NEW/REVISED PROGRAM DESCRIPTION
Innovation

County: Marin

Program Number/Name: Growing Roots: The Young Adult Collaborative Project

Date: October 28, 2015

Complete this form for each new Innovation Program.

1. Select **one** of the following purposes that most closely corresponds to the Innovation Program's learning goal and that will be a key focus of your evaluation.

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

2. Describe the reasons that your selected primary purpose is a priority for your county for which there is a need to design, develop, pilot, and evaluate approaches not already demonstrated as successful within the mental health system. If your Innovation Program reflects more than one primary purpose in addition to the one you have selected, you may explain how and why each also applies.

In 2004, before the first Mental Health Services Act (MHSA) funds were provided to counties, Marin conducted an extensive community stakeholder process to identify unmet needs and strategies for addressing those needs. Over 1,000 people participated in that planning process, including clients, their families, diverse community members, providers, and other sectors of the community. (For a copy of the original Community Services and Support Plan, visit the following web-link: https://www.marinhhs.org/mhsa). The results of this process developed the underlying framework for ensuing MHSA component plans.

The funding for the five (5) components of the Mental Health Services Act was released at different times after the Act was approved by voters. For each MHSA component, additional community stakeholder processes were conducted to develop the specific component plans. These are posted on the MHSA website at: https://www.marinhhs.org/mhsa. Every year, Marin County develops an MHSA Annual Update that reports the program descriptions and outcomes for the reporting period, and identifies challenges and changes to programs as needed.

Beginning in FY2013-14, the State required that counties develop a MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 period that includes all five (5) MHSA components. Marin County took this opportunity to conduct another in-depth community planning process, including review of the existing programs, updating the needs assessment, and gathering extensive input about what changes and additions should be made to existing MHSA component programs.

The Plan was developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, community-based providers of mental health and alcohol and other drug services, law enforcement agencies, education, social services, veterans, health care organizations, representatives and families of unserved and/or underserved and other important interests. Also included were stakeholders that reflect the diversity of the demographics of Marin, including, but not limited to, geographic location, age, gender and race/ethnicity.

Ongoing Stakeholder Input

Marin County's annual MHSA Community Planning Process includes a wide array of community stakeholders, system partners, consumers and families, and Marin County Health and Human Services (HHS) staff. The County receives input on an ongoing basis from stakeholders through a variety of forums, including through the Mental Health Board, MHSA-focused committees; and provider, consumer and family groups.

Mental Health and Substance Use Services Division (MHSUS) representatives regularly discuss MHSA services and supports with individuals, the Mental Health Board, Alcohol and Other Drug Advisory Board, the Quality Improvement Committee, Probation and other forums. Input received in these settings is brought to MHSUS Senior Management and the MHSA component coordinators for consideration.

MHSA Component Meetings

- The Prevention and Early Intervention (PEI) Committee meets quarterly to discuss PEI Program implementation,

including reviewing annual program evaluation reports. It is comprised of PEI providers of service, community advocates, consumers, Marin Health and Human Services representatives, Mental Health Board members, school representatives, and other community-based organizations.

- The WET Consumer Subcommittee meets on a monthly basis. Its 6-8 members meet at the consumer run drop in center. In addition, family members, family partners and the WET consultant meet monthly as the Family Subcommittee.
- The Innovation Advisory Committee met twice a year to oversee the implementation of the Client Choice and Hospital Prevention program to discuss and document the lessons learned during the implementation and startup of this innovative program.

MHSA Advisory Committee

The MHSA Advisory Committee has been an ongoing body of MHSA stakeholders established to review outcomes of MHSA programs and make recommendations regarding all significant changes/additions to MHSA programs. Appendix I - MHSA Advisory Committee, lists the members and affiliations for the current Advisory Committee.

In February 2012, the Mental Health Director for Marin County retired after decades of service. The Deputy Director for Health and Human Services became the Interim Mental Health Director while recruitment for a new Mental Health Director could be implemented. During this transition, additional members were asked to join the MHSA Advisory Committee to ensure Marin had the appropriate stakeholders involved. Pending the placement of a new Mental Health Director, the membership met only as needed and we saw a drop off in attendance at those meetings.

With the arrival of Marin's new Mental Health and Substance Use Services Director, in the Summer of 2013, Marin reformulated the MHSA committee membership through an application process to ensure compliance with WIC § 5848 and CCR § 3320. Current members were invited to re-apply, and the county did extensive outreach to the residents of Marin in order add new membership representing all communities.

Three-Year Planning Process

- MHSA Planning Committee
  In late 2012, MHSUS created an internal committee to oversee the planning process. This was made up of internal Mental Health and Substance Use Services Division staff, the MHSA Component Coordinators for Prevention and Early Intervention (PEI), Community Services and Supports (CSS), Workforce, Education and Training (WET), Capital Facilities and Technological Needs (CFTN) and Innovation (INN), the Ethnic Services Coordinator, fiscal representatives, and other MHSUS Senior Management. It met monthly throughout the process. Kasey Clarke, the MHSA Coordinator, coordinated the overall MHSA planning process.

- Program Evaluations
  All MHSA programs submit outcome data and narratives annually in the MHSA Annual Updates. Generally this data is used to make adjustments to the existing programs each year. In preparation for the MHSA Three-Year Program and Expenditure Plan, this data was used to assist in determining if there were more significant changes needed, such as changing program capacity or significantly altering the program.

  In addition, Marin engaged Allen, Shea and Associates (ASA) in late 2013 to assist with developing an MHSA logic model as well as component logic models. These were used to take a broader look at each program's role in achieving the overall goals of MHSA.

- Planning Steps
  Allen, Shea and Associates (ASA) also assisted with the community input meeting planning process and facilitation at the community meetings. Because Marin had their HHS Deputy Director acting as the Interim Mental Health Director, it was determined that we would contract with the recently retired Assistant Director of the Napa Health and Human Services Department, James Featherstone, to assist with the facilitation of the MHSA Community Planning Process.

  The MHSA Planning Committee, described earlier in this section, was established to oversee the process for developing the Three-Year Program and Expenditure Plan.

  MHSUS compiled original needs and priorities; evaluations of existing programs; feedback received to date from a wide variety of sources; and initial expected funding levels to develop early thoughts on which MHSA programs should be continued, which should be adjusted, which may not be funded in the future, and potential new programs.

  The proposed community process and early thoughts on MHSA programs were presented to a number of committees

with broad representation, such as the Mental Health Board, MHSA Advisory Committee, Policy Committee, Provider Meetings, and others. The feedback received informed the final shape of the community input process.

- Initial County Proposals

Given that Marin conducts annual MHSA planning processes and gathers input on an ongoing basis, as well as gathers outcome data on all MHSA programs annually, there was already a lot of information gathered about possible changes to be made in FY2014-15. In addition, sometimes the community perception of planning processes such as these is that the County has already decided what the outcome will be, and then conducts the planning process without being transparent.

Marin chose to draft up proposed changes, including which programs to continue, which to terminate, and proposed new programs, to share openly and receive feedback about during each of the community input meetings. These proposals were discussed with the Mental Health Board, the MHSA Advisory Committee, and MHSUS providers before being shared at the community input meetings.

- Community Input Process

There were multiple factors that provided the context for the process:

- While the initial MHSA planning processes were focused on how to apply a new funding source, during this planning process we had to balance the needs and priorities identified in the original planning process, the experience of the existing MHSA programs, and current feedback about services and gaps.
- In 2012, Marin County began integrating two divisions, Mental Health and Alcohol and Other Drugs, into one: Mental Health and Substance Use Services (MHSUS). This supported the focus and need to provide co-occurring competent services.
- MHSA funding interacts with a variety of other funding and policy factors, including the Affordable Care Act, Medi-cal, Grants, and substance abuse treatment funding.
- Clients and families experience services throughout the continuum of care, usually without knowledge of the funding source and related regulations.

Due to these factors, Marin determined that it was essential to get community input on the full spectrum of mental health and substance use services, without requiring them to target their feedback by funding source. MHSUS could then use this input to determine what funding sources could be used to meet the community needs expressed. Information specific to MHSA funding and programs was provided to ensure participants were able to comment more specifically, but feedback was solicited in a broader context in order to not create a barrier to participation.

In all meetings addressing the development of the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, an overview of the planning process was provided, as well as an overview of MHSA including the core purposes:

- Community collaboration
- Cultural Competence
- Client Driven
- Wellness, recovery, and resilience focused
- Integrated service experiences for clients and their families

Documents provided to those attending any of the MHSA Community Input Meetings can be found in Appendix II - Community Meeting Documents. All documents provided at the meetings were available in English, Spanish and Vietnamese. Translators were available on site for Spanish and Vietnamese participants if needed.

<u>Community Conversations</u>

Between July 23, 2013 and September 20, 2013, Marin County hosted six (6) community meetings which were held throughout Marin to gather input from all sectors of the community. Context for the meetings was presented with most of the time spent on getting input from participants in small groups. The meetings were conducted throughout the County and included translation in Spanish and Vietnamese, transportation, refreshments, and child supervision. Invitations were distributed to MHSUS staff, MHSUS contractors, all MHSA related committees, Mental Health Board, Alcohol and Other Drug Advisory Board, MHSA contact list, NAMI, Board of Supervisors. Flyers were displayed at MHSUS services, community services, libraries, stores and other locations throughout the community. Community-based organizations and providers were asked to personally invite clients and other providers. Announcements were included on the county website and in the local Marin Independent Journal newspaper.

In addition, Marin hosted an All Staff MHSUS meeting to provide the same Community Input presentation and gather

feedback from them on existing programs and recommendations for new programs. Two (2) ad hoc meetings in response to specific requests by stakeholders that attended a community meeting were also provided out in the community to gather their feedback and input on new programs. Marin also gathered feedback and recommendations at the September PEI Committee and the MLK Coalition meetings.
An online survey was also available from July 23, 2013 through September 20, 2013. The survey gave individuals who could not or did not want to attend a community meeting in person, or had other recommendations after attending a meeting, to provide their input and recommendations for the MHSA Three-Year Plan.

ASA summarized all the input and MHSUS and the MHSA Advisory Committee analyzed it to inform what changes should be made to existing MHSA programs, what additional MHSA programs are needed, and what needs should be addressed through other programmatic and funding resources. For the complete report on the community input, please see Appendix III - Community Conversation Summary Report.

Three-Year Plan Stakeholder Participation

Overall, 196 community members, consumers, families, and providers attended the community meetings and 76 individuals completed the online survey. A review of this demographic data shows that men, youth (age 0-25), LGBTQ and Veteran individuals did not participate in the community process at the same rate as other groups. In addition to the participants in the six Community Meetings and Online Survey, over 100 people participated in Board and Committee meetings (see Community and Provider Meeting table below). Demographics were not collected for all of the Board and Committee meetings.

Appendix IV shows a summary of the representation and demographic information from the 196 participants at the community meetings and the 76 online surveys, as well as an overview of the Three-Year planning meetings that were held.

On January 22, 2014, the MHSA Advisory Committee met to review program and budget recommendations created by the MHSA component coordinators based on the feedback received through the Community Planning Process. Each component coordinator provided an overview of the programs and services proposed for the MHSA Three-Year Plan, as well as budget recommendations based on projected MHSA funding for the Plan period. The Advisory Committee members provided their feedback both verbally and in writing. Members were asked to fill out a form for each Component to rank their recommendations by “Support,” “Do Not Support,” and “No Opinion.” This important feedback was gathered and used as MHSA component coordinators, the MHSA Planning Committee and the MHSUS Director finalized their draft recommendations to include in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

Innovation Plan Development

The planning process for the MHSA Three Year Plan resulted in a focus on “Reducing Disparities” for the next Innovation Plan. Efforts to reduce disparities can address both increasing access to services for those who are underserved, as well as improving quality of services to reduce disparities in outcomes. During Marin’s 2004 MHSA planning process the adult Latino population was identified as the most un/underserved by existing County mental health services. Asian Pacific Islanders were also categorized as underserved. African Americans are over-represented among County clients, possibly due to lack of appropriate services that might reduce the need for this level of service. Other identified underserved populations included older adults, transition aged youth (16- 25 years old) and persons living in West Marin. Designation of un/underserved populations is based on those Marin residents who are eligible for County mental health services, compared to those receiving county mental health services. See Appendix VI for more information about reducing disparities an cultural competency.

With “Reducing Disparities” as a focus, a specific Innovation planning process was conducted. In October 2014 a meeting was held that included Mental Health Services Oversight and Accountability Commission (MHSOAC) staff. Deborah Lee presented on Innovation to ensure stakeholders understood the purpose and requirements of Innovation. Marin’s Ethnic Services Manager presented on Reducing Disparities. After questions were answered by the presenters, Marin MHSUS staff explained how to submit ideas for Innovation projects in writing. Participants raised a couple of key concerns. (1) What if they submitted an idea, it was accepted, but they did not get the contract for implementing it? That might mean they were giving away projects that they were already implementing, or planning to implement. (2) Many people in the room did not know each other, limiting their ability to collaborate on Innovation or other projects. In response, MHSUS altered the planning process to include a second stakeholder meeting in January 2015 where time was given for participants to meet each other and work in small groups. Participants were asked to provide recommendations regarding priority populations and how to reduce disparities, without providing details about their potential projects. In addition, written submissions for Innovative ideas were gathered over a few weeks. The themes that arose from the meetings and written submissions were then distributed, without including program details. Appendix V is an overview of the

stakeholder representation at the Innovation planning meetings and Appendix VI has the Innovation meeting handouts.

MHSUS staff reviewed all input and quickly saw a central theme: A major contributor to disparities in access to mental health services is that the grassroots organizations that effectively engage un/under-served populations are disconnected from the prevention, early intervention and treatment services provided by County and established Community Based Organizations (CBOs). Grassroots organizations were identified as having an important role in engaging community members who might not access existing behavioral health services due to distrust, lack of knowledge, or other barriers. At the same time, grassroots organizations' may lack the capacity to effectively engage in existing County processes, and County and CBOs may lack the cultural competence and flexibility to effectively work with grassroots organizations. This disconnect results in grassroots organizations engaging and serving un/under-served populations, but limited in their capacity to provide all levels of service these populations need, or to link them to other existing services. Many of the recommendations for addressing this disconnect focused on bringing all parts of the continuum of care together to identify the barriers, develop relationships, create shared goals, share capacities and skills, and evaluate the ability of all parts to work together to reach shared goals.

During the planning process a number of target populations were identified. Given that the transition age youth (TAY) population was frequently specified, as well as the fact that it remains an underserved population in Marin, it was decided that the Innovation program would focus on TAY. Within TAY, an emphasis will be put on those populations that are particularly underserved due to race, ethnicity, language, gender identity, sexual orientation, geographic isolation and other criteria. In addition, the high rate of co-occurring mental health and substance use disorders will be taken into account in the implementation of this plan.

Given the Plan's focus on reducing disparities, it will directly address "Increase access to underserved groups," but the method by which this will be done mandates that "Promote interagency collaboration" be the primary purpose of this Innovation Plan.

Final MHSA Innovation Plan Approval Process

The final approval process for the MHSA Innovation Plan includes:

- The MHSA Innovation Plan will be posted for 30-day Public Comment from Wednesday, October 28, 2015 to Sunday, November 29, 2015 on Marin County's website at: **https://www.marinhhs.org/innovation**.
- For a copy of the MHSA Innovation Plan, please call: 415.473.7465 or email KClarke@marincounty.org
- On Wednesday, October 28, 2015 and Thursday, October 29, 2015 an announcement about the posting was placed in the local newspaper, the Marin Independent Journal, including how to submit comments.
- An email with a link to the website posting was sent to all Mental Health and Substance Use Services (MHSUS) providers, Mental Health Board, Alcohol and Other Drug Advisory Board, MHSUS staff, MHSA Advisory Committee, other MHSA committees, and all individuals and agencies who submitted their contact information during the planning process.
- The Mental Health Board will host the Innovation Plan Public Hearing on Tuesday, December 8, 2015 at 6pm.
- Substantive comments from the 30-day posting and public hearing will be summarized, analyzed and incorporated as appropriate to the final MHSA Innovation Plan.
- The MHSA Innovation Plan was approved by the Marin County Board of Supervisors on (January 2016 date to be determined).

Substantive Comments and Responses:

3. Which MHSA definition of an Innovation Program applies to your new program, i.e. how does the Innovation Program a) introduce a new mental health practice or approach; **or** b) make a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community; **or** c) introduce a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting? How do you expect your Innovation Program to contribute to the development and evaluation of a new or changed practice within the field of mental health?

This Innovation Plan might be best described as (c) Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health context/setting. Marin is not aware of an established model for developing a mental health continuum of care that addresses the barriers we are facing. We are aware that other counties in California are currently using Innovation funds to engage in various approaches for reducing disparities and/or increasing cultural competence that we hope to learn from during this process.

This Plan borrows concepts from a number of sources, most notably:

Collective Impact

While the Innovation Plan may or may not develop an ongoing collaboration that adheres to this model, there are certainly key components that will inform the design of the collaboration:

- Common Agenda
- Shared Measurement Systems
- Mutually Reinforcing Activities
- Continuous Communication
- Backbone Support Organization

California Reducing Disparities Project (CRDP) Strategic Plan

The CRDP Strategic Plan identifies four overarching themes that will be addressed:

- Address and Incorporate Cultural and Linguistic Competence at All Levels: Many resources for increasing participating agencies' competence, from grassroots providers bringing real life experience to Culturally and Linguistically Appropriate Services (CLAS) standards, will be used.
- Implement Capacity Building at All Levels: Participating organizations will be funded at different levels, and provided targeted technical assistance, depending on what their capacity building needs are.
- Improve Data Collection Standards at all Levels: In addition to data collection to evaluate the Innovation Plan, other data needs will be assessed.
- Address the Social and Environmental Determinants of Health: This will be an integral part of the work.

This Innovation Plan is expected to contribute to the development and evaluation of a practice in mental health by documenting and evaluating a process for engaging all parts of the mental health continuum of care for transition age youth (TAY) to address reducing disparities in access to culturally competent behavioral health care in a collaborative and intentional way. At the end of the process we expect to have identified key aspects of the collaborative process that contributed to positive mental health and related outcomes and are, ideally, replicable and applicable to other components of the mental health continuum of care. The process and the evaluation are described in more detail below.

4. Describe the new or changed mental health approach you will develop, pilot, and evaluate. Differentiate the elements that are new or changed from existing practices in the field of mental health already known to be effective.

This Innovation Plan focuses on this core question:

Can we reduce disparities in access to culturally competent behavioral health services for TAY at risk for or with a mental illness by developing an effective system of care that builds on the strengths of grassroots organizations, established Community Based Organizations (CBOs), and County services?

MHSUS will use Innovation funds to bring together grassroots organizations, CBOs, and County services that serve the transition age youth (TAY) population to determine how to develop a system of care that effectively serves members of this un/under-served population with risk or presence of a mental illness. Areas of focus will include:

- ✓ Developing collaborative relationships to provide coordinated care;
- ✓ Increasing grassroots organizations' capacity to effectively participate in the system of care;
- ✓ Increasing culturally-competent practices to best serve the clients.

To begin with, we will build on existing knowledge and strengths:

- In Marin's first Innovation Plan a hypothesis was developed: "When we partner well, the quality of our work and the outcomes for all will improve." The new Innovation Plan starts with this as an assumption, allowing us to now implement and evaluate specific methods of partnering/ collaborating. Some of the people involved in the first Innovation Plan will also participate in this Plan, bringing forward learning from that process. In addition, the findings of that program are currently being analyzed and written up, providing insight on aspects that worked in that process.
- This project recognizes that all partners bring something valuable to the table and all partners have areas for improvement. For example, grassroots organizations are successful in engaging underserved communities and can share their experiences with MHSUS and CBOs in service of increasing their cultural competency. And, MHSUS and established CBOs generally have more capacity for securing funding, evaluation, and other areas grassroots organizations could benefit from.

The "services" provided will include:

A neutral facilitator to:

- Convene the group to determine shared goals and how to reach them
- Coordinate communications among participants, focusing on developing effective relationships

- Coordinate/provide training and technical assistance to participants based on what they need, focusing on increasing capacity to be leaders in reducing mental health disparities

An external evaluator to:

- Assist in determination of the evaluation scope and process
- Compile, analyze and share the data

Funding for participating organizations to:

- Provide appropriate staff to attend collaborative meetings and carry out tasks related to the project
- Build capacities within the organizations that are identified as needing improvement in the course of the project
- Implement evaluation activities related to the Innovation Plan

As noted in answer #3, we will use key elements of Collective Impact to structure the collaborative work.

- Common Agenda: The facilitator will assist the group in developing a common understanding of the problem and a joint approach to solving it.
- Shared Measurement Systems: A plan for evaluating the goals of the Innovation Plan is described below and will be further developed by the participants.
- Mutually Reinforcing Activities: Each participating organization will have a role in reaching the Innovation Plan goals.
- Continuous Communication: Participating organizations will send appropriate representatives to regular meetings. Meetings and ongoing communication will be coordinated by an external, neutral facilitator.
- Backbone Support Organization: The external facilitator and evaluator will work with MHSUS to provide the backbone support.

This project will also explicitly incorporate the CRDP Strategic Plan's four overarching themes.

- Address and Incorporate Cultural and Linguistic Competence at All Levels: Many resources for increasing participating agencies' competence, from grassroots providers bringing real life experience to Culturally and Linguistically Appropriate Services (CLAS) standards, will be used. Training and technical assistance will be provided to each agency based on their identified need.
- Implement Capacity Building at All Levels: Participating organizations will be funded at different levels, and provided targeted technical assistance, depending on what their capacity building needs are. This may include building infrastructure such as program planning, fiscal management, and evaluation to building the leadership, procedures and relationships necessary to better serve underserved populations.
- Improve Data Collection Standards at all Levels: In addition to data collection to evaluate the Innovation Plan, other data needs will be assessed.
- Address the Social and Environmental Determinants of Health: This will be an integral part of the work. Marin County Health and Human Services has a history of working with Public Health Institute (PHI), including trainings and workgroups for County staff and community members to apply these concepts to local efforts, including mental health programs. In addition, participating grassroots organizations are anticipated to be entities that address a wide range of factors affecting mental health, such as income, education, safety and social support.

4a. If applicable, describe the population to be served, including demographic information relevant to the specific Innovation Program such as age, gender identify, race, ethnicity, sexual orientation, and language used to communicate

This Innovation Plan focuses on providers serving the Transition Age Youth (TAY) population, ages 16-25, because it is an underserved group in Marin, is at-risk for first experiences with serious mental illness, and was identified as a priority population during the stakeholder processes for the MHSA Three Year Plan and the Innovation Plan. In particular, it will improve the system of care for TAY with risk or presence of mental illness by weaving grassroots organizations into the system of care. These are organizations that at risk TAY trust and access for a variety of reasons. This increases access to mental health services for TAY with risk or presence of mental illness. It also increases that quality of services for TAY with risk or presence of mental illness by improving the cultural competence of all components of the continuum of care.

4b. If applicable, describe the estimated number of clients expected to be served annually

This Innovation Plan is not providing direct services, but rather focusing on strengthening to continuum of care to engage underserved TAY with risk or presence of mental illness and ensuring they can access culturally competent services at the level they need.

4c. Describe briefly, with specific examples, how the Innovation Program will reflect and be consistent with all relevant (potentially applicable) Mental Health Services Act General Standards set forth in Title 9 California Code of

Regulations, Section 3320. If a General Standard does not apply to your Innovation Program, explain why.

Community Collaboration: This Innovation Plan is the result of an extensive community planning process. It will ensure community based grassroots groups participate in the collaboration by conducting appropriate outreach to potential participants, providing technical assistance for applying, requiring a balance of grassroots and established organizations, and providing necessary funding to participate effectively. In FY2013-14 MHSUS provided workshops for grassroots organizations wanting to apply for County funds. This was an important step in engaging these organizations and lays a foundation for supporting grassroots organizations in participating in this Innovation project.

Cultural Competence: The grassroots organizations will bring their cultural competence to the table, helping to shape the project and define and improve cultural competence for other participants. In addition, resources, such as CLAS standards, will inform how participants implement culturally competent policies and procedures.

Client and Family driven: These are addressed in multiple ways:

- This Innovation Plan is the result of an extensive community planning process that included clients and families.
- Many of the participating organizations include peer and family staff.
- Innovation program updates will be presented at the Cultural Competence Advisory Board (bi-monthly meetings) and MHSA Advisory Committee (monthly meetings), both of which include clients and family members. Input will be solicited on key issues.
- The evaluation process will include input from clients and families (see section 6).

Wellness, Recovery, and Resilience-focused: By developing an effective continuum of care that includes grassroots community organizations, including coordinating care across the continuum, there is an increased ability to keep clients connected to their community and natural supports. Currently, WET, PEI and the Ethnic Services Manager are working with faith communities, community health advocates, and others who are increasing the capacity for communities to integrate all of their members in a meaningful way.

Integrated Service Experiences: By developing an effective continuum of care, including coordinating care across the continuum, clients will experience more integration of services. Currently, MHSUS, PEI and the Ethnic Services Manager are working with primary care providers, basic need providers, community health advocates, and others to ensure that services are coordinated among agencies.

4d. If applicable, describe how you plan to protect and provide continuity for individuals with serious mental illness who are receiving services from the Innovative Project after the end of implementation with Innovation funds

While this Innovation Plan is not providing direct services, we expect participating agencies to increase their capacity to provide culturally competent services that reduce risk and promote recovery from mental illness, effectively engage in the continuum of care, and link clients to needed services.

5. Specify the total timeframe of the Innovation program. Provide a brief explanation of how this timeframe will allow sufficient time for the development, time-limited implementation, evaluation, decision-making, and communication of results and lessons learned. Include a timeline that specifies key milestones for all of the above, including meaningful stakeholder involvement.

Timeline of Key Milestones

Month		
Jan 2016-Mar 2016	Identify Participants	Conduct a competitive Request for Proposals process to determine participating organizations that are serving the target population and prepared to participate meaningfully in the project. Conduct comprehensive outreach to potential participants with the help of the Ethnic Services Manager, the Cultural Competence Advisory Board, and the extensive network of MHSA stakeholders. Provide technical assistance to organizations with less experience applying for government funding. MHSUS will ensure that there is an effective balance of grassroots and established organizations participating.
Jan 2016-Mar 2016	Identify Facilitator and Evaluator	Conduct a competitive Request for Proposals process to determine an external, neutral facilitator and evaluator.
Mar-April 2016	Contracting	Conduct contracting with all participants that ensure that expectations are clear and founded on a collaborative relationship.

May 2016	Begin Collaborative Meetings	Key representatives from participating organizations, including MHSUS, will begin meeting with the facilitator and evaluator for a participatory process of developing a shared agenda, evaluation plans, etc.
Apr-June 2016	Begin Evaluation	Gather baseline data for evaluation, including input from TAY and their families, that will inform the priorities for the collaborative efforts as well outcomes and indicators for assessing the impact of the efforts.
Oct 2016	Timeline and Activities Developed	The collaboration will have developed a timeline for activities, such as trainings, evaluation implementation, and technical assistance needs for each agency.
Oct 2016-June 2018	Implementation	Implement trainings, technical assistance, evaluation, and changes within each organization as needed.
April-June 2018	Transition	Complete evaluation process. Determine next steps for the project. Develop the next Innovation Plan.
June 2018	Reporting	Develop report on the evaluation results and lessons learned. After the report is complete it will be shared with MHSOAC, stakeholders and others.

The timeline for this Innovation Plan is 30 months. This includes identifying participants and establishing positive working relationships, holding a series of collaborative meetings that set the direction of this project, implementing the tasks identified by the group, and evaluating the project. While this is a quick timeline, it is essential to have a fast-moving process that leads to action quickly – otherwise participants and stakeholders begin to lose interest and confidence in the process. Having a facilitator and evaluator who are responsive to participants and who have adequate time to conduct the process and keep it moving between meetings will be essential.

6. Describe how you plan to measure the results, impact, and lessons learned from your Innovation Program. Specify your intended outcomes, including at least one outcome relevant to the selected primary purpose, and explain how you will measure those outcomes, including specific indicators for each intended outcome. Explain the methods you will use to assess the elements that contributed to outcomes. Explain how the evaluation will assess the effectiveness of the element(s) of the Innovative Project that are new or changed compared to relevant existing mental health practices. Describe how stakeholders' perspectives will be included in the evaluation and in communicating results. Explain how your evaluation will be culturally competent.

There are a variety of outcomes and indicators that could help evaluate whether this Plan is successful. Below are listed outcomes and indicators that can be tracked and analyzed within the timeline of the project. In addition, MHSUS tracks the demographics of County clients, but changes in those numbers are both a longer term indicator and can be impacted by many other efforts, as well as MHSA programs, and therefore is not listed as part of this evaluation. If we can determine whether this project is successful, and identify the elements that made it successful, then what was learned in this process can be applied to other parts of the mental health system of care.

Purpose: Promote interagency collaboration

Core question:

Can we reduce disparities in access to culturally competent behavioral health services for TAY at risk for or with a mental illness by developing an effective system of care that builds on the strengths of grassroots organizations, established Community Based Organizations (CBOs), and County services?

Outcome 1: Increase the integration of grassroots organizations in the mental health continuum of care for TAY at risk or experiencing mental illness.

Indicators:

- Collaboration participants' perceptions regarding the quality of the collaborative, communication, and how it has affected the continuum of care for TAY at risk for or with a mental illness.

The evaluator will work with the collaborative to develop a survey tool to be conducted early in the process and every six months after that, to be completed by individuals directly involved in the collaborative. The survey will be based on existing collaborative measurement tools, what was learned in the process of evaluating Marin's first Innovation Plan, and participant input. In addition, interviews or focus groups will be conducted at the conclusion of the Plan. Existing collaborative measurement tools include First 5 Marin's "Collaborative Assessment Survey" measuring perceptions of shared vision, commitment, leadership, accountability, trust, and decision making; U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and the University of Southern Florida's "Interagency Collaboration Activities Scale" (IACAS) measuring collaborative activities.

- Objective measures, such as:
  - Number of Marin County Mental Health and Substance Use Services (MHSUS) contract that are awarded to grassroots organizations
  - Number of participating grassroots organizations that have implemented policies and processes, such as evaluation processes, that would increase their competitiveness for funding.
  - Level of knowledge about services and access to services provided by other participants in the continuum of care. Both among all participants and between types of participants (grassroots, CBOs, MHSUS).
  - Level of knowledge among grassroots organizations regarding mental health and mental illness, such as language in common use by mental health professionals.
  - Level of knowledge among CBOs and MHSUS regarding culturally competent approaches to engaging TAY in mental health services, such as language and strategies in use by grassroots organizations.
  - Additional measures will be identified by the participants.

- MHSA Innovation Coordinators', facilitator's, and evaluator's perceptions regarding the quality of the collaborative, communication, and how it has affected the continuum of care for TAY at risk for or with a mental illness.
  The MHSA Innovation Coordinator and the facilitator will participate in appropriate components of the surveys, and also maintain a journal to assist in analyzing the results of surveys and other tools.

Outcome 2: Implement procedures that improve access to care for underserved TAY at risk for or with a mental illness.

Indicators:

- Adoption of engagement strategies identified by clients, families, and best practices by grassroots organizations.
- Participating organizations' perceptions regarding improvement in access to care for underserved TAY at risk for or with a mental illness, including cultural competency of services.

The evaluator will work with the collaborative to develop a survey tool to be conducted early in the process and every six months after that, to be completed by staff of participating organizations.

  - Cultural Competency: Questions based on CLAS standards will be included. The US Department of Health and Human Services "CLAS A-Z: A Practical Guide for Implementing the National Standards for Culturally and Linguistically Appropriate Services (CLA) in Health Care" and the Arizona Health Disparities Center's "Implementing CLAS Standards and Improving Cultural Competency and Language Access – A Practical Toolkit" both have checklists and self-assessments appropriate for assessing organizations' status in regards to CLAS standards.
  - Referrals: Assess referral processes; whether referrals are successful, mainly referrals to mental health services or referrals from mental health providers to grassroots services; whether clients are engaged in mental health services more successfully; and whether clients are able to smoothly access all appropriate care. Interviews or focus groups will be conducted to discuss changes in referral processes and initial impacts. Participants will regularly be asked to submit anecdotes of improved service connections for mental health clients and the MHSA Innovation Coordinator will maintain these records.

- Client and family perceptions of ability to access to needed mental health care for underserved TAY at risk for or with a mental illness, including cultural competency of services.

The evaluator will work with the collaborative to determine the best process for gathering client and family input. It may include focus groups or interviews at the beginning of the project to inform priorities for the collaborative efforts as well as outcomes and indicators for assessing the success of the efforts. Client and family input would also be gathered at the conclusion of the process. Questions would address: identification of culturally competent engagement strategies; ability to access appropriate mental health services in a timely manner; cultural competency of mental health services; and appropriate aspects of satisfaction with mental health services.

- Objective measures, such as:
  - Number of clients participating grassroots organizations engaged.
  - Number of client referrals between (a) participating grassroots organizations and (b) CBOs and MHSUS.
  - Number of successful referrals between (a) participating grassroots organizations and (b) CBOs and MHSUS.
  - Frequency of case collaborations between (a) participating grassroots organizations and (b) CBOs and MHSUS.

Outcome 3: Identify the key elements that have led to success.

Indicators:

- Participant perceptions regarding what elements of the work led to success.

The evaluator will work with the collaborative to develop a survey tool to be conducted at the conclusion of the project, to be completed by individuals directly involved in the collaborative. In addition interviews or focus groups will be conducted.

Elements may include relationships, resource allocation, facilitated conversations, changes in procedures, trainings, technical assistance, and the common evaluation infrastructure.

- MHSA Innovation Coordinators' and facilitator's perceptions regarding what elements have led to success.

The MHSA Innovation Coordinator and the facilitator will participate in appropriate components of the surveys, and also maintain a journal to assist in analyzing the results of surveys and other tools.

The evaluation process and results will be shared with the MHSA Advisory Committee on a regular basis. Input will be solicited to assist with analyzing the results, as well as ensuring that the results are communicated clearly. Results will be written up for a final report to the MHSOAC, local stakeholders, California Reducing Disparities Project and other interested counties. Marin will work with other counties conducting Innovation programs with overlapping goals to share and expand upon our learnings.

7. Describe how the County will decide whether and how to continue the Innovative Project, or elements of the Project, without Innovation Funds. Specify how stakeholders will contribute to this decision.

There are multiple venues for determining the future of Innovation projects:

- MHSA Advisory Committee: This group will be kept informed about the project on a regular basis and engaged in a discussion about future plans at key decision-making points.
- MHSA Three Year Planning process: This planning process will begin in early Spring 2016. An update on the Innovation project will be shared with stakeholders and included in the input solicited. Exact nature of the feedback will depend on how Three Year Plan timeline aligns with the Innovation Plan timeline.
- Innovation Planning Process: After the Three Year Planning process an Innovation specific stakeholder planning process will be conducted that takes in to account the Three Year Plan input.

There will be a number of items considered by these stakeholder groups:

- Does the current Innovation Plan need to be extended to answer the questions posed
- If the project was successful, (a) will we continue the existing project, either at the current level or a less intensive level, and (b) how will that be funded
- If the project was successful, (a) will we apply the lessons learned to another component of the mental health system of care, and (b) how will that be funded

MHSUS will consider the total input received, recommend funding allocations based on the priorities expressed by stakeholders, and work with the MHSA Advisory Committee to make allocation decisions.

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

While this Plan leverages many resources, two specific ones important to note are:

- Providers who currently are contracted with MHSUS to serve TAY will be engaged in this process. Appropriate providers will have their contracts amended to support participation.
- The Ethnic Services Manager's engagement with grassroots organizations, the Cultural Competency Advisory Board, and the community will support this project.

9. Provide an estimated annual and total budget for this Innovation Program, utilizing the following line items. Please include information for each fiscal year or partial fiscal year for the Innovation Program.

2015/2016 ANNUAL UPDATE **EXHIBIT X**

NEW/REVISED PROGRAM DESCRIPTION
Innovation

		NEW ANNUAL PROGRAM BUDGET					
		A. EXPENDITURES					
	Type of Expenditure	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY**	**FY**	**Total**
1.	Personnel expenditures, including salaries, wages, and benefits						
2.	Operating expenditures						
3.	Non-recurring expenditures, such as cost of equipping new employees with technology necessary to perform MHSA duties to conduct the Innovation Program		$5,000				Database software for participating organizations to collect and manage program and evaluation data.
4.	Contracts						
	Coordinator	$7,200 6 mos	$14,300 12 mos	$14,300 12 mos			$55/hr x 5 hr/wk . Coordinate between MHSUS and Facilitator and Evaluator.
	Facilitator	$12,480 3 mos	$49,920 12 mos	$49,920 12 mos			$120/hr x 8 hr/wk. Oversee the project, coordinate/facilitate meetings, provide capacity building TA to participating organizations.
	Evaluator	$9,750 3 mos	$39,000 12 mos	$39,000 12 mos			$150/hr x 5 hr/wk. Conduct collaborative evaluation design and implementation. Provide evaluation training and TA to participating organizations.
	Participating Grassroots organizations	$125,000 3 mos	$500,000 12 mos	$500,000 12 mos			10 orgs x $50,000/yr
	Participating CBOs	$9,000 3 mos	$36,000 12 mos	$36,000 12 mos			12 orgs x $3,000/yr
6.	Other expenditures projected to be incurred on items not listed above and provide a justification for the expenditures in the budget narrative						
	Subtotal	**$163,430**	**$644,220**	**$639,220**			**$1,446,870 Total Direct**
7.	Indirect Costs (15% of subtotal)	**$24,515**	**$96,633**	**$95,883**			**$ 217,031 Indirect**
	Total Proposed Expenditures	**$187,945**	**$740,853**	**$735,103**			**$1,663,901 Total**
B. REVENUES							
1.	MHSA Innovation Funds						
2.	Medi-Cal Federal Financial Participation						
3.	1991 Realignment						

NEW/REVISED PROGRAM DESCRIPTION
Innovation

4.	Behavioral Health Subaccount						
5.	Any other funding (specify)						
	Total Revenues						
C. TOTAL FUNDING REQUESTED (total amount of MHSA Innovation funds you are requesting that MHSOAC approve)							

D. Budget Narrative

1. Include a brief narrative to explain how the estimated total budget is consistent with the requirements in Section 3920. The narrative should explain costs allocated for evaluation, if this information is not explicit in the budget

3. Non-recurring expenditures: The INN project will require collection of and reporting on a prescribed set of data. Participating organizations without the capacity to collect and report on the required data will be provided assistance to establish appropriate databases.

4. Contracts
   - Coordinator: A contractor will oversee the implementation of the INN Plan including RFP processes, monitoring scopes of work, and coordinating communication between contractors and MHSUS.
   - Facilitator: A neutral facilitator is required to convene the participants, coordinate communication among participants and ensure all voices are heard in the process. In addition the facilitator will provide/coordinate training and technical assistance to participants as needed.
   - Evaluator: An external evaluator is required to assist with determining the scope of and process for evaluation, as well as compile and analyze the data, in order to determine whether the project is meeting its goals.
   - Participating Organizations: Grassroots organizations will receive funding to enable them to build their infrastructure to more fully participate in the system of care, as well as staff time to participate in the Innovation project. Established CBOs will receive funding to assist them in participating in the Innovation project as needed.

7. Indirect costs at 15% of contract costs for each fiscal year.