EXHIBIT A

INNOVATION WORK PLAN
COUNTY CERTIFICATION

County Name: San Mateo

County Mental Health Director	Program Lead
Name: Louise F. Rogers, MPA	Name: Sandra M. Santana-Mora, MA
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I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this update to the Three-Year Program and Expenditure Plan. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code Section 5891 and California Code of Regulations (CCR), Title 9, Section 3410, Non-Supplant.
This Plan or update has been developed with the participation of stakeholders, in accordance with CCR, Title 9, Sections 3300, 3310(d) and 3315. The draft Program and Expenditure Plan or update was circulated for 30 days to stakeholders for review and comment. If this is the county's first submission of a PEI component, the local mental health board or commission has held a public hearing on the Plan. All input has been considered with adjustments made, as appropriate.
All documents in the attached Program and Expenditure Plan or Update are true and correct.

_____	12/31/2010	Director, Behavioral Health & Recovery Services
Signature Local MH Director/Designee	Date	Title

EXHIBIT B

INNOVATION WORK PLAN
Description of Community Program Planning and Local Review Processes

County Name:	San Mateo
Work Plan Name:	Total Wellness

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this Annual Update.

1. Briefly describe the Community Program Planning Process for development of the Innovation Work Plan. It shall include the methods for obtaining stakeholder input. (suggested length – one-half page)

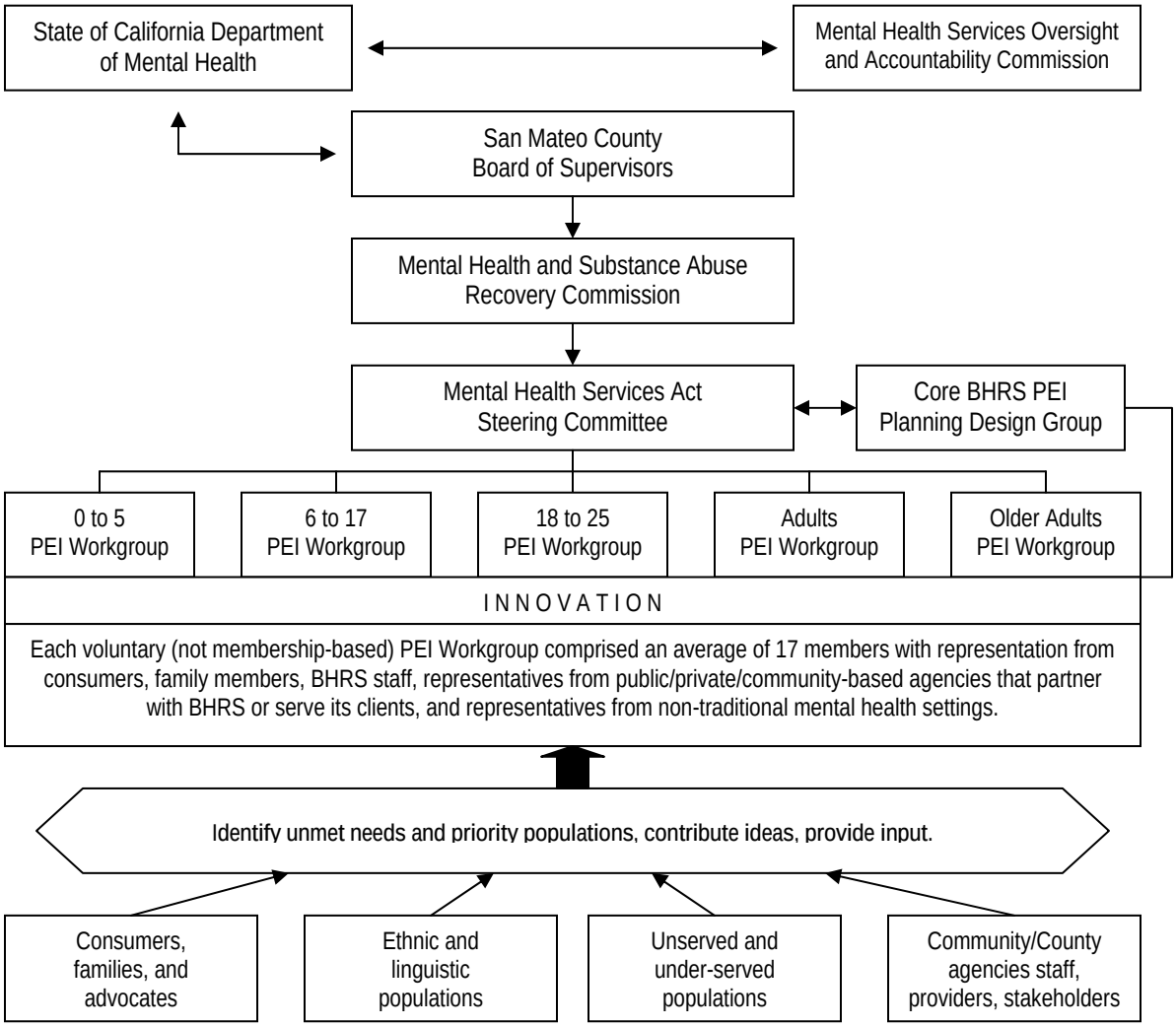
   San Mateo County's MHSA planning processes are designed to facilitate meaningful participation from stakeholders, including representatives from unserved and underserved communities. We have described at length our overall planning structure, common to all planning processes, in numerous previous plan submissions. This structure applies to all MHSA components, and minor adjustments are made as fitting. The role of the MHSA Steering Committee and of the Mental Health and Substance Abuse Recovery Commission (formerly Mental Health Board) in these processes remains in place. The Innovation Proposal benefited from this planning structure and originated during the development of our Prevention and Early Intervention proposal. The Director of the Behavioral Health and Recovery Services Division (BHRS) provided overall guidance and direction to the project, while the Director of Alcohol and Other Drug Services and the MHSA Coordinator (BHRS) designed and carried out the planning process. All three constitute the BHRS Core Process Design Group. Coordination and management for Innovation rested primarily with the MHSA Coordinator, with assistance in facilitation and research from Barbara Mauer, MSW, from *MCPP Healthcare Consulting* (www.mcpphealthcare.com). Ms. Mauer is a nationally recognized authority in integration of behavioral health and primary care. Leadership and staff of the Children, Youth (including Transition Age Youth), Adults and Older Adults Units of the Behavioral Health and Recovery Services Division were heavily involved throughout the process and collaborated and facilitated our outreach efforts.

   Aggressive outreach strategies were used to secure participation of representatives from unserved and underserved populations as well as from the community at large. Examples of our outreach strategies include:

   - Posters and flyers (bilingual) created and sent to/placed at county facilities, as well as other venues like family resource centers and community-based organizations.
   - E-mails disseminating information about the planning process sent to over 1,000 electronic addresses in our ever-expanding database.

- Outreach materials emphasized the MHSA principles of transformation, with the overarching goal of making the mental health delivery system more responsive to the needs of those unserved and underserved.
- Consumers and family members were offered stipends for their time; taxi vouchers were provided to facilitate transportation for individuals who needed assistance.
- We held special meetings with family partners to seek out their input and ideas (with simultaneous interpretation in Spanish). We held a meeting at a senior facility that houses mentally ill older adults on the more elderly side of the age spectrum; this was the only way in which this particular group could provide input into the process. A similar meeting was held for Spanish-speaking seniors.
- Participating organizations serving unserved and underserved communities that collaborated with outreach and/or were directly involved in the planning process include: Heart and Soul (client-run self-help organization); One East Palo Alto; El Concilio; Free at Last; For Youth By Youth; Pyramid Alternatives; Asian American Recovery Services, Edgewood Center for Children and Families, Caminar, among many others.

The diagram below depicts the planning structure, followed by the composition of both the MHSA Steering Committee and the MHSARC.



Mental Health Services Act Steering Committee

Maya Altman Executive Director Health Plan of San Mateo	Debby Armstrong Executive Director First 5 San Mateo County	Beverly Beasley Johnson Director, Human Services Agency County of San Mateo
Dan Becker Representative for the Hospital Council Mills Peninsula Hospitals	Clarise Blanchard Director of Substance Abuse and Co-occurring Disorders, Youth & Family Enrichment Services; Representative BHRS Contractors Association	Linda Carlson Executive Director Women's Recovery Association
Rodina Catalano Deputy Court Executive Officer of Operations, County of San Mateo	Susan Ehrlich, MD CEO San Mateo Medical Center	Patrick Field Consumer
Jean S. Fraser Health System Chief San Mateo County	Richard Gordon President of the Board of Supervisors San Mate County	Richard Holober President SMCO Community College District
Carmen Lee Stamp Out Stigma	Don Mattei Police Chief and Sheriff's Association Sheriff's Office Association	Sharon McAleavey AFSCME
Mary McMillan Deputy County Manager County of San Mateo	Alison Mills Consumer, Heart and Soul Board	Raymond Mills Consumer, Voices of Recovery
Peg Morris Executive Director, and BHRS Contractors Association	Richard Napier Executive Director City/ County Association of Government of SM County	Karen Philip Deputy Superintendent of Schools San Mateo County Offfice of Education
Melissa Platte Executive Director Mental Health Association	Stuart Forrest Chief Probation Officer Probation Department County of San Mateo	Steve Robison NAMI
Marc Sabin Executive Director – Project 90	Janeen Smith Deputy Director Sitike/Pyramid Alternatives	Deborah Torres Director, Child Welfare Human Services Agency
Teresa Walker Family Member	Patricia Way NAMI	Greg Wild Executive Director, Heart and Soul

Mental Health and Substance Abuse Recovery Commission (MHSARC) (Formerly Mental Health Board)

Kathleen Bernard Consumer	Valerie Gibbs Member of the Public	Cameron Johnson Family Member
Randall Fox Holistic Care Client Advocate	Wilson Lim Member of the Public	Amy Mah Member of Public, Family Member
Felicitas Rodriguez Family Member	Sharon Roth Family Member	Judy Schutzman, Chair Family Member
Patrisha Ragins Consumer	Katherine Sternbach Member of the Public	Josephine Thompson Family Member
Donald Livingston Youth Commission Representative	ALL MHSARC MEMBERS ARE MEMBERS OF THE MHSA STEERING COMMITTEE	

The Innovation guidelines were presented and explained to participants with a focus on facilitating an understanding about what constitutes a “learning”, and on the development of innovative practices in the mental health field. Several meetings were held with different constituencies to this end. Stakeholders coalesced around the idea of improving health outcomes of seriously mentally ill persons by developing a San Mateo-grown model –parallel to the IMPACT model in Primary Care, which has as a key component the utilization of Health and Wellness Coaches who are peers (i.e., consumers and family members).

2. Identify the stakeholder entities involved in the Community Program Planning Process.

   The following stakeholder groups also participated, in addition to those identified on item 1 above:

Organizations/Stakeholder Groups
34 Clients, Consumers and Family Members participated in the planning process
4C's of San Mateo County (Child Care Coordinating Council)
Achieve Kids, Palo Alto (serves children and youth with behavioral problems)
African American Community Health Advisory Committee (addresses health issues in the community)
Aging and Adult Services (SMC)
Alcohol and Other Drug Services (BHRS)
Asian American Recovery Services (serving the Asian Community)
Bay Area Partnership for Children and Youth (helps schools access public funding)
Bayshore Childcare (gives affordable childcare to families)
Behavioral Health and Recovery Services leadership and line staff
Belmont Police Department (law enforcement)
CAMINAR (support services in communities for people with disabilities)
Commission on Aging
Commission on Disabilities
Community Gatepath (helps children and adults achieve goals and dreams)
Community Learning Center
Crisis Center (promotes awareness about suicide and suicide prevention programs)
Doelger Senior Center (commits to improving the lives of senior cititzens)
Edgewood Center for Children and Families (serving Youth and Families of various ethnicities)
El Concilio of San Mateo (serving the Latino Community)
Family Services Agency
First 5
For Youth by Youth (youth driven youth services agency)
Fred Finch Youth Center (serving Youth and Families of various ethnicities)
Free at Last (offers street outreach and intervention for persons struggling with AOD issues)
Health Plan of San Mateo

Health System Policy and Planning (SMC)
Heart and Soul (consumer run self-help center)
Human Services Agency

3. List the dates of the 30-day stakeholder review and public hearing. Attach substantive comments received during the stakeholder review and public hearing and responses to those comments. Indicate if none received.

   The draft of the Innovation Plan was released for public comment on October 26, 2010; public comment closed on December 1st, day in which a public hearing was held by the MHSARC. Here is the summary of the public comment received during that period:

   What follows is a summary of comments received during the MHSA Steering Committee meeting held on October 26, 2010. The comments focused on suggested elements of a healthcare home for different age groups (Youth and Transition Age Youth, Adults, and Older Adults). These suggestions will be taken into account during the Total Wellness implementation phase. All members of the Committee participated in the discussion (please see list of MHSA Steering Committee members included in this submission):

   YOUTH AND TRANSITION AGE YOUTH:

   An effective healthcare home for Youth Transition Age Youth (TAY) shall:

   - Have schools involved, as well as parents.
   - Have psychologists/psychiatrists work together.

   For youth/TAY that fall on Quadrant II of the Four Quadrant Model (Low Behavioral Health needs, High Primary Care needs):

   - Make sure to look at physical health, nutrition, weight, diabetes
   - Identify early physical health screening (e.g., concept of school nursing)
   - Parent education for nutrition, exercise, modeling for parents
   - Have schools involved as partners in treatment. Coordinated care (behavioral and physical) must involve and collaborate with schools
   - Private insurers need to be involved as well
   - Provide assistance with eligibility
   - Have ability for medical screens that could keep with diagnosis, such as identification of underlying medical conditions whether they are symptomatic or not.
   - Providers involved in direct care should all be able to access lab results
   - Parent voices need to be heard
   - Utilize family partners for engagement as a way to bring families in
   - Offer parent groups

- Provide health education to youth regarding healthy choices using the peer model
- Provide education to teachers regarding health and wellness
- Offer psychiatric services
- Provide after-hour/weekend care
- Involve youth organizations as partners
- Do outreach for young parents
- Outreach will be key to engage the clients that need help
- Provide drugs and alcohol education programs, as well as sexual education and sexual health services
- Use peers for the outreach
- Be mindful of services focused on the particular needs of the LGBTQQ population; include peer support services for this population as well
- Provide incentives to youth such as food and music
- Consider drop-in centers as one possible healthcare home
- Utilize the mobile healthcare van to reach more clients who wouldn't otherwise be able to access services
- Tap into youth culture/have focus groups with kids/use social networking particularly with Transition Age Youth (TAY)
- Connect with vocational employment services
- Be creative, find ways to make it cool
- Provide support to parents of TAY
- Consider the FSPs as potential healthcare homes
- Provide support with transportation, including assistance on how use bus passes/tokens, etc.
- Safe housing

ADULTS:

Services and supports of a healthcare home for adults should include:

- Linkage to support services
- Investment in the newest brain imaging/SPECT scan technology for diagnosis
- Have someone in the system to communicate with family and client (a liaison)
- Linkage of consumer, family, and care providers
- Utilize creative engagement strategies, especially important at initial engagement
- Help to build a trusting relationship to improve access as well as follow-up
- Provide a clearly identified advocate to help consumers access services
- Consumer and professional liaisons to bolster support structure

In terms of improving engagement, suggested key factors, attitudes and activities are:

- Be respectful to clients and family members in the outreach
- Build trust (not just see someone as a mental health patient)

- Be consistent in term of possibility of continuity with the same providers in order to improve engagement
- Utilize health fairs and community picnics as outreach and engagement strategies
- Improve WRAP ("with WRAP recovery is real")
- Dental services are part of a "total", comprehensive healthcare
- Allow for flex funds to be available for urgent dental issues
- Consider dentistry and dental hygiene students to offer preventive care
- Utilize peer coaches for health education and support
- Provide training to law enforcement
- Emphasize prevention
- Go where the clients are: board and care visits
- Home visits
- Health fair (mental health awareness month, include CIT) for comprehensive "one stop" services
- Use health van to go to less accessible sites and sites where clients naturally congregate (i.e. Heart and Soul)
- Improve access by improving actual capacity at clinics (offer urgent care psychiatry services)
- Increase nurse practitioner staff

OLDER ADULTS:

Elements of an effective healthcare home for older adults should include:

- Field services for those who are homebound
- Assistance with transportation and escort services
- Partner with in-home support services (IHSS/MSSP)
- Consultation/team based care coordination needs to be a priority
- Find ways to involve other community supports –family, faith-based community
- Create consumer boards for each clinic (advisory boards)
- Develop and carry out effective outreach strategies to under-represented older adult communities, such as the LGBTQQI community
- Place great emphasis on prevention –target educational materials so that they are age appropriate
- Community education: support for family members (e.g. education regarding treatment of mental illness for adults, symptom management, medication side effects, etc.)
- Provide consistency and continuity of care
- Provide assistance with navigation and linkage
- Focused outreach and connection to the isolated older adults
- Work with board and care operators to improve monitoring
- Partner with EPS re: treatment needs, prevention, linkage
- Use older adult peers for assistance with providing field based and other services

- Be aware of cultural congruence regarding Wellness Coaches and staff development
- Include outings and social activities as an integral part of the services offered/provided
- Target resources for dementia
- Develop age appropriate strategies for engaging older adults
- Connect the Senior Peer Counseling program with Total Wellness
- Develop engagement strategies for families – field based services for family and caregivers
- Need anchor between primary and specialty care, such as Ron Robison Clinic
- Provide substance abuse services for older adults

Comments received via email from:

- **Raja Mitry, Community Advocate**

  - **Ref.: EXHIBIT B, pp.2-3:** Some interested stakeholders-in-waiting were not aware of the October 26th MHSA Steering Committee meeting. It definitely did disappoint to know these people were unreached. Vulnerable individuals and affected families who do not visit locations where flyers are posted, miss notices, nor have familiarity with online access to BHRS calendars/announcements are the hopeful stakeholders anticipating the opportunity to get help through any possibilities provided by the MHSA's Innovation plan. They may be offered chance for public comment but could sadly fall through the cracks. If the MHSA to some means "Making Hope Serve All", then more strategic and creative improvement by BHRS and its advocates to effectively reach the community-at-large is needed in order for the unserved vulnerables to be identified and engaged, disparities to be reduced, and for prevention of co-morbid plights. Investing in a paid position devoted to *effective outreach and engagement* in this county could produce positive behavioral health outcomes tenfold. Every meeting is an opportunity to help someone move toward wellness.

    Answer: Your concern regarding community involvement in MHSA stakeholder processes is well taken and appreciated. If you were able to broker direct contact between these stakeholders-in-waiting you mention, and BHRS, we would be very grateful. Please direct them to San Mateo's MHSA Coordinator, Sandra Santana-Mora, ssantana-mora@co.sanmateo.ca.us, 650.573.2889. Alternatively, you may provide us with their contact information should they be open to it so that we can include them in specific outreach lists based on their interests. The October 26, 2010 MHSA Steering Committee meeting was heavily advertised through all our communication channels, including the Mental Health and Substance Abuse Recovery Commission, standing internal and external meetings, email lists, web subscriptions, etc. All meetings are included in BHRS's master calendar also available online: www.smhealth.org/bhrs (click on "BHRS Calendars", under "Quick Links"). We

also encourage word-of-mouth transmission of meeting notices and opportunities for input; we hope you will continue to assist us in that regard.

As hard as we work in our outreach and engagement strategies, there is always room for improvement and we welcome the suggestions from committed stakeholders such as you. Since the initial launch of the first community planning process for the Mental Health Services Act, a process design and a planning structure were put in place to ensure broad involvement of various constituencies with a special focus on groups that have been traditionally unserved and underserved. Our website, www.smhealth.org/mhsa, is the clearing house for all MHSA related news and processes. The website has an e-subscription feature that notifies users when the site has been updated, hence providing an easy and effective way to keep apprised of news. Please feel free to direct the public to that website and/or to the MHSA Coordinator.

Regarding your suggestion of investing in a paid position devoted to effective outreach and engagement: Several positions are funded within BHRS and through community partners (with MHSA and non-MHSA funds) that have outreach and engagement responsibilities. While not one single person holds those responsibilities completely, outreach and engagement is an integral part of the work we do in our programmatic initiatives.

- **Ref.: p.2:** A Core BHRS PEI Planning Design Group excluding consumers and family or community members with lived experiences doesn't seem to align with the MHSA value of being consumer and family-driven. To successfully advance the MHSA principles through its implementation, the Core Design Group can give strong consideration in recruiting these citizens (who should be reflective of the MHSA's target populations) to be part of a leading design team.

  Answer: *"Core Planning Design Group" designates the staff team that looks at the task at hand (for example, launching a planning process for the implementation of a Mental Health Services Act component in response to the release of guidelines at the State level), and determines the steps needed to materializing the process. This group generally involves the Director of the Division and/or the Director of Alcohol and Other Drug Services, and the MHSA Coordinator. The Core Planning Design Group is a kind of internal "start-up team" that deals with logistics, general framework, recruiting of consultants and facilitators if needed, etc. As you can see in the diagram depicting the relationships of the Group with other bodies, the Group works with the MHSA Steering Committee (please refer to the Innovation Draft proposal for a complete membership list), and with age/issue focused Work Groups, which drive and carry out the planning process itself. These bodies comprise representatives from different constituencies, including consumers and family members, as well as representatives from unserved and underserved communities. In addition, traditionally, all planning processes include an agenda item on the first meeting that asks participants to suggest groups or other constituencies they believe should be involved in the planning process, as*

yet another way to ensure broad participation. Staff then makes reasonable efforts to outreach to those suggested constituencies.

- **Ref.: p.4:** The current MHSA Steering Committee lacks community individuals from unserved and underserved groups who are representative of different ethnicities; age groups such as TAY, older adults and family members with young children; LGBT of ages across the lifespan; special populations (e.g., developmental disabilities, single parents, esp. single fathers who have tremendous prevention needs, etc.); and not the least, individuals & families challenged with multiple complex conditions in today's harsh economic climate.

  Answer: *The MHSA Steering Committee strives to be inclusive of all relevant stakeholder groups, including representatives from the constituencies you mention. We will continue our outreach to those groups in hopes to engage them in our stakeholder processes. We design our planning processes to be open and accessible so that whoever wishes to provide input into processes and priority setting exercises has several avenues through which to do so. This planning strategy fosters participation regardless of membership in any specific group. While your comment focuses on groups that are absent from the MHSA Steering Committee, and while there is always room and will for improvement, the Committee is rich in diversity, with representatives from various constituent groups. We recently incorporated three new members, two of whom are clients/consumers (one of them from an underserved ethnic group), and the third, a family member who is also an older adult. We will continue to strive for enhancing the diversity of that body.*

- **Ref.: EXHIBIT C, p7:** You identify people with schizophrenia, but do not specifically call out others who are unserved or underserved and also prone to premature deaths due to medical conditions and have non- or under-insured coverage. These would include at-risk individuals from different cultural groups and various racial and ethnic people who may be impoverished, unemployed, refugees, people disenfranchised by stigma and the reality of bad luck, the incarcerated, the homeless, those afflicted by traumatic experiences , etc. All are at high-risk to suffer turmoil and severe stressors leading to serious mental health disorders with co-occurring conditions.

  Answer: *The section you refer to responds to a requirement in the guidelines to select purposes of the proposed innovation project. The guidelines offer four categories, one of which asks if the project would increase access for underserved groups. In our response, we mentioned people with schizophrenia only as an example of how Total Wellness would improve access for an underserved group, to name one. As stated in the project description, the goal of Total Wellness is "to improve the health status of seriously mentally ill individuals with chronic health conditions" (therefore not limited to people with schizophrenia).*

- **Ref.: p. 8:** Individuals, who may be identified by the consumer/client as family members or significant others, can be considered when offering wellness groups and make access to wellness available for them. Their participation in depression care management, for example, is opportunity to partner in care and can improve the outcomes of affected consumers/clients in the program. Honoring the familial connection aligns with cultural appropriateness.

  Answer: *Your suggestion will be taken into consideration when devising the implementation plan for Total Wellness. Thank you very much for bringing this idea to our attention.*

- **Ref.: pp. 10-12:** Some of the functions described for Health and Wellness Coaches are similar or parallel to the functions of a case manager or care coordinator. Please describe how these roles would be coordinated or distinguished so there is no duplication of service delivery but could rather enhance the experience of care.

  Answer: *All members of the Total Wellness care teams will work in coordination and will perform specific functions assigned as per the program design; we believe that there is no risk for duplication because all services provided will be part of an overall coordinated care plan. The project narrative indicates that Health and Wellness Coaches will play a key role in care management by partnering with other team members (nurse care managers, nurse practitioners) to assist clients with communication and advocacy with medical providers, health education, and support. Health and Wellness Coaches will help clients engage in the management of their chronic health conditions and will support them on their journey through many strategies: from assisting them in keeping their appointments with specialty care, to accompanying them to their appointments, to arranging for transportation, to making sure they utilize the wide array of support services at their disposal. San Mateo County has a longstanding tradition of involvement of peer partners (consumers and family members) as part of mental health treatment teams. The innovation introduced through Total Wellness will try this model assisting with the management of health conditions.*

  Regarding the following part of your question, "Would there be shared functions or distinctly separate ones, and will clients (as respected partners with the treatment team) play a role in determining that?": The functions of the team members are determined by the program design and will occur in the context of coordinated care plans. Peer Health and Wellness Coaches will work with each client and the rest of the team to identify the different aspects of the client's health that s/he wishes to focus on, and will support them in achieving their goals. The process will be very much client-driven.

- **Ref.: pp. 14-15:** The Cultural Competence Council, as a representative body for the different BHRS initiatives (i.e., Chinese, African-American, Latino, Filipino, Pacific Islander, Pride, Spirituality), along with the Suicide Prevention

Initiative group and the Anti-Stigma Advisory Council might be mentioned to have inclusion as stakeholders receiving the findings of the Full-Scale Implementation of Total Wellness. These diverse groups can also play vital roles in the Pre-Project Development to improve the quality of stakeholder process and cultural responsiveness in this project.

Answer: *Thank you for your suggestions. It would be impossible to mention all groups exhaustively, therefore we referred to presenting the findings to several stakeholder groups throughout the County, including clients involved, MHSA Steering Committee, Mental Health and Substance Abuse Recovery Commission, among others. This generic description is meant to be inclusive of all relevant stakeholders. A full-implementation scale assessment will likely seek the input of the entire stakeholder community, including but not limited to the specific groups you and we called out.*

- **Ref.: p. 15:** There is only generic indication that an input gathering mechanism for inclusion of stakeholders' perspectives will be built into the project R&A. Family member input in the review and assessment of the Project Measurement is an important piece of this process.

  Answer: Thank you for your suggestion. We have incorporated more specificity.

NOTE: After the public hearing on the plan held on December 1st, 2010 –where all the comments from the public (including the above) received to date were addressed for the benefit of the process, Mr. Mitry contacted the MHSA Coordinator to express satisfaction in regards to the responses received to his comments; he also indicated that his concerns had been addressed.

Comments received via email from:

- **Randall Fox, Holistic Care Client Advocate, Chair of the Mental Health and Substance Abuse Recovery Commission (MHSARC –formerly Mental Health Board), and member of the MHSA Steering Committee**

  - The Total Wellness Project is a beautiful work in progress. It seems to me that the plan could be enriched by including brain imaging technology (specifically, SPECT scan) for diagnostic and/or treatment purposes for high risk co-occurring, complex cases, and cases that do not show significant improvements after 1-2 years of conventional treatment. It is intriguing that psychiatrists seem to be the only medical specialists who never look at the organ they treat. I hope you will take this suggestion into consideration when designing the implementation of the project.

  - *Answer: Your suggestion has been forwarded to our Medical Director, Dr. Celia Moreno, who will evaluate feasibility in the context of the proposed Innovation Plan. Thank you very much for bringing this to our attention.*

EXHIBIT C
Innovation Work Plan Narrative

Date: December 7, 2010

County: San Mateo

Work Plan #: 1

Work Plan Name: Total Wellness

Purpose of Proposed Innovation Project (check all that apply)

- ☐ INCREASE ACCESS TO UNDERSERVED GROUPS
- ☑ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- ☐ PROMOTE INTERAGENCY COLLABORATION
- ☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

The chart below depicts how the management of risk factors associated with Coronary Heart Disease (CHD) results in improved health outcomes:

% Reduction in Risk Factor ➲ results in ➲	% Reduction in Coronary Heart Disease (CHD)
10% in cholesterol	30% decrease in heart disease
Ideal Body weight	35% to 55% decrease in heart disease
Exercise	5% to 55% decrease in heart disease
Blood pressure by 5 points	16% decrease in CHD, 42% decrease in stroke
Stop Smoking	50% to 70% decrease in CHD
Blood pressure by 5 points	16% in CHD, 42% in stroke

It follows that a successful reduction of health risk factors in persons with serious mental illness would result in better care and improved outcomes. A key learning that ***Total Wellness*** wishes to elicit is to what extent the use of peers (consumers and family members) as Health and Wellness Coaches will contribute to those improved outcomes. Please see "Project Description", where this notion is further explored.

While the focal point of ***Total Wellness*** is on increasing the quality of services – resulting in improved outcomes, we believe that ***Total Wellness*** will also result in increased access to underserved groups: 30-40% of excess mortality is caused by suicide and injury, while 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases. From the standpoint of addressing physical healthcare needs of persons with serious mental illness, this group is unquestionably underserved. National studies tell us that persons with serious mental illness are dying 25 to 30 years earlier than the general

population. Our ***Total Wellness*** project will undoubtedly improve access to healthcare services for this underserved group. In addition, since an important aspect of ***Total Wellness*** is to improve access to and utilization of primary care, specialty services, and wellness groups among program participants, we believe the project will increase the proportion of seriously mentally ill clients who:

- have baseline profiles developed with family history of diabetes, hypertension, and cardiovascular disease;
- are screened for lipid and glucose levels annually, blood pressure and weight/Body Mass Index (BMI) quarterly;
- are assessed for tobacco use and co-occurring substance abuse;
- make and keep timely follow up appointments for primary care and other services.

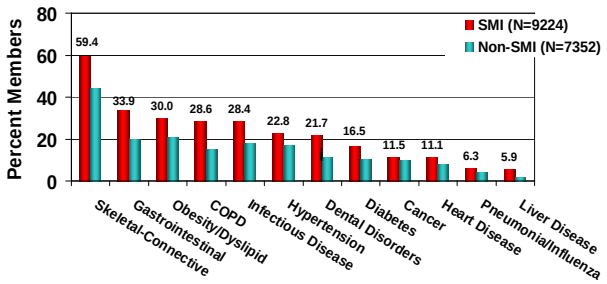
EXHIBIT C

Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e., how the innovation project may create positive change. Include a statement of how the innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length – one page)

Maine Study Results: Comparison of Health Disorders Between SMI and Non-SMI Groups



COPD=Chronic obstructive pulmonary disease

9

National Association of State Mental Health Program Directors (NASMHPD) MedicalDirectors Council. In: Parks J, Svendsen D, Singer P, Foti ME, eds. Morbidity and Mortality in People with Serious Mental Illness. Technical Report, October 2006..

The Behavioral Health and Recovery Services Division will build on several emerging, innovative practices for this program we have called **TOTAL WELLNESS**. As the graphic to the left shows, people with serious mental illness have a range of healthcare issues that compromise their ability to pursue recovery, and the behavioral health system should function as their entry point into primary healthcare --if they are not already being served or if they are underserved.

The ***Total Wellness Project*** has been conceived in San Mateo County to be parallel to the IMPACT model for the identification and treatment of depression and other behavioral health issues in primary care. Building on learnings from practices that have been successful in the primary care setting, ***Total Wellness*** aims at improving the health status of seriously mentally ill individuals who suffer chronic health conditions, adapting some of the strategies in those practices for use in the behavioral health system.

Total Wellness will also build upon and support the practices of the Nurse Practitioners currently located in BHRS clinics, providing assistance and backup to their provision of general healthcare services in the behavioral health setting. Incorporating nurse care manager and peer health and wellness services will assure the smooth and seamless collaboration of all care providers, primarily by the coordinating function of the Nurse Care Managers, the follow up/direct assistance function of the Peer Health and Wellness Coaches, and the overall communication and close collaboration of the entire care team. This will in turn ensure a seamless service experience for clients.

Total Wellness will assure universal screening and tracking for all BHRS consumers receiving psychotropic medications. Tracking will include blood pressure, Body Mass Index, weight, smoking status, as well as glucose and lipid levels.

Nurse Care Managers, in partnership with Peer Health and Wellness Coaches and other care team members as needed will work with individuals who have elevated levels of blood pressure, glucose and lipids, assuring that:

- they are connected to ongoing healthcare in a primary care medical home (using the mental health/substance use entry point as the entry point into primary healthcare as well as access to other services)
- they get clinical preventive screenings (for example, mammograms and other cancer screenings), as well as appropriate primary and specialty healthcare for chronic health conditions (by coaching and/or supporting them in primary care visits or arranging for peers to accompany them)
- they follow up on medications prescribed for physical health conditions
- they engage in a Chronic Disease Self Management Program

The nurse care managers would also link people to benefits counseling, the new Smoking Cessation initiative, and plan and co-lead with Peer Health and Wellness Coaches ongoing groups that support weight management and physical exercise.

The Chronic Disease Self Management Program we are developing for ***Total Wellness*** will benefit from the learnings of an approach conceived by Kate Lorig at Stanford University for people with chronic health conditions such as diabetes, which is being used in primary care. The Lorig model uses structured materials, trained peers, and group processes that are effective in helping people take control of their chronic health conditions. Our project will additionally benefit from an approach now being researched in Atlanta, in which the Lorig materials have been revised for use in the behavioral health system, hence with a focus on mentally ill clients. We are particularly in adapting for San Mateo the piece that involves trained peers as wellness group facilitators. ***Total Wellness*** will take this notion further by utilizing "Peer Health and Wellness Coaches" not only as wellness groups facilitators or co-facilitators, but as partners with Nurse Care Managers, Nurse Practitioners, and other members of care teams to support consumers in achieving their health self-management goals by assisting them, for example, with their primary, psychiatric and/or specialty care visits, and other supports necessary to reach success.

It is the combination of efforts that will make a difference in the health status of our consumers: regular screening and tracking of health status, Nurse Care Managers who assure preventive clinical screening and engagement in a primary care medical home, and utilization of Peer Health and Wellness Coaches to assist consumers in the management of their health conditions, capitalizing on their lived experience.

In all its MHSA and non-MHSA funded programming San Mateo County adheres strictly to principles consistent to the general standards and core values of the Mental

Health Services Act, and Title 9, CCR, Section 3320, which include the values of community collaboration, the delivery of a seamless, integrated service experience for clients, and the promotion of wellness, recovery, and resiliency while striving for a consumer and family-driven behavioral health delivery system that is culturally competent and relevant. ***Total Wellness*** will not be the exception. Case in point: ***Total Wellness***' aim of tending to the health care needs of behavioral health clients in a culturally competent manner speaks to the pursue of an integrated service experience from the point of view of clients. Encouraging and empowering clients to identify what health conditions they would like to focus on as part of this project, and making available Peer Health and Wellness Coaches to assist them in achieving those goals, put clients and family members at the center of this intervention.

Our thinking regarding cultural competence has evolved in the last few years; this evolution has been the result of a concerted effort –which extends beyond the bounds of BHRS and into the larger Health System- to shift to a "cultural humility" framework. "Cultural humility" is described by its creators, Dr. Melanie Tervalon (Children's Hospital, Oakland) and Dr. Jann Murray-Garcia (University of California, San Francisco), as a continuous, lifelong process of self- appraisal and reflection that is centered on giving thoughtful consideration to the assumptions and beliefs that are embedded in the providers' own understandings and goals of their encounter with the client –instead of focusing on learning and responding to a set of traits associated with a particular culture. In this way, cultural competence is not a box that is checked when staff completes a training. Drs. Tervalon and Murray-García state it best in their paper titled ***Cultural Humility versus Cultural Competence***: "Cultural competence […] is best defined not as a discrete end point but as a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves." Within this framework, and in the context of ***Total Wellness***, our project will be very intentional about making itself relevant to the diverse cultures of the clients. Every effort will be made to recruit culturally diverse Peer Health and Wellness Coaches, as well as by making sure that necessary materials are available in different languages as needed, among other strategies.

Lastly, it is through community collaboration, through partnerships and open communication, through a culture of information sharing and transparency that this project was developed, and its work will be carried out, in a way that realizes all the principles envisioned in the Mental Health Services Act.

EXHIBIT C

Innovation Work Plan Narrative

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length – one page)

A recent study published in December of 2009[1] looked at 407 persons with serious mental illness with the goal of testing a population-based medical care management intervention designed to improve primary care in community mental health settings. In an urban community mental health setting the authors assigned these 407 persons to either a medical care management intervention or to usual care. "For individuals in the intervention group, care managers provided communication and advocacy with medical providers, health education, and support in overcoming system-level fragmentation and barriers to primary medical care." The results were compelling:

> *At a 12-month follow-up evaluation, the intervention group received an average of 58.7% of recommended preventive services compared with a rate of 21.8% in the usual care group. They also received a significantly higher proportion of evidence-based services for cardio-metabolic conditions (34.9% versus 27.7%), and were more likely to have a primary care provider (71.2% versus 51.9%). […] Among subjects with available laboratory data, scores on the Framingham Cardiovascular Risk Index were significantly better in the intervention group (6.9%) than the usual care group (9.8%)."*

The authors concluded that "medical care management was associated with significant improvements in the quality and outcomes of primary care. These findings suggest that care management is a promising approach for improving medical care for patients treated in community mental health settings."

Medical care management, as the study above concludes, results in improved outcomes. We offer that this strategy, strengthened by Peer Health and Wellness Coaches, has an even better chance of resulting in improved outcomes. In the previous section we mentioned that our Chronic Disease Self Management Program will benefit from the Stanford (Lorig) and Atlanta (Druss/Emory) approaches, in which

[1] Benjamin G. Druss, M.D., M.P.H., Silke A. von Esenwein, Ph.D., Michael T. Compton, M.D., M.P.H., Kimberly J. Rask, M.D., Ph.D., Liping Zhao, M.S.P.H., and Ruth M. Parker, M.D.: "A Randomized Trial of Medical Care Management for Community Mental Health Settings: The Primary Care Access, Referral, and Evaluation (PCARE) Study". In: American Journal of Psychiatry 2010; 167:151-159. Original publication: December 2009.

peers act as coaches for health-related conditions. ***Total Wellness*** proposes that Peer Health and Wellness Coaches can play a key role in care management by partnering with other care team members (Nurse Care Managers, Nurse Practitioners) to assist clients with communication and advocacy with medical providers, health and wellness education, and other supports as needed. Health and Wellness Coaches will help clients engage in the management of their chronic health conditions and will support them on their journey through many strategies: from assisting them with keeping their appointments with specialty care, to accompanying them to their appointments, to arranging for transportation, to making sure they utilize the wide array of support services at their disposal, to sharing their own personal journey. San Mateo County has a longstanding tradition of involvement of peer partners (consumers and family members) as part of mental health treatment teams. The innovation introduced through ***Total Wellness*** will try this model assisting clients with the management of health conditions.

We predict that the lived experience of consumers and family members in this "Health and Wellness Coach" role will enhance the clients' experience, will engage them in the management of their health conditions, and will be an invaluable support to their journey of wellness and recovery. Furthermore, as the work of these Coaches becomes apparent in the community, especially in those communities in which mental illness and substance abuse disorders are misunderstood (which tends to take place in unserved and underserved groups), or are a source of shame or fear or both, we believe that this work will have a de-stigmatizing effect in those communities, bringing hope to families and clients alike.

EXHIBIT C

Innovation Work Plan Narrative

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication (suggested length – one page)

At this time we cannot predict how our timeline will unfold. Below are our initial thoughts on the matter. In our view, the timeline needs to spread over approximately 3 years to allow sufficient time for learnings to occur, and for feasibility of replication to be assessed.

Implementation/Completion Dates: 04/11 06/14
MM/YY – MM/YY

Pre-Project Development (April 2011 - December 2011)

- Develop screening protocols and tracking system, building on existing wisdom (such as the work of the Nurse Practitioners, the work currently being carried out as part of a Substance Abuse and Mental Health Administration primary care/behavioral health integration grant).
- Expand as feasible pharmacy assistance program for uninsured consumers to support access to necessary medications for chronic health conditions.
- Develop job descriptions of staff for the program, with cultural competence as a lens.
- Explore a possible partnership with College of San Mateo or other educational institutions to offer programs for Peer Health Education Facilitators, building it as an appropriate certification for previously certified peer counselors.
- Obtain adapted wellness materials and curriculum for peer training in health education facilitator role (coordinate with Lorig/Stanford and Druss/Emory)
- Recruit, hire and train Health and Wellness Coaches
- Develop strategy for the provision of wellness groups

Phase I: Screening and nurse care manager services initiated (December 2011 – February 2012)

- Implement process for screening, care management and engagement in primary care services

Phase II: Chronic Disease Self Management Program (March 2012 – June 2012)

- Initiate Chronic Disease Self Management Program

Phase III: Full Scale Implementation of Total Wellness (June 2012 – June 2014)

- Full scale implementation with all pieces in place including data collection and analysis. Presentation of findings to several stakeholder groups throughout the County, on an ongoing basis, including clients involved, family members, MHSA Steering Committee, Mental Health and Substance Abuse Recovery Commission, among others. Development and submission of a Total Wellness Project Report to the Mental Health Services Oversight and Accountability Commission and to the State Department of Mental Health, prepared incorporating the input received from the stakeholder community. The report will also be available online.

As stated in the introduction to this section, these are our initial thoughts on the timeline. The actual\ timeline might look different once all the implementation details are sorted out.

EXHIBIT C

Innovation Work Plan Narrative

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

We envision a series of strategies that will facilitate assessment of the project. The project demands that health outcomes be tracked over time in order to appraise improvement. In that regard, we will look at:

- Improvement on health status indicators such as blood pressure, weight, smoking, glucose and lipid levels
- Improvement in community functioning
- Improvement in self-efficacy
- Capacity built into the community of consumers and family members who can aptly perform the role of Health and Wellness Coaches

In addition, since the key learning we are trying to elicit involves assessing the contribution of Peer Health and Wellness Coaches to the success of the clients, we will also develop tools (such as surveys and/or other methods as appropriate) to evaluate that contribution.

In terms of incorporating the reviews and perspectives of the stakeholder community in the assessment, progress reports will be presented to the stakeholder community through mechanisms already in place, such as meetings of the following groups:

- MHSA Steering Committee;
- Mental Health and Substance Abuse Recovery Board (and its committees, which meet on a monthly basis);
- Meetings with community and internal partners, such as the East Palo Alto Mental Health Advisory Group, the North County Outreach Collaborative, BHRS Leadership meeting, Joint Policy, to name a few;
- Total Wellness Client Advisory Group

In addition, clients that will benefit from the ***Total Wellness Project*** will provide feedback on the full spectrum of services and activities.

Feedback from the stakeholder community will be solicited through appropriate vehicles (such as surveys or feedback forms), and recommendations/suggestions will be processed and evaluated in order to ensure a continuous quality improvement environment for the project.

EXHIBIT C

Innovation Work Plan Narrative

Leveraging Resources (if applicable).

Provide a list of resources expected to be leveraged, if applicable.

In September of 2010 San Mateo County was awarded a grant for the integration of primary care and behavioral healthcare by the Substance Abuse and Mental Health Administration. That project is slated to commence in early 2011; we foresee synergies between that and this project, as well as an opportunity for leveraging resources. MHSA Prevention and Early Intervention dollars will be leveraged for the project as well.

In addition, San Mateo County is one of six counties currently participating in a CalMEND Collaborative for Integration of Primary Care and Behavioral Care. While this project will end in September 2011, the ***Total Wellness Project*** will benefit from the lessons learned through that project.

Lastly, the current budgetary environment demands highly leveraged programming and activities; we will continue to look for new opportunities to increase efficiencies and share learnings.

EXHIBIT D

Innovation Work Plan Description

(For Posting on DMH Website)

County Name:

San Mateo

Work Plan Name:

Total Wellness

Annual Number of Clients to Be Served (If Applicable): 1200 total (this an initial estimate pre-implementation, which actual implementation might correct)

Population to Be Served (if applicable):

The purpose of ***Total Wellness*** **(TW)** is to reduce preventable physical conditions and improve health outcomes for behavioral care clients. To achieve this purpose, the San Mateo County Health System and its partners will increase access to and appropriate use of primary care, specialty care, and wellness programs by delivering integrated primary/behavioral care services at behavioral care clinics. A key strategy within ***Total Wellness*** is utilizing consumers and family members as "Health and Wellness Coaches", partnering with other team members to help project participants manage their health conditions and assist them in their journey towards achieving "total wellness".

Project Description (suggested length – one half page): Provide a concise overall description of the proposed innovation.

People with serious mental illness have a range of healthcare issues that compromise their ability to pursue recovery, and the behavioral health system should function as their entry point into primary. **TW** will use the current evidence based practices developed in the world of primary care to improve the health status of serious mentally ill individuals with chronic health conditions, adapting these practices for use in the behavioral health system. **TW** builds upon and supports the practices of the nurse practitioners currently located in BHRS clinics, providing support and backup to their provision of general healthcare services in the behavioral health setting. A key innovation introduced by **TW** is the use of clients and family members as "Health and Wellness Coaches **(HWC)**", an integral part of the treatment team. The intent is to provide smooth and seamless collaboration among all care providers.

TW will assure universal screening and tracking for all BHRS consumers receiving psychotropic medications. Tracking will include blood pressure, Body Mass Index (weight), smoking status, glucose, and lipid levels. One of the strategies of **TW** is its Chronic Disease Self Management Program, which will use structured materials, trained peers (Health and Wellness Coaches), and group processes that are effective in helping people take control of their chronic health conditions.

It is the combination of efforts that will make a difference in the health status of our consumers: regular screening and tracking of health status, nurse care managers who assure preventive clinical screening and engagement in a primary care medical home, and peer health and wellness coaches to assist consumers in the management of their health conditions as well as support them in their journey of wellness and recovery.

EXHIBIT E

Mental Health Services Act
Innovation Funding Request

County: San Mateo Date: 7-Dec-10

	Innovation Work Plans		FY 09/10 Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
	No.	Name		Children, Youth,	Transition Age Youth	Adult	Older Adult
1	1	Total Wellness	$963,165		$144,475	$674,216	$144,475
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24							
25							
26	Subtotal: Work Plans		$963,165	$0	$144,475	$674,216	$144,475
27	Plus County Administration	15%	$144,475				
28	Plus Optional 10% Operating Reserve						
29	Total MHSA Funds Required for Innovation		$1,107,640				

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: San Mateo
Fiscal Year: 2010/11
Work Plan #: 1
Work Plan Name: Total Wellness
New Work Plan ☑
Expansion ☐
Months of Operation: 04/2011-06/2014
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agenices	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	$2,044,117		$361,162	2,405,279
2. Operating Expenditures	$299,332			299,332
3. Non-recurring Expenditures				0
4. Training Consultant Contracts	$50,000			50,000
5. Work Plan Management	$144,475			144,475
6. Total Proposed Work Plan Expenditures	**$2,537,924**		**$361,162**	**2,899,086**
B. Revenues				
1. Existing Revenues				
2. Additional Revenues				
a. In-kind	$365,328			365,328
b. MHSA PEI	$226,313			226,313
c. Billing (Mental Health and Medical)	$703,562			703,562
c. SAMHSA	$496,243			496,243
3. Total New Revenues	**$1,791,446**			**1,791,446**
4. Total Revenues	**$1,791,446**			**1,791,446**
C. Total Funding Requirements	**$746,478**		**$361,162**	**1,107,640**

Prepared by: Sandra M. Santana-Mora
Date: 12/31/10
Telephone Number: (650) 573-2889

TOTAL WELLNESS BUDGET NARRATIVE

Personnel Expenditures:

- Project Director (BHRS Deputy Director for Adults and Older Adults, 0.2 FTE, in-kind, $37,921); provides oversight and management of the project
- Project Anchor (Community Health Planner, 1 FTE of which 0.5 FTE or $56,282 will be funded through Innovation): supports the Project Director and oversees daily logistical issues as they arise; manages project work-plan
- Nurse Practitioners (3.25 FTE, of which 1.25 FTE are in-kind; 2 FTE or $341,818 will be funded through Innovation): Nurse Practitioners will be responsible for being the initial primary care contact, conducting visits for screening, assessment, follow-up and referral to specialty clinics
- Supervising Physician (1 FTE of which 0.45 FTE or 115,276 will be funded through Innovation); supervises the work of the Nurse Practitioners
- Nurse Care Managers (3.5 FTE of which 2 FTE will or $296,340 will be funded through Innovation); responsible for facilitating access to specialty services and supporting consumers and primary care staff in treating individuals with more complex cases; responsible for coordination of care; work with Health and Wellness Coaches and other team members to ensure follow up and access to services
- Patient Services Assistant (1 FTE or $66,944 will be funded through Innovation); under general of the Nurse Practitioners, provides basic patient care and support to the Nurse Practitioners
- Medical Services Assistant (2 FTE of which 0.5 FTE or $31,861 will be funded through Innovation); supports Nurse Practitioners with reminder calls to clients, scheduling, and other administrative tasks
- Supervising Psychiatrist (0.5 FTE of which 0.25 FTE or $49,176 will be funded through Innovation); consults with Nurse Practitioner and/or Supervising Physician as needed for different activities related to client care, such as consultation regarding medications
- Quality Improvement Consultant (0.5 FTE or $52,697 will be funded through Innovation); provides quality assistance and improvement consultation
- Mental Health Counselor (1 FTE or $107,929); assists in coordination of and supports the work of Health and Wellness Coaches
- Pharmacist (up to $60,000); advises and provide assistance to team as needed regarding medication
- Research and Evaluation (contract, up to $96,970 of which $53,333 will be funded through Innovation); supports the Project Anchor and collaborates with IT specialists to build a bridge between the existing primary care and behavioral health information system, and to ensure adequate data collection
- Dietician (contract, up to $60,000 will be funded through Innovation); trains Health and Wellness Coaches on nutrition related matters, and might provide health education to clients as needed
- Health and Wellness Coaches (contract, up to $204,292 of which $102,096 will be funded through Innovation); Health and Wellness Coaches work in coordination with all team members to assist and support clients in achieving their self-selected physical health wellness and recovery goals

Operating Expenditures:

- Mileage ($12,910 of which $10,000 will be funded through Innovation); transportation for clients and Health and Wellness Coaches as needed. Rate per mile: $0.50
- Flex funds ($78,000 of which $46,000 will be funded through Innovation); transportation for clients and Health and Wellness Coaches as needed. Rate per mile: $0.50; flex funds provide incentives for clients to participate in wellness activities, help with co-pays, etc.
- Training ($50,000 of which $20,000 will be funded through Innovation); provision of trainings as needed for team members and educational activities about strategies to address health conditions of seriously mentally individuals
- Travel ($4,656 of which $2,500 will be funded through Innovation); attendance to conferences or seminars on integration of primary care and behavioral care
- Administration ($153,766 of which $144,475 will be funded through Innovation); expenses incurred by the

County in the administration of the Total Wellness Project

Revenues:

- Please see Exhibit F, page #27 for a detail of other revenues.

Total Wellness Project Cost (projection)

In order to have sufficient time to start up, develop, implement, evaluate and review the program, we believe a period of over 3 years in needed; we do not foresee much variation in the total annual cost of the program, estimated at $1,107,640. Adjustments will be made as needed. In terms of sustainability of the activities should the findings support it, parity laws, the 1115 Waiver, and later on the implementation of the federal Health Care Reform will all offer opportunities to sustain this program.