Innovation Annual Report FY 18-19

Contra Costa Behavioral Health Services

Mental Health Services Act

CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

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Innovation Introduction

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 2018-19:

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. The Center for Recovery and Empowerment project began implementation in FY 2018-19.

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) 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 Cognitive Behavioral Social Skills Training project began implementation in FY 2018-19.

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.

5) 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.

The allocations for these projects are summarized below:

Project	County/Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 18-19
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
Center for Recovery and Empowerment	County Operated	West	80	600,000
Cognitive Behavioral Social Skills Training	County Operated	Countywide	240	200,000
Administrative Support	County	Countywide	Innovation Support	463,227
			Total 655	***$2,159,833***

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 18-19

Projects Implemented			2,159,833
		Total	***$2,159,83***

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 populations for the current fiscal year. Data not included in this report can be found within the innovation annual reports submitted in this document.

Total Served FY 18/19 = 193

Table 1. Age Group

	# Served	
Child (0-15)	0	
Transition Age Youth (16-25)	0	
Adult (26-59)	3	
Older Adult (60+)	8	
Decline to State	0	

Table 2. Primary Language

	# Served	
English	8	
Spanish	0	
Other	0	
Decline to State	0	

Table 3. Race

	# Served	
More than one Race	1	
American Indian/Alaska Native	0	

Asian	0	
Black or African American	0	
White or Caucasian	6	
Hispanic or Latino/A	3	
Native Hawaiian or Other Pacific Islander	0	
Other	1	
Decline to State	0	

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

	# Served	
African	0	
Asian Indian/South Asian	0	
Cambodian	0	
Chinese	0	
Eastern European	0	
European	5	
Filipino	0	
Japanese	0	
Korean	0	
Middle Eastern	0	
Vietnamese	0	
More than one Ethnicity	0	
Decline to State	1	
Other	0	

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

	# Served	
Caribbean	0	
Central American	0	
Mexican/Mexican American /Chicano	5	
Puerto Rican	0	
South American	0	
Other	0	

Table 6. Sexual Orientation		
	# Served	
Heterosexual or Strait	11	
Gay or Lesbian	0	
Bisexual	0	
Queer	0	
Questioning or Unsure of Sexual Orientation	0	
Another Sexual Orientation	0	
Decline to State	0	

Table 7. Gender Assigned Sex at Birth		
	# Served	
Male	4	
Female	8	
Decline to State	0	

Table 8. Current Gender Identity		
	# Served	
Man	4	
Woman	8	
Transgender	0	
Genderqueer	0	
Questioning or Unsure of Gender Identity	0	
Another Gender Identity	0	
Decline to State	0	

Table 9. Active Military Status

	# Served
Yes	0
No	9
Decline to State	0

Table 10. Veteran Status

	# Served
Yes	0
No	9
Decline to State	0

Table 11. Disability Status

	# Served
Yes	8
No	3
Decline to State	0

Table 12. Description of Disability Status

	# Served
Difficulty Seeing	0
Difficulty Hearing or Having Speech Understood	0
Physical/Mobility	8
Chronic Health Condition	0
Other	0

Table 13. Cognitive Disability

	# Served
Yes	0
No	0

Program Profiles

Program: Center for Recovery and Empowerment (CORE)

The Center for Recovery and Empowerment (CORE) program is an intensive outpatient treatment program that contains three levels of care: intensive, transitional, and continuing care. Because recovery is not linear, teens will be able to move between these levels of care depending on their need. These levels of care involve the following criteria: Intensive Care (6 weeks): During the Intensive Care phase of treatment, teens attend the program four days a week and family members attend twice weekly. An individual treatment plan and attendance contract with the teen is developed, teens are drug tested weekly to encourage honesty and accountability, and through involvement in the 12-step principles of recovery and educational presentations, teens are introduced to the recovery process. Teens also attend weekly individual and group sessions facilitated by therapists and counselors. Teens are linked with Young People's 12-step in the community to begin building connections with a sober peer group that will continue to be a support for ongoing recovery. Phone contact is maintained between CORE staff and client on offsite days.

a. **Target Population:** Adolescents between the ages of 13-19 with substance abuse disorders and co-occurring emotional disturbance will be the targeted group.
b. **Total MHSA Funding for FY 2018/19:** $600,000
c. **MHSA-funded Staff:** 5.0 Full-time 1.0 Part-time equivalents
d. **Total Number served**: For FY 18/19: 28 individuals
e. **Outcomes**: Evaluation of the program included pre- and post-enrollment of T-ASI indicators. Other proposed indicators include utilization rate of involuntary psychiatric emergency admissions and/or acute psychiatric admissions. Child and Adolescent Level of Care Utilization System (CALOCUS).

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.

f. **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 recovery); 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.
g. **Total MHSA Funding for FY 2018/19:** $474,089
h. **MHSA-funded Staff:** 5.0 Full-time equivalents
i. **Total Number served**: For FY 18/19: 46 individuals
j. **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: Cognitive Behavioral Social Skills Training in Augmented Board and Cares (CBSST)

The CBSST project will involve having a team designed of one Mental Health Clinical Specialist (MHCS) and one Community Support Worker (CSW) whose primary responsibility will be to lead CBSST groups at B& Cs that house CCC consumers. CBSST is a combination of cognitive behavioral therapy (CBT) social skills training (SST) and problem-solving therapy (PST). This differs from traditional CBT because it not only includes the general concepts of CBT, which focus on the relationships between thoughts, but works with improving communication skills through SST and basic problem-solving skills through (PST). This intervention will be new to the public mental health system and currently has only been implemented in private hospitals or universities.

a. **Target Population:** Adults aged 18 years and older who are currently living in Board and Care Homes and are receiving services at a County-operated Adult clinic; Diagnosed with a serious mental illness.
b. **Total MHSA Funding for FY 2018/19:** $200,000
c. **MHSA-funded Staff:** 2.0 Full-time equivalents
d. **Total Number served**: For FY 18/19: 27
e. **Outcomes**: Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder (GAD-7) will be given to all group participants. Additional measuring tools would include the Recovery Assessment Scale (RAS) and the Independent Living Skills Survey (ILSS). Clinic and agency case managers will be asked to fill out the Level of Care Utilization System (LOCUS). 5150s will be tracked for pre/post data and length of hospital stay pre/post data

Program: Overcoming Transportation Barriers

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 2018/19:** $241,450

d. **MHSA Funded Staff:** 2 full-time equivalent staff positions

e. **Number Served:** For FY 18/19: 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.

Program: Partners in Aging

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 Alcohol and Other Drugs services. Peer support, rehab, and in-home and in-community coaching will allow the skills learned through psychotherapy to be practiced in the community. Partners in Aging also to provided SBIRT (Screening, Brief Intervention and Referral to Treatment) services and referrals to IMPACT consumers who screen positive for alcohol or drug misuse.

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 provided outreach to staff at Psychiatric Emergency Services and Miller Wellness Center. They were 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 also provide brief AOD screening and referrals, as well as conducting intakes, assessments, and providing 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 for the IMPACT Program is adults age 55 years and older who are insured by Medi-Cal, Medi-Cal and MediCare, or are uninsured. The program focused on treating older adults with moderate to severe 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. **Total MHSA Funding for FY 2018/19:** $181,067
d. **MHSA Funded Staff:** 2 full-time equivalent staff positions
e. **Number served:** For FY 18/19: 32
f. **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.

Innovation Project Annual and Final Reports

INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 18/19

Agency/Project Name: **Center for Recovery and Empowerment**

INNOVATIVE PROJECT 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 Center for Recovery and Empowerment (CORE) Project is an intensive outpatient treatment project located in West Contra Costa County offering three levels of care: intensive, transitional and continuing care to adolescents dually diagnosed with substance use and mental health disorders. CORE follows the disease model of addiction describing addiction as a disease associated with biological and neurological sources of origin. CORE provides a multitude of all-day services to youth that include individual therapy, family therapy, group therapy, nursing, including medication management and toxicology screening, social skills training, high school education support, adventure therapy, connection to community recovery services, transportation, and healthy meal and nutrition education.

CORE's admission process consists of first receiving a referral. Referrals come from psychiatrists, social workers, schools or school nurses, probation, Kaiser, John Muir Behavioral Health Center, community-based organizations or they are self-referrals. When a referral is received the Program Supervisor or other dedicated staff member will discuss client's background over the phone. Client and/or family member will be asked to come in for an assessment to meet with all staff located at the project. To be accepted into the project staff is looking for the client to meet an appropriate mental health diagnosis, SUD level of need and willingness/ability of either client OR family to participate in program.

If client meets admission guidelines they will be enrolled into the program and begin onsite treatment. Day program schedule is as follows:

1) Transportation provided by van pick-up
2) Check-in with teacher for Golden Gate School Program
3) Complete Daily Goals Worksheet

4) School
5) Lunch and social skills integration
6) Individual therapy – clients are pulled from milieu twice a week, or as needed throughout the day.
7) Group therapy: Moral Reconation Therapy - 1xweek, recovery assignments are done in group 5xweek
8) Tox screen and individual consultation with nurse to discuss results 1xweek
9) Adventure Therapy- ecotherapy, mindfulness and recreational activities for youth after lunch
10) Family therapy – Family therapy is conducted 1xweek per client in the late afternoon or evening
11) Community recovery meetings – Clients are transported to and from YPAA meetings 2xweek. They attend with Recovery Coach and process meeting afterwards with Recovery Coach and individual sponsors in YPAA
12) Sober social events – Clients attend social sober events, weekly, in order to develop and establish a sober peer group. These events are sponsored by YPAA and linkage is provided by Recovery Coach. They include events such as sober dances, parties, bowling, dinners, camping, etc.

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?

During the development phase of the project a few challenges were discovered. Innovation projects by design are new and different patterns of service. During the implementation process the project encountered barriers. One of these barriers included finding a location for the project outside of inner-city communities and in an area where youth could be removed from settings where they could be easily triggered to use. This made it difficult because the location needed to be close to the client's home and allow for easy access to transportation to and from the program and provides "Safe and Sober" environment critical to an intensive recovery program. The location was eventually identified and secured for a building that had access to trails and parks nearby to allow for Adventure Therapy.

Another obstacle that the project faced was during the hiring process. Many positions didn't meet current County classifications and it was decided to contract out. This ultimately delayed hiring and the opening of the Center. This also influenced decisions on future positions and how to move forward on the process of hiring. The project decided to change some of the staffing pattern to avoid further delay in hiring and promote quicker implementation of opening of the Center.

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.

Upon implementation the staffing pattern changed to meet County policy and requirements. The first change consisted of the Psychiatrist and a Registered Nursing position. These positions proved to be very hard to hire and fill. Neither position required enough hours to justify a part time position and with so few hours required recruitment proved to be difficult. After this evaluation it was proposed to replace this with a Psychiatric Nurse Practitioner (PNP). The PNP was eventually hired and supervised by a Psychiatrist over at the West County Children's Clinic. This position is responsible for providing oversite to clients who need vitals taken, meds reviewed or drug tests. An additional position that was converted was the Recovery Coach. This position was changed to a Community Support Worker because of similar job duties specified under the County classification.

Another staffing change during the onset of the project was a position that was contracted out. This position was for a Substance Abuse Counselor. The position was CADAC certified and held a License of a Professional Clinical Counselor. Eventually, the staff member vacated the position and it was converted to a Mental Health Clinical Specialist. The new person who was hired was working towards her CADAC certification and would meet the guidelines specified in the workplan within the coming year. Finally, it was determined that the project needed additional support with administrative functions. This pushed for the project to hire an experienced-level clerk to support this role which included billing set up and chart organization.

Originally, the project outline consisted of three levels in which the clients would be in each level for 12-week periods. As the project enrolled youth, it was determined that this duration was to be six weeks instead. This would allow for movement into the next phase to be quicker. It would also push for the mentorship portion of the project to be rolled out to increase flow between levels.

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 learning goals of the project are to learn if treating adolescents with substance related and co-occurring mental health conditions in an ASAM compliant intensive outpatient program will 1) result in abstinence or reduced use of substance; 2) reduce symptoms of mental illness; 3) reduce/prevent need for/or return to inpatient mental health/substance dependence treatment; 4) increase academic success.

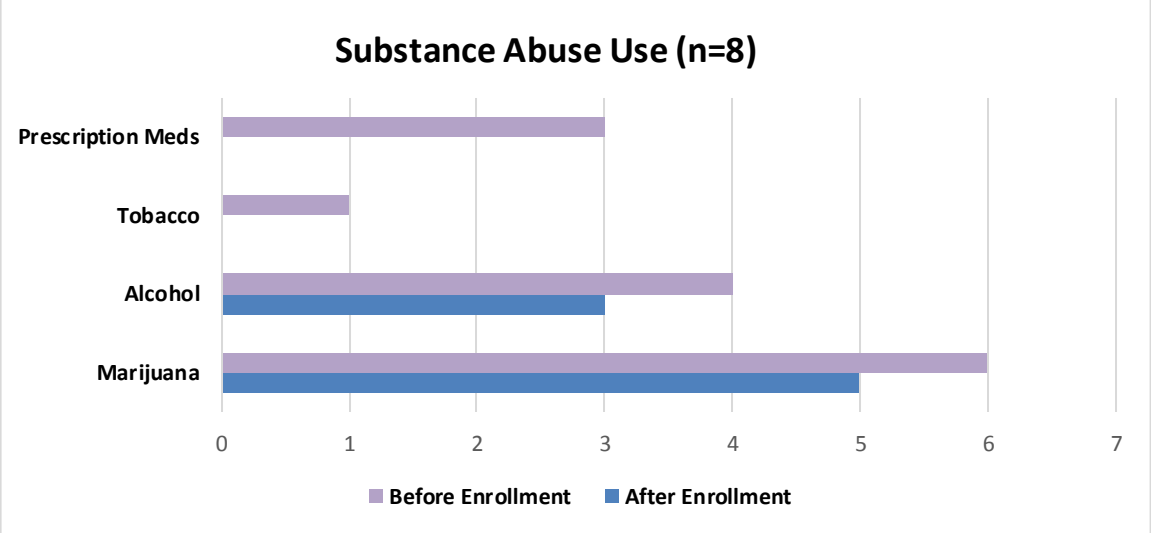
This project used the Teen Addiction Severity Index (T-ASI) to measure many of its outcome goals before enrollment and after discharge. The T-ASI can be defined as a semi-structured interview tool that was developed to fill the need for a reliable, valid, and standardized instrument for a periodic evaluation of adolescent substance abuse. The T-ASI uses a multidimensional approach of assessment as an age-appropriate modification of the Addiction Severity Index. It yields 70 ratings in seven

domains: chemical (substance) use, school status, employment/support status, family relations, peer/social relationships, legal status, and psychiatric status. [i]

The project reported that the average age of drug usage started as early as 12.5. Clients show being in SUD treatment type services 5 times before enrollment with a rate of 63 days total.

The project was able to capture some of the primary goals and respond by the following indicators:

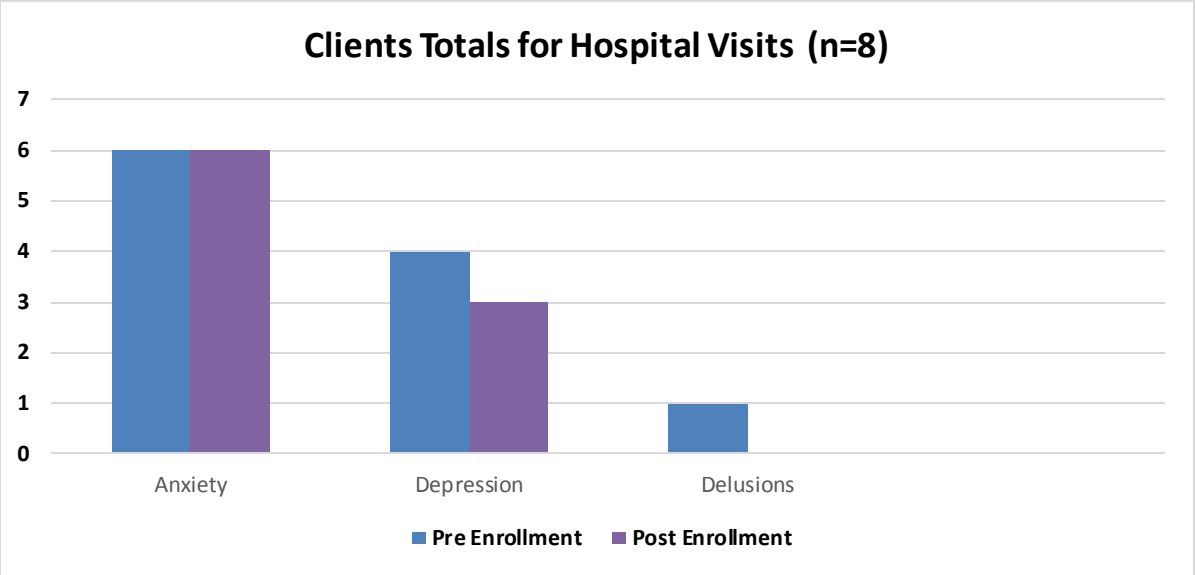
- Reported Drug Usage Impact (pre and post via the Teen Severity Addiction Severity T-ASI Index) Only eight clients completed pre and post data. Both prescription meds and tobacco use show no use after enrollment.



- Reported Mental Health Impact (pre and post via the Teen Severity Addiction Severity T-ASI Index)

This included treatment for any psychological or emotional problems in the hospital for inpatient/outpatient patients. Total visits decreased from 22 to 18 after enrollment.

Table below indicates three clients admitted for anxiety for both pre- and post-enrollment, four pre-enrollment and three post-enrollment for depression, and one pre-enrollment with no post enrollment client for delusions. Admissions decreased overall.



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.

CORE provides an extensive intake process when client arrives into the center. Upon intake if the program cannot fit the needs of the client then they will be referred out. Besides residential SUD, CORE refers youth and parents/providers on behalf of youth to the following services:

- WCCAS (West County Child & Adolescent Services) mental health
- WCCAS outpatient SUD
- PES
- Seneca Mobile Response Team
- Kaiser CDRC
- John Muir Behavioral Health
- EBYPAA
- Young People NA
- REACH
- Hanna Boys Center (residential but not primarily SUD)
- Rebekah House (residential but not primarily SUD)
- RYSE
- MISSEY (for CSEC youth)

- Golden Gate Schools/County Office of Ed Alternative Education
- Contra Costa County CFS
- First Hope
- James Morehouse Project
- MH Access Line
- West County Health Center
- Richmond Works Program
- West County High Schools Health Centers
- Monument Crisis Center
- Familias Unidas
- Latina Center

If a client is enrolled in the program and needs additional services specifically in phase two then the client could get referrals to activities such as sports, art, dance, summer jobs and other similar programs. There is no lapse in referral time therefore this is not a measured outcome.

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

Youth within the CORE project were asked how the program has changed their life. This was organized through them providing accounts of how they were affected physically, socially, emotionally and academically. Then they were asked how they would feel without the CORE project being available. Responses were given per the following:

Case Vignette 1: 15-year-old LatinX female, who came to the program just days after returning from the streets, where she had been trafficked. History of runaway and a lot of sexual trauma.

Client Statement:

"When I first came to the program, I was very sick and couldn't stop using. I was using marijuana, vape pens, and popping pills. I was losing a lot of weight and my face was full of acne. All I would do is smoke until I passed out. I lost friends that cared for me because they saw how bad I was doing. Emotionally I experienced a lot of depression and anger issues. My school attendance was really bad, and I would not even show up to classes most of the time. CORE has helped me eat better and stay sober. I am starting to socialize more with people and find good friends. I now communicate better with my family and have raised my grades while achieving more credits for high school. Without CORE I would be lost or even dead. I might even be homeless. I thank CORE for helping me find my higher power.

Case Vignette 2: Male who is 16yrs old. When he came to CORE, he had a severe eating disorder and was hanging out with gang members who were pushing him, daily, to quit program ("Don't be a p***y, no one respects you doing that" etc. He started using at age 12.

Client Statement

"When I first came into the program, I was oppositional about almost everything. I wasn't open at all to take suggestions from anyone. I was using marijuana, alcohol and pills. Physically I was skinny and unhealthy and at times looked like a zombie. Most of the time I would be with a group of friends and we would use drugs together. I quit the baseball team because of drugs. I could be calm because I was high, but if something was to make me mad, I would completely blow it out of proportion. Academically my attendance was horrible because I would be at the park smoking or drinking. CORE helped me recover physically by helping me maintain my sobriety by checking in with me and taking me out to do activities. I built relationships and bonds with other people who had the same goal to stay sober and who were on the right path. CORE has helped me emotionally by helping me find ways to control myself. I also have gotten my credits for school back up to where they are supposed to be and turned all of my F's into A's."

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i. Kaminer, Y., Wagner, E., Plumer, B. & Seifer, R. (1993). Validation of the teen addiction severity index (T-ASI): Preliminary findings. *American Journal on Addictions, 2(3)*, 250-254.

CONTRA COSTA HEALTH SERVICES

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FINAL INNOVATIVE PROJECT REPORTING FORM

FISCAL YEAR: 2018/19

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

INNOVATIVE PROJECT TYPE:

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

This innovation project was instituted based on a widely recognized disassociation between physical and behavioral health treatment being provided concurrently. The approach was to integrate health care by linking the treatment of physical and mental health to improve the quality of services which lead to better health and mental health outcomes. The innovation project was set in place to test if using Peer Wellness Coaches will improve number of clients that participate in health education and/or wellness activities, improve health outcomes, and enhance recovery and resiliency.

Before the onset of the project it was regarded that mental health clients face physical health problems and engage in risky health behaviors more frequently then the general population. People with severe mental illness (SMI) who receive services from the public mental health systems die, on average, at least 25 years earlier than the general population. Prevalence of diabetes, ischemic heart disease, cerebrovascular disease, arthritis and heart failure is three-times higher among SMI Medi-Cal population compared to general Medi-Cal population. It was decided based on this collective information that it was imperative to utilize peer providers, as a potential solution to overcoming the barriers states above.

This innovation intervention offers a potential solution to determine if using peer providers trained in wellness recovery and self-management promotes positive health outcomes, including mental health recovery and resiliency. It was the idea to determine if a patient at risk received support for both physical health and mental health would this improve the patient's overall health and ability to lead a functional and successful life within the community.

PROJECT OVERVIEW:
Please provide an overview of the innovative project.

CONTRA COSTA HEALTH SERVICES

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The Coaching to Wellness project provides an additional level of support for adult mental health consumers who are in need of health care management. Support is provided by a Wellness Team that consists of a Nurse, Mental Health Clinical Specialist and a Community Support Worker. With components from intensive peer support coupled with leveraging existing resources in the County, the Coaching to Wellness project provides a holistic team approach to providing care to consumers. The goals of the project are: 1) Improve client 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.

The Coaching to Wellness project began enrolling clients in December 2015. Clients were originally enrolled that had comorbid mental health and primary care need. As the project expanded so did the criteria for accessing this service and it was eventually opened to all clients in need of healthcare management. In general services provided included:

- 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
- 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, smoking sensation, health coaching, mindful movement, exercising, linking family members to family support, housing, etc.
- Individual nurse, clinician and peer support in the home, field, and office to work on goal setting, attainment, Injections, medi-sets, whole health education development of self-management skills, and addressing barriers to wellness such as isolation and financial limitations.
- Clinic groups that include a diabetes group, food is medicine and pain managements
- 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.

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.

Over the course of the entire innovation project period many features changed to adapt to the specific needs of the clients. The team faced many challenges and made changes as needed. During the last fiscal year, the project made some final changes to see if these changes would allow for the project to learn some additional aspects making the services viable and sustainable.

- The Project Recommendation Form that was once only required to be filled out by a Psychiatrist was made available for other potential providers within the clinic to complete.

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This would allow for more overall referral to be reached by the team.

- Community Access Tickets Service (CATS) is a service provided that allows for a group to access cultural, recreational and education experiences. The project was able to gain access to these tickets and offer the Coaching to Wellness clients the opportunity to experience positive socialization and community integration opportunities. Clients were recently able to attend baseball games and other theater type events. The event lead to positive outcomes and a greater positive response to the project.
- Post surveys were edited to allow for intimate project feedback. Form was separated out to become its own and be mailed in as a separate document. The team decided this would give clients the necessary privacy that would allow for more return on suggestions.
- The project decided to revisit their outreach efforts within the County. This consisted of presenting the project again to the Primary Care Clinics, Shelters, Detention, and other possible sites that would be able to utilize the service.

OUTCOMES AND PROJECT EVALUATION:
Please provide quantitative and qualitative data regarding your services.

- *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 project evaluation reflects cultural competency and includes stakeholder contribution.*
- *Assessment of any activities or elements of the Innovative Project which contributed to successful outcomes.*

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)

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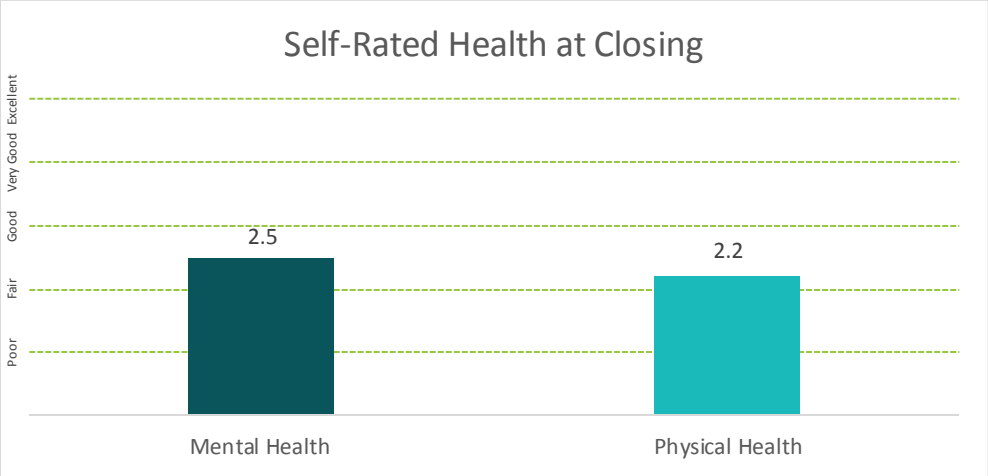
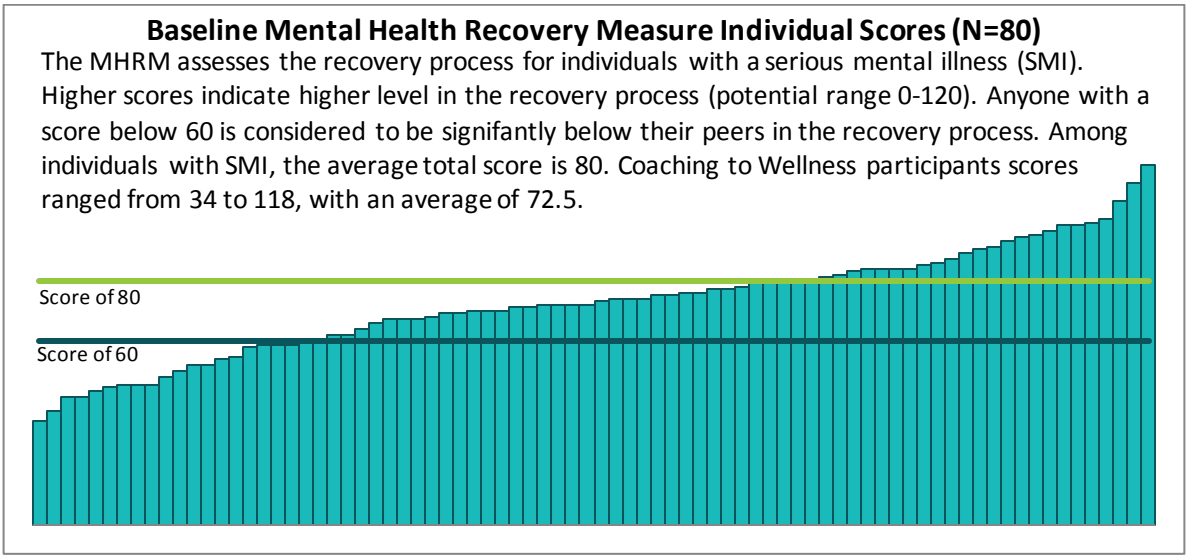
At each individual session, the Wellness Coach and Nurse interviews consumers to ask "In general, would you say your health (5) excellent, (4) very good, (3) good, (2) fair, or (1) poor." This item is used in the National Health Interview Survey and in a number of studies self-rated health has been found to be an excellent predictor of future health.[i] In addition, a similar question is asked regarding mental health, similar to other studies.[ii] 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".

- 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.

- 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.

- Quality of Life (pre and post via the Mental Health Recovery Measure)
  At baseline, participants scored an average of 8.7 points on the Advocacy/Quality of Life domain of the MHRM, with scores ranging from 0 to 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 can share that with others and help them progress along their own path.

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 8 participants with measurements, all but one (87.5%) were overweight (BMI $\geq$ 25) or obese (BMI $\geq$ 30).
     - Blood Pressure: Out of 11 participants, 7 (63.6%) have pre-hypertension and hypertension.
     - Pulse: Of 15 participants, 0 have a high pulse rate. The average pulse is 81.5 beats per minute.
     - Cholesterol: Of 5 participants, 0 have borderline high or high total cholesterol; 60.0% have borderline or very high LDL cholesterol; 100.0% have low HDL cholesterol; and 20.0% have mildly high or high triglycerides.
     - HgA1C: Of 5 participants, 60.0 % of scores indicate diabetes.

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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 project has ended as of August 2019. Overall this project had many challenges throughout the innovation funding period. Initially, the project had a very difficult time hiring a full team and this challenge continued throughout the entire innovation period. While staff were hired many positions still couldn't be filled or staff retention continued as a challenge. The project eventually changed the team's design but by that time the project was already in its third year of funding. Another challenge became when a service that replicated the project in many ways called Community Connect begin its implementation. This created overlap and seemed to support the patients for similar reasons.

Also, what demonstrated to be an additional struggle was the referral and intake process. Many clients didn't meet the criteria and as the innovation period developed it was decided to allow more clients to be able to access the service. Unfortunately, by this time the project was already gearing towards the end of the funding period and the change didn't seem to make a huge improvement. It was decided after the multiple staff left the project it was best to shut the project down. This project will not be sustained.

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

The learning goals established for the project are as follows:

Process-based learning goals:

- Do consumers develop mental health wellness recovery action plans (WRAP)?
  - Do consumers use them regularly and how can we increase their utilization?
- Do consumers develop self-management goals?
  - Do consumers use them regularly and how can we increase their utilization?
- What elements of Facing up to Health are effective?
- What elements of Facing up to Health are not effective?
- Does the use of Peer Wellness Coaches increase the number of referrals made between consumers and community resources?
- By changing the project's criteria does this increase the number of client's utilizing the project.

Outcomes-based learning goals:

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- Does interacting with Peer Wellness Coaches improve primary and mental care providers understanding of the consumer culture and recovery principles?

    - Do consumers achieve their wellness goals through this intervention?
    - Do consumers permanently change their health-related behaviors through this intervention?
    - Do consumers achieve their recovery goals through this intervention?
    - Do consumer's Self-Rated Health and Mental Health scores change through this intervention?
    - Do consumers have improved health outcomes?
    - Is this approach replicable in other integration settings?
    - If the project establishes a limited timeframe for utilization of services will this increase the overall number of clients served?

Summary:

Overall, consumer outcomes showed improvement, but low caseload counts stayed steady. In the last fiscal year of the project, new referrals became very challenging. Numbers lowered and aggregate outcome information became limited. Learning goals could not be entirely achieved because of low intake counts. According to reports, approximately 55 clients received outreach in FY18-19. 31 clients received more than 3 services from CTW clinicians/nurses/coaches. Three contact attempts were made to engage 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.

During the innovation funding period all innovation projects are scheduled to discuss updates to the Innovation Committee semi-annually. This committee is apprised of County Staff, stakeholders and members of the community in order to provide feedback, comments or suggestions on any current issues, questions or other applicable information that the project may need to consider. The final report for the project was shared at the innovation committee and discussion around what was learned was reported. Finally, this report will be shared with the Mental Health Services Oversight and Accountability Commission for dissemination through the State by its scheduled submission date.

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VALUABLE PERSPECTIVES:

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

The project was able to collect valuable perspectives from two clients who enrolled during the last fiscal year. Both clients felt that the project had a very positive influence on their life and contributed to many positive outcomes making it easier for them to lead successful lives.

Case #1 - A 63-year-old woman who lives alone in the East Region of Contra Costa County, was diagnosed with heart failure, fatty liver, type 2 diabetes, anxiety, depression with psychotic features, agoraphobia, cognitive disorder, and a panic disorder. Client was isolated at her home with only the once weekly support from her nephew who did not know how or what was going on with her care. With the support of the Coaching to Wellness team and having them meet with the client weekly to help with medication management and teaching she was able to get stable mentally and physically. Additionally, the client also attended the social outings with the wellness coach to learn and use social skills. She now is involved with the choir at the senior living where she resides.

Case #2 – A female woman who lives in the West Region of Contra Costa County, was an avid drinker with mobility issues and a hole in her colon. She stated that she was observing clients using the "Facing up to Health" group part of the Coaching to Wellness project. She noticed a few clients enrolled in the project graduating and many of these clients showed positive changes. This made her decide that she wanted to explore the project further. She said it was the best project she could have enrolled in. She learned how to take better care of herself by making her appointments, seeing a substance abuse counselor and just listening to the overall training given in the class. Since attending the class, she has made substantial improvements. She has been clean and sober for 16 months; she attends college classes to hope to provide peer support and uses the many tools she was given to improve her mental and physical care

[1] 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.

[1] 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

[1] Bullock, W. A. (2009). *The Mental Health Recovery Measure (MHRM): Updated normative data and psychometric properties*. Toledo, OH: University of Toledo, Department of Psychology.

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INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 18/19

Agency/Program Name: Contra Costa Behavioral Health/Cognitive Behavioral Social Skills Training in Augmented Board and Cares

INNOVATIVE PROJECT TYPE:

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

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

Cognitive Behavioral Social Skills Training (CBSST) in Augmented Board and Cares can be described as a new emerging practice that consists of a combination of cognitive behavioral therapy (CBT) social skills training (SST) and problem solving therapy (PST) in the County's Board and Care Homes (B&Cs). The project involves a team designed of one Mental Health Clinical Specialist (MHCS) and one Community Support Worker (CSW) whose primary responsibility will be to lead CBSST groups at B&Cs that house CCC consumers.

The project begin implementation in late August 2018 and hired it's first MHCS. The clinician began acclimation of different countywide B&Cs while shadowing the Housing Specialist and other CBSST groups already established within the Mental Health Clinics. In early September, the clinician was pulled away for 11 weeks of Jury Duty, which added to the lengthy process of implementation. Upon return the clinician was able to provide groups but only as a one-person team. Starting early in January, the clinician identified what B&Cs would be a good fit to start and begin groups. After clear assessment of numerous B&Cs the MHCS found approximately five in different regions of the County that would be appropriate.

The CSW was not brought on till May 2019. This was due to original hire falling through and other lengthy hiring processes that were unable to be prevented. The CSW began shadowing the clinician and helping assist with groups already established. This position is now fully implemented within the project and providing peer counseling in a group setting to clients who live in B&Cs.

The CBSST project is designed to enhance the quality of life for those residing in enhanced B&Cs by incorporating meaningful activity and skills into their daily routines and increasing overall functional improvement. As of this fiscal year, the project has provided the following services:

- Served six small (6-bed) ARFs (adult residential facilities)

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- Served 1 large (70-bed) RCFE (residential center for the elderly)
- Provided CBSST individual and group rehabilitation services to 27 individuals
- Support to board and care operators (psychoeducation, partnering on goals utilizing CBSST framework and skills, consultation re: concerns/consumer needs)
- Collateral with Board and Care Operators

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 project didn't start implementation until August 2018, and even after the initial start it took until January to start seeing clients. This delay resulted in not having a full reporting period in which to learn if the initial set up of the project is operational. During the current fiscal year, the project staff discovered that partnership with the board and care operators/caregivers was an important component. Building trust was gradual and spending time with them separate from the time with the consumers helped with this and allowed room for growth.

Relationships and rapport building with consumer takes time and during engagement after at least four months trust became more evident and secured. Consistence and regularity during engagement was extremely important. Having the two-person team increased ability to be consistent and groups become regular with high client attendance.

Board and cares where the majority of residents are "plugged in" to activities during the day are not always good candidates for onsite CBSST groups. At least three residents are recommended and provided a level of engagement that felt necessary for group modality. Two homes where this was not the case, did not end up being good fits for the project. At one B&C the group was discontinued due to only one resident being present and able to participate. This client was also not a County consumer.

At another B&C continued CBSST was provided individually to one engaged client. This would sometimes be joined by a second client but on a less regular scale. Transitioning such a client to CBSST work with a case manager more quickly when this occurs is definitely something that should be addressed.

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.

The project has experienced some initial changes as it has approached the second module leading up to the end of the fiscal year.

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Initially CBSST was only performed in groups but soon after the MHCS discovered that it could be beneficial to run individual therapy with the clients. The project also decided to decrease the time for groups from 150 min to 70 min. This seemed to be a better fit for the population and helped with keeping the group engaged and present.

OUTCOMES AND PROJECT 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) Will the modality of CBSST have an effect on the consumer's mental stability and growth?
2) Will the intervention lead to a higher overall functionality and quality of life?
3) Will the intervention reduce 5150 involuntary holds within the Crisis Services Unit?
4) Will a consumer have fewer evictions or avoid evictions completely?

In the first stages of this project we explored the use of four surveys to measure impact on participants' symptoms, self-perception and functioning. These include:

- **PHQ-9 (Patient Health Questionnaire)** assessment monitoring presence/severity of depressive symptoms (self-report, self-administer)
- **GAD-7 (Generalized Anxiety Disorder)** assessment monitoring presence/severity of anxiety symptoms (self-report, self-administer)
- **RAS (Recovery Assessment Scale)** assessment measuring aspects of recovery w/ focus on hope and self-determination (self-report)
- **ILSS (Independent Living Skills Survey)** assessment obtaining individual's view of his/her own community adjustment (self-report structured interview)

We adopted the PHQ-9 and GAD-7 to align with the tools utilized within the regional specialty mental health clinics to track symptoms for all clients. Similarly, the use of the ILSS aligns with those clinics' use of this tool to assess functional impairment primarily for individuals with schizophrenia/related diagnoses. Using the RAS aligns with our goal of increasing recovery orientation for project participants. In line with the recovery model this assessment looks beyond "what's wrong" to participants' view of their own capabilities, hopes and sense of self.

We attempted to have participants complete all assessments prior to beginning the program, as well as after completing the program (all 3 modules). We also implemented the PHQ-9/GAD-7/RAS after

completion of the first and second modules. Some participants declined to complete especially at the beginning of our relationship. In many cases, participants did not take each survey at least two times in this reporting period in order to get scores for comparison. Thus, data from this reporting period is not robust.

Strength of these tools: surveys create an opportunity and platform that has a consistent structure, for more in-depth conversation about participants' well-being. The PHQ-9/GAD-7 in particular seemed most helpful as a way to flag any uptick in symptoms. The RAS provides insight into cognitions/beliefs that may be "unhelpful thoughts" that CBSST participants can work on challenging, while also insight into participants' own view of strengths to tap into. The ILSS identifies issues to tackle and because it is an interview format, can allow for space to discuss where participants hope to make changes/build independent skills. These discussions can relate directly to the goal setting work of CBSST

Lessons learned: these surveys especially PHQ-9/GAD-7 may feel intrusive and are better completed when not linked to group sessions. The responses are less likely to be genuine until trust is gained. Completing with an individual 1:1 and reviewing each question out loud, supports comprehension of the questions, increases completion rate and hopefully validity of responses, and also fosters the aforementioned conversations. For the ILSS, the questions provided are at times outdated and do not capture as wide a range of independent living skills as we observe in participants (e.g., education-related activities). These lessons led to development during 2019-2020 of questions to ask as an addendum to the ILSS, as well as plans for proposing a revision of the ILSS to be tested/validated.

Data samples included in this reporting period were minimal due to the small timeline from the inception of the program until end of the fiscal year. Not included in the sample was Concord Hill Home and Monona Care Home.

Table 1. Percentage Change in Average PHQ 9 Scores, January 1, 2019 through June 30, 2020 shows the change in average PHQ 9 scores.

Table 1: Percent Change in Average PHQ 9 Scores, January 1, 2019 through June 30,2019

Fiscal Year	Average Score of First Survey of the Year	Range	Average Score of Second Survey of the Year	Range	Average Score of Third Survey of the Year	Range	Percentage Change from enrollment
2018/2019 (n=10)	20	(0 to 20)	19	(0 to 18)	11	(0 to 18)	-45%
Board and Care Homes that were not calculated in the totals were missing surveys due to modules not completed.							
PHQ 9 Score Key: 1-4 Minimal depression, 5-9 Mild depression, 10-14 Moderate depression, 15-19 Moderately severe depression, 20-27 Severe depression							

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LINKAGE AND FOLLOW-UP: ☐ Not applicable
Please explain how participants are linked to mental health and/or support services, including, how the INN Project 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.

All clients that participate in the CBSST group sessions are clients that are connected to the mental health clinics within the County. Many have psychiatrists and/or case managers and have regularly scheduled visits. If a client is not participating in services and needs to be linked the CBSST provider will proceed with joining the client with necessary services toward improving treatment outcomes. This can include the CBSST provider reaching out to clients' assigned clinic and collaborating to engage client with different types of service connections.

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

SC case vignette: the significance of onsite support

SC is a 27 y.o. (at time of admission) Caucasian female who was a resident of Afu's One Voice, 6-bed female board and care facility in Bay Point. She had moved to Afu's in October 2018, shortly before the CBSST program started engaging with the facility. For sixteen months prior, SC lived at Crestwood "The Pathway" enhanced board and care facility in Pleasant Hill, following multiple psychiatric hospitalizations during a time she lived independently. Since SC was 21, she has had multiple stays at both short and longer term residential psychiatric facilities. Afu's One Voice was the first augmented board and care home placement for her, with the idea that more support at this level of care could better help her stabilize vs. being sent again to an enhanced board and care. SC held the goal from the time of arriving at Afu's One Voice, to return to independent living.

During the engagement/assessment period, SC reported quite severe depression symptoms on the PHQ-9 including thoughts of wanting to die. This writer had a further risk assessment interview and intervention with SC to establish ways she could keep herself safe and manage her symptoms. SC was quite fearful that she would be placed on a 5150 hold, be hospitalized and sent back to a higher level of care and that in this happening, she would lose the opportunity to work toward independent living. Based on the risk assessment this did not occur. Having writer present at the home each week provided additional clinical support to help SC maintain at this level of care. Additionally, writer was able to share observations/concerns with SC's case manager, for a richer clinical picture. The case manager had attempted to get therapy approved for SC as part of the step-down plan, but this had not occurred; with writer's advocacy for more support, therapy was approved.

Writer's own alliance with SC felt strong following this event. SC became a motivated, engaged

participant in CBSST group and set a goal of employment, which she felt would help her be more independent and ready to live on her own again. SC did get a job through vocational services, at which point she was a much less frequent participant in CBSST group based on timing. However, she participated intermittently and continued to demonstrate engagement and apparent pride in her ability to set and work toward her goals.

SC is one of the first program participants to step down from the augmented board and care level of placement following CBSST program engagement. The CBSST team was involved in Dec 2019-Jan 2020 in advocating for SC's readiness to accept an MHSA unit when it came available. SC successfully moved to this unit in March 2020 and as of June 2020 continued to be stable with no PES/crisis encounters.

Johnson Care Home: Developing a Recovery Oriented Milieu

Johnson Care Home exemplifies a small board and care that while providing supportive placement for consumers, did not necessarily emphasize the potential for residents to stabilize, develop independent living skills and the capacity to move on to lower levels of care. When our program began working with Johnson Care Home, there was a core group of residents who had lived there for many years; three of the six had been there for over ten years. They were generally psychiatrically stable with no recent psychiatric hospitalizations, and encounters with specialty mental health were mostly limited to medication management. These gentlemen coexisted well, forming a family-like community. As a group however they spent most of their time isolated at home, watching tv or smoking in the yard. The caregivers wanted to establish an expectation for engagement in activities, but struggled to do this in part based on the longstanding culture in the home. Residents identified goals that would require more engagement with the outside world—finishing an associate's degree, returning to employment, stepping down to independent living—but the biggest barrier first and foremost was that they spent their days inside.

We felt the milieu culture would need to change in order to support engagement in any activities outside the home whether the push came from caregiver expectation or from the residents' personal goals. As we developed relationships and the structure for group, we kept this goal of culture change in mind. Having weekly meetings where residents came together began this shift; even just being in community vs. being in their separate spaces other than meals, was a change. CBSST encouraged them to speak openly about goals, modeling for each other that having hope for change is possible. Practicing skills of learning something new reinforced that things *do* change when we act. The social skills module helped participants practicing positive communication and get comfortable looking to others for support. Some residents turned to each other reflecting on the strength of their long-term relationships—noting this as the first time they talked about this.

We also worked with the owner/operator, supporting her efforts to encourage residents to engage in the program at Recovery Innovations-Antioch (RI). Our group became a baseline activity to help remind residents that they could enjoy/benefit from groups or activities. We also linked what they were working on in CBSST, with how they used the program at RI. Five of the six residents at Johnson Care Home in summer 2019 went to RI at least once, with three continuing consistently.

The group also began focusing more on other activities they could do outside of the home. Participants began to take steps on goals that they had held for a long time. One gentleman with high anxiety around leaving the home, got his driver's license renewed and began repairs on his car—both things he had wanted to do for years. These were short term goals on the way to returning to school and finishing his AA. As a group we planned and held on a picnic at a local regional park. For several individuals this meant overcoming significant anxiety about things like being in unknown cars or in unfamiliar places. This picnic was the culmination of the third module on problem solving. We saw it instill hope in the participants that they could engage in the world in a different way. Generally, the home felt more oriented toward hope and the capacity to achieve goals after completing the three modules of CBSST.

EM case vignette: challenging unhelpful thoughts

EM is a 70 y.o. (at time of admission) Caucasian female living at Family Courtyard, a large residential center for the elderly. At time of assessment in Feb 2019 she identified multiple creative talents; EM is a wonderful and prolific painter usually of natural landscapes which she sometimes does from memory of times spent with her mother in bay area hills. In goal setting for CBSST, EM was clear that she would like to sell her artwork—which came across more as the desire to be recognized as an artist, and having an identity expanding beyond the bounds of Family Courtyard. Another goal that evolved during the course of group was to live together with her boyfriend (another resident) in the Marin headlands.

EM also identified writing as a talent, one that she has used throughout her adult life to manage her mood and stay well. This practice is one that she struggled to maintain as consistently as the painting—and she described writing as more of a chosen tool/coping skill that requires effort to remember and utilize; it can fall by the wayside when she is feeling low.
During the first several months of group EM frequently shared about experiencing depressive symptoms. This was wrapped up with having physical ailments, aches and pains; and resulting thoughts about her age, perceived limitations, and living in a facility that places further limitations upon her.

The cognitive skills module of CBSST reinforced how our thoughts/mood/actions are all related, and EM adopted this as a frame of understanding her depressed mood as related to such thoughts.
However, she continued to struggle with really having alternative ways to frame her experience or potential. Her gorgeous landscape paintings cover the walls of the activity room where we do group, but sitting at those tables she could not think her way out of her current living situation.
Taking *action*, that third part of the cognitive triangle, had a big impact for EM. We planned an outing to a regional park with views of the bay, for a picnic. This was a huge endeavor for participants who are physically frail (three of the five utilize walkers) and very limited mobility. EM herself had trouble with significant knee pain that day making for an uncomfortable van ride. However, she filmed the scenery out the window the whole ride into the park to our picnic site; she was ecstatic to get the fresh air and time away from the daily routine. This trip was significant for EM. She wrote an essay following the excursion and stood up in group to read aloud, which she did with confidence. EM gave us permission to share her essay which is also included here.

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This experience seemed pivotal to EM. We saw a shift in her focus to be more on making things happen, whether it was taking steps to address issues with social security or supporting her boyfriend as his "manager" while he pursued his own goal of performing publicly as a singer again. With this shift her mood and sense of self-efficacy was also very much improved.

INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 2018/19

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

INNOVATIVE PROJECT 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 Barrier (OTB) innovation project began implementation in September 2016 and begin providing services by April 2017. This 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 are to try to find solutions that the clients face when reaching limitations when trying to use types of transportation. 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, links to resources, referrals, and fare information. Application assistance is provided 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 (CNS) 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.

The OTB team presented to the Central Adult and Children's Clinics to provide a project overview and continue outreach within treatment provided services. The presentation offers education about what the project entails and how clinical staff can utilize the project's services to ensure appointment adherence. The project plans on presenting to other regions of the County next fiscal year.

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.

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 OTB project continues to experience a low volume of calls throughout the year despite numerous outreach efforts. Staff believe this is due to the project not providing direct means of transportation and only putting an emphasis on transportation independence. Although, callers seem appreciative of the additional service provided it doesn't seem to be completely filling the gap for low income households or communities in which public transportation is either vacant or hard to reach. The team finds that there are many other concerns with riding public transportation that callers are still facing, and the hope is that providing more one-on-one peer support might fulfill that need. The team is working towards providing this support for the upcoming fiscal year.

Travel training was initiated during the last fiscal year but provided little to no attendance. The project staff began discussions around hosting a new workshop that would include a training with the possibility of a bike donation. After further deliberation it was decided to postpone training until additional assistance could be provided for clients to attend the training. Staff will address a training for the next fiscal year.

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.

The OTB project continues to tackle challenges due to staffing changes. During the end of the last fiscal year the team was impacted by having one CNS leave the project. This put a lot of the project on hold forcing the current CNS to only concentrate on specific immediate needs. It was noted that the hiring process takes a considerable amount of time for these positions. The new CNS started the next fiscal year and began training to cover the East end of the County. The project is working on hiring an additional CSW next fiscal year. This will ensure all regions of the county are covered.

The OTB project started collaborations with another community-based organization to provide flex funding. This funding would cover a one-time cost specific to transportation needs and help provide support to clients who need to get to their appointments. Flexible funds are client specific and are only intended to cover the client lack of funding and/or when there is no traditional payment mechanism available. Flexible funds are for time-limited services or supports; they are not intended to pay for ongoing expenditures. The flex funding will be implemented fully within the behavioral health clinics within the next couple of months. Processes are still being organized and the project is hoping to start by December 2019.

Wallet cards were constructed after feedback that came directly from the transportation sub-committee. Wallet cards are meant to be a tangible item that clients could use when they are

experiencing high stress situations or need a quick relatable reference point. Suggestions on the cards were specific to coping strategies such as: meditation, deep breathing, riding with friends, prayer, listening to music, journaling, reading, and practicing a hobby. Cards were passed out to every clinic and included with bus vouchers upon request.

OUTCOMES AND PROJECT 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

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 for the project provided outcomes showing the type of support provided by the OTB team and where the referrals originated. The support varied and provided resources, referrals and other types of educational training around different transportation avenues.

Transportation remains to be an ongoing barrier for clients. Table. 1., below defines results from surveys that were administered in November 2018 that detailed modes of transportation for missed appointments, bus/Bart/paratransit, friends/family, drive self, clinic staff, walk, bike, ride services, and

taxi. Also, the table is a breakdown of transportation modes that respondents identified. These preliminary results from the November 2018 Service Improvement Survey related to transportation are as follows:

- 37% of the responses identified transportation as a problem for missing a behavioral health appointment.

Table 1.

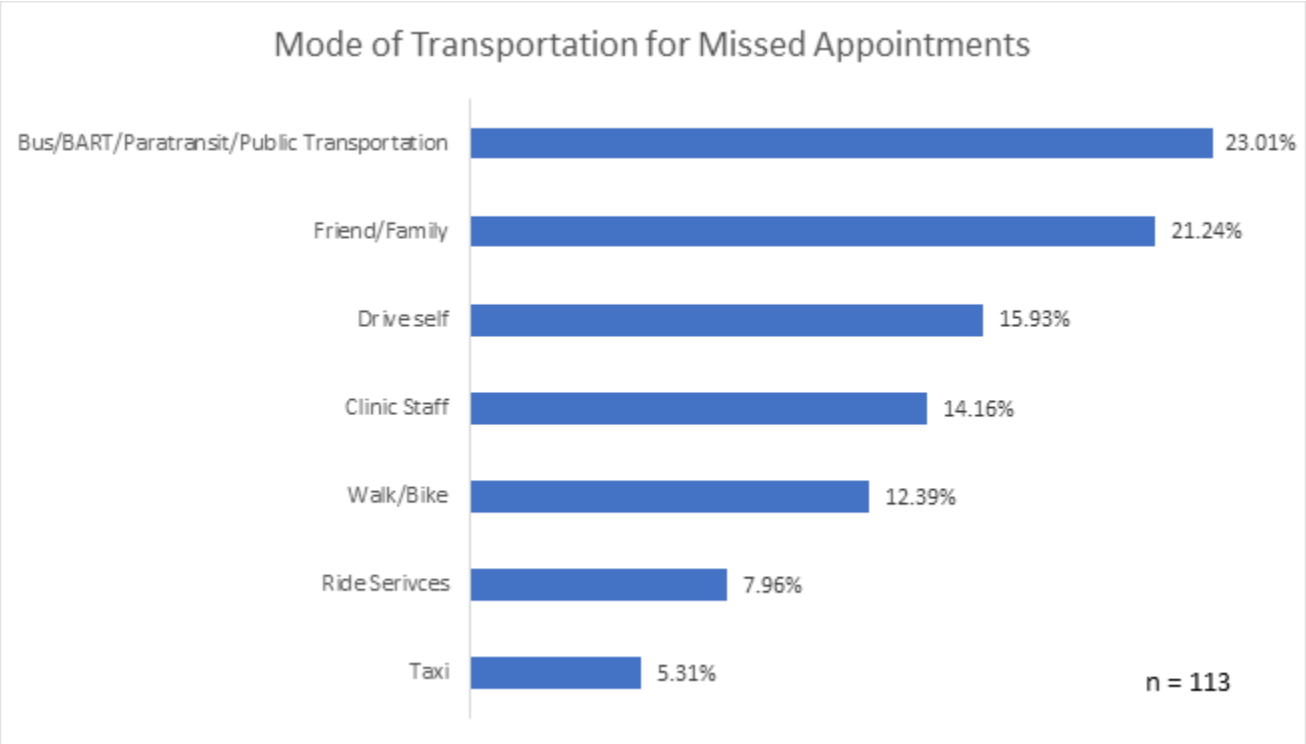


Table 2., below included data for client and staff encounters for the last fiscal year. This table defines the types of services the CNS is providing. Additional types of encounters that were added included

peer support as well as "other" encounters. Other can be explained as contacts that didn't have a specific outcome. Although, the team made numerous attempts to contact clients they were not always able to provide adequate contact or assistance.

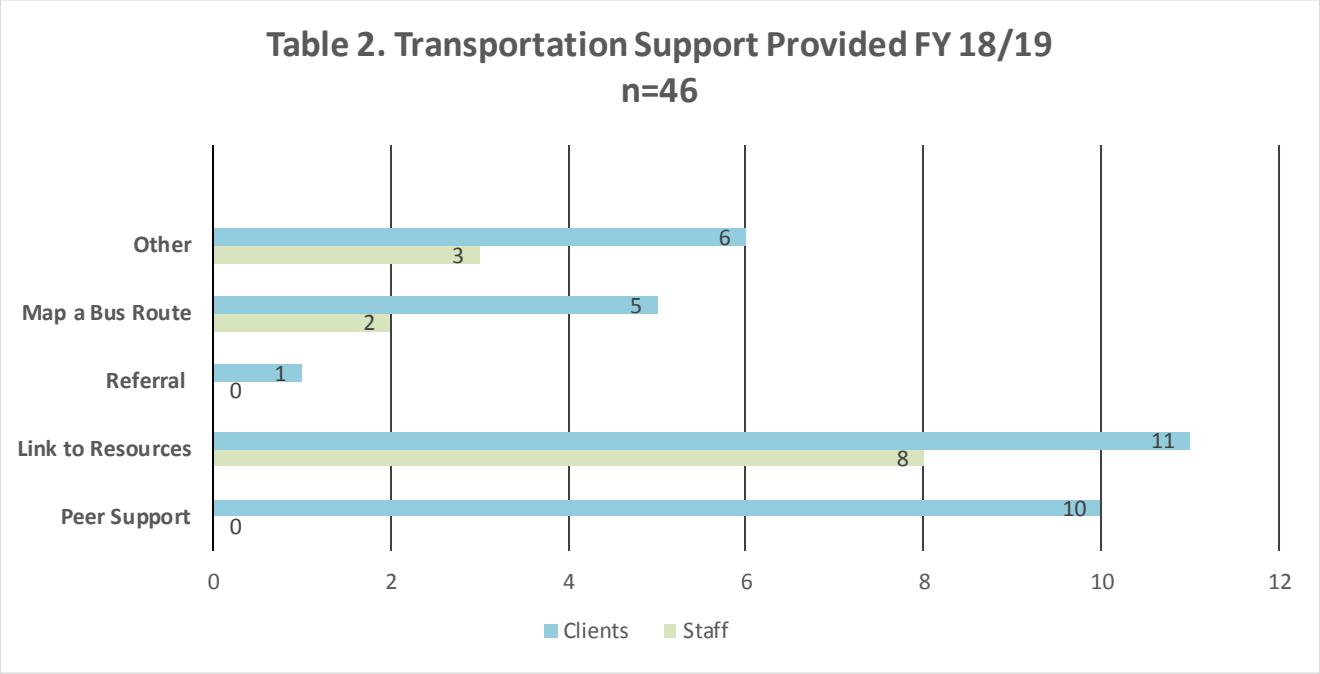
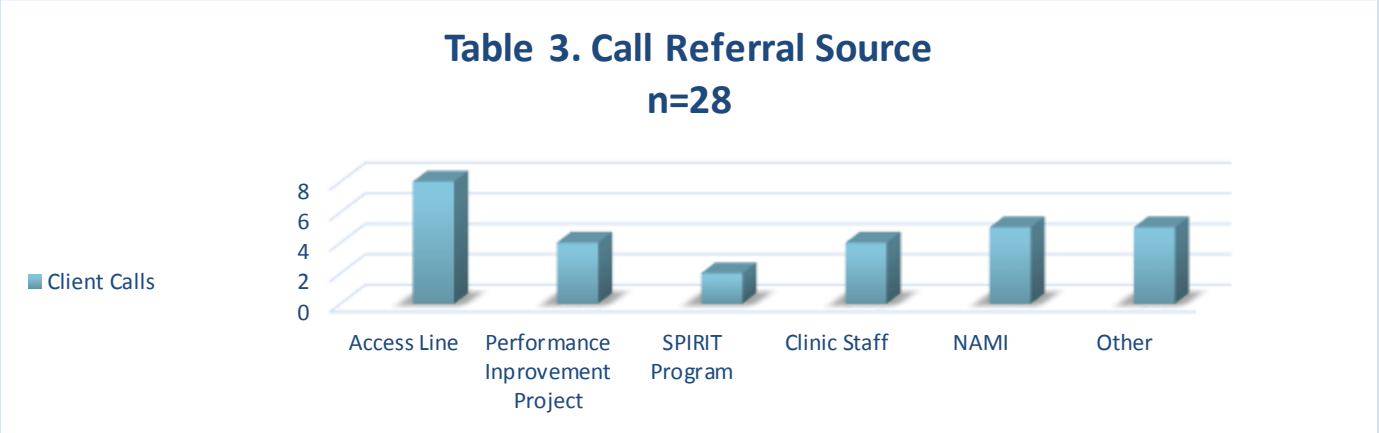


Table 3., below shows total number of calls received by clients and where the referral source originated. Referral source known as "other" describes sources such as family members, friends, word of mouth, presentations or outside therapists.



LINKAGE AND FOLLOW-UP: ☐ Not applicable

Please explain how participants are linked to mental health and/or support services, including, how the INN Project 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.

The project also has a system in place that allows the project's staff to follow up on all service contacts if an outcome is not reached. Many times, a client may leave a message after hours and the team will log the contact and then make sure to get the information requested to the client. All client contacts are documented, and extensive outreach is pursued.

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 project was able to collect valuable perspectives from clients who called the project for services and for a Focus Group that was held during the Transportation Subcommittee. Both avenues were meant to support the clients with different means of transportation service resources while gaining helpful insight into the client's perspective. Clients commented on different ways in which transportation could be improved and its overall functionality when provided in order to get to and from appointments.

Client Calls:

Caller 1: requested information on how to get a clipper card. The Commute Navigation Specialist was able to assist by providing the information and ended up sending the caller resource information on how to obtain an RTC Clipper Card and bus maps. Client felt services were helpful and would use resources in the future.

Caller 2: Client requested information on the RTC Clipper Card. The Commute Navigation Specialist (CNS) sent over resource information, but client still had a difficult time filling out paperwork. Client was asked to attend the Transportation Subcommittee and get assisted with completing the paperwork. She said the assistance she received from the specialist was very helpful and felt the resources that she received were useful. She recently passed the resource information on to others who are also in need of transportation guidance.

Transportation Subcommittee Focus Group:

The Transportation Subcommittee is composed of behavioral health stakeholders such as consumers of behavioral health services (including both Mental Health and Alcohol and Other Drugs Services), their loved ones, and their providers. It is charged with facilitating community input into the Overcoming Transportation Barriers project.

A focus group was held during the Transportation Subcommittee Meeting to get client feedback. The focus group concentrated on the specific following questions:

1) Did you use any of the transportation related resources provided to you during this meeting?
2) Did you find presentations/activities helpful?
3) Have you used the Overcoming Transportation Barriers services outside of the Transportation Subcommittee?
4) What are the biggest transportation barriers in getting to your behavioral health appointments?

Responses to Question 1

- Caught the bus; went to aquarium. Went to Santa Cruz amusement park. Really nice.
- They changed the 9, 18 and other [County Connection] routes; later buses not running.
- Grabbed bus map; went wrong way; map was helpful; showed direction of bus routes; want to know if [County Connection] Route 18 goes to Amtrak.
- Was getting my first Clipper card; roommate encouraged me.

Responses to Question 2

- Sister bought me punch cards to last me until 2020. Takes an hour and a half between buses.
- I find the information very helpful. I come here to stay updated.
- LINK [County Connection paratransit] charges $5; won't let me ride; want to apply.
- If there is a sidewalk nearly, you're less likely to qualify for paratransit.
- There should be a mental health advocate for transportation.

Responses to Question 3

- Disabled Students Programs and Services at Contra Costa College gave me a free Clipper Card [good to pay fare on any Bay Area transit system].

Responses to Question 4

- Need faster buses, longer times so people can get to work.
- Have difficulty paying fares at the end of the day; transit agency stopped giving transfers.
- At Putnam Clubhouse [mental health community-based organization], members lack knowledge of bus routes, timing of buses. They unknowingly go to bus stops on the wrong side of the street and realize it too late.
- Service available to call for rides to appointments. Can no longer use bus transfers to go the entire loop of the routes.

FISCAL YEAR: 2018/2019

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 18/19, we had one Community Support Worker (CSW) leave our program on 1/31/19. She had been working with our program since September 2016. We hired a new CSW for Partners in Aging in early June 2019, and a second CSW in late July 2019. We had an Intern throughout the Fiscal Year. Our Intern began in her position in September 2018 and continued with the program through the remainder of the fiscal year.

Our CSWs and Intern served 32 clients this fiscal year. Our CSWs can build rapport and provide multiple linkage and rehab services. They connect with clients in different ways than our clinicians since they are in the community with the clients and can relate to them as a peer. They collaborate with the clinicians and provide a valuable perspective. The CSWs have provided assistance in linking clients to important resources such as In-Home Support Services, Contra Costa Interfaith Housing, 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. They also provide several reminder calls to improve attendance at appointments, and link clients to their appointments with their IMPACT clinicians. Our CSWs have become quite knowledgeable on support service resources for older adults. The CSW that was hired in June 2019 maintains an online resource binder that is used by all of the Older Adult Mental Health staff. This has been very valuable and useful!

When our original CSW left the Partners in Aging Program in January 2019 we lost the frequent communication that she was having with the CSWs at Psychiatric Emergency Services (PES). We will work to re-establish this connection. We did not receive referrals from PES during this reporting period.

Our Intern served a caseload of approximately 10 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. Prior to terminating with her clients, she provided them with community referrals, and made recommendations for the next Intern regarding next steps for treatment, or discharge from IMPACT.

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?

Throughout FY 18/19 we have steadily received an increase in the number of clients referred to our IMPACT clinicians in all 3 regions of the county. Primary Care Providers now make referrals through the Universal Behavioral Health Referral. Most referrals for clients who are 55 and above are routed to IMPACT. We are

continuing to work to find ways to manage the large number of referrals. Due to their large caseloads IMPACT clinicians usually see their clients once every 2 to 3 weeks. Our CSWs can assist by checking in with clients in between their sessions with their IMPACT clinicians. They provide peer support, coaching, and mental health rehabilitation. We are continuing to explore ways that our CSWs can assist with managing the large number of referrals.

Barriers continue to exist related to developing a collaborative relationship with PES. We have not received referrals from PES during this reporting period. We will continue to work to strengthen this relationship through outreach. PES serves 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. As stated above, during this Fiscal Year there was a period when we did not have a CSW for Partners in Aging. We need to work to rebuild the collaborative relationship with the CSWs at PES.

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.

There was one significant change to the project in FY 18/19. We expanded the project to include 2 CSWs instead of one. We began the hiring process for this second CSW during FY 18/19, and this second CSW began working in July 2019.

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:

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

   Yes. Our CSWs successfully provided services to approximately 25 IMPACT clients to improve their access to IMPACT services during FY 18/19.

7) Do older adults engage in SBIRT?

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

8) 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 CSWs, including obtaining free phones and learning to utilize these phones, ensuring that medical needs are met, being able to utilize transportation resources, working towards financial independence, learning ways to manage clutter and increasing comfort with asking for help from others when needs arise. Our CSWs, 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, 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.

9) 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 CSWs 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. CSWs have also been coaching clients in decluttering their homes and organizing paperwork. 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?

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

10) 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.

11) 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 ccLink indicate that she continues to participate in Health Coaching services.

12) 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. We are actively working with the Business Intelligence Team to complete this report.

13) Does quality of life increase?

Yes, we have observed increases in quality of life, including clients feeling more able to engage in activities, and increase the range of activities that are available to them. For example, clients have increased their ability to use transportation independently through coaching and peer support. This greatly increases their ability to engage in social, medical and self-management activities. In addition, we have assisted one client with signing up for classes at a local community college.

14) 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 requesting a new report to evaluate the PHQ-9 scores over time. When IMPACT started using the Ambulatory Medicine documentation tools, and the Federally Qualified Health Center model of billing in November 2017, they gradually stopped using a PHQ-9 tracker since this data was entered in ccLink.

We are also 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.

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, or at closing. 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 CSWs. In addition, the CSWs follow up with consumers by phone, email the IMPACT clinicians, and remain in contact with the referral resources they are linking the consumer to in order to ensure successful engagement of services. Housing applications and brochures, transportation resources, assistance with trips to the DMV, assistance with maintenance of benefits, linkage with Community College classes, Senior Center activities, Meals on Wheels information and Contra Costa Continuum of Services are just a few examples of what resources our CSWs provide as far as linkage and follow up. The CSWs continue to establish relationships with outside agencies that will benefit the older adult population we serve. They have attended various meetings and trainings to gather additional resources, including a Forum on Suicide Prevention, training on 211 resources, the Transportation Subcommittee Meeting, Aging and Older Adult Committee 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 18/19 is approximately 4.25 days. Most clients were linked with new referrals within 1 day.

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. Assistance of the Partners in Aging Project has led to improvements in quality of life, independence, and mental health.

One is a 62-year-old Caucasian male diagnosed with Major Depressive Disorder, Recurrent, Moderate, Generalized Anxiety Disorder, Osteoarthritis, Congestive Heart Failure, Morbid Obesity and a recurrent Wound Infection. He has been receiving brief, short-term therapy through the IMPACT Program and support services through the Partners in Aging Project. Our CSW was able to assist this client through coaching and peer support to achieve the ability to use public transportation independently. He is now able to take himself to medical appointments 3 days a week. He also now goes to the store to get food and to the bank on his own. In addition, he has improved significantly in his ability to advocate for his needs with his medical providers.

Another Partners in Aging client is a 60-year-old Afghani-American female diagnosed with Post-Traumatic Stress Disorder, Back Pain, Insomnia, Hyperlipidemia, and a history of a traumatic brain injury. With the help of our clinician and CSW she has started her road towards financial independence, increasing her feelings of self-worth and self-esteem. This client expressed feeling depressed by depending on her son's family and not being able to provide anything for herself. With CSW support, client has begun the process of obtaining an income, and improving her mental health.