

Innovation Work Plan Narrative: INN-11

Work Plan Name: Care Giver Connection to Treatment
County: San Diego

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).

There is well-documented literature detailing the unique burden placed on caregivers. Caregiving has been shown to be an independent risk factor for mortality, and caregivers have higher levels of depressive symptoms, higher levels of anxiety and lower levels of perceived health (Schultz, et al 1999). Literature detailing the consequences of caregiver burden points to physical, psychological, emotional, social and financial consequences (Sorrell, 2014). Connecting caregivers to treatment and other types of support promotes wellness not only in the caregiver, but also for those whose care they provide. Historically the literature has evaluated the impact on those who care for the elderly or for those who care for persons with significant medical illnesses.

There is insufficient literature available that addresses the unique caregiver burden of those who have children ages 0-5 with complex emotional, behavioral and developmental issues and the subsequent benefit of treatment for both the caregiver and the child. There is no existing practice in San Diego County BHS system where caregivers of children ages 0-5 with complex needs who are our primary clients are routinely screened and connected to treatment. Traditional funding regulations have prohibited BHS-CYF from providing services specific to the caregiver. Anecdotally we know that caregiver stress can be a barrier to a child's treatment. Through implementation of the novel approach described below, we expect to increase access to mental health services for the caregivers of children in treatment for complex emotional, behavioral and developmental issues ages 0-5, increase caregiver satisfaction, and note improved overall emotional, behavioral and developmental gains for the child. As we move forward, we will be able to evaluate the extent of the need for caregiver mental health treatment and connection to resources and the impact of this treatment and connection to resources not only on the caregiver, but on the child receiving services within our system in the following ways:

- Children, Youth and Families (CYF) System of Care 0-5 Subcommittee identified the need for caregiver treatment separate and distinct from the treatment of the young child.
- Most caregivers of young children in the CYF System of Care do not meet criteria for public specialty mental health services typically available to those with Serious Mental Illness. However with the advent of the Affordable Care Act, more adults with mild or moderate symptoms will have access to care.

- Traditionally, caregivers who are overwhelmed with caring for a child with complex needs do not access mental health and drug and alcohol services for themselves.
- Programs serving children age 0 to 5 are focused on the child's needs in addition to parent / child interaction and at best provide referral information to caregivers for their own behavioral health needs.
- Programs can play a role in educating families about the toll of caregiver stress. Emotional consequences of caregiver stress include anger, anxiety and depression.
- Maternal depression adversely affects physical, cognitive, social, behavioral and emotional development of children (World Health Organization, 2008).
- Supporting the caregiver in their own mental health any recovery allows for increased availability to their child which ultimately enhances the whole family's quality of life and wellbeing.

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.

- Current CYF treatment programs focus on the mental health, and social/developmental needs of the child, with family work being done in direct relationship to the clinical presentation of the child. Expanding the focus to address the behavioral health and needs of the caregiver and analyze the effectiveness of this intervention on the child's treatment is not currently being done in our System of Care.
- Other systems have utilized family partners and/or other staff to engage and support caregivers, however there is no available data on the impact of this support on clients age 0 to 5.
- Given the significant developmental milestones from age 0 to 5, it is thought providing mental health treatment and connection to resources to the child's caregiver would have a measureable impact on the children in services for emotional, behavioral and developmental concerns.
- A 0 to 5 child serving program shall be augmented with a clinician who will offer support groups for caregivers focusing on providing educational information about stressors associated with caregiving in addition to providing support for the caregiver's behavioral health needs.
- The intent is for the clinician to offer specialty groups to address caregiver's symptomology such as depression, anxiety, and co-occurring disorders.
- With the advent of the Affordable Care Act and parity for behavioral health, mental health services are even more widely available to caregivers, but work is needed to make a meaningful connection to existing resources.
- Stigma associated with mental health treatment remains a barrier. Caregivers, particularly of young children, may prioritize the child's care over their own, not recognizing the impact parent mental health has on the family system.
- A Parent Care Coordinator position shall be added to ensure that parents in need of individual behavioral health services are connected to the appropriate resources.
- Care Coordinators shall form connections with Cal-Works and the Medi-Cal Health Plans who have existing behavioral health services for adults as both provide services to adults with mild to moderate mental health needs.

- The Care Coordinator shall function as the liaison between the child's treatment team and the caregiver provider.
- Care Coordinators shall be trained in Motivational Interviewing which is a clinical approach used to support those with chronic conditions make positive behavioral changes to support better health.
- A 0.5 FTE Licensed or Licensed Eligible clinician will be dedicated to screening, assessing, and coordinating with the tri-disciplinary treatment team the needs of caregivers. The clinician will offer behavioral health group sessions to family members who are assessed to have behavioral health needs.
- Two FTE Parent Care Coordinators will be available to offer caregiver support and make meaningful connections to individualized behavioral health services for the caregiver with an emphasis on identifying and addressing barriers to services.
- A research position will allow for data collection, analysis and an annual report to identify impact and offer best practices.

Based on community input and system analysis, current services focus on the child's needs and are not able to address mental health or substance abuse issues that the caregiver is at higher risk to face due to their caregiver role. To promote the health of the family unit, addressing the parent's needs is essential. Community resources are available however barriers prevent caregivers from accessing those services. A new approach of offering caregiver focused services from the team that is already working with the family to address the child's needs, as well as making some of the services available at the same site as where the child is accessing services is hypothesized to increase access to care for the caregiver and ultimately create a family unit that is healthier and better positioned to support the child.

- It is expected that 100% of families enrolled in the program will be screened to determine need.
- A Countywide program serves approximately 200 children annually with multiple caregivers per child.
- It is projected that a minimum of 200 caregivers will receive a screening and of those, roughly 50% will need and elect to receive care coordination and/or direct clinical services.
- Projected target of 200 screening and 100 treatment/care coordination participants.

This project is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320.

Community Collaboration: The concept for this work plan was developed based on local stakeholder process for input on system needs. An Early Childhood Mental Health Subcommittee of the Children's System of Care Council which has four sector representation of public, private, education, and family & youth expanded the overall input of caregiver services to outline a co-location component. Care Coordinators will work to establish strong working relationships with community resources and medical and behavioral healthcare providers. This will include, but not be limited to, connection with Cal-WORKS, Federally Qualified Health Centers, primary care providers and community based behavioral health care providers. It is anticipated that these connections will, in turn, raise awareness of the importance of early intervention for children with emotional, behavioral and developmental needs.

Cultural Competence: As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services and to improve outcomes for unserved and underserved adults with mental illness. The program will work to establish, at baseline, disparities in services accessed by racial/ethnic, cultural and linguistic populations or communities. An independent assessor will identify and measure disparities when compiling data regarding the impact of the program on minority children and caregivers. This information will allow the program to tailor services to engage and retain caregivers of diverse racial/ethnic, cultural, and linguistic populations. This information will be incorporated into policy, program planning and service delivery. Program staff will receive ongoing training so they can best understand and address particular racial/ethnic, cultural and/or linguistic communities.

Client Driven and Family Driven Mental Health System: Provider input has given voice to family members who expressed desire to address their own mental health struggles outside of the work that is being done within the family unit. This program can offer more options to family members and addresses the barriers to access. This program includes the ongoing involvement of clients and family members in roles such as, but not limited to, implementation, evaluation, and future dissemination. Impact on both clients and caregivers will be measured as an outcome of this project. Ultimately, the program strives to create healthier families in our community.

Wellness, Recovery and Resilience Focus: This program increases resilience and promotes recovery and wellness for caregivers with serious mental illness by increasing access to services. The goal is to strengthen the overall family unit by addressing individual needs that allow for a more stable and resilient family system with strength to sustain wellness.

Integrated Service Experience: This program encourages access to a full range of services provided by community resources, multiple agencies, programs and funding sources for family members. Care Coordinators will be tasked with learning about public and private resources to optimize referrals. Focus will be on educating the family about their options as well as facilitating connections to needed services.

Number of Participants to be Served

- It is expected that 100% of families enrolled in the program will be screened to determine need.
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- Projected target of 200 screening and 100 treatment/care coordination participants.

Total Funding

Note: The 3rd year of proposed Innovation funding will occur in FY 2017-18, which is outside of the time frame for this Three Year Plan.

Annual Program Cost	\$218,446	3 Year Program Cost	\$655,338
Evaluation Cost (4.4% of Total)	\$10,054	3 Year Evaluation Cost	\$30,162
Total Annual Innovation Funding	\$228,500	3 Year Grand Total	\$685,500
Inclusive of estimated MHSA costs only (estimated administrative costs are not included).			

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.

The learning objective is to determine if having a component within a program that serves children 0-5 focusing on providing services to the caregiver will successfully engage caregivers in their own mental health treatment. The approach of having a traditional behavioral health child program specifically address the individual behavioral health needs of the caregiver is not currently practiced. Our goal is to learn if these new approaches will lead to improved access to mental health services for unserved and underserved caregivers. Furthermore, we hope to learn if new approaches will lead to improved outcomes for the children whose caregivers become engaged in their own care. Because the program has two components of offering on site services as well as individualized connection to existing services, we will be able to look at the preferred method through utilization, and perhaps identify if cultural preferences exist.

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.

NOTE: Program design to be developed from competitive process. The dates identified below are a projection of implementation, actual datelines to be determined by winning proposal.

Implementation/ 07/2015 – 06/2018

Completion Dates:

By 6/2015 Program contract procurement process ends

7/2015 Contract award. The contractor will be allowed up to 6 weeks start-up time to

recruit, hire and train staff.

- 7/2015 Core services begin in July 2015, with innovation component implemented by mid-September 2015. Parents of children age 0-5 enrolled in services will be connected with the Care Coordinator and the process of assessment, motivational interviewing and linkage to services will begin. Provider shall establish mechanisms to obtain caregivers input and recommendations regarding the two distinct services they will be offered (on-site psychoeducation and mental health services and personalized and supported connection to existing mental health, substance abuse treatment and community resources) Hire an independent evaluator to initiate data analysis process.
- 7/2015
- 8/2015 Care Coordinator begins formalizing referral pathways with other agencies that offer adult mental health and substance abuse services.
- 8/2015 Independent evaluator with contractor establishes a research and data collection outline and tools to capture effectiveness of caregiver component of the program. Provider shall identify a clear measure of increased access by caregiver.
- 9/2015 Begin ongoing data collection and evaluations.
- 1/2016 The first semi-annual report will be due 30 days after the second quarter of the project. This report will include all data elements year-to-date; analysis of the barriers and successes of the project and recommendations based on lessons learned thus far.
- 8/2016 The first annual report will be due 30 days after the end of the first year of the project and will follow the outline of the first semi-annual report but also include results of a consumer survey, as well as any new data elements and/or additional analyses recommended by the first report.
- 1/2017 Follows same format as 1/2016
- 8/2017 Follows same format of 8/2016
- 1/2018 Follows same format as 1/2016
- 8/2018 Provide final program assessment and outcome with recommendations. Report will be made available for review by other counties. Best practices shall be assembled into a document that will be shared across the CYF System of Care.
- 8/2018 Evaluation by Behavioral Health Services to determination of efficacy and feasibility or replication with other funding, dissemination of results.

An evaluation component will be embedded within the program with quarterly data reporting, annual reports and recommendations with a final project review to determine program effectiveness and identify the most successful practices from the implementation phase and measure system impact. This will also allow for review of new and adapted strategies that may increase the feasibility of the program for future replication.

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.

- All participants will be surveyed to determine the baseline percentage of caregivers accessing treatment. All new participants to the program will be surveyed on intake.
- Clinician shall offer a minimum of 5 group therapy sessions per week.
- Clinician shall serve a minimum of 100 caregivers per fiscal year.
- 100% of those caregivers engaged in group therapy will report high level of satisfaction with having coordinated services with their child's provider.
- Care Coordinator shall connect a minimum of 100 caregivers to their own behavioral health treatment per fiscal year.
- 100% of those caregivers receiving care coordination connection to their own behavioral health services will report high level of satisfaction with having linking services through their child's provider.
- Independent assessors will work to determine how much access increased (using access data gathered before Care Coordinators implemented)
- Independent assessors will work to determine if access increased more for subpopulations (e.g., caregivers who are married vs single, if a caregiver has other children, if a caregiver is employed, racial/ethnic minorities)
- Independent assessors will work to determine the impact on connecting caregivers to treatment has on the progress of the child enrolled in the program
- Families will be asked to complete questionnaires about satisfaction and what programmatic variables they found to be helpful.
- Contracted Evaluator shall compile data into a Tool Kit to be made available to CYF System of Care.

Leveraging Resources (if applicable)

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

Contractor shall be tasked with exploring leveraging opportunities. This plan will directly provide additional staff support that will contribute to leveraging the following resources:

- San Diego County Behavioral Health Service Providers
- Specifically services through Cal-Works program
- Connections with Medi-Cal Health Plans
- Community Resources
- Faith Based Communities

NOTE: Actual budget to be determined by winning proposal from competitive process. The following are proposed guidelines:

NEW ANNUAL PROGRAM BUDGET – YEAR 1					
A. EXPENDITURES					
	Type of Expenditure	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers/ CBO's	Total
1.	Personnel			\$190,000	\$190,000
2.	Operating Expenditures			NA	
3.	Non-recurring Expenditures			NA	
4.	Contracts (Training Consultant Contracts)			\$10,054	\$10,054
5.	Work Plan Management			\$28,500	\$28,500
6.	Other Expenditures			NA	NA
	Total Proposed Expenditures			\$228,500	\$228,500
B. REVENUES					
1.	New Revenues				
	a. Medi-Cal (FFP only)				
	b. State General Funds				
	c. Other Revenues				
	Total Revenues			\$0	\$0
	C. TOTAL FUNDING REQUESTED			\$228,500	\$228,500

BUDGET NARRATIVE

Provide a detailed budget narrative explaining the proposed annual program expenditures for each line item.
1- Personnel: 1 Care Coordinator FTE at approximately \$65,000 per year. For 2 FTEs= \$130,000
2- Operating Expenditures: Enhance existing contract by adding the Caregiver Connection to Treatment component. Therefore, no extra operating expenditures anticipated.
3- Non-recurring Expenditures: Enhance existing contract by adding the Caregiver Connection to Treatment component. Therefore, no Non-recurring expenditures needed.
4- Contract (Training Consultant Contracts): \$10,054 for consultant to provide data analysis and dissemination for evaluation purposes.
5- Work Plan Management: \$\$28,500 is 15% indirect cost from Personnel cost (\$190,000 X 15% = \$28,500)

NEW ANNUAL PROGRAM BUDGET – YEAR 2					
A. EXPENDITURES					
	Type of Expenditure	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers/ CBO's	Total
1.	Personnel			\$190,000	\$190,000
2.	Operating Expenditures			NA	
3.	Non-recurring Expenditures			NA	
4.	Contracts (Training Consultant Contracts)			\$10,054	\$10,054
5.	Work Plan Management			\$28,500	\$28,500
6.	Other Expenditures			NA	NA
	Total Proposed Expenditures			\$228,500	\$228,500
B. REVENUES					
1.	New Revenues				
	a. Medi-Cal (FFP only)				
	b. State General Funds				
	c. Other Revenues				
	Total Revenues			\$0	\$0
	C. TOTAL FUNDING REQUESTED			\$228,500	\$228,500

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4- Work Plan Management: \$\$28,500 is 15% indirect cost from Personnel cost (\$190,000 X 15% = \$28,500)

NEW ANNUAL PROGRAM BUDGET – YEAR 3					
A. EXPENDITURES					
	Type of Expenditure	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers/ CBO's	Total
1.	Personnel			\$190,000	\$190,000
2.	Operating Expenditures			NA	
3.	Non-recurring Expenditures			NA	
4.	Contracts (Training Consultant Contracts)			\$10,054	\$10,054
5.	Work Plan Management			\$28,500	\$28,500
6.	Other Expenditures			NA	NA
	Total Proposed Expenditures			\$228,500	\$228,500
B. REVENUES					
1.	New Revenues				
	a. Medi-Cal (FFP only)				
	b. State General Funds				
	c. Other Revenues				
	Total Revenues			\$0	\$0
	C. TOTAL FUNDING REQUESTED			\$228,500	\$228,500

BUDGET NARRATIVE

Provide a detailed budget narrative explaining the proposed annual program expenditures for each line item.
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