EXHIBIT A

INNOVATION WORK PLAN
COUNTY CERTIFICATION

County Name: Tri-City Mental Health Center

County Mental Health Director	**Project Lead**
Name: Jesse H. Duff	Name: Rimmi Hundal
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Mailing Address: Tri-City Mental Health Center 1717 N. Indian Hill Blvd. #B Claremont, CA 91711	Mailing Address: Tri-City Mental Health Center 1717 N. Indian Hill Blvd. #B Claremont, CA 91711

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.

Jesse H. Duff — Signature (Local Mental Health Director/Designee)

01-30-2012 — Date

Executive Director — Title

EXHIBIT B
(PAGE 1 OF 2)

Innovation Community Program Planning and Local Review Processes

County Name: Tri-City Mental Health Center
Work Plan Name: Innovation Plan

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 the development of the Innovation Work Plan. It shall include the methods of obtaining stakeholder input. (suggested length – one-half page)

   Tri-City Mental Health Center (TCMHC) engaged in expansive community engagement and stakeholder processes throughout its MHSA planning and implementation efforts, including more than 6,000 people for its Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) plans. As a demonstration of its commitment to engaging community stakeholders, TCMHC created a permanent Delegates structure in July 2011. This sixty-member TCMHC Delegates Group is intended to ensure that broad stakeholder and community engagement takes a deep hold in our transformed mental health system.

   The Delegates began developing this Innovation Work Plan in October 2011. We brainstormed "learning edges" -- places where focused learning could significantly advance the transformation of the mental health systeM – and organized six workgroups that met intensively over the next two months to develop specific work plans for the learning edges. The Delegates convened in early November to share updates on work group progress and provide feedback on the workplan proposals in development.

   Once the workgroups completed their workplan proposals, the Delegates met again in late November and early December 2011 to arrive at a consensus recommendation for the TCMHC Governing Board's consideration. Another ad hoc workgroup formed to closely review and discuss the plan's budgets. On December 7, 2011, the Delegates agreed by consensus to endorse the two work plans which constitute the Innovation Plan as submitted here. More than 60 Delegates and other stakeholder participants developed this Innovation Plan.

Innovation Community Program Planning and Local Review Processes

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

   Delegates and their alternates represented stakeholder perspectives including individuals who receive services; family members; community providers; leaders of community groups in unserved and underserved communities; representatives from the three cities of Claremont, LaVerne and Pomona; representatives from the local school districts; primary health care providers; law enforcement representatives; faith-based community representatives; representatives from the LGBTQ community; representatives from LACDMH and other county agencies; and many others. Attachment A contains a roster of individuals in attendance at these meetings.

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 was received.

   The 30-day stakeholder review began December 19, 2011 and ended on January 17, 2012. The public hearing was held on January 18, 2012, and 59 people were in attendance. Stakeholders were provided multiple options to submit their comments prior to the public hearing such as by mail, email and phone. No comments were received through these means.

   Comments received during the public hearing and responses to the comments are included as Attachment H. In addition, we have attached the presentation slides used during the public hearing as Attachment I.

Innovation Work Plan Narrative

Date:	**December 16, 2011**
County:	**Tri-City Mental Health Center**
Work Plan #:	**1**
Work Plan Name:	**Modifications to Cognitive Enhancement Therapy**

Purpose of Proposed Innovation Project (check all that apply)

X INCREASE ACCESS TO UNDERSERVED GROUPS

X 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).

The purpose of this project is to increase the quality of available services including better outcomes by modifying an existing evidence-based practice, Cognitive Enhancement Therapy (CET). Specifically, this project will tailor CET to treat a population group not included in the research on CET: individuals who have been diagnosed with bipolar disorder, including individuals from underserved population groups who are mono-lingual Spanish speakers.

Existing treatment options in the three cities of Claremont, La Verne and Pomona support recovery by alleviating symptoms of mental illnesses (e.g. hallucinations, voices, etc.), but they do not yet focus on improving the underlying loss of cognition associated with mental illnesses such as schizophrenia and bipolar disorder.[1] Loss of cognition can significantly affect a person's essential life functions such as his or her ability to sustain supportive relationships and to become employed in a satisfying job that can provide economic independence.

TCMHC's emphasis on increasing the wellbeing of all community members urges us to consider treatments and approaches that can more directly allow individuals with cognitive impairment to live productive, connected and meaningful lives.

[1] Medalia A, Revheim N. Dealing with cognitive dysfunction associated with psychiatric disabilities: a handbook for families and friends of individuals with psychiatric disorders. New York State Office of Mental Health, October 2002. www.omh.state.ny.us/omhweb/cogdys_manual/cogdyshndbk.htm.

Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses in the expected outcome, i.e. how the Innovation project makes a 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)

CET is a highly structured, 48-week program that integrates: computerized exercises to strengthen cognition, interactive psycho-educational sessions to improve social functioning, and individualized coaching sessions to customize support for learning. Two two-year clinical trials on CET with individuals who have been diagnosed with schizophrenia, including 1-year follow-up assessments demonstrated significant improvements on composite measures of cognitive functioning that were sustained one year after treatment. [2] [3] Further, a study of the participants' brains from one of the clinical trials suggested that cognitive rehabilitation provides a protective effect against gray matter loss in key regions of the brain associated with schizophrenia.

Cognitive impairment for individuals with bipolar disorder, while not as severe as those with schizophrenia, can also lead to long-term disability. In one study, 75% of asymptomatic patients with bipolar disorder scored below healthy individuals on at least four cognitive measures.[4] While cognitive remediation has been used to treat individuals with schizophrenia, its use as a form of treatment for individuals with bipolar disorder has been far more limited. For example, there are only five studies available with very small sample sizes exploring the effects of cognitive remediation on individuals with bipolar disorder.[5] As a result, this learning project will help us to fill this gap in knowledge by exploring how CET can be modified to treat individuals with bipolar disorder. Further, a public mental health system like TCMHC strives to serve as many individuals from underserved populations as possible. As a result, we will innovate CET by further modifying it to become accessible to mono-lingual Spanish speakers.

The innovation that this project offers is a creative approach to the persistent, intractable challenge of improving the wellbeing of individuals with cognitive impairment. Finding avenues for improving their wellbeing is consistent with TCMHC's and MHSA's commitment to recovery.

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[2] Hogarty G, Flesher S, Ulrich R, Carter M, Greenwald D, Pogue-Geile M, Kechavan M, Cooley S, DiBarry AL, Garrett A, Parepally H, Zoretich R. Cognitive enhancement therapy for schizophrenia: effects of a 2-year randomized trial on cognition and behavior. Archives General Psychiatry, September 2004, 61, pp. 866-876.

[3] Hogarty G, Greenwald D, Eack S. Durability and mechanism of effects of cognitive enhancement therapy. Psychiatry Services, December 2006, 57, 12, pp. 1751-1757.

[4] Glahn D, Velligan D. Cognitive impairment in patients with bipolar disorder: effect on psychosocial functioning. *Psychiatric Times May 2007, 24, 6, www.psychiatrictimes.com*

[5] Martinez-Aran A, Torrent C, Sole B, Bonnin CM, Rosa A, Sanchez-Moreno J, Vieta E. Functional remediation for bipolar disorder. *Clinical practice & epidemiology in mental health, 2011, 7, pp. 113.*

Innovation Work Plan Narrative

This project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. In particular, the project seeks to pursue services that can offer a deep and meaningful contribution to wellness and recovery in a culturally competent manner. The project also has high potential for promoting recovery and increased resilience and health because of its reliance on an evidence-based practice with promising applications to new populations.

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)

This Innovation project changes an existing, evidence-based approach in mental health. While currently available medication and treatment options in the three cities of Claremont, La Verne and Pomona help individuals with schizophrenia and bipolar disorder more effectively manage their symptoms, these strategies do not address the underlying cognitive impairment associated with these illnesses. Cognitive impairment is central to a person's recovery because it negatively impacts his or her ability to function effectively in life. If CET can be successfully introduced into TCMHC's system of care and proven to be effective in addressing underlying cognitive impairment, it can significantly improve the system's overall ability to support the processes of recovery.

To begin this project, TCMHC will contract with consultants who can help us implement CET. The first year will be spent learning the CET model applied to those persons with schizophrenia or schizo-affective disorder to demonstrate fidelity to model. Once that is established, subsequent applications will modify CET to individuals with bipolar disorder and to individuals who are mono-lingual Spanish. The exact number of applications will depend upon many factors not currently within our control such as the number of eligible consumers.

Throughout, a Recovery Learning Team made up of multiple stakeholders will help us assess and document lessons learned. A total of 60 consumers will receive either CET in its original form or a modified CET modified as part of this learning project.

Innovation Work Plan Narrative

This project will explore the following learning questions:

- Are the recovery outcomes for CET improved compared to outcomes for existing forms of support for recovery for individuals with schizophrenia?
- Can CET be integrated into the overall system of care made available to TCMHC clients?
- Can TCMHC implement CET in a cost effective manner?
- Can CET be modified to treat individuals with bipolar disorder and non-English speakers? Are the recovery outcomes for CET improved compared to outcomes for existing forms of support for recovery for individuals with bipolar disorder?

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: 03/2012 – 02/2015

March 2012

- Select and retain consultants who can help TCMHC set up and implement CET

April 2012-September 2013

- Hire two FTE clinicians, at least one of whom is bilingual
- Train clinicians to conduct CET and identify mentor trainer
- Implement 48-week CET sessions for individuals with schizophrenia and schizo-affective disorder to demonstrate fidelity to model
- Establish Recovery Learning Team (RLT)
- Recruit participants for RLT, facilitate learning dialogues among RLT participants, and document learning

October 2013-November 2014

- Implement Year Two of CET with modifications
- RLT to continue assessment and documentation of learning questions
- Build capacity within TCMHC to implement CET with minimal support from consultants

December 2014-February 2015

- Produce final learning report including RLT recommendations

Innovation Work Plan Narrative

This timeline allows for a reasonable schedule of introducing CET and testing the modified elements of CET. As documentation and learning occurs throughout the project period, we believe there is sufficient opportunity to assess the feasibility of replication and report our findings.

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.

A Recovery Learning Team (RLT) will periodically assess learning questions and document findings. Other stakeholders will provide feedback to the interim and final learning reports. The RLT will function in parallel to TCMHC's three-year implementation of CET: first to demonstrate fidelity to the evidence-based model and then to test out the modified versions of CET. The RLT will be comprised of approximately 10-14 individuals representing the following participants and stakeholders:

- Clinicians implementing CET and clinicians implementing other available forms of treatments such as Full Service Partnerships;
- CET consultants;
- Clinical supervisor overseeing the CET implementation;
- Researcher from a local university;
- Family members;
- Consumers; and,
- Innovation project workgroup members.

Leveraging Resources (if applicable)

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

TCMHC has received interest in our project from Los Angeles County and San Bernardino County. They would like us to share with them what we learn about the "real world" application of CET, as well as what we learn from the modifications. San Francisco County is also exploring issues of cognitive impairment and Supportive Employment, another evidence-based practice. The Recovery Learning Team (RLT) will make sure that there are some opportunities for mutual learning and explore how we can leverage resources.

Innovation Work Plan Narrative

Date:	**December 16, 2011**
County:	**Tri-City Mental Health Center**
Work Plan #:	**2**
Work Plan Name:	**Integrated Services**

Purpose of Proposed Innovation Project (check all that apply)

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

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

The purpose of this project is to increase the quality of services and produce better client outcomes by promoting greater interagency collaboration. TCMHC understands that to transform our systems of care we need a more holistic way of thinking about service delivery that addresses the fragmented manner in which services are provided currently by physical health, substance abuse, and mental health agencies. We seek a standard of truly integrated care with high levels of communication and coordination among providers and a shared commitment to the consumer's wellness.

Today, providers in the separate fields of physical health, substance abuse and mental health experience rigid boundaries between their scopes of practice and systemic barriers to truly integrative care. As a result, consumers receive disjointed services with one aspect of their care being addressed while others are neglected, which consequently can result in incorrect diagnoses, incomplete treatments, misinformation, and medication inconsistencies. Practitioners' lack of familiarity with service approaches and delivery in the other disciplines can result in delayed access to services. In addition, consumers and agencies incur significant financial costs with such fragmented service.

This project aims to improve community members' overall health by building relationships, understanding and knowledge among providers of physical health, substance abuse and mental health services, and changing policies and procedures in ways that result in truly integrated care. By testing a variety of activities with a pilot cohort of physical health, mental health and substance abuse practitioners, our hope is to answer our learning questions in a way that is compelling for additional organizations and staff. Through replication of the elements that prove to be effective, broader circles of professionals can work together to provide integrated services, and greater numbers of consumers will benefit from higher quality care.

Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses in the expected outcome, i.e. how the Innovation project makes a 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)

While other counties traditionally have occasion to work across health and substance abuse departments (such as at regular cross-departmental meetings), TCMHC as a Joint Powers Authority has not had similar opportunities. As a result, representatives from all three fields were brought together to form the workgroup that conceived this project work plan, thus beginning to model the project itself. Representatives from all three fields are deeply commitment to the success and learning potential of this project.

The key innovation of this project is that we are challenging existing paradigms in the fields of physical health, substance abuse and mental health. We consider the "patient" to be the system of care, and our goal is to heal that system. To learn how to improve the quality of care through integrated services, we will engage formal leaders, medical providers, receptionists and administrative staff, and consumers from all three disciplines in a learning project that aims at deep, transformational commitment to integrated services.

Based on the experiences of Western University in launching its inter-professional education program, this project is envisioned as a three-year one. In the first year the team will develop the approach, curriculum, and convene the initial cohort. Based on the learning, they will revise the approach, and over the remaining two years conduct two more cohorts, perhaps engaging different organizations in the system of mental health, physical health and substance abuse care. By the end of the three years and three cohorts, a full evaluation can assess the approach as well as the depth of change in the system, to consider what appropriate next steps will further support the transformation to integrated care. Described below are the main components of the program:

1. **Learning Cohort Experiences** – Staff from physical health, substance abuse and mental health services will create a learning cohort of no more than 20 people, in which they will gather for an intensive launch event (ideally a full day) and then briefer connections over a six- to nine-month period. Through interactive case studies and facilitated sessions with guest speakers, participants will explore the curriculum and develop their own skills and practice of integrated care. Sessions will rotate their location among the participating organizations, giving all cohort members an immersion experience through which they can understand the environment and meet other staff in-person. Other activities may include Skype-based sessions, web-based written interactions, long hosted lunches, "ride alongs," and other formats to accommodate schedules.

Innovation Work Plan Narrative

2. **Learning Curriculum** – Modeled on techniques used at Western University's inter-professional education program and other adult learning settings, and drawing from research and effective practice elsewhere, the curriculum will address areas such as:
   - Building trust, celebrating what is working among the systems already;
   - Articulating the qualities they seek in integrated care;
   - Engaging with consumers about their experiences;
   - Exploring risks and barriers to change within their own formal and informal structures;
   - Using case studies and standardized patients (trained actors), to explore possible approaches and practice responses;
   - Building shared understanding of roles and responsibilities as well as boundaries for each provider and discipline;
   - Applying customer service concepts in health care settings;
   - Using technology to support relationship building among professionals, not as a replacement to that relationship;
   - Incorporating opportunities from health care reform into integrated care; and,
   - Reflecting on applications in their daily practices.

3. **Policy and Procedure Changes** – Based on barriers identified by the cohort, formal leaders from the participating organizations will simultaneously work to build tools and agreements to help make integrated care possible, such as patient releases, memoranda of understanding that may articulate specific roles and responsibilities, shared data systems and client notes, aligned intake, etc.

4. **Integration Conference** – The conference will convene a larger circle of staff from participating organizations and others in the field, bringing together what the cohort has learned, and expanding the opportunity for awareness to other staff. In addition to professional staff, front line and other administrative staff will have tracks designed especially for their role in integrated services. Consumers who have experienced the integrated care approach will be experts who can provide insights. Conference attendees will increase their understanding of and commitment to integrated care while building understanding of the other disciplines and relationship with the other providers.

5. **Evaluation** – Based on the evaluation design, we will review learning and make recommendations at the end of each cohort.

Innovation Work Plan Narrative

6. **Additional Cohorts** – We anticipate completing three cycles of learning during the three-year period. Cohorts may be drawn from different organizations to expanding the reach of the project. Participants from earlier cohorts will continue to connect, build their relationships, and support the learning of later participants.

7. **Documentation of Lessons Learned** -- We will seek to document our lessons learned in order to share them, and we may also pursue journal publication.

Our program design intentionally engages people from all across the organizations – people in formal leadership roles, as well as people who provide informal leadership from various professional and administrative positions. Our belief is that support for integration must come from the ground-up as well as from top leadership levels. This program design also weaves together intentional change at different levels of the system of care:

- **Systems level changes to policies and procedures** within and among all participating organizations, and in their funding and regulating bodies, must be implemented to achieve lasting impact;
- **Individual change in understanding, knowledge, and practice** by staff with the full range of roles interfacing with clients will be the focus of annual cohorts of 20 people; and,
- **Community-wide learning** through dissemination of project results at an annual conference that integrates and shares the lessons from the systems level and individual level efforts.

A cross-disciplinary steering committee will develop the curriculum, guide the creation of necessary policies and procedures, monitor the progress of the pilot cohort, and document lessons learned along the way. The steering committee members should have both formal and informal leadership roles in their organizations, including those organizations represented in the cohort. People who have received services across the disciplines will be an important part of this group; we anticipate that number to be approximately 25 per year.

The pilot cohorts should each include up to 20 professionals and administrative staff representing TCMHC, physical health providers, and substance abuse providers. As a pilot, the participating organizations should have a significant number of commonly-shared consumers. Individuals chosen to participate should be seen as leaders within their organizations (regardless of formal position), should be enthusiastic about the possible benefits of integrated care, and committed to investing the time necessary to participate fully throughout the time of the pilot.

Innovation Work Plan Narrative

This Innovation project supports and is consistent with the General Standards and Title 9, CCR, section 3320 in that it is grounded in community collaboration and integrated services. Collaboration will be enhanced, moving beyond warm referrals or even co-location, to a higher level of true integrated care. The integration of services across physical health, substance abuse, and mental health fields offers a deep and meaningful opportunity for transformation of care for consumers all focused on their wellness. Through engagement in the design and evaluation, consumer voices are essential to the project. The significantly different cultures and approaches of providing substance abuse treatment, physical health care and mental health care are at the center of this project, which will help participants understand their own and each other's cultural assumptions, beliefs, and philosophies as a step toward respect and integration.

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)

TCMHC expects this project to change existing models of "integrated care" (usually defined as warm referrals or co-location) and to yield many contributions to our understanding of mental health's role in a truly integrated care system. New practices and approaches learned from physical health and substance abuse treatment providers may enhance and improve mental health services. We anticipate that existing mental health system practices of coordination with these two disciplines will be improved in ways that meaningfully improve the quality of care for consumers. The use of standardized patients (trained actors, possibly including former consumers), a practice borrowed from medical training, has great potential in this setting.

In addition, learning in this method requires all participants to "be" the model of care that we seek. For example, to be successful, this project requires participants to be respectful and open to other disciplines, to demonstrate commitment throughout their organizations (formal leadership, medical care providers, front line and administrative staff), become familiar with other treatment settings, and develop personal relationships with the other providers. It also requires organizational alignment through policy and procedure, with support for integrated care from leadership throughout the organization. The result we anticipate is that consumers will be treated as a whole people, not silos of symptoms, when we can model treating the system as a whole system of care.

Innovation Work Plan Narrative

The project will address the following learning questions:

- What challenges or needs make it difficult for providers of physical health, substance abuse, and mental health services to provide truly integrated care? What are formal and informal barriers?
- What methods of building relationships, understanding, and knowledge are most attractive to participants and effective at leading to direct honest communication?
- What policies, agreements, and/or supports might make it easier for providers across fields to provide integrated care?
- What incremental costs are related to providing integrated care? What offsetting benefits also arise? What are financially sustainable ways for this type of care to be provided?

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: 02/0212 – 06/2015

February 2012-June 2012

- Hire & train staff
- Convene steering committee
- Develop curriculum
- Develop evaluation tools
- Recruit first cohort participants

July 2012-June 2013

- Conduct learning cohort experiences
- Identify policy and procedure changes
- Review learning and make recommendations
- Organize and offer conference to share learning with broader community
- Recruit second cohort participants

July 2013-June 2014

- Conduct learning cohort experiences
- Identify policy and procedure changes
- Review learning and make recommendations
- Organize and offer conference to share learning with broader community
- Recruit third cohort participants

Innovation Work Plan Narrative

July 2014-June 2015

- Conduct learning cohort experiences
- Identify policy and procedure changes
- Review learning and make recommendations
- Organize and offer conference to share learning with broader community
- Draft learnings as paper for distribution, possible publication

This timeframe will allow sufficient learning time for three cohorts to engage, learn and reflect upon the experiences and develop recommendations for their organizations. We intend to share what we learn widely so that others may replicate the model if they wish.

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.

Our desired result is for providers to move away from positions of discomfort with learning something new to a recognition that their work is more alike than different from the other disciplines and that everyone benefits from integrated care.

A thorough review of the project after its completion will draw conclusions about the learning questions as well as capture lessons to inform replication. The project review will be informed by the following three types of evaluation:

- **Pre- and Post-test Evaluations** – Recommended for both staff and consumers, they will be tailored to reflect the specific respondents. The questionnaires will gather a view of the system of care before and after the learning activities;
- **Reflection** – Participants will practice reflection as part of each activity as a way to reinforce their learning, identify opportunities to apply what they have learned immediately into their work, and find ways to improve the learning process; and,
- **Process evaluation** – This evaluation will track the steps required to design and implement the project, and will allow for revision along the way, documenting areas where it is succeeding, and determining adjustments that will lead to improved results.

The perspectives of consumers, medical practitioners, front line and administrative staff, and organizational leadership will be involved in the assessment. Other stakeholders can engage in the learning at the conference.

Innovation Work Plan Narrative

Leveraging Resources (if applicable)

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

As a result of truly integrated services, more consumers will become connected to each of the types of service, and many of these consumers will not have insurance or the funds to pay for care. Our budget includes a significant pool of funds to offset incremental services provided by participating organizations. FSP funding will also offset some of these costs. In the future, Medi-Cal expansion (scheduled for 2014) will be a resource for sustaining the integrated services beyond the timeframe of this learning project.

EXHIBIT D-1

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Tri-City Mental Health Center

Work Plan Name

Modifications to Cognitive Enhancement Therapy

Annual Number of Clients to Be Served (If Applicable)

60 Total

Population to Be Served (if applicable):

The populations to be served by this project include individuals who have been diagnosed with schizophrenia and individuals diagnosed with bipolar disorder, including mono-lingual Spanish speakers.

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

This project seeks to modify an existing evidence-based practice, Cognitive Enhancement Therapy (CET), to treat a population group not included in the research on CET: individuals who have been diagnosed with bipolar disorder, including individuals from underserved population groups who are mono-lingual Spanish speakers. CET has been demonstrated to be an effective treatment for individuals with schizophrenia by improving their cognitive functioning. Individuals with bipolar disorder also experience cognitive impairments (although with lesser severity than individuals with schizophrenia), and this project seeks to test whether CET can be similarly successful with this population. If so, we will have improved the range of services provided at Tri-City Mental Health Center in a way that leads to greater psychosocial functioning and wellbeing for these individuals.

EXHIBIT D-2

Innovation Work Plan Description
(For Posting on DMH Website)

County Name
Tri-City Mental Health Center
Work Plan Name
Integrated Services

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

Population to Be Served (if applicable):

The client population to be served by this project are those persons with co-occurring disorders and being treated by physical health, substance abuse, and/or mental health providers involved in this project. Because these clients will need to be ones that are held in common by the agencies involved, we anticipate being able to identify 25 per year.

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

TCMHC understands that to transform our systems of care we need a more holistic way of thinking about service delivery that addresses the fragmented manner in which services are provided currently by physical health, substance abuse, and mental health agencies. We seek a standard of truly integrated care with high levels of communication and coordination among providers and a shared commitment to the consumer's wellness.

This project aims to improve community members' overall health by building relationships, understanding and knowledge among providers of physical health, substance abuse and mental health services, and changing policies and procedures in ways that result in truly integrated care. By testing a variety of activities with a pilot cohort of physical health, mental health and substance abuse practitioners, our hope is to answer our learning questions in a way that is compelling for additional organizations and staff. Through replication of the elements that prove to be effective, broader circles of professionals can work together to provide integrated services, and greater numbers of consumers will benefit from higher quality care.

EXHIBIT E

Mental Health Services Act
Innovation Funding Request

County: Tri-City MHC Date: 12/16/2011

	Innovation Work Plans		FY 11/12 through FY 13/14 Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
	No.	Name		Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	# 01	Modified Cognitive Enhancement Therapy	559,536	-	186,512	373,024	-
2	# 02	Integrated Services	671,395	167,849	167,849	167,849	167,849
3							
4							
5							
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24							
25							
26	Subtotal: Work Plans		$1,230,931	$167,849	$354,361	$540,873	$167,849
27	Plus County Administration		184,640				
28	Plus Optional 10% Operating Reserve		141,557				
29	Total MHSA Funds Required for Innovation		$1,557,128				

EXHIBIT F-1
(PAGE 1 OF 3)

Innovation Projected Revenues and Expenditures

County: Tri-City MHC

Fiscal Year: 2011-12 through 2013-14

Work Plan #: INN #01

Work Plan Name: Modifications to Cognitive Enhancement Therapy (MCET)

New Work Plan ☑

Expansion ☐

Months of Operation: 03/12-06/14
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	348,080			$348,080
2. Operating Expenditures	3,675			$3,675
3. Non-recurring expenditures	0			$0
4. Training Consultant Contracts	113,000			$113,000
5. Work Plan Management	94,781			$94,781
6. Total Proposed Work Plan Expenditures	**$559,536**	**$0**	**$0**	**$559,536**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$559,536**	**$0**	**$0**	**$559,536**

Prepared by: Margaret Harris

Date: 12/16/2011

Telephone Number: (909) 623-6131 ext 2308

EXHIBIT F-1
(PAGE 2 of 3)

BUDGET NARRATIVE

County Name: **Tri-City MHC** Date: December 16, 2011

INN Work Plan Name: **Modifications to Cognitive Enhancement Therapy (MCET)**

General

The costs included in this budget covers the initial four-month period of the work plan starting in March 2012 through June 2012 and two full fiscal years 2012-13 and 2013-14 of CET services.

A. Expenditures

1. Personnel Expenditures – $348,080

   Personnel expenditures include:

   a) Salaries of $271,938 cover the twenty eight month period ending June 30, 2014 and were determined based on Tri-City's job classifications and compensation ranges.

      Positions include:

      - Clinical Supervisor – .25 FTE
      - Clinical Staff – 2.0 FTE

   b) Benefits of $76,143 were based on Tri-City's average benefit rate of 28% and include all payroll taxes, retirement costs, health insurance and worker's compensation insurance.

2. Operating Expenditures – $3,675

   Operating expenditures include material and supply costs of the 2.25 FTE's for the twenty-eight month period.

3. Non-recurring expenditures – None

   Non-recurring expenditures for six laptop computers and one video recorder will be donated during the plan duration by the contracted training consultants.

4. Training Consultant Contracts – $113,000

   Training consultant contracts will be entered to provide training to the staff on cognitive enhancement therapy as well as any required therapy modifications

and implement the program in fiscal 2011-12 and fiscal 2012-13. In addition, these costs will cover the annual agency license fees and the ongoing training of mentor trainers in fiscal 2013-14.

5. Work Plan Management – $94,781

   Work plan management, including ongoing planning, monitoring, data collection and outcome reporting will be conducted by Tri-City staff. Such staff will include .5 FTE of administrative and technical assistance as well as .15 FTE of quality assurance management.

6. Total Proposed Work Plan Expenditures – $559,536

   The total proposed work plan expenditures will cover the costs of the plan over the 28 month period as follows:

Fiscal 2011-12 (four months)	$ 84,837
Fiscal 2012-13	$272,430
Fiscal 2013-14	$202,269

B. Revenues – None

1. Existing Revenues – None
2. Additional Revenues – None
3. Total New Revenues – None
4. Total Revenues – None

C. Funding Requirements—$559,536

EXHIBIT F-2
(PAGE 1 OF 3)

Innovation Projected Revenues and Expenditures

County: Tri-City MHC

Work Plan #: INN #02

Work Plan Name: Integrated Services

New Work Plan ☑

Expansion ☐

Months of Operation: 01/12-06/14
MM/YY - MM/YY

Fiscal Year: 2011-12 through 2013-14

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	176,880			$176,880
2. Operating Expenditures	247,970			$247,970
3. Non-recurring expenditures	4,700			$4,700
4. Training Consultant Contracts	10,400			$10,400
5. Work Plan Management	231,445			$231,445
6. Total Proposed Work Plan Expenditures	**$671,395**	**$0**	**$0**	**$671,395**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$671,395**	**$0**	**$0**	**$671,395**

Prepared by: Margaret Harris

Telephone Number: (909) 623-6131 ext 2308

Date: 12/16/2011

BUDGET NARRATIVE

County Name: **Tri-City MHC** Date: December 16, 2011

INN Work Plan Name: **Integrated Services**

General

The costs included in this budget covers the initial six-month period of the work plan starting in January 2012 through June 2012 and two full fiscal years 2012-13 and 2013-14 of integrated services and learning.

It is estimated that this plan will carry through to fiscal 2014-15 with a budget of approximately $200,000.

A. Expenditures

1. Personnel Expenditures – $176,880

   Personnel expenditures include:

   a) Salaries of $138,188 cover the thirty month period ending June 30, 2014 and were determined based on Tri-City's job classifications and compensation ranges.

      Positions include:

      - Clinical Supervisor – .75 FTE

   b) Benefits of $38,692 were based on Tri-City's average benefit rate of 28% and include all payroll taxes, retirement costs, health insurance and worker's compensation insurance.

2. Operating Expenditures – $247,970

   Operating expenditures for the thirty month period include:

   a) $13,540 during the first six months to cover meeting costs for member cohorts who represent physical health, and mental health and substance abuse providers. These costs include stipends, facility costs, communications and mileage reimbursement.

   b) $117,840 and $116,590 for fiscal years 2012-13 and 2013-14, respectively, to cover meeting costs for the member cohorts. These costs include stipends, facility costs, communications and mileage reimbursement. In addition, the operating expenditures for fiscal

2012-13 and 2013-14 above include a pool of funds approximating $50,000 per year that will be required to cover incremental services provided by participating organizations as a bridge to future expanded Medi-Cal covered services.

3. Non-recurring Expenditures – $4,700

   Non-recurring expenditures will be incurred in the first six months for two laptop stations and two cell phones.

4. Training Consultant Contracts – $10,400

   Training consultant contracts will be entered for the training of cohorts in the provision of integrated care coordination between medical care, substance abuse treatment and mental health care.

5. Work Plan Management – $231,445

   Work plan management, including ongoing planning, monitoring, data collection and outcome reporting will be conducted by Tri-City staff. Such staff will include 1.5 FTE of administrative, design and evaluation assistance.

6. Total Proposed Work Plan Expenditures – $671,395

   The total proposed work plan expenditures will cover the costs of the plan over the 30 month period as follows:

Fiscal 2011-12 (six months)	$ 91,088
Fiscal 2012-13	$290,124
Fiscal 2013-14	$290,183

B. Revenues – None

1. Existing Revenues – None
2. Additional Revenues – None
3. Total New Revenues – None
4. Total Revenues – None

C. Funding Requirements—$671,395

EXHIBIT G
(Optional)

Innovation Component
Request for Funding for Community Program Planning

Date: December 16, 2011

County: Tri-City Mental Health Center

Total Amount Requested: $ 100,000.00

Funding Purposes

Please briefly describe the purpose and amount for which the requested funding will be used.

Innovation planning.

Certification

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said County and the following statements are true. I have not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements listed above represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures. The proposed activities are consistent with the Mental Health Services Act, the Department's regulations governing the MHSA, and draft proposed guidelines for the Innovation component of the Three-Year Program and Expenditure Plan; and to the best of my knowledge and belief this request in all respects is true, correct, and in accordance with the law.

Signature (Director/Designee, County Mental Health Department)

Summary of Written and Oral Comments Received During Public Hearing for Tri-City Mental Health Center's MHSA Innovation Plan of January 18, 2012

What we like about the proposed Innovation projects

- CET improves employment outcomes.
- Cognitive remediation stimulates the brain, a chance to repair and re-train.
- Integration: when referrals are made, providers don't know if the client went nor the results
- Great logic; great theory
- CET because it is innovative, proven effective and expands its use beyond English speakers and into other diagnosis - maybe PTSD or others
- Excited about hope for improvement for serious mental health impairment
- Something that could be used to enhance treatment for many monolingual consumers
- Provides a great start to learning that could hopefully be sustained with other MHSA monies.
- Project held hope for the ability to bill for the computer aspect of CET
- The integrated project gives the hope of improved care when all treating parties are able to collaborate.
- Eliminating the duplication of paperwork.
- Broad application
- Actual funding for projects
- Speeds up the process for helping the patient/client
- Cross training and cross learning
- Multiple referrals can be frustrating for the client
- Giving opportunity to Spanish speakers & individuals diagnosed with bipolar disorder
- There's hope for these people and their loved ones and the community.
- Focus on learning, not doing.
- Focus on recovery (CET).
- Cohesiveness of integrated healthcare project, more geared toward treating whole person rather than separate symptoms.

Questions or concerns we have about the Innovation projects

- Will there be a transition team for CET after the 48 weeks? Will this process be structured?
- Will there be continued resources provided to CET participants after treatment?
- Cognitive remediation is being provided in the community. Is the CET project a duplicated effort?
- Will there be assistance with job searches for CET participants?
- None, all is very clear.
- If the Obama healthcare innovation doesn't come through, there is a concern about whether these types of projects will be launched and used.

Summary of Written and Oral Comments Received During Public Hearing for Tri-City Mental Health Center's MHSA Innovation Plan of January 18, 2012

- CET program will present a new challenge in getting Spanish monolingual patients to participate.
- Cultural barriers
- What's the follow up after graduating from CET program?
- Why is employment not included in the CET project?
- What is an example of a collaborative question from the 3 disciplines to a client?
- Sharing information between disciplines for integrated care project (HIPPA)
- Will there be a plan to have health homes – e.g. like in HMOs? If there is, how will the clients' freedom of choice be maintained?

Other comments we want to share (use the back of the sheet if needed)

- There are some asking for more understanding about what is meant by the statement: "Recovery is feasible for most people who suffer from mental illness." Specifically what do we mean by recovery?
- It is exciting to think about the possibilities for improved mental health for consumers whom these projects will affect.
- Exciting to think about improved mental health care.
- Hopefully expand CET to other languages.
- What about assistance to help consumers navigate between different disciplines while leaving control with consumer?
- Andrea knows of someone who recovered from neurological damage through treatment similar to CET.

Responses to Oral Questions Received During Public Hearing

Question: For the CET project, what will happen to the participants at the end of the 48 weeks?
Response: Good, ethical treatments must include a plan for transitioning a client out of treatment. The one-hour, individual coaching sessions will continue for another 3 months to focus on transitional support. In addition, an employment specialist from the Wellness Center will also be providing support.

Question: For the CET project, what will happen if a participant is not making progress in their recovery? Will they be dropped?
Response: This is an evidence-based practice that is designed for individuals who are already stabilized and there will be an individualized plan appropriate for each person. The graduation rates for the consulting firm that we expect to provide the training for us are very high so we don't anticipant this to be an issue. The aim of the CET learning project is to better understand how CET can be integrated into the existing system of care. The many resources - professional and community - within our system of care will therefore also be accessible to participants of this program.

Summary of Written and Oral Comments Received During Public Hearing for Tri-City Mental Health Center's MHSA Innovation Plan of January 18, 2012

Question: How many individuals are expected to participate in the CET project?
Response: There will be four therapists trained and 12 clients per group so we expect about 48 individuals to participate in the project. The first year will focus on demonstrating fidelity to the model. The second iteration will adapt the model to individuals who are mono-lingual Spanish speakers and who have been diagnosed with bipolar disorder.

Question: CET is available for free at Mt. SAC. Will the CET project therefore be a duplication of service?
Response: Their service is intended for individuals with traumatic brain injury. There are many forms of cognitive remediation therapies and CET is only one. The founders of CET were inspired by the success of cognitive remediation for helping individuals with traumatic brain injury but CET has been modified to be more specifically appropriate to individuals with schizophrenia and schizo-affective disorders. The project intends to learn from many different sources in the local area so yes, we expect to reach out to them and other counties who have expressed an interest in CET as well.

Question: Will CET require a doctor's order?
Response: The focus for the first year is on demonstrating fidelity to an evidence-based model so we will need to engage participants who have been diagnosed with schizophrenia or schizo-affective disorder. This learning project is intended to meet the needs of the community and the system. Currently, 28% of the Tri-City clients are diagnosed with schizophrenia or schizo-affective disorder and if we add bipolar disorder, the total is over 40%. So, in addition to helping the system evolve to provide cognitive remediation, there's also a need for providing support to this population. In future years, we definitely hope to learn how aspects of CET can be modified to benefit a much larger population.

Question: How will we hear about what was learned through these projects?
Response: Beginning this summer, the permanent delegates will be convened to begin exploring that question. All community members are welcome at these meetings and announcement will be e-mailed and posted on the Tri-City web site. The learning projects are intended to help evolve the system of care so reflecting on the learning and searching for ways to leverage the learning will be an important topic moving forward.

Tri-City Mental Health System
First Innovation Plan Public Hearing

Luminescence Consulting
310 422 2256 • luminescence.org

Tri-City Mental Health Commission
Tri-City Mental Health Center Governing Board

Call their meetings to order

Exhibit I. Innovation Work Plan - Presentation Slides Utilized During Public Hearing for Tri-City Mental Health Center's MHSA Innovation Plan of January 18, 2012

Tri-City Mental Health Commission

Meeting business

Public comment on anything other than focus of public hearing

Open public hearing

3

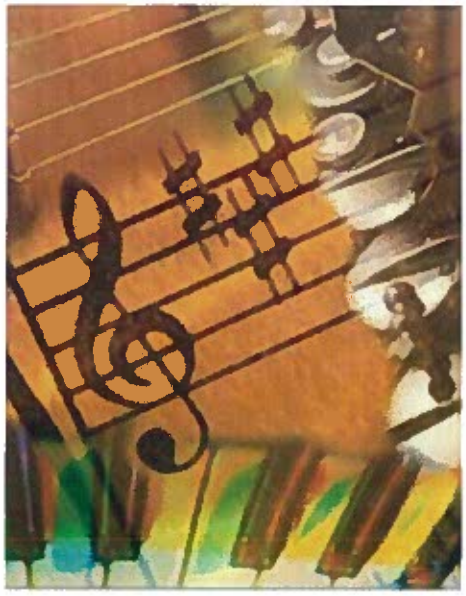
Structure of the public hearing

Describe context for the Innovation Plan

Outline the essential components of the first Innovation plan

Small group discussion

Large group comments and feedback



4

Exhibit I. Innovation Work Plan - Presentation Slides Utilized During Public Hearing for Tri-City Mental Health Center's MHSA Innovation Plan of January 18, 2012

Basics of Mental Health Services Act

Community Services + Supports (**CSS**) + Housing

Prevention + Early Intervention (**PEI**)

Innovation

Workforce Education + Training (**WET**)

Capital Facilities + Technology

5

Innovation Plan: The givens

Primary focus: Learning, not services (services ok, just can't be the point)

Essential MHSA elements

- Community collaboration
- Integrated services
- Wellness + recovery + resiliency
- Consumer- + family-driven system
- Culturally competent system

The givens, cont'd

One or more foci (1 is better)

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

The givens, cont'd

Potential contribution to learning

- Introduces new mental health practices/approaches
- Makes a change to an existing mental health system practice/ approach
- Introduces a new application of a promising practice/approach that has been successful in a non-mental health context

Core concept: formal authority + power

Formal authority (group exterior)

Defined: official jurisdiction and right to make decisions

MHSA: Mental Health Commission • Tri-City Board • State entities (this is shifting)

Power (all 4 quadrants)

Defined: ability to do something

From where it arises: Relationships; Alignment of intention, will, and action among multiple stakeholders

9

EMERGING INNOVATION TIMELINE

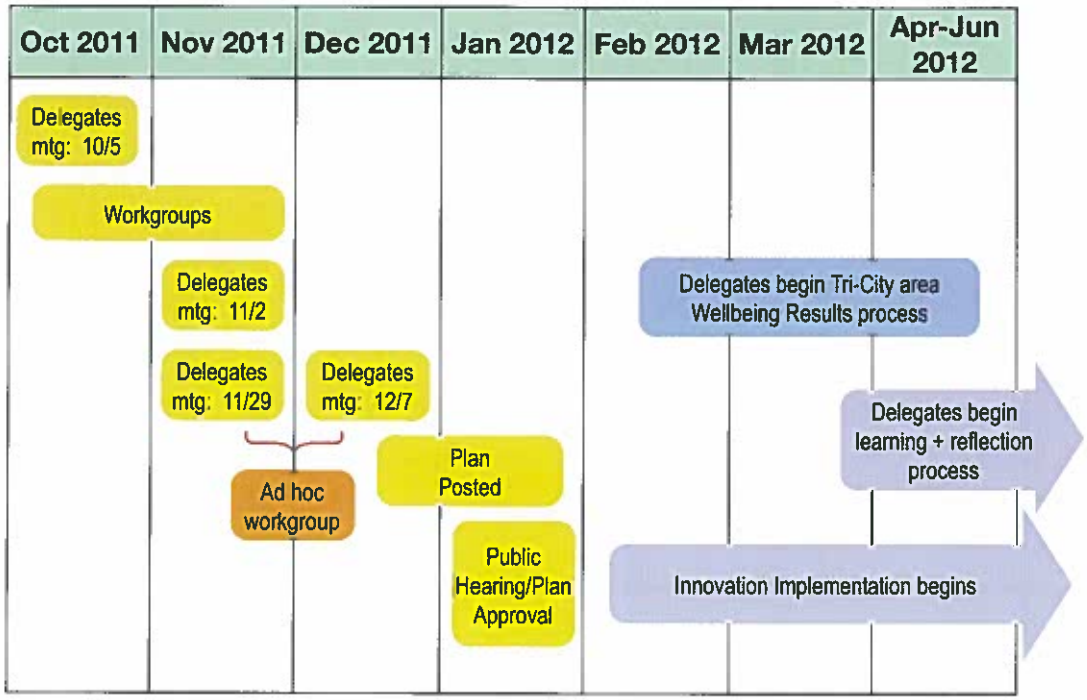


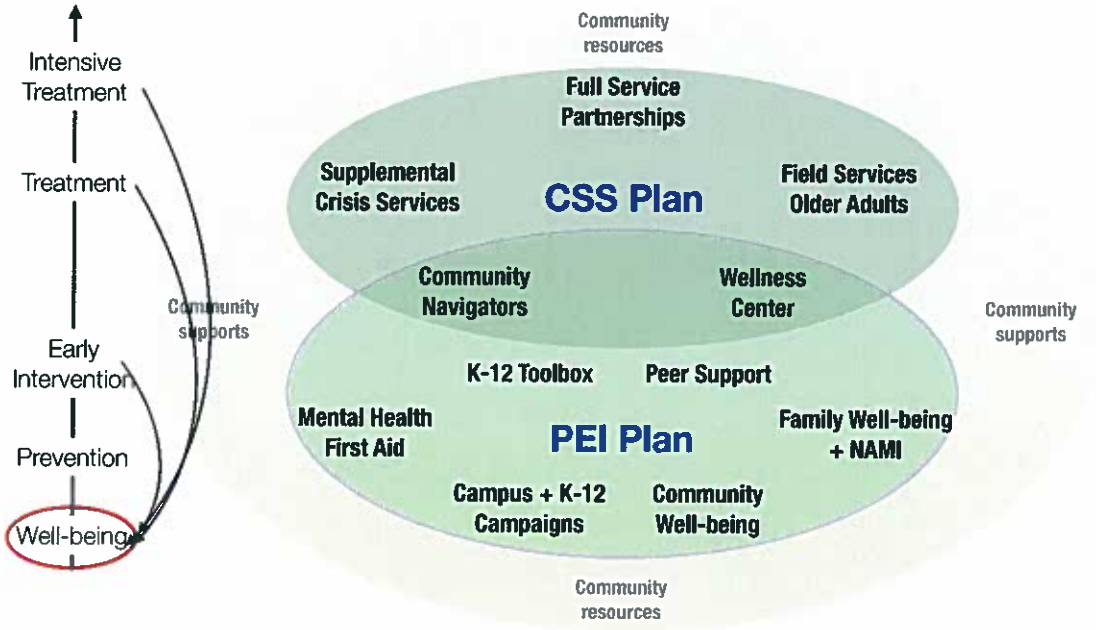
Exhibit I. Innovation Work Plan - Presentation Slides Utilized During Public Hearing for Tri-City Mental Health Center's MHSA Innovation Plan of January 18, 2012

Where delegates focused their exploration: Learning edges

Defined: a place where focused learning can significantly advance the transformation of the system

The process to date

Mapping the emerging system of care



12

Exhibit I. Innovation Work Plan - Presentation Slides Utilized During Public Hearing for Tri-City Mental Health Center's MHSA Innovation Plan of January 18, 2012

6 original project proposals

Reducing stigma through engagement of cultural groups

Student resiliency

Landlords

Urban farming

Cognitive Enhancement Therapy

Integrated mental health, physical health, and AOD services

2 proposals in the first plan

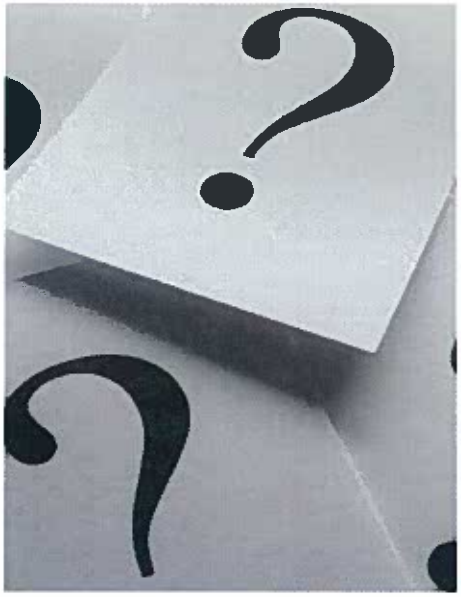
Cognitive Enhancement Therapy and Supportive Employment

Integrated mental health, physical health, and AOD (alcohol and other drug) services

Questions for small groups

What did you like about the two Innovation project proposals?

What questions or concerns do you have about the proposals?



15

Tri-City Mental Health Commission

Do we recommend the Innovation Plan to the Governing Board?

16

Question to Tri-City Governing Board

Do we approve the draft Innovation Plan?

17

Next steps

Innovation plan

- Implementation begins

Annual plan update

- Delegates meeting in Feb
- Update posted in late Feb - early March (including new projects)
- Public hearing: late March - early April

Exhibit I. Innovation Work Plan - Presentation Slides Utilized During Public Hearing for Tri-City Mental Health Center's MHSA Innovation Plan of January 18, 2012

End of Document