Innovation Annual Report FY 17-18

Contra Costa Behavioral Health Services

Mental Health Services Act

Table of Contents

Innovation Introduction 3
Approved Programs 3
Appendices A1
Appendix A - Aggregate Innovation Demographics A1
Appendix B - Program Profiles B1
Appendix C - Innovation Project Annual and Final Reports C1

Innovation

Innovation is the component of the Three Year Program and Expenditure Plan that funds new or different patterns of service that contribute to informing the mental health system of care as to best or promising practices that can be subsequently added or incorporated into the system. Innovative projects for CCBHS are developed by an ongoing community program planning process that is sponsored by the Consolidated Planning Advisory Workgroup through its Innovation Committee.

New Innovation Regulations went into effect in October 2015. As before, innovative projects accomplish one or more of the following objectives; i) increase access to underserved groups, ii) increase the quality of services, to include better outcomes, iii) promote interagency collaboration, and iv) increase access to services. While Innovation projects have always been time-limited, the Innovation Regulations have placed a five-year time limit on Innovation projects. During FYs 2015-16 and 16-17, CCBHS staff and stakeholders reviewed and ensured that all existing and emerging Innovation projects complied with the Innovation Regulations.

Approved Programs

The following programs have been approved, implemented, and funds have been allocated for Fiscal Year 2017-18:

1) Recovery Through Employment Readiness. The community program planning process has placed an urgent priority on the County providing pre-vocational and employment services to a large number of mental health consumers who are not currently receiving this service. An analysis indicates that Contra Costa Vocational Services currently partners with the California Department of Rehabilitation to provide a "place and train" model of employment services. This model screens applicant for readiness to enter competitive employment, and then provides job placement and supported employment services to facilitate job retention. However, a large number of individuals who need training, education and other pre-employment services are being screened out. A new and innovative model has been developed to combine a "train and place" approach with the existing "place and train" approach in order to serve a larger number of consumers who represent a broader spectrum of readiness for employment. Contra Costa Vocational Services partners with the Putnam Clubhouse to enable flexible funds to be made available for pre-employment goods and services. The Recovery Through Employment Readiness Project began in FY 2015-16.

2) Coaching to Wellness. Individuals who have experience as a consumer and/or family member of the mental health system have been trained to provide mental health and health wellness coaching to recipients of integrated health and mental health services within CCBHS. These peer providers are part of the County's Behavioral Health Services integration plans that are currently being implemented. Three Wellness Coaches are paired with two Wellness Nurses, and are assigned to the adult mental health clinics. The Coaches have received training specific to the skill sets needed to improve health and wellness outcomes for consumers. The Coaching to Wellness Project began implementation in FY 2015-16.
3) Partners in Aging. Older adults who are frail, homebound and suffer from mental health issues experience higher rates of isolation, psychiatric emergency interventions, and institutionalization that could be prevented. When fully implemented this project will field three field-based peer support workers to engage older adults who have been identified by their IMPACT clinicians, primary care providers, or Psychiatric Emergency Services as individuals who need additional staff care in order to avoid repeated crises, engage in ongoing mental health treatment, increase their skills in the activities of daily living, and engage appropriate resources and social networks. The Partners in Aging Project began implementation in FY 2016-17.
4) Overcoming Transportation Barriers. Transportation challenges provide a constant barrier to accessing mental health services. A comprehensive study was completed via the County's community program planning process, and a number of needs and strategies were documented. Findings indicated a need for multiple strategies to be combined in a systemic and comprehensive manner. These strategies include training consumers to independently navigate public transportation, providing flexible resources to assist with transportation costs, educating consumers regarding schedules, costs and means of various modes of public transportation, and creating a centralized staff response to coordinate efforts and respond to emerging transportation needs. Three Peer Specialists address these needs and provide a means to inform the mental health system of care regarding solutions for improving transportation access to care. The Overcoming Transportation Barriers Project began implementation in FY 2016-17.

The allocation for these projects are summarized below:

Project	County/Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 17-18
Recovery Through Employment Readiness	County Operated in partnership with Putnam Clubhouse	Countywide	100	100,000
Coaching to Wellness	County Operated	Countywide	90	474,089
Partners in Aging	County Operated	Countywide	45	181,067
Overcoming Transportation Barriers	County Operated	Countywide	200	241,450
Administrative Support	County	Countywide	Innovation Support	423,670
		Total	*435*	*$1,420,276*

Emerging Programs

The following concepts have been designated to be Innovation Projects, and are on track to be fully developed, approved and implemented during the period of FY 18/19:

1) Center for Recovery and Empowerment (CORE). CCBHS recognizes substance abuse/dependence in adolescence as it negatively affects physical, social, emotional and cognitive development. Early onset of alcohol or other drug use is one of the strongest predictors of later alcohol dependence. This is a priority because CCBHS does not have a coordinated system of care to provide treatment services to youths with addictions and co-occurring emotional disturbances. The CORE Project will be an intensive outpatient treatment program offering three levels of care; intensive, transitional and continuing care to adolescents dually diagnosed with substance use and mental health disorders. Services will be provided by a multi-disciplinary team, and will include individual, group and family therapy, and linkage to community services.

2) Cognitive Behavioral Social Skills Training (CBSST). Many consumers spend years residing at County augmented board and care facilities with little or no mental health treatment provided, and little or no functional improvement taking place. Often this lack of progress results in multiple admissions to the County's Psychiatric Emergency Services and other, more costly, interventions. Cognitive Behavioral Social Skills Training (CBSST) is an emerging practice with demonstrated positive results for persons with severe and persistent mental illness. The CBSST Project proposes to apply this therapeutic practice to the population of individuals that have been placed in augmented board and care facilities. The CBSST Project will create a clinical team, consisting of a licensed clinician and peer support worker, to lead cognitive behavioral social skills training groups at board and care facilities. Adults with serious mental illness will learn and practice skills that will enable them to achieve and consolidate recovery based skills.

The above concepts have been recommended by the Innovation Committee for development and submittal to the Mental Health Services Oversight and Accountability (MHSOAC) for

approval. Detailed project descriptions will be submitted to the MHSOAC for approval in a separate document. These concepts have been discussed by stakeholders in this year's community program planning process, and are consistent with stakeholder identified priorities.

The Mental Health Services Act states that five percent of MHSA funds will be for Innovation Projects. In order to meet this five percent requirement additional funds will be set aside for the emerging projects listed above.

Innovation (INN) Component Yearly Program Budget Summary for FY 17-18

Projects Implemented			1,420,226
Funds allocated for emerging projects			700,000
		Total	***$2,120,226***

Appendices

Aggregate Innovation Demographics

In response to the new Innovative Project Regulations issued in July 2015, per California Code of Regulations, Title 9, Section 3580 and 3580.010, Contra Costa County begun collecting new outcome indicators for all Innovation projects. Starting in July 2016, projects started capturing demographic data, such as age group, race/ethnicity, primary language and sexual orientation. This data defines outreach to all underserved population for the current fiscal year. Data not included in this report can be found within the innovation annual reports submitted in this document. Programs not included are Overcoming Transportation Barriers and Recovery through Employment Readiness.

Total Served FY 17/18 = 27

Table 1. Age Group

	# Served
Child (0-15)	
Transition Age Youth (16-25)	
Adult (26-59)	9
Older Adult (60+)	4
Decline to State	

Table 2. Primary Language

	# Served
English	10
Spanish	3
Other	
Decline to State	

Table 3. Race

	# Served
More than one Race	2
American Indian/Alaska Native	
Asian	2
Black or African American	2
White or Caucasian	5
Hispanic or Latino/A	
Native Hawaiian or Other Pacific Islander	
Other	2
Decline to State	

Table 4. Ethnicity (If Non-Hispanic or Latino/a)

	# Served
African	
Asian Indian/South Asian	
Cambodian	
Chinese	1
Eastern European	
European	1
Filipino	
Japanese	
Korean	
Middle Eastern	1
Vietnamese	
More than one Ethnicity	2
Decline to State	4
Other	2

Table 5. Ethnicity (If Hispanic or Latino/a)

	# Served
Caribbean	
Central American	
Mexican/Mexican American /Chicano	
Puerto Rican	
South American	
Other	

Table 6. Sexual Orientation

	# Served
Heterosexual or Straight	10
Gay or Lesbian	
Bisexual	1
Queer	
Questioning or Unsure of Sexual Orientation	
Another Sexual Orientation	
Decline to State	2

Table 7. Gender Assigned Sex at Birth

	# Served
Male	6
Female	6
Decline to State	1

Table 8. Current Gender Identity

	# Served
Man	4
Woman	4
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to State	4

Table 9. Active Military Status

	# Served
Yes	1
No	9
Decline to State	3

Table 10. Veteran Status

	# Served
Yes	
No	
Decline to State	

Table 11. Disability Status

	# Served
Yes	
No	10
Decline to State	3

Table 12. Description of Disability Status

	# Served
Difficulty Seeing	5
Difficulty Hearing or Having Speech Understood	3
Physical/Mobility	5
Chronic Health Condition	6
Other	

Table 13. Cognitive Disability

	# Served
Yes	1
No	12

Program Profiles

Coaching to Wellness ……………………………………………………………………………………..B1

Overcoming Transportation Barriers…………………………………………………………….............B2

Partners in Aging……………………………………………………………………………………….B3

Recovery through Employment Readiness………………………………………………………......B4

Program: Coaching to Wellness/Performance Improvement Project

The Coaching to Wellness program provided an additional level of support for adult mental health consumers with certain chronic health conditions through intensive peer and nurse support. With components from intensive peer support coupled with leveraging existing resources in the County, the Coaching to Wellness program provided a holistic team approach to providing care to our consumers. The goals of the program were to: 1) Improve consumer perception of their own wellness and well-being; 2) Increase healthy behaviors and decrease symptoms for consumers; and 3) Increase cross-service collaboration among primary and mental health care staff.

a. **Target Population:** Adults aged 18 years and older who were currently receiving psychiatric-only services at a County-operated Adult clinic; Diagnosed with a serious mental illness (but at a stage to be engaged in recover); Diagnosed with a chronic health risk condition of cardiac, metabolic, respiratory, and/or have weight issues; Expressed an interest in the program; and indicated a moderate to high composite score on mental health and medical levels of support needed.
b. **Total Budget:** $474,089
c. **MHSA-funded Staff:** 5.0 Full-time equivalents
d. **Total Number served**: For FY 17/18: 27 individuals
e. **Outcomes**: Evaluation of the program included pre- and post-surveys that measured key indicators in areas such as: perceived recovery, functioning, and quality of life. Self-rated health and mental health data is collected by the Wellness Coaches and Nurses at most individual contacts and vitals collected and levels of support assessed by the Wellness Nurses as needed. Satisfaction and achievement on self-identified wellness goals recorded at post-program. Other proposed indicators include primary care and mental health appointment attendance, and utilization rate of involuntary psychiatric emergency admissions and/or acute psychiatric admissions.

Program: Overcoming Transportation Barriers (Innovation)

a. **Scope of Services:**
   The Overcoming Transportation Barriers program is a systemic approach to develop an effective consumer-driven transportation infrastructure that supports the entire mental health system of care. The goals of the program were to improve access to mental health services, improve public transit navigation, and improve independent living and self-management skills among consumers. The program targeted consumers throughout the mental health system of care.
b. **Target Population:** Consumers of public mental health services and their families; the general public.
c. **Total MHSA Funding for FY 2017-18:** $241,450
d. **Staff:** 2 full-time equivalent staff positions
e. **Number Served:** For FY 17/18: 46 encounters
f. **Outcomes:**
   - Increased access to wellness and empowerment knowledge and skills by consumers of mental health services.
   - Decreased stigma and discrimination associated with mental illness.
   - Increased acceptance and inclusion of mental health consumers in all domains of the community.

5. **Program: Partners in Aging - INN**

Partners in Aging is an Innovation Project that was implemented on September 1st, 2016. Partners in Aging adds up to two Community Support Workers, up to 3 Student Interns and 8 hours/week of Psychiatric Services to the IMPACT program. The project is designed to increase the ability of the IMPACT program to reach out to underserved older adult populations through outreach at the Miller Wellness Center and Psychiatric Emergency Services. Through Partners in Aging, IMPACT has provided more comprehensive services, including providing linkage to Behavioral Health, Ambulatory Care, and community resources. Peer support, rehab, and in-home and in-community coaching will allow the skills learned through psychotherapy to be practiced in the community.

a. Scope of Services**:** Community Support Workers and Student Interns provided linkage, in-home and in-community peer support, and health/mental health coaching to consumers open to or referred to the IMPACT program. In addition, the CSW and Student Intern provide outreach to staff at Psychiatric Emergency Services and Miller Wellness Center. They are available to meet with consumers at PES and MWC that meet the criteria for IMPACT to provide outreach, and linkage to services. The Student Intern conducts intakes, assessments, and provides individual psychotherapy. Additionally, a Geropsychiatrist will be available 8 hours/week to provide consultation, and in-person evaluations of IMPACT clients.
b. Target Population: The target population receiving health care services at the Federally Qualified Health Center for the IMPACT Program is adults age 55 years and older. The program focuses on treating older adults with late-life depression or anxiety and co-occurring physical health impairments, such as cardio-vascular disease, diabetes, or chronic pain. Partners in Aging also focused on providing outreach and services to older adults who are experiencing both mental health symptoms and alcohol or drug misuse.
c. Annual Payment Limit: $181,067
d. Number served: For FY 17/18: 38 individuals
e. Outcomes: Reductions in Level of Care Utilization System (LOCUS) scores, reductions in Psychiatric Emergency Service visits, reductions in hospitalizations, and decreased Patient Health Questionnaire (PHQ-9) scores would indicate the effectiveness of this program.

Program: Recovery through Employment Readiness (Innovation)

a. **Scope of Services**

Recover through Employment Readiness integrated a vocational rehabilitation counselor as part of the mental health multi-disciplinary team. This team implemented a treatment plan for persons with serious mental illness. As identified on the treatment plan the vocational rehabilitation counselor partnered with the consumer to address any and all issues that affect employment readiness prior to any potential referral to the existing job placement specialists and job coaches that are part of the mental health cooperative program. In addition to the vocational rehabilitation counselor providing counseling, life coaching and advocacy in the community, the new program design provided flexible funding that would enable timely removal of barriers due to a lack of consumer resources. This Innovation Program added pre-vocational preparation services designed to address common barriers that prevent many consumers from participating in these employment services. These preparation services were client determined and implemented at the client's pace with the assistance of a highly trained vocational rehabilitation counselor, working in collaboration with the mental health treatment team. The learning goal was to significantly increase the number of consumers actively working on their vocational rehabilitation as part of their mental health treatment plan. The Contra Costa Clubhouses, Inc. worked in partnership with the Contra Costa Mental Health Cooperative Program and assisted clients with educational, training, transportation and miscellaneous expenses directly supporting pre-vocational activities by overseeing the administration of the project's Flexible Funds.

b. **Payment Limit:** $100,000

c. **Target Population:** Target population were adults who were determined to be seriously mentally ill, meet medical necessity, and were being served by Contra Costa Mental Health's Adult System of Care.

d. **Number Served:** In FY 17-18: 115 Individuals

e. **Outcomes:** After extensive research, planning and evaluation, the Innovation program was rolled out to Central County on November 1, 2015 to address any data tracking, vendor issues and workflow improvements prior to rolling it out to East and West Counties. The Innovation Program was rolled out to East County on February 1, 2016 and to West County on May 1, 2016. During Fiscal Year 2017-18, a total of 174 services were provided to 115 clients who participated at least once in referred service. Transportation has been the most needed service among the participants with 94 bus tickets and 54 gas cards issued by the Vocational Rehabilitation Counselors. Work boots and school fees were the next needed items of services to be issued. Out of the 115 clients who received services, 81 clients (70%) met the criteria for successful outcomes and 34 clients (30%) met the criteria for unsuccessful outcomes. Criteria used to determine successful outcomes were clients who (1) received services and (2) had been placed in jobs, were in educational/training programs, were in job search, or had been referred to DOR. These measures best met the project's definition of "meaningful activity" - an activity that increased the client's mental health / well-being and increased potential opportunities that would benefit the client's growth. Criteria used to determine unsuccessful outcomes were a client who (1) declined Vocational Counseling services or (2) failed to comply or follow through, resulting in early termination of the program

Innovation Project Annual and Final Reports

Coaching to Wellness……………………………………………………………………………..C2

Overcoming Transportation Barriers………………………………………………………...C10

Partners in Aging……………………………………………………………………………….................C15

Recovery Through Employment Readiness………………………………………….....................C21

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
1220 Morello Ave, SUITE 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624
E-MAIL: Windy.Taylor@CCHEALTH.ORG

INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 2017/18

Agency/Program Name: Contra Costa Behavioral Health/Coaching to Wellness

INNOVATIVE PROGRAM TYPE:

*Please check **all** that apply:* ☐ PEI – services for individuals at risk of SMI/SED X CSS – services for individuals with SMI/SED

DRAFT

SERVICES PROVIDED:
Please describe the services you provided in the past reporting period.

Coaching to Wellness is a collaboration and integration of physical and mental health care for adult mental health consumers with certain health conditions. Care is served through an intensive form of treatment that involves a Wellness Team. This team consists of a Mental Health Clinical Specialist, Community Support Work and Registered Nurse. With components from intensive peer support coupled with leveraging existing resources in the County, the Coaching to Wellness program provides a holistic team approach to providing care to consumers. The goals of the program are to: 1) Improve consumer perception of their own wellness and well-being; 2) Increase healthy behaviors and decrease symptoms for consumers; and 3) Increase cross-services collaboration among primary and mental health care staff.

The Coaching to Wellness pilot program began enrolling consumers in December 2015 for consumers with comorbid mental health and primary care needs.

- Facing Up To Health: a peer-led group intervention guides participants through identifying and understanding their personal wellness resources and helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness (one group was held in each region, with the Central clinic completing another group that was started in the previous fiscal year).
- Wellness Recovery Action Plan (WRAP): an evidence-based peer-led group intervention that guides participants through identifying and understanding their personal wellness resources and helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness (one group was held in the Central clinic this fiscal year).
- Wellness Management related activities including referrals and linkages to primary care and other medical appointments such as nutrition, dental, optometry, ultrasounds, as well as community resources for food, clothing, linking family members to family support, housing, etc.
- Individual nurse and peer support in the home, field, and office to work on goal setting, goal

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
1220 Morello Ave, SUITE 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624
E-MAIL: Windy.Taylor@CCHEALTH.ORG

attainment, whole health education, development of self-management skills, and addressing barriers to wellness such as isolation and financial limitations.

- Alumni Group: a peer-led group that provides regular check-ins on progress and need for support goals while promoting the achievement of wellness, recovery, and chronic disease self-management skills.
- Graduation Ceremony activities include inviting Coaching to Wellness and Facing up To Health graduates to attend a ceremony designed to acknowledge participation and successful completion of programs and groups.

LESSONS LEARNED:

Please describe any lessons learned (positive and negative) throughout the implementation of this project. If applicable, how have you used these lessons to change the model?

- Previous lessons learned during last fiscal year 16/17continued to prove difficult in filling the second Wellness Nurse position. Position remained vacant for most of the current fiscal year as well. This vacancy showed to be very impactful on the West County region and efforts remained unchanged until June 2018. Currently, the West clinic is not enrolling any new participants other than the initial cohort that were already enrolled.
- Staff felt that over the duration of the project that how the program was presented made a difference on what clients were referred and how a client perceived the overall program's benefits to relieve mental and/or medical conditions. Several screening sessions were suggested before enrollment to determine if the program would be a good fit for the client's needs.
- Coaching to Wellness Team has identified that the timeframe for participants enrolled doesn't necessarily benefit the client to the best possible outcomes. Clients who work longer with the team overall have shown that they maintain positive health standards and improvements over time. The relationship with the team is vital especially because clients will call members of the team after graduation to continue to receive resources or referrals.
- Graduation and follow up after the completion of the project ensured the client doesn't backslide and continues to maintain skills and education around treatment that they have learned.
- Wellness Coaches experienced a number of situations where the initial attempt of engagement with a client was not successful. The next step would be for the Coach to focus on building rapport with the client while remaining persistent but gentle, which resulted in eventual success with enrolling them. Coaches felt that any "baby steps" a consumer takes should constitute a success, because it starts them down the road to recovery and they should gain mastery over time.

DRAFT

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
1220 Morello Ave, SUITE 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624
E-MAIL: Windy.Taylor@CCHEALTH.ORG

PROJECT CHANGES: ☐ No changes

Please explain whether any changes were made to the Innovative Project during the reporting period and the reasons for the changes, if applicable.

- Due to the hiring challenges for the Wellness Nurse position the team began discussions around changing the model and replacing the position with a Mental Health Clinical Specialist. The position would be mostly responsible for clinical assessments, annual clinical updates and developing treatment plans and could work at all regions. This position was hired and started in June 2018.
- Enrollment process and criteria was established in the onset of the project. The original program criteria enabled Wellness Team to focus on specific chronic health risk conditions and concentrate on a limited population only. The project has decided to expand criteria and open enrollment to all consumers in need of health care management. The desired outcome is to increase the number of clients utilizing services.
- Care monitoring at the 12 month follow up period required Wellness Team to follow up on all post-graduate members at 1,3,6, and 12 months to check current status using the Follow Up Survey. It was decided to remove the requirement of checking in at the 3 month period to avoid redundancy.
- Contact Summary Form is no longer being used because the team has come up with an alternate method of collecting this information on a developed report.
- Groups have been limited this year due to a staff coverage flux. The Central and West regions have started running groups for both Coaching to Wellness and non-Coaching to Wellness clients. Clinic staff have been helping with Wellness Recovery Action Plan (WRAP) and Facing Up To Health (FUTH) groups as well.

DRAFT

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
1220 Morello Ave, SUITE 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624
E-MAIL: Windy.Taylor@CCHEALTH.ORG

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

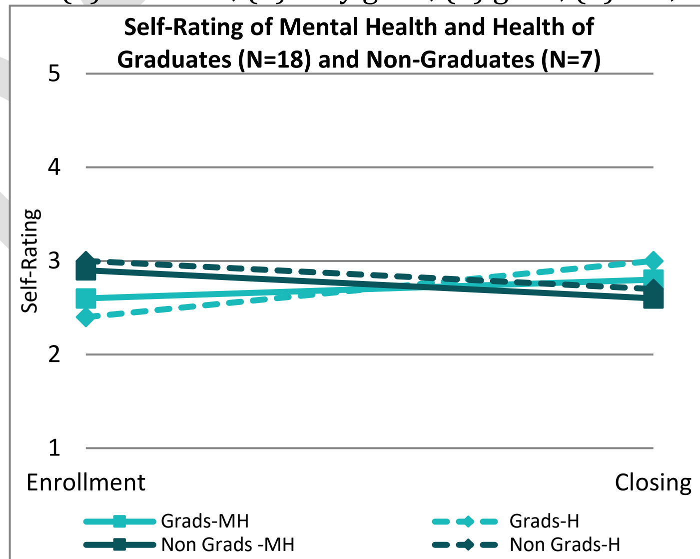
- *What are the learning goals of the project?*
- *Which elements of the project are contributing to outcomes?*
- *List of indicators measured; including results and an explanation as to how often data was collected and analyzed.*

The original learning goals of the project were to learn if and how modifying HARP curriculum and adding peer Wellness Coaches to health integration projects will: 1) improve wellness and health outcomes for consumers; 2) increase primary and mental health care staffs' understanding of mental health "consumer culture" and recovery principles; 3) increase the number of consumers with wellness, recovery, and/or self-management goals; 4) reduce feelings of stigmatization; and 5) enhance recovery. The proposal was written several years before the project was able to be implemented; therefore, the goals were amended by the Coaching to Wellness committee as described in the following.

The Coaching to Wellness pilot has three overarching goals with corresponding indicators:

1. Improve consumer perception of their own wellness and wellbeing.

- Self-Rated Health and Mental Health (asked at each visit and recorded on Contact Summary Form)
  At each individual session, the Wellness Coach and Nurse interviews consumers to ask "In general, would you say your health is…(5) excellent, (4) very good, (3) good, (2) fair, or (1) poor." This item is used in the National Health Interview Survey and in a number of studies self-rated health has been found to be an excellent predictor of future health.[i] In addition, a similar question is asked regarding mental health, similar to other studies.[ii] Consumer responses are recorded by on a Contact Summary form at baseline; participants were more likely to rate their mental health more positively than their physical health with the majority rating their physical and mental health as "good". At closing, 44.4% of graduates improved in perceived health and 33.3% improved perceived mental health; graduates saw improved self-ratings of health. Compared to non-graduates, those who graduated from Coaching to Wellness had higher



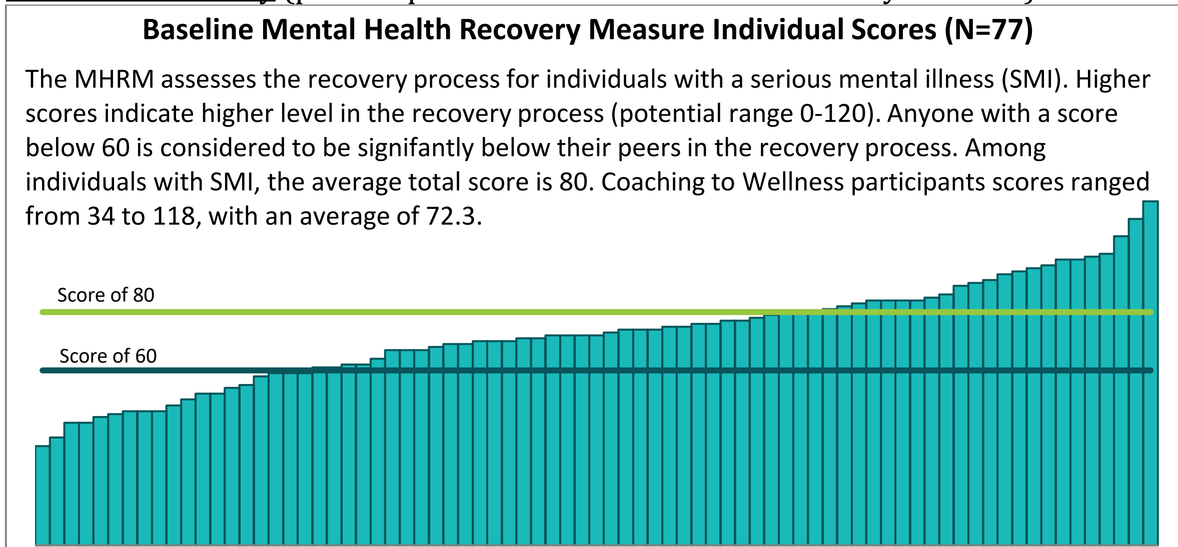
DRAFT

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
1220 Morello Ave, SUITE 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624
E-MAIL: Windy.Taylor@CCHEALTH.ORG

self-ratings at closing.

- Perceived Recovery (pre and post via the Mental Health Recovery Measure)



The Mental Health Recovery Measure (MHRM) survey is completed by participants at pre and post and administered by the Wellness Coach. The development of the MHRM involved a grounded theory analysis of qualitative data to develop a model of recovery based upon the experiences of individuals with psychiatric disabilities.[iii] All items are rated using a 5-point Likert scale that ranges from “strongly disagree” to “strongly agree.” The MHRM contains 30 items across eight conceptual domains. On average, participants score 8 points lower than the average of most individuals with SMI. For the 3 graduates who completed the MHRM at enrollment and closing, there was an average decrease of 6.8 points.

- Functioning (pre and post via the Mental Health Recovery Measure)
  At baseline, participants scored an average of 8.7 points on the Basic Functioning domain of the MHRM, with scores ranging from 0 to 16. Individuals scoring high in this domain are getting their basic needs met and are not depending on others for help. For the 3 graduates who completed the MHRM at enrollment and closing, there was an average domain deterioration of 0.3 of a point, a non-significant difference.

- Quality of Life (pre and post via the Mental Health Recovery Measure)
  At baseline, participants scored an average of 8.2 points on the Advocacy/Quality of Life domain of the MHRM, with scores ranging from 3 to 16 [potential range 0-16]. Individuals scoring high in this domain are making the transition into becoming a role model of recovery; they are becoming confident and comfortable in their journey so they are able to share that with others and help them progress along their own path. For the 3 graduates who completed the MHRM at enrollment and closing, there was an average domain improvement of 0.8 of a point, a significant difference.

DRAFT

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
1220 Morello Ave, SUITE 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624
E-MAIL: Windy.Taylor@CCHEALTH.ORG

2. Increase healthy behaviors and decrease symptoms for consumers.

- Physical Health Vital Signs and Labs (as needed recorded via Nurse Contact and Lab Summary Form)
  With consumer permission, the Wellness Nurse measures vital signs including height, weight, BMI, blood pressure, pulse, and waist circumference and recorded on a Contact Summary form. In addition, the Nurse will ask about the number of days and minutes of physical activity engaged in during the week. Labs (e.g., Cholesterol, HgA1C, etc.) are requested as needed; the Wellness Nurse monitors these requests and enters information into a Participant Lab Summary form. There is not enough post data for pre and post analyses. At baseline:
  - BMI: Of 13 participants, all but one (92.3%) were overweight (BMI ≥ 25) or obese (BMI ≥ 30).
  - Blood Pressure: Out of 15 participants, 9 (60.0%) have pre-hypertension and hypertension.
  - Pulse: Of 15 participants, 3 (20.0%) have a high pulse rate.
  - Cholesterol: Of 10 participants, 20.0% have borderline high or high total cholesterol; 10.0% have borderline or very high LDL cholesterol; 80.0% have low HDL cholesterol; and 60.0% have mildly high or high triglycerides.
  - HgA1C: Of 10 participants, 20.0% scores indicate pre-diabetes and 6 (60.0%) diabetes.

3. Increase cross-service collaboration among primary and mental health care staff.

- # and type of referrals and linkages (recorded as made via the Referral Summary Form)

Classification	Type of Referral	# of Referrals	# Referrals Completed	% Successful Referrals
In House Mental Health	Transportation	1	1	**100%**
	Appointments	4	1	25%
	Group	1	1	**100%**
	Family Support	1	1	**100%**
In House Support Services	Health Group	1	0	0%
	Specialty Health Care (e.g., ophthalmology, pulmonary, podiatry)	3	3	**100%**
	Health Aid (e.g., walker, glucose strips)	6	6	**100%**
	Change PCP	3	1	33.3%
	Labs/Scans	1	1	**100%**
	Financial	1	1	**100%**
External Support Services	Specialty Health Care	3	2	66.7%
	Food	2	0	0.0%
	Dental	1	1	**100.0%**
	Recreation	1	0	0.0%
	Medication	3	2	66.7%
	Education	2	1	50.0%
	General	3	3	**100.0%**
Total	**--**	**49**	**25**	**51.0%**

Table shows referrals submitted in FY17-18. Note that the table does not reflect referrals still in process or coordination to get Medicare approval, contact with pharmacies on medications, or communication with PCP and mental health providers.

DRAFT

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
1220 Morello Ave, SUITE 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624
E-MAIL: Windy.Taylor@CCHEALTH.ORG

LINKAGE AND FOLLOW-UP: ☐ Not applicable

Please explain how participants are linked to mental health and/or support services, including, how the INN program follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

Participants are receiving medication support services only, so if during the course of participation in the program it is noticed that a participant needs a higher level of mental health services, appropriate referrals are made. For instance, participants have been referred to Case Management, Alcohol and Other Drug Services, Older Adult Mental Health, and Hume's Partial Hospitalization Program. Participants are also encouraged to engage in other mental health recovery programs such as the Wellness Recovery Action Program (WRAP) and SPIRIT, and get help scheduling psychiatric appointments as needed. From onset, participants are encouraged to utilize consumer run organizations like Putnam Clubhouse and RI International as a support in their recovery process and for socialization purposes to decrease isolation and reduce dependence on clinic staff.

Referrals are also made to other support services, most particularly to primary care in which In Basket is used as the primary mode of communication. For participants dis-engaged from primary care services, efforts are made to re-engage via ordering lab work, switching to new providers, transportation support, attending appointments with participants, appointment reminders, and check ins after appointments and medical procedures. Participants have also been referred to health specialists such as dermatology, dysplasia, dentistry, ophthalmology, optometry, pulmonary, podiatry, and ultrasound and imaging. In addition, the coaching team does follow up on medical devices and materials such as CPAP machines, glucose meters and test strips for diabetics and follow up on prescriptions with pharmacies. As needed, referrals are also made to other support services such as housing, food, and clothing. To aid this effort, staff complete a referral summary to document details on referrals made such as type of referral and outcome of the referral. Referrals take, on average, 2 weeks to be processed. Of note, as appropriate, we also make initial referrals for consumers recommended to the program who do not meet criteria or who are not interested in participating but request assistance.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

The following is an example of how participation in the program has impacted a participant life:

DRAFT

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
1220 Morello Ave, SUITE 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624
E-MAIL: Windy.Taylor@CCHEALTH.ORG

Client is a supportive and gracious mother of five children working hard during financial and often stressful circumstances. She experienced great trauma around 15 and was placed in various foster homes, became pregnant and was bullied in High School. Then she dropped out in her sophomore year. Eventually she returned and then graduated in 2018 from High School with a Diploma. She became a graduate of Medical Terminology on October 11, 2018.
Working with the Wellness Clinic and on her own with the support of Sakura, RN, and Sheryle Herron FNP has significantly lowered her A1C numbers along with weight reduction and is modeling well for her children. Client used recent medical knowledge to save a cardiac distressed neighbor by administering aspirin. The physician that treated the patient was amazed by her quick action and told her he would help her secure placement in the medical field when she was ready. She is presently enrolled and expected to graduate in February, 2018.
In addition, she is working on a plan to receive a Pell Grant or Scholarship to complete a $4750.00 Medical Assisting Certificate program. She is working with both Behavioral Health Vocational Rehabilitation services and with the school Mt. Diablo Adult Education a division of the Mt. Diablo Unified School District to accomplish this assignment.

---

[i] Idler, E. L., & Angel, R. J. (1990). Self-rated health and mortality in the NHANES-I epidemiologic follow-up study. *American Journal of Public Health, 80*, 1990, 446-452.
U.S. Bureau of the Census. (1985). *National Health Interview Survey*. Washington DC: U.S. Dept. of Commerce.
Ware, J. E., Nelson, E. C., Sherbourne, C. D., & Stewart, A.L. (1992). Preliminary tests of a 6-item general health survey: A patient application. In A. L. Stewart & J. E. Ware (Eds.), *Measuring functioning and well-being: The Medical Outcomes Study approach* (pp. 291-303). Durham NC: Duke University Press.
[ii] Kaiser Family Foundation. (2009). *Survey of healthy San Francisco participants*. Retrieved from http://healthysanfrancisco.org/wp-content/uploads/Kaiser-Survey-of-HSF-Participants-Aug-2009.pdf
Peel Public Health. (2015). *Quick stats: Self-rated mental health*. Retrieved from https://www.peelregion.ca/health/statusdata/pdf/self-rated-a.pdf
[iii] Bullock, W. A. (2009). *The Mental Health Recovery Measure (MHRM): Updated normative data and psychometric properties*. Toledo, OH: University of Toledo, Department of Psychology.

DRAFT

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA BEHAVIORAL HEALTH
1220 Morello Ave SUITE 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624
E-MAIL: Windy.Taylor@CCHEALTH.ORG

INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 2017/18

Agency/Program Name: Contra Costa Behavioral Health/Overcoming Transportation Barriers

INNOVATIVE PROGRAM TYPE:

*Please check **all** that apply:* ☐ PEI – *services for individuals at risk of SMI/SED* X CSS – *services for individuals with SMI/SED*

SERVICES PROVIDED:

Please describe the services you provided in the past reporting period.

The Overcoming Transportation Barriers (OTB) project was established to help clients build self-sufficiency and apply independent travel skills while increasing access to mental health services. Other goals of the project also included improving system navigation and expanding independent living and self-management skills. The project started to serve clients beginning April 2017. As of June 30th, 46 clients accessed help from the OTB Team for this fiscal year.

Client services received from the OTB Team range from peer support, mapping bus routes and links to resources, referrals, fare information and travel training. . Application assistance for discount/disabled transit passes, Regional Transit Connection (RTC), Senior Youth Cards and Paratransit. Clients will typically access some of these services by calling the dedicated phone line for transportation assistance where a Commute Navigation Specialist will help with assisting the client's needs. During this call clients will receive one-on-one support on how to access services to get to appointments.

Travel Training was initiated once during the current fiscal year. Training consisted of Tri Delta Transit facilitating two sessions that consisted of an educational course and a field trip where participants rode a bus with the guidance of an instructor. Unfortunately, attendance was low this training but planning for future training and how to advertise will be re-evaluated. Training will be held again during the next fiscal year at the East part of the region.

The OTB Team presented to the Service Provider Individualized Recovery Intensive Training (SPIRIT) class to provide information on the (RTC) Card. The presentation demonstrated a specific outline around the project's goals, target population, staff roles and tasks. SPIRIT students have lived experience in the mental health field and can use this information in future placements in their careers.

CONTRA COSTA BEHAVIORAL HEALTH
1220 Morello Ave SUITE 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624
E-MAIL: Windy.Taylor@CCHEALTH.ORG

Many of them also utilized the Commute Navigation Specialists for peer support around transportation to class, the SPIRIT Work Study Fair, and their internships.

A sub-committee was formed to further the collaboration of stakeholders and staff in supporting the OTB project. This unique committee was created and joined together to start addressing the needs of clients with a perspective of people who utilize the transportation system on a daily basis. The committee identifies and shares transportation resources, advocates for the needs of behavioral health clients and empowers and encourages clients and caregivers to engage in independent travel to get to and from behavioral health services and supports.

LESSONS LEARNED:

Please describe any lessons learned (positive and negative) throughout the implementation of this project. If applicable, how have you used these lessons to change the model?

The Overcoming Transportation Barriers Project (OTB) had some minor staff changes. A bilingual Commute Navigation Specialist was originally hired during the onset of the project and stayed with the project through the beginning of FY 17/18. It was discovered that although there were interpretation services provided in the County that this was an added benefit to the project and allowed the project to have faster means to translate transportation material and calls.

The OTB project was part of a performance improvement project pilot to assist clients in making their first clinical assessment appointment within the East County Region. This included both the East County Adult and Children's Behavioral Health Clinics. It also provided extra support in getting to appointments by referring clients to a Community Support Worker or Family Partner. Additionally, another part of the pilot included a recorded reminder call through Televox. During the recorded call a client would be given the option that if they needed additional transportation support and/or guidance then they could be transferred to a Commute Navigation Specialist. The pilot project lasted for only a few months and wasn't successful. The calls comprised of clients wanting information for the clinic and wanting to know what time their appointment was taking place. This was found as problematic for the OTB Team and the message was later on removed from the recorded message.

The project continues to have challenges around clients or staff assuming that rides are provided. Many times a client or staff member will call to request transportation to or from appointments. The OTB Team has had to continue to educate clients and staff seeking services that the services provided by the OTB team are only to help foster transportation independence as well as provide linkage to resources.

DRAFT

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA BEHAVIORAL HEALTH
1220 Morello Ave SUITE 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624
E-MAIL: Windy.Taylor@CCHEALTH.ORG

PROJECT CHANGES: ☐ No changes

Please explain whether any changes were made to the Innovative Project during the reporting period and the reasons for the changes, if applicable.

Services began in the East region of the County and later expanded to the Central region. This required a second Commute Navigation Specialist to be hired. The project hopes to hire a third Specialist to support the West region of the County. This will enable the project to provide additional services and fulfill the entire County's need for transportation resources.

The OTB project implemented a phone line for clients and staff to be able to call in order to obtain resources and benefits. As calls were coming in it was recommended to create a way to track and follow up on transportation inquiries. A database was then developed in order to track transportation related requests. The database consists of two tracking methods for both staff and clients. The data includes encounter sources and other relevant notes so that services are received and followed up on as needed.

The OTB team was instrumental in developing Transportation Resource Guides and other documents to support the project's overall mission to improve transportation independence. The transportation guides were completed for the East and Central County regions and comprised of resources and fare information. Also, a series of maps were created to help guide stakeholders on how to use transportation services to get to a public committee, forums, SPIRIT event and SPIRIT Work Study Fair. These maps were distributed beforehand and demonstrated to be helpful towards attendance.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- *What are the learning goals of the project?*
- *Which elements of the project are contributing to outcomes?*
- *List of indicators measured; including results and an explanation as to how often data was collected and analyzed.*

The goals of the project are to learn the following:

1) Client education on usage of transportation and encouragement of independent living skills in getting to and from services to improve service access

DRAFT

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA BEHAVIORAL HEALTH
1220 Morello Ave SUITE 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624
E-MAIL: Windy.Taylor@CCHEALTH.ORG

2) Client support in navigation of the transportation system through education on how to use public transit, read transit schedules, plan travel routes, and apply for discount passes, promoting more efficient use of transportation resources

3) Client application of learned transportation skills to promote productive, meaningful activity, life skills for social engagement, and reduced isolation

4) Reducing no-show rates at county-operated clinics by addressing both physical and emotional safety barriers through development of solutions regarding transportation

5) Reduction of internal stigma among clients through ongoing peer support from Commute Navigation Specialists

The OTB project started collecting data April 25, 2017. The data collected provided outcomes showing the type of support provided by the OTB team. The support varied and provided resources, referrals and other educational training around utilization of services. Data included staff and client encounters and led to a follow up method for all callers to ensure services rendered.

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA BEHAVIORAL HEALTH
1220 Morello Ave SUITE 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624
E-MAIL: Windy.Taylor@CCHEALTH.ORG

LINKAGE AND FOLLOW-UP: ☐ Not applicable

Please explain how participants are linked to mental health and/or support services, including, how the INN program follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

In order to provide support services the Overcoming Transportation Barriers project reached out to various transportation agencies, and service providers located throughout multiple regions within the County. This action established a process to help in providing a connection between these entities and the project's team. During this process improved access to resources and materials became available for clients and the team was better able to provide further support to clients.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

Case Vignette- Sarah

Sarah a SPIRIT graduate and a peer/consumer/family member of Behavioral Health Services called to get her RTC card replaced. The Commute Navigation Specialist provided contact information for both Clipper and the "RTC Medical Verifier". Upon calling for the replacement cared she discovered that Clipper was not helpful in the process and provided little support. The "RTC Medical Verifier" though was very helpful and took demographic information to verify identity and replace the card. Feedback was given on the process and the request was completed. Sarah was very grateful on the follow up of the overall call and thanked the Commute Navigation Specialist for the service.

DRAFT

CONTRA COSTA MENTAL HEALTH
Mental Health Services Act
1220 Morello Avenue, Suite 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624 E-MAIL:
Windy.Taylor@CCHELATH.ORG

INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 2017/2018

Agency/Program Name: Partners in Aging

INNOVATIVE PROGRAM TYPE:

*Please check **all** that apply:* ☐ PEI – services for individuals at risk of SMI/SED ☐ X CSS – services for individuals with SMI/SED

SERVICES PROVIDED:
Please describe the services you provided in the past reporting period.

During FY 17/18, we had one Community Support Worker (CSW) and one Intern. Our CSW was in her position with Partners in Aging (PIA) beginning in September 2016, and throughout the fiscal year. She left this position on 1/31/19. Our Intern began in her position in September 2017, and continued with the program through the remainder of the fiscal year. Our CSW and Intern served 38 clients this fiscal year. Our CSW has been able to build rapport and provide multiple linkage and rehab services. She is able to connect with clients in different ways than our clinicians since she is in the community with the clients and can relate to them as a peer. She collaborates with the clinicians and provides her perspective. The CSW has provided assistance in linking clients to important resources such as In-Home Support Services, Contra Costa Housing Interfaith, legal services, Social Security Administration, housing resources (including linking to Housing Navigators at Care Centers and linking to organizations that assist with rent payments), Monument Crisis Center, food banks and medical appointments. She also provides several reminder calls to improve attendance at appointments. Our CSW has become quite knowledgeable on support service resources for older adults.

The CSW also continued to collaborate with the CSWs at Psychiatric Emergency Services (PES) and was available for referrals. She continued to communicate by email, and through the CSW meetings. We did not receive referrals from PES during this reporting period.

Our Intern served a caseload of approximately 5 IMPACT clients. She completed intakes and provided psychotherapy. She was able to develop rapport with a range of clients and make progress towards therapeutic goals. In addition, our PIA Intern created a comprehensive binder detailing resources for clients who have early signs of or have been diagnosed with Dementia. We are not able to provide services to clients who have a primary diagnosis of Dementia, thus, having a thorough understanding of resources and referrals for this population is essential.

LESSONS LEARNED:
Please describe any lessons learned (positive and negative) throughout the implementation of this project. If applicable, how have you used these lessons to change the model?

CONTRA COSTA MENTAL HEALTH
Mental Health Services Act
1220 Morello Avenue, Suite 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624 E-MAIL: Windy.Taylor@CCHEALTH.ORG

Throughout FY 17/18 we have steadily received an increase in the number of clients referred to our IMPACT clinicians in all 3 regions of the county. During the previous reporting period we had explored the tendency for there to be fewer referrals in the West County region. During this reporting period, the increase in referrals indicates that Primary Care Providers may be more aware of IMPACT services throughout the county and value this resource. The increase in referrals is also likely related to the increase in the aging population. In addition, there may be a reduction in stigma related to participating in mental health treatment among this group of older adults, which include “baby boomers.” Our new challenge will be finding ways to manage the significant increase in referrals. We are currently exploring ways that our PIA CSW can assist with managing the high volume of referrals (i.e., possibly doing outreach calls to clients who are waiting for an initial appointment).

Barriers continue to exist related to developing a collaborative relationship with PES and Miller Wellness Center (MWC). We have not received referrals from either PES or MWC during this reporting period. We will continue to work to strengthen this relationship through outreach. Both PES and MWC serve a high volume of clients in a very quick short-term model, thus, it can be challenging to initiate the referral to IMPACT and PIA under the time constraints of their services. We will continue to work to develop these relationships.

We continue to see the incredible benefits of the collaborative relationship between our CSW, Intern and IMPACT clinicians. Our CSW can provide a different perspective on client functioning based on her experiences with clients in the community. This has had a positive impact on client functioning, progress towards treatment goals, and maintaining client safety.

PROJECT CHANGES: ☐ No changes
Please explain whether any changes were made to the Innovative Project during the reporting period and the reasons for the changes, if applicable.

A change was made to the IMPACT Program during this reporting period. In November 2017 the 3 licensed IMPACT clinicians began to provide services using the billing model for the Federally Qualified Health Centers (FQHC). They have phased out the use of Medi-Cal billing. This impacts PIA in that since these clients are not open to a specialty mental health program, the CSW can not bill Medi-Cal. Our CSW utilizes the electronic health record, which was implemented on 9/26/17 to document services provided; however, there is no billing component. This change also impacts PIA in that now the IMPACT clinicians are primarily serving clients with mild to moderate mental health concerns rather than moderate to severe. In addition, clients who have Medicare as their only source of insurance are now eligible for IMPACT. The change to FQHC billing was driven by the implementation of the electronic health record (EHR) for specialty mental health billing. Attempts to utilize the model of the EHR by the IMPACT clinicians in the Ambulatory Care Centers were complicated and not successful. Utilizing FQHC billing allows the clinicians to use the EHR model used by the other providers in the Ambulatory Care Center.

The PIA Intern continues to utilize Medi-Cal billing to provide intakes and psychotherapy to clients with moderate to severe mental illness. Her client visits took place at the Older Adult Mental Health office. Since our Intern is not located at a FQHC, she can not use this model of billing.

CONTRA COSTA
HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
Mental Health Services Act
1220 Morello Avenue, Suite 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624 E-MAIL:
Windy.Taylor@CCHEALTH.ORG

OUTCOMES AND PROGRAM EVALUATION:
Please provide quantitative and qualitative data regarding your services.
- *What are the learning goals of the project?*
- *Which elements of the project are contributing to outcomes?*
- *List of indicators measured; including results and an explanation as to how often data was collected and analyzed.*

The goals of the project are to learn the following:

1) Do older adults access IMPACT services with the assistance of peer support workers?

   Yes. Our CSW successfully provided services to approximately 33 IMPACT clients to improve their access to IMPACT services during FY 17/18.

2) Do older adults engage in SBIRT?

   All patients seen at the health centers engage in SBIRT evaluation.

3) Do older adults develop life skills with the assistance of peer support workers?

   Yes, our Partners in Aging clients have developed numerous life skills with the assistance of our CSW, including managing immigration related legal stressors, being able to travel again, obtaining free phones and learning to utilize these phones, ensuring that medical needs are met, being able to utilize transportation resources, and increasing comfort with asking for help from others when needs arise. Our CSW, in conjunction with the IMPACT clinicians, have been able to empower clients to engage in new activities and activities that they thought were no longer possible for them (i.e., traveling back to their home countries), and have been able to increase independence.

   - Do clients use them regularly and how can we increase utilization?

     Yes, they are using these skills regularly, and our CSW can continue to encourage clients, and provide reminders and support.

4) Do clients develop self-management goals?

   Yes, our Partners in Aging clients have been able to identify and carry out self-management goals with the assistance of our CSW and IMPACT clinicians. For example, clients have been utilizing sleep hygiene tools, are learning to set reminders to eat at regular intervals and also learning the benefits of creating a schedule. In addition, clients have been assisted in setting up myccLink profiles to improve communication with their medical providers through their smartphones.

   - Do clients use them regularly and how can we increase their utilization?

CONTRA COSTA
HEALTH SERVICES

Yes, some clients use these skills regularly, including going for walks. We can encourage them, remind them and provide support.

5) Does the use of peer support workers increase the number of linkages made between clients and community resources?

Yes, prior to the implementation of Partners in Aging, IMPACT clients were not being linked to community resources. Referrals were provided, but it was up to the clients to obtain transportation and follow through on these referrals. Our PIA CSW has greatly expanded the scope of the IMPACT Program, and the ability to provide linkage.

6) Does the 60-day recidivism rate of older adults being readmitted to PES decrease?

Yes, our client that was referred from PES in March 2017 has not returned to PES. She was linked to psychotherapy through an IMPACT clinician and participated from June 2017 to June 2018. A review of the EHR indicates that she continues to receive mental health services through Health Coaching.

7) Does social isolation decrease?

Yes, we have observed that social isolation decreases through the support of Partners in Aging. We began utilizing the PEARLS (Program to Encourage Active and Rewarding LiveS) Questionnaire in approximately August 2017 with Partners in Aging clients. The PEARLS Questionnaire includes the Patient Health Questionnaire-9 (PHQ-9), and also includes questions on general health, social activities, physical activities and pleasant activities. This questionnaire was developed by researchers at the University of Washington to be used in their community-based, evidence-based treatment program designed to reduce depression in physically impaired and socially isolated people. We have requested a report that will demonstrate the differences in scores from the initial PEARLS assessment to the subsequent assessments.

8) Does quality of life increase?

Yes, we have observed increases in quality of life, including clients feeling more able to engage in activities.

9) Do older adults have improved depression scores?

Yes, over the 17/18 fiscal year on average 75.8% of IMPACT clients experienced an improvement in depressive symptoms based on their PHQ-9 scores, and 51.6% of these clients experienced a significant improvement (5 points or more). We are currently in the process of separating out the clients who have received Partners in Aging services to determine if their depression scores show a different pattern than the general trends shown for all IMPACT clients. The PEARLS report referenced above will help to address this question.

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
Mental Health Services Act
1220 Morello Avenue, Suite 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624 E-MAIL:
Windy.Taylor@CCHEALTH.ORG

The indicators that we have used to assess our learning goals include, PHQ-9 scores, chart review to determine numbers of PES visits, Monthly Service Summaries, and qualitative interviews with our staff. The PHQ-9 are administered frequently by the IMPACT clinicians. The PEARLS has been administered with new Partners in Aging clients beginning in August 2017. The plan is to administer the PEARLS every 6 months. The outcomes that we are observing appear to be related to the combined efforts of our CSW, Intern, and IMPACT clinicians. Our CSW has expanded our ability as a program to provide linkage and rehab support, increase the independence of our clients by linking them to resources, and increase their ability to learn and utilize new life skills and self-management tools.

LINKAGE AND FOLLOW-UP: ☐ Not applicable

Please explain how participants are linked to mental health and/or support services, including, how the INN program follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

Participants are linked to mental health and/or support services by the Partners in Aging CSW. In addition, the CSW follows up with consumers by phone, emails the IMPACT clinicians, and remains in contact with the referral resources she is linking the consumer to in order to ensure successful engagement of services. Housing applications and brochures, transportation resources, Senior Center activities, Meals on Wheels information and Contra Costa Continuum of Services are just a few examples of what resources our CSW provides as far as linkage and follow up. The CSW continues to establish relationships with outside agencies that will benefit the older adult population we serve. She has attended various meetings including Meals on Wheels, the Elder Abuse Scam Stoppers Meeting, the Transportation Subcommittee Meeting, and the Social Inclusion Meeting to continue to learn about new resources.

The average length of time between referral and entry to treatment during FY 17/18 is approximately 10 days. During FY 17/18, there was one referral that required 2 months before the client could enter treatment. If this outlier is removed, then the average length of time between referral and entry to treatment is approximately 3 days.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

We have chosen two case vignettes that demonstrate the successful outcomes of the Partners in Aging Innovation Project. One is a 62 year-old Caucasian male diagnosed with Major Depressive Disorder and Bereavement, COPD, and Diabetes. He has been receiving brief, short-term therapy through the IMPACT Program and support services through the Partners in Aging Project. He was evicted from his brother's house in March 2018 after his brother passed away. At that time, he moved in with his mother as her caregiver until she passed away in November 2018. This gentleman was in the process of losing housing yet again because his mother had done a reverse mortgage with the bank and they had served him with an eviction

CONTRA COSTA MENTAL HEALTH
Mental Health Services Act
1220 Morello Avenue, Suite 100
MARTINEZ, CA 94553-4639
PH: (925) 957-2615 FAX: (925) 957-2624 E-MAIL:
Windy.Taylor@CCHEALTH.ORG

notice. Unfortunately, his sister and son were not able to assist due to their own life stressors at the time. Partners in Aging was helpful for this gentleman because our CSW supported him by transporting him to his IMPACT appointments and providing emotional support during the transport. In addition, she was able to recommend and implement the Safeway food delivery service for him, make referrals on his behalf to Monument Crisis Center and Senior Legal Services for assistance with his housing situation, and linked him to medical appointments/emergency room related to complications from his diabetes and advocated for his care. Patient was also linked to Community Connect due to advocacy by the Partners in Aging CSW, IMPACT clinician, and Older Adult Mental Health psychiatrist.

In another case, we have been serving a 77 year-old Caucasian female originally from England with a diagnosis of Major Depressive Disorder. This client married at age 21 to a Pakistani national and they have been together for over 50 years. She and her husband have lived in California for approximately 20 years after raising their 5 children in Pakistan for more than 20 years. Client's daughters are supportive, but she finds she is unable to talk to them about the stressors of taking care of her ailing husband who is on dialysis three times per week, taking care of the couple's finances, and completing the household chores. Our CSW has assisted in linking her to her therapy appointments with the IMPACT clinician and providing client with rehab support. Client has actually referred to our Partners in Aging CSW as her "best friend" due to the emotional support she has received. As a result of the therapy she receives through the IMPACT Program and support services through the Partners in Aging Project, client was able to make the trip back to England in November 2018 to visit her sister and extended family that she had not seen in more than 40 years.

FINAL INNOVATIVE PROJECT REPORTING FORM

FISCAL YEAR: 2017 - 2018

Agency/Program Name:

Contra Costa County Behavioral Health Vocational Services
"Recovery through Employment Readiness"

INNOVATIVE PROGRAM TYPE:

*Please check **all** that apply:* ☐ PEI – *services for individuals at risk of SMI/SED services* ☐ CSS – *for individuals with SMI/SED*

INNOVATION

Please provide a brief summary of the priority issue related to mental illness or to an aspect of the mental health system for which this program/project tests the idea of an innovative concept.

Contra Costa Mental Health (CCMH) completed a Community Program Planning Process which identified services to enable employment readiness as a critical unmet priority need. Data from this process showed that the unemployment rate for adults with serious and persistent mental illness in Contra Costa County is 85 to 90 percent. Research shows that stable employment promotes recovery for individuals with serious mental illness by improving quality of life, constructing identity, fostering pride, providing coping strategies for psychiatric symptoms, enhancing self-worth, increasing self-sufficiency, and increasing income. Employment has also been highlighted as a determinant of health and as an essential milestone in the recovery process of people with serious mental illness. Additionally, mental health treatment plans consistently list meaningful preparation activities leading to employment as necessary to a client's mental health recovery and resiliency.

The role of employment and the meaning of work for individuals experiencing serious mental health problems continue to be complex and multifaceted. Employment provides day to day structure and activity, as well as the financial means for survival. It has impacts on social inclusion, self-esteem, status and identity, which have been viewed as important aspects of employment in the lives of people living with serious mental health problems (Boardman, Grove, Perkins & Shepherd, 2013). Moreover, unemployment and its attendant problems, such as poverty and social exclusion, are contributory factors in the development of poor mental health (Ritsher, Warners, Johnson, & Dohrenwend, 2001, Winefield, Tiggerman, Winefield & Goldney, 1997).

Contra Costa Vocational Services (CCVS) is a program within CCMH that provides services targeted to meet the unmet employment needs of adults with serious and persistent mental illness. CCVS provides job placement and retention services as part of the Mental Health Cooperative Program, where primary funding derives from a cooperative contract with the California Department of Rehabilitation (DOR). CCVS and DOR have combined staff and resources to provide vocational rehabilitation services to persons with psychiatric and substance abuse disabilities. This contract provides vocational rehabilitation services and assists individuals with disabilities to find and retain jobs in the community. The cooperative program targets to serve 160 clients a year and consists of the following specialists to serve eligible clients: Vocational Rehabilitation Counselors, Benefits Counselor, Employment Placement Specialists, Job Coaches and Supportive Education Specialists.

Client and family member stakeholder input has pointed to significant numbers of clients who have not been accepted for this service due to a combination of lack of appropriate work habits, lack of career direction, fear of losing disability benefits, language and computer communication challenges, psychiatric symptom manifestation, and multiple employment barriers, such as criminal justice, transportation, and citizenship issues. These issues become barriers that screen out clients from being accepted as clients of the Mental Health Cooperative Program. This innovative project will enable CCMH to develop a new and unique pattern of employment services by combining a client directed vocational preparation service with the existing "place and train" employment services currently provided by CCVS.

1. Boardman, J., Grove, B., Perkins, R.,& Shepherd, G. (2003). Work and employment for people with psychiatric disabilities. British Journal of Psychiatry, 182, 467-468.
2. Ritsher, J. E. B., Warner, V., Johnson, J. G., & Dohrenwend, B. P. (2001). Inter-generational longitudinal study of social class and depression: a test of social causation and social selection models. British Journal of Psychiatry, 178 (40), 84-90.

PROJECT OVERVIEW

Please provide an overview of the innovative project.

The innovative project, "Recovery Through Employment Readiness," adds pre-vocational preparation services to address barriers that prevent many clients from immediately participating in existing employment or vocational services, which often hold the "place and train" model. Stakeholders' feedback has suggested that there are a significant number of clients who have not been accepted or have not been able to begin employment services due to a combination of lack of appropriate work habits, lack of career direction, fear of losing disability benefits, language barriers, computer challenges, psychiatric symptom manifestation, and multiple employment barriers such as criminal justice, transportation, and citizenship issues.

These barriers have screened out clients from participating in existing employment services. With the implementation of the project and flexible funding, CCVS has been able to assist clients by removing barriers to employment caused by a lack of client resources and/or vocational readiness skills. Access to these additional resources also

shortens the time period between referral and actual receipt or start of services compared to the existing employment service models. Finally, it enables clients to have a starting point to eventually reach an overarching goal for employment, and allows them to pursue a meaningful activity or pre-employment activities, such as volunteer opportunities and various job readiness tasks.

The target population for the project is adults who are established to be seriously mentally ill, meet medical necessity, and are being served by CCMH Adult System of Care. It is planned that 150 clients will be served annually in this new pattern of service.

Pre-vocational preparation services have included providing transportation tickets, interview and work clothing, paid fees to obtain certification, paid fees for educational and training courses, and any other tools and supplies required to maintain a job or enrollment and successful completion of classes. It is important to note that the services provided from the first half are different from the second half of the reporting fiscal year. The services provided were limited in the latter part of the year and depicted as follows:

During the first half of the reporting period, 7/1/2017 – 12/31/2017, pre-vocational preparation services have included assistance with:

- Means of transportation by providing bus passes, gas cards, and BART passes
- Interview clothing
- Work-appropriate clothing, including work shoes, to obtain and maintain temporary, part-time or full time employment
- Certifications or other tools required to obtain and maintain a job, such as a food-handler's card
- Adult educational classes by providing paid fees for enrollment
- Books or other supplies required to maintain enrollment and successful completion of classes

During the latter reporting period 1/1/2018 – 6/30/2018, pre-vocational preparation services have included assistance with:

- Means of transportation by providing bus passes, gas cards, and BART passes

With the assistance of the above requested items, the Vocational Rehabilitation Counselors have also made client referrals to the following entity of services or activities:

- Department of Rehabilitation
- Anka Caltrans work crew and/or workshop
- Eastbay Works
- Education/Training: Community Colleges and Adult Education
- Job search
- Volunteer opportunities

- Employment Preparation
- ID services
- Obtain/maintain temporary, part-time, full-time employment

PROJECT CHANGES

Please explain whether any changes were made to the Innovative Project during the reporting period and the reasons for the changes, if applicable.

Effective January 1, 2018, CCVS discontinued all pre-vocational preparation services with the exception of transportation services (bus passes, gas cards, and BART passes). The findings from previous years indicated that the discontinued pre-vocational services assisted clients with reducing their employment barriers. However in doing so, many clients no longer required referral services from the Department of Rehabilitation (DOR), which decreased CCVS's program outcomes and referrals to this primary funding source. It was decided that CCVS will be able to simultaneously reduce the target population's employment barriers and meet CCVS program goals by solely providing clients with gas cards, BART cards, or bus passes corresponding to the area they are served within West County, Central County, or East County. Having reliable means of transportation enables CCVS's most underserved clients with multiple employment barriers to participate in the client referrals made by the Vocational Rehabilitation Counselors to assist with obtaining meaningful work and/or competitive employment.

Findings indicated that having a means of transportation reduced pre-vocational barriers for clients by making participation in pre-vocational services including job search, volunteer opportunities, employment preparation, ID services, and maintaining enrollment and successful completion of training programs or completion of classes possible for clients. Additionally, having means of transportation enabled clients to more easily participate and succeed in the services offered by referrals to DOR, Anka Caltrans work crew and/or workshop, Eastbay Works, and Education/Training programs.

OUTCOMES AND PROGRAM EVALUATION

- *What is the evaluation methodology?*
- *What are outcomes of the project that focus on what is new or changed compared to established mental health practices?*
- *If applicable, was there any variation in outcomes based on demographics of participants?*
- *List of indicators measured, including how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and includes stakeholder contribution.*
- *Assessment of any activities or elements of the Innovative Project which contributed to successful outcomes.*

Evaluation Methodology and Data Collection

In prior years during the development stage of INN07, CCVS and MHSA staff met multiple times to determine the scope of items and services to be offered through the use of funding, as well as the framework and domains that would be utilized in order to measure and track outcomes. It was determined that "meaningful activities" would be defined as any activity that increased a client's mental health/well-being and increased potential opportunities that would benefit the client's growth. A baseline of items and services have been established to include transportation, work clothing, ID services, adult educational classes, school related materials, and certifications. These items/services were created in CCVS' operating system, Efforts to Outcomes (ETO), to further assist vocational counselors in tracking and measuring outcomes for clients who were not yet ready for competitive employment.

Different statistical information has been collected and because of its complexity, various methods are used to better capture the data. A flex funds touchpoint was created in the CCVS ETO software to specifically capture the date of the referral, the referral source, the type of service provided, the reason of the referral to services and length of time from request to receipt of services. A separate excel master client list is used to track the client's progress, follow through and success stories, and makes it easy to identify clients who have received services more than once. An initial intake is completed in ETO where the client demographics are entered and captured. Both the touchpoint and the initial intake data reports are generated through ETO.

The plan utilizes measures currently in place in order to develop a set of outcomes that can be measured pre and post-intervention. The intervention articulates a set of Vocational Rehabilitation Counselor strategies to assist clients in their efforts to reduce or eliminate employment barriers, and to improve timely request and receipt of services and resources to support implementing these strategies. Tracked outcomes compare mental health treatment plan success indicators before and after the innovation project intervention, such as reduction in psychiatric crises, symptom reduction, and quality of life improvement. In addition, tracked outcomes compare the existing mental health cooperative program before and after the innovation project is added. These outcomes include number of persons served, number obtaining competitive employment or meaningful activity including volunteer work, taking educational classes or continuing onto their vocational rehabilitation plan, as well as the turnaround time from request to receipt of services. The assumption is that the addition of pre-vocational support as part of a mental health treatment plan will result in higher mental health treatment plan success, as well as increasing the number of persons with a serious mental illness obtaining and retaining a job. The community program planning process has consistently emphasized the prioritizing need of engaging significantly more clients in employment preparation activities. Future community program planning processes will gauge the efficacy of these new services from the perspectives of stakeholders.

The populations eligible for CCVS services are:

- Mental Health (MH) clients who receive mental health care from Contra Costa Mental Health
- Mental Health Services Act (MHSA) populations: Transitional Age Youth (TAY) / Adult MHSA
- Individuals who are already in plan with DOR who have a primary or secondary mental health disability (and are in treatment w/other private insurance) who are ready for employment may receive placement services only
- Alcohol and Other Drug (AOD) clients who are in residential treatment in Contra Costa Alcohol and Other Drug Service Facilities

CCMH and AOD staff, through the Vocational Services program, refers prospective DOR clients to CCVS Vocational Rehabilitation Counselors throughout Contra Costa County. When a client is initially referred to CCVS, the Vocational Rehabilitation Counselor completes an intake appointment to assess client's functional limitations, job readiness and eligibility for other services and resources. If the Vocational Rehabilitation Counselor and client find that the client can benefit from resources and services, the client is enrolled. The basic client eligibility requirements, duration of services and process of funds tracking is as follows:

Basic Client Eligibility Requirements and Duration of Services

- Client must be a resident of Contra Costa County.
- Client must not be a parolee or AB109.
- Client is enrolled indefinitely until the client is referred to DOR and has an Individual Plan for Employment (IPE) in place; or client fails to comply with the innovation project agreement, client denies services or other reasons leading to client inactivity.

Flex Funds Tracking

- Client utilization of flex funds begins after the innovation project enrollment process is completed.
- Client utilization of flex funds end once DOR services begin according to the start date on the IPE.

<u>Outcomes</u>

After extensive research, planning and evaluation, the project was rolled out to Central County on November 1, 2015 to address any data tracking, vendor issues and workflow improvements prior to rolling it out to East and West Counties. The project was rolled out to East County on February 1, 2016 and to West County on May 1, 2016. Because CCVS primarily utilizes a "place and train" model, referrals to services were determined as follows:

External Mental Health Referrals

- Putnam
- Anka
- Rubicon

External Support Services Referrals

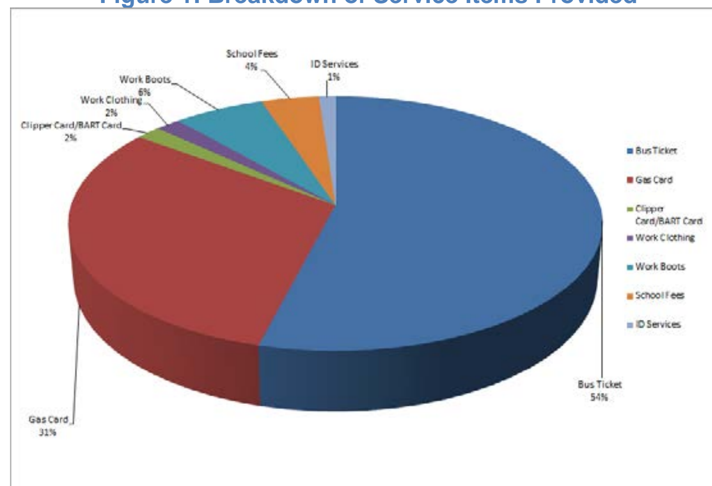
- DOR
- Eastbay Works
- Job Search
- Volunteer
- Employment Prep
- Education/Training
- ID Services
- Obtain/Retain Employment
- Schooling

During Fiscal Year 2017 – 2018, a total of 174 services were provided to 115 unduplicated clients in referred services as indicated on Table 1 and Figure 1 below. Transportation has been the most needed service among the participants with 94 bus tickets and 54 gas cards issued by the Vocational Rehabilitation Counselors. Work boots and school fees were the next needed items of services to be issued.

Table 1: Service Items Provided

Services Provided													
bus ticket	Gas Card	Clipper Card/BART Card	Work Clothing	Work Boots	Food Handling Card	School Books	School Fees	Notary Fees	Birth Certificate	TWIC/ BAT Card	ID Services	Number of Participants Served FY 17-18	Number of Participants served at least once
94	54	3	3	11	0	0	7	0	0	0	2	174	115

Figure 1: Breakdown of Service Items Provided



Criteria used to determine successful outcomes were clients who (1) received services and (2) had been placed in jobs, were in educational/training programs, were in job search, or had been referred to DOR. These measures best met the project's definition of "meaningful activity" - an activity that increased the client's mental health / well-being and increased potential opportunities that would benefit the client's growth. Criteria used to determine unsuccessful outcomes were a client who (1) declined Vocational Counseling services or (2) failed to comply or follow through, resulting in early termination of the program.

Out of the 115 clients who received services, 81 clients (70%) met the criteria for successful outcomes and 34 clients (30%) met the criteria for unsuccessful outcomes.

Client Demographics

The CCVS innovation project collected demographic information from self-reported surveys given to clients at the time of intake. Demographic information collected included age, gender identity, sexual orientation, race, ethnicity, veteran status, and disability status.

Demographic data showed that within the last fiscal year, 81.7% of clients served were adults (26-59 years old), 6.28% were transition age youth (16-25 years old) and 12.55% were older adults (60+ years old).

Clients who participated in this project identified as somewhat ethnically diverse. The majority identified as Caucasian (39.75%), 12.9% identified as African, 10.04% identified as more than one ethnicity, and the remaining 37.31% either declined to state (8.37%), did not answer (6.69%), or identified as one of the remaining ethnicity categories shown in Table 2.

Regarding gender identity and sexual orientation, clients primarily identified as either male (48.54%) or female (49.37%). Only 0.42% of clients identified as transgender (male-to-female), and 1.68% either declined to state or did not answer as shown in Table 4. The majority of clients identified as heterosexual (88.70%), while the remaining 12% of clients identified as bisexual (2.09%), gay (2.09%), lesbian (1.26%), declined to state (3.77%), or not did not answer (2.09%), as shown in Table 5.

Most clients did not identify as having Veteran status (87.45%), and the remaining 12.55% identified as having Veteran status (2.93%), not answering (7.53%) or declining to state (2.09%), as indicated in Table 6.

Additionally, disability demographics for clients were reported through the same self-reported survey. However, the term "disability" was not identified and there were limitations to accurately reporting the data in ETO. Of the data recorded in ETO, the majority of clients (89.06%) did not answer. Just 5.06% of clients identified as having a disability and 5.88% of clients identified as not having a disability, as shown in Table 7.

Table 2: Age Group Demographics

Age Group	Participant Count	Percentage
Adult (26-59)	194	81.17%
Older Adult (60+)	30	12.55%
Transition Age Youth (16-25)	15	6.28%
	Percentage:	100.00%

Table 3: Ethnicity Demographics

Ethnicity	Participant Count	Percentage
African	31	12.97%
Asian Indian/South Asian	1	0.42%
Caucasian	95	39.75%
Central American	2	0.84%
Decline to state	20	8.37%
European	3	1.26%
Filipino	6	2.51%
Hispanic or Latino/Latina	9	3.77%
Japanese	2	0.84%
Mexican/Mexican-American/Chicano	15	6.28%
Middle Eastern	1	0.42%
More than one ethnicity	24	10.04%
Native American	2	0.84%
Not Answered	16	6.69%
Other	8	3.35%
Puerto Rican	3	1.26%
South American	1	0.42%
	Percentage:	100.00%

Table 4: Gender Identity Demographics

Gender Identity	Participant Count	Percentage
Declined To State	2	0.84%
Female	118	49.37%
Male	116	48.54%
Not Answered	2	0.84%
Transgender, male-to-female	1	0.42%
	Percentage:	100.00%

Table 5: Sexual Orientation Demographics

Sexual Orientation	Participant Count	Percentage
Bisexual	5	2.09%
Decline to State	9	3.77%
Gay	5	2.09%
Heterosexual (Straight)	212	88.70%
Lesbian	3	1.26%
Not Answered	5	2.09%
	Percentage:	100.00%

Table 6: Veteran Status Demographics

Veteran Status	Participant Count	Percentage
Declined to State	5	2.09%
Not Answered	18	7.53%
Not a Veteran	209	87.45%
Veteran	7	2.93%
	Percentage:	100.00%

Table 7: Disability Status Demographics

Disability Status	Participant Count	Percentage
Does Not Have Disability	114	5.88%
Has Disability, Not Specified	98	5.06%
Not Answered	1726	89.06%
	Percentage:	100.00%

Limitations in Data Collection

There were limitations in reporting accurate demographic data due to the limited data reporting functionality of our web-based system, ETO. While demographic data was collected primarily through self-reported surveys and then entered into ETO by vocational counselors, pulling that data accurately was a challenge due to the limitations of domain selection allowed by ETO. Additionally, successful and unsuccessful outcomes were primarily collected and analyzed manually through the usage of Excel spreadsheets.

FUNDING

Please explain whether and how the project will be sustained after Innovation funding. Include the source of ongoing funding, if applicable, the reason for the decision, and how stakeholders are involved in the decision-making process.

The Recovery Through Employment Readiness project provided a much needed service to a population that was underserved and in need of specialty services. Throughout the course of the project, many things were learned and identified and upon the evolution of the project, barriers were discovered. This affected the sustainability of the project and provided further insight to whether the project and population could still benefit from these services. Upon further deliberation, it was decided that benefits could still be utilized through CCVS that were originally available through the innovation project. This information has suggested that sustainability for the project is not advised therefore ending the project indefinitely.

LEARNING GOALS

Please explain whether the project achieved its intended outcomes or learning goals and a summary of what was learned.

The primary goal of the project was to increase the number of clients actively working on their vocational rehabilitation as part of their mental health treatment plan. CCVS initially sought to determine whether this new model of services will result in more clients successfully completing their treatment plan while working towards a meaningful activity.

It appears the project has been able to assist clients in moving forward with their vocational rehabilitation plan and has connected clients to services such as DOR, Anka Caltrans or the Anka workshop, educational courses or directly to job placements. As mentioned above, 70% of clients served in the project were considered successful in moving forward with their vocational rehabilitation.

Although findings indicated that the pre-vocational services assisted clients with reducing their employment barriers and assisted in the primary goal of the project, the program goals of the cooperative program contract between CCVS and DOR were not met. With the use of the flex funds, many clients no longer required referral services to DOR, which decreased CCVS' program outcomes and referrals to this primary funding source. With the change of services provided in the middle of the reporting fiscal year, CCVS speculated that they would be able to simultaneously reduce the target population's employment barriers and meet CCVS program goals by solely providing clients with transportation services only. As demonstrated by the data above, CCVS was still able to assist a number of clients move forward in their vocational rehabilitation goals with the change in services.

After reviewing the data and outcomes, CCVS does not believe the project will be able to maintain sustainability. CCVS is funded by DOR and MHSA, each mandating specific goals. Those goals were unfortunately not met due to a number of reasons including staffing issues and time split between counselor roles between the project and the cooperative contract demands. Although the project has been able to assist a small number of clients and increase the number of clients actively working towards a meaningful activity, CCVS must also meet the program goals with the DOR cooperative contract. By reducing project services to transportation only, CCVS was able to meet both the project and the CCVS and DOR cooperative program contract goals while still reducing a large employment barrier experience by multiple clients.

Information Sharing

Please describe how the results of this Innovative Project have been shared with stakeholders, and if applicable, beneficial to other mental health systems or counties.

This report was shared with stakeholder groups throughout the county as well as with county staff. Additionally, this project attended semi-annual meetings with the innovation committee. Finally, the report was shared with the Mental Health Services Oversight and Accountability Commission for dissemination through the State.

Valuable Perspectives

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

CCVS Vocational Rehabilitation Counselors, in differing regions of the county, identified clients' success stories achieved utilizing innovation funds below.

Success Story #1
VJ is a married 41-year old African American woman with a history of depression with psychotic features and a limited work history. She reported that she was taking medications prescribed by her psychiatrist and she had no history of legal problems or drug abuse. She wanted to start working as soon as possible as a security guard and was given bus passes, enabling her to do so.

Success Story #2
Client obtained a job as a temporary security guard shortly after she received the bus pass. Client could not have obtained these temporary jobs without the help from Innovations as she did not have money for transportation to these jobs. Client was referred to the Richmond Department of Rehabilitation. With their help she obtained a guard card and a permanent job as a security guard.

Success Story #3
Client was provided a couple of bus passes to help her get to and from the work program until she was connected to DOR. Client was able to obtain a job at Taco Bell and would like to focus on the job. Client's case was opened to DOR and she received assistance in obtaining other job supports.

Success Story #4
Client is a 39-year old Caucasian widowed mother of two children. Her youngest, almost 2 years old, was born three weeks after her husband overdosed on methamphetamines. She and her husband were in recovery together. Client completed a 90-day residential treatment and after an intake with CCVS expressed interest in working with the Caltrans program at Anka. Through the project, CCVS was able to assist the client with a bus pass to get to Caltrans and boots required to work. Client decided on Caltrans as her vocational goal and was successfully closed.

Success Story #5
JKS a 41-year old Caucasian mother of a little girl was abusing alcohol and living in her car and decided to make a change in her life by getting treatment at the Frederic Oznam Center for 90 days. As she was preparing to leave residential treatment she sought vocational services to get back to her career as a real estate appraiser. JKS used a bus pass funded by the innovation project to attend appointments at CCVS and the project funded her online class for real estate appraisal before it expired. CCVS also assisted client with Homeless Court so that she could clear tickets and drive her car again. Client was able to get back to work with her license in place and move on with her new sober life.