SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Innovation Project Plan

County Name: San Mateo
Date submitted:
Project Title: Preventing Homelessness to Economic and Emotionally Stressed Older Adults

Total amount requested: $750,000 ($600K services; $90K admin; $60K eval)
Duration of project: 3.9 years

Section 1: Innovations Regulations Requirement Categories

GENERAL REQUIREMENT:

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

- ☑ **Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention**
- ☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement.

- ☑ **Increases access to mental health services to underserved groups**
- ☐ Increases the quality of mental health services, including measured outcomes
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM:

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community.

Older Adult Homelessness

According to the Elder Index[1], 43% of all adults age 65 years and older do not have enough income to meet their most basic needs. In San Mateo County, that's over 38,000 elders struggling to make ends meet. On the March 10, 2019 Sunday San Francisco Chronicle, the front-page article Homeless After 50 as Safety Net Fails[2], discussed the growing older adult homeless population and expectation that this trend will continue to increase. As the article states this problem is especially acute in the Bay Area, where housing costs, including rents, have risen dramatically over the past decade.

In San Mateo County, the cost of living is outpacing the fixed incomes and low to moderate assets of older adults, especially for those over 75 years old. In recent years, San Mateo County Adult Protective Services has seen an increase in referrals of older adults who are evicted or at imminent risk of eviction. San Mateo County's TIES Lines, the 24-hour information and emergency response line for older adults and people with disabilities, received 3,301 housing related calls and 598 calls regarding homelessness. With most of these calls, the older adult is calling at a desperate time, e.g. "Just evicted!", and few options are available. Referrals are made to homeless programs and shelters. Yet, homeless shelters are not designed to serve older adults. Older adults often have physical and cognitive challenges including incontinence, multiple medications, usage of durable medical equipment such as walkers and wheelchairs, hearing aids and glasses. As a result, many older adults choose to live in their vehicles over a shelter.

Research has found that nearly half of the older homeless adults are becoming homeless for the first in their lives after the age of 50. This cohort of older adults have had fewer adverse life experiences and reached more adult milestones than those with earlier homelessness. Some researchers have raised the question of whether some individuals who became homeless after age 50 would respond to less intensive intervention than those with earlier homelessness – particularly if their homelessness were addressed early.[3]

Primary Problem: Housed older adults at risk of homelessness due to economic stress

[1] https://www.ncoa.org/economic-security/money-management/elder-index/
[2] https://projects.sfchronicle.com/2019/visuals/homeless-after-50/
[3] Brown, R. T., Goodman, L., Guzman, D., Tieu, L., Ponath, C., & Kushel, M. B. (2016). Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study. Plos One, 11(5). doi: 10.1371/journal.pone.0155065

The older adult "hope's" they will die before they are evicted; they are embarrassed to discuss their situation and feel shame over their "personal failure"; the client makes statements that resemble symptoms of mild/moderate depression and anxiety.

- Adult Protective Services social worker

Economic Stress

The National Association of Area Agencies on Aging 2018 Housing and Homelessness[4] report, identified indicators that would put older adults at risk of homelessness including, the cost of rental housing, shortages of affordable housing, physical and financial challenges to pay for home repair and maintenance, and limited federal funding for housing programs. These challenges create significant "economic stress" for the older adult. The physical and mental consequences of high social stress include: anxiety, poor nutrition, medication non-compliance, depression, poor decision making, isolation, and homelessness. Economically stressed older adults are reluctant to seek help due to embarrassment, stigma, anxiety, and depression, putting themselves at risk of homelessness. Older adults often minimize their anxiety and other mental health related features related to economic stresses, also contributing to their risk of homelessness. Older adults who experience stigma and embarrassment older over their economic stress don't reach out to a peer or a non-clinical person to share their distress. Compounding any social isolation, they may currently be experiencing.

There is a cohort of older adults who don't want to contemplate losing their housing; don't discuss worries with others; don't trust or know how to use technology for housing resources; and as voiced by one older adult: "hope they are not alive to deal with a housing crisis arises." These older adults are also least likely to reach out for behavioral health services.

PROPOSED PROJECT

Describe the INN Project you are proposing.

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

The proposed project will reach-out and engage isolated older adults who may be at risk of becoming homeless. Trust and safety will be established to reduce shame/stigma. Older adults will be screened for economic stress, behavioral health issues, and connected to homeless, housing and behavioral health resources for planning, and support, to prevent acute homelessness and to slow the growing older adult homeless population trend. The innovation will create a new partnership between Human Services Agency Center for Homelessness providers, Older American Act programs, Behavioral Health and Recovery Services, and Aging and Adult Services.

Reaching out to isolated older adults at risk of becoming homeless

The proposed project will focus on strategies that prevent housing loss in late life and provide early support for currently housed older adults at risk of becoming homeless based on the indicators cited in the literature. Identifying those at high risk of losing

[4] National Association of Area Agencies on Aging, https://www.n4a.org, Housing and Homelessness: Services and Partnerships to Address a Growing Issue (2018)

housing in late life and working to prevent housing loss or provide early support to help older adults remain in their homes is recommended in the research as an effective strategy to prevent progression to chronic homelessness in these adults.[5]

The Older Americans Act (OAA) Congregate Nutrition and Home-Delivered Meals Programs can provide ideal entry points to reach-out to isolated older adults at risk of becoming homeless. These programs provide nutrition services to homebound older adults who have potentially the greatest economic or social needs. In fiscal year 2018-2019 approximately 4,950 eligible 60+ older adults received meals at a nutrition site; and approximately 1,185 eligible 60+ older adults received Home Delivered Meals in San Mateo County. Both programs are staffed with non-clinicians and volunteers. The proposed project will hire one Mental Health Program Specialist and one Mental Health Counselor to fulfill the projects' objectives. They will partner with the two nutrition programs in two disparate cities, engage and establish trust with the older adult meal recipients through individual and group conversations about economic stress and behavioral health.

Reducing shame/stigma

The proposed project will provide isolated older adults with a "safe" place and person(s) with whom they can engage in conversations related to social and economic stresses and behavioral health. The "Behavioral Health Coach Model[6]" is a successful strategy that has been implemented in Atlanta Housing Authority (AHA) properties; by addressing behavioral issues such as disruptive behaviors and hoarding, lease violations and evictions were reduced for a specific cohort of older adults. The program also reduced stigma. As residents became aware and saw other residents engaging with the coaches, they were more likely to self-refer and to refer others to the program.

Economic stress

The proposed project will develop a screening tool, which currently does not exist, that incorporates the risk factors cited in the literature. Shinn et.al.2007, examined several risk factors in their work to identify predictors of homelessness among older adults that include the: inability to afford rent increases after retirement; unexpected disability preventing gainful employment to afford rent; apartment fire; long-term hoarding behavior leading to eviction; and loss of partner who shared the cost of housing. Brown, et.al. 2016, had similar findings and acknowledged little was known about pathways to homelessness among older adults in the United States, yet cited research conducted on older adults in England, which found death of a spouse, retirement, loss of housing tied to employment, worsened mental health problems, cognitive impairments contributing to homelessness in late life.

Behavioral health issues

The proposed project will screen for behavioral health issues, which often go

[5] Brown, R. T., Goodman, L., Guzman, D., Tieu, L., Ponath, C., & Kushel, M. B. (2016). Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study. Plos One, 11(5). doi: 10.1371/journal.pone.0155065

[6] National Association of Area Agencies on Aging, https://www.n4a.org, Housing and Homelessness: Services and Partnerships to Address a Growing Issue (2018)

undiagnosed in older adults. These behavioral health issues may contribute to an older adult's reluctance to seek help when their housing is threatened. Koychev, et.al., 2016, found anxiety disorder in the elderly to be twice as common as dementia and 4-6 times more common than major depression. Anxiety was associated with poorer quality of life, significant distress, and contributed to the onset of disability. Porensky's, et.al., 2009, found anxiety severity in late-life Generalized Anxiety Disorder to be associated with disability and health related quality of life impairments above and beyond the impairments accounted for by depression and medical burden.

Referrals and warm hand-offs

The proposed project will connect older adults to housing and behavioral health resources for planning and support to prevent homelessness. This narrow list of resources includes: San Mateo County Human Resource Services Center on Homelessness Core Service Agencies and San Mateo County Behavioral Health and Recovery Services Senior Mental Health Services Senior Peer Counseling program and community-based bereavement, general counseling and crisis services.

Project activities:

- Project team will outreach to isolated older adults through the Congregate Nutrition and Home-Delivered Meal programs.
- Provide a "safe" stigma free conversation with the home delivered meal recipients, on social and economic stresses that may possibly create an opportunity for economic stress, anxiety and/or depression screening.
- Create "safe" settings at two senior centers, where congregate nutrition and home delivered meal programs exist, for older adults to discuss amongst peers, topics related to social and economic stresses, housing options and planning, to mitigate the risk of homelessness.
- Develop an economic stress tool, which currently does not exist, that incorporates the risk factors cited in the literature.
- Screen older adults to identify behavioral health issues and economic stresses that would put older adults at greater risk of homelessness.
- Refer and provide warm hand-offs to connect the older adults to appropriate behavioral health services and supports.
- Once identified additional preventive interventions will be put in place to support and reduce identified stressors.

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

☑ **Increases access to mental health services to underserved groups**

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

Our approach is based on a comprehensive review of published literature, web-based searches, and through the development of a LEAP process Improvement Charter (IP). An IP is a single page living document that is visual and describes a problem to be improved. An IP will have a: Business Case; Current State; Future State and Action Plan – in addition to a stated Target Problem and Hypothesis. In the fall of 2017, representatives from Human Services Agency Center on Homelessness, Aging and Adult Services, Behavioral Health and Recovery Services, and several community-based homeless and behavioral health agencies met to discuss older adults and homelessness and to develop an initial IP on older adult homelessness in San Mateo county. The following key learnings and characteristics of newly homeless older adults were identified:

1. *Socially Isolated:* older adults were socially isolated prior to becoming homeless
2. *Shame and Stigma:* older adults did not reach out for help due to stigma
3. *Predictors of Homelessness:* there are economic stress warning signs prior to becoming homeless
4. *Behavioral Health Issues:* may contribute to an older adult's reluctance to seek help when their housing is threatened
5. *Preventative Interventions:* for housed older adults, less intensive preventative interventions could mitigate the risk of becoming homeless

These findings were used as supporting evidence for the proposed interventions and selected approach for this project. Appendix 1. Theory of Change illustrates the pathways between these five 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.

The Mental Health Counselor will outreach to isolated older adults through the Home-Delivered Meal and Congregate Nutrition Programs at two senior centers in the cities of Pacifica and Redwood City. These two sites have voiced the most concern about homeless older adults at their center. Pacifica and Redwood City also had high homeless count numbers from this years' Point In-Time homeless count.

In Fiscal Year (FY) 2018-2019 approximately 4,950 eligible 60+ older adults received meals at a nutrition site; and approximately 1,185 eligible 60+ older adults received

home delivered meals in San Mateo County.

- In Pacifica, there were 446 unduplicated nutrition site older adults and 131 unduplicated home delivered meal recipients.
- In Redwood City, there were 230 unduplicated nutrition site older adults and 146 unduplicated home delivered meal recipients.

The expected reach based on this data is as follows:

- 340 home visits by the Mental Health Counselor
- 277 initial conversations to build rapport with homebound older adults
- 24 forums held with 6 participants on average attending each forum
- 75 older adults screened at senior centers
- 120 homebound older adults screened
- 195 linkages to behavioral health and housing resources

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

The project aims to serve the socially and economically challenged 60+ years of age older adult in the Pacifica and Redwood City communities. San Mateo county has a diverse and growing older adult population in general. Yet, Redwood City is more suburban with a large mono-lingual Spanish speaking community, while Pacifica is a coastal semi-rural community. As the "baby boomer" generation ages, our Sexual Orientation and Gender Identity initiative is identifying a growing number of older adults who identify as lesbian, gay, bisexual, transgender and questioning.

Demographic Indicator[7]	**Pacifica**	**Redwood City**	**San Mateo County**
Total Population	38,844	82,595	754, 748
Ages 65+	14%	12%	15%
Race Ethnicity			
• Asian	18%	13%	27%
• Black	2%	2%	2%
• Latino	18%	39%	25%
• Pacific Islander	1%	1%	1%
• White	54%	43%	40%
Percent of Households Who Are Rent Burdened	48%	55%	52%
Percent of Residents Living below 200% of the Federal Poverty Level	13%	25%	20%

[7] U.S. Census Bureau, 2012-2016 American Community Survey 5-year Estimates

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?

As mentioned, prior, the "Behavioral Health Coach Model" is a successful strategy that has been implemented in low income older adult properties to help address behavioral health needs that resulted in lease violations or evictions. The key differences with the proposed project include:

- Implementation of the model in collaboration with the Older Americans Act (OAA) Congregate Nutrition and Home-Delivered Meal Programs as a means of reaching isolated older adults at risk of homelessness.
- Integrating economic stress conversations and screenings

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.

Literature searches were conducted through the San Mateo Medical Center Inter-Library Loan system, Google Scholar and Google search engine. The subjects searched included: "preventing older adult homelessness"; "economic stresses and the older adult"; "pathways to older adult homelessness"; "stress and depression in homeless older adults"; "anxiety and depression in older adults"; "stress and depression in the elderly". The literature review identified research gaps on these subjects and areas of focus for this project.

Gaps in the literature and practice	Proposed intervention
Searches for "economic stress" and "stress in the elderly" mostly produced literature with a clinical/ pathological focus.	The proposed project will focus on prevention and early intervention efforts.
The literature provided some insight into older adults' mental health that may contribute to their experience with "economic stress" and reluctance to seek help if their housing situation is at risk and into older adults.	The proposed project will incorporate behavioral health screenings and linkages.
Searches for screening tools determined that there are NO good screening tools to predict homelessness.	The proposed project will develop a screening tool for economic stress-based indicators cited in the literature.
Searches for older adult homelessness prevention strategies identified the need for adapting interventions for individuals who become homeless after age 50, which may respond to less intensive interventions than those with earlier homelessness. There is a lack of strategies that focus on preventing housing loss in late life.	The proposed project will engage housed older adults and provide referrals and warm hand-offs to services and supports to mitigate the risk of homelessness.

Citations and links used to gather information:

- https://www.ncoa.org/economic-security/money-management/elder-index/
- https://projects.sfchronicle.com/2019/visuals/homeless-after-50/
- National Association of Area Agencies on Aging, https://www.n4a.org, Housing and Homelessness: Services and Partnerships to Address a Growing Issue (2018)
- Bor, J. S. (2015). Among the Elderly, Many Mental Illnesses Go Undiagnosed. *Health Affairs*, 34(5), 727–731. doi: 10.1377/hlthaff.2015.0314
- Shinn, M., Gottlieb, J., Wett, J. L., Bahl, A., Cohen, A., & Ellis, D. B. (2007). Predictors of Homelessness among Older Adults in New York City. *Journal of Health Psychology*, *12*(5), 696–708. doi: 10.1177/1359105307080581
- Brown, R. T., Goodman, L., Guzman, D., Tieu, L., Ponath, C., & Kushel, M. B. (2016). Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study. *Plos One*, 11(5). doi: 10.1371/journal.pone.0155065Koychev I., Ebmeier, K.P. (2016) Anxiety in older adults often goes undiagnosed. *Practitioner,* 260(1789):17-20, 2-3.
- Porensky, E. K., Dew, M. A., Karp, J. F., Skidmore, E., Rollman, B. L., Shear, M. K., & Lenze, E. J. (2009). The Burden of Late-Life Generalized Anxiety Disorder: Effects on Disability, Health-Related Quality of Life, and Healthcare Utilization. *The American Journal of Geriatric Psychiatry*, 17(6), 473–482. doi: 10.1097/jgp.0b013e31819b87b2

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

Learning Goal #1

- Does outreach through congregate nutrition and home delivered meal programs offer an effective approach for reaching isolated older adults?

Learning Goal #2

- Do "Counselors" in these settings establish the trust and rapport needed to reduce stigma and engage older adults in conversations about economic stress and behavioral health?

Learning Goal #3

- Does the pairing of behavioral health and economic stress screening for OA's lead to linkages that prevent more severe behavioral health issues and prevent homelessness?

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

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

- Implementation of the Behavioral Health Coaching model in collaboration with the Older Americans Act (OAA) Congregate Nutrition and Home-Delivered Meal Programs as a means of reaching isolated older adults at risk of homelessness. *(Learning Goal #1 and #2)*
- Integration of economic stress conversations and screenings *(Learning Goal #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 monitor and the Aging and Adult Services 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 outreach through congregate nutrition and home delivered meal programs reach isolated older adults at risk of homelessness?

The outputs for Learning Goal #1 could include:

- Number of home visits with older adults completed in partnership with home delivered meals program
- Number of forums held with senior centers in partnership with congregate nutrition program
- Number of older adults attending the forums

Additionally, demographics of participants that include a few questions on existing social supports, networks and participation can help us determine whether the approach reaches *isolated* older adults. The proposed screening activity for economic stress and behavioral health issues will allow us to determine if the approach reaches older adults *at risk of homelessness*.

Learning Goal #2

- Do "Counselors" in these settings establish the trust and rapport needed to reduce stigma and engage older adults in conversations about economic stress and behavioral health?

The outputs for Learning Goal #2 could include:

- Number of economic stress and behavioral health- related conversations held with homebound older adults
- Number of economic stress and behavioral health- related forums held and participants attended

Additionally, interviews with homebound older adults engaged in conversations and focus groups with forum participants can help us determine the level of trust and rapport that was established, the level of confidence in getting support services when/if needed, and satisfaction with the services provided.

Learning Goal #3

- Does the pairing of behavioral health and economic stress screening for OA's lead to linkages that prevent more severe behavioral health issues and prevent homelessness?

The outputs for Learning Goal #3 could include:

- Number of screenings completed with homebound older adults
- Number of screenings completed at senior centers with older adults
- Number of linkages made to behavioral health services
- Number of linkages made to housing support resources

Additionally, occasional interviews with older adults that were referred to services can help us determine whether older adults engaged in support, the level of satisfaction and outcomes of the referrals.

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

All BHRS service agreements (contracts, MOU's) are monitored by a BHRS Manager that has the subject matter expertise. Contract monitors check-in at least monthly with service providers to review challenges, successes, troubleshoot and stay up-to-date on the progress of the project. Additionally, reporting deliverables are set in place in the agreements and linked to invoicing. Payments of services are contingent on the reporting. Evaluation contracts are monitored in a similar fashion by the MHSA Manager in collaboration with the assigned BHRS Manager.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning (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.);
- 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.smcbhrsblog.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, all comments will be included in Appendix 3. [This section to be updated following the 30-day public comment process].

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

Collaboration has been integral to the development of this project. Human Services Agency Center on Homelessness, Aging and Adult Services, Behavioral Health and Recovery Services, and several community-based homeless and behavioral health agencies who represented the needs and concerns of older adults served, met to discuss older adults and homelessness and to develop an initial improvement plan on older adult homelessness in San Mateo county.

The proposed project will require continued partnerships for success specifically between the Older Americans Act (OAA), Human Services Agency Center for Homelessness, Behavioral Health and Recovery Services (BHRS), Aging and Adult Services (AAS), local senior centers and the older adult service recipients.

- The Congregate Nutrition and Home-Delivered Meal Programs and senior centers provide services for older adults who have the greatest economic or social needs. The staff and volunteers are gatekeepers and they have access to an ideal entry point to reaching isolated seniors at risk of homelessness. They are a trusted service and space in the community that will be integrating a Mental Health Counselor into routine activities and collaborating regularly with AAS to troubleshoot, strategize and monitor the success of the program.
- Older adult recipients will be engaged in safe conversations about economic challenges and behavioral health, their partnership and input into the process will drive the linkages made and the development or procurement of additional preventive interventions that may be needed to support and reduce identified stressors.

B) Cultural Competency

The older adult population in the two target areas considered for this project are culturally different. In order to deliver culturally responsive services, ideally the Mental Health Counselor will be a mature adult with bilingual/bicultural Spanish speaking skills, with personal experience with housing challenges, to represent the low-income older adults being served in both communities. This will support trust-building and linkages for some of the most vulnerable older adults.

C) Client/Family-Driven

As mentioned above, older adult recipients of services will be driving the linkages made and development of any additional resources and interventions needed. This program is a prevention strategy targeting individuals that have not been diagnosed with a mental health condition. 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 Older 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 including hiring bilingual/bicultural peer mental health worker to conduct the outreach, focusing the outreach on trust building, conversations and a process that aims to creating safe spaces and reduce stigma and shame.

E) Integrated Service Experience for Clients and Families

A memorandum of understanding will be drafted between AAS and BHRS, who will be the primary monitors of the work, outlining responsibilities and expectations for this project. Pre-launch planning and ongoing collaboration will be critical to offering an integrated service experience for recipients. The Mental Health Counselor will need to be well-informed on the full range of services at BHRS and the community and build relationships with gatekeepers to ensure a coordinated referral and warm hand-off process.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

As mentioned earlier, the evaluation contractor will engage an advisory group of diverse clients, family members and providers to gather input on the evaluation questions, strategies and on quarterly progress reports. Cultural and language demographics will be collected and analyzed as part of the quarterly reports to ensure equal access to services among racial/ethnic, cultural, and linguistic populations or communities. The quarterly reports will be used to inform and adjust as needed the direction, outreach strategies and activities.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety or keep particular elements of the INN project without utilizing INN Funds following project completion. Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

The advisory group will be engaged in the evaluation and adjustments of the project. In addition, the MHSA Steering Committee will be a venue for vetting next steps with diverse stakeholders.

If the evaluation indicates that the proposed project is an effective means of increasing access to behavioral health services for at risk older adults and there is availability of Prevention and Early Intervention (PEI) funding, a proposal of continuation would be brought to the MHSA Steering Committee and the Mental Health and Substance Abuse Recovery Commission for approval and to a 30-day public comment process to secure ongoing PEI funding. Contractors will be asked to develop a sustainability plan as part of their project proposal.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

MHSA implementation is very much a part of BHRS' day-to-day business. Information is shared, and input collected with a diverse group of stakeholders, on an ongoing basis. All MHSA information is made available to stakeholders on the MHSA webpage, www.smchealth.org/bhrs/mhsa. The site includes a subscription feature to receive an email notification when the website is updated with MHSA developments, meetings and opportunities for input. This is currently at over 1,500 subscribers.

The BHRS's e-journal, Wellness Matters is published the first Wednesday of every other month and distributed electronically to county wide partners and stakeholders, and serves as an information dissemination and educational tool, with a standing column written by the County's MHSA Manager. The BHRS Blog also provides a forum for sharing and disseminating information broadly. In addition, presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the monthly Mental Health and Substance Abuse and Recovery Commission meeting at the MHSA Steering Committee meeting; at meetings with community partners and advocates; and internally with staff.

Opportunities to present at statewide conferences will also be sought.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

- Older Adults and Economic Stress
- Preventing Older Adult Homelessness
- Mental Health and Older Adult Homelessness

TIMELINE

A) Specify the expected start date and end date of your INN Project
February 1, 2020 – December 31, 2023

B) Specify the total timeframe (duration) of the INN Project
3.9 years;

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

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

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

February 1, 2020 – June 30, 2020

- BHRS Administrative startup activities –MOU development and negotiations

July 1, 2020 – September 30, 2020

- Project startup activities – establish/formalize agreements as needed (with senior centers and OAA), establish advisory group, hire staff, set up infrastructure for implementation/evaluation and referral system and resources
- Development of economic screening tool begins
- Evaluator to meet with AAS Process and Improvement unit, advisory group, AAS and BHRS staff to discuss evaluation plan and tools

October 1, 2020 – December 31, 2020

- Onboarding of staff – training, relationship building, networking
- Determine schedule of home visits and forums, finalize promotion materials, referral resources and screening tools
- Evaluation plan finalized including data collection and input tools

January 1, 2021 – June 30, 2021

- Outreach, home visits, community forums, referrals and warm hand-offs begin
- Data tracking and collection begins
- First evaluation quarterly report January 1, 2021 – March 31, 2021 presented to advisory group for input, adjustments to strategies, tools and resources, based on operational learnings to-date and quantitative data available.
- Identify any additional preventive interventions that may be needed to support and reduce identified stressors.

July 1, 2021 – December 31, 2021

- Explore and finalize any recommendations for additional preventive interventions that may be needed to support and reduce identified stressors.
- Qualitative data collection begins (interviews, focus groups, etc.)
- Sustainability planning begins
- Continue outreach, home visits, forums, referrals and warm hand-offs
- Continue evaluation quarterly reports to request input and determine adjustments, as needed

January 1, 2022 – June 30, 2022

- Explore and finalize any recommendations related to additional preventive interventions that may be needed to support and reduce identified stressors.
- Continue sustainability planning
- Continue outreach, home visits, forums, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2022 – December 31, 2022

- Initial sustainability plan presented
- Engage MHSA Steering Committee and MHSARC on issue of continuation of the project with non-INN funds
- Determine if PEI dollars will be available to fund all or portions of the project
- Continue outreach, home visits, forums, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

January 1, 2023 – June 30, 2023

- Sustainability plan finalized
- Continue outreach, home visits, forums, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2023 – December 31, 2023

- Complete evaluation analysis and report
- Disseminate final findings and evaluation report

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)
C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project.

The total Innovation funding request for 3.9 years is $750,000, which will be allocated out as follows:

Service Contract: $600,000
- $200,000 for FY 20/21
- $200,000 for FY 21/22
- $200,000 for FY 22/23

Evaluation (10%): $60,000
- $16,000 for FY 20/21
- $16,000 for FY 21/22
- $16,000 for FY 22/23
- $12,000 For FY 23/24

Administration (15%): $90,000
- $15,000 for FY 19/20
- $30,000 for FY 20/21
- $30,000 for FY 21/22
- $15,000 for FY 22/23

Direct Costs will total $600,000 over a three-year term and includes all contractor expenses related to delivering the services (salaries and benefits, program supplies, rent/utilities, mileage, transportation of clients, translation services, subcontracts for outreach, etc.).

Indirect Costs will total $150,000
- $90,000 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.
- $60,000 for BHRS administration, monitoring and management of the innovation project(s).

Federal Financial Participation (FFP) there is no anticipated FFP.

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						
2.	Direct Costs						
3.	Indirect Costs	$15,000	$30,000	$30,000	$15,000		$90,000
4.	**Total Personnel Costs**	**$15,000**	**$30,000**	**$30,000**	**$15,000**		**$90,000**
OPERATING COSTS		**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**TOTAL**
5.	Direct Costs						
6.	Indirect Costs						
7.	Total Operating Costs						
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		$200,000	$200,000	$200,000		$600,000
12.	Indirect Costs		$16,000	$16,000	$16,000	$12,000	$60,000
13.	**Total Consultant Costs**		**$216,000**	**$216,000**	**$216,000**	**$12,000**	**$660,000**
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**	**$15,000**	**$246,000**	**$246,000**	**$231,000**	**$12,000**	**$750,000**
BUDGET TOTALS							
Personnel (line 1)							
Direct Costs (add lines 2, 5 and 11 from above)			$200,000	$200,000	$200,000		$600,000
Indirect Costs (add lines 3, 6 and 12 from above)		$15,000	$46,000	$46,000	$31,000	$12,000	$150,000
Non-recurring costs (line 10)							
Other Expenditures (line 16)							
TOTAL INNOVATION BUDGET		**$15,000**	**$246,000**	**$246,000**	**$231,000**	**$12,000**	**$750,000**

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

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures 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 ~~MH~~SA Funds	$15,000	$230,000	$230,000	$215,000		$690,000
2.	~~Federal Financial~~ Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	**$15,000**	**$230,000**	**$230,000**	**$215,000**		**$690,000**
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~~		$16,000	$16,000	$16,000	$12,000	$60,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**		**$16,000**	**$16,000**	**$16,000**	**$12,000**	**$60,000**
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	$15,000	$246,000	$246,000	$231,000	$12,000	$750,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**	**$15,000**	**$246,000**	**$246,000**	**$231,000**	**$12,000**	**$750,000**
*If "Other funding" is included, please explain.							

Appendix 1. Theory of Change

Theory of Change

Primary Problem: Housed Older Adults (OA) at Risk of Homelessness Due to Economic Stress

Key Considerations (from the literature)

Socially Isolated
OA's were socially isolated prior to becoming homeless

Shame and Stigma
OA's did not reach out for help prior to becoming homeless due stigma

Predictors of Homelessness
There are economic stress warning signs prior to becoming homeless

Behavioral Health Issues
May contribute to an older adult's reluctance to seek help when their housing is threatened

Preventative Interventions
For housed OA's, less intensive interventions could mitigate the risk of becoming homeless

Interventions

Outreach
Peer Counselors will outreach to isolated OA's through congregate nutrition and home delivered meals

Trust Building
Peer Counselors will engage homebound OA's and provide group forums at senior centers to facilitate stigma-free conversations

Economic Stress Screening
Screening tool will be developed incorporating economic stress risk factors cited in literature.

Behavioral Health Screening
Peer Counselors will also screen OA's for anxiety and depression

Referrals/Warm Hand-offs
Peer Counselors link OA's to services, information and planning resources to support housing stability, based on the screening results

Outcomes

Home Visits and Forums
340 OA visits with home delivered meals program
24 forums held at senior centers
144 participants attend forums

Conversations
277 conversations regarding social and economic stress with homebound OA's

Screening and Linkages
120 screenings completed with homebound OA's
75 screenings completed at senior centers with OA's
195 to behavioral health and housing support resources

Learning Objectives

Learning Goal #1
Does outreach through congregate nutrition and home delivered meal programs reach isolated older adults at risk for homelessness?

Learning Goal #2
Do Peer Counselors in these settings establish the trust and rapport needed to reduce stigma and engage older adults in conversations about economic stress and behavioral health?

Learning Goal #3
Does the pairing of behavioral health and economic stress screening for OA's lead to linkages that prevent more severe behavioral health issues and prevent homelessness?

MHSA INN Primary Purpose

Increased access to behavioral health services

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 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

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.

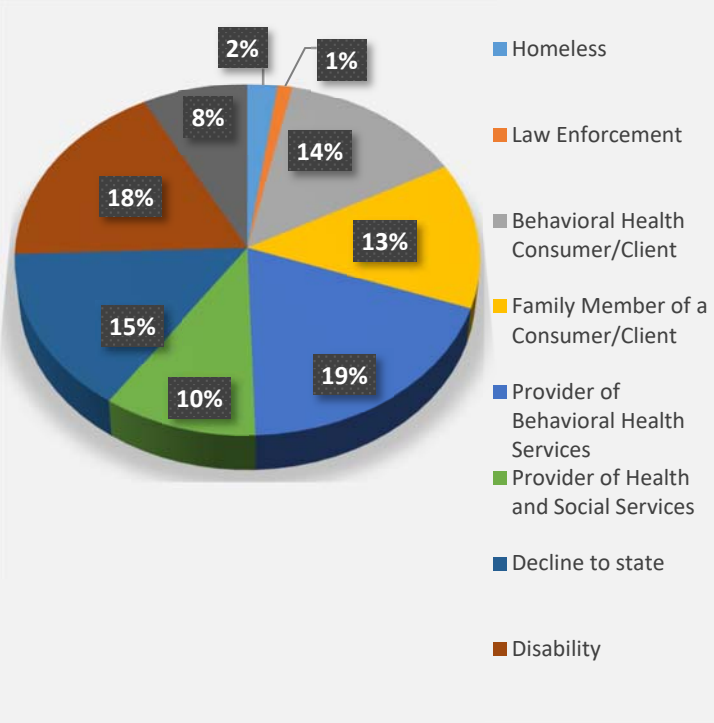
Additionally, a Pre-Launch session was held with clients/consumers hosted by the Peer Recovery Collaborative, a collaborative of peer-run agencies including California Clubhouse, Heart and Soul and Voice of Recovery. At this session information was presented and shared to help prepare clients/consumers 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

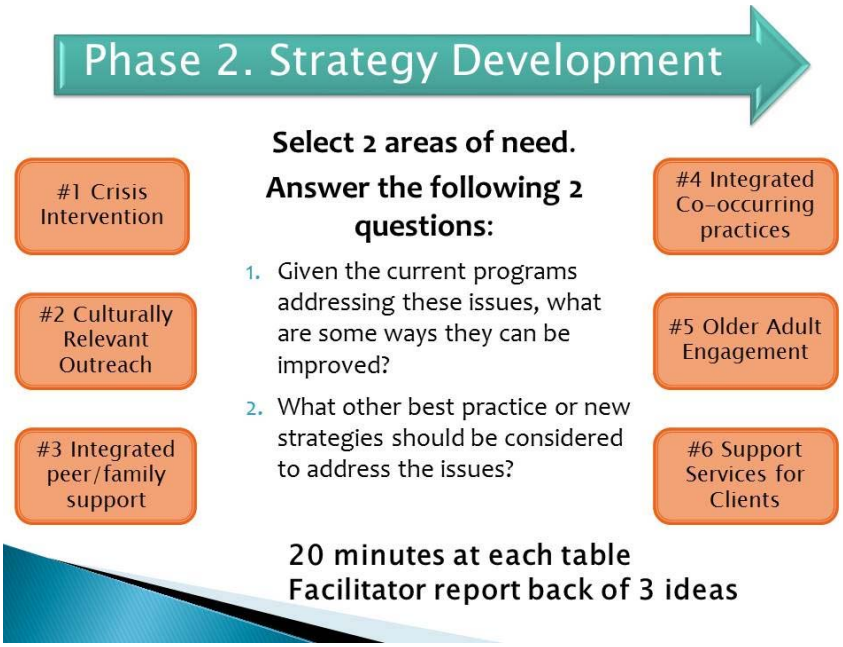
For Phase I and the initial input sessions, stakeholders where asked the following questions, based on the priority gaps identified in previous years for continuity:

- From your perpective, do these MHSA services 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. See Appendix 3, Needs Analysis Summary of Input, for the complete list of themes and comments received. The CPP Launch Session was a joint MHSARC and MHSA Steering Committee meeting and included a facilitated community input. Agenda items included 1) an MHSA Housing proposal for use of unencumbered housing funds 2) public comment from clients, families and community members on priority needs and gaps in mental health services, and 3) breakout groups to begin developing strategies to address the key needs/service gaps identified. About 120 clients, families, community members and stakeholders attended the CPP Launch Session. See Appendix 4 for all CPP Launch Session materials, handouts, minutes and attendance.

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.



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

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