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March 8, 2011

MHSOAC
1300 17th St., Suite 1000
Sacramento, CA 95811
E-mail: mhsoac@dmh.ca.gov

Dear MHSOAC Plan Review:

As outlined in DMH Information Notice No. 10-01, enclosed you will find the Draft proposed UPDATE to Contra Costa County's already approved MHSA Fiscal Year (FY) 2010-2011 Annual Update to the three year program and expenditure plan. The Draft proposed UPDATE to the MHSA FY 2010-2011 Annual Update was posted for the required 30 day public review and comment period from February 3, 2011 through March 7, 2011.

Because this is an UPDATE to the already approved MHSA FY 10/11 Annual Plan Update, no Public Hearing is required.

As required, we have enclosed one original copy, and one hard copy and one electronic copy (that is a single document in pdf format), which is being submitted to both the MHSOAC and the State DMH MHSA Plan Review Section, under separate cover.

If you have any questions on this request, please contact: Sherry Bradley, MHSA Program Manager, 925-957-5114, or sbradley@hsd.cccounty.us

Thank you.

Sincerely,



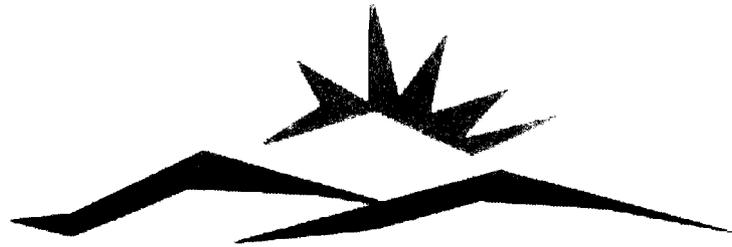
Donna M. Wigand, LCSW
Mental Health Director

Enclosure: Contra Costa County UPDATE to the MHSA – FY 2010-2011 Annual Update to the Three Year Program and Expenditure Plan

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Mental Health Services Act



CONTRA COSTA

HEALTH SERVICES
MENTAL HEALTH DIVISION

**Update to MHSA Fiscal Year 2010 – 2011
Annual Plan Update**

Executive Summary

Introduction

Contra Costa County's MHSAs Fiscal Year 2010/2011 Annual Update to the Three Year Program and Expenditure Plan was approved by the State Department of mental Health (DMH) on May 20, 2010, and for the Prevention and Early Intervention (PEI) by the Mental Health Services Oversight and Accountability Commission (MHSOAC) on May 20, 2010.

The purpose of this Update to the FY 2010/2011 MHSAs Plan Update is to seek approval for the following:

- Request funding in the amount of \$1,206,938 during FY 2010/2011 for a new PEI project;
- Request funding of \$138,700 during FY 2010/2011 for PEI Training, Technical Assistance and Capacity Building.
- Request funding of \$281,781 during FY 2010/2011 for new Innovation Program

New PEI Program: The new PEI Program request is the result of an ongoing planning process to do further development of an "Intensive Early Psychosis Intervention Program – PEI Program Number 10". This program was mentioned in the county's originally approved MHSAs Prevention and Early Intervention Three Year Program and Expenditure Plan Fiscal Years 2007-1008 and 2008-2009. The initial PEI Plan was approved by the Mental Health Services and Oversight Accountability Commission (MHSOAC) in May 2009. Planning for this newest program was delayed until the county could recruit and hire a Prevention and Early Intervention Coordinator. That goal was achieved in September of 2009, and planning for the new program was initiated.

The MHSAs stakeholders who comprise the county's Consolidated Planning Advisory Workgroup (hereinafter "CPAW") have been involved in the evolving development of this program during the past 6-7 months. Additional subcommittee of stakeholders gathered to meet and work with the PEI Coordinator in the planning and development for this draft proposed new program. The MHSAs Planning Committee, county's Senior Administrative Staff, and ultimately CPAW, all have worked together in the ongoing development of this draft proposal.

New PEI Training, Technical Assistance and Capacity Building: The request for PEI Training, Technical Assistance and Capacity Building is being submitted because when this County submitted its FY 2010/2011 MHSAs Plan Update, the form required for submission of this piece of funding request was not included in its submission or approval in June 2010. There also needed to be a period of planning to evaluate the first two years of PEI Training, TA and Capacity Building activities in order to determine if those activities would be revised in any way. Hence, the submission at this time.

New Innovation Program: The new Innovation Program is also the result of the ongoing Innovation planning process for the County. The county's initial Innovation Work Plan was approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) on April 29, 2010. This request for approval of a new Program is therefore

being submitted as an Update to the Initial approved Innovation Workplan and the FY 10/11 Annual Plan Update.

The new program is titled "Promoting Wellness, Recovery and Self-Management in an Integration Pilot Project". The County is currently developing and/or implementing several health integration projects, including one that is part of a six-county, state-sponsored health integration learning collaborative. Contra Costa County proposes creating a complementary component to augment existing pilots and add a new facet to the County's learning. It will use the Innovation Work Plan to determine if using of Peer Wellness Coaches will improve service navigation, increase the number of consumers who participate in health education and/or wellness activities, improve health outcomes, and enhance mental health recovery and resiliency. The Peer Wellness Coaches would serve as trained wellness, recovery and chronic disease (including severe mental illness) self-management* coaches. The County proposes placing the Coaches on pilot primary-mental health care service integration teams.

New MHSa PEI Program Proposal

The county is proposing the creation and implementation of a new program which is aimed at providing intensive early psychosis intervention. The proposed program will be based on the PIER Model, an early detection and intervention approach based on the Portland Identification and Early Referral (PIER) Program. The program will focus on both the early onset of psychosis (within the first 3 years of the onset of psychosis and those at ultra high risk for the onset of psychosis as identified by the Structured Interview for Prodromal Syndromes (SIPS).

Adolescents and young adults between the ages of 12 and 25 will be targeted for participation in this program.

There are multiple components included in the program:

1. Community Outreach
2. Assessment
3. Treatment
4. Family Psycho-education
5. Community Re-Entry
6. Multi-family Groups
7. Social Vocational Re-engagement
8. Supported Education and Employment
9. Psycho-Pharmo-therapy

Details for each of these components are included in Exhibit 4, which follows later in this packet.

The county plans to implement the model first as a pilot (using one team) in one geographical region of the county. When fully implemented, there will be a total of three teams (one in each geographical region of the county). All team members will be recruited at the same time, in order that training costs can be packaged for all team members.

The county also plans to link these services with the Crisis Stabilization Unit (CSU) to enable families to make the connections early and be provided with alternative support to psychiatric hospitalization. The county will also work to link the PIER Model with the Recovery Services offered through the county's Office of Consumer Empowerment and also the Family Support Workers. Linkages to other County and Community services will be made to support the consumer and their family/loved ones to improve consumer re-integration into the community and reduce stressors and expectations during their period of greatest vulnerability.

New PEI Technology, Technical Assistance & Capacity Building Request

The new PEI Technology, Technical Assistance & Capacity Building Request for FY 10/11 not only build upon, but expands upon the foundation of the activities for the first two years (08/09 and 09/10). Funding will again be used in partnership with local and community partners with contracts and/or other arrangements to assure the local community needs are met while demonstrating the capacity to develop and provide statewide training, technical assistance and capacity building to partner with community based organizations or others. Those activities include:

1. Partnering with local mental health consumer and family run group(s) to plan, implement, evaluate, edit, and film, recovery and wellness education, in order to provide that education to the community. The training will teach peers empowerment and wellness skills, etc.
2. Advanced training to peer providers, Speaker's Bureau members, peer interns, and graduates of the county's Service Provider Individualized Recovery Intensive Training (SPIRIT) program. Peers will learn techniques to improve interpersonal relationships and reduce the internalization of stigma.
3. Increase the capacity of the county to deliver recovery and wellness education to clients, community, and others.
4. Collaborate with Spirituality Training consultants, and the Alameda County Behavioral Health Care Services, Office of Consumer Relations, to provide education on spirituality and its impact on the recovery of persons facing serious mental illness, to mental health providers.
5. Continue development of curriculum (as per the activity of year one and year two), intended to teach peers and providers in recovery-based techniques.

New Innovation Program Proposal

A new Innovation Program is proposed titled "Promoting Wellness, Recovery and Self-Management in an Integration Pilot Project". The purpose of the proposed Innovation Program is to Increase the Quality of Services, Including Better Outcomes.

Health professionals widely recognize the direct association between physical and behavioral health; however, mental health consumers often receive primary and behavioral health care in isolation of one another¹. Integrating health care by linking the treatment of physical and mental health should improve the quality of services and lead to better health and mental health

¹ WHO and Wonca. "Integrating Mental Health into Primary Care: A Global Perspective". WHO. 2008. Available at: http://www.who.int/mental_health/policy/Integratingmhintopriarycare2008_lastversion.pdf . Accessed on July 7, 2010.

outcomes. Contra Costa County Mental Health Department believes encouraging a holistic approach to health will promote the wellness, recovery and resiliency of mental health consumers. As a result, it would like to use this Innovation Work Plan to test whether utilizing peer service providers in primary-mental health integration will lead to not only improved health outcomes, but also enhanced mental health recovery and resiliency.

Contra Costa County proposes creating a complementary component to augment existing pilots and add a new facet to the County's learning. It will use the Innovation Work Plan to determine if using of Peer Wellness Coaches will improve service navigation, increase the number of consumers who participate in health education and/or wellness activities, improve health outcomes, and enhance mental health recovery and resiliency. The Peer Wellness Coaches would serve as trained wellness, recovery and chronic disease (including severe mental illness) self-management* coaches. The County proposes placing the Coaches on pilot primary-mental health care service integration teams.

Contra Costa County proposes using this Innovation Work Plan to determine if using peer providers trained in wellness, recovery and self-management as part of health integration pilots promotes positive health outcomes, including mental health recovery and resiliency, and reduces feelings of stigmatization. First, the Work Plan will train peer providers in advanced wellness, recovery and self-management skills using a modified version of HARP. Then it will place them in a county-run mental health clinic as Peer Wellness Coaches and test the effectiveness of this model. It will test model replicability by placing the Peer Wellness Coaches in additional settings, such as Wellness and Recovery Centers, measuring their effectiveness at achieving the desired outcomes and comparing the results at each site. Peer Wellness Coaches will supplement existing service integration teams.

Planning Process

The process for gathering stakeholder input and review for each proposed new Program is summarized as follows:

- For the new PEI Program, and the PEI Training, Technical Assistance and Capacity Building (PEI-TTACB):
 - Stakeholder input and data gathering for both the new proposed PEI Program and PEI-TTACB was obtained through 3 community forums in 2010; focus group discussions; brief survey to consumers, family members, service providers;
 - Ongoing MHSa stakeholder committee meetings, during which additional analysis of county data regarding hospitalizations was reviewed;
 - Ad Hoc "Multi-Family Therapy" stakeholder committee meetings (consumers, family members, service providers);
 - Review and input by the CPAW stakeholder workgroup;
 - Input/review of the proposal by the Mental Health Commission;
 - 30 day public review and comment period.
- For the new Innovation Program:
 - Stakeholder input through an Innovation Launch project on 10/7/2009;
 - Innovation Brown Bag Lunches for discussion and further input from consumers, family members, service providers, staff, etc.

- Innovation Committee meetings for stakeholders, including consumers, family members, service providers, education, etc., with monthly meetings throughout FY 09/10. A “Fast Track” theme was developed by stakeholders, allowing for submissions of proposed Innovation ideas/programs where the learning objective could be completed within a time-frame less than two years, and/or at a total overall cost of \$250,000 or less.
- Review and recommendation by the MHSA Consolidated Planning Advisory Workgroup, a workgroup of representative MHSA stakeholders, including consumers, family members, service providers, law enforcement, education, social services, cultural communities, probation, etc.
- 30 day public review and comment period.

Public Comment

(See attached *Chart of Public Comments Received*, which includes Division responses, as Appendix 4.)

COMMUNITY PROGRAM PLANNING AND LOCAL REVIEW PROCESS

County: Contra Costa County

Date: February 3, 2011

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/update per title 9 of the California Code of Regulations, sections 3300 and 3315.

Counties may elect to attach the Mental Health Board meeting minutes in which the annual update was discussed if it provides additional information that augments the responses to these questions.

1. Briefly describe the Community Program Planning (CPP) Process for development of the FY 2010/11 annual update/update. Include the methods used to obtain stakeholder input.

Contra Costa County engaged in a planning process to gather input in developing the Fiscal Year FY 2010/2011 MHSA Annual Update to the Three Year Program and Expenditure Plan. This county's Fiscal Year (FY) 2010-11 Community Services and Supports (CSS) and Workforce Education and Training (WET) annual update funding request was approved by the State Department of Mental Health (DMH) on May 20, 1010. The county's Fiscal Year (FY) 2010-11 annual update funding request for Prevention and Early Intervention (PEI) was approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) on May 20, 2010.

This update to the MHSA FY 2010/2011 Annual Update to the Three Year Program and Expenditure Plan is submitted for the following purposes:

- Request funding during FY 2010/2011 for a new PEI Project;
Request funding during FY 2010/2011 for PEI Training, Technical Assistance, and Capacity Building;

Stakeholder input and data gathering for the new proposed PEI Program, the FY 10/11 PEI Training, Technical Assistance and Capacity Building funding, and the new Innovation Program, was not completed in time for submission of the MHSA Fiscal Year (FY) 2010/11 Annual Update. Therefore, this update to the MHSA FY 2010/11 Annual Update is being submitted.

New PEI Program: Development of the newly proposed PEI Program was derived from the following methods used to obtain stakeholder input:

- Three community forums to join in a group discussion and to contribute to the assessment of priorities for PEI;
Thirty five focus group discussions conducted throughout the county;
Brief survey to consumers, family members, service providers, etc., to learn more about priorities, community needs, target population and types of interventions.
An original PEI Stakeholder Workgroup was formed, with diverse stakeholders;
Analysis of county data regarding hospitalizations for the targeted population;

- Discussions/input in committee meetings, including the MHSA Data Committee, the MHSA Consolidated Planning Advisory Workgroup (CPAW), the MHSA Planning/Tracking Committee, and the Mental Health Commission.
- Stakeholder Ad Hoc “Multi-Family Therapy” Committee meetings (consisted of consumers, family members, service providers, and others).
- 30 day public review and comment period.

Request for PEI TTACB: Developing the request for MHSA FY 2010/2011 PEI Training, Technical Assistance, and Capacity Building project was also derived and based upon the methods used to obtain stakeholder input, as identified above. The activities identified in the funding request build upon existing/already approved activities (for FY 08/09 and 09/10), and expand the trainings more to continue to develop capacity.

Request for New Innovation Program Approval: The county has continued to utilize the stakeholder entities that were engaged in initial Innovation Workplan development and planning. CPAW provides ongoing review and input of its Innovation Committee. The MHSA Innovation Committee consists of stakeholder participants including consumers, family members, service providers, representatives from education, and also from vocational and rehab services.

Methods used to obtain stakeholder input included:

- Review and use of data from previous planning processes for Community Supports and Services (CSS), Workforce Education and Training (WET), and Prevention and Early Intervention (PEI);
- Focus groups, brainstorming with various existing age-focused committees and cultural communities, surveys;
- Innovation Launch event to do a training to the Innovation Component, and to solicit the input of ideas;
- Innovative idea forms were circulated via email, website, etc;
- Innovation Committee workgroup played a leading role in the Innovation planning process.
- An algorithm was developed, consisting of five general levels for which to evaluate submissions, an ultimately, overall, 10 theme areas were identified, with the top five theme areas to be considered for development of Innovation Programs.
- Key informant interviews were held to further develop the new program submission included with this update to the Plan Update;
- CPAW reviewed/recommended the new program be posted for the required 30 day review and comment period;
- 30 day public review and comment period.

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

The following various stakeholder entities and/or representative stakeholder groups were included in the Community Program Planning Process for the new PEI program, the PEI-TTACB Funding Request, and the new Innovation Program:

- Underserved communities, including Asian/PI, African American, Latino, Native American, LGBTQ;
- Education (special education districts, schools, school based health centers, students);
- Mental health consumers and families/loved ones;
- Providers of Mental Health Services;
- Health Care, including primary care and school based health centers
- Social Services (Employment and Human Services)

- Law enforcement
- Faith based community
- Drug and alcohol services
- Contra Costa Mental Health Commission
- MHSAs Consolidated Planning Advisory Workgroup (CPAW);
- Innovation Workgroup
- MHSAs Planning and Tracking/Senior Staff

3. If eliminating a program/project, please include how the stakeholders were involved and had the opportunity to participate in the decision to eliminate the program/project.

Not applicable.

4. Describe methods used to circulate, for the purpose of public comment, the annual update or update.

The update to the MHSAs FY 2010/2011 Annual Update was posted for public review and comment period from Thursday, February 3, 2011 to Monday, March 7, 2011. The Update was circulated via email, posting on the web-site, hard copies made available to those requesting it, etc.

MHSA SUMMARY FUNDING REQUEST

County: <u>Contra Costa</u>		Date: <u>3/8/2011</u>				
	CSS	WET	CFTN	PEJ	INN	Local Prudent Reserve
A. FY 2010/11 Planning Estimates						
1. Published Planning Estimate				\$5,016,100	\$1,106,800	
2. Transfers						
3. Adjusted Planning Estimates	\$0					
B. FY 2010/11 Funding Request						
1. Requested Funding in FY 2010/11				\$1,206,938	\$281,781	
2. Requested Funding for CPP						
3. Net Available Unexpended Funds						
a. Unexpended FY 06/07 Funds						
b. Unexpended FY 2007/08 Funds ^{a/}						
c. Unexpended FY 2008/09 Funds				\$5,816,326	\$406,215	
d. Adjustment for FY 2009/2010		\$0	\$0	\$5,816,326	\$406,215	
e. Total Net Available Unexpended Funds		\$0	\$0	\$0	\$0	
4. Total FY 2010/11 Funding Request	\$0	\$0	\$0	\$1,206,938	\$281,781	
C. Funds Requested for FY 2010/11						
1. Previously Approved Programs/Projects						
a. Unapproved FY 06/07 Planning Estimates						
b. Unapproved FY 07/08 Planning Estimates ^{a/}						
c. Unapproved FY 08/09 Planning Estimates						
d. Unapproved FY 09/10 Planning Estimates						
e. Unapproved FY10/11 Planning Estimates	\$0					
Sub-total	\$0	\$0		\$0	\$0	
f. Local Prudent Reserve						
2. New Programs/Projects						
a. Unapproved FY 06/07 Planning Estimates						
b. Unapproved FY 07/08 Planning Estimates ^{a/}						
c. Unapproved FY 08/09 Planning Estimates						
d. Unapproved FY 09/10 Planning Estimates					\$281,781	
e. Unapproved FY10/11 Planning Estimates				\$1,206,938		
Sub-total	\$0	\$0	\$0	\$1,206,938	\$281,781	
f. Local Prudent Reserve						
3. FY 2010/11 Total Allocation ^{b/}	\$0	\$0	\$0	\$1,206,938	\$281,781	

a/Only applies to CSS augmentation planning estimates released pursuant to DMH Info. Notice 07-21, as the FY 07/08 Planning Estimate for CSS is scheduled for reversion on June 30, 2010.

b/ Must equal line B.4. for each component.

3/8/2011

County: Contra Costa

Date: _____

INN Programs		FY 10/11 Requested MHSA Funding	Estimated MHSA Funds by Age Group (if applicable)			
No.	Name		Children and Youth	Transition Age Youth	Adult	Older Adult
Previously Approved Programs						
1.		\$0				
2.		\$0				
3.		\$0				
4.		\$0				
5.		\$0				
6.		\$0				
7.		\$0				
8.		\$0				
9.		\$0				
10.		\$0				
11.		\$0				
12.		\$0				
13.		\$0				
14.		\$0				
15.		\$0				
16.	Subtotal: Programs	\$0	\$0	\$0	\$0	\$0
17.	Plus up to 15% County Administration	\$0				
18.	Plus up to 10% Operating Reserve	\$0				
19.	Subtotal: Previously Approved Programs/County Admin./Operating Reserve	\$0				
New Programs						
1.	INNFT Promoting Wellness, Recovery and Self-Management through Peers	\$222,752			\$222,752	
2.		\$0				
3.		\$0				
4.		\$0				
5.		\$0				
6.	Subtotal: Programs	\$222,752	\$0	\$0	\$222,752	\$0
7.	Plus up to 15% County Administration	\$33,413				
8.	Plus up to 10% Operating Reserve	\$25,616				
9.	Subtotal: New Programs/County Admin./Operating Reserve	\$281,781				
10.	Total MHSA Funds Requested for INN	\$281,781				

NEW INNOVATION PROJECT PROPOSAL

County: Contra Costa County

Program Number/Name: INNFT01: Promoting Wellness, Recovery and Self-Management through Peers

Date: 02/01/2011

Select one of the following purposes that corresponds to the Innovation's key learning goal. Please note that while the program might embody all four purposes, a learning goal cluster around a single Essential Purpose.

- Increase access to underserved groups
- Increase the quality of services, including better outcomes
- Promote interagency collaboration
- Increase access to services

1. Describe which of the four essential purposes of Innovation is most relevant to your learning goal and why is this purpose a priority for your county.

Health professionals widely recognize the direct association between physical and behavioral health; however, mental health consumers often receive primary and behavioral health care in isolation of one another³. Integrating health care by linking the treatment of physical and mental health should improve the quality of services and lead to better health and mental health outcomes. This is a priority for Contra Costa County Mental Health Department because it believes encouraging a holistic approach to health will promote the wellness, recovery and resiliency of mental health consumers. As a result, it would like to use this Innovation Work Plan to test whether utilizing peer service providers in primary-mental health integration will lead to improved health outcomes as well as enhanced mental health recovery and resiliency.

The County is currently developing and/or implementing several health integration projects, including one that is part of a six-county, state-sponsored health integration learning collaborative. Contra Costa County proposes creating a complementary component to augment the existing health integration learning collaborative pilot and add a new facet to county learning. It will use the Innovation Work Plan to determine if using of Peer Wellness Coaches will improve service navigation, increase the number of consumers who participate in health education and/or wellness activities, improve health outcomes, and enhance mental health recovery and resiliency. The Peer Wellness Coaches would serve as trained wellness, recovery and chronic disease (including severe mental illness) self-management* coaches. The County proposes placing the Coaches on pilot primary-mental health care service integration teams.

*For the duration of this Work Plan, self-management will refer to self-management of all chronic illnesses, including severe mental illness.

2. Describe the INN Program, the issue and key learning goals it addresses, and the expected learning outcomes, i.e., how the Innovation may create positive change, introduce a new mental health practice, make a specific change to an existing mental health practice, or introduce to the mental

³ WHO and Wonca. "Integrating Mental Health into Primary Care: A Global Perspective". WHO. 2008. Available at: http://www.who.int/mental_health/policy/Integratingmhintopriarycare2008_lastversion.pdf . Accessed on July 7, 2010.

health system a community driven approach that has been successful in a non-mental health context.

As stated above, health professionals widely recognize the association between physical and behavioral health⁴. Moreover, mental health consumers face a disproportionate burden of physical health problems and engage in risky health behaviors more frequently than the general population. People with severe mental illness (SMI) who receive services from the public mental health systems die, on average, at least 25 years earlier than the general population⁵. Prevalence of diabetes, ischemic heart disease, cerebrovascular disease, arthritis and heart failure is three-times higher among SMI Medi-Cal population compared to general Medi-Cal population⁶. About 75 percent of people with SMI are tobacco dependent as compared to 22 percent of the rest of the population⁴. Medication side effects may place the SMI population at a greater risk for developing certain chronic health conditions. Research shows second generation antipsychotic medications are highly associated with weight gain, diabetes, dyslipidemia, insulin resistance and metabolic syndrome⁴.

Collaboration and integration of health services allows health systems to address the primary and mental health disparities of mental health consumers in a more effective manner. However, during the early stages of development and implementation of some of the County's integration projects, barriers to seeking primary care exist for consumers. One such example is Primary Care Providers often are unaware of the mental health "consumer culture" as well as the concept of mental health recovery. This lack of knowledge can lead to distrust and feelings of stigmatization. Another is, while some wellness, recovery and self-management resources exist in the community, mental consumers may not understand the relationship between their primary and mental health and are often unaware of these services. Consequently, consumers may require assistance in making linkages with health and wellness resources. To be effective, an integration project should address barriers to service utilization.

Many integration models exist^{7, 8, 9} and some utilize peer providers, a potential solution to overcoming the barriers stated above. Trained peer providers are valuable resources as they are uniquely able to serve as role models for consumers as well as providing them support, service navigation, psychosocial training and the knowledge of lived experience. Research shows the use of a peer-led intervention to improve medical self-management targeting mental health consumers with chronic medical comorbidities improved: rates of primary care visits, physical health-related quality of life scores, participation in physical activity and medication adherence¹⁰.

This intervention, called The Health and Recovery Peer (HARP) Program⁸, offers a potential solution to reducing physical health disparities experienced by mental health consumers. However, HARP research did not examine

⁴ WHO and Wonca. "Integrating Mental Health into Primary Care: A Global Perspective". WHO. 2008. Available at: http://www.who.int/mental_health/policy/Integratingmhintopriarycare2008_lastversion.pdf. Accessed on July 7, 2010.

⁵ Parks, Joe et al. "Morbidity and Mortality in People with Serious Mental Illness". 13th in a Series of Technical Reports. October 2006. Available at:

http://www.nasmhpd.org/general_files/publications/med_directors_pubs/technical%20report%20on%20morbidity%20and%20mortality%20-%20final%2011-06.pdf. Accessed on July 7, 2010.

⁶ CalMend. "Pilot-Collaborative to Integrate Primary Care and Mental Health Services". *Pre-Work Manual*. May 2010. Page 2.

⁷ Integrated Behavioral Health Project. "Partners in Health: Primary Care /County Mental Health Collaboration Toolkit". First Edition. October 2009. Available at: <http://www.ibhp.org/uploads/file/IBHP%20Collaborative%20Tool%20Kit%20final.pdf>.

⁸ Integrated Behavioral Health Project. "Volume I: Report". *California Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative*. September 14, 2009. Available at: <http://www.ibhp.org/uploads/file/IPI%20report%20Final.pdf>.

⁹ Integrated Behavioral Health Project. "Volume III: Examples for Dissemination". *California Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative*. September 14, 2009. Available at: [http://www.ibhp.org/uploads/file/IPI-Vol-III-Examples-9-14-09\[1\]\(1\).pdf](http://www.ibhp.org/uploads/file/IPI-Vol-III-Examples-9-14-091.pdf).

¹⁰ Druss, Benjamin G et al. "The Health and Recovery Peer (HARP) Program: A peer-led intervention to improve medical self-management for persons with serious mental illness". *Schizophrenia Research*. 2010. 118: 264-270.

the relationship between medical self-management, improved physical health outcomes and recovery from mental illness. Nor did researchers examine if the use of peer providers reduced feelings of stigmatization. In order to create a program focusing on the holistic health and wellness needs of mental health consumers, it must not only address medical self-management but mental health recovery and resiliency as well.

Contra Costa County proposes using this Innovation Work Plan to determine if using peer providers trained in wellness, recovery and self-management as part of health integration pilots promotes positive health outcomes, including mental health recovery and resiliency, and reduces feelings of stigmatization. First, the Work Plan will train peer providers in advanced wellness, recovery and self-management skills using a modified version of HARP. Then it will place them in a county-run mental health clinic as Peer Wellness Coaches and test the effectiveness of this model. It will test if the model is replicable by placing the Peer Wellness Coaches in additional settings, such as Wellness and Recovery Centers, measuring their effectiveness at achieving the desired outcomes and comparing the results at each site. Peer Wellness Coaches will supplement existing service integration teams.

During the initial phases of the Work Plan, the County will place the Coaches on the pilot learning collaborative primary-mental health care integration team located in a county-operated mental health clinic. The initial target population of the Innovation Work Plan is up to 100 consumers enrolled in both Contra Costa Health Plan (CCHP) and Contra Costa Mental Health Plan (CCMHP) receiving services at the West County Adult Mental Health Clinic (El Portal) located in San Pablo. After the conclusion of the learning collaborative pilot in September of 2011, the County will place a Wellness Coach in each of its three county-operated adult mental health clinics and test the model's replicability.

Before the start of the Work Plan, Wellness Coaches will attend two intensive three-day advanced peer support, chronic disease self-management and wellness coaching training given by Recovery Innovations, Inc. This training will certify the Peer Wellness Coaches to use the self-management Health and Recovery Peer (HARP) Program¹¹ curriculum. The trainings will supplement the HARP curriculum, adding sessions in wellness basics, mental health recovery, role modeling, and advanced wellness-coaching skills. Wellness Coaches will then use this modified curriculum to teach consumers wellness, recovery and self-management principles and techniques.

The Coaches will work with clinic staff to:

- Assist in the provision of wellness education to consumers
- Facilitate wellness groups
- Educate consumers about recovery
- Assist consumers in developing recovery goals and chronic disease self-management plans
- Provide Wellness Recovery Action Plan (WRAP) training
- Aid consumers with skill-building, including mental health coping skills, to promote the achievement of their wellness, recovery and chronic disease self-management goals
- Educate consumers about working with primary and mental health care providers to promote wellness and increase consumer's participation in physical and mental health treatment
- Link consumers to existing wellness and recovery resources in the community
- Provide peer leadership support
- Educate primary and mental health care staff about mental health recovery principles as well as mental health "consumer culture"

¹¹ Druss, Benjamin G et al. "The Health and Recovery Peer (HARP) Program: A peer-led intervention to improve medical self-management for persons with serious mental illness". *Schizophrenia Research*. 2010. 118: 264-270.

Some potential specific tasks and skill building exercises the Wellness Coaches will perform:

- Nutrition education, including cooking lessons, demonstrations and taste testing
- Physical activity facilitation
- Introductions to wellness and community centers (warm hand-offs)
- Teaching consumers to take public transportation
- Accompanying consumers to physical and mental health care appointments to provide linkage and support
- Teaching consumers how to create WRAP for mental and primary health
- Teaching consumers self-management and wellness tools for managing their health care
- Smoking cessation classes
- Teaching self-management classes using the HARP curriculum
- Data collection, focus group facilitation and program evaluation
- Teaching consumers to build peer support networks to enhance participation and ultimately increase self reliance in achieving wellness goals

At the conclusion of this Work Plan, if using Peer Wellness Coaches in the pilot mental health clinic proves effective in improving the health and well-being of consumers, the County will place the Wellness Coaches on the integration teams at other primary-mental health care integration pilot sites.

If the Innovation Work Plan proves effective, it will lead to greater integration of primary and mental health care and a cadre of Peer Wellness Coaches. It will also lead to an increase in the number of mental health consumers with wellness, recovery and self-management skills and goals as well as a greater awareness of wellness resources among consumers and a greater awareness of mental health consumers' needs and services among health care providers. In the long term, when coupled with other integration projects, the Work Plan will promote mental health recovery and aid in decreasing the health disparities experienced by mental health consumers.

As mentioned earlier, Contra Costa County is piloting various models of primary and mental health care integration, attempting to find the model(s) most effective for the County. It intends to use the Innovation Work Plan to augment this process by learning if and how utilizing peers as health educators and system navigators will increase consumer's participation in wellness and primary health care as well as improve service outcomes. The Work Plan is innovative for several reasons. First, it changes an existing approach to providing mental health and wellness services. It will use peer providers as Wellness Coaches to provide wellness activities and chronic disease self-management as well as recovery skills. The Coaches will link mental health consumers to existing wellness resources in the community. The Work Plan will modify the role and skill set of an existing cadre of trained mental health peer providers. It will then test if creating these changes produced the following results:

- a change in both physical and mental health providers' awareness and expectations about the primary health and wellness needs of mental health consumers
- an increase in mental health consumers receiving an appropriate level of exposure to wellness promotion and health education
- facilitation of consumers' navigation of a fractured health care system
- mental health consumers' improved communication and knowledge about their holistic health care needs
- improved health, wellness, recovery and self-management skills and behaviors among consumers

- an increase in mental health consumer's participation in his or her primary health care.

It will also test how the use of Wellness Coaches leads to these changes. It will determine what elements of the training and service provision are beneficial and which are not.

Second, while the HARP curriculum exists, it had minimal impact upon changing consumers' eating habits¹². Nor have studies using the HARP model looked at how using peers may or may not enhance consumer's recovery from mental health¹³. Nor have studies examined whether use of the HARP model decreases feelings of stigmatization¹¹. This Work Plan will be a substantial change of an existing mental health practice because it will modify the HARP Curriculum in several ways. To try to increase the number of consumers who change their eating habits, the Work Plan will add additional nutrition lessons, including cooking demonstrations and taste testing. It will enhance the physical activity lesson to include actual group physical activities. It will also add role modeling components as well as lessons about mental health recovery skills.

The County wishes to learn if and how modifying the HARP curriculum and adding peer Wellness Coaches to health integration projects will: 1) improve wellness and health outcomes for consumers; 2) increase primary and mental health care staffs' understanding of mental health "consumer culture" and recovery principles; 3) increase the number of consumers with wellness, recovery and/or self-management goals; 4) reduce feelings of stigmatization; and 5) enhance recovery.

This Innovation Work Plan has the following process-based learning goals:

- Do consumers develop physical wellness plans?
 - Do consumers use them regularly and how can we increase their utilization?
- Do consumers develop mental health recovery plans?
 - Do consumers use them regularly and how can we increase their utilization?
- Do consumers develop self-management goals?
 - Do consumers use them regularly and how can we increase their utilization?
- What elements of the modified HARP curriculum are effective?
- What elements of the modified HARP curriculum are not effective?
- Does the use of Peer Wellness Coaches increase the number of linkages made between consumers and community resources?
- Are Peer Wellness Coaches activities more effective with some sub-populations of the target population?

This Innovation Work Plan has the following outcomes-based learning goals:

- Does interacting with Peer Wellness Coaches improve primary and mental care providers understanding of the consumer culture and recovery principles?
- Do consumers achieve their wellness goals through this intervention?
- Do consumers permanently change their health-related behaviors through this intervention?
- Do consumers achieve their recovery goals through this intervention?
- Do consumers' recovery scores change through this intervention?
- Do consumers perceive less stigmatization from primary and mental health care providers because of education efforts and the direct contact between health care providers and mental health peer providers?

¹² Appalachian Consulting Group, Inc. "Peer Support Whole Health Training Manual-Appalachian". *HARP Training Manual*. 2009. Information Available at: <http://www.qmhcnc.org/ACG/index.html> .

¹³ Druss, Benjamin G et al. "The Health and Recovery Peer (HARP) Program: A peer-led intervention to improve medical self-management for persons with serious mental illness". *Schizophrenia Research*. 2010. 118: 264-270.

- Do consumers have improved health outcomes?
- Is this approach replicable in other integration settings?

2a. Include a description of how the project supports and is consistent with the applicable General Standards as set forth in CCR, Title 9, Section 3320.

The innovation project supports the General Standards as set forth in CCR, Title 9, section 3320 in the following ways:

Community Collaboration

One of the central elements of the Innovation Work Plan is the collaboration between primary health care providers, mental health care providers, community and peer organizations and consumers. By working together to implement the Work Plan, these partners will improve the health and well-being of mental health consumers.

Cultural Competence

The County will ensure the services provided by this Innovation Work Plan are culturally competent. Additionally, the Work Plan will educate primary and mental health care providers about mental health consumers and the mental health consumer “culture”.

Client and Family Driven Mental Health System

The work plan will involve consumers and their families in its needs assessment, design and implementation of services, resource development, and evaluation. By teaching consumers wellness, recovery and self-management skills, Peer Wellness Coaches will be training consumers to participate actively in their health care.

Wellness, Recovery and Resilience Focus

One of the primary goals of the Work Plan is to promote the wellness and recovery of mental health consumers by teaching them wellness, recovery and self-management skills as well as linking them to community-based supports and resources. The Work Plan will track changes in consumers’ wellness and recovery from chronic illness, including physical health issues and severe mental illness.

Integrated Service Experience

The Work Plan will include a range of educational and program initiatives integrated into existing programs and service providers. The Work Plan will test if the use of Peer Wellness Coaches enhances the integration of primary and mental health care. The long-term goals of the learning provided by the Work Plan are to: 1) decrease the health disparities experienced by mental health consumers and 2) promote their mental health recovery by decreasing relapses as well as increasing self-reliance and active participation in their holistic wellness.

2b. If applicable, describe the population to be served, number of clients to be served annually, and demographic information including age, gender, race, ethnicity, language spoken, and situational characteristic(s) of the population to be served.

The target population for this proposal is consumers served in the county-operated adult mental health clinics who suffer from diabetes and/or cardiovascular disease. The target population will consist of individuals 18 years and older from diverse ethnicities, languages, gender identities and sexual orientations. The Work Plan will target 100 consumers. The first phase of implementation will target consumers who receive Services at the EI

Portal Mental Health Clinic in West County. After September of 2011, the proposal will target consumers in all three county-operated adult mental health clinics.

3. Describe the timeframe of the program. In your description include key actions of the time line and milestones relating to assessing your Innovation and communicating results significance and lessons learned.

Activity	July – September 2011	October – December 2011	January – March 2012	April – June 2012
Establishing baselines for all indicators at initial pilot site				
Implementation of Work Plan in initial pilot site				
Establishing baselines for all indicators in scaled-up setting				
Implementation of Work Plan in scaled-up setting				
Monthly assessments of service utilization and learning				
Quarterly assessments of indicators related to # of goals, plans, service utilization, trainings and linkages				
Assessments of indicators related to behavior changes, knowledge, recovery, stigma, health outcomes and indicators (at 9-months and 18-months)				
Monthly reports with Work Plan staff and integration pilot learning collaborative team				
Annual reports to Work Plan staff, County, stakeholders and the State				
KEY				
Green boxes indicate learning is being measured (Work Plan Evaluation)	Blue boxes indicate communication of results and lessons learned		Lilac boxes indicate Work Plan implementation	

Please see the timeline above for a detailed explanation of the Work Plan timeframe. The total timeframe is 12-months. The first three months of the Work Plan will coincide with the County's primary-mental health integration pilot. The scale-up of the Work Plan will occur after the conclusion of the pilot and will continue to measure the effectiveness of using peers as wellness coaches at the pilot site. During this time, it will simultaneously test the feasibility of replicating the use of Peer Wellness Coaches in two additional mental health clinics.

Depending on the indicator, Work Plan staff will collect data to answer the learning goal at baseline as well as on a monthly, quarterly, twice annual and/or annual basis. Work Plan staff will conduct a final evaluation of both the pilot and study of the feasibility of replication during the final month of the Work Plan.

Contra Costa County will create tailored reports for various stakeholder groups. It will report on the following schedule: monthly to Work Plan staff and members of the integration pilot learning collaborative team and annually to stakeholders and the State.

4. Describe how you plan to measure the results, impacts, and lessons learned of your Innovation. Include in your description how the perspectives of stakeholders in the review and assessment were included.

Contra Costa County will establish a baseline for all indicators during the first three months of Work Plan Implementation. It will then collect data about indicators on a monthly, quarterly, twice annual or annual basis; frequency of measurement will depend on the indicator. It will write annual updates and/or reports for stakeholders as appropriate. The County will share data with stakeholders during various committee meetings, public meetings and/or forums, mental health commission meetings and integration pilot learning collaborative team meetings. During these presentations, the County will request feedback from stakeholders about potential changes to the Work Plan. The County will share data with Work Plan staff as well as members of the integration pilot learning collaborative team and discuss potential changes to the Work Plan on a monthly basis.

Indicators for the process-based learning goals:

- Do consumers develop physical wellness plans?
 - # wellness plans
 - Do consumers use them?
 - # plans with progress made
 - # and type of wellness activities each consumer participated in
- Do consumers develop mental health recovery plans?
 - # recovery plans
 - Do consumers use them?
 - # plans with progress made
 - # and type of recovery activities each consumer participated in
- Do consumers develop self-management goals?
 - # self-management goals
 - Do consumers use them?
 - progress each consumer makes towards achieving goals
- What elements of the modified HARP curriculum are/are not effective?
 - # goals and plans created
 - # goals and plans achieved

- Peer Wellness Coaches impressions of effectiveness
- Consumer satisfaction
- Does the use of Peer Wellness Coaches increase the number of linkages made between consumers and community resources?
 - # and type of linkages
- Are Peer Wellness Coaches activities more effective with some sub-populations of the target population?
 - Differences in other indicators between sub-populations

Indicators for the outcomes-based learning goals:

- Does interacting with Peer Wellness Coaches improve primary and mental health care providers understanding of the consumer culture and recovery principles?
 - Changes in primary care providers understanding
 - Changes in consumers' perception of providers understanding
- Do consumers achieve their wellness goals?
 - # and type of wellness goals achieved
- Do consumers change their health-related behaviors?
 - # and type of health-related behaviors changed
- Do consumers achieve their recovery goals?
 - # and type of recovery goals achieved
- Do consumers' recovery scores change?
 - Changes in recovery scores
- Do consumers perceive less stigmatization from health care providers?
 - Changes in perceptions of stigmatization
- Do consumers have improved health outcomes?
 - Changes in health outcomes
- Is this approach replicable in other integration settings?
 - # additional sites using Peer Wellness Coaches

Consumers (Wellness Coaches and Community Support Workers) will assist with the data collection and evaluation of the Innovation Work Plan. This proposal includes hiring a half-time community support worker to assist in performing data collection and evaluation.

5. Please include a total budget for your Innovation with a breakdown of expected expenses per year. In addition provide a budget narrative for costs identified for this work plan as outlined in Exhibit F. Include the number of FTE personnel positions/classifications and a brief description of each FTE's functions. In addition, include a brief description of operating and non-recurring expenditures associated with this work plan. If applicable, provide a brief description of training consultant contracts and work plan management. This description should include the purpose for the contract and work plan management, functions, and length of contract.

The total budget for this Innovation Work Plan is \$222,752. Personnel costs total \$212,752 (for both salary and benefits). Training costs for the Work Plan total \$10,000. Work Plan Management costs are \$27,248. There are

no non-recurring expenditures associated with this work plan.

3.0 FTE Peer Wellness Coaches (classified as Mental Health Community Support Worker I-Project). The total cost of the Peer Wellness Coaches, including benefits, is \$182,359. The Peer Wellness Coaches will provide self-management coaching, wellness and health education, and recovery support to mental health consumers. Peer Wellness Coaches will also assist consumers in navigating the health system as well as accessing health and wellness resources.

0.5 FTE Mental Health Community Support Worker I-Project. The total cost of the Community Support Worker, including benefits, is \$30,393. The Community Support Worker will assist staff in data collection and work plan evaluation. The Community Support Worker will administer surveys, log learning and activities, conduct focus groups, monitor the work plan's progress towards achieving the learning goals, as well as completing other activities related to program evaluation.

Training Consultant Contract with Recovery Innovations Inc. The total cost of the contract is \$10,000. The training will consist of two three-day trainings for the Peer Wellness Coaches. The training will instruct the Coaches in how to use the HARP curriculum, wellness basics, mental health recovery, role modeling, and advanced wellness coaching skills. Wellness Coaches will then use this modified curriculum to teach consumers wellness, recovery and self-management principles and techniques.

Work Plan Management. The total cost of work plan management is \$27,248. This includes any MHSA management of Work Plan costs to ensure fidelity to learning goals and timely submissions of reports to the State, administrative costs associated with contract processing, etc.

6. If applicable, provide a list of resources to be leveraged.

The Innovation Work Plan will leverage several resources. First, it will utilize existing primary and mental health care staffing, facilities and services. Second, it will bill Medi-Cal for eligible services. Third, it will utilize existing community-based wellness, recovery and self-management resources to provide services to consumers.

Program/Project Name and #INNFT01 - Promoting Wellness, Recovery & Self-Management Through Peers

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. EXPENDITURES				
Community Services and Supports				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				\$0
b. Other Supports				\$0
2. General System Development Housing				\$0
3. Personnel Expenditures				\$0
4. Operating Expenditures				\$0
5. Estimated Expenditures when service provider is not known				\$0
6. Non-recurring expenditures				\$0
7. Other Expenditures*				\$0
8. Total Proposed Expenditures	\$0	\$0	\$0	\$0
Workforce Education and Training				
1. Personnel Expenditures				\$0
2. Operating Expenditures				\$0
3. Training Expenditures				\$0
4. Training Consultant Contracts				\$0
5. Residency Expenditures				\$0
6. Internship Expenditures				\$0
7. Mental Health Career Pathway Expenditures				\$0
8. Stipend Funds				\$0
9. Scholarship Funds				\$0
10. Loan Repayment Funds				\$0
11. Non-recurring Expenditures				\$0
12. Other Expenditures*				\$0
13. Total Proposed Expenditures	\$0	\$0	\$0	\$0
Capital Facilities				
1. Pre-Development Costs				\$0
2. Building/Land Acquisition				\$0
3. Renovation				\$0
4. Construction				\$0
5. Repair/Replacement Reserve				\$0
6. Other Expenditures*				\$0
7. Total Proposed Expenditures	\$0	\$0	\$0	\$0
Technological Needs				
1. Personnel				\$0
2. Hardware				\$0
3. Software				\$0
4. Contract Services				\$0
5. Other Expenditures*				\$0
6. Total Proposed Expenditures	\$0	\$0	\$0	\$0
Prevention and Early Intervention (PEI)				
1. Personnel				\$0
2. Operating Expenditures				\$0
3. Non-recurring Expenditures				\$0
4. Subcontracts/Professional Services				\$0
5. Other				\$0
6. Total Proposed Expenditures	\$0	\$0	\$0	\$0

Innovation (INN)				
1. Personnel		\$212,752		\$212,752
2. Operating Expenditures				\$0
3. Non-recurring Expenditures				\$0
4. Training Consultant Contracts		\$10,000		\$10,000
5. Work Plan Management		\$27,248		\$27,248
6. Other				\$0
7. Total Proposed Expenditures		\$250,000	\$0	\$250,000
B. REVENUES				
1. New Revenues				
a. Medi-Cal (FFP only)				\$0
b. State General Funds				\$0
c. Other Revenue				\$0
2. Total Revenues		\$0	\$0	\$0
C. TOTAL FUNDING REQUESTED		\$250,000	\$0	\$250,000

*Enter the justification for items that are requested under the "Other Expenditures" category.

Justification: _____

Please include your budget narrative on a separate page.

Prepared by _____ Sherry Bradley _____

Telephone Number: _____ (925) 957-5114 _____