SAN BERNARDINO COUNTY

Behavioral Health

Mental Health Services Act

Innovation Plan 2019

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Thank you for your interest in the San Bernardino County Department of Behavioral Health's (DBH) Mental Health Services Act (MHSA) Innovation Plan. Across San Bernardino County, an extensive network of services has been established through the use of MHSA funds. These services include Community Services and Supports, Prevention and Early Interventions, Innovation Projects, Capital Facilities and Technology, and Workforce Education and Training.

The Innovation Component of MHSA provides counties with the opportunity and challenge to think outside the box and implement projects that encourage learning in the field of behavioral health. The purpose of Innovation projects is to enhance quality of services, improve outcomes, promote interagency collaboration, and increase access to services, especially for underserved groups. Innovation projects are time-limited and learning focused. These projects provide an opportunity to improve aspects of the community mental health system creatively. Innovation projects may introduce a new mental health practice, make a change to an existing mental health practice, apply an existing non-mental health approach or implement a promising community driven practice into mental health.

This plan provides in depth information about the proposed projects, *Eating Disorder Collaborative (EDC)*, *Cracked Eggs* and the *Multi-County Full Service Partnership (FSP) Innovation Initiative*.

Both, the *EDC* and the *Multi-County FSP Innovation Initiative,* are derived from the idea that working collaboratively with our community and statewide partners will help inform behavioral health systems on ways to deliver and improve much-needed service within our complex system. *Cracked Eggs* taps into the creative, peer-driven approach that puts our most valuable resource, our clients, in the center of a peer-designed workshop series aimed to educate and empower.

It is only after extensive collaboration and careful consideration that projects are proposed to be funded under the Innovation Component of MHSA. Detailed in the Program Planning section of the plan, you will find a synopsis of the extensive and diverse stakeholder planning process that DBH facilitated in order to develop these Innovation project plans.

DBH is using these Innovation Projects to further the San Bernardino Countywide Vision of promoting wellness through improving collaboration and partnerships to better treat the whole person. I invite you to read the project plan and provide feedback at MHSA@dbh.sbcounty.gov. Your time and feedback is greatly appreciated.

Thank you.

Veronica Kelley, DSW, LCSW
Director
San Bernardino County Department of Behavioral Health

Gracias por su interés en el Plan de Innovación de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés) del Departamento de Salud Mental (DBH por sus siglas en inglés) del Condado de San Bernardino. A través del condado de San Bernardino, una red extensa de servicios ha sido establecida a través del uso de fondos de MHSA. Estos servicios incluyen: Servicios y Apoyos Comunitarios, Prevención e Intervenciones Tempranas, proyectos de Innovación, Obras de Infraestructura y Tecnología, y Educación y Capitación de la Fuerza Laboral.

El componente de Innovación de MHSA proporciona a los condados la oportunidad y reto de pensar fuera de la caja e implementar proyectos que estimulan el aprendizaje en el campo de salud mental. El propósito de los proyectos de Innovación es de aumentar la calidad de servicios, mejorar resultados, promover colaboración interinstitucional, y aumentar el acceso a servicios, especialmente para los grupos desatendidos. Los proyectos de innovación tienen un tiempo limitado y están centrados en el aprendizaje. Estos proyectos ofrecen una oportunidad para mejorar los aspectos del sistema comunitario de salud mental de manera creativa. Los proyectos de innovación pueden introducir una nueva práctica de salud mental, hacer un cambio en una práctica de salud mental existente, aplicar un enfoque existente no relacionado con salud mental o implementar una práctica prometedora impulsada por la comunidad hacia la salud mental.

Este plan proporciona información en profundidad sobre los proyectos propuestos, *Eating Disorder Collaborative (EDC)*, *Cracked Eggs* y el *Multi-County Full Service Partnership (FSP) Innovation Initiative* (por sus nombres en inglés).

Ambos, el *EDC* y *Multi-County FSP Innovation Initiative*, se nacen de la idea de que trabajando en colaboración con nuestra comunidad y socios estatales ayudará a informar a los sistemas de salud mental en formas de como entregar y mejorar el servicio muy necesario dentro de nuestro sistema complejo de salud. *Cracked Eggs* aprovecha el enfoque creativo e impulsado por nuestros pares que pone nuestro recurso más valioso, nuestros clientes, en el centro de una serie de talleres diseñados por pares destinados a educar y empoderar.

Sólo después de una amplia colaboración y una cuidadosa consideración se propone que los proyectos sean financiados en el marco del Componente de Innovación de MHSA. Detalladas en la sección de Planificación del plan, usted encontrará una sinopsis del extenso y diverso proceso de planificación de partes interesadas que DBH facilitó para desarrollar estos planes de proyectos de Innovación.

DBH está utilizando estos Proyectos de Innovación para promover la Visión del Condado de San Bernardino de promover el bienestar a través del mejoramiento de la colaboración y las asociaciones para tratar de mejorar a la persona entera. Los invito a leer el plan del proyecto y proporcionar sus sugerencias a MHSA@dbh.sbcounty.gov. Agradecemos antemano su tiempo y sugerencias.

Gracias,

Veronica Kelley, DSW, LCSW
Director
San Bernardino County Department of Behavioral Health

Public Review

The SBC-DBH Mental Health Services Act Innovation Plan 2019 was posted on the department's website for stakeholder review and comment from **November 27, 2019 through December 26, 2019**, at http://wp.sbcounty.gov/dbh/admin/mhsa/. The Public Hearing to affirm the stakeholder process took place at the regularly scheduled Behavioral Health Commission Meeting on January 2, 2020, which was held from 12:00 until 2:00 p.m.

Substantive Comments/Recommendations

Comments/recommendations were submitted via email to the SBC-DBH MHSA email box at MHSA@dbh.sbcounty.gov during the time the MHSA Innovation Plan 2019 draft was posted for public comment. Stakeholders were informed that comments can be received anytime through the year but will not be included in the final plan unless provided during the 30-day comment period. The plan was posted for 30-days, per Welfare and Institutions Code 5848, between **November 27, 2019 through December 26, 2019** at http://wp.sbcounty.gov/dbh/admin/mhsa/.

SBC-DBH encourages and supports community collaboration, particularly the involvement of stakeholders, in all aspects of the MHSA programs. To address concerns related to SBC-DBH MHSA program issues in the areas of access to behavioral health services, violations of statutes or regulations relating the use of MHSA funds, non-compliance with MHSA general standards, inconsistency between the approved MHSA Innovation Plan and its implementation, the local MHSA community program planning process, and supplantation, please refer to the MHSA Issue Resolution process located at http://wp.sbcounty.gov/dbh/wp-content/uploads/2016/06/COM0947_Issue-Resolution.pdf.

Community members do not have to wait for a meeting to provide feedback to the Department. Feedback can be provided at any time via email at MHSA@dbh.sbcounty.gov or phone by calling 1-800-722-9866. Program data, outcomes, statistics and ongoing operations are discussed on a regular basis and shared with the community. The Community Policy and Advisory Committee (CPAC) specifically addresses MHSA programs. If you would like to be added to the invite list for CPAC meetings, please email MHSA@dbh.sbcounty.gov.

As feedback is collected from the community, it is analyzed with county demographic information, prevalence, and incidence rates for behavioral health services, specific treatment information collected by programs, consumers served, number and types of services provided, geographic regions served by zip code, data provided to the department by state agencies evaluating access to county services, cultural and linguistic needs, poverty indexes, current program capacity, and demonstrated needs in specific geographic regions and areas within the system of care (e.g., inpatient, residential, long-term care, day treatment, intensive outpatient, general outpatient care), and program needs are considered.

Public Posting and Comment

The San Bernardino County Department of Behavioral Health (SBC-DBH) would like to thank those who participated in the public comment portion of the stakeholder process. During the 30-day public posting of the SBC-DBH MHSA Innovation Plan 2019, SBC-DBH continued to promote the 30-day posting and provided overviews and information related to the MHSA Innovation Plan 2019. A press release, in English and Spanish, notifying the public of the posting was sent to media outlets. A series of web blasts were released to all SBC-DBH clinics, contracted provider agencies, the Community Policy Advisory Committee, the Cultural Competency Advisory Committee and all associated cultural sub-committees, the Association of Community Based Organizations, and the Behavioral Health Commission, were included on all SBC-DBH sponsored social media sites, including Facebook and Twitter, and was posted on the main SBC-DBH website.

Printed copies of the plan were available upon request and an electronic copy was available on the SBC-DBH website. As a result, 52 returned surveys were received during the public posting period. All of the comments were received on the Stakeholder Comment Form that was available to all stakeholders. Of the 52 respondents 47 completed the satisfaction portion of the survey. Of those that responded, 85% indicated they were satisfied with the method of communication concerning this Innovation plan.

SATISFACTION WITH CPP PROCESS

Source: SBC-DBH MHSA Innovation Plan 2019 30-Day Comment Period Stakehodler Feedback Survey

Summary and Analysis of Substantive Comments

Comments received about the MHSA Innovation Plan 2019 and stakeholder process, were supportive of the plan and the SBC-DBH Community Program Planning process. Comments received during the 30-day posting included opportunities to correct spelling; support for the proposed projects, information that will be used during implementation planning, and positive feedback in general. No comments or recommendations requiring substansive changes to the Innovation Plan were received.

Fifty-two comment forms were received during the 30-day posting and public comment period of the draft MHSA Innovation Plan 2019. A summary of the comments includes:

- Community support for the proposed innovation projects.
- Support for the inclusion of peer designed programming.
- Feedback concerning the proposed target population for the Eating Disorder Collaborative.

Thirty-four stakeholder forms had direct questions, comments, or concerns submitted. Each of these forms were reviewed and followed up by thanking the individual for their feedback and participation and by providing appropriate information and resources. Those requesting information on job training and placement or housing assistance were directed to contact the Housing and Employment Program at (909) 421-9451; those requesting information for behavioral/mental health crisis services in their local area were advised to call the 24 hour Access & Referral line at (888) 743-1478.

Many individuals complimented SBC-DBH services, staff, and clubhouses saying they were thankful for the facilities and services they have experienced. Those were responded to by thanking the individual for their participation and feedback and for sharing their positive experiences with SBC-DBH. A total of 10 comments were received from the Santa Fe Social Club Clubhouse located in Yucca Valley. These comments all expressed the need for transportation as well as excitement and a desire to be able to participate in the Cracked Eggs Innovation Project. These comments were responded to by thanking each individual for their participation and feedback as well as sharing SBC-DBH's intent to bring Cracked Eggs to the Santa Fe Social Club.

The following are a sampling of direct comments received regarding specific programs in the MHSA Innovation Plan 2019 as well as the responses from SBC-DBH. Wording and grammar edits have been made and are included below.

STAKEHOLDER COMMENT AND RESPONSE

Comment: Thank you for putting together such a thoughtful plan and addressing the needs of underserved. Eating disorders have not been systematically addressed, especially for people enrolled in public insurance plans.

Response: Thank you for your comment. DBH looks forward to learning from this project and sharing outcomes to improve our service delivery for this underserved population, individuals experiencing Eating Disorders.

Comment: I believe the eating disorder collaborative is a very important addition to the behavioral health services offered. Increasing the understanding of eating disorders along with early identification and better access to treatment will help individuals and families who are struggling with this vital health concern.

Response: Thank you for your feedback. DBH also believes that treating Eating Disorders is an important part of the services offered, along with providing trainings that supports staff competencies and comfort in assisting clients and their families experiencing eating disorders.

Community Program Planning Meeting

Comment: EATING DISORDER COLLABORATIVE Because the most common age of onset of an eating disorder is between ages 12-25, there needs to be more inclusion of middle and high school youth in this proposal. There seems to be a disconnect in the narrative of the project in that even though the target population listed on page 17 states TAY age, all outreach in other parts of the narrative is only to college campuses. Middle and high schools are not mentioned at all. Your own data on page 18 lists ages 0-17 as 43% of the diagnosed clients - more than any other age category, yet they are almost left out of the proposal. The Project Deliverables on page 15, #1 only list materials to be disseminated again at the college level. The EDO Teams, as described in the narrative, have a focus solely on the client and working through the client's physician. However, research demonstrates that for clients 18 and under that family therapy has the best outcomes. This may be assumed, but it would be important to delineate it as part of the Plan. It appears that this is an internal-only proposal, meaning that it won't have an opportunity for contract agencies to be involved. Especially where school sites are involved, this is a missed opportunity for our qualified contract agencies to play a role in information dissemination, early identification, and linkages.

Response: Thank you for your feedback and participation. We appreciate your input. DBH has an established children's system of care that provides care and treatment for children within the family system. The established system does address the needs of the children suffering from eating disorders. Through this project, DBH is working with local community colleges to learn the best approach to working within the higher education system. Based on the learning we may expand outreach into the middle schools and high schools through our existing service programs [e.g., Student Assistance Program (SAP) and School Aged Treatment Services (SATS)]. Regarding care and treatment of individuals, behavioral health staff working with minors do utilize Family Based Treatment and work with the physical health staff as appropriate treatment for each individual case. This program will also explore the use of family treatment with adults.

Community Program Planning Meeting

Comment: More information about how providers will incorporate the EDO collaborative into existing mental health program (FSP). More information about which type of disciplines will receive EDO training and what those trainings will be.

Response: Thank you for your feedback and participation. Once DBH has received approval from the Mental Health Services Oversight and Accountability Commission we will be able to further discuss the formation of the EDO treatment teams and incorporation with Adult Full Service Partnerships as well as the trainings that will be available to multiple disciplines. At this point in time the intention is to have the team work as both consultants to an existing mental health program and potentially join a team in direct provision of services, depending upon the client's needs and the expertise of the staff within the existing program.

Comment: I am writing in strong support of the Cracked Eggs project led by Linda Carmella Sibio. I have participated in Linda's workshops in both one-on-one and group settings, and my work with her has influenced my mental health in a positive way. Her ability to conjure and facilitate expression of pure emotions is a unique talent. I am confident that the Cracked Eggs program will have a positive effect on our community. Arts-based treatments are very necessary and can help people access experiences, memories, and emotions that are difficult to achieve in other types of treatments.

Response: Thank you for your feedback and support. DBH is looking forward to learning from Cracked Eggs and seeing the impact in our community.

Comment: Cracked Eggs sounds like an exciting opportunity to increase access to mental health services by providing an outlet for participants to give voice to their experiences and feelings and to build their self-awareness and self-esteem.

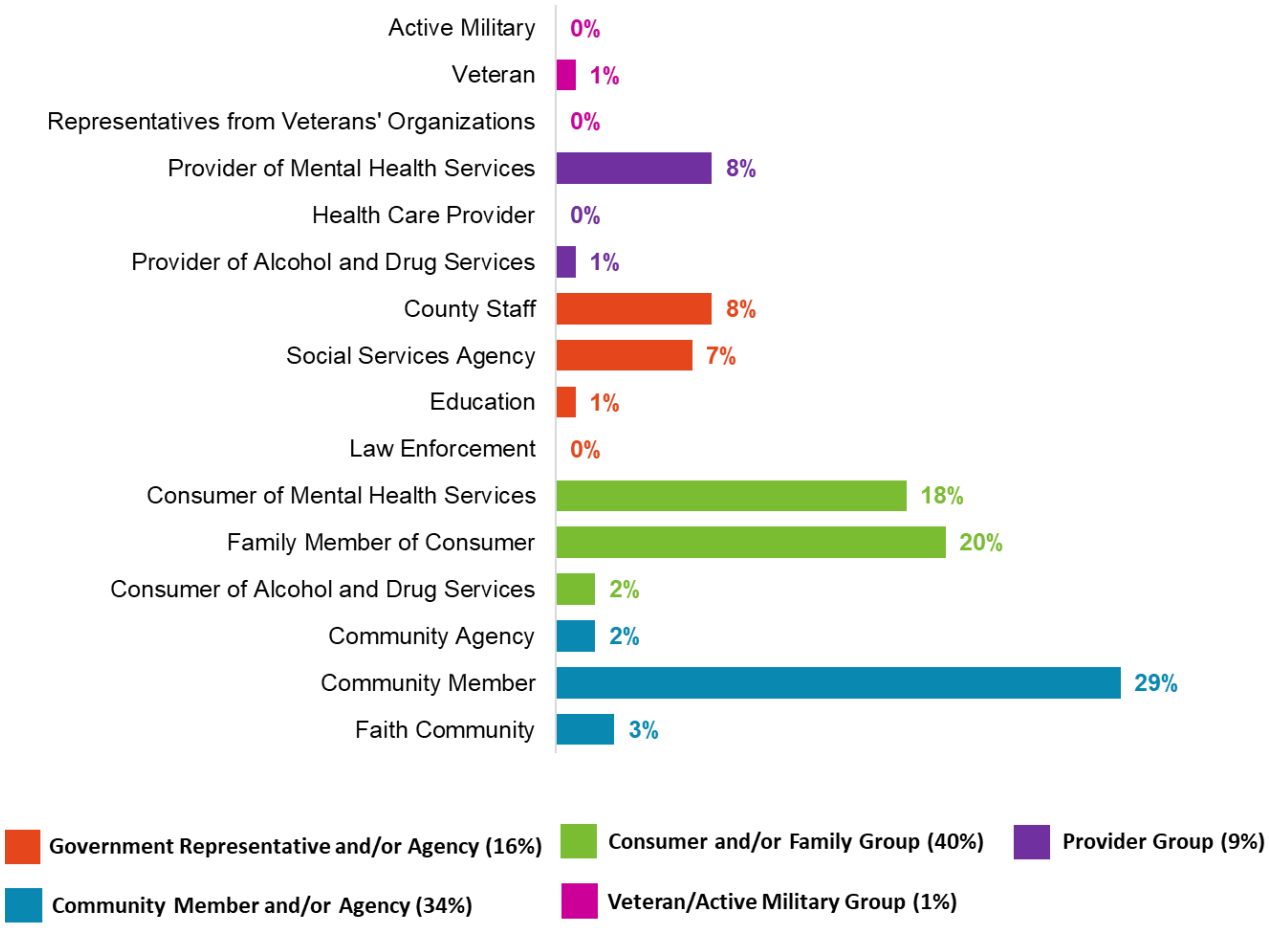
Response: Thank you for your feedback. We hope that through Cracked eggs we are able to make a positive impact with participants.

Comment: I think the Cracked Egg Art program would be a great thing to add to Amazing Place. I [particulary] think that having some type of [in-person] workshop with Artist Linda Carmello Sibio would be especially [rewarding] to see how someone with mental symptoms channeled her creativity into an artful expression.

Response: Thank you for your feedback and support. We look forward to learning from the Cracked Eggs project and working with Linda Sibio.

Stakeholder Demographics from 30 Day Public Comment Period

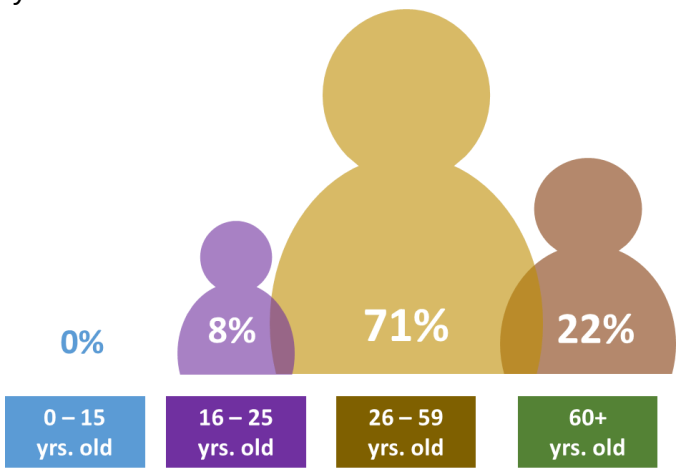
Surveys were returned from a diverse group of stakeholders. “Community members and/or agencies”, along with “consumer and/or family members” represented 74% of all returned surveys, by far the largest group represented. The next largest group were “government representatives and/or agencies” representing 16% of the responses. The final two groups were “providers of mental health and/or substance use disorder services”, and “veteran and active military” represented 9% and 1% of the responses.



Source: SBC-DBH MHSA Innovation Plan 2019 30-Day Comment Period Stakehodler Feedback Survey

STAKEHOLDER AGE

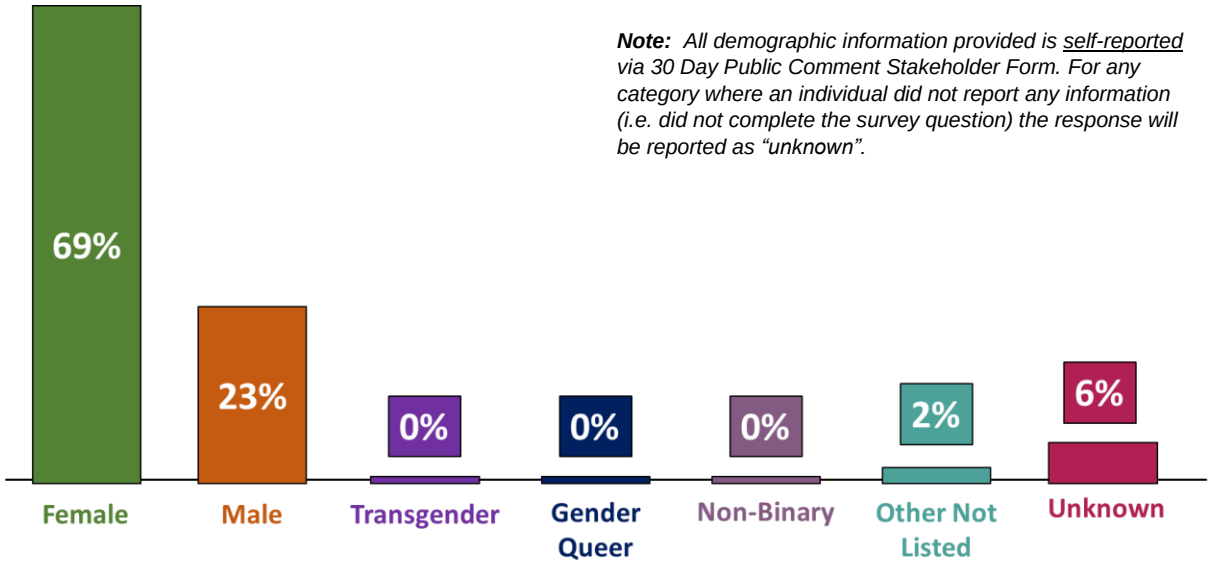
The largest portion of stakeholder fell within the 26-59 year old age range (71%). The remaining stakeholders were split between the 16-25 year old range and 60 year and older, 8% and 22% respectively.



Source: SBC-DBH MHSA Innovation Plan 2019 30-Day Comment Period Stakehodler Feedback Survey

STAKEHOLDER GENDER

The breakdown of participants from the Innovation stakeholder meetings by gender is as follows: 69% of the participants are female, 23% of the participants are male, 2% of the participants identify as something other than what was listed on stakeholder forms, and 6% of participants' gender are unknown.



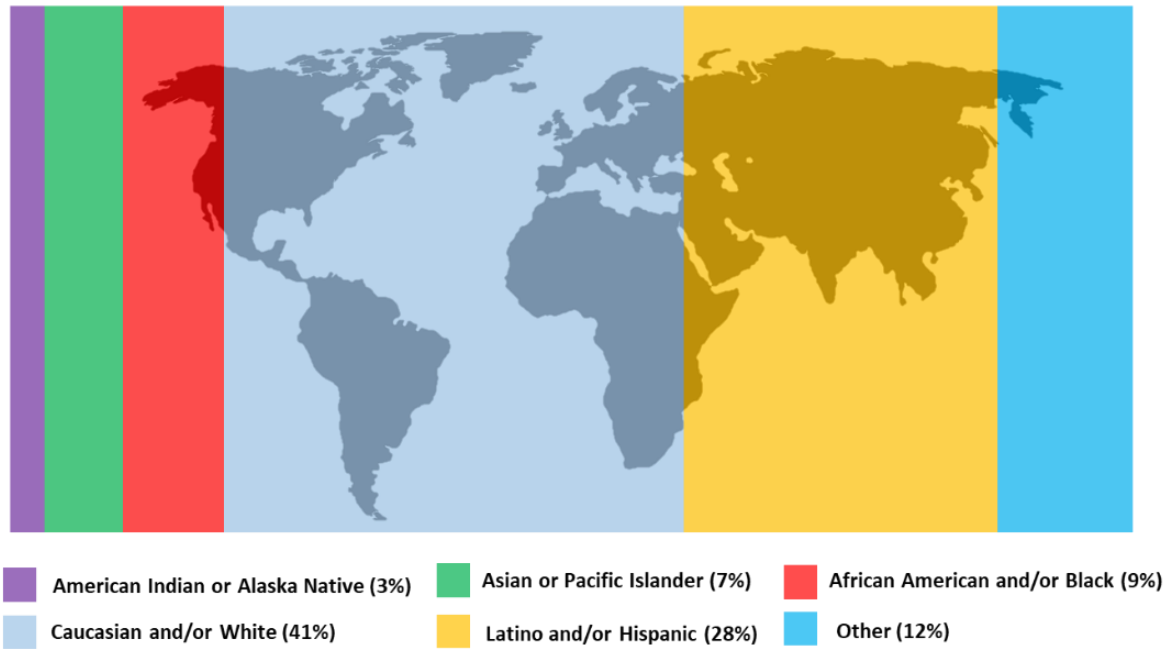
Note: *All demographic information provided is self-reported via 30 Day Public Comment Stakeholder Form. For any category where an individual did not report any information (i.e. did not complete the survey question) the response will be reported as "unknown".*

Source: SBC-DBH MHSA Innovation Plan 2019 30-Day Comment Period Stakehodler Feedback Survey

STAKEHOLDER ETHNICITY

The ethnic breakdown of the CPP participants is as follows:

- The group with the largest representation is the Caucasian population representing 41% of participants.
- Participants who identified as Latino and/or Hispanic, the second largest group, represented 28% of the participants.
- Individuals identifying as African-American or Black represented 9% of the stakeholder responses.
- Participants identifying as Asian or Pacific Islander represented 7% of the stakeholder responses.
- Native-American or Alaska Native participants were the smallest group, representing 3% of the stakeholder responses.



Source: SBC-DBH MHSA Innovation Plan 2019 30-Day Comment Period Stakehodler Feedback Survey

SAN BERNARDINO COUNTY

Behavioral Health

Innovative Project Proposal

Eating Disorder Collaborative

Promoting Wellness, Recovery, & Resilience for those diagnosed with or at risk of developing an eating disorder.

Innovative Project Concept

Eating disorder (EDO) onset occurs typically between 18 and 21 years of age with the average age of onset for anorexia being 19 years old, bulimia 20 years old, and binge eating disorder at 25 years old (Eating disorders on the College Campus. National Eating Disorders Association. Feb 2013). For many young adults, leaving home to go to college will be the first time living away from home and no longer having family members or other loved ones manage their food choice and/or preparation. As such, this is the natural time period where behaviors and attitudes toward food may become dangerous without anyone noticing. This is also the first time where young adults will be expected to make their own choices concerning their health and healthcare. Without additional education or intervention concerning healthy eating habits and body weight, young adults may fall victim to our current cultural attitude that idealizes thinness and sees weight as the primary indicator of health. In this environment, 35% of "normal" dieters progress to pathological dieting, and of those 20-25% progress to a partial- or full-syndrome EDOs (Hart, S. Nutrition and dietetic practice in eating disorder management. Journal of Human Nutrition and Dietetics. 2011). In part, the slide from dieting to pathological dieting to eating disorder, is driven by a lack of awareness and education. This is supported by a study that found students who attended a one-time intervention program for "Disordered Eating Awareness Week" had higher levels of factual knowledge of available campus resources for body image issues and disordered eating behaviors than students who did not attend (Tillman, KS; Arbaugh Jr, T; Balaban, MS. Campus Programming for National Eating Disorders Awareness Week: An Investigation of stigma, help-seeking, and resource knowledge. Eating Behaviors. 2012). Given that eating disorders are the mental illness with the highest mortality rate, early detection, intervention, and treatment are extremely important and gives an individual the best chance at recovery (Arcelus, Mitchel, Wales & Nelson. Mortality rate in patients with Anorexia Nervosa and other eating disorders. Archives of General Psychiatry. 2011)

Anorexia is the third most common chronic disease among young Americans, after asthma and Type-1 diabetes.

-National Eating Disorder Association

According to a 2012 National Survey of Eating Disorder Programs and Resources on College Campuses, conducted by the National Eating Disorders Association, availability of screenings for eating disorders are sporadic. One-hundred and thirty-nine (139) campuses took part in the survey. Only 22.4% of those surveyed offered year-round screening opportunities and less than half offer screenings only once per year/semester. These results mirror the lack of screening opportunities here within San Bernardino County college campuses. The California State Board of Education indicates San Bernardino County contains 22 college and/or university campuses. Of those, only six campuses maintain a student body of 4,000 or more students with an accompanying health center. Only two of the six campuses mention disordered eating screening as a service provided on their health center website. Neither of these two campuses mention the Department of Behavioral Health as a resource for disordered eating within their resource directories. In addition to a lack of screenings, self-report surveys/questionnaires, which measure symptoms and risk behavior, are also not made available. These questionnaires could lead to a self-referral to a primary care physician or to an appointment within the health center itself.

> *We need to detect people's symptoms early so we can get them into care. Currently, only a third of people in the U.S. with an eating disorder ever receive treatment. And many clinicians don't receive training in early detection, so they aren't equipped to refer people to treatment. Eating disorders are treatable. We've got good treatments in place for most people, if we can get them access to health care and overcome the barriers of stigma and affordability. (Leavitt, Noah. A Call for the CDC to track eating disorders. Harvard University's Strategic Training Initiative for the Prevention of Eating Disorders (STRIPED). 2017).*

According to a 2011 Advisory published by the Substance Abuse and Mental Health Services Administration, a 2010 review of literature yielded reports of a high co-occurrence of EDOs among women with Substance Use Disorders (SUD), noting that women with either a SUD or an ED were four times more likely to develop the other disorder in comparison to women with neither disorder (SAMHSA Advisory. Volume 10, Issue1, February 2011). Additionally, the SAMHSA Advisory cited studies that indicate that the more severe the EDO, the number of substances used increases, as attempts to lose weight were associated with stimulant/amphetamine, sleeping pill abuse, or use of laxatives or diuretics.

At a 2018 San Bernardino County Eating Disorder Collaborative meeting with clinicians and representatives from San Bernardino County's two managed care plans, the idea of a "recommended" screening tool was discussed. Seven different assessments were reported being used throughout the county with no clear data-driven determination of a best practice. If student health centers are not equipped and trained to provide assessments, and the county

mental health plan cannot assist in the conversation with a recommend best practice and training, students who rely on the student health center may remain undiagnosed. In order to begin a system wide educational push to educate clinicians, student health centers, other health professionals, substance use disorder providers a recommended assessment and training model would need to be determined.

When discussing treatment, anorexia, bulimia, and other eating disorders have proven resistant to traditional treatment. Since an eating disorder is both a physical and a mental illness, the medical treatment and psychological intervention must be integrated to provide the best results. That is why a multidisciplinary team approach is essential for successful treatment. No one professional has the expertise to fill all of the patient's medical and psychiatric needs. While multidisciplinary teams are a standard approach for treatment, most are working without an established continuum of care, by which, an individual in treatment may receive more and less intensive services in a coordinated fashion. Additionally, these teams have very little input in the determinations on how the system of care should been organized. To address this, in 2016, SBC-DBH convened a focus group of clinicians and management to improve treatment and care coordination for diverse individuals with eating disorders seeking treatment with SBC-DBH. Ongoing educational concerns were identified at multiple points during focus group questioning. This group noted the need for a coordinated regional educational effort to improve understanding of disorder eating in order to increase the probability of earlier detection, as well as, educate those providing treatment to the resources available and barriers experienced within the existing system of care. Specifically, there was a lack of data-driven education informed by the best practices and experiences from the treatment team. While having a multi-disciplinary team approach to the treatment of eating disorders is a standard practice, incorporating this team in the development and delivery of training is not. The focus group findings indicated that any training on treatment modalities is appreciated, training influenced by the treatment team's real-world experience would have benefits for the larger system of care. Previous attempts at constructing this type of training infrastructure were limited based on the time available to the treatment team.

Lastly, within the current model for treatment of eating disorders, there exists a lack of parity concerning treatment options based on health insurance coverage (White House Parity Task Force, 2017). Individuals that have insurance coverage through Medicare and/or Medi-Cal do not have the same access to treatments as those individuals with private health plans.

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Medicare/Medi-Cal Coverage for Eating Disorders – Benefit Coverage for Adults (21 yr. old+)

Treatment Program	Medicare Coverage	Medi-Cal Coverage
General Acute Hospitalization	Yes	Yes
Acute Inpatient Psychiatric	Yes	Yes
Residential Treatment	**No**	**No**
Partial Hospital Program (PHP)	Yes	**No**
Intensive Outpatient Program (IOP)	Yes	**No**
Full Service Partnership (FSP)	Yes	Yes

Source: California Association of Health Plans

Reduced access to treatment may also skew research and perpetuate the stereotypes about EDOs—what they look like, who gets them, and how old they are. One of the most comprehensive ways to collect data about who suffers from EDOs is to survey those who are getting help.

What Has Been Done Elsewhere to Address this Problem?

SBC-DBH and local managed care providers have met together to find solutions to complex eating disorder (EDO) cases. Staff come together to determine the best course of treatment for individual cases because a system to effectively manage these cases does not currently exist. A system to manage complex EDO does not exist for many reasons, including frequent changes in staff, lack of resources, no clear funding stream for EDO clients, and lack of cooperation from clients and family. Outcomes to these cases tend to be highly individualized because of an inconsistent approach to cases, predicated by no clear funding stream or reporting structure, forcing providers to put individualized treatment plans together. A lack of consistent training also adds an extra layer to the inconsistency. Individual doctors, therapists, alcohol and drug counselors, and case managers may develop different treatment plans, even when working for the same organization, based on their level of comfort, training, knowledge of community resources, and personal understanding of the available funding sources. Because a formal structure for analyzing and reporting outcomes does not exist, the current meeting method does not produce system-wide best practices that could be shared or further developed to improve efficiency. Individuals are left to overcome system challenges and institutional barriers outside of any documented process improvement effort.

Additionally, ongoing discussions in this group noted the treatment barriers that were preventing better outcomes on cases had similarities between income level and health insurance coverage.

Some barriers identified include:

- No integrated care model that covers both the medical and behavioral health concerns.
- Financial considerations based on the cost of treatment.
- Patients with transportation problems, unable to get to appointments.
- Work obligations for adults seeking EDO treatment and parents with children seeking EDO treatment.
- Lack of dietitian support in certain areas.
- Size of county makes doing multiple in-home assessment in one day difficult.
- Lack of understanding of how hospitals complete assessments (use of diagnostic software).

This group has also noted that there is a gap in the literature regarding culturally competent treatments for eating disorders. Furthermore, SBC-DBH has identified client and family cultural barriers that may adversely impact understanding, acceptance, and support of eating disorders treatment, and need to be addressed. Based on the discoveries and the resulting questions the idea for the current Innovation project was first considered.

While preparing for this project scholarly databases where searched looking for literature reviews or published reports that were similar to this project. Nothing was located. Internet searches were also conducted finding no other project similar to this project with published results that could be found through Google Scholar, Journal of Eating Disorders, Biological Psychiatry, or the National Eating Disorder Information Center.

The Proposed Project

The focus of this project is to improve upon San Bernardino County Department of Behavioral Health's (SBC-DBH) approach to comprehensively meet the physical and mental health needs of people suffering from EDOs by:

1. Creating trainings and informational materials to reach out to Primary Care Physicians, Allied Health Professionals (e.g., nurse practitioners, physician assistants), Mental Health and Substance Use Disorder Staff, and local Colleges and Universities,
2. Creating a more comprehensive and validated initial needs assessment (i.e., an Engagement Assessment) to assist in level of care determination, and
3. Creating multidisciplinary teams to provide more comprehensive treatment services and ensure policies and practices of mental health and physical health are consistent across agencies.

TRAININGS AND INFORMATIONAL MATERIALS

A primary goal of this project is to **increase the regional understanding of eating disorders across the spectrum of care to facilitate earlier identification of eating disorders and**

access to effective treatments. This will specifically include targeting local colleges and universities, primary care providers, and behavioral health providers (substance use disorder counselors and mental health practitioners). The trainings and materials will be developed by the multidisciplinary teams in close consultation and collaboration with the training and informational units of DBH and community partners.

Trainings and informational materials targeting colleges and universities will focus on public information campaigns and materials which could be utilized in public settings (e.g., dorm halls, student centers) as well as informational trainings for staff. During the course of the project, specifics regarding the information trainings will be developed (e.g., short duration information training for student center staff). Additionally, college and university staff involved in health care and counseling centers will be included in the training efforts for primary medical care staff and behavioral health staff.

Trainings and informational materials targeting primary care physicians, allied health staff, and substance use disorder counselors will focus on the screening process, brief interventions, and referral process, and physical health providers' role in the ongoing care of individuals with EDOs. Project activities will include trainings on:

- Efficient and effective screenings (e.g., adaption of existing questionnaire) which could be completed during an interview or provided in the waiting area,
- Simplified referral processes, and
- Standards for monitoring essential aspects of physical health during the course of care.

Trainings and informational material targeting behavioral health care providers will focus on enhancing behavioral health providers' comfort and competency levels in working with persons with eating disorders, as SBC-DBH has found that the psychiatric and medical complexities and risk of mortality in persons with these disorders can create significant angst amongst providers, ensuring the inclusion of assessing for EDOs, understanding the referral process, and the provision of appropriate services at different levels of care. One element of this project will include an evaluation of which evidenced-based practice is the most sustainable within the context of San Bernardino County's existing system of care and trainings on this selected practice will be provided to clinical staff who will be involved in the clinic and home based interventions.

This comprehensive training model, including a knowledge and resource directory, will require coordination between DBH, community partners including managed care plans as appropriate, multiple Independent Physicians' Associations (IPAs), substance use disorder providers, and college/university health centers. The creation of this model will facilitate the development of relationships and networks with, among, and between subject matter experts, to include those

with lived experience, and those requiring additional information on EDOs. It is expected that this training model will include both training provided by contracted experts on EDOs and training developed internally from the lessons learned from this project. An outside training company may also be contracted to help with the initial development and knowledge capture from the system's existing subject matter experts. All trainings will be ongoing in order to maintain an existing and further grow the knowledge-base within the community and to ensure the development of new subject matter experts. A centralized point of contact, or training coordinator, would be available for DBH, managed care plans, community partners, colleges/universities, and primary-care providers to manage the development and provision of trainings. Additionally, the multidisciplinary teams will be available for case-by-case consultations and generalized system navigation questions. Repeated inquires will be researched and included back into the standardized training to improve the information provided to trainees. This internal feedback is intended to continuously refresh the ongoing training provided with the newest information possible.

ENGAGEMENT ASSESSMENT

An initial deliverable for this project will be the creation of a more robust initial assessment tool which builds upon the effectiveness of the Eating Disorder Examination – Questionnaire (EDE-Q) (Fairburn and Beglin, 2008). The EDE-Q will continue to be utilized; however, additional information will be included in this process to aid in proper treatment planning. Additional information will include, but not be limited to, the following: individual and family's circumstances, potential protective factors (e.g., family relationships, informal supports, additional resources), and potential barriers to treatment (e.g., work schedule, travel time/distance, transportation, other family obligations, and technological access).

The EDE-Q and the newly developed engagement assessment will be used to identify the most appropriate services for the individual. Current practice is for the level of care to be determined by the EDE-Q responses without consideration of additional important psychosocial factors. In some instances, there are barriers to treatment for the indicated level of care (e.g., travel time or other family obligations) which prohibit individuals from participating effectively, or at all, in the indicated level of care. In this project the engagement assessment will be created and evaluated in regards to effectiveness of aiding in identifying additional means (e.g., intensive in home services) that could meet the individual's needs when barriers prohibit treatment participation in traditional services.

MULTIDISCIPLINARY TEAMS

Coordinated delivery of services from both physical and behavioral health providers is essential for the effective treatment of EDOs, but effective collaboration is limited due to a variety of issues that can occur when working across agencies and professions. This project will include the

creation of two regional multidisciplinary EDO treatment teams (EDO-Team) that will include the following positions:

- Case Manager
- Family coordinator (a peer position)
- Behavioral Health Clinician
- Program Specialist
- Dietician/Nutritionist specializing in EDOs
- Nursing staff

The project will begin with one centralized EDO-Team. It is anticipated that as training and informational materials are dispersed there will be an increase in referrals received. Based on learning from previous innovation projects, determination of regional team deployment will be dictated based on referral volume. The second EDO-Team will be brought online as demand for additional staff becomes apparent.

Referrals will be received from primary care providers, local universities and colleges, managed care plans, county-run behavioral health clinic and health centers, substance use disorder providers, and self/family. These referrals will be processed by the appropriate regional EDO-Team.

The multidisciplinary EDO treatment teams (EDO-Team) will be involved in the care provided to all clients; however, involvement will range from direct provision of services to liaising with both more and less intensive levels of care. In all circumstances the EDO-Team will be proactive in liaising with the client's primary care physician. Levels of appropriate care that will be utilized include, but are not limited to, the following:

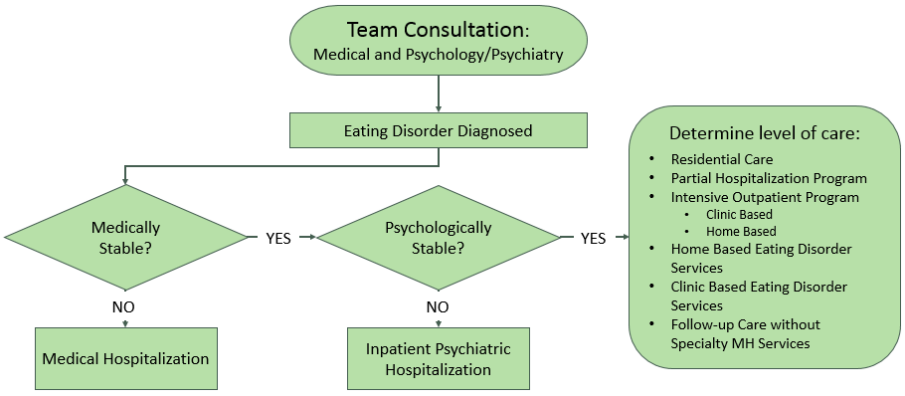
- Residential Care - Contracted with a Community Based Organization (CBO)
  - Includes liaison activities with EDO-Team
- Partial Hospitalization Program (PHP) - Contracted with a CBO
  - Includes liaison activities with EDO-Team
- Intensive Outpatient Program - Clinic Based (IOP-CB) - Contracted with a CBO
  - Includes liaison activities with EDO-Team
- Intensive Outpatient Services - Home Based (IOP-HB) - Provided by EDO-Team in conjunction with Primary Care Physician
  - May include remote telehealth services as needed
- Home Based Eating Disorder Services (HB-EDO) - Provided by EDO-Team in conjunction with Primary Care Physician
  - May include remote telehealth services as needed
- Clinic Based Eating Disorder Services - Provided by EDO-Team and/or local provider in conjunction with Primary Care Physician

- Follow-up Care without Specialty Mental Health Services - Provided by EDO-Team in conjunction with Primary Care Physician

This model will serve as San Bernardino's universal approach to Eating Disorder treatment. For this model, Innovation funding will be used as a foundational funding stream for the creation of a comprehensive training mode, creation of a robust initial assessment tool which builds on the EDE-Q, and the staffing of the EDO-Teams. Innovation funding will also support treatment for those individuals who do not have access to another way to fund EDO treatment; however, this is expected to be the exception and not utilized frequently since all other means of funding EDO treatment will be investigated prior to innovation funding being used. Over the course of the innovation project, other shared funding approaches will be developed with our managed care partners in order to ensure ongoing sustainability (e.g., exploration of Health Homes for this target population). By eliminating barriers inherent to inconsistent funding, this model will ensure that all participating individuals have the same access to care.

TREATMENT MODEL

As the project develops it is anticipated that this triage model will be modified by the learning achieved; ideally, by project's end SBC-DBH will have a sharable, system transforming triage model that can be replicated in various public and private healthcare environments.



PEER PARTNERS AND FAMILY ADVOCATES

To provide system navigation assistance and support, SBC-DBH will recruit individuals with lived experience in disordered eating recovery. EDOs present complex challenges in the care coordination between medical and mental health care professionals, where the assistance of someone with lived experience working with a care coordination and treatment team will be valuable. These individuals will also be able to assist in designing, reviewing, and providing the needed psychoeducation that will be provided to individuals in treatment as well as their loved ones.

PROJECT DELIVERABLES

The result of this project will be a toolkit that other counties and agencies can use to adopt the highlighted best practices within their system of care.

1. Information Materials, Standardized care guidelines/protocols, Micro-Trainings, and Trainings for
    - College Health Centers, Student Centers, Residential Life, and Recreational Centers
    - Primary Care Physicians, Allied Health Professionals, and Nursing staff
    - Behavioral Health Providers
2. Shared ongoing training and regional asset/knowledge repository
3. Expanded service level guidelines that build upon the Eating Disorder Examination - Questionnaire (EDE-Q) that consider factors that may be protective and/or create barriers to effective treatment.

Project Implementation Timeline

The implementation of the EDC project will roll-out in a phased approach with some overlapping elements between phases. The description of each phase is below:

Reaching Out and Implementation
Months 1-6

During this phase, SBC-DBH will be working with Community Colleges within the County for collaboration opportunities. SBC-DBH will also share the project concept with local managed care agencies and solicit input and collaborative opportunities. A steering committee will be implemented and preliminary project planning meetings will be scheduled to begin shaping the project. SBD-DBH will work with County HR to put together a special recruitment for the positions needed to staff the multidisciplinary team. In this early phase all the administrative implementation tasks associated with starting a project will be done.

Team Development and Logistics

Months 3-12

During this phase, SBC-DBH will begin the hiring process to staff the multidisciplinary teams. Permanent office space will be located with the goal of having communal work spaces to allow for networking and on-the-spot problem solving between the various disciplines. The multi-disciplinary teams will begin working on creating and documenting business practices. SBC-DBH will begin and manage the process for working with an external agency to create and develop the public information campaign and training.

Business Practices, Contracts, and Evaluation Metrics

Months 6-18

This phase will consist of the finalizing any required contracts, as needed. Complete hiring of new staff, as appropriate. A team, consisting of professionals and stakeholders will come together to start the development of the assessment tool with opportunities for stakeholders to provide feedback. Assessment tool will be introduced to select locations for trial and analysis.

Full Implementation

Months 6-54

Multidisciplinary teams will be working in the field and with local service providers. Work with community colleges and local physician associations will help to influence the materials developed. The assessment will be shared with providers interested in participating and providing feedback.

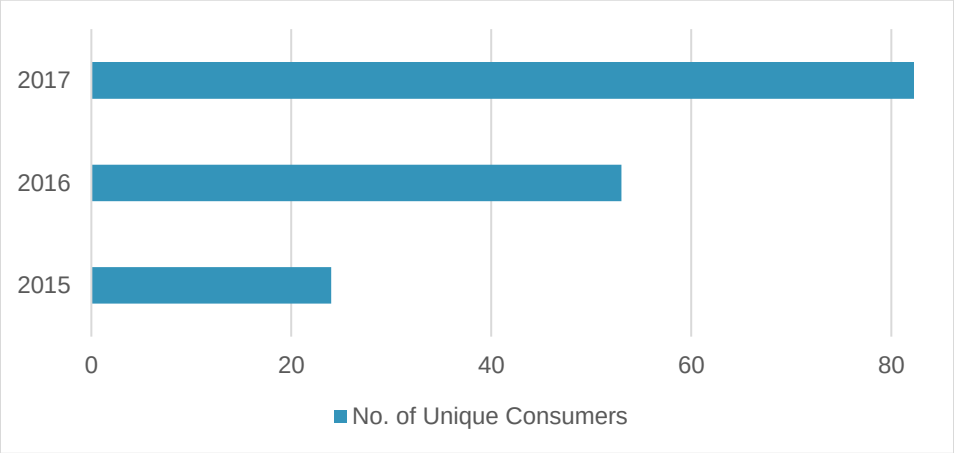
Target Population

San Bernardino County Department of Behavioral Health (SBC-DBH) has seen an increase in the number of individuals being treated for an EDO over the last three fiscal years. Because of these increases, this project's target population is as follows:

Project Component	Target Population
Interventions and Treatment	Transitional-aged youth (16 – 25 yrs. old) and adults (over 26 yrs. old) residing in San Bernardino County diagnosed with an eating disorder.
Regional knowledge and resource directory	The Inland Empire's behavioral health professionals (both public and private), primary-care physicians, contracted providers, and community partners.

From 2015 through 2017, SBC-DBH began treatment for 166 unique clients with an EDO as a primary or secondary diagnosis. During this time period 236 clients received treatment for an EDO with SBC-DBH, to include those clients that began treatment prior to 2015.

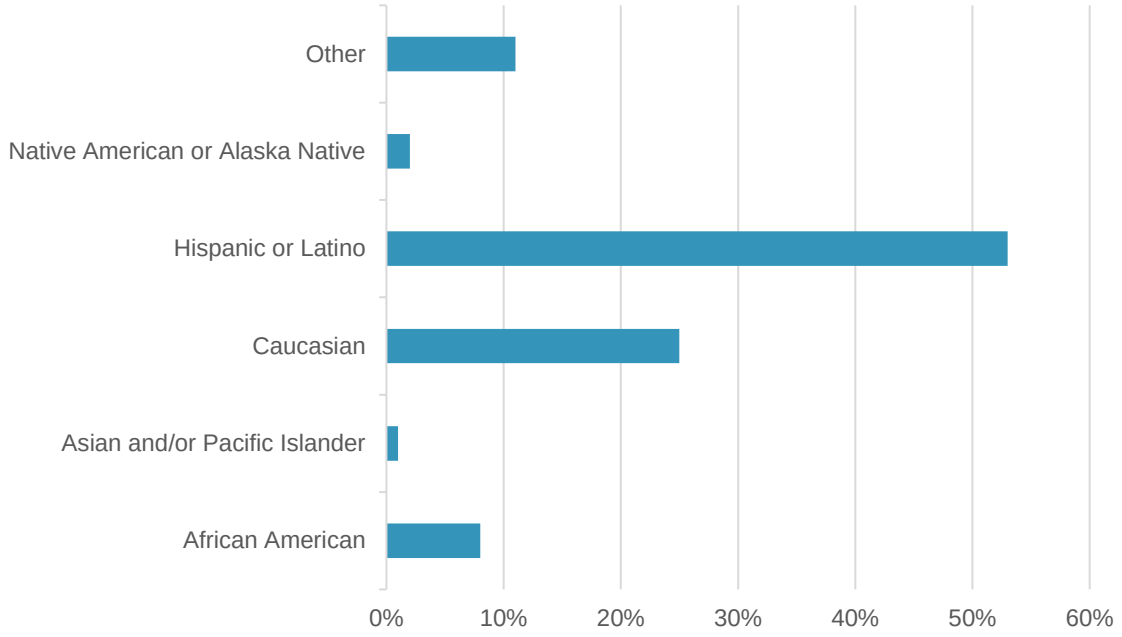
SBC-DBH CLIENTS DIAGNOSED WITH AN EATING DISORDER 2015 - 2017:



Source: SBC-DBH Consumer Records (SIMON), n=166

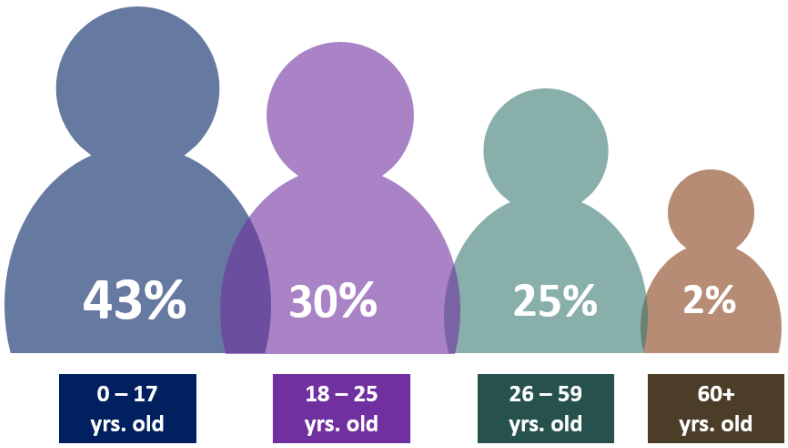
NOTE: Data is limited to those unique clients that had an episode **opened** during the reported years and does not indicate the total number of individuals being treated for disordered eating by SBC-DBH.

SBC-DBH CLIENTS DIAGNOSED WITH AN EATING DISORDER – ETHNICITY:



Source: SBC-DBH Consumer Records (SIMON), n=236
NOTE: Data represents the total number of unique clients currently receiving services through SBC-DBH for disordered eating.

SBC-DBH CLIENTS DIAGNOSED WITH AN EATING DISORDER – AGE:



Source: SBC-DBH Consumer Records (SIMON), n=236
NOTE: Data represents the total number of unique clients currently receiving services through SBC-DBH for an eating disorder.

SBC-DBH CLIENTS DIAGNOSED WITH AN EATING DISORDER – GENDER:

Source: SBC-DBH Consumer Records (SIMON), n=236
NOTE: Data represents the total number of unique clients currently receiving services through SBC-DBH for an eating disorder.

While SBC-DBH has seen a steady increase in the number of individuals seeking treatment for an EDO, there are many more individuals who are either 1) undiagnosed, or 2) forgoing treatment because of financial barriers. Given the population of San Bernardino County is roughly two million people (US Census Bureau QuickFacts, 2015) and nine percent of the American public will suffer from an EDO in their lifetime, San Bernardino County could have as many as 180,000 individuals in need of some form of education, assistance, and/or treatment for an EDO.

Based on this information, this project is estimated to serve **4,175** clients.

The Innovative Component

- Collaboration between local college campuses, the County Mental Health Plan, and two Medi-Cal Managed Plans to create public information campaigns and materials to educate populations most at risk for developing disordered eating practices and pairing this with a screening and referral process for services.
- The identification and/or development of screening tools which may be effectively used in a variety of settings (e.g., college student centers, health centers, substance use disorder providors, physician's offices) which allow for either professional or self-screening and providing a single point of contact to facilitate effective referrals to the appropriate level of care.
- The development of an initial assessment tool which builds upon the effectiveness of the Eating Disorder Examination – Questionnaire (EDE-Q) which also takes into account individual and family's circumstances, potential protective factors, and potential barriers to treatment to aid in effective treatment planning.
- The establishment of regional multi-disciplinary teams to aid in the initial assessment and facilitate the appropriate level of services either through direct provision of care or collaboration with other local providers.

Learning Goals & Evaluation Plan

The goal of every Innovation project is learning and, as such, each Innovation project establishes a learning plan, learning goals, and an evaluation plan as part of the project design.

The learning goals for the Eating Disorder Collaborative are:

1. Examine if a collaborative approach with local colleges can result in the development and utilization of public information campaigns and materials to educate populations most at risk for developing disordered eating practices at the multiple college campuses within one county.
2. Examine if the development and dissemination a screening tool which may be used in a variety of settings (e.g., college student centers, health centers, substance use disorder providers physician's offices) is effective at increasing the number of individuals assessed for disordered eating issues.
3. Examine if the development and utilization of the engagement assessment facilitates better linkage to effective treatment services.
4. Examine if the use of multidisciplinary team, all comprised of MHP staff, can effectively liaise with the variety of organizations (e.g., Colleges, College Health Centers, individual Physician Offices, Independent Physician Associations, Management Care Plans, and behavioral health providers) to (1) provide additional assessment services, (2) facilitate effective referrals, and (3) provide ongoing care as needed.

Evaluation Plan

Learning Goal #1	
Examine the factors that make collaboration with local colleges effective for the development and utilization of public information campaigns/materials to educate populations most at risk for developing disordered eating.	
Evaluation Plan	The evaluation plan will measure the: • Collaboration with colleges in public information campaign and material development. • Effective development of information campaigns/materials. • Effective utilization of information campaigns/materials. • Effectiveness of the public information campaign and materials in enhancing the knowledge of at risk populations.
Intended Outcomes	
• Increase collaboration between local college/university partner organizations leading to dynamic, ongoing working relationships. • Develop a toolkit that includes lessons learned about collaborating with colleges/universities and their health centers. • Creation of an Eating Disorder public information campaign. • Implementation of public information campaign; dissemination of public information campaign materials.	

Learning Goal #2	
Examine the benefits and challenges of developing and disseminating a screening and referral tool which may be used in a variety of settings (e.g., college student centers, health centers, physician's offices); examine the effectiveness of the screening and referral tool at increasing the number of individuals assessed for disordered eating.	
Evaluation Plan	The evaluation plan will: • Document and analyze the benefits and challenges in developing and disseminating a screening and referral tool. • Measure the effectiveness of the screening/referral tool at getting people with disordered eating linked to an assessment.
Intended Outcomes	
• Development of a disordered eating screening and referral tool. • The eating disorder screening and referral tool is disseminated to and used by community partners (colleges/universities, health centers, substance use disorder providors, physician's offices). • Develop a toolkit that includes lessons learned about developing and disseminating a screening and referral tool to community partners. • Increase the number of new clients screened, referred, and assessed for eating disorders. • Increase the number of existing DBH clients screened, referred, and assessed for eating disorders.	

Learning Goal #3	
Examine the effectiveness of engagement assessments in facilitating participation in treatment services.	
Evaluation Plan	The evaluation plan will measure the: • Willingness of providers to adopt engagement assessment tool. • Effectiveness of engagement assessments for (better) linkage.
Intended Outcomes	

- Provider satisfaction with engagement assessment tool.
- Development and implementation of an eating disorder engagement assessment.
- Increase the length of time and/or number of services utilized by clients with an eating disorder diagnosis and episode who receive an engagement assessment.

Learning Goal #4	
Examine the multiple dimensions of the best practices established for a multidisciplinary team, all comprised of MHP staff, effectively liaising with a variety of organizations (e.g. colleges, college health centers, individual physician's offices, Independent Physicians Associations, Managed Care Plans, and behavioral health providers) to (1) provide additional assessment services, (2) facilitate effective referrals, and (3) provide ongoing care as needed.	
Evaluation Plan	The evaluation plan will: • Document and analyze the role/strength/challenges of the multidisciplinary Eating Disorder Collaborative team. • Measure additional engagement services by the Eating Disorder Collaborative team. • Measure effectiveness of referrals by the Eating Disorder Collaborative team. • Provide ongoing disordered eating treatment and care.
Intended Outcomes	
• Develop a toolkit that includes lessons learned about creating, implementing, and maintaining an eating disorder multidisciplinary team. • Sixty percent of clients will receive engagement services before and after assessment to ensure effective connection to treatment. • Referrals by the eating disorder team will lead to client engagement in treatment, both within the DBH system of care and outside of the DBH system of care. • Improved client outcomes, such as decreased psychiatric hospitalizations, increased use of outpatient services.	

For further information on the evaluation plan, please see the logic model in the attachment section.

INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement.

SBC-DBH understands and acknowledges that those who engage in evaluation do so from perspectives that reflect their values, their ways of seeing the world, and their culture. This culture can shape the ways in which evaluation questions are conceptualized, which in turn influences what data is collected, and how data is analyzed and interpreted. To draw valid

conclusions, the evaluation must consider important contributors to human behavior, including those related to culture, personal habit, situational limitations, assimilation and acculturation, or the effect that the knowledge of observation can have on the observed (Cultural Competence in Evaluation Task Force. (2011). Public Statement on Cultural Competence in Evaluation. American Evaluation Association). Without accounting for the ways in which culture can affect behavior, evaluations can arrive at flawed findings with potentially devastating consequences.

Because of these concerns the SBC-DBH Office of Cultural Competency and Ethnic Service (OCCES) is a key partner in all Innovation projects to ensure compliance with cultural competency standards and to ensure that the services provided address cultural and linguistic needs. OCCES remains available for consultation and to provide support to the Innovation Team regarding issues of diversity when necessary.

Issues of cultural diversity and the social norms of a specific cultural group may present a barrier to an individual living with mental illness participating in psychiatric treatment. These issues will be explored with OCCES as they arise in order to provide services to the community in a culturally and linguistically meaningful and appropriate manner. In addition to working with the OCCES, SBC-DBH Office of Innovation also partners with stakeholder sub-committees in an active way (beyond an advisory capacity) to further ensure effective, culturally-sensitive interactions. These sub-committees are presented with the evaluation questions and results to ensure that the evaluation framework and outcome results are inclusive and foster learning across cultural boundaries while respecting different worldviews. Every effort will be made to staff the Innovation project with individuals that are diverse and representative of the demographics of the Department's clients.

For all the reasons listed above, SBC-DBH maintains a commitment to meaningful stakeholder participation in the evaluation process. Based on the continuous feedback from our community stakeholders, SBC-DBH has designed a meeting to address outcomes and evaluation in a setting that involves stakeholders. This Innovation project will be presented at the monthly meetings to each cultural sub-committees to ensure that the community planning process includes the voices of individuals who reflect the cultural, ethnic, and racial diversity that exists within San Bernardino County.

Community Program Planning

In 2016, SBC-DBH convened a focus group of clinicians and management to improve treatment and care coordination for individuals with eating disorders seeking treatment with SBC-DBH. This focus group was initiated, in part, as a response to questions from clients and community partners. The focus group was comprised of 43 participants from SBC-DBH clinics and contract providers. One area that was highlighted from the focus group feedback was perceived barriers to treatment that involved benefit structures.

In their own words…

"WE NEED A CONSISTENT MANAGED CARE PROVIDER TO FACILITATE COLLABORATION."

"WE NEED TO GET INVOLVED WHEN THE CONSUMER IS AN INPATIENT. IT IS HARD TO START FBT IN THE MEDICAL MODEL, BUT ENGAGEMENT CAN START ANYTIME."

"WE NEED WARM HAND-OFFS AND DISCHARGE MEETINGS."

In part, based on this feedback, the Eating Disorder Collaborative meeting was developed. This meeting involved both SBC-DBH and managed care partners, in the same room, discussing coordination, and treatment opinions for cases that needed a high level of inter-agency coordination and/or cases that needed additional assistance in navigating benefit structures.

This group achieved positive outcomes on a case-by-case basis, but when surveyed, there were concerns about the ability to achieve transformative change within the larger system of care. Meeting members identified key areas that needed data-driven best practices in order to effect greater change than what had already occurred. Identified areas are:

- Standardized assessment tool
- Providing regional education/training to community partners
- Establish a recommended framework or continuum of care that regional mental health providers could use when creating a treatment plan

These findings were presented to stakeholders and it was determined that an additional (targeted) CPP process was needed for the development of an innovation project.

TARGETED COMMUNITY PLANNING

Beginning in January 2018, the SBC-DBH Office of Innovation began the community planning process to develop the project outline for a focused innovation for the engagement, recovery, and coordination of eating disorders. **Thirty-six meetings** were held between January 2018 and October 2019 at various times and locations in the community to ensure the broadest range of participation. SBC-DBH ensures diverse attendance by advertising these meetings using social media, press releases, other county departments, and an expansive network of known community partners and contracted vendors.

SBC-DBH also has established 12 cultural subcommittees and four district advisory committees that meet monthly. SBC-DBH Office of Innovation shared SBC-DBH's intention of using Innovation funds to support an EDO project. Feedback from each of these cultural subcommittees was requested to ensure that the Community Program Planning process included the voices of individuals who reflect the cultural, ethnic, and racial diversity that exists within San Bernardino County.

From this planning process, the stakeholder comments received revealed support for the innovative use of MHSA funds to transform the eating disorder system of care for the most vulnerable in our communities.

In their own words…

"I HAD NO IDEA THAT EATING DISORDERS KILL SO MANY PEOPLE. THIS IS ABSOLUTELY SOMETHING THAT MHSA FUNDS SHOULD BE USED FOR."

"FINALLY SOMEONE IS LOOKING AT PUTTING ALL THE SEPARATE PIECES TOGETHER."

"PLEASE INCLUDE TRANSGENDER PEOPLE IN YOUR PLANNING- WE HAVE A HIGH PREVALENCE OF EATING DISORDERS. SAME IS TRUE OF GAY MEN. ALSO, CONSIDER INCLUDING GYMS IN YOUR STUDY CENTER."

"I WASN'T AWARE THAT EATING DISORDERS AFFECTED SO MANY PEOPLE. THE COMMUNITY NEEDS MORE EDUCATION ON THIS."

"SEEMS TO ME THAT WE SHOULD BE SPENDING MORE MONEY TO PREVENT THIS TYPE OF THING FROM HAPPENING IN THE FIRST PLACE."

"I'M A PARENT, AND THIS WASN'T EVEN ON MY RADAR. WHY ISN'T MY FAMILY DOCTOR ASKING QUESTIONS ABOUT HEALTHY EATING?"

In addition to the stakeholder meetings scheduled for community members, clients, and family members, SBC-DBH also scheduled planning meetings with invitations extended to all interested County departments, managed healthcare plan representatives, and local physicians. These meetings allowed for direct input from the involved participants concerning the design, implementation, and evaluation of the project.

The format used for the Innovation stakeholder meetings was standardized to ensure each group of participants went through the same process. Each meeting began with an introduction of MHSA and an overview of the Innovation component conducted by a member of the SBC-DBH Office of Innovation. The introduction included a description of MHSA, current funding context, the purpose of the planning process, and an explanation of the Innovation component. Handouts were provided to further explain this same information.

Office of Innovation staff provided an overview of the project, detailing the purpose, population(s) served, and key activities. Throughout the meeting, participants were provided data in a client friendly, simple, straightforward manner with handouts, and question and answer periods. Participants had an opportunity to ask clarifying questions directly to the Innovation staff during and after the meeting. Contact information for the Innovation staff was also provided to meeting attendees, in case, the attendee had additional questions later.

An additional opportunity to provide written feedback during the meeting was provided to participants in the form of individual stakeholder comment forms. This was intended to aid in the collection of demographic information and to enable individuals attending the meeting to submit additional input and program ideas they may not have had the opportunity to offer during the small or large group discussions. The form asked a series of questions designed to parallel those asked in the facilitated process in the community meetings.

A Spanish-language interpreter was available at all community participation meetings, as well as American Sign Language (ASL) or any other language, upon request.

Stakeholder Demographics

WIC § 5848 states that each Plan shall be developed with local stakeholders, including:

- Adults and seniors with severe mental illness
- Families of children, adults, and seniors with severe mental illness
- Providers of services
- Law enforcement agencies
- Education
- Social services agencies
- Veterans
- Representatives from veterans organizations
- Providers of alcohol and drug services
- Health care organizations
- Other important interests

9 CCR § 3300 further includes:

- Representatives of unserved and/or underserved populations and family members of unserved/underserved populations
- Stakeholders that represent the diversity of the demographics of the county, including but not limited to geographic location, age, gender, and race/ethnicity
- Clients with serious mental illness and/or serious emotional disturbance, and their family members

The Innovation (INN) Stakeholder Meetings attracted a diverse array of participants from throughout the County. Stakeholder comment forms were used to collect demographic information on the backgrounds and interests of the participants, their region of origin within the county, stakeholder representation or organizational affiliation, ethnicity, age group, and gender.

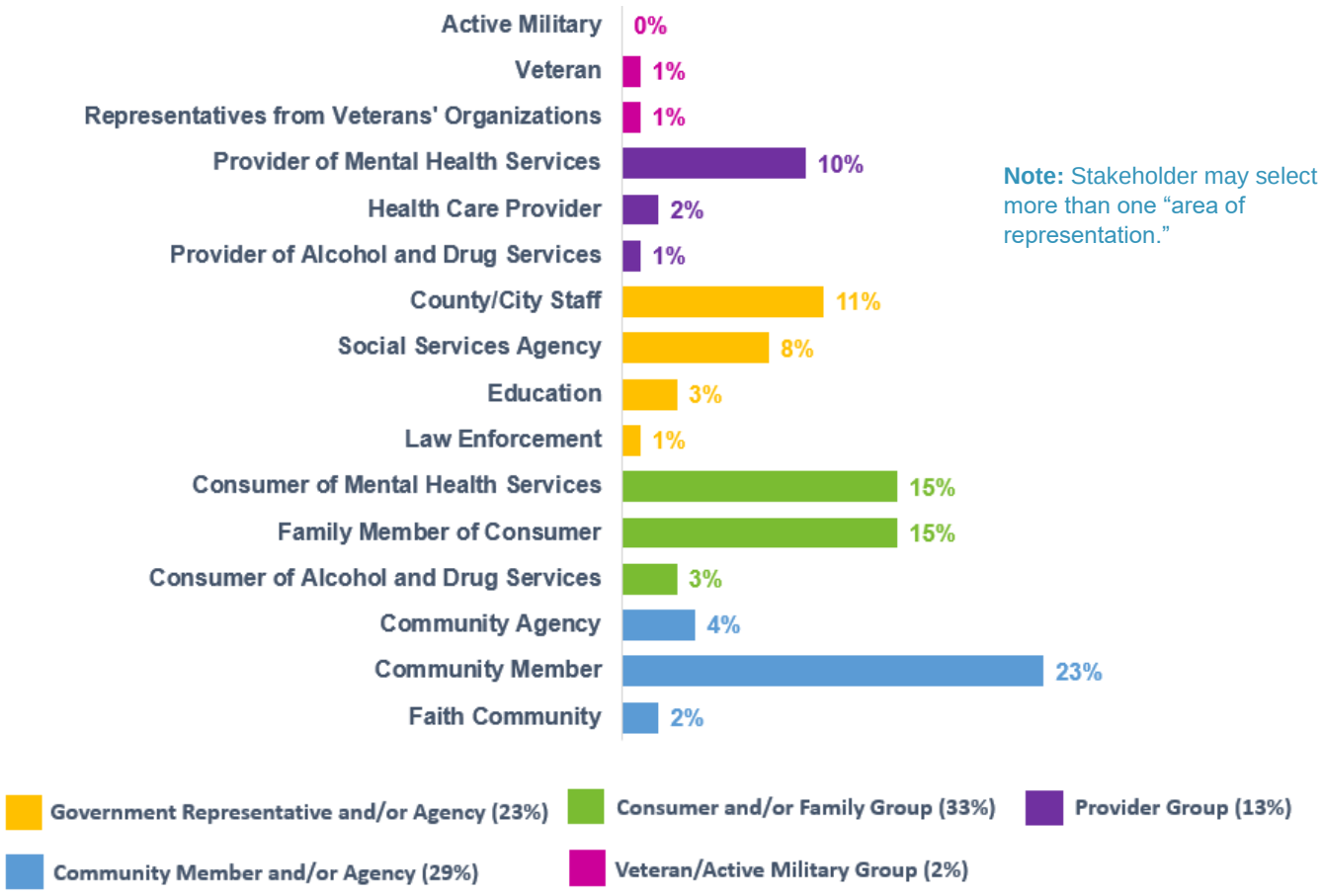
Stakeholder meeting participants came from a variety of regions of the county. The greatest number of participants, 27%, identified as part of the Desert and Mountain regions and 22% identified as part of the Central Valley and West Valley regions, with another 16% coming from the East Valley region. Twenty-six percent of responses were from stakeholders that lived outside of San Bernardino County, but participated in the stakeholder process because they either work or are family members of clients in San Bernardino County. **Note:** Nine percent of survey responses did not include a response to this question.

The quality of the discussions which took place in the stakeholder meetings were a result of the diverse backgrounds of participants who attended. People with organizational affiliations were the second largest group, with 29% of the responses indicating they were a community member

or a community agency. However, clients were also well represented, with 81%, or 352 of the 435 returned surveys, of the responses indicating an association as a direct client and/or a family/caregiver of a client.

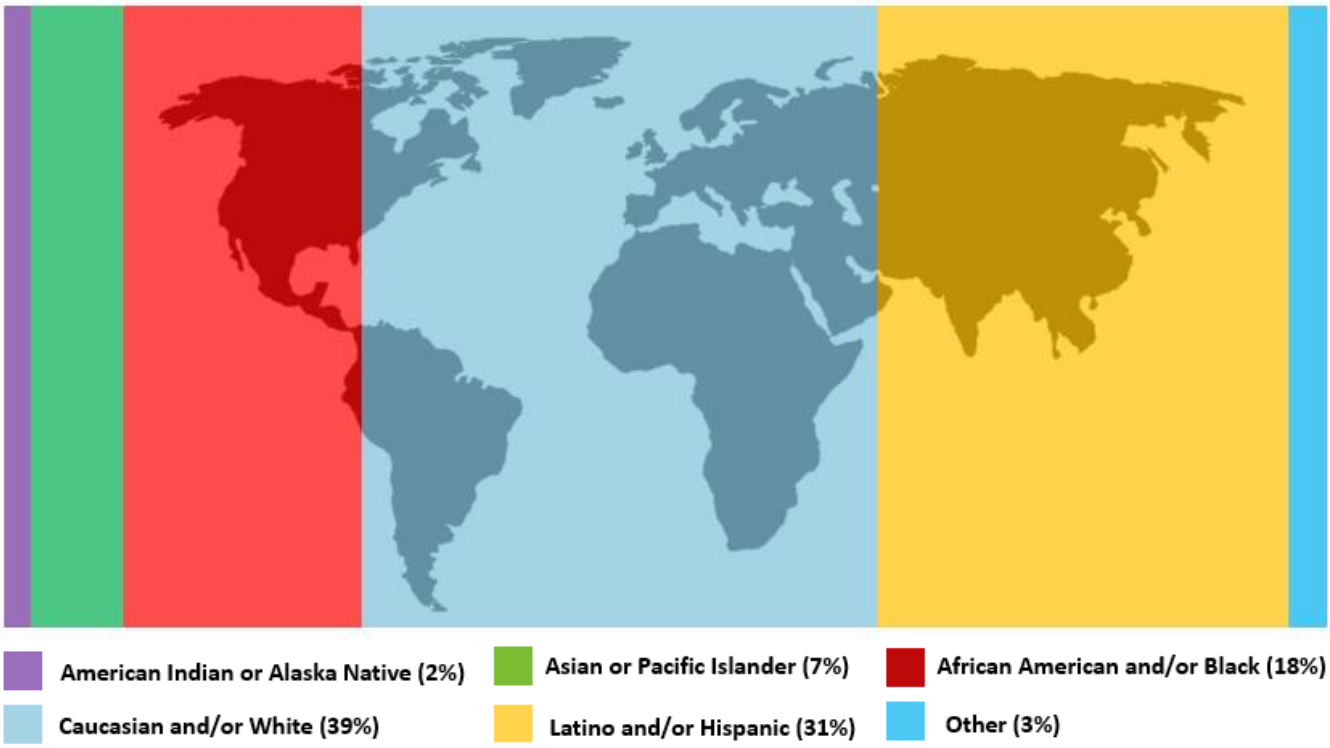
From the 505 attendees, 445 surveys were returned. Those 445 surveys contained 1,095 responses due to the participants' ability to select more than one "area of representation." Each participant selected approximately 2 - 3 "areas of representation"

STAKEHOLDER REPRESENTATION



Source: *2018 & 2019 Innovation Stakeholder Feedback Survey.* N= 1,095

STAKEHOLDER ETHNICITY



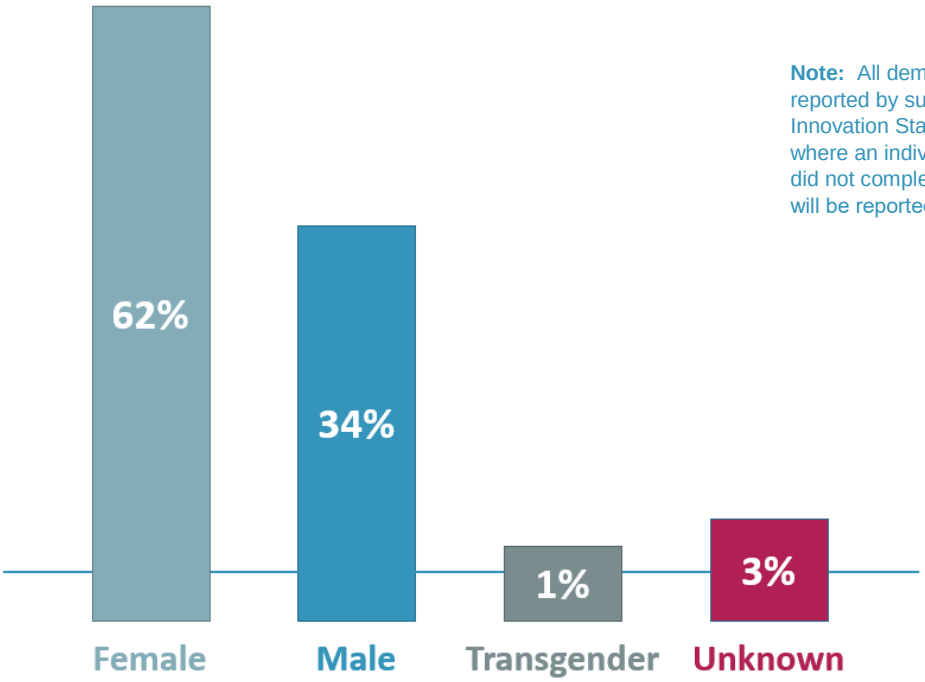
Source: *2018 & 2019 Innovation Stakeholder Feedback Survey*. N= 435

The ethnic breakdown of the CPP participants is as follows:

- The group with the largest representation is the Caucasian and/or White population representing 39% of participants.
- Participants who identifies as Latino and/or Hispanic, the second largest group, represented 31% of the participants.
- Individuals identifying as African and/or Black represented 18% of the stakeholder responses.
- American Indian or Alaska Native, and Asian or Pacific Islander represented the two smallest groups representing 2% and 7% respectively, of the stakeholder responses.

STAKEHOLDER GENDER

The breakdown of participants from the Innovation stakeholder meetings by gender is as follows: 62% of the participants are female, 34% of the participants are male, and 1% identified as transgender.

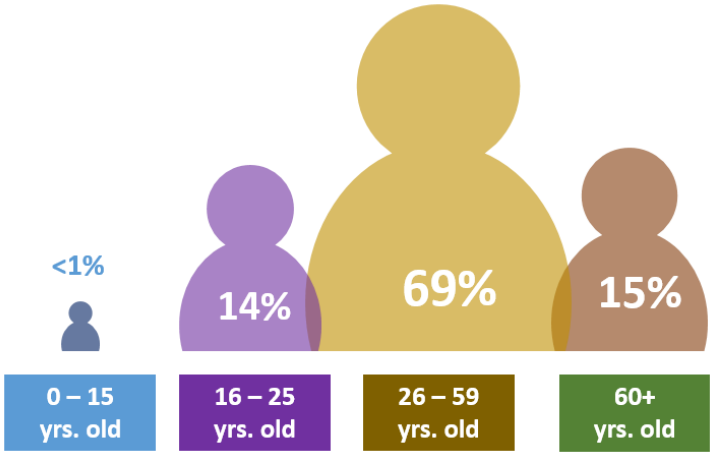


Note: All demographics information provided is self-reported by survey during the 2018 and 2019 Innovation Stakeholder process. For any category where an individual did not report any information (i.e. did not complete the survey question) the response will be reported as "unknown."

Source: *2018 & 2019 Innovation Stakeholder Feedback Survey*. N= 435

STAKEHOLDER AGE

Participants varied a fair amount in age. Although the largest portion fell in the age range of 26-59 (69%), there was good representation of older adults over 60 years of age at 15%, and transitional-aged youth 16-25 years at 14%.



Note: <1% of returned surveys did not contain a response in the AGE category.
Source: *2018-2019 Innovation Stakeholder Feedback Survey.* N= 435

The Department of Behavioral Health's stakeholder engagement process is a continuous year long process where the overall satisfaction of participants is an important measurement to ensure that the diverse voices within our community are being engaged. During cycle of meetings, 88% of meeting participants who completed a stakeholder comment form, were satisfied with the meeting process and community program planning. Two percent (2%) of meeting participants were unsatisfied with the stakeholder engagement process, with 10% of participants indicating a neutral response or no response. As part of the continuous process improvement, any unsatisfied stakeholders were given an opportunity to provide contact information for additional follow-up on how the CPP process could be approved on behalf of all community stakeholders. But when specifically asked if they supported this innovation project, 91% of participants were Very Supportive or Supportive.

STAKEHOLDER SUPPORT FOR THE EATING DISORDER COLLABORATIVE INNOVATION (EDC) PROJECT PROPOSAL

91%

Of Stakeholders Surveyed **Support** an Innovative Project to Transform the Eating Disorder System of Care

Public Posting and Comment

The SBC-DBH MHSA Innovation Plan will be posted on the department's website for stakeholder review and comment from **November 27, 2019 through December 27, 2019** at http://wp.sbcounty.gov/dbh/admin/mhsa/.

The Public Hearing to affirm the stakeholder process will take place at the regularly scheduled Behavioral Health Commission Meeting on **January 2, 2019**, which is held from **12:00 p.m. until 2:00 p.m.**

Summary and Analysis of Substantive Comments/Recommendations

An analysis of substantive recommendations will be included in the Public Posting and Comment section of the final MHSA Innovation Plan. Comments/recommendations can be submitted via email to the SBC-DBH MHSA email box at MHSA@dbh.sbcounty.gov during the time the MHSA Innovation Plan draft is posted for public comment. Stakeholders are informed that comments can be received anytime through the year, but will not be included in the final plan unless provided during the 30-day comment period. The plan is scheduled to be posted for 30 days, per Welfare and Institutions Code 5848, between November 27, 2019 and December 27, 2019 at www.sbcounty.gov/dbh/.

The development and preparation of San Bernardino County's MHSA Innovation Plan resulted from concentrated efforts from the community, clients, family members, service providers, county agencies, and representatives of interested organizations throughout the county.

SBC-DBH, through the MHSA, is supporting the Countywide Vision by providing behavioral health services and ensuring residents have the resources they need to promote recovery, wellness, and resilience in the community.

Should you have any questions, would like to provide additional input, receive additional information about SBC-DBH projects or activities, or to be included on our distribution lists please contact:

Department of Behavioral Health
Mental Health Services Act Administration
1950 S. Sunwest Lane, Ste. 200
San Bernardino, CA 92415
(800) 722-9866
MHSA@dbh.sbcounty.gov

MHSA General Standards

In accordance with 9 CCR § 3320, this innovation project adheres to the MHSA General Standards in the following ways:

COMMUNITY COLLABORATION - SBC-DBH has conducted an ongoing extensive Community Program Planning (CPP) process that involved stakeholders within the community which is consistent with MHSA regulations. This project will work in collaboration with all available psychiatric treatment modalities in the County and will promote access to the most appropriate level of care for the individual. This will include SBC-DBH operated programs and outpatient clinics, drug and alcohol programs, fee-for-service providers, faith-based organizations, social service organizations, veteran services, housing programs and alternatives, other County Departments such as the Department of Aging and Adult Services, Transitional Assistance Department, Public Health, County Medical clinics and community based organizations. Educational organizations and vocational organizations will be utilized to assist clients in meeting their personal goals as well as a means to more fully integrate the clients into their surrounding community. Clients and family members will be linked with regionally based providers to minimize any geographical obstacles to accessing services. Our partnership with the Cultural Competency Advisory Sub-Committees, Community Health Workers program, and the Office of Consumer and Family Affairs will assist us in bridging the cultural and geographical diversity of our County in a community-driven manner.

CULTURAL COMPETENCE - The SBC-DBH Office of Cultural Competency and Ethnic Services (OCCES) will be involved to ensure compliance with cultural competency standards and ensure that the services provided address cultural and linguistic needs. OCCES remains available for

consultation and to provide support to the teams regarding issues of diversity when necessary. Issues of cultural diversity and the social norms of a specific cultural group may present a barrier to a mentally ill individual participating in psychiatric treatment. These issues will be explored with the OCCES as they arise in order to provide services to the community in a culturally and linguistically meaningful and appropriate manner. Partnering with the Sub-Committees in a more active way (beyond an advisory capacity) will further ensure effective, culturally-sensitive interactions. Every effort will be made to staff the teams so that they are diverse and representative of the demographics of the Department's clients. Efforts will be made to include bi-lingual staff members, especially in Spanish, which is the threshold language for San Bernardino County. Additionally, materials will be available in threshold languages and interpreter services will be provided as needed.

CLIENT DRIVEN - All services provided through MHSA are committed to a behavioral health treatment approach that places extreme importance on the client taking an active and directive role in his or her treatment decisions. In this model the clinician and support staff take supportive roles in assisting the client in achieving their identified treatment goals and promote self-understanding.

FAMILY DRIVEN - SBC-DBH supports a family driven treatment model where client families have a key role in assisting the decision making process of the client. While maintaining the appropriate level of confidentiality, as determined by the client, SBC-DBH invites and encourages a client's family, biological or otherwise, to be an active part in their loved one's treatment and/or treatment decisions. Learning has shown that a client's family and loved ones are a valuable asset when determining a client's readiness for treatment.

WELLNESS, RECOVERY, AND RESILIENCE - Starting where the individual "is at in their recovery" is a central component of the MHSA. This project promotes wellness, recovery, and resiliency by providing an increased level of access and linkage to a variety of services in a field-based model. The project will work to link the individual and their families to the most appropriate service modalities in their community that will meet their unmet behavioral health and support needs. Outreach and engagement efforts will work towards involving the individual in the types of services and activities that will enable them to remain at the lowest level of care in the community thereby eliminating the need to use the emergency department as a primary source of behavioral health services. By helping the individual access the necessary and appropriate supportive services and therapeutic services in the community, this Innovation project will assist the clients on their journey towards greater wellness, recovery and resiliency.

INTEGRATED SERVICE EXPERIENCES FOR CLIENTS AND THEIR FAMILIES - One focus of this project will be the linkage of individual to culturally appropriate services in the local community and/or bring those services to the individuals via mobile treatment options. These referrals to resources will be coordinated and integrated to most appropriately meet the stated needs and discharge plan of the client. It is anticipated that referrals will be made to all venues and modalities of therapeutic and social programs. A holistic approach will be utilized in making referrals for services to the individual and their families in recognition of the need to address the psychiatric treatment needs of the individual but also their many educational, cultural, spiritual, social, and health needs. The project, as designed will provide educational and supportive services to the individual and their families to increase understanding and awareness of behavioral health disorders, outpatient services, knowledge of how to access services, as well as how to navigate the complicated system of care.

Continuity of Care for Individuals with Serious Mental Illness

Clients with serious mental illness will receive services from this proposed innovative project. Clients who receive care through this project will continue to receive care when the project ends via the existing DBH system of care. Upon completion of the proposed project, collaborating agencies would continue to provide the services they provided as part of this innovative project.

Innovative Project Timeline

Total time frame (duration) of the innovative project is five (5) years.

The expected Start Date: 04/01/2020; Expected End Date: 03/31/2025.

Deciding Whether and How to Continue the Project without INN Funds

The decision to continue this project will depend on the project outcomes, funding, and stakeholder feedback. If the project is deemed successful, funding could come from Medi-Cal and MHSA Community Services and Supports program expansion in order to deliver services to the identified populations with blended funding in partnership with collaborating agencies and community partners. Additionally, this project presents the option to explore partnerships with the local health plans for applicable clients.

Review History

Innovative Project proposals submitted for approval by the MHSOAC must include documented evidence of County Board of Supervisors review and approval as well as certain certifications. Additionally, we ask that you explain how you have obtained or waived the necessity for human subjects review, such as by your County Institutional Review Board.

Regulatory Requirement	Completed
Adoption by County Board of Supervisors	After OAC approval
Certification by the County mental health director that the County has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act (MHSA).	After OAC approval
Certification by the County mental health director and by the County auditor-controller if necessary that the County has complied with any fiscal accountability requirements, and that all expenditures are consistent with the requirements of the MHSA.	After OAC approval
Public Hearing of Innovation Project	1/2/2020
Public Posting of Innovation Project Plan	11/27/19-12/27/19
Technical Assistance from MHSOAC	11/12/19
Community Program Planning (specific to this plan)	Feb 2018 - ongoing

Budget

The total estimated budget for the Eating Disorder Collaborative Project is $12,113,426 over the course of five years.

Per AB114 and DBH's MHSA Plan to Spend Reverted Funds, the first year of this project will utilize approximately $850,000 in funds that are subject to reversion from Fiscal Year 2008-2009. Innovation funding will cover the costs for this project however, additional funding sources such as Medi-Cal reimbursement will be utilized, if possible, once the project is established.

Funding will allow for staffing of the multidisciplinary team, which includes a Clinic Supervisor to oversee the team made up of two Registered Nurses, two Social Worker II's, two Peer and Family Advocate III's, two Clinical Therapist II's, a Program Specialist II, a Dietitian/Nutritionist, and an Office Assistant III. A Staff Analyst II will manage the evaluation with support from the Innovation project team that includes a Program Manager, Program Specialist I and II. Funding for the evaluation and administrative support accounts for four percent of the budget.

The proposed project design includes funding to support operating costs of the multidisciplinary team as well as one-time costs to establish a working location and purchase equipment needed such as computers, phones, and office furniture. Vehicles will also be purchased, as the teams will conduct fieldwork in order to meet clients where they are housed, which includes medical residential facilities throughout the County and neighboring Counties.

The budget also includes costs associated with consultants who will work with SBC-DBH to collaborate with the local colleges, SUD providers, primary care physicians and allied health professionals to develop the public service campaign and materials to provide the San Bernardino Community information and education related to eating disorders and the resources available within the community.

Consultant costs also include funds for training and education specific to SBC-DBH staff in order to build the peers and clinician's

knowledge, skills, and confidence in working with individuals living with eating disorders. Additional consultant costs include patient care that is not covered by other funding sources that EDO clients need while establishing a relationship with SBC-DBH.

Funding also includes a 15% administrative fee that covers the cost of executive staff and administration cost of the department doing business.

SBC-DBH - Eating Disorder Collaborative						
	Year 1	Year 2	Year 3	Year 4	Year 5	
Personnel Costs	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**5 Year Total**
Salaries & Benefits						
Salaries & Benefits	$1,178,524	$1,213,880	$1,250,296	$1,287,805	$1,326,439	$6,256,945
Direct Costs	$0	$0	$0	$0	$0	$0
Indirect Costs	$0	$0	$0	$0	$0	$0
Total Personnel Costs	**$1,178,524**	**$1,213,880**	**$1,250,296**	**$1,287,805**	**$1,326,439**	**$6,256,945**
Operating Costs	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**5 Year Total**
Direct Costs	$194,686	$197,348	$200,065	$202,836	$205,665	$1,000,599
Indirect Costs	$0	$0	$0	$0	$0	$0
Total Operating Costs	**$194,686**	**$197,348**	**$200,065**	**$202,836**	**$205,665**	**$1,000,599**
One Time Costs	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**5 Year Total**
Direct Costs	$205,870	$0	$0	$0	$36,470	$242,340
Indirect Costs	$0	$0	$0	$0	$0	$0
Total One Time Costs	**$205,870**	**$0**	**$0**	**$0**	**$36,470**	**$242,340**
Consulstant Costs/Contracts	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**5 Year Total**
Direct Costs	$575,000	$670,000	$765,000	$785,000	$880,000	$3,675,000
Indirect Costs	$0	$0	$0	$0	$0	$0
Total Consultant Costs	**$575,000**	**$670,000**	**$765,000**	**$785,000**	**$880,000**	**$3,675,000**
Other	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**5 Year Total**
DBH Admin Fee	$176,779	$182,082	$187,544	$193,171	$198,966	$938,542
						$0
Total Other Costs	**$176,779**	**$182,082**	**$187,544**	**$193,171**	**$198,966**	**$938,542**
Budget Totals						
Personnel	**$1,178,524**	**$1,213,880**	**$1,250,296**	**$1,287,805**	**$1,326,439**	**$6,256,945**
Direct Costs	**$1,152,335**	**$1,049,430**	**$1,152,609**	**$1,181,007**	**$1,321,100**	**$5,856,481**
Indirect Costs	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Total INN Funding Requested	**$2,330,859**	**$2,263,310**	**$2,402,905**	**$2,468,812**	**$2,647,540**	**$12,113,426**

SAN BERNARDINO COUNTY

Behavioral Health

Innovative Project Proposal

Cracked Eggs

A Peer Designed Art Workshop

Innovative Project Concept

Since the implementation of the Mental Health Services Act in 2005, California has made it a priority to have Peer Advisors, individuals with lived-experience, included into the larger behavioral health workforce. These Peer Advisors, also called peer/family advocates or navigators depending on their role within the organization, are pivotal members of the workforce that provide a unique perspective that enhances that overall relevance and value of the care provided (Wells, C., Axis Group I. The Roles of Consumers with Lived Experience in Mental Health Workforce Development. 2011). The 2007 *Executive Summary of An Action Plan on Behavioral Health Workforce Development* reports that there are too many in the workforce that lack familiarity with resilience- and recovery-oriented practices, and have a general reluctance to engage adult consumers in collaborative relationships that involve shared-decision making about treatment options (Annapolis Coalition; Senior authosa; M. A. Hoge, J. A. Morris, A. S. Daniels, G. W. Stuart, L. Y. Huey, and N. Adams, The 2007 Executive Summary of An Action Plan on Behavioral Health Workforce Development, 2007). Peer Advisors have the important role of bridging the gap between those in the workplace that lack first-hand experience with recovery-oriented treatment practices and those clients that ultimately benefit from recovery-oriented treatment that emphasizes collaborative relationships and shared-decision making concerning treatment options (i.e., a client-informed behavioral health system).

Peer advisors, clients of behavioral health services, and other stakeholders with lived experience have the potential to improve, expand, and innovate services because of their innate ability to understand and support others impacted by mental illness. By bringing the expertise of those with lived experience to the field as employees and/or contract providers, services may be enhanced for those receiving behavioral health care. Employing persons with lived experience provides a number of benefits for clients, communities, and public behavioral health organizations that can include:

- Serving as recovery role models for other clients
- Representing client needs in the service system through the lens of lived experience
- Broadening the capacity of the system to be client-driven and culturally competent
- Providing information and motivation for staff and peers
- Filling gaps and augmenting services for clients
- Serving as liaisons between client and staff populations
- Refuting biases and stigmas regarding the ability of persons with lived experience to lead independent lives

Having behavioral health programming that includes peers supports has been shown to reduce hospital readmissions, reduce the symptoms of depression, and has shown success in providing information, skills and support needed by individuals with serious mental illness to be more engaged in their care (Purington, Kitty. *Using Peers to Support Physical and Mental Health Integration for Adults with Serious Mental Illness.* National Academy for State Health Policy. January 2016).

Even with this support, behavioral health programs continue to lack programming ***designed*** by clients. By supporting programs designed by and for clients, and integrating these programs into the larger system of care, the overall system will benefit from a decrease in stigma and discrimination.

What Has Been Done Elsewhere to Address this Problem?

SBC-DBH's system of care includes a Clubhouses Program. These nine Clubhouses are recovery-oriented centers that provide programs using a recovery, wellness, and resilience model for adult clients living with serious mental illness. The main objective of the Clubhouse Program is to assist clients in making their own choices and integrating into their chosen community.

Clubhouses are primarily run by adult clients with minimal support from SBC-DBH staff. In an effort to increase overall functioning and community integration, members are encouraged to provide input related to program and activity choices. Members often take ownership of the individual clubhouses demonstrating an eagerness to participate in the various opportunities and activities.

Activities within the Clubhouses provide growth opportunities and activities that increase members' ability to integrate and cope within the community, examples of topics covered include:

- Living skills
- Volunteerism
- Job skills
- Community integration excursions
- Nutrition and cooking
- Physical health

Clubhouses also sponsor regularly scheduled social and recreational activities, both in the community and on-site.

During Fiscal Year 2017-2018, the Clubhouses experienced growth in the number of members attending, the number of groups being offered, and the amount of participation in each group. During FY2017-2018 the Clubhouses hosted 160 different group meetings per month with a monthly attendance of approximately 14,100 individuals. Of the 160 meetings, 88% were conducted by members with no direct SBC-DBH staff involvement.

Based on the successes seen in the Clubhouse Programming, SBC-DBH began to look for other ways to expand and enhance the activities offered as part of the Clubhouse Programming.

The Proposed Project

San Bernardino County Department of Behavioral Health (SBC-DBH) will provide funding and administrative support, through the Innovation component of the Mental Health Services Act (MHSA), to a peer designed art workshop titled **CRACKED EGGS**.

The focus of this project will be to explore the ways in which SBC-DBH's larger system of care can be enhanced and modified to create an empowered environment for individuals with lived-experience. To begin to learn and understand the best ways to accomplish this, SBC-DBH will provide funding and administrative support, through the Innovation component of the Mental Health Services Act (MHSA), to the following:

- Incorporate a peer-designed art workshop entitled The Cracked Eggs into SBC-DBH's larger system of care.
- Determining if SBC-DBH can use different funding structures to provide the flexibility in billing that is needed by smaller non-profits and community groups without working capital, of which, may be peer-owned and operated.

All lessons learned from this project will be used in any future SBC-DBH peer-centered innovation projects. Workshops will be hosted at SBC-DBH Clubhouses and One Stop Transitional Age Youth Centers.

ART WORKSHOP

This workshop series is designed around teaching participants to utilize the symptoms from their mental illness as techniques to create art. This workshop empowers peers to not see symptoms as negative but as aspects of themselves that can be used as a creative tool. Using a strength-based approach helps a participant find a form of expression, beyond words, that can be used to describe their lived experiences. The scope of an art workshop is limited only by the imagination in finding new modes of expression. The Journal of Clinical Psychology notes that using art to communicate a mental state and past trauma "complements the biomedical view by focusing on not only sickness and symptoms themselves but the holistic nature of the person."

The Cracked Eggs workshop is run by a peer-owned and operated production company: Bezerk Productions. The workshops are a multi-session process that results in the completion of a participant-designed art exhibition and/or performance. Workshop classes will focus on performance, writing, and art using a series of techniques that include the use of the psychological model (now known as the biopsychosocial model of health and illness) as a method of expression.

Participants focus on the creative process rather than the final "creative" product. Focusing on the creative process allows the workshop facilitator to create an environment that empowers the participants to:

- Give voice to experiences and feelings not easily expressed in words
- Develop self-awareness and self-esteem
- Work on social skills
- Explore experiences and feelings through the lens of spirituality and religious iconography

- Explore other means to manage behaviors and/or symptoms
- Gain different perspective to assist in problem solving

Workshop facilitators will guide the workgroup participants through exercises designed to use the symptoms from mental illness as art-making tools and techniques. Focus is given to understanding and identifying individual thoughts and feelings and helping workshop participants cope with difficulties and stress in an effort to help with the recovery process.

As currently designed, each workgroup "session" or cohort will be 12 weeks in length. Each week there will be two classes that are 3 ½ hours long. A total of 6 cohorts, held in different regions throughout the County, will constitute a series with at least two series completed during the course of this project. Learning achieved during the first series may impact the scheduling as the second and any subsequent series as to the length of a cohort and the number of series offered.

	Project Months											
	1	2	3	4	5	6	7	8	9	10	11	12
YR 1	Cohort 1			BRK	Cohort 2			BRK	Cohort 3			BRK
YR 2	Cohort 4			BRK	Cohort 5			BRK	Cohort 6			BRK
YR 3	Cohort 1a			BRK	Cohort 2a			BRK	Cohort 3a			BRK
YR 4	Cohort 4a			BRK	Cohort 5a			BRK	Cohort 6a			BRK
YR 5	Final Analysis of All Project Data							Final Report				

After each 12 weeks cohort, a one month break will occur between each cohort. During these breaks the following activities will occur:

- Presentation of performance and/or art project completed by participants of previous cohort
- Collection and analysis of data from previous cohort
- Collection of lessons learned from previous cohort
- Adjustment to future cohorts based on lessons learned and data analysis, as appropriate.

One of the central questions being asked during this project is: Can this workshop, designed by a peer, be replicated using different facilitators with lived-experience? In order to determine this, during the first series, possible facilitators will be identified, empowered, and trained by the program director in order to become the future facilitators of the workshop cohorts. During the second series, the program director will take on an oversight role while those that were trained become the primary facilitators for the workshop. If successful, this opens the possibility of running multiple cohorts simultaneously and increase the ability to serve more clients.

This project aligns with the MHSA Innovation Component purpose by **making a change to an existing mental health practice/approach** including adaptation for a new setting or community.

ALTERNATIVE FUNDING STRUCTURES

In order to successfully work with a small, non-profit organization SBC-DBH is willing to explore alternative payment structures that provide flexibility and support for community partners. Within the established county fiscal structure, payment to contracted providers is done in arears on a monthly or quarterly basis. This means that the contracted organization is paying for all the costs with funding from their capital and then billing the county to replenish or reimburse the funding. This type of structure can be challenging for small businesses/nonprofits who may not have the capital to launch and maintain a new program. SBC-DBH is exploring and would like to test a combination of options within the established fiscal system to provide both advance payment for startup costs within the first few months of the project and the development of a milestone payment methodology. The advance payment would provide the smaller community-based non-profit nonprofit with startup funds that would allow them to establish a physical presence in the community, purchase items needed, as well as hire support staff and have capital to start providing services. Another possible alternative funding structure to be tested is to set up milestone deliverables associated with payment within the program design. For example, within the Cracked Eggs project, the completion of the half the workshop series or the full workshop series could be considered a milestone. Payment would be made upon completion of the agreed upon milestone. This would allow both the County and the nonprofit to identify the cash flow necessary to be able to manage a County contract, as well as how much capital they are able to spend and manage between milestones. The milestone payment methodology would be monitored in conjunction with the non-profit and be settled to cost.

MEET THE ARTIST

Linda Carmella Sibio is an accomplished artist who has overcome many of the challenges that come with living with severe mental illness. After her father died, Linda grew up watching her mother struggle with both bipolar disorder and schizophrenia, resulting in her mother's eventual suicide. Linda spent much of her youth in an orphanage, where she began to express herself and her reality through art. The arts became Linda's passion and she went on to graduate from Ohio University with a Bachelor of Fine Arts in painting (with minors in creative writing and silk-screening), study art history and sculpture in Italy, and take on a combination of classes, trainings, and mentorships that spanned across nine years.

Although Linda showed signs and symptoms of mental illness throughout her childhood, it was not until after she graduated from college that she was diagnosed with paranoid schizophrenia, the same illnesses her own mother suffered from. Linda sought help for her symptoms. At one point, she was in an institution and taking over 20 medications, many of which were anti-psychotic medications. Linda used her art as her way to speak to the rest of the world about mental illness and express to the world what life is like living on the fringe of society. Linda has put on art exhibitions from Los Angeles to New York and has been the recipient of numerous honors, awards, and grants for her art and performance work. Linda realized the benefits of incorporating expression and commentary through art, in combination with behavioral health services and medications, as an innovative approach that led her to stabilize her own mental illness and live a productive and inspiring life. Linda was able to assist in starting the Los Angeles Poverty

Department (LAPD), a performance troupe consisting of people who were homeless and living with mental disabilities on "Skid Row" that promote awareness and demonstrate experiences and perceptions they have due to their illness.

Linda now resides in Joshua Tree, California where she facilitates a series of workshops at a local community center. These workshops encourage and assist people with psychological challenges to express themselves through various forms of art, writing and performance. "Art creates a bridge that helps people understand in an intelligent manner what the artist is feeling and seeing. It is what bridges the gap and allows intelligent discussions between the mentally ill and those who are not." Linda believes that using art can strengthen cognitive abilities and socialization skills as well as empower those with mental illness to accept their own idiosyncrasies and utilize their creativity and emotions to show mental illness in a more positive light, reducing mental illness stigma. Now, Linda wants to bring her peer-driven methods into the forefront of alternative and innovative therapy options through the program, ***Cracked Eggs***.

Target Population

The intended target population for this innovative project is as follows:

Project Component	Target Population
Art Workshops	Transitional-aged youth (16 – 25 yrs. old) and adults (over 26 yrs. old), who have been diagnosed or identify as having a mental illness.

Based on this information, this project is estimated to serve 30 clients per year, or 120 clients over the course of 5 years.

The Innovative Component

The innovative component is that Cracked Eggs programming is 100% consumer-developed, and will primarily be consumer-implemented and consumer-run within the larger SBC-DBH system of care.

The primary purpose of this Innovation project is to **INCREASE ACCESS TO MENTAL HEALTH SERVICES.**

This project will achieve this purpose by **INTRODUCING A NEW APPLICATION TO THE MENTAL HEALTH SYSTEM OF A PROMISING COMMUNITY-DRIVEN PRACTICE OR AN APPROACH THAT HAS BEEN SUCCESSFUL IN A NON-MENTAL HEALTH CONTEXT OR SETTING.**

Learning Goals & Evaluation Plan

The goal of every Innovation project is learning and, as such, each Innovation project establishes a learning plan, learning goals, and an evaluation plan as part of the project design.

The learning goals for Cracked Eggs are:

1. Examine if participation in Cracked Eggs leads to clients reaching treatment, social, educational/vocational, and other goals. Examine how participation in Cracked Eggs influences clients' goals and identities.
2. Examine if participation in Cracked Eggs leads to improved client outcomes.
3. Examine the challenges and opportunities in scaling-up Cracked Eggs, including developing a train-the-trainer model/curriculum/toolkit.
4. Examine if Cracked Eggs, and not least of all Cracked Eggs exhibits and performances, lead to stigma reduction and increased understanding about mental health issues for both clients and community participants.
5. Examine how program evaluation can adapt to best capture emerging themes that clients find important from their Cracked Eggs experience. Is there a way to include and centralize art as a leading indicator in an evaluation?

Evaluation Plan

Learning Goal #1	
Examine if participation in Cracked Eggs leads to clients reaching treatment, social, educational/vocational, and other goals. Examine how participation in Cracked Eggs influences clients' goals.	
Evaluation Plan	• Document clients' goals before, during, and after participation in Cracked Eggs.
Intended Outcomes	
	• Clients make progress towards existing goals, measured through ongoing surveys and interviews. • Clients create new goals, measured through ongoing surveys and interviews.

Learning Goal #2	
Examine if participation in Cracked Eggs leads to improved client outcomes.	
Evaluation Plan	• Monitor psychiatric hospitalizations, participation in routine outpatient services, and Adult Needs and Strengths Assessment (ANSA) scores.
Intended Outcomes	
• Deceased psychiatric hospitalizations, measured by the number of psychiatric hospitalizations and bed days 90/180/360 days after Cracked Eggs participation compared to the baseline number of psychiatric hospitalizations and bed days 90/180/360 days before Cracked Eggs participation, based on data from the Treatment Authorization Request Log (TAR Log). • Increased participation in routine outpatient services, measured by the number of routine outpatient services clients participated in 90/180/360 days after Cracked Eggs participation compared to the baseline number of routine outpatient services clients participated in 90/180/360 days before Cracked Eggs participation, based on data from SIMON/Electronic Health Record (EHR). • Improved Adult Needs and Strengths Assessment (ANSA) outcomes, measured by comparing assessment scores from before or at the beginning of Cracked Eggs participation to assessment scores during and after Cracked Eggs participation.	

Learning Goal #3	
Examine the challenges and opportunities in scaling-up Cracked Eggs, including developing a train-the-trainer model/curriculum/toolkit.	
Evaluation Plan	• Document the process in creating a Cracked Eggs curriculum, which includes a train-the-trainer module and implementation toolkit.
Intended Outcomes	
• Creation of a Cracked Eggs curriculum, train-the-trainer module, and implementation toolkit. • Plans for sustainable, client-led Cracked Eggs sessions.	

Learning Goal #4	
Examine if Cracked Eggs, and not least of all Cracked Eggs exhibits and performances, lead to stigma reduction and increased understanding about mental health issues for both clients and community participants.	
Evaluation Plan	• Document change in stigma and understanding of mental health issues for clients throughout their participation in Cracked Eggs. • Document change in stigma and understanding of mental health issues for community members from their participation in Cracked Eggs exhibits and performances
Intended Outcomes	

	• Clients experience a decrease in internal stigma and increased understanding about their mental health, measured through:
	  ○ An adapted internalized stigma scale and customized Cracked Eggs self-awareness scale, with a baseline score established before Cracked Eggs participation compared to scores on the same scales during and after Cracked Eggs participation.
	  ○ An analysis of themes that emerge in client interviews.
	• Community members experience a decrease in stigma towards mental health and increased understanding, measured through adapted mental health stigma and knowledge scales completed by community member participants at the Cracked Eggs exhibits and performances.

Learning Goal #5	
Examine how program evaluation can adapt to best capture emerging themes that clients find important from their Cracked Eggs experience. Is there a way to include and centralize art as a leading indicator in an evaluation?	
Evaluation Plan	• Document the art that clients create, the meaning they give their art, and the description of the process of creating the art.
Intended Outcomes	
	• Analysis of themes that emerge from client experiences in Cracked Eggs and the art they create, measured by client interviews. • Create a toolkit of best practices for capturing emerging themes and using art as a leading indicator in evaluation.

For further information on the evaluation plan, please see the logic model in the attachment section.

INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement.

SBC-DBH understands and acknowledges that those who engage in evaluation do so from perspectives that reflect their values, their ways of seeing the world, and their culture. This culture can shape the ways in which evaluation questions are conceptualized, which in turn influences what data is collected, and how data is analyzed and interpreted. To draw valid conclusions, the evaluation must consider important contributors to human behavior, including those related to culture, personal habit, situational limitations, assimilation and acculturation, or the effect that the knowledge of observation can have on the observed (Cultural Competence in Evaluation Task Force. (2011). Public Statement on Cultural Competence in Evaluation. American Evaluation Association). Without accounting for the ways in which culture can affect behavior, evaluations can arrive at flawed findings with potentially devastating consequences.

Because of these concerns the SBC-DBH Office of Cultural Competency and Ethnic Services (OCCES) is a key partner in all Innovation projects to ensure compliance with cultural competency standards and to ensure that the services provided address cultural and linguistic needs. OCCES remains available for consultation and to provide support to the Innovation Team regarding issues of diversity when necessary.

Issues of cultural diversity and the social norms of a specific cultural group may present a barrier to a mentally ill individual participating in psychiatric treatment. These issues will be explored with OCCES as they arise in order to provide services to the community in a culturally and linguistically meaningful and appropriate manner. In addition to working with the OCCES, SBC-DBH Office of Innovation also partners with stakeholder sub-committees in an active way (beyond an advisory capacity) to further ensure effective, culturally-sensitive interactions. These sub-committees are presented with the evaluation questions and results to ensure that the evaluation framework and outcome results are inclusive and foster learning across cultural boundaries while respecting different worldviews. Every effort will be made to staff the Innovation project with individuals that are diverse and representative of the demographics of the Department's clients.

For all the reasons listed above, SBC-DBH maintains a commitment to meaningful stakeholder participation in the evaluation process. Based on the continuous feedback from our community stakeholders, SBC-DBH has designed a meeting to address outcomes and evaluation in a setting that involves stakeholders. This Innovation project will be presented at the monthly meetings to each cultural sub-committees to ensure that the community planning process includes the voices of individuals who reflect the cultural, ethnic, and racial diversity that exists within San Bernardino County.

Community Program Planning

SBC-DBH began engaging stakeholders in 2005 in order to solicit community ideas, feedback, and participation in the designing of MHSA programs. As a result, a continuous stakeholder engagement process has been established that includes a series of ongoing monthly stakeholder meetings from diverse groups that provide input on program design, development, evaluation, policy, funding, and program improvement. Initial stakeholder feedback identified four stakeholder priorities that relate directly to how peers and those with lived experience are incorporated into the SBC-DBH recovery-oriented system of care:

- Need for support programs that can be run primarily by client/family members with administrative support from SBC-DBH,
- Allow for greater opportunities for SBC-DBH staff, not just clinical staff, to work with and learn from clients in ways that would decrease system barriers associated with stigma and discrimination,
- Develop social activities for clients that would allow for the development of self-awareness, self-esteem, and social skills that is part of the larger system of care, and
- Explore funding structures and sources to determine if/how the county's rigid billing system is a barrier to working with smaller community-based non-profits.

In their own words…

"Need more programs that I can practice… how to do interviews, or meet new people… that is with more people than my doctor."

"We need more help than just what the clinics provide…."

"I would like to see program funding going to more community agencies that are actually part of the community, not just people doing business in the community."

"Hearing about the Clubhouse program added perspective. Why are there not more programs like this?"

Based on this initial feedback, the Clubhouse Program was created, and later expanded, into SBC-DBH's larger system of care. There are currently nine Clubhouses and serve as recovery-oriented centers that provide programming using a recovery, wellness, and resilience model for adult clients living with serious mental illness. The main objective of the Clubhouse Program is to assist clients in making their own choices and integrating into their chosen community.

Clubhouses are primarily run by adult clients with minimal support from SBC-DBH staff. Clubhouses also sponsor regularly scheduled and recreational activities, both in the community and on-site.

During Fiscal Year 2017-2018, the Clubhouses experienced growth in the number of members attending, the number of groups being offered, and the amount of participation in each group.

During this time period, the Clubhouse hosted 160 different group meetings, 88% were conducted by clubhouse members with minimal direct SBC-DBH staff involvement aside from administrative duties.

Since implementation of these programs, SBC-DBH has continually provided the outcomes to our community stakeholders as part of SBC-DBH's continuous CPP process. As part of this process SBC-DBH completed an updated stakeholder feedback analysis which reviewed all feedback received from 2005-2014. The result of this analysis was presented in the *Three Year Integrated Plan for Fiscal Years 2014/15 through 2016/17*.

While the analysis indicated general community satisfaction with the Clubhouse Programming, feedback indicated a desire to see more client-run programming, and if possible client created programming. When reviewed, the feedback from those that identified as clients or family members of clients, overwhelmingly supported the creation and continuation of Clubhouse-like programming but without impacting the current running or operation of the existing Clubhouse Program. These updated findings were presented to stakeholders and it was determined that an additional (targeted) CPP process was needed for the development of an innovation project to identify and implement more client-run and/or -created programming. Additionally, if possible, determine system related barriers preventing smaller non-profits from contracting with SBC-DBH to provide services.

TARGETED COMMUNITY PLANNING

Beginning in March 2019, the SBC-DBH Office of Innovation began the community planning process to develop the project outline for a client-based innovation project. **Twenty-eight meetings** were held between March 2019 and October 2019 at various times and locations in the community to ensure the broadest range of participation. SBC-DBH ensures diverse attendance by advertising these meetings in the community using county departments, and an expansive network of known community partners and contracted vendors.

SBC-DBH also has established 12 cultural subcommittees and four district advisory committees that meet monthly. SBC-DBH Office of Innovation shared SBC-DBH's intention of using Innovation funds to support a client-based innovation project. Feedback from each of these cultural subcommittees was requested to ensure that the Community Program Planning process included the voices of individuals who reflect the cultural, ethnic, and racial diversity that exists within San Bernardino County.

From this planning process, the SBC-DBH Innovation Team was introduced to Linda Sibio by a community member. Ms. Sibio presented her program Cracked Eggs. She disclosed that not only was she an artist, but also a client. She explained that her ideas and techniques for Cracked Eggs assisted her in the struggle with mental illness. Using her outline, the artwork shop idea was presented to stakeholders with emphasis given to clients. The stakeholder comments received were supportive of the innovative use of MHSA funds to include an art workshop, using Ms. Sibio's existing workshop outline, as part of the existing system of care.

In their own words…

"GREAT THAT IT'S CONSUMER-BASED."

"CRACKED EGGS WOULD BE A GREAT PROGRAM TO PARTNER WITH THE VETERAN HEALTH CARE SYSTEM."

"ART IS A GREAT WAY TO GET TO KNOW YOURSELF."

"LOVE IT! WHERE DO I SIGN UP?"

"IT MAY BE BENEFICIAL TO OPEN SOMETHING LIKE THIS UP TO FRIENDS AND FAMILY."

"GREAT CONSUMER EMPOWERMENT."

"NICE TO SEE PROGRAMMING THAT IS CONSUMER-DRIVEN."

In addition to the stakeholder meetings scheduled for community members, clients, and family members, SBC-DBH also scheduled planning meetings with invitations extended to all interested County departments, managed healthcare plan representatives, and local physicians. These meetings allowed for direct input from the involved participants concerning the design, implementation, and evaluation of the project.

The format used for the Innovation stakeholder meetings was standardized to ensure each group of participants went through the same process. Each meeting began with an introduction of MHSA and an overview of the Innovation component conducted by a member of the SBC-DBH Office of Innovation. The introduction included a description of MHSA, current funding context, the purpose of the planning process, and an explanation of the Innovation component. Handouts were provided to further explain this same information.

Office of Innovation staff provided an overview of the project, detailing the purpose, population(s) served, and key activities. Throughout the meeting, participants were provided data in a client friendly, simple, straightforward manner with handouts, and question and answer periods. Participants had an opportunity to ask clarifying questions directly to the Innovation staff during and after the meeting. Contact information for the Innovation staff was also provided to meeting attendees, in case, the attendee had additional questions later.

An additional opportunity to provide written feedback during the meeting was provided to participants in the form of individual stakeholder comment forms. This was intended to aid in the collection of demographic information and to enable individuals attending the meeting to submit additional input and program ideas they may not have had the opportunity to offer during the small or large group discussions. The form asked a series of questions designed to parallel those asked in the facilitated process in the community meetings.

A Spanish-language interpreter was available at all community participation meetings, as well as American Sign Language (ASL) or any other language, upon request.

INNOVATION STAKEHOLDER DEMOGRAPHICS

WIC § 5848 states that each Plan shall be developed with local stakeholders, including:

- Adults and seniors with severe mental illness
- Families of children, adults, and seniors with severe mental illness
- Providers of services
- Law enforcement agencies
- Education
- Social services agencies
- Veterans
- Representatives from veterans organizations
- Providers of alcohol and drug services
- Health care organizations
- Other important interests

9 CCR § 3300 further includes:

- Representatives of unserved and/or underserved populations and family members of unserved/underserved populations
- Stakeholders that represent the diversity of the demographics of the county, including but not limited to geographic location, age, gender, and race/ethnicity
- Clients with serious mental illness and/or serious emotional disturbance, and their family members

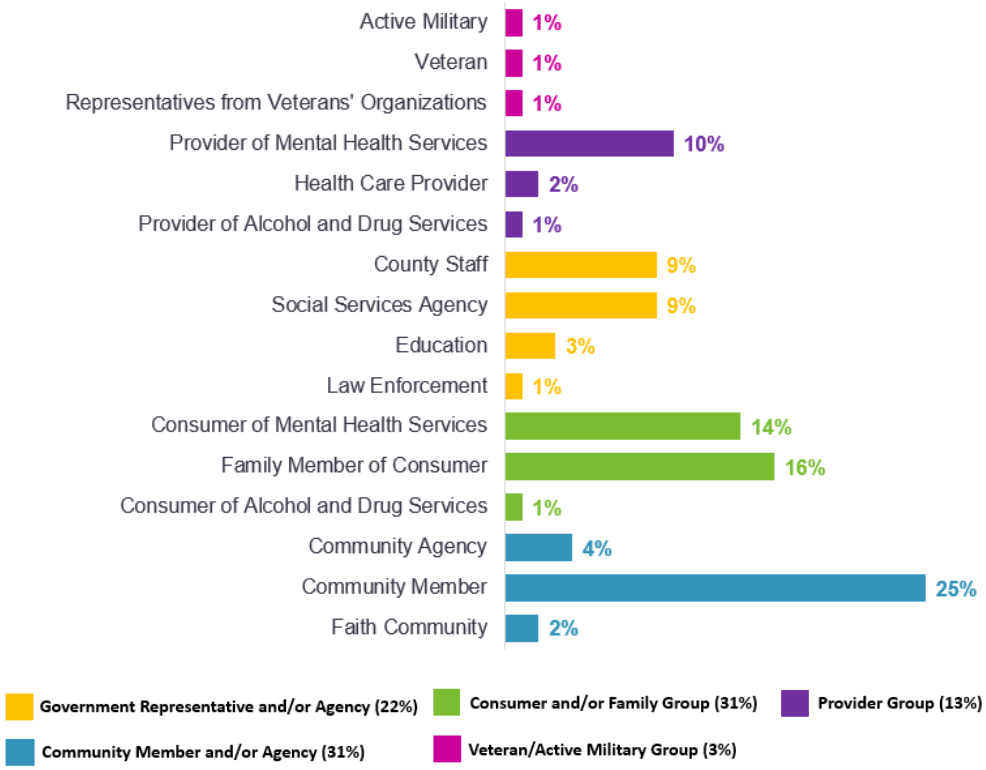
The Innovation (INN) Stakeholder Meetings attracted a diverse array of participants from throughout the County. Stakeholder comment forms were used to collect demographic information on the backgrounds and interests of the participants, their region of origin within the county, stakeholder representation or organizational affiliation, ethnicity, age group, and gender.

Stakeholder meeting participants came from a variety of regions of the county. The greatest number of participants, 29%, identified as part of the Desert and Mountain regions and 22% identified as part of the Central Valley and West Valley regions, with another 26% coming from the East Valley region. Twenty-three percent (23%) of responses were from stakeholders that lived outside of San Bernardino County, but participated in the stakeholder process because they either work or are family members of clients in San Bernardino County.

The quality of the discussions which took place in the stakeholder meetings were a result of the diverse backgrounds of participants who attended. However, clients and family members were the largest group with 88%, or 262 of the 298 returned surveys, of the responses indicating an association as a direct client and/or a family/caregiver of a client.

STAKEHOLDER REPRESENTATION

From the 394 attendees, 298 surveys were returned. Those 298 surveys contained 825 responses due to the participants' ability to select more than one "area of representation." Each participant selected approximately 2 - 3 "areas of representation"



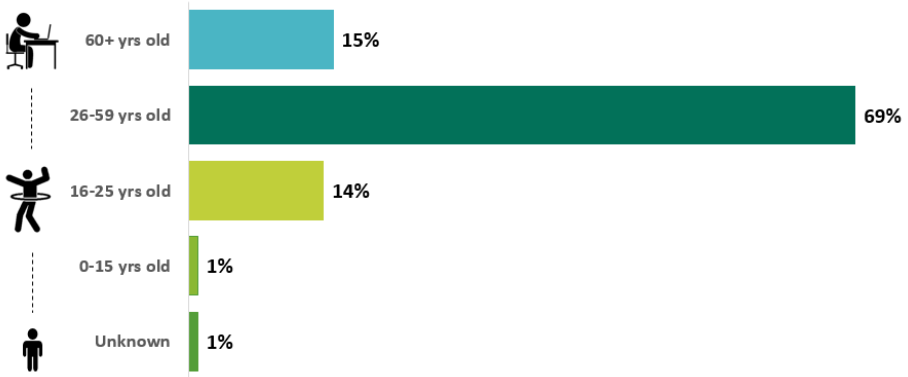
STAKEHOLDER ETHNICITY

The ethnic breakdown of the CPP participants is as follows:

- The group with the largest representation is the Caucasian and/or White population representing 24% of participants.
- Participants who identifies as Latino and/or Hispanic, African American and/or Black, and More than One Ethnicity represented 48% of the participants (16% for each category).
- American Indian or Alaska Native, and Asian or Pacific Islander represented the two smallest groups representing 5% and 4% respectively, of the stakeholder responses.

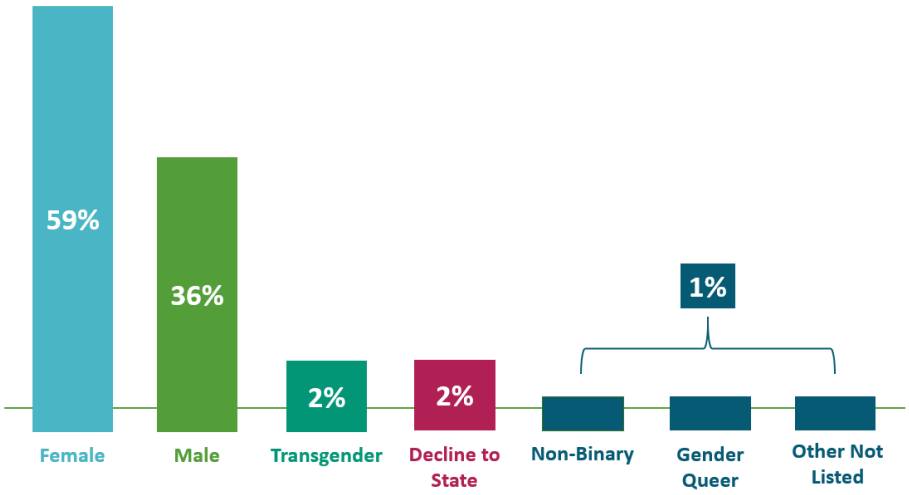
STAKEHOLDER AGE

Participants varied a fair amount in age. Although the largest portion fell in the age range of 26-59 (69%), there was good representation of older adults over 60 years of age at 15%, and transitional-aged youth 16-25 years at 14%.



STAKEHOLDER GENDER

The breakdown of participants from the Innovation stakeholder meetings by gender is as follows: 59% of the participants are female, 36% of the participants are male, and 2% identified as transgender. One percent (1%) of the participants identified as Non-Binary, Gender Queer, or Other: Not Listed.

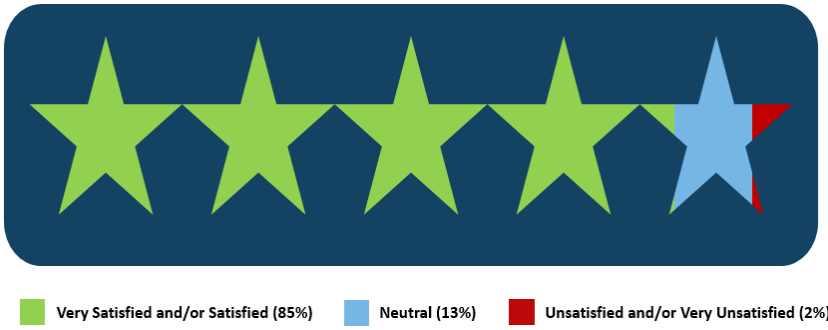


STAKEHOLDER SATISFACTION

SBC-DBH's stakeholder engagement process is a continuous year long process where the overall satisfaction of participants is an important measurement to ensure that the diverse voices within our community are being engaged. During the stakeholder meeting associated with this project, 88% of meeting participants who completed a stakeholder comment form, were satisfied with the meeting process and community program planning process. Two percent (2%) of meeting participants were unsatisfied with the stakeholder engagement process, with 10% of participants indicating a neutral response or no response. As part of the continuous process improvement, any unsatisfied stakeholder were given the opportunity to provide contact information for additional follow-up on how the CPP process could be improved on behalf of all community stakeholders.

When specifically asked if they supported this innovation project, **85% of participants were Very Supportive or Supportive**.

STAKEHOLDER SUPPORT FOR CRACKED EGGS PROJECT PROPOSAL



Public Posting and Comment

The SBC-DBH MHSA Innovation Plan will be posted on the department's website for stakeholder review and comment from **November 27, 2019 through December 27, 2019** at http://wp.sbcounty.gov/dbh/admin/mhsa/.

The Public Hearing to affirm the stakeholder process will take place at the regularly scheduled Behavioral Health Commission Meeting on **January 2, 2019**, which is held from **12:00 p.m. until 2:00 p.m.**

Summary and Analysis of Substantive Comments/Recommendations

An analysis of substantive recommendations will be included in the Public Posting and Comment section of the final MHSA Innovation Plan. Comments/recommendations can be submitted via email to the SBC-DBH MHSA email box at MHSA@dbh.sbcounty.gov during the time the MHSA Innovation Plan draft is posted for public comment. Stakeholders are informed that comments can be received anytime through the year, but will not be included in the final plan unless provided during the 30-day comment period. The plan is scheduled to be posted for 30 days, per Welfare and Institutions Code 5848, between November 27, 2019 and December 27, 2019 at www.sbcounty.gov/dbh/.

The development and preparation of San Bernardino County's MHSA Innovation Plan resulted from concentrated efforts from the community, clients, family members, service providers, county agencies, and representatives of interested organizations throughout the county.

SBC-DBH, through the MHSA, is supporting the Countywide Vision by providing behavioral health services and ensuring residents have the resources they need to promote recovery, wellness, and resilience in the community.

Should you have any questions, would like to provide additional input, receive additional information about SBC-DBH projects or activities, or to be included on our distribution lists please contact:

Department of Behavioral Health
Mental Health Services Act Administration
1950 S. Sunwest Lane, Ste. 200
San Bernardino, CA 92415
(800) 722-9866
MHSA@dbh.sbcounty.gov

MHSA General Standards

COMMUNITY COLLABORATION - SBC-DBH has conducted an ongoing extensive Community Program Planning (CPP) process that involved stakeholders within the community which is consistent with MHSA regulations.

CULTURAL COMPETENCE - The SBC-DBH Office of Cultural Competency and Ethnic Services (OCCES) will be involved to ensure compliance with cultural competency standards and ensure that the services provided address cultural and linguistic needs. OCCES remains available for consultation and to provide support to the teams regarding issues of diversity when necessary. Issues of cultural diversity and the social norms of a specific cultural group may present a barrier to a mentally ill individual participating in treatment and recovery. These issues will be explored with the OCCES as they arise in order to provide services to the community in a culturally and linguistically meaningful and appropriate manner. Partnering with the Sub-Committees in a more active way (beyond an advisory capacity) will further ensure effective, culturally-sensitive interactions. Every effort will be made to staff the teams so that they are diverse and representative of the demographics of the Department's clients. Efforts will be made to include bi-lingual staff members, especially in Spanish, which is the threshold language for San Bernardino County. Additionally, materials will be available in threshold languages and interpreter services will be provided as needed.

CLIENT DRIVEN – All services provided through MHSA are committed to a behavioral health treatment approach that places extreme importance on the client taking an active and directive role in his or her treatment decisions. In this model the clinician and support staff take supportive roles in assisting the client in achieving their identified treatment goals and promote self-understanding.

FAMILY DRIVEN – SBC-DBH supports a family driven treatment model where client families have a key role in assisting the decision making process of the client. While maintaining the appropriate level of confidentiality, as determined by the client, SBC-DBH invites and encourages a client's family, biological or otherwise, to be an active part in their loved one's treatment and/or treatment decisions. Learning has shown that a client's family and loved ones are a valuable asset when determining a client's readiness for treatment.

WELLNESS, RECOVERY, AND RESILIENCE – Starting where the individual "is at in their recovery" is a central component of the MHSA. This project promotes wellness, recovery, and resiliency by providing an increased level of access to the larger SBC-DBH system of care through participation in the art workshop. The project will work to link the individual and their families to the most appropriate service modalities in their community that will meet their unmet behavioral health and support needs. By helping the individual access the necessary and appropriate supportive services and therapeutic services in the community, this Innovation project will assist the clients on their journey towards greater wellness, recovery and resiliency.

INTEGRATED SERVICE EXPERIENCES FOR CLIENTS AND THEIR FAMILIES – SBC-DBH MHSA programming focuses on providing linkage of individual to culturally appropriate services in the local community and/or bring those services to the individuals via mobile treatment options. SBC-DBH embraces a "no wrong door" approach allowing this art workshop to function as another access point into the larger system of care. Any referrals made by this program to resources will be coordinated and integrated to meet the stated needs of the client. It is anticipated that referrals will be made to all venues and modalities of therapeutic and social programs. A holistic approach will be utilized in making referrals for services to the individual and their families in recognition of the need to address the psychiatric treatment needs of the individual but also their many educational, cultural, spiritual, social, and health needs.

Review History

Innovative Project proposals submitted for approval by the MHSOAC must include documented evidence of County Board of Supervisors review and approval as well as certain certifications. Additionally, we ask that you explain how you have obtained or waived the necessity for human subjects review, such as by your County Institutional Review Board.

Regulatory Requirement	Completed
Adoption by County Board of Supervisors	After OAC Approval
Certification by the County mental health director that the County has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act (MHSA).	After OAC Approval
Certification by the County mental health director and by the County auditor-controller if necessary that the County has complied with any fiscal accountability requirements, and that all expenditures are consistent with the requirements of the MHSA.	After OAC Approval
Public Hearing of Innovation Project	1/2/2020
Public Posting of Innovation Project Plan	11/27/2019 – 12/27/2019
Technical Assistance from MHSOAC	11/12/2019
Community Program Planning (specific to this plan)	3/2019 - continuous

Budget

The total estimated budget for the Cracked Eggs Project is $1,568,143 over the course of five years.

Personnel Costs include SBC-DBH Innovation staff to support the project every step of the way as well as conduct the evaluation of the project. Staffing will consist of Program Manager, Program Specialist II and I and Staff Analyst II. The remainder of the funding will be part of the contractor's budget and has been separated out to show one-time costs, operating costs and the consultant's administrative costs.

One-time costs include the cost of the consultant to become established in the community, as well as for the supplies needed to conduct business such as space, furniture, a vehicle to travel to and from the workshops throughout the county. Operating costs allow for the purchase of the items and supplies needed for clients to go through the eight-week workshop series.

The Consultant costs include the cost of the consultant doing business with the county and provide for a support staff that include a Finance Manager, Office Manager, Workshop Assistant and Videographer. Bezerk Productions is Ms. Sibio's non-profit organization where she is the Director.

Other Costs include funding for the DBH administrative fee that covers the cost of DBH executive staff and administration cost of the department doing business. The administrative fee is 15% of the cost of DBH staff assigned to the project.

Cracked Eggs						
	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25	5 Year Total
Personnel Costs						
Salaries	$101,685	$104,736	$107,878	$111,114	$114,448	**$539,861**
Direct costs	$0	$0	$0	$0	$0	**$0**
Indirect costs	$0	$0	$0	$0	$0	**$0**
Total Personnel Costs	**$101,685**	**$104,736**	**$107,878**	**$111,114**	**$114,448**	**$539,861**
One Time Costs						
Direct costs	$40,650	$0	$0	$0	$0	**$40,650**
Indirect costs	$0	$0	$0	$0	$0	**$0**
Total One Time Costs	**$40,650**	**$0**	**$0**	**$0**	**$0**	**$40,650**
Operating Costs						
Direct costs	$46,447	$45,807	$47,178	$46,560	$46,953	**$232,945**
Indirect costs	$0	$0	$0	$0	$0	**$0**
Total Operating Costs	**$46,447**	**$45,807**	**$47,178**	**$46,560**	**$46,953**	**$232,945**
Consultant costs						
Direct Costs (Bezerk Inc.)	$126,896	$130,703	$134,624	$138,663	$142,823	**$673,708**
Indirect Costs	$0	$0	$0	$0	$0	**$0**
Total Consultant Costs	**$126,896**	**$130,703**	**$134,624**	**$138,663**	**$142,823**	**$673,708**
Other Expenditures						
Direct Costs	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Indirect costs - DBH Admin Fee	**$15,253**	**$15,710**	**$16,182**	**$16,667**	**$17,167**	**$80,979**
Total Other Expenditures	**$15,253**	**$15,710**	**$16,182**	**$16,667**	**$17,167**	**$80,979**
Budget Totals						
Personnel	$101,685	$104,736	$107,878	$111,114	$114,448	$539,861
Direct Costs	$213,993	$176,510	$181,802	$185,222	$189,776	$947,303
Indirect Costs	$15,253	$15,710	$16,182	$16,667	$17,167	$80,979
Total Individual County Innovation Budget	**$330,931**	**$296,956**	**$305,861**	**$313,004**	**$321,390**	**$1,568,143**

SAN BERNARDINO COUNTY

Behavioral Health

Innovative Project Proposal

Multi-County Full Service Partnership Initiative

A Multi-County Data-Informed Approach to Improving Outcomes

Innovative Project Concept

Since the creation of the Mental Health Services Act (MHSA) in 2004, California has made significant strides in improving the lives of those most in need across the state. In particular, Full Service Partnerships (FSP) support people with the most severe and often co-occurring mental health needs. These MHSA-funded FSP programs are designed to apply a "whatever it takes" approach to serving and partnering with individuals living with severe mental illness. In San Bernardino County, FSP programs are effectively improving life outcomes and staff can point to success stories, highlighting dedicated staff and programs tailored to specific cultural groups and ages.

Even so, variation in FSP populations, needs, and local context has presented a challenge: FSP programs frequently apply different approaches to program design, outcomes measurement, and overall implementation. As a result, San Bernardino County and other counties across California do not have consensus about the best way to maximize impact for FSP participants, and many would like to understand which core components of FSP drive better outcomes. Information flows often feel one-directional, as county staff and providers report data up to the state but struggle to interpret and analyze the data they receive back to examine outcomes or inform future decisions. Additionally, current state-required metrics are difficult to compare across programs, providers, and geographies. In practice, for county staff, providers, and community members, these challenges have meant that state-required performance measures do not fully capture how FSP clients are faring as whole people. Current metrics are limited: they do not prioritize what individuals need most, and in some cases, they fail to capture exactly how much improvement an FSP client has made. Additionally, processes for enrolling, discharging, and graduating clients from FSP programs are either inconsistent or not optimally informed by available data.

Project Purpose

The primary purpose of this innovation project is to INCREASE THE QUALITY OF MENTAL HEALTH SERVICES, INCLUDING MEASUREABLE OUTCOMES by PROMOTING INTERAGENCY COLLABORATION AND COMMUNITY COLLABORATION RELATED TO MENTAL HEALTH SERVICES OR SUPPORTS OR OUTCOMES.

This project responds to the aforementioned challenges by reframing FSP programs around meaningful outcomes and the partner (client) experience. This multi-county Innovation Project represents an innovative opportunity for San Bernardino to partner with a diverse group of participating counties (Fresno, Ventura, Marin, Sacramento, Siskiyou, and San Mateo) to develop and implement new data-driven strategies to better coordinate Adult FSP service delivery, operations, data collection, and evaluation.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) has supported Third Sector in leading counties through the process of developing and implementing this Innovation Project, as well as in facilitating a broader statewide exchange of collective learning and shared opportunities for improving FSPs. A San Francisco-based nonprofit, Third Sector has

helped behavioral and mental health programs nationwide create an improved focus on outcomes, guiding government agencies through the process of implementing and sustaining outcomes-oriented, data-driven services focused on improved meaningful life outcomes. The *Projects Activities, Deliverables and Timeline* Section below further describes Third Sector's experience and approach to transitioning social services programs to an outcomes orientation. Third Sector will act as the overall project lead and project manager, developing recommendations and customized strategies, leading working group calls and collaborating with each participating county to meaningfully elevate stakeholder voice, while ensuring the project remains on schedule and adjusting responsively to any challenges.

Through participation in this multi-county Innovation Project, San Bernardino County will implement new data-informed strategies to program design and continuous improvement for their Adult FSP programs, supported by county-specific implementation and evaluation technical assistance. Staff will examine what matters in improving individual wellness and recovery and take a data-informed approach to program design, evaluation, and continuous improvement, leading to more effective and responsive programs. The overall purpose and goals of the Innovation Project are to:

- **Improve how counties define and track priority outcomes** and related performance measures, as well as counties' ability to apply these measures consistently across FSP programs
- **Develop new and/or strengthen existing processes for continuous improvement** with the goals of improving outcomes, fostering shared learning and accountability, supporting meaningful program comparison, and better using qualitative and quantitative data to inform potential FSP program modifications
- **Develop a clear strategy for how outcomes and performance measures can best be tracked and streamlined** through various state-level and county-specific reporting tools
- **Develop a shared understanding and more consistent interpretation of the core FSP components** across counties, creating a common FSP framework that both reflects service design best practices and is adaptive to local context
- **Increase the clarity and consistency of enrollment criteria, referral, and graduation processes** through the development and dissemination of clear tools and guidelines intended for county, providers, and referral partners

Collaboration with a Statewide FSP Learning Community

In addition to the county-specific implementation, Technical Assistance (TA) proposed in this Innovation Project, San Bernardino County will participate in a concurrent, statewide FSP Outcomes-Driven Learning Community that Third Sector is leading with funding from the MHSOAC. County MHSA and FSP staff, FSP providers, FSP clients, and other community stakeholders will engage in an interactive learning process that includes hearing and sharing lived experiences, developing tools to elevate FSP participant voice, and attending sessions at local FSP sites. Third Sector will synthesize and disseminate learnings between counties participating in this Innovation Plan and the Learning Community, helping each group build upon the work of the other, and develop a set of recommendations for any state-level changes to FSP requirements

and/or data collection practices that are supported by a broad coalition of participating California counties.

Rationale for Using the Proposed Approach

This project was in part a response to the Commission's finding that counties continue to struggle to demonstrate the original premise of FSP: to partner with the most at-risk mental health clients, providing a "whatever it takes" standard of care that helps individuals achieve fuller, more independent lives and avoid the negative outcomes that MHSA prioritizes (i.e. reduced criminal justice involvement, incarceration, unnecessary hospitalizations, in-patient stays, and homelessness).

Over the past several months, a broad group of counties (beyond just those participating in this Innovation Project) and Third Sector have convened to further unpack these challenges in a collective setting.[1] Specifically, counties and Third Sector have collaborated in several virtual and in-person convenings to develop:

- An initial baseline understanding of counties' current FSP programs, including
  - Unique assets and challenges as it relates to defining and measuring important FSP client outcomes
  - Data collection, data sharing, and data use
  - FSP services and population guidelines
  - Ongoing FSP performance management / continuous improvement processes
- An initial, shared plan for implementing outcomes-focused FSP improvements.

The activities and goals proposed by this project are directly informed by these efforts, designed to respond to common challenges, capacity needs, and shared opportunities for FSP program improvements cited by counties. This approach is also inspired by the Los Angeles (LA) County Department of Mental Health's journey to similarly focus their FSP programs on meaningful outcomes. This Innovation Project will build off LA County's early successes, implementing adjusted strategies and approaches that are appropriate for a statewide context.

Target Population

This project focuses on transforming the data and processes counties use to manage their FSP programs to improve performance at scale; it does not entail direct services for FSP clients. Accordingly, we have not estimated the number of individuals that will be served or identified specific subpopulations of focus. This project will build outcomes-focused approaches across a variety of age-specific and population-specific FSP programs statewide, exploring and identifying key commonalities and relevant differences by population of focus, and building a flexible, scalable set of strategies that can be further implemented statewide.

Research on the Innovative Component

This Innovation Project presents a new opportunity and innovative practice for San Bernardino and the other participating counties in several ways:

[1] Counties engaged in early project planning and visioning discussions included: Butte, Kern, Fresno, Los Angeles, Marin, Orange, Plumas, Sacramento, Santa Barbara, San Bernardino, Shasta, Siskiyou,, Sonoma, Ventura, Yolo

County-Driven Origins

MHSA prioritizes specific outcome measures, including reduced criminal justice involvement, incarceration, unnecessary hospitalizations, in-patient stays, and homelessness. As it stands, many counties struggle to track these outcomes using existing tools, making it difficult to determine effectiveness or identify opportunities for improvement. Recognizing these gaps, counties themselves took the initiative to form this project as a response to their FSP program challenges and after hearing reflections on LA County's Department of Mental Health FSP transformation.

The county-driven origins of this project, paired with support from the MHSOAC, present a unique opportunity for San Bernardino to both (i) pursue county-specific implementation efforts that will drive lasting improvements within the San Bernardino's own FSP programs, and (ii) exchange learnings from these implementation efforts with other counties via a structured learning community designed to help increase *statewide* consensus on FSP's core components and develop shared recommendations for state-level changes to FSP data requirements and guidelines.

Introducing New Practices for Encouraging Continuous Improvement & Learning

This project proposes to introduce new data-driven practices for managing FSP programs that center on improving clients' experiences, client life outcomes, and aim to increase consistency in how FSP's are administered within and across different counties. This project will build on tools and learnings emerging from Third Sector's existing work with the Los Angeles County Department of Mental Health's FSP transformation, which centered on understanding and improving core child, adult, and older adult FSP outcomes, inclusive of improving stable housing, reducing emergency services utilization, and reducing criminal justice involvement.

Importantly, the project will also contribute to these learnings and tools, creating new approaches and strategies intended to achieve similar and further results. It aims to develop and pilot continuous improvement processes and actionable data use strategies that are tailored to San Bernardino's specific context, and to generate new learning and shared consensus around FSP program and performance management best practices, alongside other participating counties.

Proposing Changes to State-level FSP Data Requirements

Building from the above, this project also intends to surface specific data collection and data use elements that counties can use to track their FSP outcome goals in a more streamlined, consistent fashion that can be feasibly applied across the state. Through this project, counties will develop a more cohesive vision around which data elements and metrics are most relevant and recommend changes to state-wide FSP data requirements that better prioritize and streamline their use. Ultimately, these recommendations and any changes aim to better support counties in understanding who FSP services, what services they receive, and the outcomes that clients ultimately achieve.

Project Activities, Deliverables, and Timeline

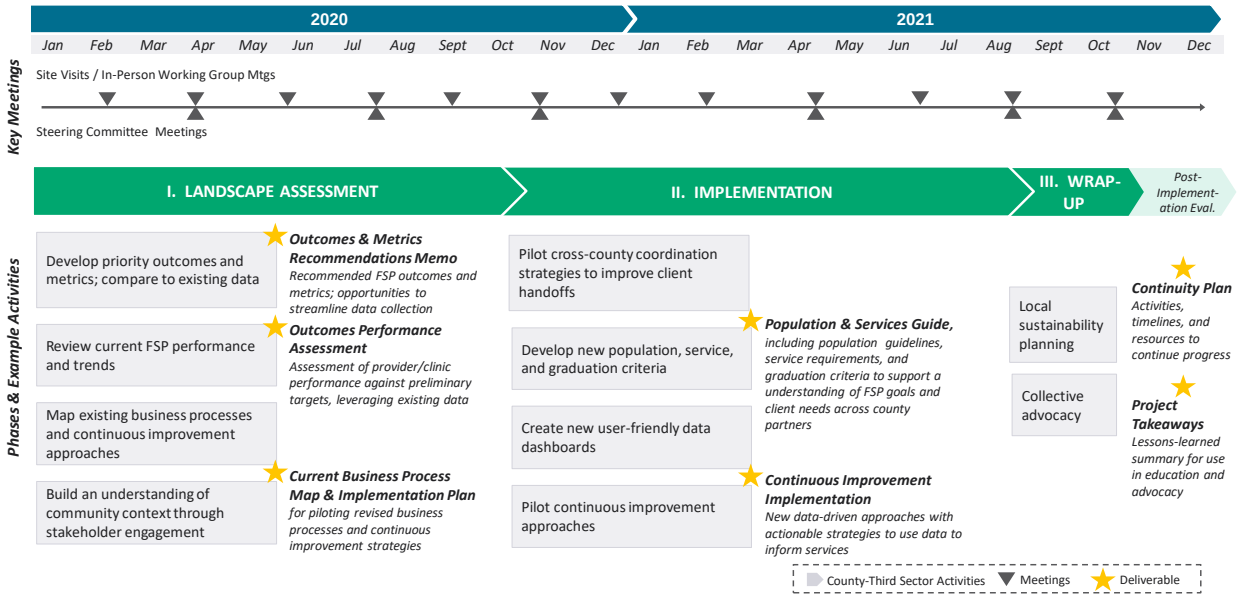
The Innovation Project will begin in January 2020 and end in June 2024 for a total project duration of 4.5 years. The project will be divided into two periods: an implementation technical assistance (TA) period and an evaluation period.

In the first 23-month implementation technical assistance (TA) period, Third Sector will work directly with San Bernardino County and the six other participating counties to understand each county's local FSP context and provide targeted, county-specific technical assistance in implementing outcomes-focused improvements. Third Sector will leverage a combination of regular (weekly to biweekly) virtual meetings/calls with counties' core project staff, regular site visits and in-person working groups, and in-person stakeholder meetings with San Bernardino County leadership and community representatives, in order to advance the project objectives. These efforts will build on learnings and tools developed in Third Sector's work with the Los Angeles County Department of Mental Health, as well as Third Sector's previous partnerships with other California and national behavioral health, human services, justice, and housing agencies. San Bernardino County will receive dedicated technical support with a combination of activities and deliverables tailored for the San Bernardino's specific context, while also having access to shared resources and tools applicable across all FSP programs and counties.

This TA period will be divided into three discrete phases (Landscape Assessment; Implementation; Sustainability Planning). The activities and deliverables outlined below are illustrative, as exact phase dates, content, and sequencing of deliverables will depend on which selection of deliverables is most relevant to San Bernardino County's needs and goals. San Bernardino County and Third Sector will collaborate over the next several months to identify San Bernardino's most priority activities and goals and to create a unique scope of work to meet these needs. See ***Figure 1*** below for an illustrative Implementation TA work plan and timeline by phase.

In the second period of the project, San Bernardino and other participating counties will pursue a post-implementation evaluation, conducted by a third-party evaluator, with the goal of assessing the impacts and learning that this project produces. This post-implementation evaluation and the overall Innovation Project will conclude at the end of June 2024.

Figure 1: Illustrative Implementation TA Work Plan



PHASE 1: LANDSCAPE ASSESSMENT

The Landscape Assessment phase will act as a ramp-up period and an opportunity for Third Sector to learn about San Bernardino County's context in further detail, including local community assets, resources, and opportunities, existing FSP program practices, and performance on existing outcomes measures. Building off of templates from national mental/behavioral health projects, Third Sector will customize deliverables and activities for San Bernardino County's local FSP context. During this phase, Third Sector will work with staff to lead working groups and interviews, analyze county data, and facilitate meetings with local stakeholders to identify opportunities for improvement. Staff will share data and documents with Third Sector and provide guidance on local priorities and past experiences. Other example activities may include conducting logic models and root cause analyses to create consensus around FSP's desired outcomes, reviewing current outcomes and performance data to understand trends, and gathering qualitative data about the client journey and staff challenges. By the end of this phase, San Bernardino County will have an understanding of the current state of its FSP programs, customized recommendations to create a more data-driven, outcomes-oriented FSP program, and a realistic work plan for piloting new improvements during the Implementation phase.
Third Sector will produce a selection of the following illustrative deliverables, as appropriate for San Bernardino County's unique context and needs:

- **Outcomes & Metrics Plan:** Recommended improved FSP outcomes and metrics to understand model fidelity and client success, including recommended areas of commonality, alignment, and consistency across counties.

- **Population to Program Map:** A map of current FSP sub-populations, FSP programs, and community need, to illuminate any potential gaps or opportunities.
- **Population Criteria Outline:** Recommended changes to population eligibility criteria, service requirements, and graduation criteria.
- **Current State to Opportunity Map:** A map of metrics and existing data sources, including identification of any gaps and opportunities for improved linkages and continuity (e.g., auto-population of fields, removal of duplicate metrics, linking services/billing data to understand trends, opportunities to use additional administrative data sources to validate self-reported data).
- **Outcomes Performance Assessment:** An assessment of provider and clinic performance against preliminary performance targets, leveraging existing data and metrics.
- **Business Process Map:** A process map identifying current continuous improvement and data-sharing processes and opportunities for improvement.
- **Implementation Plan:** An implementation plan for new continuous improvement processes, both internal (i.e., creating improved feedback loops and coordination between county data, funding, and clinical/program teams) and external (i.e., creating improved feedback loops between county teams and contracted providers).

Included in this phase, Third Sector and the counties will develop a set of qualifications and work plan for procuring a third-party evaluator. Example evaluator-led activities and deliverables include:

- Recommended evaluation methodology (e.g., randomized control trial, quasi-experimental method, etc.)
- Work plan for executing any required data-sharing agreements and/or research board approvals that may be necessary to implement the post-implementation evaluation
- Post-implementation evaluation plan that identifies specific outcomes, metrics, data sources and timeline for measuring client and systems level impacts
- Final impact report

Phase 2: Implementation

Third Sector will provide individualized guidance and support to San Bernardino County and other participating counties through the Phase 2 Implementation process, piloting new strategies that were developed during Phase 1. Understanding limitations on staff capacity, Third Sector will support staff by preparing materials, analyzing and benchmarking performance data, helping execute on data-sharing agreements, and leading working group or Steering Committee meetings. Staff will assist with local and internal coordination in order to meet project milestones. Additional activities in Phase 2 may include the following: improving coordination across county agencies to create a human-centered approach to client handoffs and transfers, completing data feedback loops, and developing new referral approaches for equitable access across client FSP

populations. As a result of this phase, San Bernardino will have piloted and begun implementing new outcomes-oriented, data-driven strategies.
With Third Sector's implementation support, San Bernardino County may achieve a selection of the following deliverables in Phase 2:

- **Referral Strategies:** Piloted strategies to improve coordination with referral partners and the flow of clients through the system.
- **Population and Services Guide**: New and/or revised population guidelines, service requirements, and graduation criteria.
- **Updated Data Collection & Reporting Guidelines:** Streamlined data reporting and submission requirements.
- **Data Dashboards:** User-friendly data dashboards displaying performance against priority FSP metrics.
- **Continuous Improvement Process Implementation:** Piloted continuous improvement and business processes to create clear data feedback loops to improve services and outcomes.
- **Staff Training:** Staff trained on continuous improvement best practices.
- **FSP Framework:** Synthesized learnings and recommendations for the FSP Framework that counties and Third Sector can share with the broader statewide Learning Community for further refinement.
- **FSP Outcomes & Metrics Advocacy Packet:** Recommendations on improved FSP outcomes, metrics, and data collection and sharing practices for use in conversations and advocacy in stakeholder forums and with policy makers.

Further, in this phase, a third-party evaluator will be selected based upon the qualifications and work plan developed in Phase 1. Third Sector, participating counties, and the evaluator will develop a scope of work detailing the exact deliverables and activities that the evaluator will lead as part of the post-implementation evaluation.

Phase 3: Sustainability Planning

In Phase 3, Third Sector will work with participating counties to understand the success of the changes to-date and develop strategies to sustain and build on these new data-driven approaches. Third Sector will work closely with San Bernardino to ensure that there is a transition plan in place and staff have the capacity to continue these new strategies. San Bernardino County may also partner with other counties to elevate project implementation successes in order to champion broad understanding, support, and continued resources for outcomes-focused, data-driven mental health and social services. Specific activities may include articulating lessons learned, applying lessons learned to other mental health and social service efforts, creating ongoing county work plans, and developing an FSP impact story. As a result of Phase 3, San Bernardino County will have a clear path forward to continue building on the accomplishments of the project.

Third Sector will produce a selection of the following deliverables for San Bernardino County:

- **Project Case Study:** A project case study highlighting the specific implementation approach, concrete changes, and lessons learned.
- **Continuity Plan:** A continuity plan that identifies specific activities, timelines and resources required to continue to implement additional outcomes-oriented, data-driven approaches.
- **Project Toolkit:** A project toolkit articulating the specific approaches and strategies that were successful in the local FSP transformation for use in similarly shifting other mental health and related services to an outcomes orientation.
- **Communications Plan:** A communications plan/strategy articulating communications activities, timelines, and messaging.
- **Project Takeaways:** Summary documents articulating major takeaways for use educating statewide stakeholders on the value of the new approach.
- **Evaluation Work Plan & Governance:** An evaluation work plan to assist the counties and the evaluation partner in project managing the post-Implementation evaluation phase.

Mental Health Services Act General Standards

This project meets MHSA General Standards in the following ways:

- It is a **multi-county collaboration** between Fresno, Ventura, Marin, Sacramento, Siskiyou, San Bernardino, and San Mateo to address FSP program challenges and opportunities
- It is **client-driven**, as it seeks to reframe FSP programs around meaningful outcomes for the individual, centering on holistic client **wellness and recovery**
- It seeks to create a coordinated approach to program design and service delivery, leading to an **integrated service experience for clients and family**
- It will establish a shared understanding of FSP's core components and create a common framework that reflects best practices while adapting for local context and **cultural competency**
- **Diverse stakeholders** will be meaningfully engaged throughout the development and implementation of the project

Learning Goals & Evaluation Plan

This project expects to contribute new learnings and capacities for San Bernardino and other participating counties throughout the county-specific technical assistance and evaluation activities involved. Guiding research questions that this project aims to further explore include, but are not limited to, the following:

1. What was the process that San Bernardino County and Third Sector took to identify and refine FSP program practices?
2. What changes were made and piloted?

3. What impacts did they generate following implementation, both for partners (clients) and FSP program providers?
    a. Compared to current FSP program practices, do practices developed by this project streamline, simplify, and/or improve the overall usefulness of data collection and reporting for FSP programs?
    b. To what extent has this project helped to streamline data collection/reporting within participating counties (e.g. improved satisfaction with reporting forms; reduced paperwork)? Has this project improved how data is shared and used to inform discussions on FSP program performance and strategies for continuous improvement?
    c. What impacts has this project and related changes create for clients' outcomes and clients' experiences in FSP?
4. What broader learning did the project produce?
    a. How have staff learnings through participation in this FSP-focused project led to shared learning across other programs and services within San Bernardino County?
    b. How has the statewide FSP Learning Community helped to drive collective learning and fostered a unified county voice for potential state-level change? Specifically, which types of forums and topics have yielded the greatest value for county participants?

Evaluation & Learning Plan

The Innovation Project includes a significant learning and evaluation component. Third Sector and the counties will pursue a number of evaluation and data analysis activities throughout the duration of the project (as described in the *Project Activities, Deliverables and Timeline* section above*).* Third Sector will also support counties in identifying, procuring, and establishing an ongoing governance structure for partnering with a third-party evaluator that can provide an independent assessment of the project's impacts and meaningfully assess the above learning goals via a post-implementation evaluation.

The post-implementation evaluation will aim to assess two types of impacts: (A) the overall impact and influence of the project activities and intended changes to FSP practices and program administration ("systems-level impacts"), and (B) the overall improvements for FSP client outcomes ("client-level impacts"). These two types of measures will help determine whether the practices developed by this project effectively simplify and improve the usefulness of data collection and management, *and* whether these practices supported the project's ultimate goal of improving FSP client outcomes.

Counties, Third Sector, and the evaluator will develop and finalize these measures after procuring the third-party evaluator (i.e. 2021) via a written evaluation plan. The evaluation plan will include a timeline for defined deliverables and will crystallize these research questions, outcome measures, data-sharing requirements and resulting evaluation activities.

INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement

SBC-DBH understands and acknowledges that those who engage in evaluation do so from perspectives that reflect their values, their ways of seeing the world, and their culture. This culture can shape the ways in which evaluation questions are conceptualized, which in turn influences what data is collected, and how data is analyzed and interpreted. To draw valid conclusions, the evaluation must consider important contributors to human behavior, including those related to culture, personal habit, situational limitations, assimilation and acculturation, or the effect that the knowledge of observation can have on the observed (Cultural Competence in Evaluation Task Force. (2011). Public Statement on Cultural Competence in Evaluation. American Evaluation Association). Without accounting for the ways in which culture can affect behavior, evaluations can arrive at flawed findings with potentially devastating consequences.

Because of these concerns the SBC-DBH Office of Cultural Competency and Ethnic Services (OCCES) is a key partner in all Innovation projects to ensure compliance with cultural competency standards and to ensure that the services provided address cultural and linguistic needs. OCCES remains available for consultation and to provide support to the Innovation Team regarding issues of diversity when necessary.

Issues of cultural diversity and the social norms of a specific cultural group may present a barrier to a mentally ill individual participating in psychiatric treatment. These issues will be explored with OCCES as they arise in order to provide services to the community in a culturally and linguistically meaningful and appropriate manner. In addition to working with the OCCES, SBC-DBH Office of Innovation also partners with stakeholder sub-committees in an active way (beyond an advisory capacity) to further ensure effective, culturally-sensitive interactions. These sub-committees are presented with the evaluation questions and results to ensure that the evaluation framework and outcome results are inclusive and foster learning across cultural boundaries while respecting different worldviews. Every effort will be made to staff the Innovation project with individuals that are diverse and representative of the demographics of the Department's clients.

For all the reasons listed above, SBC-DBH maintains a commitment to meaningful stakeholder participation in the evaluation process. Based on the continuous feedback from our community stakeholders, SBC-DBH has designed a meeting to address outcomes and evaluation in a setting that involves stakeholders. This Innovation project will be presented at the monthly meetings to each cultural sub-committees to ensure that the community planning process includes the voices of individuals who reflect the cultural, ethnic, and racial diversity that exists within San Bernardino County.

Community Program Planning

San Bernardino County Department of Behavioral Health is dedicated to including diverse clients, family members, stakeholders, and community members in the planning and implementation of MHSA programs and services. The community planning process helps the county determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of county residents. It empowers community members to generate ideas, contribute to decision making, and partner with the county to improve behavioral health outcomes for all San Bernardino County residents. San Bernardino is committed to incorporating best practices in the planning processes that allow client and stakeholder partners to participate in meaningful discussions around critical behavioral health issues. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

San Bernardino County has eight (8) FSP programs serving an estimated three thousand-four hundred-fifty-eight (3,458) individuals annually. Two (2) of these assist underserved children and youth living with serious emotional disturbance; one (1) serves Transitional Age Youth (TAY); four (4) serve adults with serious mental illness, and one (1) program specifically focuses on older adult populations. In addition to San Bernardino County FSP programs targeting specific age ranges, the programs are designed to serve unique populations such as those experiencing homelessness, who may be involved in criminal or juvenile justice, individuals transitioning from institutional care facilities, and high frequency users of emergency psychiatric services and hospitalizations, however all programs provide full wraparound services to the client. The specificity and number of these FSP programs are both an asset and a challenge. While they enable our county to better serve specific age, cultural, and geographic groups, our county stakeholders express the desire to establish consistency in FSP service guidelines or disseminate best practices across county regions, programs, or while transferring FSP services from one county to another. San Bernardino County intends to focus this project on Adult Full Service Partnership programs.

Through public forums, community members have identified the need for consistency in FSP services across regions, programs, and counties to better serve and stabilize clients moving from one geographic region or program to another. Clients have also expressed interest in a standardized format for eligibility criteria and consistency in services that are offered and/or provided. Community members, FSP staff, and clinicians have also identified an opportunity for data collection to be better integrated with assessment and therapeutic activities. Through this Innovation proposal, San Bernardino County seeks to participate in the statewide initiative seeking to increase counties' collective capacity to gather and use data to better design, implement, and manage adult FSP programs and services. The key priorities outlined in the Innovation Plan (i.e., improve how counties define and track priority outcomes, develop processes for continuous improvement, develop a clear strategy for tracking outcomes and performance measures, updating and disseminating clear FSP service guidelines, improving enrollment and referral process implementation consistency) will allow San Bernardino County to address current challenges and center FSP programs and services around meaningful outcomes for participants.

TARGETED COMMUNITY PLANNING

Beginning in March 2019, the SBC-DBH Office of Innovation began the community planning process to develop the project outline for a client-based innovation project. **Twenty-eight meetings** were held between March 2019 and October 2019 at various times and locations in the community to ensure the broadest range of participation. SBC-DBH ensures diverse attendance by advertising these meetings in the community using county departments, and an expansive network of known community partners and contracted vendors.

SBC-DBH also has established 12 cultural subcommittees and four district advisory committees that meet monthly. SBC-DBH Office of Innovation shared SBC-DBH's intention of using Innovation funds to support a client-based innovation project. Feedback from each of these cultural subcommittees was requested to ensure that the Community Program Planning process included the voices of individuals who reflect the cultural, ethnic, and racial diversity that exists within San Bernardino County.

In addition to the stakeholder meetings scheduled for community members, clients, and family members, SBC-DBH also scheduled planning meetings with invitations extended to all interested County departments, managed healthcare plan representatives, and local physicians. These meetings allowed for direct input from the involved participants concerning the design, implementation, and evaluation of the project.

Office of Innovation staff provided an overview of the project, detailing the purpose, population(s) served, and key activities. Throughout the meeting, participants were provided data in a client friendly, simple, straightforward manner with handouts, and question and answer periods. Participants had an opportunity to ask clarifying questions directly to the Innovation staff during and after the meeting. Contact information for the Innovation staff was also provided to meeting attendees, in case, the attendee had additional questions later.

An additional opportunity to provide written feedback during the meeting was provided to participants in the form of individual stakeholder comment forms. This was intended to aid in the collection of demographic information and to enable individuals attending the meeting to submit additional input and program ideas they may not have had the opportunity to offer during the small or large group discussions. The form asked a series of questions designed to parallel those asked in the facilitated process in the community meetings.

A Spanish-language interpreter was available at all community participation meetings, as well as American Sign Language (ASL) or any other language, upon request.

INNOVATION STAKEHOLDER DEMOGRAPHICS

WIC § 5848 states that each Plan shall be developed with local stakeholders, including:

- Adults and seniors with severe mental illness
- Families of children, adults, and seniors with severe mental illness
- Providers of services
- Law enforcement agencies
- Education
- Social services agencies
- Veterans
- Representatives from veterans organizations
- Providers of alcohol and drug services
- Health care organizations
- Other important interests

9 CCR § 3300 further includes:

- Representatives of unserved and/or underserved populations and family members of unserved/underserved populations
- Stakeholders that represent the diversity of the demographics of the county, including but not limited to geographic location, age, gender, and race/ethnicity
- Clients with serious mental illness and/or serious emotional disturbance, and their family members

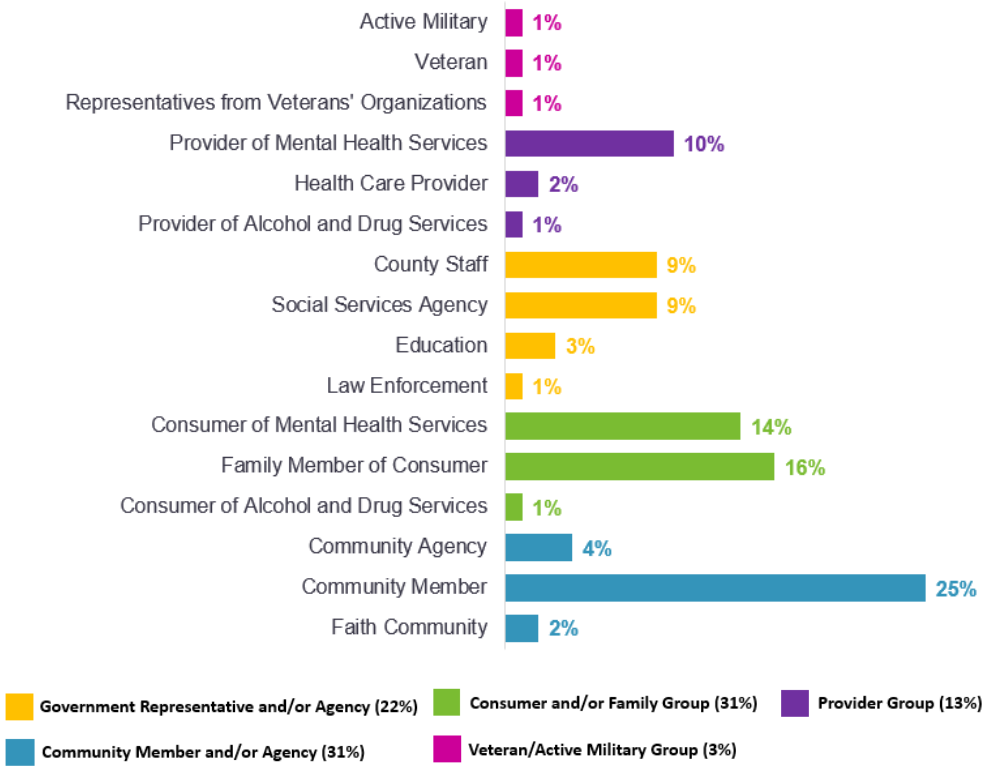
The Innovation (INN) Stakeholder Meetings attracted a diverse array of participants from throughout the County. Stakeholder comment forms were used to collect demographic information on the backgrounds and interests of the participants, their region of origin within the county, stakeholder representation or organizational affiliation, ethnicity, age group, and gender.

Stakeholder meeting participants came from a variety of regions of the county. The greatest number of participants, 29%, identified as part of the Desert and Mountain regions and 22% identified as part of the Central Valley and West Valley regions, with another 26% coming from the East Valley region. Twenty-three percent (23%) of responses were from stakeholders that lived outside of San Bernardino County, but participated in the stakeholder process because they either work or are family members of clients in San Bernardino County.

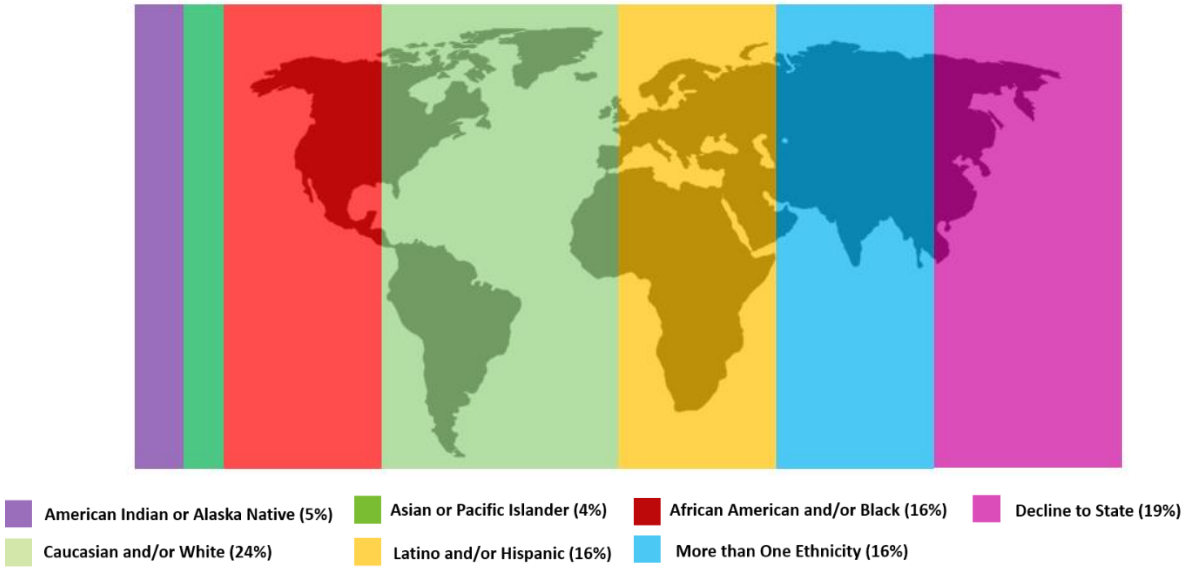
The quality of the discussions which took place in the stakeholder meetings were a result of the diverse backgrounds of participants who attended. However, clients and family members were the largest group with 88%, or 262 of the 298 returned surveys, of the responses indicating an association as a direct client and/or a family/caregiver of a client.

STAKEHOLDER REPRESENTATION

From the 394 attendees, 298 surveys were returned. Those 298 surveys contained 825 responses due to the participants' ability to select more than one "area of representation." Each participant selected approximately 2 - 3 "areas of representation"



STAKEHOLDER ETHNICITY

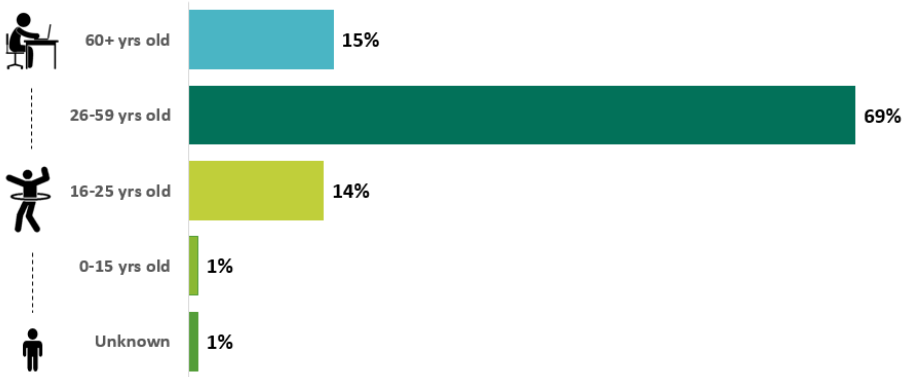


The ethnic breakdown of the CPP participants is as follows:

- The group with the largest representation is the Caucasian and/or White population representing 24% of participants.
- Participants who identifies as Latino and/or Hispanic, African American and/or Black, and More than One Ethnicity represented 48% of the participants (16% for each category).
- American Indian or Alaska Native, and Asian or Pacific Islander represented the two smallest groups representing 5% and 4% respectively, of the stakeholder responses.

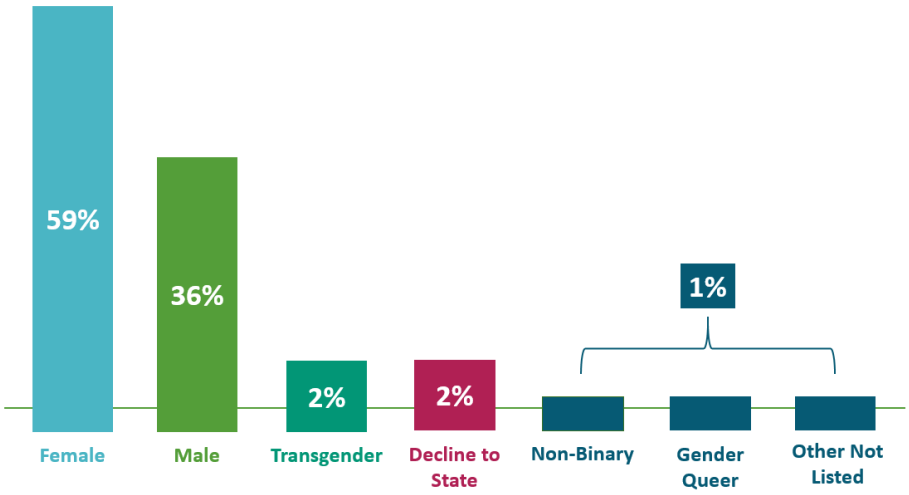
STAKEHOLDER AGE

Participants varied a fair amount in age. Although the largest portion fell in the age range of 26-59 (69%), there was good representation of older adults over 60 years of age at 15%, and transitional-aged youth 16-25 years at 14%.



STAKEHOLDER GENDER

The breakdown of participants from the Innovation stakeholder meetings by gender is as follows: 59% of the participants are female, 36% of the participants are male, and 2% identified as transgender. One percent (1%) of the participants identified as Non-Binary, Gender Queer, or Other: Not Listed.

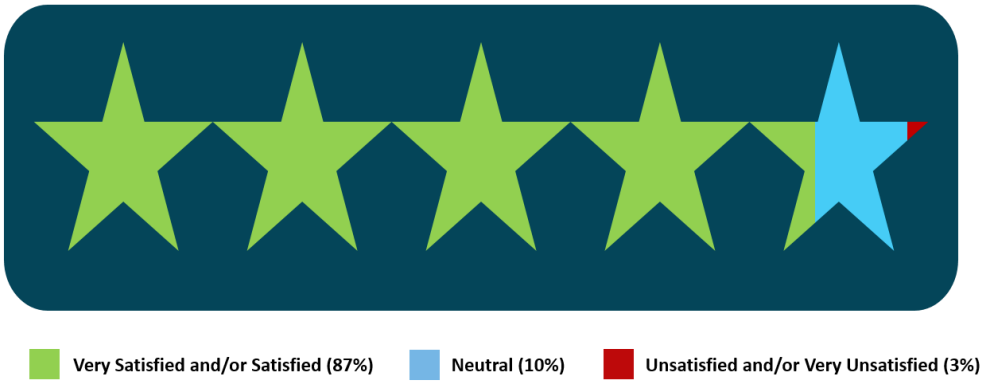


STAKEHOLDER SATISFACTION

SBC-DBH's stakeholder engagement process is a continuous year long process where the overall satisfaction of participants is an important measurement to ensure that the diverse voices within our community are being engaged. During the stakeholder meeting associated with this project, 87% of meeting participants who completed a stakeholder comment form, were satisfied with the meeting process and community program planning process. Three percent (3%) of meeting participants were unsatisfied with the stakeholder engagement process, with 3% of participants indicating a neutral response or no response. As part of the continuous process improvement, any unsatisfied stakeholder are given the opportunity to provide contact information for additional follow-up on how the CPP process could be improved on behalf of all community stakeholders.

When specifically asked if they supported this innovation project, **87% of participants were Very Supportive or Supportive**.

STAKEHOLDER SUPPORT FOR MULTICOUNTY FSP INITIATIVE PROJECT PROPOSAL



Public Posting and Comment

The SBC-DBH MHSA Innovation Plan will be posted on the department's website for stakeholder review and comment from **November 27, 2019 through December 27, 2019** at http://wp.sbcounty.gov/dbh/admin/mhsa/.

The Public Hearing to affirm the stakeholder process will take place at the regularly scheduled Behavioral Health Commission Meeting on **January 2, 2019**, which is held from **12:00 p.m. until 2:00 p.m.**

Summary and Analysis of Substantive Comments/Recommendations

An analysis of substantive recommendations will be included in the Public Posting and Comment section of the final MHSA Innovation Plan. Comments/recommendations can be submitted via email to the SBC-DBH MHSA email box at MHSA@dbh.sbcounty.gov during the time the MHSA Innovation Plan draft is posted for public comment. Stakeholders are informed that comments can be received anytime through the year, but will not be included in the final plan unless provided during the 30-day comment period. The plan is scheduled to be posted for 30 days, per Welfare and Institutions Code 5848, between November 27, 2019 and December 27, 2019 at www.sbcounty.gov/dbh/.

The development and preparation of San Bernardino County's MHSA Innovation Plan resulted from concentrated efforts from the community, clients, family members, service providers, county agencies, and representatives of interested organizations throughout the county.

SBC-DBH, through the MHSA, is supporting the Countywide Vision by providing behavioral health services and ensuring residents have the resources they need to promote recovery, wellness, and resilience in the community.

Should you have any questions, would like to provide additional input, receive additional information about SBC-DBH projects or activities, or to be included on our distribution lists please contact:

Department of Behavioral Health
Mental Health Services Act Administration
1950 S. Sunwest Lane, Ste. 200
San Bernardino, CA 92415
(800) 722-9866
MHSA@dbh.sbcounty.gov

MHSA General Standards

COMMUNITY COLLABORATION - SBC-DBH has conducted an ongoing extensive Community Program Planning (CPP) process that involved stakeholders within the community which is consistent with MHSA regulations.

CULTURAL COMPETENCE - The SBC-DBH Office of Cultural Competency and Ethnic Services (OCCES) will be involved to ensure compliance with cultural competency standards and ensure that the services provided address cultural and linguistic needs. OCCES remains available for consultation and to provide support to the teams regarding issues of diversity when necessary. Issues of cultural diversity and the social norms of a specific cultural group may present a barrier to a mentally ill individual participating in treatment and recovery. These issues will be explored with the OCCES as they arise in order to provide services to the community in a culturally and linguistically meaningful and appropriate manner. Partnering with the Sub-Committees in a more active way (beyond an advisory capacity) will further ensure effective, culturally-sensitive interactions. Every effort will be made to staff the teams so that they are diverse and representative of the demographics of the Department's clients. Efforts will be made to include bi-lingual staff members, especially in Spanish, which is the threshold language for San Bernardino County. Additionally, materials will be available in threshold languages and interpreter services will be provided as needed.

CLIENT DRIVEN – All services provided through MHSA are committed to a behavioral health treatment approach that places extreme importance on the client taking an active and directive role in his or her treatment decisions. In this model the clinician and support staff take supportive roles in assisting the client in achieving their identified treatment goals and promote self-understanding.

FAMILY DRIVEN – SBC-DBH supports a family driven treatment model where client families have a key role in assisting the decision making process of the client. While maintaining the appropriate level of confidentiality, as determined by the client, SBC-DBH invites and encourages a client's family, biological or otherwise, to be an active part in their loved one's treatment and/or

treatment decisions. Learning has shown that a client's family and loved ones are a valuable asset when determining a client's readiness for treatment.

WELLNESS, RECOVERY, AND RESILIENCE – Starting where the individual "is at in their recovery" is a central component of the MHSA. This project promotes wellness, recovery, and resiliency by providing an increased level of access to the larger SBC-DBH system of care. The project will work to link the individual and their families to the most appropriate service modalities in their community that will meet their unmet behavioral health and support needs. By helping the individual access the necessary and appropriate supportive services and therapeutic services in the community, this Innovation project will assist the clients on their journey towards greater wellness, recovery and resiliency.

INTEGRATED SERVICE EXPERIENCES FOR CLIENTS AND THEIR FAMILIES – SBC-DBH MHSA programming focuses on providing linkage of individual to culturally appropriate services in the local community and/or bring those services to the individuals via mobile treatment options. SBC-DBH embraces a "no wrong door" approach allowing this project to function as another access point into the larger system of care. Any referrals made by this program to resources will be coordinated and integrated to meet the stated needs of the client. It is anticipated that referrals will be made to all venues and modalities of therapeutic and social programs. A holistic approach will be utilized in making referrals for services to the individual and their families in recognition of the need to address the psychiatric treatment needs of the individual but also their many educational, cultural, spiritual, social, and health needs.

Review History

Innovative Project proposals submitted for approval by the MHSOAC must include documented evidence of County Board of Supervisors review and approval as well as certain certifications. Additionally, we ask that you explain how you have obtained or waived the necessity for human subjects review, such as by your County Institutional Review Board.

Regulatory Requirement	Completed
Adoption by County Board of Supervisors	After OAC Approval
Certification by the County mental health director that the County has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act (MHSA).	After OAC Approval
Certification by the County mental health director and by the County auditor-controller if necessary that the County has complied with any fiscal accountability requirements, and that all expenditures are consistent with the requirements of the MHSA.	After OAC Approval
Public Hearing of Innovation Project	1/2/2020
Public Posting of Innovation Project Plan	11/27/2019 – 12/27/2019
Technical Assistance from MHSOAC	11/12/2019
Community Program Planning (specific to this plan)	3/2019 - continuous

Budget

The total proposed budget for supporting all seven participating counties in pursuing this Innovation Project is approximately $5M over 4.5-years. This includes project expenditures that are shared across counties (i.e. Third Sector technical assistance; CalMHSA; third-party evaluation), as well as any additional county-specific expenditures that participating counties may choose to support for the purposes of this project (e.g. salary and benefits costs for county supporting staff).

All costs will be funded using county MHSA Innovation funds, with the exception of San Mateo County which will contribute CSS & PEI funding. Counties will contribute varying levels of funding towards a collective pool of resources to support shared project costs. This will streamline counties' funding contributions and drawdowns through sharing resources, reduce individual project overhead, and increase coordination across counties in the use of these funds.

Project Budget & Expenditures: San Bernardino County

San Bernardino County requests to contribute a total of $979,634 in MHSA Innovation funds to support this project over the 4.5 year project duration. A portion of these funds ($386,222) will cover San Bernardino County-specific expenditures, while the remainder ($593,412) will go towards the shared pool of resources that counties will use to cover shared project costs (i.e. Third Sector TA: CalMHSA; third-party evaluation). See Figure 2 below for an estimated breakdown of requested funds by fiscal year. Figure 3 includes an estimated breakdown of budget expenditures by fiscal year.

Note that all of San Bernardino's funding contributions would come from MHSA Innovation funding. See Figure 2 below for an estimated breakdown of requested funds by fiscal year. Figure 3 includes an estimated breakdown of budget expenditures by fiscal year.

Figure 2: San Bernardino County Budget Request by Fiscal Year

	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
Individual County Contribution Towards Shared Project Costs(1)	$64,202	$370,460	$136,040	$11,355	$11,355	$593,412
Additional Funding for County-Specific Project Costs(2)	$73,177	$75,150	$77,184	$79,277	$81,434	$386,222
Total County Funding	$137,379	$445,610	$213,224	$90,632	$92,789	$979,634

(1) Represents San Bernardino County's funding contribution towards shared project costs (Third Sector; CalMHSA; Third Party Evaluation)
(2) Represents San Bernardino County's funding for county-specific expenditures

Figure 3: San Bernardino County Budget Expenditures[2]

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1.	Salaries	$65,787	$67,760	$69,794	$71,887	$74,044	$349,272
2.	Direct Costs	$0	$0	$0	$0	$0	$0
3.	Indirect Costs	$0	$0	$0	$0	$0	$0
4.	Total Personnel Costs	$65,787	$67,760	$69,794	$71,887	$74,044	$349,272
Operating Costs (travel, hotel)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
5.	Direct Costs	$7,390	$7,390	$7,390	$7,390	$7,390	$36,950
6.	Indirect Costs	$0	$0	$0	$0	$0	$0
7.	Total Operating Costs	$7,390	$7,390	$7,390	$7,390	$7,390	$36,950
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8.	Direct Costs	$0	$0	$0	$0	$0	$0
9.	Indirect Costs	$0	$0	$0	$0	$0	$0
10.	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11a.	Direct Costs (Third Sector)	$58,353	$326,706	$113,435	$0	$0	$498,494
11b.	Direct Costs (CalMHSA)	$5,850	$33,338	$12,188	$938	$938	$53,250
11c.	Direct Costs (Evaluator)	$0	$10,417	$10,417	$10,417	$10,417	$41,668
12.	Indirect Costs						
13.	Total Consultant Costs	$64,203	$370,460	$136,039	$11,355	$11,355	$593,412

[2] FY Budget amounts are estimates and subject to change, as other participating counties finalize their funding contributions and county-specific expenditure amounts. Any updates to these figures will be included in the final version of the plan that is submitted to the MHSOAC and San Bernardino County Board of Supervisors.

Other Expenditures		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
14.	Program/Project Cost	$0	$0	$0	$0	$0	$0
15.	Total Other Expenditures	$0	$0	$0	$0	$0	$0
BUDGET TOTALS							
Personnel		$65,787	$67,760	$69,794	$71,887	$74,044	$349,272
Direct Costs		$71,593	$377,851	$143,430	$18,744	$18,744	$630,362
Indirect Costs		$0	$0	$0	$0	$0	$0
Total Individual County Innovation Budget*		$137,380	$445,611	$213,224	$90,631	$92,788	$979,634

As detailed above, San Bernardino County will pool most of its funding with other counties to support consultant and contracting costs (i.e. Third Sector; CalMHSA; third-party evaluation), with an additional portion of San Bernardino's funding also set aside for county staff personnel, travel, and administrative costs, as well as additional, county-specific evaluation support. Details of these costs follow below:

San Bernardino County Personnel Costs: San Bernardino County is committing $349,272 over the 4.5 years to fund county staff to support the project implementation and evaluation activities. A 3% yearly escalator has been applied.

San Bernardino County Staff Travel: San Bernardino County anticipates travel costs up to $36,950 over the 4.5 years, or approximately $7,390 per year, which may vary based on the number of staff traveling and the number of in-person meetings.

Consultant Costs

Third Sector: As described in the Project Activities & Deliverables section above, Third Sector will lead counties through individualized implementation TA over a 23-month timeframe (January 2020 through November 2021). Of the $979,634 in total county MHSA Innovation funds that San Bernardino is contributing towards this project, approximately $500,000 will go towards Third Sector. These costs will support a dedicated Third Sector team who will partner with San Bernardino County and provide a wide range of dedicated technical assistance (TA) services and subject matter experience, as the county pursues the goals of this Innovation Plan. Third Sector staff will leverage regular site visits to each county, in addition to leading weekly to biweekly virtual meetings with different working groups, developing recommendations for the project Steering Committee, and supporting county staff throughout each of the four TA phases.

Third-Party Evaluation: Third Sector and the counties will determine the appropriate procurement approach and qualifications for a third-party evaluator during the first nine months of the project. Once selected, the third-party evaluator will contract with counties either individually or collectively via the JPA administered through CalMHSA. Third Sector will support counties in determining the appropriate statement of work, budget, and funding plan for the third-party evaluator.

The current budget assumes a total evaluation cost of $250,000 combined across all counties. Actual costs may be higher/lower, depending on the organization selected and the final scope and deliverables counties elect to pursue for the post-implementation evaluation. San Bernardino would contribute approximately $42,000 of county MHSA Innovation funds towards this total cost.

Fiscal Intermediary Costs (CalMHSA): San Bernardino County and other participating counties propose to use their existing CalMHSA Joint Powers Agreement (JPA) for the purpose of contracting with Third Sector and the third-party evaluator. The JPA sets forward specific governance standards to guide county relationships with one another and Third Sector/the evaluator. CalMHSA would develop participation agreements with each participating county that will further memorialize these standards and CalMHSA's specific role and responsibilities in providing fiscal and contract management support to the counties. CalMHSA charges an estimated 9% for its services. Rates are based on the specific activities and responsibilities CalMHSA assumes. The project budget currently assumes a fee of 9% of total pooled funds, or ~$315,000 total for the duration of the project across all counties. San Bernardino's contribution would support approximately $53,250 of this total.