

# CORE

*Community Outreach Recovery Empowerment*



## Adult Outpatient Services Transformation - Transition Plan

MHSA Steering Committee  
August 18, 2022



# Agenda

8/17/2022



Introductions



Review



CORE Transition Plan



Questions

# Review of Community/Stakeholder Input

8/17/2022

## Behavioral Health Town Hall sessions

held over 3 dates in  
July, August 2019, and  
February 2020

## Adult Outpatient Services Focus Groups

held over several  
dates from September  
through November  
2019

## Smaller cultural- specific community conversations

held over several  
dates from December  
2019 through  
February 2020

## Behavioral Health Racial Equity Collaborative focus groups and key information interviews

held in January 2021

## Adult Outpatient Online Survey

open from March 5th  
through March 19th,  
2021

# Recovery Stepping Stones

## Journey To Wellness And Optimal Health

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### CORE

**Community:** Increase community engagement and connections, belonging and supportive

**Outreach:** Inclusive, Inviting, welcoming, educational and inspirational

**Recovery:** Intentional progression towards optimal health and wellbeing

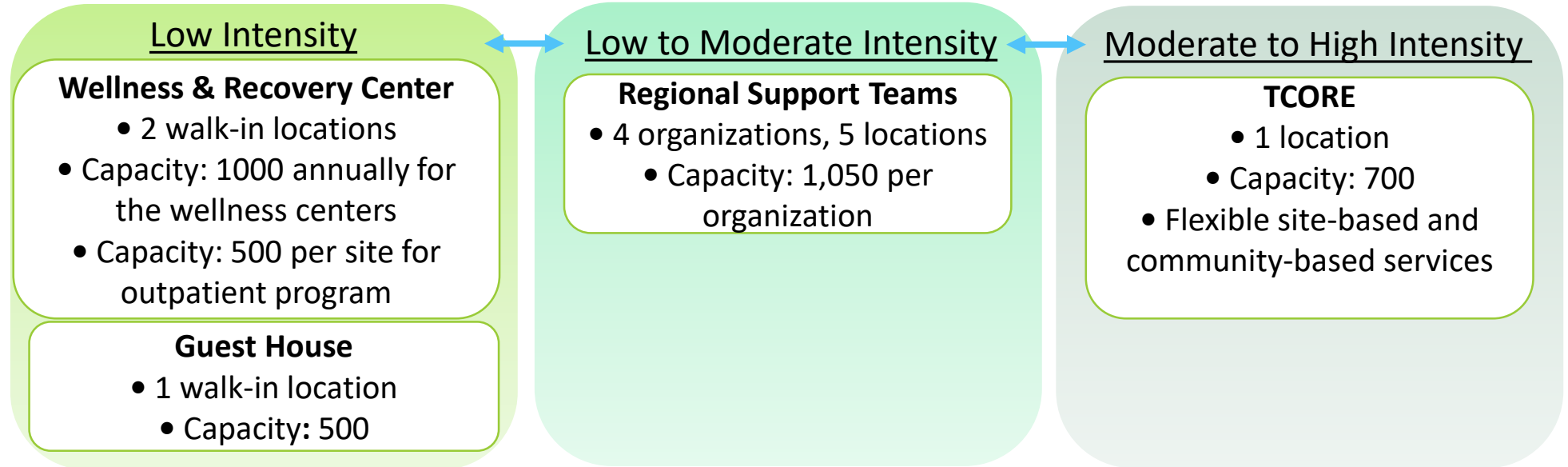
**Empowerment:** Client and family driven goals and outcomes, independent, confident, courageous and resourceful



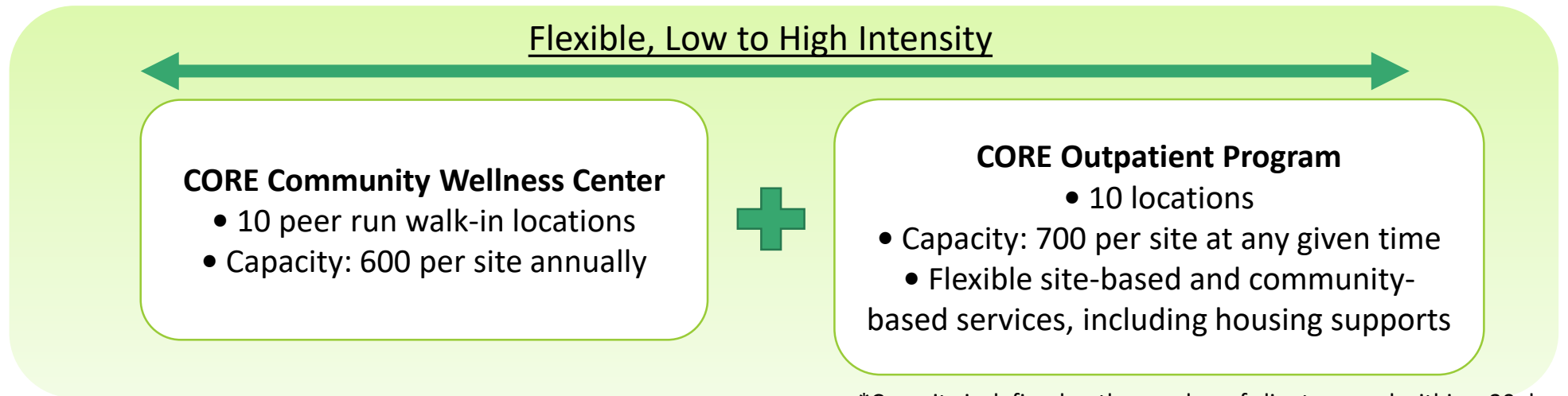
# Adult Outpatient System of Care Continuum

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## Current System

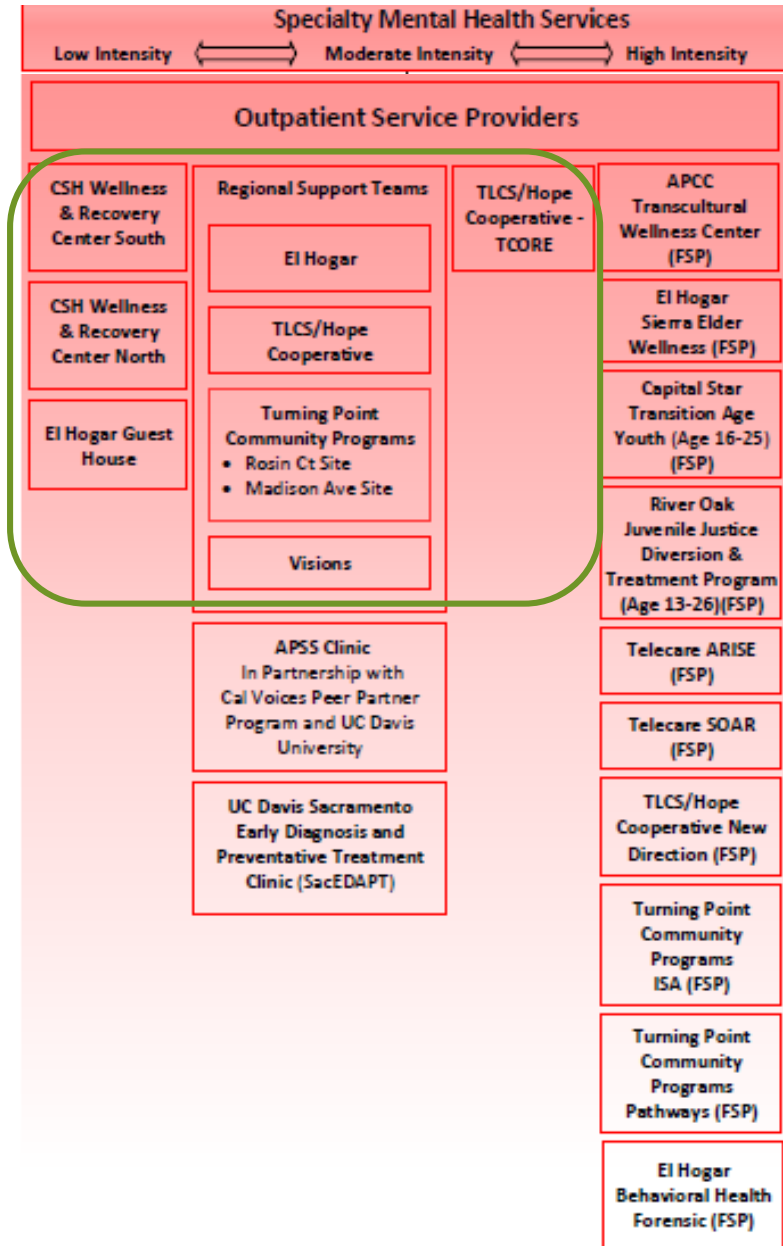


## Transformed System

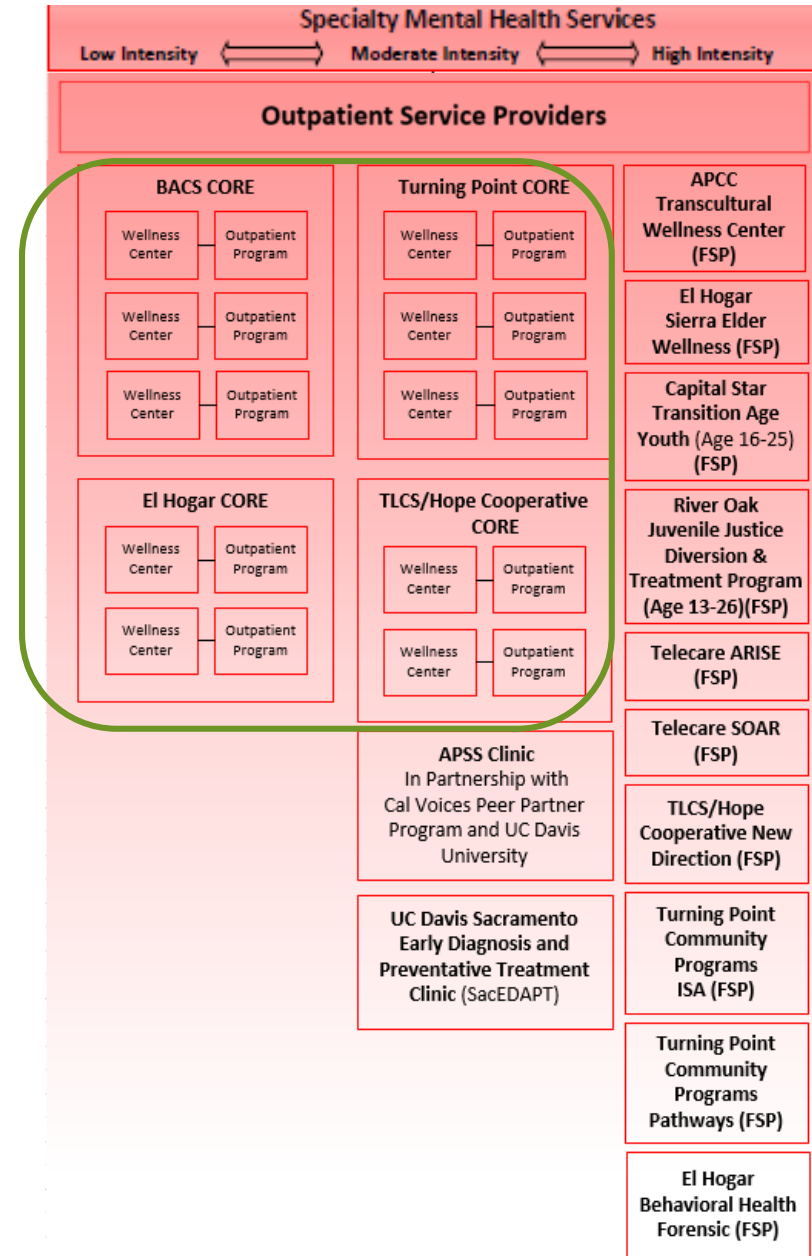


\*Capacity is defined as the number of clients served within a 30 day period.

# Current Outpatient Continuum



# Future Outpatient Continuum



# Service Delivery Approaches


8/17/2022

1. Trauma informed care
2. Culturally and linguistically responsive and recovery-oriented care.
3. The “Strengths Model,” a recovery-oriented practice model that will guide outpatient program practices and service delivery
4. Provide focused, time-limited, individual and/or group mental health services using best practices, community defined practices, evidence based practices, curriculum based practices and/or promising practices to all clients.
5. The “SSI/SSDI Outreach, Access, and Recovery (SOAR)” program model increases access to Social Security disability benefits for people experiencing or at risk of homelessness
6. Peer Support Services, a system of giving and receiving help based on key principles that include shared responsibility, and mutual agreement of what is helpful
7. Flexible, community/field-based specialty mental health service level of intensity and phase of treatment that matches the needs of the client.



# CORE Phases of Treatment

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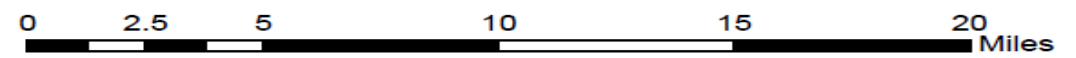
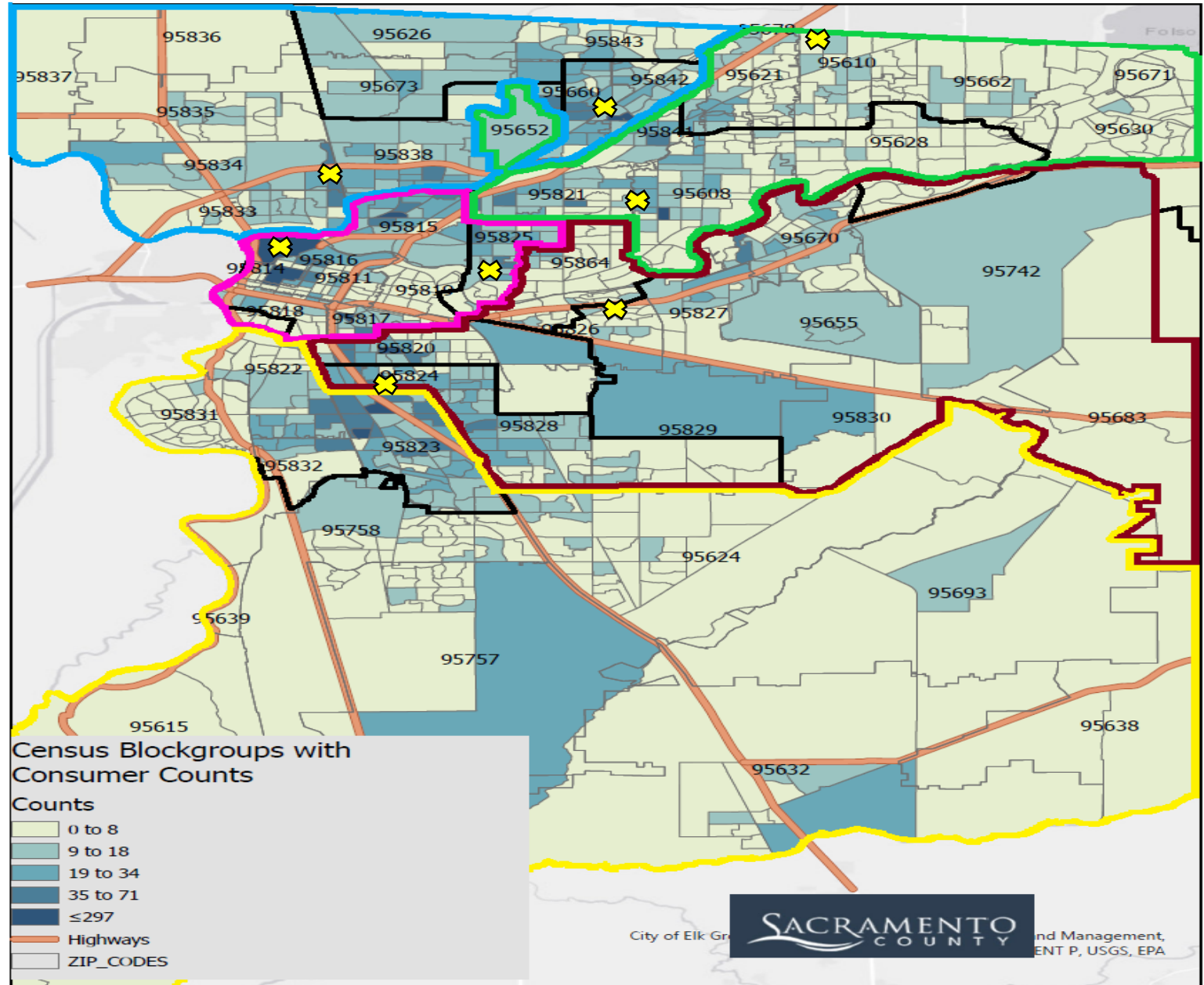
- 
- Engagement & Planning Phase
  - Monitoring and Adapting Phase
  - Transition Phase



## Where is CORE?

The CORE map features a general overview of the five areas with geographic boundaries identified by color along with the population density of adults served throughout Sacramento County in various shades of blue.

Two additional sites will be added in the yellow area very soon.



# Referrals

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## Sacramento County Mental Health Access Team



- 916-875-1055 or toll free 888-881-4881



- Online Mental Health Service Request  
(<https://mentalhealthservicerequest.sacounty.net>)



- Sacramento County Mental Health Access Team  
7000-A East Parkway, Suite 700  
Sacramento, CA 95823



- Community Wellness Center linkage to Mental Health Access Team

# CORE Transition Workgroup

## Composition:

- Representatives from Wellness and Recovery Center, Regional Support Team, Guest House, TCORE, CORE, individuals with lived experience, client and family advocate liaisons, and Behavioral Health Services staff.

## Scope:

- ✓ Create standardized communication to clients, family members, and community/system partners regarding the upcoming transformation to CORE.
- ✓ Create a standardized client-tracking tool for providers to ensure no one is lost in the transition, and to document client choice.
- ✓ Create organization warm hand off plans and contact list to ensure successful client discharges and transfers.

# Deliverables

- The following deliverables were created, finalized and approved by the CORE Transition Workgroup:
  - ✓ Current Consumer Letter Template
  - ✓ CORE Information Flyers
  - ✓ Community Collaboration List
  - ✓ CORE Standardized Client Transition Tracker Tool
  - ✓ Warm Hand-Off Plans and Contact lists

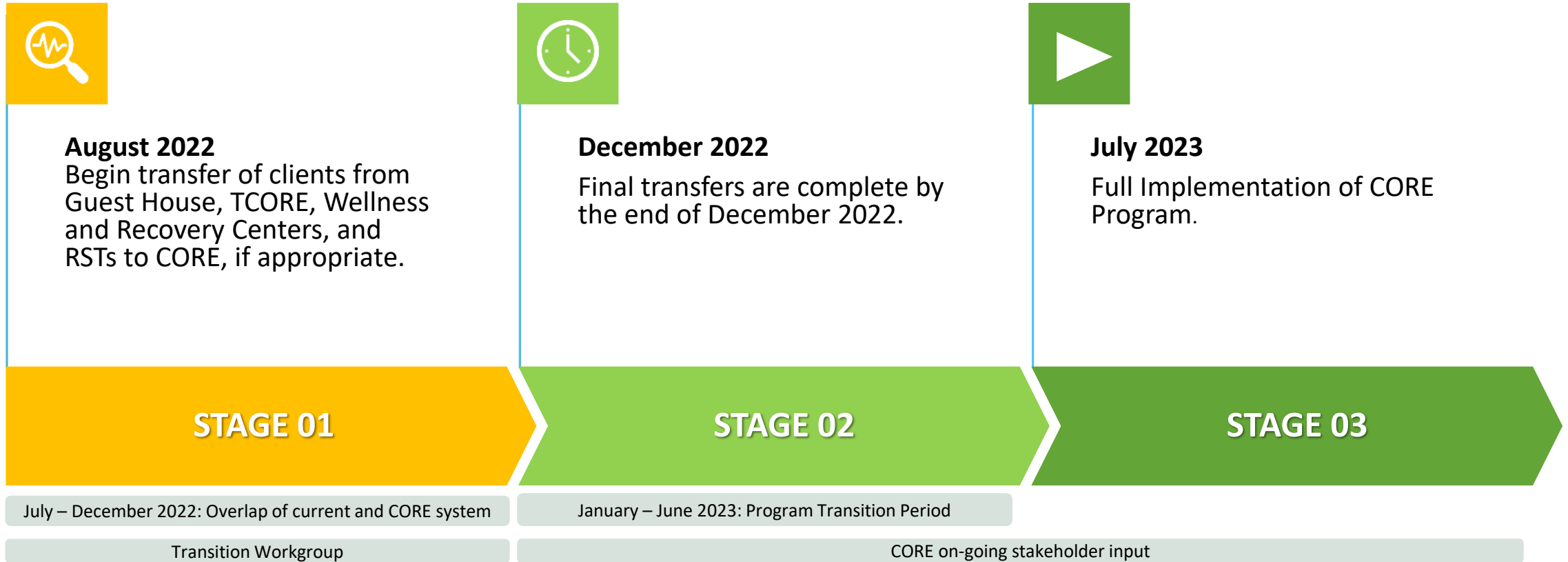
# CORE Transition Plan

Prior to Transfer, providers will:

- ✓ Ensure clients and if requested, family members, have an orientation on the new model. Providers will use the standardized letter template and CORE flyers as talking points.
- ✓ Ensure and document that clients are aware of changes that may affect them directly or indirectly. Providers may use the CORE Standardized Client Transition Tracker Tool to track these discussions and outcomes, such as request to transfer to specific CORE locations.
- ✓ Document the plan agreed upon by the client.
- ✓ Utilize the contact list to coordinate transition.
- ✓ Ensure warm hand-off plans are followed and clients are not discharged without a scheduled first appointment with the new provider.

# Transformation to CORE Timeline\*

\*subject to change



# Resources

- Adult Outpatient Services Transformation website:
  - <https://dhs.saccounty.gov/BHS/Pages/Adult-Outpatient-Services-Transformation.aspx>
- CIBHS Strengths Model
  - [Introduction to the Strengths Model](#)
  - [Strengths Model Case Management](#)
- Trauma Informed Care
  - [Key Ingredients for Trauma Informed Care](#)
- SAMHSA SOAR Initiative
  - [SSI/SSDI Outreach, Access, and Recovery \(SOAR\) Overview](#)
  - [Implementing State and Local SOAR Initiatives](#)
  - [SOAR Online Course Catalog](#)

# Questions?

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