EXHIBIT A

INNOVATION WORK PLAN
COUNTY CERTIFICATION

County Name: El Dorado

County Mental Health Director	**Project Lead**
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Mailing Address: El Dorado County Health Services Administration 931 Spring Street Placerville, CA 95667	Mailing Address: El Dorado County Mental Health Division 670 Placerville Drive, Suite 1B Placerville, CA 95667

I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this Innovation Work Plan. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code Section 5891 and Title 9, California Code of Regulations (CCR), Section 3410, Non-Supplant.

This Work Plan has been developed with the participation of stakeholders, in accordance with Title 9, CCR Sections 3300, 3310(d) and 3315(a). The draft Work Plan was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board or commission. All input has been considered with adjustments made, as appropriate. Any Work Plan requiring participation from individuals has been designed for voluntary participation therefore all participation by individuals in the proposed Work Plan is voluntary, pursuant to Title 9, CCR, Section 3400 (b)(2).

All documents in the attached Work Plan are true and correct.

Signature (Local Mental Health Director/Designee)	Date	Director Title

EXHIBIT B

INNOVATION WORK PLAN
Description of Community Program Planning and Local Review Processes

County Name: El Dorado
Work Plan Name: Closing the Gap through Community Capacity Building

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this Annual Update.

1. Briefly describe the Community Program Planning Process for development of the Innovation Work Plan. It shall include the methods for obtaining stakeholder input. (suggested length – one-half page)

The MHSA Project Management Team was responsible for the Community Program Planning Process. A key feature of ensuring comprehensive and representative participation was providing a range of avenues for input. This included emailing meeting notices to the MHSA e-mail group as well as posting the notices on the MHSA website. Options for participation outside of the planning meetings included providing input via a local phone line, MHSA e-mail address, and submission in person or in writing.

In October of 2009, El Dorado's MHSA Project Management Team initiated the MHSA Innovation Community Planning Meetings. Two meetings were scheduled, one in Placerville on October 13, 2009 and a second in South Lake Tahoe on October 15, 2009. The planning meeting was noticed via e-mail to the MHSA e-mail group of over 400 members. El Dorado County staff provided training and information regarding the design of an Innovation Plan. On October 16, 2009 a meeting was held with the El Dorado County Mental Health Advisory Board where a similar innovation presentation was made. As part of the planning process, the MHSA Project Management Team members provided an overview of the Innovation Guidelines and MHSA priorities for Innovation. Several community planning meetings were held in 2009 and throughout 2010 to the present time.

Included in the community planning meetings have been representatives from adult and children's advocates, community based organizations (health care, Latino, Native American, county mental health and education). A critical aspect of El Dorado's planning process included consideration of the work we were doing with consultant John Ott, of Luminescence Consulting, around Community Capacity Building (CCB) - and incorporating a CCB strategy that recognizes the strength of communities in improving mental health outcomes. Community meetings were held in January and February of 2010 with community Health partners, faith-based and non-profit organizations with continued discussion regarding CCB strategies and a model that strengthens natural community supports.

Addtionally, to efficiently and effectively develop this Innovation Plan,the MHSA project team also used the input from previous outreach efforts conducted during earlier MHSA plan developments. The MHSA project team reviewed the input collected during the development of the Prevention and Early Intervention (PEI) and the Workforce Education and Training (WET) components of the Mental Health Services Act (MHSA). Upon review, an innovative Health Navigator - Community Capacity Building strategy was crafted to further our learning process in this approach, address a range of healthcare issues, and to address the current and future challenges facing El Dorado County.

2. Identify the stakeholder entities involved in the Community Program Planning Process.

Throughout the community program planning process the MHSA Project Management Team collected input for the development of El Dorado's Innovation plan. In 2009 and throughout 2010 input was collected during the planning meetings and reviewed by the MHSA Project Management Team. In December of 2010 the discussions included representatives from several El Dorado County Health Services Department programs, including the Alcohol and Drug Program, Children's Mental Health Initiative, the Health Director's Office, and the Mental Health Program Planning and Implementation sections. Below is a summary of the organizations represented during the planning process.

Boards:
El Dorado County Mental Health Commission
El Dorado County MHSA Advisory Board

Government Partners:
El Dorado County Office of Education
South Lake Tahoe Unified School District Board of Education
El Dorado County Health Services Department, Public Health Division
El Dorado County Health Services Department, Alcohol and Drug Program
El Dorado County Health Services Department, Children's Health Initiative
El Dorado County Public Health Director's Office

Family and Consumer Advocates:
NAMI of El Dorado County - Placerville
NAMI of El Dorado County - South Lake Tahoe
Disability Rights California

Community Partners:
El Dorado County Community Health Center
South Lake Tahoe Collaborative
Turning Point of South Lake Tahoe
Crossroads Employment Services

New Arenas
Partners in Care
Native American Resource Collaborative
Foothill Indian Education Alliance
El Dorado County Youth Commission
Family Resource Center

3. List the dates of the 30-day stakeholder review and public hearing. Attach substantive comments received during the stakeholder review and public hearing and responses to those comments. Indicate if none received.

El Dorado's Innovation program, Closing the Gap through Community Capacity Building was posted on the El Dorado County Mental Health Division's Website for a 30 day public review and comment period from February 22 to March 23, 2011. Notification of the posting was sent to the El Dorado County Board of Supervisors, the El Dorado County Chief Adminsitrator's Office, the MHSA Advisory Committee, The Mental Health Commission, El Dorado County Mental Health and Public Health Division Staff and the MHSA e-mail group.

A request for public service announcements regarding this posting were presented to the two local El Dorado County newspapers (the Mountain Democrat and the Tahoe Tribune) and the Sacramento Bee.

Questions and feedback were invited via e-mail, mail or phone (see contact information below) and in person at the Mental Health Commission Public hearing held from 12:00 1:00 p.m. on March 25, 2011. A summary of substantive comments received during the stakeholder and public hearing and responses to those comments is attached.

The El Dorado County Health Services Department
Mental Health Division
MHSA Project Management Team
670 Placerville Drive, Suite IB
Placerville, CA 95667
(530) 621-6315
MHSA@edcgov.us

Comment #1: Exhibit C, page 4 of 13, Project Design, paragraph 5, contains references to "fund[ing] community capacity building mini-grants" and "holding a competitive process for interested participants for these positions" where the positions are Community Navigators who will be employed by private contractors. In the Innovation Projected Revenues and Expenditures are projected expenditures of $50,000 and $240,000 respectively for these mini-grants and contracts, for a total of $290,000. The Vendor Guide of the Procurement & Contracts Division of the Chief Administrative Office does not specify the membership of any team of reviewers. Presumably, purchasing decisions are made with the input from the relevant county department involved.

Recommendations: The Requests for Proposal shall be more widely advertised than is required by the usual County standards. The Mental Health Division review team responsible for evaluating the bids shall include a volunteer member appointed by the El Dorado County Mental Health Commission and a volunteer member appointed by the El Dorado Community Foundation.

Response #1

.All Requests For Proposals (RFP) are posted on the El Dorado County Procurement and Contracts website as soon as possible after issuance. Vendors/Bidders are encouraged to access the page regularly for new Bids or RFPs. Additionally, in accordance with procurement policy RFPs are published in a newspaper of general circulation in the County. The El Dorado County Health Services Department, Mental Health Division (MHD) appreciates the concerns that the RFPs are widely advertised and have a broader distribution than is required by County procedure. While maintaining compliance with county procedure the MHD will take measures to ensure that the RFPs have a wide distribution.

While the members of the review team(s) have not yet been identified, MHD expects to assemble a review team that reflects the expertise necessary to establish the proposal/grant criteria and evaluate submitted plans. MHD appreciates and will consider the suggested review team composition.

Comment #2

The Innovation Plan does not provide a budget for the total innovation program. The plan's timeline documents implementation/completion dates as 06/11 – 06/14, a 3-year period. The plan only provides projected revenues and expenditures, as well as budget narrative, for a two year period. We are not provided with the total costs of all years of the innovation program, with projected total cost for each fiscal year. We need more complete budgetary information so we can understand what is being spent for components of the program within the 3-year timeline.

Recommendation: Provide a budget for the total innovation program, a 3-year program. Include estimated total costs for all years of the innovation program.

Include projected total cost for each fiscal year. Include what is to be spent yearly for the program as it goes through the different stages of the timeline.

Response #2
The Innovation Plan timeline is designed to give community stakeholders a broad overview of the entire plan, from start to finish. We anticipate that the majority of client services, and therefore also the majority of program expenditures, will occur during the first two years of program operation. As noted on Exhibit 3, page 4: "We plan to utilize a two-year period (FY 11-12 through FY 12-13) to operate this team and in the third year (FY 13-14) we will be conducting the evaluation portion of the project and transitioning to the appropriate next step."

The MHD is requesting to use Innovation allocations available through FY 10-11 to fund the first two years of the program, and those funds are reflected in the budget that has been posted. The third year of operation will be funded by the County's FY 11-12 Innovation allocation. FY 11-12 funds are currently projected to total $198,100 but they are not yet available from the State. The MHD Innovation budget did not include either revenue or expenditures for FY 13-14 because those funds are not yet available and their inclusion in our budget request would delay program implementation.

Below is a budget that represents expected annual revenue and expenditures during FY 11-12 and 12-13. Following that, we have provided an initial cost estimate of the required program evaluation and transitioning portion of the project (year 3 of the project, FY 13-14). Please note, any funds from the County's FY 11-12 Innovation allocation that remain unexpended after program evaluation and transition (FY 13-14) could and would be applied to a subsequent Innovation project.

Revenue:

Planning* (existing revenue)	$146,000
Innovation Plan (initial submission)	$923,500
Medi-Cal FFP	$43,215
Total Revenue	$1,112,715

	FY 2010-11	FY 2011-12	FY 2012-13	Total
Anticipated Expenditures				
Planning	$15,060			$ 15,060
	FY 2010-11	**FY 2011-12**	**FY 2012-13**	**Total**
Personnel:				
County Salaries & Benefits		$174,836	$174,836	$349,672

Contract Personnel		$120,000	$120,000	$240,000
Operating Expenditures		$117,619	$117,619	$235,238
Non-Recurring Expenditures (mini-grants)		$50,000		$50,000
Training Consultant Contracts		$15,000	$5,250	$20,250
Administrative Expenditures		$101,248	$101,248	$202,495
Total Planned INN Expenditures FY 2010-11 (planning) & FY 2011-12, 2012-13 (implementation)	**$15,060**	**$578,703**	**$518,953**	**$1,112,715**

* Planning funds from FY 2008-09 and FY 2009-10 received FY 2009-10

Additional annual budget detail, as reflected in Exhibit E and Exhibit F of the posted Innovation plan:

A. Total County Personnel: $174,836 per year x 2 years = $349,672
   - 2.0 FTE Health System Navigators (1 WS, 1 SLT)
     Direct Salary and Benefits, per year: $154,107 x2 years = $308,214
   - 0.20 FTE Supervisor
     Direct Salary and Benefits, per year: $20,729 x 2 years = $41,458

B. Total Community Mental Health Contract Providers/CBO's: $120,000 per year x 2 years = $240,000
   - Community Navigators (1 WS, 1 SLT)
   - Actual rate pending RFP (competitive contract) process; budgeted at $60,000 per year, per location.

C. County Operating Costs: $117,619 per year x 2 years = $235,238
   - Indirect rate of 66.13% of total direct salary and benefits:
     $174,836 x 66.13% = $115,619 x 2 years = $231, 238

     Note: Indirect rate includes clinical management and support, facility costs, telephone charges, janitorial services, refuse disposal, insurance, utilities, vehicle and equipment maintenance, office expenses, etc.

   - Additional operating expenditures of $2,000 per year x 2 years = $4,000 budgeted in support of outreach and collaborative activities, to include food, travel (mileage), and materials.

D. County Administrative Costs: $101,248 per year x 2 years = $202,495
   - Administrative costs include a share of MH administrative and fiscal staff salary, benefits and overhead costs, as well as County costs allocated to the Department and derived using methodologies consistent with both DMH Letter No. 05-10 and with former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225).
   - Administrative costs represent 22.6% of the total program budget.

FY 2013-14
(Preliminary Budget for money not yet available from the State MHSA fund)

Anticipated Revenue:

Innovation (Plan Update)	$198,100
Total Revenue	$198,100

	FY 2013-14
Anticipated Expenditures	
Personnel:	
County Salaries & Benefits	$68,990
Contract Personnel	$ -
Operating Expenditures	$47,623
Non-Recurring Expenditures	$ -
Training Consultant Contracts	$5,250
Administrative Expenditures	$39,456
Total Preliminary INN Expenditures FY 2013-14	**$161,319**

Anticipated County Personnel, FY 2013-14:

Transition Staff:	(Salaries & Benefits)
Health Program Specialist (0.2 FTE)	$13.127
Health Education Coordinator (0.2 FTE)	$17,694
Supervising Health Ed Coordinator (0.2 FTE)	$20,729
Program Evaluation:	
Program Manager I (0.1 FTE)	$11,165
Department Analyst II (0.1 FTE)	$6,275

Comment #3
The innovation work plan evidences no discernable involvement by consumers. Such involvement is a fundamental aspect of the Mental Health Services Act. What the consumers want should be the basis of what the Innovation plan strives to provide. The plan's community planning process only mentions earlier efforts in the development of PEI and WET. The PEI documents input collected from consumers in 2005. The current innovation plan revisited collecting stakeholder input in 2009 and 2010. However, they left out consumers, instead relying upon 2005 input. The 2005 input did not address the innovation project.

Recommendation: Collect and document current input from consumers including those with serious mental illness and/or serious emotional disturbance, family members, and people that reflect El Dorado County's demographics, including people currently un-served and underserved by mental health and explain their ideas and contributions as the basis of an innovation program. Include in the innovation plan thorough documentation of a current comprehensive outreach effort focused on consumers as described above.

Response #3
The MHD agrees on the importance of consumer involvement in program planning, along with the importance of developing plans within our communities through a process that is inclusive and representative of unserved and underserved individuals.

In 2009 and 2010, the MHD held several Innovation Community Planning meetings with notice given via a very large and diverse MHSA e-mail group that includes both consumers and family-members. We are aware that some consumers did participate as individuals in these community groups; we also appreciate that not all interested consumers may have wanted to attend these more general meetings. In response the Commission's suggestion that MHD obtain more direct and current consumer input, MHD subsequently held two focus groups with consumers prior to finalizing the Innovation Plan. MHD intends to continue to host these small focus groups with consumers to improve the dialog and further include those who receive mental health services in the planning and implementation stages of the Innovation plan.

Comment #4
I appreciated and valued all of the interactions and workshops that I was able to participate in leading up to the formation of the Plan. This was a much-needed part of the planning process, and it is unfortunate for those members who were not able to participate, as it makes understanding the Plan more difficult. Because the Commission is placed in an advisory role and hosts the Public Hearing, they need to be advised and informed of all meetings and availability for attendance at workshops in all stages of the planning process.

Response #4
MHD agrees that the MH commission in its statutorily mandated capacity plays a vital role in its review of the planning and review process. While the MHD held several Innovation Community Planning meetings that included notice to the MH Commission members, we appreciate that not all members were able to participate in the meetings. In view of this, the MHD also discussed Innovation Plan development efforts directly at some of the MH Commission meetings. The MHD will work with the MH Commission and its members to identify meeting strategies that will help ensure that MH Commission members have opportunities to be involved and have meaningful participation.

Comment #5
Enclosure 3, Number 2 – Stakeholder entities involved. Comment: With the increasing importance of Primary care as initial access to services, inclusion of Primary Care and Pediatric Providers should be on the list. While they may not be direct partners, they are part of the community's network of services and would

benefit directly from the educational component of the plan. Bipolar Insights should also be on the list of Community Partners.

Response #5
Enclosure 3, Item number 2 – Stakeholder entities involved - identifies those stakeholders and partners that participated in the previous community planning meetings that informed the development of this Innovation plan. MHD agrees that successful implementation of the innovation plan will require contact with and the inclusion of Primary Care and Pediatric providers. As we prepare to move forward, MHD will, with assistance from community members, identify and engage a diverse range of stakeholders including primary care providers that would benefit from the various aspects of the plan i.e. community strengthening strategies, education and technical assistance and training.

Comment #6
Exhibit C, page 1 – Purpose of Proposed Innovation Project (check all that apply) I believe that by promoting interagency cooperation through the process of connecting people needing services with support within the community, the Plan will; increase access to underserved groups, increase quality and better outcomes of services, and increase access to services. Therefore all boxes could be checked.

Response #6
In selecting the purpose of the Innovation plan MHD considered what we expected to learn from the plan. The purpose of this Innovation plan is to test – to "learn" – whether the promotion of interagency collaboration, specifically collaboration between various communities of support would result in a strengthening of communities and an improved ability of the community to overcome barriers and better serve its members.

While we agree that a community capacity building strategy that strengthens communities of support and connects individuals to these communities could result in increased access to underserved groups, increased access to services, and an increase in the quality of services for individuals, the purpose of this Innovation plan is to test the effectiveness of a community navigator model with a focus on improving the relationships and collaboration with communities of natural supports.

Comment #7
Exhibit C, page 4 – It is important that the Supervisor of this Plan be someone who has a broad knowledge of health issues as well as being familiar with the various providers and county agencies. To avoid additional burden on Mental Health staff and to truly create a collaborative feel to this program, this person would be best independent of the MHD.

Response #7
MHD agrees that due to the integrated care aspects that will need to be addressed in the proposed Innovation plan the program oversight and Supervision should be performed by an individual with broad knowledge of the public health systems and related issues. MHD has identified and expects to fill the position with a Supervising Health Education Coordinator with the Public Health Division who has broad experience in working with the community regarding access to health and other social service resources.

Comment #8
Exhibit C, page 4 – Expert training for primary care and behavioral healthcare providers – This would be an opportunity to use the newly adopted Mental Health First Aid program. Combining these programs would save money and allow for more individuals to go for training, including consumers and/or family members.

Response #8
MHD agrees that the Mental Health First Aid program could play an important role and provide training opportunities for providers, the public and consumers and family members. Using Prevention and Early Intervention (PEI) funds, MHD will train four additional staff as Mental Health First Aid trainers by the end of the Fiscal year. The additional trainers will provide training for a broad range of community partners in South Lake Tahoe and on the Western Slope. MHD will leverage PEI and Workforce, Education and Training (WET) funds to support the Innovation plan and expects to expand its Mental Health First Aid Training capacity in fiscal year 11/12 with additional opportunities to train trainers.

Comment #9
Exhibit C, page 5 – Cultural Competency – It will be a challenge to find Navigators that represent all the communities they will be serving. An emphasis needs to be for those communities that are currently underserved, i.e. the Latino community.

Response #9
An important factor to the success of a Community Navigator models lies in the familiarity and trust that exists between the navigator and the community that the program intends to serve. MHD agrees that while it would be challenging to find community navigators that represent all of the diverse communities that comprise El Dorado County, identifying ways to support under-represented populations (such as the Latino population) is critical.

Comment #10
Mini- grants – Who and how will these grants be considered, selected, and reviewed.

Response #10
The $50,000 budged for mini-grants are one-time expenditures that will be introduced near the mid-point of the plan implementation as a strategy for strengthening natural supports within our communities. Mini-grants will be available on a competitive basis in amounts to be determined (for example five mini-grants at a maximum of $10,000 each). While specific evaluation criteria have not been developed, applicants will be asked to identify and present evidence of a specific need within a local community, and propose a strategy and budget to address that need. A grant review team will be convened to review and evaluate the applications based on the established evaluation criteria.

We expect that small natural community organizations such as consumer groups, faith based organizations, volunteer associations and advocacy groups could benefit from community mini-grants, and that their proposed strategies could initiate a sustainable benefit for their communities.

Comment #11
As with all MHSA plans, every effort should be made to make sure Consumers and Family members are involved in the planning, implementation, and review. This could be made clearer in the plan's narrative.

Response #11
MHD agrees that consumers and family members must be involved in the planning, implementation and review of the Innovation project. The Innovation Project measurement description states: "Consumer stakeholders (including healthcare providers, community members, consumers and families) will be invited to assist in developing the community driven outcomes, indicators, measures, the data collection tools, application of these tools, and the analysis of the data. Furthermore, strategies such as the use of focus groups and key interviews with community stakeholders related to the benefit of the project will be explored."

MHD intends to include consumers and family members in the planning and implementation stages of the plan. MHD will also address the concern that there are many individuals who are isolated and not connected to "communities". In establishing and building community capacity all individuals living in the community, especially those not connected to a community, and most likely not connected to services, must be identified and engaged in the conversation so that the strategies and outcomes reflect the needs of all members.

MHD will include additional narrative regarding consumer and family involvement in the project measurement section of the Innovation plan.

Comment #12
I support this plan and look forward to the opportunities it will bring in bringing members of the community together in greater understanding and support of those who need mental health services.

Response #12
MHD appreciates the community support and is looking forward to working with community partners to successfully implement the Innovation plan.

Comment #13
We must remember that Capacity Building means Collaboration. In order to implement this program among community agencies and support agencies successfully, a steering committee to drive the program would be important. If the work required to implement this program is shared, less MH staff would need to be involved. This would leave staff to do the critical work of providing services to the serious mentally ill people in our community who are in dire need of help now. Remember that MHSA $ were intended to 'transform the mental health system' which would lead to meaningful programs and services for mentally ill individuals and their family members.

Response #13
MHD appreciates this comment and agrees that collaboration with partners and organizations that provide community supports will be necessary to build community capacity. Community partners will be invited to attend informational meetings regarding the community capacity building model and will be invited to participate in meetings designed to identify needs, barriers and desired project outcomes. While a steering committee is not included as part of the plan management, there will be meetings throughout the project implementation to discuss the progress of the plan.

Comment #14
An area that concerns me is the issue of new people trying to access MH Services who do not meet criteria and are referred to 'other resources' which if I understand correctly is being provided primarily by the Community Health Center. How many of those people being out-sourced actually end up being served there. How will the Innovation money help these individuals?

Response #14
The Innovation work plan is named "Closing the Gap through Community Capacity Building" recognizing that there are individuals who currently do not meet necessity criteria (required to receive specialty mental health services) and must access mental health and/or support services through community providers and community systems of support.

Through community capacity building efforts that will be funded by Innovation funds we expect to 1) educate the provider communities so that they become familiar with and competent in addressing the needs of members of their communities; 2) educate and strengthen the natural supports that exist in all communities enabling them to recognize the needs of their members and assist them in accessing appropriate services; and 3) Innovation funds will be used to award mini-grants that will provide organizations/communities with resources enabling them to address barriers that impact the well-being of their community members. Through these community capacity building efforts we expect that new people who do not meet necessity criteria will have improved access to both professional medical/mental health services and assistance from their natural community supports who will assist their members to identify, locate and access needed services.

Comment #15

We must remember what is at stake for those people in our community who are unserved and/or underserved. Their lives are at stake. Whatever we endeavor to do as organizations/commissions we have to put the mentally ill and their families first. Another program is an opportunity only if it is implemented correctly.

Response #15

MHD appreciates this comment and understands the importance of ensuring that when programs are developed and implemented they appropriately and competently meet the needs of not only consumers and their families but of the community as a whole. With this Innovation plan, MHD expects to identify existing communities of support, facilitate the establishment of natural supports and provide resources and technical assistance that strengthen those communities so that they may be better able to help and support their members.

Comment #16

Mental Health needs a connection to ALTA Regional. We have noted that client's issues such as mild retardation, seizure disorder, brain damage and developmental delay have not been taken into account when working to get services for our son who also has mental health issues. These issues are real and documented but under current ALTA guidelines are not considered severe enough to be re-admitted to ALTA. The problem is that "one size does not fit all." There are clients who will need all aspects of their issues considered in order for treatment to be successful. There have to be other clients like our son, un-treated or under treated, who cannot obtain the services they need without the department learning from ALTA how to work with these special issues. With all of the community capacity building and natural supports talked about in the proposed plan, we are asking for some recognition of the problems we are describing. The Innovation Plan does not address clients who have dual mental/developmental issues.

Recommendation: Develop a program that "connects" Mental Health Services to ALTA Regional Services for developmental issues. Consumers who have both issues should not have to continue to go under served. Please change this ongoing problem by addressing it by learning from ALTA Regional and building an Innovation Program that will address the needed learning component of how to successfully treat these individuals. Despite our repeated efforts, we have been unable to get Mental Health to offer us services that take both problems into consideration.

Response #16
MHD acknowledges the difficulties associated with identifying and obtaining services for individuals with co-occurring developmental and mental health issues. The Innovation plan does not address clients with dual mental/developmental issues or any other specific population or issue, but rather proposes that through community capacity building and the identification, development and strengthening of supports that are present in every community all the members of that community will benefit.

MHD appreciates the challenges faced when dealing with more than one agency, such as the Regional Center and the Mental Health systems when trying to obtain the most appropriate and effective services and an Innovation plan that addresses the concerns associated with co-occurring disorders can be discussed for inclusion in the development of future innovative plans.

Comment # 17
Mental Health needs to foster self-help groups for consumers. Groups such as Bi-Polar Insights and groups for OCD, Depression and Anxiety could very effectively help consumers. Consumers could develop and run self help groups, using Mental Health facilities. Mental Health needs to build a program where, for minimal funding, clients could be funded for those outside groups requiring minimal payment. Bi Polar Insights charges $5.00 per session and is very well esteemed within the community. Transportation problems could be creatively solved when there is a realization that the relatively small amount of money necessary to fund a new program of using self-help groups could reap immense benefits for consumers in terms of health and self esteem from working to manage psychiatric disabilities. This could well be a "hometown" solution to helping people for little funding.

Recommendation: Develop and fund an Innovation Program making the most of Self-Help Groups. Allow consumers to institute their own groups and run them. Also develop a self help program that operates outside of Mental Health and uses departmental resources to help fund any minimal attendance fees and effectively use transportation vehicles the department already owns to facilitate consumers in attending the groups.

Response # 17
MHD agrees that peer support groups and self-help groups are important in promoting recovery and well being of consumers and community members. The community capacity building model will support the establishment of "communities" by connecting isolated individuals to each other so they become a community and connecting isolated individuals to an existing community in ways that help the individual become part of the community. Communities of support will develop based on the interests and relationships of the members.

Community members will be invited to participate in the planning and development of the Innovation plan strategies and outcomes where the need and desire for peer support and self-help groups may be considered as a strategy in the current plan. A plan that is specific to the establishment and funding of self-help groups could be considered in future MHSA planning meetings

Comment # 18
The Innovation Plan proposed by the department seems to spend a large amount of money on training, training, and more training. Also on salaries. We have not seen any assurance that the training will be conducted by credentialed, qualified consultants. I believe there are many ways the department could put that money to better use by putting it on the "front lines"; why not develop an Innovation Plan that does some of the following: Allow consumers to run a crisis type program where they work with other clients using emotional CPR. Allow consumers to establish outreach programs and use the results to determine what resources consumers need and want. Ask consumers what type of new program they want. Don't just assume that the many advocate and professional groups within this county, and in Sacramento, have the best answer to what will help most for the least amount of money. When a large number of groups organize around a concept coming from Sacramento and effectively ignores consumers, there is a problem.

Recommendation: Please disclose the credentials and qualifications of training consultants. Please get current input from consumers on what type of Innovation Plan they wish to have. Please develop a plan based upon consumer input. Please use new and current input, not input from 2005.

Response #18
MHD expects to use Luminescence Consulting (John Ott) to provide consultation and training for staff and community partners. Luminescence Consulting is a consulting firm that helps communities and organizations forge cultures of sustained innovation, build structures for effective collaboration, and craft and implement results-oriented strategic plans. We have provided the qualifications of John Ott as an attachment.

In response to suggestions expressed during the public comment period that MHD obtain more current consumer input regarding programs that would address their

concerns and needs, MHD held two focus groups with Wellness participants: the first in South Lake Tahoe on March 28, 2011 and the second in Placerville on April 5, 2011. Fourteen adult consumers shared their ideas and concerns, talking both about their existing networks of support and about problems they experience. Access to physical health care - especially dental care and to a lesser extent, vision care – has in fact become an urgent issue with consumers due to changes in Medi-Cal benefits. The absence of dental care services was a particularly critical issue for consumers in Tahoe. More generally, consumers were interested in accessing and improving community-wide resources in addition to services specific to Mental Health: transportation and job placement (Tahoe); coordination of a health faire and outreach to the homeless community (WS). On both slopes, consumers would like to participate in more recreational, outdoor and athletic activities.

To the extent that the suggestions and ideas expressed in the focus groups are compatible with the learning objective and principles of this Innovation plan, they can be incorporated into the strategies and desired outcomes during the planning and development of the plan. MHD will continue to hold community planning meetings and consumer focus groups that will inform future MHSA plans and the development of subsequent Innovative plans.

luminescence
CONSULTING

JOHN G. OTT VITA

PROFESSIONAL EXPERIENCE

Principal: Luminescence Consulting, 2008-present • Principal: John G. Ott & Associates. 1990-present
Luminescence Consulting and John G. Ott & Associates are consulting firms that help communities and organizations forge cultures of sustained innovation, build structures for effective collaboration, and craft and implement results-oriented strategic plans. Some of our recent work includes:

- Designing and facilitating comprehensive stakeholder processes to confront major budget shortfalls or plan for major systems transformation. Several recent examples include facilitating a process that generated consensus among multiple stakeholders about how to absorb tens of millions of dollars in budget cuts for Los Angeles County's CalWORKs program, and a separate process that achieved consensus among 29 stakeholder groups about how to redesign the Los Angeles County mental health system to absorb over $30 million dollars in cuts. This latter process laid the foundation for the Mental Health Services Act planning process that engaged over 11,000 people and achieved consensus among delegates from over 40 stakeholder groups for a $300 million plan to transform mental health services in Los Angeles County.

- Serving as lead design consultant and facilitator for the California Institute of Mental Health's learning collaborative focused on helping mental health departments develop the capacity for partnering with communities to promote behavioral health and emotional well-being. This initiative has led to several comprehensive change efforts, including a multi-year effort currently underway in Stanislaus County.

- Designing and leading strategic planning, leadership development, and culture change initiatives for myriad non-profit and community-based organizations undergoing profound change. A recent example includes serving as lead consultant for the Angell Foundation's Organizational Spirituality Initiative, an initiative designed to support eight non-profit organizations in building a more compassionate and creative organizational culture.

- Serving as a lead consultant for the National League of Cities initiative on Democratic Governance, including designing a learning lab for the city of Lakewood, Colorado to develop effective processes of community engagement and governance to confront a range of challenges facing the city.

- Designing and leading the community learning and leadership development process for Smart Start, Governor Hunt's initiative to insure that every child in North Carolina begins kindergarten healthy and ready to succeed. From 1993-95, I assembled and trained a team of 12 consultants and worked to develop individual learning plans for the first 32 counties chosen for Smart Start, including the state's most rural and most urban counties. Each county assembled a collaborative team comprising representatives from the private sector, schools, county agencies, non-profits, and community groups. The Carnegie Foundation and others have recognized Smart Start as one of the most pioneering change strategies ever attempted by a state.

- Serving as the lead designer and facilitator for a countywide change process in Durham County, North Carolina to improve quality of life indicators across a broad spectrum of outcomes. This process included designing and facilitating several retreats for Durham County Commissioners and for County and community leaders, and working with County staff to develop the infrastructure necessary to sustain this change effort over time.

- Designing training and evaluation strategies for Mary Reynolds Babcock Foundation's Organization Development Initiative, an initiative to help non-profits throughout the southern United States improve their capacity to work on issues of race, economic justice, and community building.

- Working with ConocoPhillips' refineries in Los Angeles County to design and implement a culture-change initiative focused on improving communication, personal responsibility, and leadership skills across the refinery.

Founder and Director: Good Work, Inc., Durham, NC. 1991-1993
Good Work is a non-profit organization that helps people with low and moderate incomes start their own businesses. Borrowers organize themselves into peer groups, where each group member's ability to receive a loan depends on the repayments of other members. Group support and peer pressure replace collateral as the guarantee of loan repayments.

My duties included: overall program design; fundraising; hiring and supervising staff; working with the Board of Directors; designing the orientation and training materials for the loan circles; recruiting loan circles; organizing a network of technical assistance and support from the local business community; and coordinating training with the Literacy Council and county welfare and employment programs. I left Good Work to devote full time to John G. Ott and Associates, and in particular to help lead Governor Hunt's Smart Start Initiative.

Director: The Philadelphia Leadership Project, Philadelphia, Pennsylvania. 1989-1990
Funded by a grant from the Pew Charitable Trusts, I moved to Philadelphia in 1989 to help Pew's staff and Board develop strategies for strengthening community leadership in Philadelphia. During the project, I conducted hundreds of interviews--with CEOs, political leaders, community organizers, academics, and union, church, and neighborhood leaders, as well as with people who were homeless, and families living in neighborhoods and housing projects throughout the city. I concluded this project with a series of recommended action plans for the Board and staff. Pew's Philadelphia Fund grew out of this project.

Co-Founder and Associate Director: The Leadership Program, Duke University, Durham, NC. 1985-1989
Instructor/Lecturer: Public Policy Studies Department, Duke University, Durham, NC. 1986-1989
I joined the faculty at Duke in 1985 and worked with a colleague to begin the Leadership Program, an undergraduate program in the Public Policy Studies Department. I developed and taught curriculum for the Program, including the introductory Leadership Program course, "Leadership, Policy and Change," a course on ethics and policy-making, "Policy Choice as Value Conflict," and an advanced undergraduate seminar entitled "Leadership and Judgment." Other duties included: coordinating the administrative and teaching staff, including as many as 30 volunteers per semester; developing community project opportunities each year for over 80 leadership students; designing and coordinating the Interns in Conscience Program, a program that placed up to 50 interns with organizations working with the homeless, with youth in crisis, and with migrant workers and refugees.

Staff Organizer/Lead Organizer: Carolina Action, North Carolina; The Metropolitan Organization and the Metropolitan Congregational Alliance, Texas; San Mateo County Organizing Project, California. 1980-1983; 1984-1985.
In the early 1980's, I worked with several community organizations, learning the skills necessary to help people with moderate and low-incomes take greater control of their lives and their communities' futures. My duties included: recruiting and training leaders from church communities and neighborhoods for multi-ethnic, multi-class, grassroots organizations; and designing and conducting leadership development sessions, including sessions on recruitment, negotiating skills, fundraising, community research, community economic development, planning and running meetings, analyzing community decision-making structures, developing action campaigns, as well as sessions to strengthen relationships of common values and commitments among people from diverse backgrounds and histories.

EDUCATION AND PROFESSIONAL ASSOCIATIONS

Duke University:	B.A., Public Policy Studies, May, 1979 Summa Cum Laude Phi Beta Kappa Angier B. Duke Memorial Scholarship
Stanford Law School:	J.D., June, 1985 Harry S. Truman Memorial Scholarship
California State Bar:	Member
Covey Leadership Center:	Master Facilitator

PARTIAL LIST OF BOOKS AND PUBLICATIONS

The Power of Collective Wisdom. Co-authored with Alan Briskin, Sheryl Erickson, and Tom Callanan. Barrett Kohler Publishers, San Francisco, CA 2009.

"Exploring Spirituality in the Workplace." July 2007. A paper co-authored with Rose Pinard and funded by the Angell Foundation. This paper led to the creation of an organizational spirituality initiative funded by the Angell Foundation in 2007-08.

"Wisdom Labs: Creating Conditions for the Reliable Emergence of Wisdom and Right Action in Groups." April 2005. A paper co-authored with Mitch Saunders and Elizabeth Doty and funded by the Fetzer Institute as part of its Collective Wisdom Initiative.

"Measures of Success: An Analysis of the CalWORKs Prioritization Process in Los Angeles County." November 2003. A paper funded by the Foundation Consortium for the Children's Planning Council in Los Angeles County.

"Towards a Family and Community Centered Focus: Helping County and Community Service Providers Build Partnerships with Families and Communities." January 2002. A paper presented to the Chief Administrative Office and the New Directions Task Force in Los Angeles County as part of an implementation strategy for the Service Integration Action Plan.

Centered on the Edge: Mapping a Field of Collective Intelligence and Spiritual Wisdom. Co-author. September 2001. A study supported by the Fetzer Institute, Kalamazoo, Michigan.

"Ignoring the Interior: Some Hypotheses about Why Large-Scale Change Efforts Often Fall Short." May 2001. A paper presented to the Foundation Consortium's May 2001 Academy for Healthy Start Collaboratives in California.

"Meeting the Leadership Challenge." Published in the Spring 1996 issue of the Georgia Academy Journal.

"Surviving Tax Cuts and Preparing for Block Grants: An Invitation to Communities to Create Their Future." Published in the Fall 1995 issue of the Georgia Academy Journal.

UPLIFT'S County Collaboration Manual: A Step-By-Step Guide to the 1994-95 Strategic Planning Process for Smart Start. November 1994.

EXHIBIT C
(Page 1 of 12)

Innovation Work Plan Narrative

Date: February 22,2011

County: El Dorado

Work Plan #: 1

Work Plan Name: Closing the Gap through Community Capacity Building

Purpose of Proposed Innovation Project (check all that apply)

- ☐ INCREASE ACCESS TO UNDERSERVED GROUPS
- ☐ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- ☒ PROMOTE INTERAGENCY COLLABORATION
- ☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

Throughout the Mental Health Services Act (MHSA) community program planning process, the communtiy feedback included the following themes: Concerns related to access and disparities in access to both behavioral and physical health care, the insufficient resources to serve individuals with mental illness and substance use disorders and barriers to service created by stigma. A desire for cross-training among physical health and behavioral health providers, increased coordination and collaboration among service providers and greater community inclusive practices.

Community stakeholdes also related a growing perception of a "gap" in publically funded behavioral health services - somewhere between primary behavioral health care and specialty mental health care; and an interest in an approach which would enhance the broader community's capacity to support the vulnerable indivuals that live in the community.

Therefore, barriers related to the lack of access (behavioral and physical health care services), equity (un-served and under-served individuals falling between the gaps in the system), and service coordination (among providers of behavioral physical health services and with communties of support) became the focus of the Innovation (INN) Project.

El Dorado County proposes to test the model to determine if the use of Navigators to develop and improve relationships with communities of support that serve as natural supports to individual will close the gap in unmet needs, and thereby result in improvements in community health and well-being.

Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)

Issues addressed

Community concerns regarding access, service gaps, and lack of service coordination reflect various issues related to resources, health disparities, and collaboration. These were the themes brought forward to the INN Project.

Barriers to health service utilization and collaboration range significantly in the diverse communities that comprise El Dorado County (EDC). EDC encompasses a large geographic area (1,711 square miles) with a relatively small population (approximately 180,000). The county seat, Placerville, is located in a region known as the Western Slope (WS) and is surrounded by small rural communities and unincorporated areas. Each of these diverse communities have different and limited health care resources and there are varying barriers to these services.

Community Capacity Building Framework

The ongoing concern regarding unmet need and barriers to access has only become more challenging in today's economy. Therefore, use of MHSA INN funding to explore new perspectives, approaches, and solutions is timely.

The Community Capacity Building (CCB) framework developed by Luminescence Consulting suggests that the discrepency between publicly-funded resources for behavioral health services and need is insurmountable if communities rely on these resources to fully care for individuals with serious mental illness/serious emotional disturbance/substance use disorders. Yet, communities are rich with (natural) resources that support these individuals on a daily basis allowing them to remain part of the community - many without the support of public behavioral health services. The hope is that an investment in identifying and developing relationships with these communities and strengthening these natural support serves to enhance the well-being of the broader community even while behavioral health services funding and resources decline.

Project Innovation

Health Navigators have been used effectively to provide health education, advocacy, and service linkage to under-represented groups and communities. This model brings strength to any project. A different application of this model, in the context of the CCB framework, provides an exciting opportunity to gain knowledge regarding the potential efficacy of using Navigators to strengthen communities in their ability to address the local barriers to behavioral health needs and the well-being of their members. We

believe this application of the Navigator role to a CCB approach comprises a new and innovative mental health approach.

Therefore, the application of a Navigator model within the Community Capacity Building framework is designed to identify and address the community-specific barriers with community-driven solutions through the use of the community natural supports. We hope to learn from a range of strategies and, perhaps, what is effectively acted upon by community in contrast to what may be needed from the public system.

What is unknown in this approach is whether this effort will result in increased health services utilization and, if so, for whom? Furthermore, can improved relationships between the health care system entities and communities of natural supports result in better outcomes for those already being served in the "system". Finally, in El Dorado County, the abiity to test out this framework in various, diverse geographic regions can assist us in learning a range of strategies to address the multiple barriers faced for individuals with behavioral health issues in achieving health and well-being.

Study question:

Will use of Navigators to 1) identify communities of natural support, 2) strengthen their ability to address barriers to their members' behavioral health needs, and 3) build relationships between the various health services providers and the diverse communities of support overcome barriers to the behavioral health and well-being of un-served and/or under-served community members?

Project Design

Therefore, the MHSA INN Project is designed to:

1) improve relationships and collaboration among the Health Services Department behavioral health programs, health care providers on the Western Slope and SLT and the various communities of natural support through a team of Navigators;

2) strengthen the capacity of health care providers for collaboration through Leadership Development Training focusing on community partnership development;

3) strengthen the capacity of various communities to support their members through Leadership Development Training focusing on system partnership development;

4) increase understanding and decrease stigma related to individuals with behavioral healthcare needs through provider and community education; and,

5) fund community capacity building mini-grants by which communities can test their local strategies to address barriers, report their findings, and possibly generate sustained capacity to support members' health and well-being.

A County-wide Integrated CCB Navigator Team will be funded with MHSA innovation dollars to target work on the Western Slope and South Lake Tahoe communities. We hope to maximize both resources and learnings through the design of an integrated team that can share experiences and learnings. In addition, the team will be comprised of System Navigators that focus on the strengthening of relationship building within and amongst health services providers (staffed by the County) as well as Community Navigators that will focus on the strengthening of relationship building with the diverse

communities of natural supports (we anticipate holding a competitive process for interested participants for these positions).

o 0.2 Supervisor (based in Placerville)

o 2.0 Health System Navigators (one in South Lake Tahoe and one on the Western Slope)

o 2.0 Community Navigators (one in South Lake Tahoe and one on the Western Slope)

Additional INN Project strategies include:

o Utilization of expert consultation and training (Luminescence Consulting) for the County, partner providers, and the community related to the CCB model, specifically to build collaborative relationships and to strengthen the use of natural supports.

o Acquisition of expert training for primary care and behavioral healthcare providers to address stigma reduction and enhanced collaboration skills relative to serving individuals with multiple, chronic co-occurring diseases.

We plan to utilize a two-year period (FY 11-12 through FY 12-13) to operate this team and in the third year (FY 13-14) we will be conducting the evaluation portion of the project and transitioning to the appropriate next step.

The expected outcome (what we hope to learn)

A critical learning goal of this INN Project is to better understand at a community level what the underlying contributing factors are to the barriers to access, equity and collaboration, and what comprise the community-driven solutions to these issues.

Issues identified through the Community Program Planning process that will be explored in this learning project:

o Lack of access - does use of Navigators to apply a CCB model result in increased access? Increased service utilization? If so, why, whom and in which communities?

o Lack of equity - is there gap in the behavioral health care system and therefore a need for a level of behavioral healthcare that closes the gap between primary behavioral healthcare services and specialty mental health services? If so, in what communities?

o Lack of collaboration - what are the effective strategies to relationship-building among healthcare providers and with communities that result in increased collaboration related to serving individuals with behavioral health issues? What are the results?

How the Project may create positive change

A commitment of staff and training resources to establish an integrated team of CCB Navigators may enhance county-community partnership which may, in turn, have dramatic and long-lasting effects on vulnerable individuals and community well-being by fostering a change in perception, action, and related outcomes in how we support and serve individuals with behavioral health needs most effectively with public funds and in harmony with the communities that we serve.

The use of community capacity building mini-grants is intended to support diverse communities within the county to apply and test out the CCB approach, and build the related knowledge, experience, skills and capacity.

INN Project relationship to the MHSA General Standards:

Community Collaboration - this project seeks to expand collaboration and linkages with a focus on relationships among the healthcare system providers (mental health, addiction treatment programs, primary care) and with a diverse range of local communities of natural supports.

Integrated Service Experience - this project seeks to facilitate access to a full range of services and supports.

Cultural Competency - this project seeks to incorporate Community Navigators as individuals who represent local communities and serve, thereby, to strengthen the cultural competence of the Project Team.

Recovery Orientation - this approach is based on a strengths-based perspective related to individual resiliency and the role of natural supports in the recovery process.

Consumer and Family-driven service delivery - this project seeks to support client and family agency in the pursuit of well-being.

Sustainability of the desired positive change may be achieved by:

- Provider education/cross-training among healthcare providers is hoped to build the level of collaboration throughout the healthcare system that can be sustained by establishing some local training capacity and structure by which to continue training forums.

- By definition, the focus on Community Capacity Building (CCB) concepts and training in an integrated team approach (county, agencies and communities) is intended to establish the knowledge, skills and capacity to continue this work independent of MHSA programming.

- The use of mini-grants is further intended to strengthen the community capacity to support the health and well-being of their members independent of county resources.

Innovation Work Plan Narrative

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)

The identified community issues of access, service gaps, and lack of service coordination lead to a desire to better understand the underlying and contributing factors to the barriers to access, to health disparities, and to effective collaboration. This approach seeks to learn from the perspectives of multi-disciplinary providers and the diverse communities.

To this end, the project proposes to integrate an effective healthcare practice typically applied to individual service delivery - use of Navigators - to a broader application in relationship to community building. This project proposes to use Navigators to improve partnership and collaboration among various health services entities and with their local communities (System Navigators) while simultaneously identifying and strengthening diverse communities of natural support (Community Navigators) to engage with health services systems and providers to improve the health and well-being of their members and to provide natural supports independent of health services.

Navigators are historically effective in part due to their existing membership and relationship with the community that they serve. In increasingly complex systems and diverse communities, the ability to speak different languages, live in different worlds, and cross over system/community lines may serve as an asset. Therefore, individuals well-suited for the work of "navigation" may contribute significantly to the challenge of bringing together divergent groups toward common goals.

This innovative approach, therefore, may contribute to learning how application of a health services resource (Navigator) within a community-driven approach/model (CCB) may effectively facilitate healthcare systems change.

In addition, the identification, understanding, and removal of barriers to goals is a significant and ongoing challenge in any system and/or community. This INN Project is believed to offer an opportunity to engage both health care providers and client communities in arriving at a level of shared understanding regarding the nature of the barriers related to the community-identified issues and to identify agreed upon solutions. If effective, the learning may be two-fold: 1) what are the specific findings regarding barriers, causes, and solutions and 2) what was effective in arriving at these findings together and can these efforts (processes) be generalized? Then, perhaps a final question to explore is, "Was this effort (use of resources) worth it - did the outcomes justify the investment?"

Innovation Work Plan Narrative

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)

Implementation/Completion Dates: 06/11-6/14
MM/YY – MM/YY

Start up
This INN Project will benefit from the work currently in operation related to the EDC participation in the CiMH CCB Learning Collaborative in which training in the CCB model has been provided to MHD and PHD Leadership, clinical staff, and five community groups with additional trainings pending.

As a result, rapid mobilization is anticipated upon the INN Plan approval, which is anticipated in June 2011.

It is anticipated that two years of operation will be realized under the INN funding with the third year serving as a period of evaluation and transition.

FY 11-12
Full year of funding for the INN Project Team.
CCB consultation and training with Luminescence Consulting.
Provider education.
CCB mini-grants.

FY 12-13
Full year of funding for the INN Project Team.
CCB consultation and training with Luminescence Consulting.
Provider education.

FY 13-14
CCB consultation with Luminescence Consulting in relationship to program evaluation.

The quarterly dates below serve as milestones for the various components listed. Service strategies, use of consultation/training, mini-grants, community planning and inclusion, and reporting dates are included.

Completion date: October 2011
Recruitment of INN Project Team.
Award of through competitive RFP for Community Navigator positions contracts.
Execution of contract for CCB consulting/training with Luminescence Consulting.
Execution of contract for provider training with CiMH, Regional Collaborative, or other appropriate vendor.

Completion of introductory CCB and Navigation training fundamentals for the System Navigators.
Initial consultation of INN Project Team and HSD Leadership Team with Luminescense Consulting.
Quarterly MHSA Community and Advisory Meeting Update.

Completion date: December 2011
Collaboration to identify the desired community outcomes, indicators, and measures.
Development of parameters for mini-grant program and related competitive process.
Provider training event.
Monthly CCB consultation/training with Luminescence Consulting.
CCB events.
Quarterly MHSA Community and Advisory Meeting Update.

Completion date: April 2012
Annual Report - INN Update.
Mini-grant program awards.
Continued CCB consultation/training with Luminescence Consulting.
CCB events.
Quarterly MHSA Community and Advisory Meeting Update.

Completion date: July 2012
Continued CCB consultation/training with Luminescence Consulting.
CCB events.
Provider training event.
Quarterly MHSA Community and Advisory Meeting Update.

Completion date: October 2012
CCB events.
Collaborative planning related to future provider education post INN Project completion.
Continued CCB consultation/training with Luminescence Consulting.
Quarterly MHSA Community and Advisory Meeting Update.

Completion date: December 2012
Provider training event.
CCB events.
Collaborative planning related to future navigation services post INN project completion.
Continued CCB consultation/training with Luminescence Consulting.
Quarterly MHSA Community and Advisory Meeting Update.

Completion date: April 2013
Annual Report - INN Update.
CCB events.
Collaborative planning related to sustaining natural supports post INN Project completion.
Continued CCB consultation/training with Luminescence Consulting.

Quarterly MHSA Community and Advisory Meeting Update.

Completion date: July 2013
Mini-grants annual reports due.
INN CCB event celebration.
Transition planning for INN Project Team.
Continued CCB consultation/training with Luminescence Consulting.
Quarterly MHSA Community and Advisory Meeting Update.

Completion date: October 2013
Analysis of program evaluation data.
Evaluation and transition work with Luminescence Consulting.
Quarterly MHSA Community and Advisory Meeting Update.

Completion date: December 2013
Draft report of program evaluation data.
Evaluation and transition work with Luminescence Consulting.Quarterly MHSA Community and Advisory Meeting Update.

Completion date: April 2014
Finalization of INN evaluation report.
Evaluation and transition work with Luminescence Consulting.Annual Report - INN Update.
Quarterly MHSA Community and Advisory Meeting Update.

Completion date: July 2014
Submittal of Final Innovation Report.
Final consultation and project report from Luminesence Consulting.
Quarterly MHSA Community and Advisory Meeting Update.

Innovation Work Plan Narrative

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

Community stakeholders (including healthcare providers, community members, consumers, and families) will be invited to assist in developing the community-desired outcomes, indicators, measures, the data collection tools, application of these tools, and the analysis of the data. Furthermore, strategies such as the use of focus groups and key interview with community stakeholders related to the benefit of the project will be explored.

As a starting point, a critical learning goal of this INN Project is to better understand at a community level what the underlying contributing factors are to the barriers to access, equity and collaboration, and what comprise the community-driven solutions to these issues. Community members, consumers and family members will be invited to participate in the planning, development and implemenation of the plan throughout all stages of the project. Strategies to address identifed barriers and desired outcomes will be developed with the involvement of the community membership. Therefore, we anticipate an exploration of the following questions as part of the project reivew process:

Lack of access -

Does the use of Navigators to a) strengthen communities of natural supports, and b) to build collaboration among and between health care providers and communities result in decreased unmet behavioral health needs?

Is there a decrease in un-served and/or under-served behavioral healthcare needs?

Is there an increase in behavioral healthcare service utilization?

Is there an increase in primary healthcare service utilization by those with behavioral healthcare needs?

If so, why, whom and in which communities?

If a decrease in unmet needs was found, what were the contributing factors?

Lack of equity -

Has a gap in the behavioral health care system been identified?

If so, for whom and in what communities?

Was the gap closed during the Project period?

If so, how, for whom, and in what communities?

Were increased services established?

Were barriers removed to access previously existing services?

Were previously unmet needs subsequently met outside of the behavioral health care system (by communities of natural support)? How, for whom, and where? Was it effective? What lessons learned can be considered in other settings?

Lack of collaboration -

What were the effective strategies to relationship-building among healthcare providers?

What were the effective strategies to relationship-building between healthcare providers and communities of natural supports?

If relationships were improved, what were the results (processes to serve clients, outcomes for clients, any replicable strategies)?

Mini-grant evaluation:

- What barriers or contributing factors to access, equity and/or collaboration were targeted?

- What strategy(ies) was used?

- What benefit was seen and how was it measured?

- What lessons were learned?

- How was the community strengthened as a result of this project?

- How can these efforts continue into the future independent of this funding?

Provider and community training evaluation:

Course evaluation forms will be constructed - findings will be made available at quarterly community meetings, MHSA Advisory meetings, and will be included as part of project reports.

Consultation and Training evaluation:

Evaluation forms will be constructed and used at the close of training sessions and on an annual basis in relationship to consultation services. Findings will be made available at quarterly community meetings, MHSA Advisory meetings, and will be included as part of project reports.

Innovation Work Plan Narrative

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

We will seek to leverage the following funding and resources:

CiMH - we will explore collaboration regarding training opportunities related to integration with Primary Care, Stigma/Discrimination reduction, collaboration, and use of natural supports.

Regional Collaborative - we will explore collaboration regarding training opportunities related to integration with Primary Care, Stigma/Discrimination reduction, collaboration, and use of natural supports.

PEI Training, Technical Assistance, and Capacity Building Allocation - we will use these funds to access continued training, Leadership Development Training, and consultation services in Community Capacity Building with Luminescence Consulting.

WET Plan, Action #2: Staff Development - we will use some of this funding to provide training opportunities related to integration with Primary Care, Stigma/Discrimination reduction, collaboration, and use of natural supports.

CiMH CCB Learning Collaborative - Round 2 - Mental Health staff, Public Health staff, and community members are actively participating in this learning process. The training and consultation services available through this forum have contributed significantly to the development of this project.

EXHIBIT D

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

El Dorado

Work Plan Name

Closing the Gap through Community Capacity Building

Annual Number of Clients to Be Served (If Applicable)
_____ Total

Population to Be Served (if applicable):

Un-served or under-served individuals with serious mental illness/serious emotional disturbance/substance use disorders (SMI/SED/SUD) who may not be connected with communities of natural support (or services).

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

El Dorado County seeks to explore the impact of an Integrated Community Capacity Building Navigator Team in addressing barriers resulting in the lack of access, equity (gap in the system), and collaboration in communities on the Western Slope and South Lake Tahoe.

Our hypothesis is that these communities offer different opportunities to explore application of Community Capacity Building (CCB) strategies.

Health Navigators have been used effectively to provide health education, advocacy, and service linkage to under-represented groups and communities. This model brings strength to any project. A different application of this model, in the context of the CCB framework, provides an exciting opportunity to gain knowledge and experience regarding the potential efficacy of using Navigators to strengthen communities in their ability to address the local barriers to behavioral health needs and the well-being of their members. We believe this application of the Navigator role to a CCB approach comprises a new and innovative mental health approach.

Therefore, the application of a Navigator model within the Community Capacity Building framework is designed to identify and address the community-specific barriers with community-driven solutions through the use of the community natural supports. We hope to learn from a range of strategies and, perhaps, what is effectively acted upon by community in contrast to what may be needed from the public system.

Study question: Will use of Navigators to 1) identify communities of natural support, 2) strengthen their ability to address barriers to their members' behavioral health needs, and 3) build relationships between the various health services providers and the diverse communities of support overcome barriers to the behavioral health and well-being of un-served and/or under-served community members?

Project Design

Therefore, the MHSA INN Project is designed to:

1) improve relationships and collaboration among the Health Services Department behavioral health programs, health care providers on the Western Slope and SLT and the various communities of natural support through a team of Navigators;

2) strengthen the capacity of health care providers for community collaboration through Leadership Development Training focusing on community partnership development;

3) strengthen the capacity of various communities to support their members through Leadership Development Training focusing on system partnership development;

4) increase understanding and decrease stigma related to individuals with behavioral healthcare needs through provider and community education; and,

5) fund community capacity building mini-grants by which communities can test their local strategies to address barriers, report their findings, and possibly generate sustained capacity to support members' health and well-being.

Mental Health Services Act
Innovation Funding Request

County: El Dorado Date: #######

	Inntovation Work Plans		FY 2010/11 Required MHSA funding	Estimated Plans by Age Group (if applicable)			
	No.	Name		Children, Youth	Transitional Aged Youth	Adult	Older Adult
1	1	Closing the Gap through Community Ca	$ 721,005	n/a	n/a	n/a	n/a
2							
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20							
21							
22							
23							
24							
25							
26		Subtotal Work Plans	$721,005	$0	$0	$0	$0
27		Plus County Administration	$202,495				
28		Plus Optional 10% Operating Reserve	$0				
29		Total MHSA funds required for Innovati	$923,500				

Innovation Projected Revenues and Expenditures

Fiscal Year: 2010/11

County: El Dorado
Work Plan # 1
Work Plan name: Closing the Gap through Community Capacity Building
New Work Plan ✓
Expansion ☐
Months of Operation: 07/11 - 06/13
MMYY - MMYY

	County Mental Health Division	Other Governmental Agencies	Community Mental Health Contract Providers/ CBO's	Total
A. Expenditures				
1. Personnel Expenditures	349,672		240,000	$589,672
2. Operating Expenditures	235,238			$235,238
3. Non-recurring Expenditures			50,000	$50,000
4. Training Consultant Contracts			20,250	$20,250
5. Work Plan Management				$0
Expenditures	**$584,910**	**$0**	**$310,250**	**$895,160**
B. Revenues				
1. Existing Revenues	$130,940			$130,940
2. Additional Revenues				$0
a. Medi-Cal (FFP only)		$43,215		$43,215
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	$0	$43,215	$0	$43,215
4. Total Revenues	**$130,940**	**$43,215**	**$0**	**$174,155**
C. TOTAL FUNDING REQUESTED	**$453,970**	**($43,215)**	**$310,250**	**$721,005**

Prepared by: Janet Stevens
Telephone Number: 530 621-6226

Date: 2/22/2011

EL DORADO COUNTY
INN NEW PROGRAM DESCRIPTION EXHIBIT F cont.
BUDGET NARRATIVE

Program #1 – Closing the Gap through Community Capacity Building

Note: The following represents the budget for an anticipated 24 months of operation (07/2011 through 06/2013)

1. Personnel
   - Budgeting for this program consists of the following County personnel costs, estimated to total $349,672 for salaries, benefits and taxes:
     - 1.0 FTE Health Program Specialist (staffed on the West Slope) and 1.0 FTE Health Education Coordinator (staffed in South Lake Tahoe) to function as Health System Navigators.
     - 0.2 FTE supervisor position will provide program oversight in both locations.
   - In addition, the County will initiate a competitive contract (RFP) process with local Community Based Organizations (CBO's) to select and hire Community Navigators from within local neighborhoods; contract costs are estimated to total $240,000:
     - 1.0 FTE Community Navigator (staffed on the West Slope) and 1.0 FTE Community Navigator (staffed in South Lake Tahoe).
2. Operating Expenditures
   - We estimate a total of $235,238 in operating expenditures, to include:
     - $4,000 in support of outreach and collaborative activities, to include food, travel (mileage), and materials.
     - Additional operating expenditures of $231,238, to include facility costs such as rent, utilities, and janitorial services on the West Slope and in South Lake Tahoe, as well as indirect and overhead expenses, including clinical management, computing equipment and software licenses required to support the program.
3. Non-recurring Expenditures
   - We have budgeted $50,000 in mini-grants, to be introduced near the mid-point of plan implementation, and designed to strengthen natural community supports. Mini-grants will be funded as a means by which communities can test their local strategies to address barriers, report their findings, and possibly generate sustained capacity to support members' health and well-being.
4. Training Consultant Contracts
   - We have budgeted $20,250 to fund training and related expenses (facility costs, food, materials, travel, etc.) that will guide County staff, community organizations and stakeholders in the development of strategies for strengthening our communities, building successful partnerships and reducing barriers to successful collaboration.

5. Work Plan Management
   - No additional costs associated with work plan management.

Total program budget: $895,160