will be tracked throughout the project to inform Learning Goal #2



Learning Goal #3

- Does an addiction medicine fellowship improve coordination and integration of addiction treatment?

Key interviews and/or **satisfaction surveys** of addiction treatment providers, peer supports and other providers in contact with fellow and staff that typically support the providers with substance use treatment.

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.

Between February and March 2019, a broad solicitation of innovation ideas was launched. Both a flyer and an MHSa 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.);



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- 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 MHSA webpage smchealth.org/bhrs/mhsa, the BHRS Wellness Matters bi-monthly e-journal and the BHRS Blog www.smcbhersblog.org
- MHSA Innovation brainstorming sessions held with groups that requested it (Lived Experience Workgroup, MHSARC Older Adult Committee).

The MHSA 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 MHSA 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 MHSA 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 MHSA 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 MHSA 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 and reviewed substantive comments, including MHSOAC comments, during the public hearing and closing of the public comment period on November 6, 2019; all comments are included in Appendix 3.

MHSA GENERAL STANDARDS

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

A) Community Collaboration

The 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 MHSAs 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 MHSAs Community Services and Supports, General Systems Development funding, a proposal of continuation would be brought to the MHSAs Steering Committee and the Mental Health and Substance Abuse Recovery Commission for approval and to a 30-day public comment process to secure ongoing MHSAs funding. A sustainability and workforce retention 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?

MHSAs 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 MHSAs information is made available to stakeholders on the MHSAs webpage, www.smchealth.org/bhrs/mhsa. The site includes a subscription feature to receive an email notification when the website is updated with MHSAs 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 MHSAs 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 MHSAs 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

April 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:

April 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



SAN MATEO COUNTY HEALTH

**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

- 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 and retention planning begins

January 1, 2022 – June 30, 2022

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



SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

January 1, 2023 – June 30, 2023

- Sustainability and retention 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 MHSAs 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 MHSAs 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 over 3 years.

FTE Position	Annual Cost	Total Cost
1.0 FTE Fellow -	\$ 122,000	\$366,000
.25 FTE Program Director, Staff Psychiatrist, Addiction Specialist	In-kind	-
.25 FTE Program Coordinator	\$20,000	\$60,000
.10 FTE Faculty Supervisor, ED Physician/Addiction Specialist	\$18,000	\$54,000
TOTAL		\$480,000

Direct Costs will total \$46,500 over 3 years. The annual costs include insurance (\$2,500) conferences, supplies, equipment, and travel/mileage (\$13,000) per year.

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 **administration** costs including 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



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

*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		\$613,125
2.	Federal Financial Participation		\$8,500	\$25,500	\$17,000		\$51,000
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Administration	\$14,438	\$178,875	\$263,875	\$206,937		\$664,125

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	\$5,000	\$50,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Evaluation		\$15,000	\$15,000	\$15,000	\$5,000	\$50,000

TOTAL:

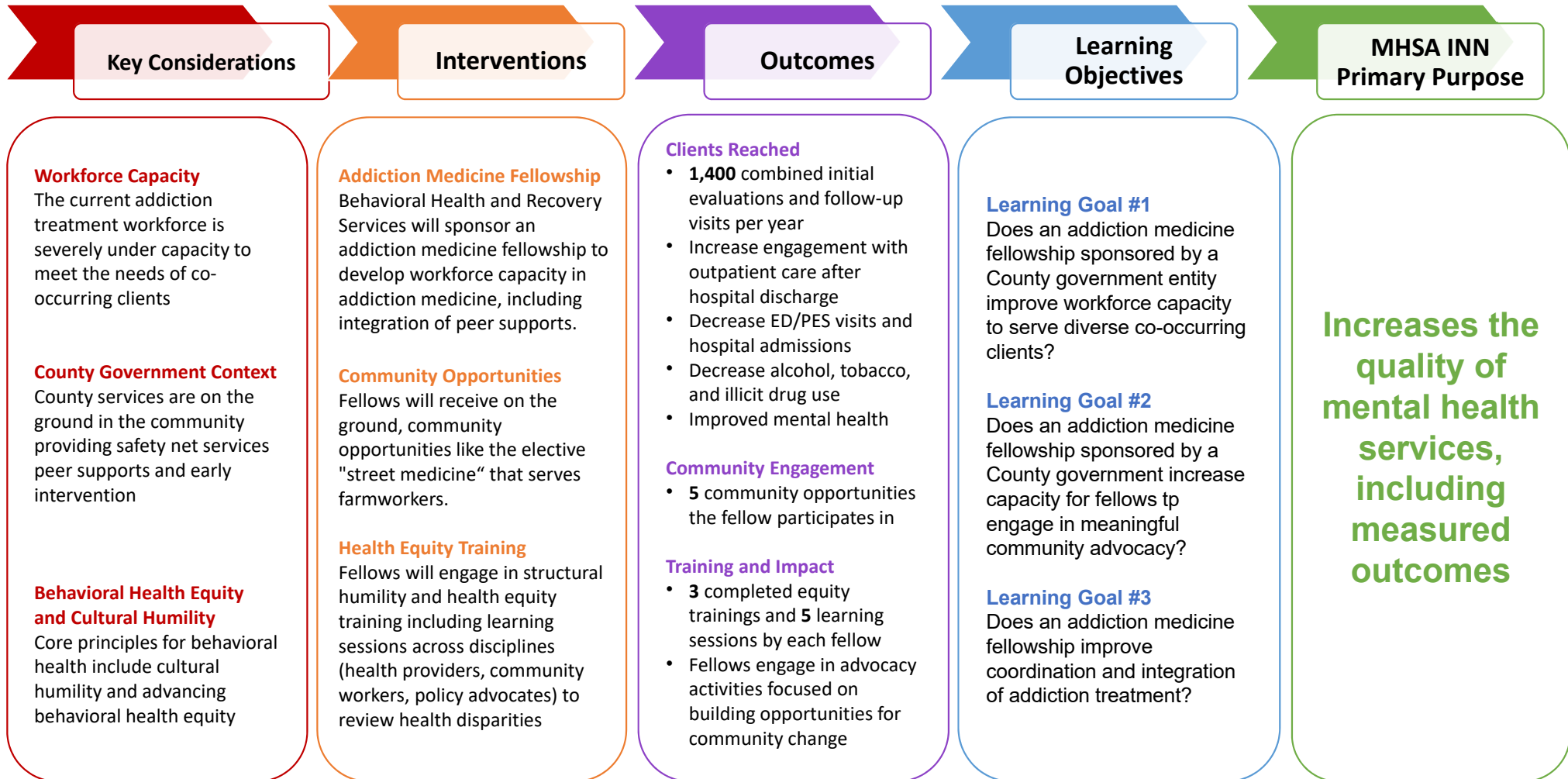
C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
1.	Innovative MHSA Funds	\$14,438	\$185,375	\$253,375	\$204,937	\$5,000	\$663,125
2.	Federal Financial Participation		\$8,500	\$25,500	\$17,000		\$51,000
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Expenditures	\$14,438	\$193,875	\$278,875	\$221,937	\$5,000	\$714,125

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

Appendix 1. Theory of Change

Theory of Change

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



Key Considerations

Workforce Capacity

The current addiction treatment workforce is severely under capacity to meet the needs of co-occurring clients

County Government Context

County services are on the ground in the community providing safety net services peer supports and early intervention

Behavioral Health Equity and Cultural Humility

Core principles for behavioral health include cultural humility and advancing behavioral health equity

Interventions

Addiction Medicine Fellowship

Behavioral Health and Recovery Services will sponsor an addiction medicine fellowship to develop workforce capacity in addiction medicine, including integration of peer supports.

Community Opportunities

Fellows will receive on the ground, community opportunities like the elective "street medicine" that serves farmworkers.

Health Equity Training

Fellows will engage in structural humility and health equity training including learning sessions across disciplines (health providers, community workers, policy advocates) to review health disparities

Outcomes

Clients Reached

- **1,400** combined initial evaluations and follow-up visits per year
- Increase engagement with outpatient care after hospital discharge
- Decrease ED/PES visits and hospital admissions
- Decrease alcohol, tobacco, and illicit drug use
- Improved mental health

Community Engagement

- **5** community opportunities the fellow participates in

Training and Impact

- **3** completed equity trainings and **5** learning sessions by each fellow
- Fellows engage in advocacy activities focused on building opportunities for community change

Learning Objectives

Learning Goal #1

Does an addiction medicine fellowship sponsored by a County government entity improve workforce capacity to serve diverse co-occurring clients?

Learning Goal #2

Does an addiction medicine fellowship sponsored by a County government increase capacity for fellows to engage in meaningful community advocacy?

Learning Goal #3

Does an addiction medicine fellowship improve coordination and integration of addiction treatment?

MHSa INN Primary Purpose

Increases the quality of mental health services, including measured outcomes

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

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.

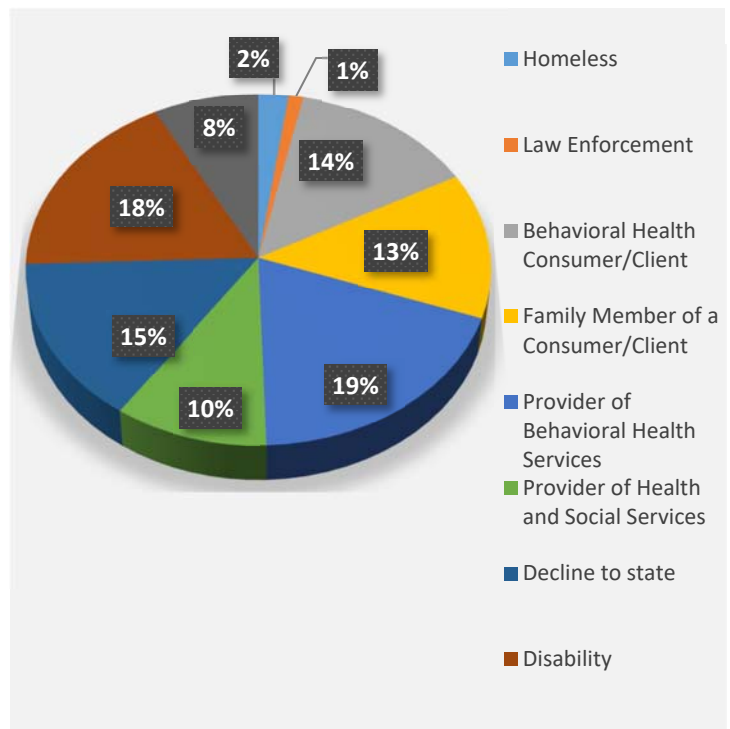
Additionally, a Pre-Launch session was held with clients/consumers hosted by the Peer Recovery Collaborative, a collaborative of peer-run agencies including California Clubhouse, Heart and Soul and Voice of Recovery. At this session information was presented and shared to help prepare clients/consumers 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
12/7/16	MHSARC and MHSA Steering Committee (Input on CPP Process)
2/15/17	MHSARC Adult Committee
2/15/17	NAMI Board Meeting
2/16/17	Filipino Mental Health Initiative
2/21/17	Coastside Community Service Area
2/21/17	Northwest Community Service Area
3/1/17	MHSARC Older Adult Committee
3/2/17	Central Community Service Area
3/2/17	Peer Recovery Collaborative
3/3/17	Diversity and Equity Council
3/3/17	Northwest School-Based Mental Health Collaborative
3/7/17	Pacific Islander Initiative
3/7/17	Coastside School-Based Mental Health Collaborative
3/8/17	AOD Change Agents/CARE Committee
3/9/17	Peer Recovery Collaborative (Pre-Launch Session)
3/9/17	East Palo Alto Community Service Area
3/9/17	Central School Collaborative
3/13/17	MHSA Steering Committee (CPP Launch)
3/14/17	African American Community Initiative
3/16/17	Ravenswood School-Based Mental Health Collaborative
3/17/17	South Community Service Area and Child/Youth Committee
3/23/17	Chinese Health Initiative
3/23/17	Northeast School-Based Mental Health Collaborative
3/28/17	Latino Collaborative
4/10/17	Coastside Youth Advisory Committee
4/11/17	Spirituality Initiative
4/13/17	East Palo Alto (Community Prioritization Session)
4/18/17	Coastside (Community Prioritization Session)
4/19/17	MHSARC Child and Youth Committee
4/20/17	Native American Initiative
4/20/17	Contractor's Association
4/21/17	Latino Immigrant Parent Group
4/24/17	Veterans
4/25/17	TAY recipients of services
4/26/17	MHSA Steering Committee (CPP Prioritization)

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?

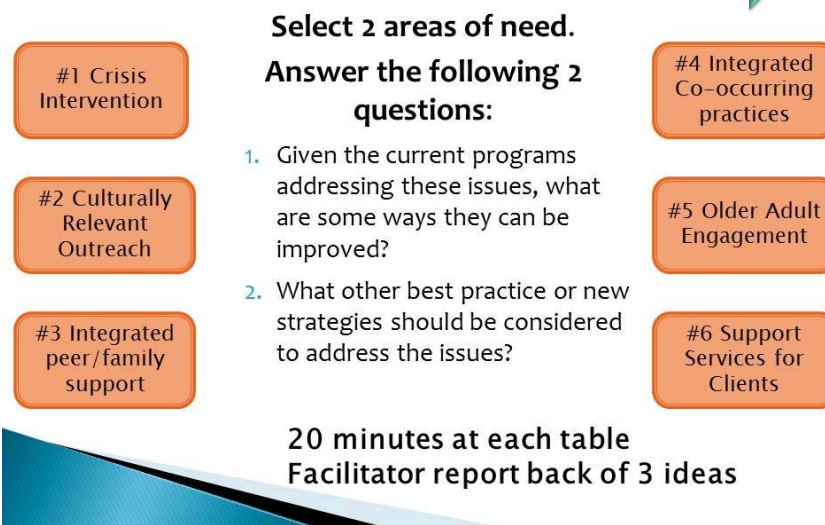
All comments received up to the date of the CPP Launch Session on March 13th were grouped into themes and presented at the CPP Launch. Additional input was sought regarding both the needs/service gaps and whether there were any voices (or communities) missing from the Needs Analysis phase. The CPP Launch 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.

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.

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.

Appendix 3. Public Comments



Mental Health Services Act (MHSARC) Steering Committee

Wednesday, October 2, 2019 / 4:00 – 5:30 PM

County Health Campus, Room 100, 225 37th Ave. San Mateo, CA 94403

NOTES – MHSARC INNOVATIONS

- | | |
|---|--------|
| 1. Welcome & Background | 4:05pm |
| 2. MHSARC One-Time Funds | 4:10pm |
| 3. MHSARC Innovations (INN) Breakout Activity | 4:40pm |

- Innovation funding allows for pilot projects that:
 - Introduce a new practice
 - Make changes to existing practices
 - Apply promising non-behavioral health practices
- A new cycle of funding was launched in January, received 35 ideas, 20 were reviewed by a Selection Committee and 5 ideas moved forward, we will hear about these ideas today.

MHSARC Motion:

Vote to open a 30-day public comment period for the
 MHSARC Innovation Project Proposals

- Isabelle opened the motion
- Chris seconded the motion
- Unanimous vote to open 30-day public comment period

- Innovation Project Proposals - Input Activity
 - Select 2 projects you want to learn about (20 min each)
 - Hear from folks who proposed the ideas
 - Ask questions, what do you believe is important to consider in the project
 - At each presentation you will receive a Theory of Change as a reference that identifies key considerations from the literature that supports the interventions
 - Pick two presentations you would like to learn more about



SAN MATEO COUNTY HEALTH

**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

INN Breakout - Comments

- **Addiction Fellowship**
 - How many fellows?
 - One to begin
 - Compliment with nurses and case managers?
 - Yes, IMAT open to assigning nurses/CMS
 - Will it be collaborative? Will fellows work with certified peer addiction specialists?
 - Yes, we will add this to the proposal
 - Why isn't this fellowship federally funded?
 - No addiction med fellowships currently are
 - Where are the others in CA?
 - Stanford, VA, UCSF, Kaiser, etc
 - Aiming to keep all of our rotations in county health
 - What is the curriculum?
 - Interest in input from communities, want folks with substance use disorders to have input
 - Where will the expertise come from?
 - Dr Chatterjee and three other psychiatrists at SMMC
 - How many could you train per year?
 - Two per year, starting with one per year
 - Do you have people interested?
 - Yes, people reach out from the addiction fellowship website
 - 157K what does it include?
 - Fellow salary and admin costs
 - Does part of this project go towards training FSP staff?
 - The expertise will be developed in house vs. training contractors for the innovation pilot

Please continue to provide public comments through November 6, 2019

- Email: mhsa@smcgov.org
- Phone: Doris Estremera, MHSA Manager (650) 573-2889
- Mail: 310 Harbor Blvd, Bldg E, Belmont CA 94002
- Optional Public Comment Form available on line at www.smcgov.org/mhsa

4. Adjourn

5:30pm

Next Mental Health and Substance Abuse Recovery Commission (MHSARC) Meeting
Closing of 30-day public comment period for MHSA Innovation Projects and Plan to Spend
Available One-Time Funds:

November 6, 2019 from 3:30-5:00pm
County Health Campus, Room 100, 225 37th Ave. San Mateo

Public Comments Received – for MHSARC Review

➤ Addiction Fellowship Innovation Project

Received 7 Public Comments (included below) in support of the Addiction Fellowship Innovation Project Proposal.

Comment	Response
I would like you to consider collaborative care with peer certified addiction specialists, peers providing services and supports in the community	Thank you for your input on including a peer component and specifically involving Peer Certified Addiction Specialists, we will add this to the proposal. This is critical to recovery principles. Currently as proposed, the IMAT team will provide case management for patients seen by the fellow in the hospitals and clinics.
Why MHSa funding and not primary health or drug Medi-Cal dollars for a medical-based fellowship.	Addiction is a specialty that touches on all fields of medicine, including mental health. Substance use disorders and mental health disorders have a very high rate of co-occurrence (at least 50% in both directions). Given this, addiction specialist will receive training in the diagnosis and treatment of mental health disorders. We want people suffering from addiction to be served wherever they enter our health system. In San Mateo County Health, people with only the most serious of mental illnesses are treated in clinics purely devoted to mental health; all others with mild to moderate, and often severe, disorders are treated by primary care providers with the help of integrated behavioral health teams. Most primary care providers, hospitalists, and psychiatrists are not trained to treat substance use disorders. This is one reason that only ten percent of people with addictions receive any MH treatment and why MHSa can provide a great opportunity to fill this much needed gap.
One-year fellowship then what? Where are the certified addiction fellows housed, in hospital or BHRS clinics?	This proposal is for 3 years, so we would hopefully be able to train 3 fellows, adding to the workforce of physicians able to treat this very under-served population. If it is successful, we hope our positive findings will help us secure additional funding. The fellow will be rotating through various locations such as the integrated mental health team within primary care, the hospital wards, emergency department, and specialty clinics such as the Pain Clinic and Edison Clinic.

Additional Public Comments Received

Received 7 Public Comments (included below) in support of the Addiction Fellowship Innovation Project Proposal.

Email from Monika K., October 24, 2019

Hi, I am an addiction psychiatrist in San Francisco and part president of the California Society of Addiction Medicine (CSAM). There is an ongoing shortage of qualified addiction medicine providers in the Bay Area and across the state as well as the country. I would strongly support the planned Addiction Medicine Fellowship for San Mateo County. Local training will aid developing a local addiction medicine work force and improve access and quality of care for patients.

Sincerely

Monika Koch MD PhD FASAM

Public Comment Form submitted October 27, 2019 by Lori D.K., MD, Veterans Administration

Physicians need increased training in addiction medicine, and we need new leaders in this field to serve our next generations of patients.

While Substance Use Disorder(SUD) is an equal opportunity illness, often the persons most severely affected by SUD(s) lose their jobs, health insurance, and family support. It is the San Mateo County Health System that serves as the 'safety net' for these individuals. Training Addiction Fellows to work in the County Health System can increase service delivery immediately, and bolster the county's workforce to effectively care for this population over the long-term.

Governor Gavin Newsome plans to spend 500 million dollars over the next five years to improve the health and reduce recidivism of California's justice-involved population. California Prisons and Jails have a new mandate to provide Medically Assisted Treatment (MAT) with Buprenorphine or Naltrexone to incarcerated persons who have opioid use disorders. Throughout the state, this may affect as many as 70,000 of CDCR's 130,000 prisoners. MAT has been proven to lower mortality and prevent overdose, especially during the first two weeks after an inmate is released from incarceration. However, who will continue caring for these patients and providing these medications? It will be the Counties who will need to provide reentry services. The San Mateo County Fellowship can proactively address this issue. The Addiction Medicine Fellowship can provide a skilled physician workforce to enable continuity of care for its residents, and to make this initiative a success.

Email from Anna L., October 28, 2019

We have a shortage of physicians trained in treating addiction. Substance use disorders occur in about 50% of people with mental illness, and worsen their prognosis. People with mental illness, like all people, receive treatment in hospitals and primary care, mental health, and specialty clinics, so all physicians need to be able to recognize and either treat or refer for treatment. This fellowship would train physicians of all backgrounds to diagnose and treat people with substance use disorders. County safety net health systems can benefit immensely by addiction medicine training opportunities such as this, and if San Mateo County Health is successful in this project, it will be a model for all California counties.

Sincerely,
Anna Lembke, MD
Associate Professor, Psychiatry and Behavioral Sciences
Medical Director, Addiction Medicine
Program Director, Addiction Medicine Fellowship
Chief, Addiction Medicine Dual Diagnosis Clinic
Stanford University School of Medicine

Public Comment Form submitted October 30, 2019 by Vivian L., San Mateo Medical Center

I am an Infectious Diseases (ID) physician, and Chief of ID at San Mateo Medical Center (SMMC). Addiction is a driver of infection, specifically viral hepatitis, HIV and sexually transmitted infections.

The creation of an Addiction Medicine Fellowship program at SMMC would serve an essential function of integrating the myriad of providers who provide services to patients with addiction. It would increase the workforce trained in Addiction Medicine, promote collaboration within SMC Health System and in surrounding counties. SMMC would also be the first Addiction Medicine fellowship program based in a local health safety net health system, serving as a model for California's 58 counties. I urge you to support this essential and wise investment.

Email from Jean M., November 4, 2019

Yes, I am in favor of the addiction fellowship application. To sum up my comments, I believe it is a lot of return on investment, that the proposal is well written and ambitious to get the most out of the training program for the county. I like that they trainees will be expected to also develop advocacy skills and do education/outreach as part of their experience. Best, Jean

Email from Paula L., November 5, 2019

I am writing as a primary care internist and addiction medicine physician to support MHSA funding for an addiction medicine fellowship embedded in the public health system of San Mateo County. Such a program has the potential to greatly improve the health and well-being of county residents of all ages in both urban and rural settings. In San Mateo and other counties in California, there is a tragically unmet need for a nimble health professional workforce that can identify and treat unhealthy alcohol, tobacco, and other drug use. Many primary care and behavioral health providers in practice today have received little or no evidence-based education in addiction medicine during their training; they lack the confidence and skills needed to identify, prevent and manage this complex, stigmatized, but common disorder. Alcohol and tobacco still kill and injure more people than most other diseases. An opioid and methamphetamine epidemic strike daily at the heart of our community. This has only escalated in the Bay Area as income disparities widen and the role of social determinants of health are magnified. Despair grows, families are broken and lives are lost. The benefit of a public health approach to substance use disorders and the potential of a public sector addiction medicine fellowship is multiplicative. A fellowship not only expands the public health addiction medicine workforce available in the county, but it also develops providers with the leadership skills and expertise to teach and support primary care and behavioral health providers in the larger system of health care. Substance use disorders are preventable and treatable. Prevention and treatment saves lives.

Respectfully submitted, Paula J. Lum, M.D., M.P.H., Professor of Medicine
Program Director, UCSF Primary Care Addiction Medicine Fellowship HIV, ID and Global Medicine Division,
University of California, San Francisco and San Francisco General Hospital

Email from Farah Z., November 6, 2019

Hi Ms. Estremera, I hope you are well!

I wanted to send you my comments in strong support of Addiction Medicine Fellowship proposal for San Mateo County. As a psychiatrist, I work on a regular basis with diverse patient population struggling with

Co-Occurring substance use and Mental health disorder. Despite SUD prevalent in our patient population, a very small percentage of patients receive treatment. The patients who are willing to engage in SU treatment struggle in finding the providers and treatment due to many barriers. Addiction Medicine Fellowship through County system will help overcome one of the barriers by generating and retaining the workforce of competent physicians for treating complex illness of addiction. Therefore, I fully support this project. Thank you!

Best, Farah Zaidi, MD, San Mateo Medical Center, Department of Psychiatry