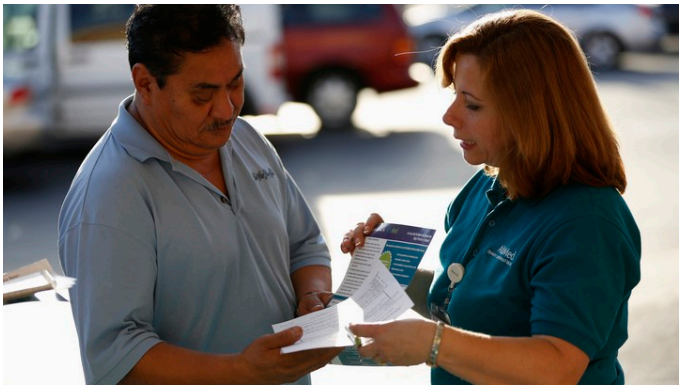
WELLNESS • RECOVERY • RESILIENCE

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION



Collaborative Care Enhanced Recovery Project (CCERP)

Sonoma County Innovation 2020-2023 Plan Proposal

MENTAL HEALTH SERVICES ACT (MHSA) INNOVATIONS PROJECT PLAN:

Collaborative Care Enhanced Recovery Project (CCERP): Advancing Older Adult Depression Care Through Extended Supportive Services

A Project of Santa Rosa Community Health & Sonoma County Human Services Department

SECTION 1: INNOVATIONS REGULATIONS REQUIREMENT CATEGORIES

General Requirement

	Introduces a new practice or approach to the overall mental health system, including prevention and early intervention
X	Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
	Applies a promising community driven practice or approach that has been successful in non-mental health context or setting to the mental health system
	Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

Primary Purpose

X	Increases access to mental health services to underserved groups
X	Increases the quality of mental health services, including measured outcomes
X	Promotes interagency and community collaboration related to mental health services or supports or outcomes
	Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

SECTION 2: PROJECT OVERVIEW

2.A) PRIMARY PROBLEM:

Sonoma County faces an increasingly senior and Hispanic/Latino population; increases in depression, suicide and chronic health problems; disparities in culturally responsive treatment and access to care among low-income and Hispanic residents; and significant challenges in the local mental health care system. In response, the County of Sonoma Human Services Department (HSD) Adult and Aging Division (A&A) and Santa Rosa Community Health (SRCH) propose a pilot project to improve treatment for older adults struggling with depression. The *Collaborative Care Enhanced Recovery Project: Advancing Older Adult Depression Care through Extended Supportive Services (CCERP)* will augment an established short-term intervention model with longer-term, in-home case management and target it to the underserved Hispanic/Latinx population, resulting in positive and more equitable impacts on mental health, physical health, and quality of life for older adults with depression.

Demographic Profile: Sonoma County as a whole is experiencing a profound demographic shift, mirroring that which is underway throughout the state and the nation, as the population ages and demand for behavioral health services grows among older adults. Sonoma County's percentage of aging adults continues to grow faster than the US average and makes up a significantly larger share of the total population than the state average: 39.1% of the County's approximately 504,000 residents are over the age of 50, compared to

31.6% for the state.[1] Further, the number of residents aged 60 and older is projected to increase by nearly 38% between 2015 and 2025.[2]

Hispanic/Latino individuals also make up a growing proportion of the population of Sonoma County: 27% of the County's population is Hispanic and 62.1% is white.[3] Correspondingly, more than a quarter of County residents speak a primary language other than English, 77% of which is Spanish.[4] Further, as the largest city in Sonoma County and the biggest urban center between San Francisco and Portland, Santa Rosa is home to a disproportionate share of low-income Sonoma County residents struggling with unaddressed mental health disorders, chronic disease, and contributing social determinants of health.

Health & Well-Being Risks: Older adults are at increased risk of being socially isolated or lonely, leading to depression, and other health concerns, including high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, cognitive decline, Alzheimer's disease, and even death.[5] A PubMed literature review examining research into the risk-factors for suicide in older adults identified a range of causes, from psychiatric disorders or cognitive impairment to social exclusion, illness and physical or psychological pain.[6]

It is adults 50+ who have the highest rates of depression and a greater suicide risk than any other age group. In 2017, the highest suicide rate in the nation (20.2/100,000) was among adults aged 45 to 54, followed closely by those aged 55 to 64 (19/100,000).[7] Local rates for contemplating suicide are higher than in the state; 13% of Sonoma County adults have considered suicide, compared to 10% statewide.

The correlation between depression and chronic disease is also clearly documented. Depression and diabetes, for example, co-occur twice as frequently as would be predicted by chance. When diabetes co-occurs with depression, the outcomes for both conditions are compounded, and one's capacity to self-manage the disease decreases while the likelihood of complications increases.[8] Patients with poor control of their diabetes are at high risk for complications such as blindness, end stage renal disease, amputation, and significantly reduced longevity and quality of life.

Unfortunately, the rate for certain chronic diseases like diabetes is higher in Santa Rosa than in the county or state.13% of Santa Rosa Community Health (SRCH)'s adult patients[9] have a diagnosis of diabetes mellitus (DM), compared with 9% in CA and 10% in Sonoma County. Of those SRCH patients with DM, 34.6% had A1c (blood glucose level) greater than 9% in 2018, which indicates very poor control over the disease and also places SRCH and its patients in the third performance quartile among all US health centers. Of those individuals with poor DM control, 681 (61%) are Hispanic, and 422 (37.9%) are non-Hispanic (N=1113).[10] In short, diabetes with all its potential physical and mental health impacts is 73% more prevalent in SRCH's Hispanic/Latinx patients.

There are also notable disparities in the availability and utilization of mental health services among the immigrant and Hispanic population. Only 33% of Hispanic and Latino adults diagnosed with mental illness receive treatment each year compared to the national average of 43%,[11] and Hispanic and Latino individuals

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[1] 2013-2017 American Community Survey Estimates

[2] California Department of Finance. http://www.dof.ca.gov/Forecasting/Demographics/projections/

[3] Ibid

[4] Ibid

[5] National Institute on Aging. Social isolation, loneliness in older people pose health risk. 2019. https://www.nia.nih.gov/news/social-isolation-loneliness-older-people-pose-health-risks

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5916258/

[7] American Foundation for Suicide Prevention, 2019. https://afsp.org/about-suicide/suicide-statistics

[8] Holt, R. I., de Groot, M., & Golden, S. H. (2014). "Diabetes and depression." Current Diabetes Reports, 14(6), 491. doi:10.1007/s11892-014-0491-3

[9] The term "Patients" is used in this document in reference to those served at Santa Rosa Community Health (SRCH). Since this proposed project is a collaborative model, the term "client" will be interchangeable with reference to patients of SRCH.

[10] Santa Rosa Community Health, 2019

[11] National Alliance on Mental Illness, https://www.nami.org/find-support/diverse-communities/latino-mental-health

also face cultural barriers to mental health care, in particular late-life depression care.[12] SRCH and other Federally Qualified Health Centers are also observing a decline in Hispanic/Latino mental and physical health care utilization in the wake of the final rule on public charge due to immigration fears, regardless of an individual's immigration status.[13]

Social Factors: It is important to note that social determinants of health play a significant role in older adult depression, heightening the urgency for increased services, especially as the aging population in Sonoma County grows. The likelihood of depression increases as household income decreases. 15.8% of families below the FPL had depression, but only 3.5% of adults living at/above 400% of the FPL had depression.[14] In Sonoma County, nearly 14% of residents over age 60 live below 150% of the federal poverty level (FPL), often in communities with substandard housing, geographic isolation, inaccessible transportation, lack of access to supportive services, food insecurity, crime, and/or violence.[15] A combination of two or more such factors places older adults at risk of decreased quality of life, poor health and social outcomes, and high susceptibility to abuse and neglect. These factors are also correlated with heightened occurrence of depression among the aging population.[16] Among SRCH patients, poverty and other social determinants of health are even higher. 97% of SRCH patients live at or below 200% of FPL and 78.6% live at or below 100% of FPL.

The risk for depression is even greater among low-income, Hispanic/Latinx people. Hispanic/Latinx and Spanish-speaking individuals living below the poverty level are 200% more likely to report psychological distress than those over twice the poverty level.[17] In addition, feelings of anxiety, frustration, fear, and stress have increased in more than half of immigrant families since the 2016 election.[18] This is compounded by social stigma around accessing mental health care. Nationally, only 33% of Hispanic and Latino adults with mental illness receive treatment each year compared to the national average of 43%.[19] Undocumented Latinos were the least likely to have seen a mental health professional in the past year and were unlikely to seek mental health treatment due to cost.[20]

Access to Mental Health Care and Supporting Services: Current local community needs surveys identified access to mental health care as a top priority. In Kaiser Permanente's 2019 report for Santa Rosa, community stakeholders stated a need for increased accessibility to mental health services, but also to reduce stigma around mental health issues. This is heightened by the fact that rates of depression, hopelessness, and anxiety reportedly doubled among at least one member of households in the year following the 2017 wildfires.[21] The majority of the residents who perished in the 2017 fires were older adults, and hundreds were displaced by the destruction of the senior mobile home park Journey's End. Given the 2019 Kincade fire, repeated Planned Safety Power Shutoffs by Pacific Gas & Electric, two wildfires in 2020 to say nothing of COVID-19, these priorities will likely remain the same or very probably increase.

Disturbingly, the 2019 California Future Health Care Workforce Commission report highlights a looming crisis in the workforce supply for primary care and mental health services.[22] The Commission estimates that by

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[12] Hoeft, T; Hinton, L; Liu, J; Unutzer, J. "Directions for effectiveness research to improve health services for late-life depression in the United States." American Journal of Geriatric Psychiatry. 2016 Jan; 24(1): 18-30.

[13] CalMatters. Immigrants afraid of Trump's 'public charge' rule are dropping food stamps, Medi-Cal. 22 September 2019. https://calmatters.org/california-divide/2019/09/immigrants-afraid-trump-public-charge-rule-food-stamps-medical-benefits/

[14] CDC. Prevalence of Depression among Adults Aged 20 and Over. https://www.cdc.gov/nchs/products/databriefs/db303.htm

[15] Ibid

[16] Sonoma County Human Services Department. The Art of Aging in Sonoma County, 2015

[17] U.S. Department of Health and Human Services, Office of Minority Health https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=69

[18] California Pan-Ethnic Health Network. Accessing Mental Health in the Shadows: How Immigrants in California Struggle to Get Needed Care. 2019

[19] National Alliance on Mental Illness, https://www.nami.org/find-support/diverse-communities/latino-mental-health

[20] Ibid

[21] Kaiser Permanente. 2019 Community Health Needs Assessment. Kaiser Foundation Hospital: Santa Rosa, 2019

[22] California Future Health Workforce Commission. Meeting the Demand of Health: Final Report of the California Future Health Workforce Commission. February 2019, https://futurehealthworkforce.org/

2030 California will have a 40% deficit in the psychiatric workforce to cover California's needs. This workforce shortage is disproportionately represented in rural communities and mirrors the crisis seen across the nation. Sonoma County has not been immune to this alarming trend and continues to carry a designation as a Health Professional Shortage Area (HPSA) for both primary care and mental health services. HPSA scores are the leading federal indicator for critical labor shortages in meeting the need for medical, dental and mental health care in a U.S. city or region. SRCH has a mental health HPSA score of 19, up by two points in the last three years, and a HPSA primary care score of 18.[23] So, while the need for mental health services is increasing, the number of professionals trained to deliver such services is facing a dire shortage.

In its capacity as Sonoma County's largest agency focused on serving older adult clients, Adult & Aging (A&A) has observed long waiting lists for existing home-based care coordination programs, a vital way to address the risks and social determinants of health that directly impact older adults' physical and mental health. These services are a critical part of addressing mental and physical health in the aging population. A home-visiting case manager can observe and address safety risks ranging from something as simple as a loose throw rug that poses a slipping hazard, to more complex issues such as food insecurity and hoarding. Person-centered care planning and a home visiting approach is vital to support older adults to address these risks over time. Many A&A clients show symptoms of depression that are compounded by unresolved barriers including housing, food, transportation, and others. In Sonoma County, existing service delivery models for older adults require that clients be at least aged 60, and for many services (including the existing Collaborative Care Model) the minimum age is 65.

The County of Sonoma also provides proportionately fewer mental health services to Hispanic/Latino and Spanish-speaking clients than to Caucasian and English-speaking clients. The recent Sonoma County Mental Health Service Act, 2019 Capacity Assessment Report states that culturally responsive behavioral health services offered for the Hispanic/Latino population is limited. Overall, this population represents 42% of the Medi-Cal enrollment and yet only represents 13% of the adult consumers in the behavioral health system. Based on local data, the Capacity Assessment continues to assert that language accessibility, citizenship status, lack of culturally competent and bi-lingual staffing all contribute to older adult Latinx populations being deterred from accessing services. However, in fiscal year, 2018-2019 a higher proportion of Hispanic/Latino consumers were admitted to the CSU (Crisis Stabilization Unit). This indicates that Hispanic/Latinx people are being seen only when they reach a crisis phase. Nationally, Hispanic/Latino individuals face cultural barriers to care and health systems with differing levels of cultural competency in late-life depression care.[24] A 2019 report on immigrant disparities in mental health care documents the critical role socio-economic and community-based supports play in reducing these service limitations. They call out the lack of formal and consistent referral pathways and specifically recommend agreements between community-based organizations (CBOs) and safety-net organizations like health centers to improve mental health care.[25]

The previously cited PubMed literature review on suicide risk in older adults emphasized in its conclusions:

> "...the need to integrate specific stress factors, such as feelings of social disconnectedness, neurocognitive impairment or decision making, as well as chronic physical illnesses and disability in suicide models and in suicide prevention programs in older adults. Furthermore, the chronic care model should be adapted for the treatment of older people with long-term conditions in order to improve the treatment of depressive disorders and the prevention of suicidal thoughts and acts."

2.B) Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Clearly, to be effective, the provision of mental health services for older adults requires a holistic approach that cannot rely on a single program or agency working alone and instead must leverage inter- and intra-organizational strengths for collective impact. As a CBO serving over 120,000 clients in Sonoma County

[23] HRSA. HPSA Finder. https://datawarehouse.hrsa.gov/tools/analyzers/HpsaFindResults.aspx

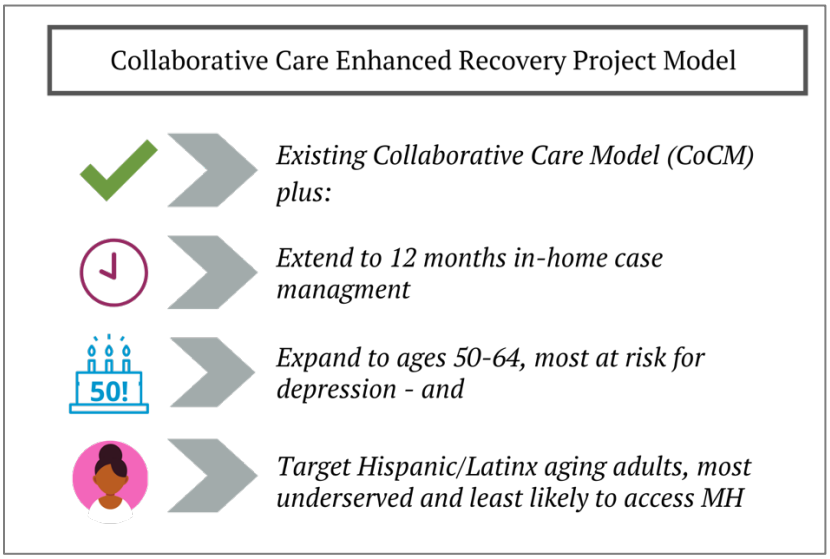
[24] Hoeft, T; Hinton, L; Liu, J; Unutzer, J. "Directions for effectiveness research to improve health services for late-life depression in the United States." American Journal of Geriatric Psychiatry. 2016 Jan; 24(1): 18-30

[25] California Pan-Ethnic Health Network. Accessing Mental Health in the Shadows: How Immigrants in California Struggle to Get Needed Care. 2019

annually, Adult & Aging specializes in community-based care, collaborating with internal and external partners to offer a comprehensive network of community resources and referrals. As the largest Federally Qualified Health Center (FQHC) in Sonoma County delivering medical, dental and mental health care to over 42,000 individuals, Santa Rosa Community Health (SRCH) specializes in a whole-person primary care model, with expertise in culturally responsive and trauma-informed diagnosis and treatment. Together, A&A and SRCH are uniquely positioned to develop and test such an intervention for older adults in Santa Rosa, including those who are Hispanic/Latino.

Adult & Aging has identified four areas in which services are not responding to community need: 1) among adults aged 50 to 64; 2) among Hispanic/Latino older adults; 3) in access to home-based coordination of care; and 4) in collaboration across programs and agencies. In response to these four areas and the clearly established need, the County of Sonoma Human Services Department (HSD) Adult and Aging Division (A&A) and Santa Rosa Community Health (SRCH) propose a pilot project to improve treatment for older adults struggling with depression. The *Collaborative Care Enhanced Recovery Project: Advancing Older Adult Depression Care through Extended Supportive Services (CCERP)* will augment an established short-term intervention model with longer-term, in-home case management, resulting in positive and more equitable impacts on mental health, physical health, and quality of life for older adults with depression. CCERP will utilize a comprehensive Collaborative Care Model (CoCM) and lengthen the duration of established older adult depression interventions while also expanding the project's focus to increase access to services for two underserved populations as follows:

1. Expand the existing target age group from 65 and older to include ages 50-64;
2. Increase access to depression services for Hispanic/Latino older adults through a focus on providing culturally and linguistically appropriate services and outreach.



The development of this program model was based on several factors. First, A&A has observed service limitations in programs currently available. Existing service delivery models for older adults, in Sonoma County as well as throughout the state, require that clients be at least aged 60, and for many services (including the existing Collaborative Care Model) the minimum age is 65. This leaves adults ages 50-64 underserved, despite this age group being at greatest risk for suicide.[26]

Second, A&A and SRCH are prioritizing linguistically and culturally appropriate services for Hispanic and Latino adults because this group comprises a significant portion of Sonoma County's population, specifically 64% of SRCH's patients. They are less likely to utilize mental health services due to prevalent cultural stigma

[26] American Foundation for Suicide Prevention, 2019. https://afsp.org/about-suicide/suicide-statistics

around mental illness and a shortage of Spanish-language materials and culturally responsive services.[27] [28] Mental health care delivered in the primary care environment, however, is less stigmatizing and easier to access when it is co-located with health care. This is especially important for low-income and Hispanic/Latinx people, for whom there is a high drop-off rate when they are referred to external mental health care, and for treating chronic disease which is closely correlated to depression. Integrated, non-pathologizing care – both from a trusted primary care doctor and, by extension, the trusted in-home case manager, is more effective. Lastly, as noted above, the Hispanic/Latinx population also have a higher prevalence of chronic disease, which correlates to higher rates of depression. There is evidence, however, that using collaborative depression care within a diabetes disease management program is a scalable approach that improves both depression outcomes and patient care satisfaction among Latino patients with diabetes in safety-net clinics.[29] CCERP's proposal to extend the existing CoCM model to twelve months will provide the time needed to build the personal relationships that are central to caring for people who are Hispanic/Latinx, prevent relapses, and maintain health and behavior improvements.

To identify the priority issues to be addressed through CCERP, A&A and SRCH also solicited confidential input from social worker stakeholders and consumers, particularly Hispanic/Latino individuals, who reported cultural and language barriers both to identifying a need for and accessing mental health services. Consumer and service provider stakeholders reported the need for stronger outreach to Hispanic populations (many of whom have linguistic barriers), improved communication across service providers, and in-home support for related issues such as finances, housing, and transportation.

Social workers and clients of A&A's In-Home Supportive Services (IHSS) Program, a program which provides in-home care to older and disabled adults, identified a need for expanding existing mental health services to include ongoing in-home case management and culturally appropriate outreach, specifically through informal resources, and were optimistic about the potential for success. IHSS clients shared that CCERP "…could probably reach a window of people who wouldn't normally reach out for help" and would be "…beneficial to help not just people's mental health but also other problems like finances and housing."

Using the same set of interview questions, SRCH conducted key informant interviews with its staff and patients. Patients interviewed reported that the period after the symptoms have been reduced is a crucial time to establish long-term connections that will contribute to a high quality of life. The results indicated a pressing need for extended care and support such as accessing infrastructure (including medical and public transportation) and reconnecting with their social networks after the critical symptoms of depression have been alleviated.

Both consumer and service provider stakeholders reported the need for stronger outreach to Hispanic/Latino populations, improved communication across service providers, and in-home support for related issues such as finances, housing, and transportation. For example, although Sonoma County residents have access to the North Bay Suicide Prevention hotline, there is a need for expanded mental health supports, particularly for older adults, to reduce the likelihood of a mental health crisis. During post-wildfire mental-health mapping sessions hosted by the Red Cross and the Wildfire Mental Health Collaborative, professionals from NAMI, CA HOPE and other CBOs concurred that there is still significant stigma around "mental health" and how important it was (and is) to adapt the language and approach to remove that barrier to effectively engage people in the care and support they need.

Based on the budgeted case-load, A&A and SRCH anticipate that a minimum of 225 clients could be served during the three-year program: 50 clients in Year 1, 75 in Year 2, and 100 in Year 3 by a care manager[30]

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[27] Hoeft, T; Hinton, L; Liu, J; Unutzer, J. "Directions for effectiveness research to improve health services for late-life depression in the United States." American Journal of Geriatric Psychiatry. 2016 Jan; 24(1): 18-30

[28] National Alliance on Mental Illness, https://www.nami.org/find-support/diverse-communities/latino-mental-health

[29] Wu B, Jin H, Vidyanti I, Lee P, Ell K, Wu S. Collaborative Depression Care Among Latino Patients in Diabetes Disease Management, Los Angeles, 2011–2013. Prev Chronic Dis 2014;11:140081.

[30] The terms case manager and care manager (and case management/care management) are used interchangeably in Sections 2-4 of this document. The Collaborative Care Model uses the term care manager, whereas the more general term for this role, and the term used in most of the citations, is *case manager*.

using a person-centered and culturally responsive approach. Once the program is established and tested, A&A and SRCH fully anticipates both a need and desire to expand the program to other SRCH campuses in Sonoma County based on patient demographics and the established unmet need for mental/behavioral health services.

PROPOSED PROJECT: Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) Provide a brief narrative overview description of the proposed project.

The *Collaborative Care Enhanced Recovery Project: Advancing Older Adult Depression Care through Extended Supportive Services* (CCERP) will augment an established short-term intervention, the Collaborative Care Model (CoCM), with longer-term, in-home case management, resulting in positive and more equitable impacts on mental health, physical health, and quality of life for older adults with depression. As a community-based organization (CBO), A&A specializes in collaborating with internal and external partners to deliver community-based care and offer a comprehensive network of community resources and referrals. As a Joint Commission and Patient Centered Medical Home accredited health care provider, Santa Rosa Community Health (SRCH) specializes in integrated primary medical and mental health care that diagnoses and treats the whole person. The integration of community-based social workers trained to work with older adults in the primary care setting and working collaboratively with the patients for a 1-year period is intended to impact the patient's depression symptoms as well as address longer term social determinants of health.

CoCM is an evidence-based approach for integrating physical and behavioral health services. The model includes: brief care coordination (12 weeks); regular monitoring and treatment using validated clinical rating scales; and regular, systematic psychiatric caseload reviews and consultations for clients who do not show clinical improvement. More than 70 randomized controlled trials conducted across diverse practice settings and client populations have demonstrated that collaborative care is more effective and cost-effective than non-integrative care in the treatment of depression, as evidenced by close tracking of depression symptoms using validated rating scales (such as the PHQ-9). The inclusion of a psychiatric consultant in this model gives the primary care provider the ability to utilize psychiatric input when adjusting treatment. Although clients can be referred to mental health specialty care if they don't respond to treatment or request a referral, in practice only a small fraction seek or require referrals to specialty care.[31]

The integrative nature of collaborative care creates new lines of communication and multi-disciplinary channels for information-sharing between the primary care team and other care providers and consultants. A study on clinical inertia in depression treatment shows that this enhanced communication within physician/non-physician teams, paired with psychiatrist consultations, may improve appropriate antidepressant adjustments.[32] Patient outcomes indicated that this systematic approach "can overcome the clinical inertia at is often responsible for ineffective treatments of common mental disorders in primary care.[33] [34]

[31] Unützer, J., Henry Harbin, H., Schoenbaum, M., and Druss, B. (2013). The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes.
[32] Henke RM, Zaslavsky AM, McGuire TG, Ayanian JZ, Rubenstein LV. "Clinical Inertia in Depression Treatment." Medical Care. September 2009;47(9):959-96
[33] Unützer, J., Henry Harbin, H., Schoenbaum, M., and Druss, B. (2013). The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes
[34] Henke RM, Zaslavsky AM, McGuire TG, Ayanian JZ, Rubenstein LV. "Clinical Inertia in Depression Treatment." Medical Care. September 2009;47(9):959-96

Additionally, follow-up care with care managers increases the frequency of contact with clients, thereby enhancing the ability to monitor and detect changes in severity of depression symptoms, which can improve rates of appropriate depression adjustment.[35] Although depression treatment guidelines recommend that clients be seen every one to two weeks during the acute treatment phase, this target is rarely met in clinical treatment models.[36] [37] By supplementing office visits with care management home visits and follow-up, the collaborative treatment model can meet this target guideline for best practice during the acute treatment phase.

The home-visiting care manager delivers the evidence-based intervention Healthy IDEAS (Identifying Depression & Empowering Activities for Seniors).[38] Program components include screening for symptoms of depression; the care manager measures depression through completion of a PHQ-9 (Patient Health Questionnaire depression screening) at regular intervals. The Healthy IDEAS model also includes providing depression education to older adults and their primary caregivers, referrals to social services and resources, and follow-up with primary care and mental health service providers.

Additionally, the care manager provides an in-home assessment of health and social needs, including evaluation of physical health, living conditions, support network, cognition, transportation, home safety, unmet care needs, financial needs, nutritional status, and life-planning. In collaboration with the client, the care manager creates a person-centered care plan that establishes the individual's needs and goals for case management. The care plan can include referrals to community-based organizations for resources such as mental health services, legal assistance, landlord/tenant relations, nutritional services, financial, homecare, transportation, and socialization. Using a brokerage model, the care manager acts as a coach, supporting the client to access and engage in community resources while developing problem-solving skills.

A home-visiting case manager can observe and address safety risks ranging from something as simple as a loose throw rug that poses a slipping hazard, to more complex issues such as food insecurity and hoarding. Person-centered care planning and a home-visiting approach is essential to support older adults to address these risks over time. CoCM essentially gives the primary care provider "eyes in the home," allowing the patient's medical care to be informed and improved by observations that could only occur in the home. To be effective long-term, the provision of mental health services for older adults requires a holistic approach that leverages strengths for collective impact and does not rely on a single program working alone.

Through CCERP, A&A and Santa Rosa Community Health (SRCH) will partner to expand the existing Collaborative Care Model (CoCM) with the addition of long-term home-based case management services. The full intervention will consist of the 12-week (3 months) CoCM intervention and 9 additional months of home-based case management services for a total of 1 year (12 months) of intervention for each patient. Due to the short duration of CoCM's existing 12-week intervention, the supportive services end just as clients are starting to feel better. By extending the length of the intervention to a full year, CCERP's objective is to support clients in maintaining improved depression symptoms and behavioral changes through ongoing case management and support. One study concluded that case management in combination with other depression interventions improves outcomes for both depression and social problems, and that case management may also improve access to health care and reduce hardship by connecting clients with other needed services.[39] Another study showed positive results for practices such as case management, including a drop of 56% in average monthly expenditures on participants after program participation, much of which came from lower inpatient hospital spending.[40]

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[35] Ibid

[36] Ibid

[37] National Committee for Quality Assurance. The State of Health Care Quality 2006. Washington, DC: National Committee for Quality Assurance; 2006. Antidepressant Medication Management; pp. 19–20.

[38] For more information, see http://healthyideasprograms.org/

[39] Areán, P.; Mackin, S.; Vargas-Dwyer, E.; Raue, P.; Sirey, J.; Kanellopoulos, D.; Alexopoulos, G. "Treating Depression in Disabled, Low-income Elderly: A Conceptual Model and Recommendations for Care." International Journal of Geriatric Psychiatry. 2010 Aug; 25(8): 765–769

[40] County Medical Services Provider (2013). Local Health Connections Pilot: Findings and Lessons Learned

To help facilitate clients transitioning out of the case management program and into independent care maintenance, A&A and SRCH will take a phased approach to case management for CCERP clients, gradually decreasing the frequency and level of case management support over the course of the nine-month period. Phasing case management services according to client's individual needs will enable project staff to connect clients with necessary supports and resources as they move toward stability before gradually transferring care. Staff will use practices to mobilize community support for vulnerable older adults during the period of transition out of CCERP, facilitating continuity of care through enduring ties to the community and support systems.

A&A and SRCH will launch services at SRCH's Lombardi Campus. The Lombardi Campus offers comprehensive primary care, integrated mental health care, women's health, specialty care, and also has an onsite pharmacy and lab. It opened in 1996 and is located adjacent to the Roseland neighborhood that has a population of 43% Hispanic/Latino people. As such, the Lombardi Campus has the highest concentration of SRCH's Hispanic/Latinx clients, up to 80% of whom are best served in Spanish. The longer-term goal is to expand the model to three other large SRCH campuses, making this innovative approach to depression care available to the majority of low-income older adult clients of in metropolitan Santa Rosa.

Care management meetings will be held at SRCH and attended by all CCERP staff. As clients demonstrate fewer depression symptoms over the nine-month case management period, their cases will be brought back to the multidisciplinary team for brief monthly or biweekly check-ins.

CCERP will be implemented by a designated project team as follows:

- 1.0 FTE CBO Care Manager (embedded at SRCH)
- 0.5 FTE CBO Program Planning and Evaluation Analyst (PPEA)
- 0.1 FTE CBO Supervisor
- 0.275 SRCH Program Administrator
- 0.5 SRCH Care Coordinator/Patient Navigator
- 0.1 SRCH Primary Care Physician
- 0.013 FTE SRCH Psychiatric Consultant
- 0.1 FTE SRCH RN Case Manager
- 0.1 FTE SRCH Behavioral Health Manager Supervision
- 0.2 FTE SRCH Behavioral Health Provider

CCERP will ensure that A&A and SRCH's innovative recovery model provides Hispanic and Latino older adults with services that are both culturally responsive and linguistically appropriate. To that end, A&A will require that Social Workers who serve as project staff are bilingual in Spanish, and SRCH will have strong bilingual representation in all project-related positions. CCERP will ensure that all community outreach and education, including printed materials, are provided in both culturally appropriate English and Spanish.

Further, SRCH has extensive experience working with the Hispanic and Latino community, and almost all providers and all team staff are bilingual and/or bicultural. This is highly unique and valuable as there is a recognized shortage of bilingual and bicultural medical and mental health providers locally and nationally. All SRCH providers are trained to see mental health as a part of overall health and to offer services in a non-stigmatizing fashion in the context of primary care. SRCH care teams also recognize the necessity of and prioritize building up the personal relationships and trust that are central to delivering sensitive and effective health care for the Hispanic/Latino community. Receiving care in a trusted setting from a bilingual and/or bicultural provider also enables conversations that can address the traditional stigma around mental health in the Latino culture. With trust and time, clients can become more receptive to receiving services and pursuing different treatment options, such as medication for depression. SRCH has also established relationships with Hispanic and Latino-serving partners such as Latino Service Providers, La Plaza, California Human Development Corporation, Community Action Partnership of Sonoma, Binational Health Fairs, Center for Well-Being, and others, and will leverage these to expand outreach and ensure that CCERP delivers culturally appropriate services.

A&A is committed to ensuring continuity of care for CCERP clients and will continue to actively work on identifying ways to make the proposed project sustainable beyond the duration of the project period. Following the end of MHSA Innovation funding, clients will continue to have access to the programs of the Sonoma County Behavioral Health Division and available SRCH services. To help facilitate clients transitioning out of the case management program and into independent care maintenance, A&A and SRCH will take a phased approach to case management for CCERP clients, gradually decreasing the frequency and level of case management support over the course of the nine-month period. Adjusting case management services according to individual needs will enable project staff to connect clients with the necessary resources to support their recovery as they move toward stability before a gradual transfer of care. Staff will use practices to mobilize community support for vulnerable older adults during the period of transition out of CCERP, facilitating continuity of care through enduring ties to the community and support systems.

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population.

C) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

The Collaborative Care Model (CoCM) is an evidence-based approach for integrating physical and behavioral health services, which in its existing form has been successfully implemented by A&A in partnership with local clinics to serve Sonoma County's older adults with depression. Bringing together the clinical expertise of Santa Rosa Community Health (SRCH) and the social services expertise of community-based senior services of Sonoma County Adult & Aging (A&A), this intervention improves access to effective depression treatment in primary care for older low-income adults.

Since 2015, A&A has partnered with Petaluma Health Center (PHC) in the implementation of a CoCM program for late-life depression, with A&A serving in the role of the community-based organization (CBO). To date, A&A has acted as the backbone agency and project manager to implement CoCM with adults 65 years and older in three Federally Qualified Health Centers (FQHCs) in the county.

In this model, A&A care managers are co-located at the health center, with responsibility for home visits and care coordination at the clinic. The home-visiting care manager is an integral part of the care team, which also includes a primary care provider, RN care manager, and psychiatric consultant. Through the CoCM approach, A&A care managers provide person-centered assistance, addressing depression symptoms and social needs by empowering individuals to access the resources needed to remain safely at home, with a focus on improving health and safety, reducing depression, and developing social and community connections.

Looking specifically at the effectiveness of the CoCM model for low-income Spanish-speaking Hispanic/Latinx people, a 2012 study showed that Spanish-speaking Hispanic clients had significantly greater odds of achieving a clinically meaningful improvement in depression at the 3-month follow-up compared to non-Hispanic whites, even accounting for age. The study further concluded that results suggest "a strong opportunity to improve mental health care for non-English-speaking Hispanic adults in the US.[41]

Although the existing CoCM model has been demonstrated as effective in improving depression symptoms as measured by the PHQ-9 depression screening, including with a low-income and Spanish-speaking population, the modifications proposed through CCERP have the potential to improve upon this model by addressing identified limitations in services. Through serving thousands of older adults over ten years of

[41] Sanchez, Katherine and Terling Watt, Toni. 2012. Collaborative Care for the Treatment of Depression in Primary Care with a Low-Income, Spanish-Speaking Population: Outcomes from a Community Based Program Evaluation. The University of Texas at Arlington School of Social Work.

MHSA-funded work, A&A has observed four areas in which there are opportunities to strengthen services: 1) among adults aged 50 to 64; 2) among Hispanic and Latino aging adults; 3) in access to extended home-based case management and follow-up; and 4) in collaboration across programs, especially medical and community-based services. This CCERP project seeks to address the aforementioned challenges.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

Based on the number of individuals served in Adult & Aging (A&A)'s existing CoCM programs, and A&A's experience with community-based care coordination, it is anticipated that CCERP will have the capacity to serve a minimum of 225 clients with care management services during the three-year project: 50 clients in Year 1; 75 clients in Year 2, and 100 clients in Year 3. Year 1 will be a ramp-up period focused on training, hiring, developing workflows, and establishing evaluation structures, and thus will serve fewer clients. In Years 2 and 3, the program will have the capacity to serve more individuals.

Based on the experience of A&A and Petaluma Health Center (PHC), maximum caseloads for a half-time care manager are approximately 25 to 30 clients per caseload, a benchmark which is supported by the findings of a Cost Study conducted on the PHC & A&A CoCM project in April 2019, which indicated the program served 28 unique clients during a 4-week period.[42] These findings pertain to the 12-week CoCM intervention model as utilized by a half-time (0.5 FTE) care manager, and in the 4th year of a well-established program. Since CCERP will employ a full-time care manager (1.0 FTE), the caseload capacity for the established intervention model would translate to an estimated 50-60 clients, except that CCERP will also utilize a phased case management approach which will substantially increase caseload capacity.

With CCERP's phased case management approach, clients will remain active for a more sustained period of 12 months, but with a decreased level of intervention as they build a network of supportive resources and move towards transfer of care. This graduated level of care over time will allow for a larger capacity caseload, since clients in later phases (i.e. in the latter half of the 12-month period) will require less time than newer clients. Due to these variations in levels of care, combined with the utilization of a full-time care manager, CCERP will have a caseload capacity that is substantially higher than the existing CoCM program.

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

The target population is low-income clients at SRCH's Lombardi Campus who are 50 and over with a focus on inclusion of Hispanic/Latino Spanish-speaking clients through targeted in-reach and linguistically/culturally appropriate care. SRCH currently serves over 42,000 culturally diverse and low-income people living in the greater Santa Rosa area every year.[43] SRCH clients struggle with numerous socioeconomic and cultural barriers to health including poverty, language, literacy, food insecurity, addiction, and homelessness. More than 97% of SRCH clients live below 200% of the federal poverty level. Almost one-quarter are over the age of 50 and two-thirds of these are ages 50 to 64, the age range that CCERP will add to CoCM. 60% of SRCH clients are Hispanic and 38% are best served in a language other than English.

At the SRCH Lombardi Campus, where CCERP will launch, the concentration of Hispanic and Latino clients is especially high. 80% of Lombardi clients either prefer to receive care in Spanish or are monolingual Spanish. Across the agency, over 4,500 clients are diagnosed with depression. 25% of the 1,718 clients with mental health visits in the last 12 months at the Lombardi Campus were over age 50 (430), close to half of whom (46%) are identified in the electronic health record (EHR) as Hispanic (210). The Lombardi Campus only has a 64% compliance rate for a documented follow-up plan following a positive screen for depression (PHQ2). This reflects a 17% drop from a high of 80% in 2017, much of which is due to the bottom-line demands of SRCH's fire-recovery combined with the shortage of mental health support across the county.

[42] University of Washington AIMS Center, 2019. Report on Cost of Care for Collaborative Care Innovation at Sonoma County Human Services Dept, Adult & Aging Division and Petaluma Health Center

[43] Santa Rosa Community Health, 2019

RESEARCH ON INN COMPONENT A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

Through CCERP, A&A will expand the existing CoCM to serve a more diverse group for a longer period of time through the following modifications:

1. Extending the period of in-home care management services from 12 weeks to 12 months in order to: (1) ensure social determinants of health are addressed over a one-year period; and (2) allow the primary care team to align the community care plan goals with the medical and behavioral health goals established in the clinic setting;
2. Expanding the program population to include adults aged 50 to 64 (in addition to 65+) who have two or more activities of daily living (Katz Scale) or instrumental activities of daily living (Lawton scale) impairments;
3. Increasing targeted outreach to and engagement of Hispanic and Latino Spanish-speaking individuals, with an enhanced focus on culturally and linguistically appropriate care.

In addition, the existing service (CoCM) that is evidence-based is a 12-week intervention that begins to address identified depression in older adults yet has limiting factors in that the brief intervention does not allow for more comprehensive home-based assessment and follow-up support to address barriers to wellness. The additional 9-months of home-based care management will provide the continuity for the client and at the minimum support sustained outcomes, if not improve both physical and mental health outcomes.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

The closest models that currently exist are those currently being implemented in California through a grant from the Archstone Foundation. These models are overseen by the University of Washington (also funded by the Archstone Foundation). There are currently two Collaborative Care models being implemented in Sonoma County (one at Petaluma Health Center/Rohnert Park Health Center and one at West County Health Centers). These models are short-term (12 weeks) and only focused on clients that are 65 years and older. Literature reviews do not reveal any other similar models whereby primary care clinics are partnering with community-based organizations to focus on depression in older adults (or depression in clients 50 years and older).

Based on a review of existing literature and information collected through key informant interviews, the expanded scope of CCERP's programming and target population is both novel and needed. Although case management in combination with other depression interventions has been shown to improve outcomes,[44] we could not find documentation of the CoCM depression intervention model being applied in combination with long-term case management nor to the age group 50-64. Additionally, the need for culturally and linguistically appropriate depression care for Hispanic, Latino and immigrant adults is also well-documented both nationally[45] [46] and locally.[47]

University of Washington AIMS Center (Advancing Integrated Mental Health Solutions), that oversees California's CoCM depression programs for older adults and is at the forefront of late-life depression research, has verified the absence of CoCM depression care programs that include these new, expanded applications. The limitations of current programs' capacity to meet the needs of Sonoma County's aging

[44] Areán, P.; Mackin, S.; Vargas-Dwyer, E.; Raue, P.; Sirey, J.; Kanellopoulos, D.; Alexopoulos, G. "Treating Depression in Disabled, Low-income Elderly: A Conceptual Model and Recommendations for Care." International Journal of Geriatric Psychiatry. 2010 Aug; 25(8): 765–769.

[45] National Alliance on Mental Illness, https://www.nami.org/find-support/diverse-communities/latino-mental-health

[46] California Pan-Ethnic Health Network. Accessing Mental Health in the Shadows: How Immigrants in California Struggle to Get Needed Care. 2019

[47] Santa Rosa Community Health, 2019

population is also demonstrated by A&A's long waiting lists for existing home-based care coordination programs,[48] which are a vital way to address the risks and social determinants of health that directly impact older adults' physical and mental health.

LEARNING GOALS/PROJECT AIMS The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.
A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?
B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

A&A and SRCH will take a three-pronged approach to evaluating the success of CCERP's innovation in meeting the primary purposes described above. Through the following learning goals and related questions, A&A and SRCH will measure the success of the CCERP innovations with the goal of demonstrating a new precedent for expansion of effective practices in the mental health system.

Learning Goal/Project Aim #1: To assess the project's population impact via sustained patient outcomes by establishing whether extending the duration of home-based care management from 12 weeks to 12 months results in sustained improvement of depression symptoms over the course of the intervention period. CCERP will contribute to the expansion of effective practices in the mental health system by demonstrating whether an extended period of case management is an effective method of improving long-term outcomes for older adult depression CoCM interventions. By adding this new element to an evidence-based practice, CCERP can also set a precedent for a more comprehensive Collaborative Care Model that provides not only an extended period of case management, but also lengthens the duration of collaborative care's integration of both the medical model and the recovery model in optimizing patient care.

Question: For adults 50 and older whose depression symptoms improve with the existing CoCM's 12-week intervention, are these improvements sustained over the course of an additional 9-month case management period?

Learning Goal/Project Aim #2: To assess the project's system impact via appropriate health care utilization, as indicators that clients are accessing optimal medical care that is preventative in nature and supports their overall physical and mental health. CCERP will contribute to the expansion of effective practices in the mental health field by demonstrating how (or whether) combining an established CoCM depression intervention with long-term case management, while also extending the period of collaboration between the medical model and recovery model, can support older adults' in their appropriate utilization of health care. This new approach can also further the understanding of how collaborative teams that integrate medical care with mental health care can lead to improved patient outcomes that in turn have a positive impact on the health care system via more appropriate utilization of care and resources.

Question: For adults age 50 and older who receive a 12-week CoCM depression intervention plus nine months of case management, is there an improvement in appropriate utilization of preventative health care, as compared to participants' health care utilization prior to the intervention (baseline) and over the course of the treatment intervention?

Learning Goal/Project Aim #3: To assess the effectiveness of this intervention for the Hispanic and Latino population. Santa Rosa Community Health serves a large population of Hispanic and Latino adults. The goal of serving this population is to address the cultural barriers to serving Hispanic and Latino adults with symptoms of depression. CCERP will accomplish this goal by leveraging SRCH's deep expertise working with and for the Hispanic and Latino community, and their relationships with Hispanic and Latino-serving partners, to inform program development and ensure that culturally/ linguistically appropriate services and materials are provided.

[48] Sonoma County Human Services, Adult & Aging Division, 2019

Question: For Hispanic and Latino adults age 50 and older who receive the CCERP intervention, are there sustained depression symptom improvements and improvements in appropriate health care utilization? Pre and post PHQ-9 scores will be used in addition to metrics to be determined e.g., pre- and post-surveys on patient perception of mental health services.

EVALUATION OR LEARNING PLAN For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify HOW EACH goal will be measured and the proposed data you intend on using.

Learning Goal/Project Aim #1: To assess the project's population impact via sustained patient outcomes, with the goal of establishing that lengthening the duration of home-based case management from 12-weeks to 12-months results in sustained improvement of depression symptoms over the course of the intervention period.

Indicator(s): PHQ-9 scores will be used to measure the rate of response and remission maintained over the full-service period, by administering the PHQ-9 at regular intervals throughout the 12-month period. The post scores will also be compared to pre-scores taken at both at intake (baseline) and at the 12-week mark.

Learning Goal #2: To assess the project's system impact via appropriate utilization of preventative health care as an indicator that clients are receiving optimal medical care that is preventative in nature and supporting their overall physical and mental well-being.

Indicator(s): CCERP staff will measure appropriate utilization by metrics to be determined during the planning period. Indicators of appropriate health care utilization include: fewer urgent medical visits, decreased ER visits, increase in preventative primary care visits, tie to A1c/Hypertension (HTN)/cancer screenings, and medication adherence.

Learning Goal #3: To assess the effectiveness of this intervention for the Hispanic and Latino population.

Indicator(s): PHQ-9 scores will be used to measure the rate of response and remission maintained over the full-service period, by administering the PHQ-9 at regular intervals throughout the 12-month period. The post scores will also be compared to pre-scores taken both at intake (baseline) and at the 12-week mark. In addition, CCERP staff will measure appropriate utilization by metrics to be determined during the planning period. Indicators of appropriate health care utilization include: fewer urgent medical visits, decreased ER visits, increase in preventative primary care visits, tie to A1c/HTN/cancer screenings, and medication adherence.

Learning and Evaluation Approach:

The CBO Program Planning and Evaluation Analyst (PPEA) will partner with the SRCH Program Administrator and additional A&A and SRCH staff to evaluate the project. Based on stakeholder and staff input obtained during proposal development, the evaluation will draw upon existing data and evaluation infrastructure both at A&A and at SRCH to measure the learning goals. A&A currently acts as the administrative backbone for the existing CoCM projects at other locations, (Petaluma Health Center and West County Health Centers), as well as for other depression intervention programs that utilize PHQ-9 scores to measure and track depression symptoms, including the MHSA-funded (Prevention & Early Intervention) Older Adult Collaborative (OAC) project. The OAC project will be leveraged by CCERP as this project provides solely community-based case management (no primary care involvement) using the Healthy IDEAS intervention. As a result, CCERP clients may be referred to OAC partners if they have on-going case management needs after the 1-year CCERP intervention. The evaluation tracking systems developed for the data collection and reporting of these existing projects can inform the structure for the evaluation of CCERP and will be adapted to align with CCERP project goals.

The A&A Care Manager will record PHQ-9 scores and other applicable care management documentation in SRCH's Electronic Health Record (EHR), so that the care manager's documentation is integrated with that of the care team at SRCH. The A&A PPEA will work with the SRCH Program Administrator to coordinate the

collection and integration of de-identified data from both organizations into a format that meets program requirements and tracks performance measurements.

A&A and SRCH will evaluate client focused outcomes through PHQ-9 scores and additional metrics that can serve as a proxy for appropriate utilization, including self-reports, data points in electronic medical health records, hospitalization, and emergency room visits. The Sonoma County Human Services Department's Planning, Research, and Evaluation Team (PREE) will support clinical staff to measure these outcomes. A&A and SRCH will additionally evaluate the success of the program purpose of increasing access for unserved or underserved groups, by assessing whether the percentage of Spanish-speaking adults enrolled in CCERP is statistically similar to the total percentage of Spanish-speaking SRCH clients age 50 and older. System-wide outcomes will be evaluated through metrics to be developed during the planning period.

The CBO PPEA, with support from the HSD Planning, Research, and Evaluation Team and additional A&A and SRCH staff as needed, will work to track health care utilization data from SRCH and, as available, through the County and/or Partnership Health Plan to analyze the utilization of care in the county's medical and mental health service delivery system.

SRCH's Quality and Data team will support the CBO PPEA and SRCH Program Administrator in data collection, analysis, reporting, and dissemination. SRCH data staff will utilize the Relevant analytics tool to collect and analyze actionable data. This tool provides standard reports for depression screening and follow-ups, and a full array of medical data, and the capability to develop additional reports to support CCERP goals.

Evaluation Measures and Methods

SRCH has a comprehensive electronic health record (EHR) that is used by the integrated care team to capture all patient information, health issues, and visit history. SRCH also uses a very robust data-analytics and visualization platform to mine, analyze and share that data to manage population health at the patient, provider, care team, clinic, and health condition level. All information for CCERP will be kept in and drawn from the EHR. This includes demographics, chronic disease diagnoses, visit histories, screening scores, etc. Reports that target the project population will be developed over the course of the project to track evaluation measures and enable continuous monitoring and quality improvement.

Upon project initiation, the CCERP team will convene to finalize the specific set of measures to track, establish the required workflows for gathering, sharing, and analyzing data, and establish baselines for all measures. Data will be analyzed first for improvement with the program cohort and then compared against baseline of the target population not participating in the intervention. Any screens or tools will also be checked for cultural and linguistic appropriateness and effectiveness for Hispanic/Latino and Spanish-speaking clients. Given the stated learning goals/project aims, measures and methods will likely include such items as:

- **Response and remission rates for depression:** Collect participant PHQ-9 scores at induction, three-, six-, nine-, and twelve-month marks in the program. Compare to depression response rates for the established 12-week CoCM program, and to individual baselines for each participant.
- **Program adoption and adherence rates**: Track the number of potential program participants, how many accept the program, # of visits and calls completed, and how long they stay in the program. Compare to rates for the established CoCM program.
- **Positive health care utilization behaviors:**
    - # of patient preventative care visits. Monitor follow through or no-show rate for primary care and mental health appointments, i.e. when primary care provider recommends additional visits to check in on physical and mental health issues (depression, diabetes, heart health, etc.). Use EHR data to compare against baseline of depressed clients not participating in program with the goal of increasing program participant follow through in recommended and preventative care.
    - % of clients compliant with recommended health screenings. Track cohort compliance with cancer, HIV/HepC, A1c, etc. Use EHR data to compare against baseline with the goal to increase compliance.

    - Medication adherence. Monitor patient's use of prescribed medication with the goal of increasing adherence by a reasonable percentage, data collected through provider and care manager interactions.
- **Decreases in social isolation:** Results from The Campaign to End Loneliness Measurement Scale, a three-question self-assessment. Capture at induction, three-, six-, nine-, and twelve-month marks in the program with the goal to see an increase in positive indicators such as the quality of relationships.
- **Improvement in social determinants of health:**
    - # and type of Social Determinants of Health (SDOH) in program participants. Compile results from the PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences) screening tool and Healthy IDEAS toolkit, gathered in-clinic and at in-home assessments.
    - Progress on the goals each patient establishes as priorities for their improved health and well-being. Definitions for progress will be defined based on the various categories included in the assessments. For example, housing may be an identified priority issue, but complex to solve. Throughout the project, the CCERP team will collate data to identify themes around patient needs and barriers to care.
    - # of referrals made. Use EHR and NorCal Resources database to make, share and track referrals made to connect clients with available resources such as a healthy food box or yoga groups.
- **Improve outcomes and reduce disparities or limitations in care for Hispanic/Latino and Spanish speaking clients age 50 and above with depression**.
    - Of those identified with depression, how do their A1c and hypertension compare to their white cohort at induction and over the program period?
    - Of those identified with depression, how do their SDOH compare to their white cohort at induction and over the program period?
    - How do program adoption and adherence rates vary between Hispanic/Latino and white clients?
    - Is insurance coverage a barrier to program participation or engagement with recommended care for immigrant or undocumented clients? There is a high-percentage of these individuals at the Lombardi Campus. Insurance status can be collected from the EHR to identify care limitations for this population.

SECTION 3: ADDITIONAL INFORMATION FOR REGULATORY REQUIREMENTS

CONTRACTING

Sonoma County Department of Health Services (DHS) will establish an inter-departmental Memorandum of Understanding (MOU) with the Human Services Department, Adult and Aging Division (A&A) to establish goals, scope of work, roles and responsibilities for the proposed three-years of Innovation funding.

The proposed project, Collaborative Care Enhanced Recovery Project (CCERP), will be a collaboration between the Sonoma County Human Services Department/Adult & Aging Division (A&A) and Santa Rosa Community Health Centers (SRCH), with A&A acting as the administrative backbone of the project. As the administrative lead, A&A will ensure that the project and its execution are in alignment with the Project Plan, including regulatory compliance, structuralization of the evaluation plan, and establishment of contracts. A&A will establish a contract with SRCH that clarifies these same items as well as payment terms, since SRCH's funding will pass through A&A. HSD's dedicated Contracts & Procurement unit will develop the contract with input from A&A and SRCH. The Contracts & Procurement unit will handle all aspects of insurance compliance, risk management, and the signature process. The A&A team also includes a dedicated fiscal team to coordinate and manage revenue, invoicing, and payment.

The MHSA Coordinator of the Sonoma County DHS Behavioral Health Division will be the main point of

contact to monitor progress of CCERP and assure contract compliance and MHSA adherence per County and State regulations. The MHSA Coordinator may provide technical support in program delivery and evaluation, fiscal reporting and program reporting for this project. Project coordination meetings will be held quarterly to establish expectations in reporting and to assure compliance with MHSA and Innovation regulations. In addition, A&A will be expected to submit quarterly reports that include quantitative (number of clients served, demographics) and qualitative data (narrative reporting that includes findings, challenges, and solutions).

In addition, the A&A PPEA will schedule project planning meetings during the ramp-up period and administrative meetings throughout the contract period, to support and facilitate relationship building, and project fidelity. A&A will also offer technical assistance to SRCH as needed, including connecting SRCH staff with their peers on PHC's CoCM team to leverage PHC's experience regarding best practices, workflow, and other lessons learned. The evaluation will be conducted internally with a team from both HSD and SRCH.

COMMUNITY PROGRAM PLANNING

The County has robust stakeholder engagement in the MHSA Community Program Planning process. This includes the MHSA Steering Committee, Stakeholder Committee, county staff and contractors and any other interested parties. The County's MHSA Steering Committee is a key stakeholder and the committee is comprised of 27 diverse community members, including consumers, family members, TAY, ethnic and LGBTQ+ representation, various public sector personnel and advocates (see Appendix A for membership representation).

Since January of 2019, The MHSA Steering Committee has met at least quarterly to participate in shaping the mental health system of care funded by MHSA. In the summer of 2019, the MHSA Steering Committee established an Innovation Subcommittee to develop an inclusive community process that would solicit innovative project proposals, develop and apply a selection criterion for the incoming proposals and make a recommendation to award Innovation funds to selected projects. The Community Program Planning process is outlined below:

2019	Task
May-June	Understand Innovation regulations and requirements, discuss and define community planning process.
July	Develop and adopt community application, scoring criteria and FAQs to solicit Innovation Project Ideas.
Aug	Establish a calendar of community meetings for outreach and to inform the community about the Innovation opportunity; develop community presentation; conduct outreach for community meetings.
Sept	Conduct five community meetings in strategic geographic locations throughout the county to inform interested parties about MHSA and Innovation opportunity, including requirements, application form and selection criteria.
Oct	Received sixteen Innovation applications from the community; Innovation Subcommittee members reviewed and scored all applications based upon previously agreed upon selection criteria; Innovation Subcommittee held 2 full day meetings to discuss applications and arrive at consensus on prioritized projects and developed recommendation for funding.
Dec	Presented recommendation to MHSA Steering Committee and Mental Health Board (public meeting). Recommendation forwarded to the Behavioral Health Director and the Department of Health Services administration. Innovation applicants notified of status; meetings convened with approved projects to further develop their proposals.

In the table below the dates and locations of the community meetings are provided:

Date	Time	Location
September 4, 2019	10:30am – 12:30pm	Guerneville Regional Library 14107 Armstrong Woods Rd., Guerneville (West County)
September 4, 2019	3:00pm – 5:00pm	Sonoma Valley Regional Library 755 West Napa Street, Sonoma (East County)
September 11, 2019	9:00am – 11:00am	DHS Administration Santa Rosa Conference Room, 1450 Neotomas Ave., Santa Rosa (Central County)
September 11, 2019	1:00pm – 3:00pm	Petaluma Health District, 1425 N. McDowell Blvd., Rm 100, Petaluma (South County)
September 13, 2019	1:00pm – 3:00pm	Healdsburg Library 139 Piper St., Healdsburg (North County)

The table below provides the 16 applicant names and project titles.

Applicant	Project Title
Action Network (Sonoma County Indian Health Project, Redwood Coast Medical Services, Community Wellness Coalition)	Implement Community Resilience Leadership Model on the Rural Redwood Coast
Brief and Strategic Integrated Counseling Services (BASICS) [First Responder Support Network (FRSN)]	Approach to address workplace trauma among Sonoma County's first responders
Buckelew Programs (Aldea Children and Family Services, On the Move/VOICES)	Early Psychosis Intervention Care EPIC Program (EP LHCN)*
Center for Innovation and Resources	Effective, Equitable, Expanded (3E) Mental Health in Sonoma County Project
Early Learning Institute	Instructions Not Included (INI) with Dads Matter*

First 5 Sonoma County	Promoting Early Relational Mental Health: New Parent TLC*
Hanna Institute [Center for Well Being (CWB), International Trauma Center (ITC)]	"Bridging Gaps in Mental Health Care in Vulnerable Communities"
Human Services Department Adult and Aging Division	CCERP: Collaborative
On the Move/VOICES (La Plaza, Humanidad, Latino Service Providers, Raizes Collective and North Bay Organizing Project)	Nuestra Cultura Cura Social Innovations Lab*
Petaluma Health Center	Psychiatric Nurse Practitioner Residency
Petaluma People Services Center	Manhood 2.0
Side by Side	New Residents Resource Collaborative
Social Advocates for Youth	Innovative Grief Services
Social Advocates for Youth	Street-Based Mental Health Outreach
Sonoma County Human Services Department Adult & Aging (and Santa Rosa Community Health)	Collaborative Care Enhanced Recovery Project: Advancing Older Adult Depression Care through Extended Supportive Services (CCERP)
Sonoma County Indian Health Project	Primary and Behavioral Health Care Integration Program with Traditional Native Healing Practices
Sonoma County Public Health Maternal Child and Adolescent Health	Trauma-Informed Approach in Public Health Nursing

In preparing the Innovation projects proposals for public review and appropriate approvals from local and state authorities, the following timeline has been developed.

2020	Task

Feb-Mar	Prepared draft proposals for submission to Mental Health Services Oversight and Accountability Commission (MHSOAC) for technical assistance.
Mar	Submitted draft proposals to MHSAOC for review and technical assistance
Apr	Posted MHSA 2020-2023 Three-Year Plan with the five prioritized Innovation proposals for 30 days
May	Held public hearing at the Sonoma County Mental Health Board meeting. No substantive comments were received about the Innovation proposals.
June	Sonoma County Board of Supervisors approved the MHSA 2020-2023 Three-Year Plan that included the five prioritized Innovation proposals.
Sept/Oct	Received feedback and technical assistance from MHSOAC and incorporated feedback into proposals.
Nov	Posted Innovation proposals for 30-day public review period.
Dec	Held public hearing at the Sonoma County Mental Health Board meeting. No substantive comments were received about the Innovation proposals.
2021	Task
Jan	Resubmit projects to MHSOAC for approval.
Feb	February 23, 2021 submit board item for Board of Supervisors review and approval.

On November 13, 2020, the County posted 4 proposed Innovation Projects, Instructions Not Included, CCERP, New Parent TLC and Nuestra Cultura Cura for the 30-day public review period. Followed by a public hearing hosted by Sonoma's Mental Health Board on December 15, 2020. No substantive comments were received on any of the projects during the 30-day review period or at the public hearing.

For the review period, the County's process is to post the project proposal on the Department's website/Behavioral Health Division webpage and send notification out to MHSA Steering Committee members, MHSA Stakeholder Committee, contacts on the MHSA Newsletter list) (over 2000 contacts), County staff and contractors and any other interested parties.

In addition to the County's community program planning process, each of the applicants were required to develop their proposed projects with consumer and community input to validate the need among the population and that the innovation proposed was a feasible and strategic approach to the defined community/mental health challenge and this is detailed on page 6.

MHSA GENERAL STANDARDS Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration – CCERP is a collaboration between a community-based social services agency focused on serving older adults (A&A) and an FQHC primary care clinic (SRCH). The project will also include collaboration with other community-based organizations, especially SRCH's Hispanic and Latino-serving partners, as well as stakeholders and consumers to inform program refinement through surveys and other community engagement opportunities to share progress updates and solicit input from the community.

B) Cultural Competency – CCERP will facilitate improved access to services to two underserved populations: older adults including ages 50-64, and the subset of Hispanic and Latino older adults. The

project will leverage existing expertise from both agencies utilizing bilingual/bicultural staff and ensure that the agencies hire and train culturally competent staff to focus on the Hispanic and Latino older adult population experiencing symptoms of depression.

C) Client-Driven – The care management model being employed in CCERP is Healthy IDEAS,[49] a person-centered and client-driven model of care focused on the client's goals for care management. Santa Rosa Community Health is accredited as a designated Patient Centered Medical Home.

D) Family-Driven – Where appropriate and with the consent of the patient, this model will incorporate the client's family into the care management goals.

E) Wellness, Recovery, and Resilience-Focused – CCERP's in-home case management model supports and facilitates wellness, recovery, and resilience by empowering clients to set and reach individual goals while addressing social determinants of health***.*** The collaborative care model also addresses wellness by integrating the patient's medical and mental health care to optimize the patient experience of whole-person care. Extending the duration of the intervention from 12 weeks to 12 months will allow care managers to assist the patient in building the supports and resources necessary to continue pursuing wellness and recovery.

F) Integrated Service Experience for Clients and Families – CCERP brings together a social service provider with a medical provider is a model for an integrated service experience for clients.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

During the planning phase, A&A and SRCH leadership will convene an Older Adult Steering Committee (Committee) that is comprised of consumers, service providers, project staff and social workers, and adult community members aged 50-64, with a focus on Hispanic and Latino stakeholders. Evaluation of CCERP's success will include stakeholder engagement via the Older Adult Steering Committee. The Committee will meet at predetermined intervals and will serve as an oversight body to track the project's progress towards meeting its learning goals through regular group discussions and project updates. The Committee will provide strategic direction for CCERP, including input on project refinement and a plan for soliciting feedback from the larger community.

SRCH will also leverage their expertise in outreaching Spanish-speaking populations, as well as their relationships with Hispanic and Latino-serving community partners, to ensure that CCERP identifies culturally competent initiatives and pursues the most effective and inclusive communication channels. As the project progresses, A&A and SRCH leadership will determine whether any stakeholder group is not meaningfully involved in the engagement and evaluation process, and will actively reach out to those groups as necessary.

The CBO PPEA and SRCH Program Administrator will be responsible for obtaining end-user feedback. These staff members will leverage existing community groups, including the Area Agency on Aging (AAA), Geriatric Workforce Enhancement Program, Sonoma County Health Action, My Care My Plan, and Redwood Community Health Coalition (RCHC). The CBO PPEA and SRCH Program Administrator will work with these groups, and others, to solicit consumer and other stakeholder feedback that will be shared with the Older Adult Steering Committee.

SRCH has demonstrated dedication to meaningful involvement of stakeholders to ensure culturally appropriate services; SRCH uses questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to regularly survey clients regarding their satisfaction with services received at SRCH sites. Clients are additionally invited to participate in an annual mail-in survey about their experiences, which may be

[49] For more information, see http://healthyideasprograms.org/

expanded to include questions about CCERP. SRCH will include questions about the evaluation on its annual survey to be administered to all clients of the proposed project and the staff who serve them.

CCERP will ensure that A&A and SRCH's innovative recovery model provides Hispanic/Latino older adults with services that are both culturally responsive and linguistically appropriate. To that end, A&A will require that Social Workers who serve as project staff are bilingual in Spanish, and SRCH will have strong bilingual representation in all project-related positions. CCERP will ensure that all community outreach and education, including printed materials, are provided in both culturally-appropriate English and Spanish. As well-documented in other sections of this plan, SRCH's experience working with and for the Hispanic and Latino community is extensive, as are their relationships with Hispanic and Latino-serving community partners, both of which will be leveraged to inform and expand outreach and to ensure that CCERP delivers culturally appropriate services.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

The MHSA Coordinator, with the assistance of the MHSA Innovation Subcommittee, will host an annual meeting to review progress of the active Innovation Projects. Each Innovation Project will be required to submit an annual evaluation report on findings to date. These annual reports will be reviewed and discussed among the Innovation Subcommittee members who will focus on successful outcomes and challenges that may prompt the need for technical assistance and additional resources.

Specific to this proposed project, the Sonoma County Behavioral Health Division will work in collaboration with the A&A and SRCH to look holistically at the success of the project. Data driven decision-making will determine if the project is promising and additional time is indicated to further develop definitive results for the project. If necessary, a criterium will be developed to determine if an Innovation project should be extended for up to two years with continued Innovation funding (up to five years total) or supported with alternative funding. Projects can be supported in whole or focused on specific components that are particularly successful in addressing the mental health challenge for the community. It will be necessary to consult with the full MHSA Steering Committee, Behavioral Health Division administration, and/or other community resources such as local foundations, and the Board of Supervisors.

A&A is committed to ensuring continuity of care for CCERP clients and will continue to actively work on identifying ways to make the proposed project sustainable beyond the duration of the project period. Following the end of MHSA Innovations funding, clients will continue to have access to the programs of the Sonoma County Behavioral Health Division and available SRCH services. To help facilitate clients transitioning out of the case management program and into independent care maintenance, A&A and SRCH will take a phased approach to case management for CCERP clients, gradually decreasing the frequency and level of support over the course of the nine-month period. Phasing case management services according to client's individual needs will enable project staff to connect clients with necessary supports and resources as they move toward stability before gradually transferring care.

Staff will use practices to mobilize community support for vulnerable older adults during the period of transition out of CCERP, facilitating continuity of care through enduring ties to the community and support systems. After observing the improvements in patient outcomes resulting from the existing CoCM project, PHC has committed to sustaining services beyond the life of the initial grant; similarly, SRCH aims to develop methods to sustain the model beyond the duration of Innovation funding.

To explore options that will support long-term sustainability and ongoing funding, A&A is currently consulting with the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center to incorporate Medicare billing to reimburse partners, including SRCH and PHC, for costs associated with CoCM. It is A&A's goal to identify a process by which to reimburse SRCH for time spent administratively on CCERP and for time spent on the project by multidisciplinary team staff. The primary care physician would bill Medicare monthly when the multidisciplinary care team delivers services that meet or exceed a time threshold defined under the billing code, following which the internist would pay the behavioral health care

manager and psychiatric consultant directly. This billing model for CoCM has been implemented successfully in other health care settings nationally, including Rush University Medical Center in Chicago.

Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

The Collaborative Care Enhanced Recovery Project (**CCERP)** is aimed at serving adults with mild to moderate depression. At the same time, CCERP will extend its ability to identify the range of mental health issues in the Latino community from mild to moderate to severe, and then connect community members to the most appropriate level of care. CCERP model includes referral to the psychiatrist or higher levels of intervention where higher levels of risk are identified. The great benefit is identifying untreated, undertreated, unidentified issues or those lost to care. If and when people with serious mental illness are identified through CCERP outreach, they will be connected to the appropriate level of care. Both project partners are highly versed in community resources to ensure appropriate and continuous care and SRCH, in particular as an FQHC, would be the primary care home for these clients and follow all the established protocols for clients with severe mental illness.

COMMUNICATION AND DISSEMINATION PLAN Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties?

Lessons learned through CCERP will be shared with the community through regular evaluation summaries, developed by A&A and SRCH in accessible language in both English and Spanish with feedback from the Older Adult Steering Committee. The Committee will engage a broad representation of stakeholders, including strong representation from the Hispanic and Latino community and a culturally diverse assembly of staff and consumers, to participate in the planning and execution of communication initiatives to disseminate CCERP results. The Committee's participation will help ensure effective outreach to Spanish-speaking populations and will support CCERP's ability to clarify key messages and identify initiatives to attract community members' attention.

With support and assistance from HSD's dedicated Communications Manager, A&A will disseminate this summary through established County, agency, and Older Adult Steering Committee public information channels, including social media. Leveraging the channels of CCERP lead agencies, and their partners, will ensure communication with a wide group of stakeholders. A&A and SRCH will disseminate information about CCERP, its evaluation, and lessons learned with similar programs, agencies, and clinics within the county and regionally that would benefit from implementation of the model.

How will program participants or other stakeholders be involved in communication efforts?

The aforementioned Older Adult Steering Committee (Committee) will engage a broad representation of stakeholders, including a culturally diverse assembly of staff and consumers, to participate in the planning and execution of communication initiatives to disseminate CCERP results. The Committee will include strong representation from the Hispanic and Latino community, whose participation will help ensure effective outreach to Spanish-speaking populations and will support CCERP's ability to clarify key messages and identify initiatives to attract community members' attention.

CCERP will leverage relationships and partnerships with existing community groups, including the Area Agency on Aging (AAA), Geriatric Workforce Enhancement Program, Health Action, My Care My Plan, and RCHC, to contribute to and facilitate community outreach, education, and dissemination of results. The CBO PPEA and SRCH Program Administrator will work with these groups, and others, to disseminate information and solicit stakeholder feedback regarding communication and information-sharing.

Program participants will also be encouraged to support and inform communication efforts through participation in the Committee, participation in patient advisory groups, and answering patient surveys. Since all printed materials, including summaries and results, will be available in both English and Spanish, clients will be invited to share this information with their community.

B) ***KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.***

(1) Collaborative Care; (2) Depression; (3) Older adult; (4) Home visit; (5) Case Management

C) TIMELINE A) Specify the expected start date and end date of your INN Project B) Specify the total time frame (duration) of the INN Project C) Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

A. The expected start date of the project is July 2021 and the expected end date is June 2024.
B. The total time frame (duration) of the project is 36 months (3 years).
C. The key activities, milestones, and deliverables are included in the table below corresponding with the 12 quarters of the project.

* This timeline is dependent on the public review process and project approval by the MHSOAC.

PROJECT PLAN TIMELINE		
Quarter	**Activity/Milestone**	**Deliverable**
Q1 Jul-Sep 2021	- Hire CCERP staff - Convene multi-disciplinary CCERP team - Begin development of the evaluation plan with specific metrics	- Staff hired - Team charter that defines roles, responsibilities, and work plan
Q2 Oct-Dec 2021	- Onboard and train staff - Solicit end-user feedback to share with committee - Finalize the evaluation plan - Begin build of queries and reports to track patient/program data - Develop bilingual materials for outreach, education and engagement	- Staff trained and oriented - Feedback analyzed and prepared for committee - Final evaluation plan - Bilingual printed materials
Q3 Jan-Mar 2022	- Convene Older Adult Steering Committee to refine project and evaluation - Identify clients in target population and begin providing depression intervention (traditional CoCM) - Complete the build of queries and reports to track patient/program data - Implement evaluation plan	- Project reviewed and refined based on feedback - First patient/clients begin being served - Completed reports in SRCH “Relevant” data-analytics platform - Program evaluation and data collection begin
Q4 Apr-Jun 2022	- Client enrolled in Q3 begin receiving long term in-home care management	- Long-term care management begins for first set of clients
Q5 Jul-Sep 2022	- Reconvene Older Adult Steering Committee to continue refining project - Evaluate Year 1 progress and findings	- Project reviewed and refined based on feedback - Disseminate Year 1 progress to relevant groups and stakeholders

Q6 Oct-Dec 2022	- Annual survey administered to all CCERP clients	- Survey results received and evaluated
Q7 Jan-Mar 2023	- Clients continue to be enrolled in both phases of the program - Clients enrolled 1 year ago begin discharge from program	- Ongoing client services - First quarter with full year of client data to evaluate
Q8 Apr-Jun 2023	- Clients continue to be enrolled in both phases of the program	- Ongoing client services
Q9 Jul-Sep 2023	- Reconvene Older Adult Steering Committee to continue project refinement - Evaluate Year 2 findings - Evaluation report and preliminary findings review with DHS/BHD administration for sustainability	- Project reviewed and refined based on feedback - Disseminate Year 2 progress to key partners and County Behavioral Health - Sustainability planning begins
Q10 Oct-Dec 2023	- Final clients enrolled in short-term phase of program	- Last quarter of new enrollments into program - Ongoing services for those already enrolled
Q11 Jan-Mar 2024	- Evaluation report draft presented to key partners and stakeholders for feedback - Case management focus on client transition	- Evaluation report finalized with input - Ongoing client services and transition planning
Q12 Apr-Jun 2024	- Complete evaluation and share internally with CCERP team - Develop summary of project results accessible in English and Spanish – share with Older Adult Steering Committee for feedback - Summary of project results shared with Sonoma County Behavioral Health	- Evaluation completed and shared internally - Summary shared with Older Adult Steering Committee - Summary of project results disseminated through all appropriate communication channels

SECTION 4: INNOVATIONS PROJECT BUDGET AND SOURCE OF EXPENDITURES

A. Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project.

A&A requests $998,558 in MHSA Innovation funding to implement CCERP in collaboration with SRCH. To ensure funding supports direct services to the identified population, all project expenditures will pay for staffing costs as detailed in the attached budget. A&A and SRCH plan to leverage existing resources and funding streams and to that end will not request the standard indirect cost of 10%. Indirect costs such as as communications, travel/mileage, printed materials, and operating costs, will be funded solely through in-kind match.

CCERP will be carried out by a program team comprising 1.0 FTE CBO Care Manager (embedded at SRCH), 0.5 FTE CBO Program Planning and Evaluation Analyst (PPEA), 0.1 FTE CBO Supervisor, 0.275 SRCH Program Administrator, 0.5 SRCH Care Coordinator/Patient Navigator, 0.1 SRCH Primary Care Physician, 0.013 FTE SRCH Psychiatric Consultant, 0.1 FTE SRCH RN Case Manager, 0.1 FTE SRCH Behavioral Health Manager Supervision, and 0.2 FTE SRCH Behavioral Health Provider.

In addition to patient/client services and day-to-day operations, CCERP staffing time includes participation in care management meetings, which will be held at SRCH and attended by all CCERP services staff. As clients demonstrate fewer depression symptoms over the nine-month case management period, their cases will be brought back to the multidisciplinary team for brief monthly or biweekly check-ins. Leadership staff and program staff from SRCH and A&A will also participate in quarterly project administration meetings

C. BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

To demonstrate their strong commitment to this work, A&A and SRCH plan to leverage existing resources and funding streams and will not request the standard indirect cost of 10%. Instead, all indirect costs will be funded solely through in-kind match, including expenses such as communications, travel/mileage, printed materials, and operating costs.

The A&A Section Manager, with support from A&A support staff, will contribute to program implementation, contracting, and reporting requirements as in-kind match, and A&A personnel benefits will be partially funded as match. Similarly, the SRCH Directors of Quality Integrated Behavioral Health Services, and Grants will provide evaluation, program, and grant support as an in-kind match.

SRCH will deliver CCERP services within the context of primary care delivery, integrated with essential mental and behavioral health care; this primary care infrastructure is supported through patient visit revenue and limited Health Resources & Services Administration (HRSA) grants. As introduced in Section IIc, PHC will provide training and technical assistance for CCERP staff on an as-needed basis at no cost to the county. Staff will participate in online trainings, accessible through the University of Washington, with whom A&A has worked extensively on the existing CoCM projects.

Funds Subject to Reversion

Sonoma County has $822,000 in MHSA Innovation dollars that are subject to reversion on June 30, 2021. Sonoma County is submitting four Innovation proposals simultaneously, including this proposal for CCERP, to the MHSOAC in December 2020 following the public hearing on December 15th at the Sonoma County Mental Health Board meeting. The combined total of the four Innovation proposals that are being submitted to the MHSOAC in December 2020 is $2,783,034.

B. BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY

Expenditures							
Personnel Costs	FY20/21	FY21/22	FY22/23	FY 23/24	TOTAL	Match	Total Project Cost
Salaries							
1.0 FTE CBO Care Manager	$0	$87,925	$74,600	$50,775	$213,300	$0	$213,300
0.5 FTE CBO PPEA	$0	$48,600	$41,200	$28,050	$117,850	$0	$117,850
0.1 FTE CBO Supervisor	$0	$9,830	$8,340	$5,670	$23,840	$0	$23,840
0.275 FTE SRCH Program Administrator	$0	$34,046	$28,218	$19,949	$82,213	$0	$82,212
0.5 FTE SRCH Care Coordinator/Navigator	$0	$43,264	$35,858	$25,350	$104,472	$0	$104,472
0.1 FTE SRCH Primary Care Physician	$0	$25,293	$20,963	$14,820	$61,076	$0	$61,076
0.013 FTE SRCH Psychiatric Consultant	$0	$4,992	$4,138	$2,925	$12,055	$0	$12,055
0.1 FTE SRCH RN Case Management	$0	$12,913	$10,702	$7,566	$31,181	$0	$31,181
0.1 FTE SRCH BH Manager Supervisor	$0	$14,643	$12,137	$8,580	$35,360	$0	$35,360
0.2 FTE Behavioral Health Provider	$0	$23,962	$19,860	$14,040	$57,862	$0	$57,862
Direct Costs							
CBO benefits @ 46%	$0	$67,323	$57,104	$38,868	$163,296	$117,147	$280,442
Clinic benefits @ 25%	$0	$39,778	$32,969	$23,307	$96,054	$0	$96,054
Indirect Costs	$0	$0	$0		$0	$51,829	$51,829
Total Personnel Costs	$0	$412,569	$346,089	$239,900	$998,558	$168,975	$1,167,534
Other Expenditures		FY21/22	FY22/23	FY23/24	TOTAL	In-Kind Match	Total Project Cost
0.025 FTE Director Integrated Behavioral Health		$0	$0	$0	$0	$12,364	$12,364
0.025 FTE Director Quality and Data		$0	$0	$0	$0	$12,364	$12,364
0.01 FTE Director Grants		$0	$0	$0	$0	$8,886	$8,886
Clinic benefits @ 25%		$0	$0	$0	$0	$8,403	$8,403
Indirect Costs		$0	$0	$0	$0	$52,229	$52,229
Total Other Expenditures		$0	$0	$0	$0	$94,246	$94,246
Budget Totals							
Personnel	$0	$305,468	$256,016	$177,725	$739,209	$0	$739,209
Direct Costs	$0	$107,101	$90,073	$62,175	$259,350	$168,976	$428,326
Other Expenditures	$0	$0	$0	$0	$0	$94,246	$94,246
Total Innovation Budget		$412,569	$346,089	$239,900	$998,558	$263,222	$1,261,780

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	FY 20/21	FY 21/22	FY 22/23	FY 23/24	N/A	TOTAL
1.	Innovative MHSA Funds	$0	341,620	285,932	198,947		826,499
		$0	0				
2.	Federal Financial Participation	$0	0				
3.	1991 Realignment	$0	46,537	39,475	26,869		112,881
4.	Behavioral Health Subaccount	$0					
5.	Other funding* (Medi-Cal Reimbursements)	$0	39,029	32,349	22,868		94,246
6.	Total Proposed Administration		427,186	357,756	248,684	0	1,033,626
EVALUATION:							
B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 20/21	FY 21/22	FY 22/23	FY 23/24	N/A	TOTAL
1.	Innovative MHSA Funds	$0	70,949	60,157	40953		172,059
2.	Federal Financial Participation	$0					
3.	1991 Realignment	$0	23,129	19,614	13,352		56,095
4.	Behavioral Health Subaccount	$0					
5.	Other funding*	$0					
6.	Total Proposed Evaluation	$0	94,078	79,771	54,305	0	228,154
TOTAL:							
C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 20/21	FY 21/22	FY 22/23	FY 23/24	N/A	TOTAL
1.	Innovative MHSA Funds	$0	412,569	346,089	239,900		998,558
2.	Federal Financial Participation	$0					
3.	1991 Realignment	$0	69,666	59,089	40,221		168,976
4.	Behavioral Health Subaccount	$0					
5.	Other funding*	$0	39,029	32,349	22,868		94,246
6.	Total Proposed Expenditures	$0	521,264	437,527	302,989	0	1,261,780
*If “Other funding” is included, please explain. Other funding is from Medi-Cal Reimbursements (for SRCH)							

First Name	Last Name	Industry	Representing
Claudia	Abend	Community at-large	Consumer, Family member
Mechelle	Buchignani	Law Enforcement	
Jessica	Carroll	MH, Social Services	Consumer, LGBTQ+
Sophie Marie	Clifford	Substance Abuse	Consumer, Latina, LGBTQ+
Mandy	Corbin	Education	Family Member
Christy	Davila	Social Services	
Angie	Dillon-Shore	0-5	LGBTQ
Jeane	Erlenborn	Education	
Cynthia	Kane Hyman	Education	
Ozzy	Jimenez	Businessman	LGBTQ, Latino
Erika	Klohe	MH, Community Benefits,	Family Member
Claire	McDonell	Education	Family Member, TAY
John	Mackey	Healthcare	Veteran
Shannon	McEntee		Consumer, TAY
Mike	Merchen	Law Enforcement	Family Member
Allison	Murphy	0-5	Family Member
Ernesto	Olivares	Social Services	Latino
Matt	Perry	Probation	
Ellisa	Reiff	Disabilities	
Kate	Roberge	MH, Disabilities, Workforce	Consumer, Peer
Kurt	Schweigman	Healthcare, MH	Native American
Kathy	Smith	Mental Health Board	Family member
Susan	Standen	Self-employed, MH peers	Consumer
Angela	Struckmann	Social Services	Family Member
Katie	Swan	Mental Health	Family Member, LGBTQ+, TAY
Sam	Tuttelman	Community at-large	Family member
Carol Faye	West	Peer	Consumer, Family member