Program Dates: January 1, 2019 – December 31, 2023
Budget: $5,253,376
Budget for Evaluation: $230,890 (4.4% of total)

1) Primary Problem

The County of San Diego has roughly 3.2 million residents making it the second most populous county in the state. It is estimated that, in any given year, approximately 5% of adults meet criteria for a mental illness, 7% of adults meet criteria for a substance use disorder and, conservatively, 7% of children and youth meet criteria for serious emotional disturbance and 3% youth meet criteria for substance use disorder (California Mental Health Prevalence Estimates, Hozler, 2010). These illnesses often disrupt an individual's ability to function at home, at school, and at work, in social relationships, and may impair their ability to succeed in our society. Psychiatric emergency services are a critical component of the array of services in place to support individuals with behavioral health issues and processes are in place to connect these individuals to outpatient programs post-discharge. In Fiscal Year 15/16, the San Diego County System of Care had over 10,000 individuals access psychiatric emergency services. Of these, roughly 12% did not receive follow-up mental health services post-discharge and, instead, returned to emergency psychiatric setting within 30 days post discharge. The County tracks client follow-up post emergency services by age and by which facility the client most recently accessed services, as recorded in Client Services After a Psychiatric Hospital Discharge (CO-20) report.

This Innovation project is aimed at increasing access and connection to follow up behavioral health services after a psychiatric emergency in which a client utilized a psychiatric hospital, emergency screening and/or crisis response services. The key component for this Innovation project is to reduce recidivism rates for clients utilizing emergency services when they encounter a subsequent psychiatric crisis. Current local data reveals that recidivism for hospitalization or crisis services most frequently occurs 3-14 days after client's discharge from hospital or crisis stabilization service (CO-20 report). Based on recidivism rates for these unconnected clients, there have been continued efforts to develop programs that serve as a therapeutic bridge and connect clients to outpatient treatment services. This Innovation project identifies Telemental Health as novel treatment modality for this acute population.

After conducting a review of literature, examining feedback from providers offering services to this population, and input through local community forums and from various stakeholders, specific barriers were identified in receiving follow-up services for unconnected clients. There was significant overlap in barrier reported from all parties and included (Burnett, L., Davis, E., Lynch, E. 2014, input from local providers/stakeholders):

a) The individual feeling overwhelmed about mental health obstacles.
b) Limited insight, stigmatization for seeking mental health treatment, apprehensions about the benefits of mental health services, lack of motivation, lack of transportation, and financial constraints.
c) Presence of a co-occurring disorder.
d) For those that depend on a caregiver, the caregiver's willingness to accept follow up services can be impacted by barriers mentioned above, as well as the stress of taking on another commitment.

The current treatment programs in the County of San Diego's System of Care (SOC) that assist and support acute clients with transitioning out of psychiatric hospitals and crisis settings provide services at the client's residence or at traditional outpatient clinic programs. All existing services rely on face-to-face contact with a provider. Crisis, Action & Connection (CAC) is a primary

provider for the Children's SOC when clients transition from a psychiatric hospital or the Emergency Screening Unit (ESU) and are not already connected to mental health services. CAC offers assessment, brief therapy and linkage to outpatient providers. Next Steps and Transition Team are the current providers for the Adult SOC when clients transition out of Emergency Psychiatric Unit (EPU), inpatient services at San Diego County Psychiatric Hospital (SDCPH), and other local psychiatric hospitals and also provide support and linkages to outpatient providers.

The goal of this Innovation project is to increase connections to follow-up outpatient treatment services by providing Telemental Health services to a population experiencing barriers with current modalities of behavioral health service provision, with an ultimate goal of decreasing recidivism of acute episode and working towards stabilization of mental health needs.

2) What Has Been Done Elsewhere To Address Your Primary Problem?

As described in Question 1, The County of San Diego has coordinated intensive, short term services to support both youth and adults transitioning out of psychiatric hospitals and other emergency settings. These programs have utilized a variety of strategies (informed by the literature and best practices) to connect clients including initiating services while the individual is still in the psychiatric emergency setting, providing service in the client's home, utilizing service providers with lived experience, etc. Despite these efforts, recidivism remains an identified challenge for our Systems of Care.

A review of literature was conducted to identify the efficacy of Telemental Health as an appropriate modality of service delivery. The review of literature supported the effectiveness of this service delivery and the most profound finding was that Telemental Health has been utilized in Europe as a general treatment modality for over a decade with great success (Richards D. 2015-Healthcare ITNews). Additional findings in the literature review concluded that Telemental Health is a viable form of treatment delivery for adults with a number of disorders, particularly those who may underutilize formal services or not follow up with referrals to appropriate agencies (Jones, A. et al.- Psychol Serv. 2014 Nov). Further findings revealed that Telemental Health is an effective (e.g., positive outcomes, parent and clinician satisfaction) treatment delivery modality for youth (Ellington & McGuinness, 2011; Myers, Valentine, & Melzer, 2008; Van Allen, Davis, & Lassen, 2011), specifically for those experiencing depression (Germain, Marchand, Bouchard, Guay, & Drouin, 2010). The ease of care that Telemental Health provides for patients living in rural and underserved Telemental Health-care services has been found to be an effective way to engage clients which ultimately may prevent the need to access psychiatric hospitalization (Lerman, A., Quashie, R.-Bloomberg BNA Health Law Reporter-June 2016). Additionally, the continued advances in technology has made Telemental Health an increasingly viable option for service and is presently supported by Medicaid/Medicare and a variety of private insurance agencies.

Recent research has concluded that the feasibility, acceptability, and sustainability of Telemental Health for children and adolescents have now been shown (Myers KM, Valentine JM, Melzer SM Psych. Serv. 2007) and it has been hypothesized that this approach may be better for some disorders, such as autism-spectrum patients, than in-person care (Morland LA, Greene CJ, Rosen C, Mauldin PD, Frueh BC Contemp Clin Trials, 2009). A qualitative study of young people's perspectives on receiving telepsychiatric services revealed that the sessions were helpful, they felt a sense of personal choice during the consultation, and they generally liked the technology (Myers KM, Palmer NB, Geyer JR Child Adol. Psych. Clin N Am., 2011). Child research in Telemental Health has established that cognitive behavioral interventions demonstrate noted improvement in terms of depression and subscales of the Child Behavioral Check list (Donald M. Hilty, MD, Daphne C. Ferrer, MD, Michelle Burke Parish, MA, Barb Johnston, MSN, Edward J. Callahan, PhD, and Peter M. Yellowlees, MD, Telemedicine Journal, 2013).

Early reports indicate that Telemedicine technology shows promise in reducing medical readmission rates for select groups of medically ill patients. Research has included review of telemedicine for post-acute myocardial infarction patients (Ben-Assa E., et al, Telemed J E Health, 2014 Sep), patients with heart failure (Lee, J et al; JBI Libr Syst Rev. 2010), spinal cord injury patients (Soopramanien, A et al; J Telemed Telecare, 2005; 11 Suppl). There is not a global consensus about the use of telemedicine to reduce readmission rates, but studies are ongoing.

While the literature supports the benefits that Telemental Health brings to the traditional outpatient service level of care, a comprehensive review of literature did not reveal any instances where Telemental Health has been studied for use with clients who are not connected to services post-discharge from psychiatric emergency settings. This represents a gap in Telemental Health service delivery data. This project would study the ability to increase access to services, reduce gaps in treatment, and to improve prognosis for a population that tends to have a high recidivism rate with psychiatric emergencies and hospital readmissions. This Innovation project hypothesizes that supporting clients through Telemental Health would provide linkage to follow -up behavioral health support in a less intrusive, less stigmatizing and less stressful manner to a subset of the population that has not been successfully engaged.

3) The Proposed Project

This Innovation project proposes that Telemental Health is a viable treatment modality that could provide successful outcomes with connecting clients to follow up mental health treatment after a psychiatric emergency service. The target population would be clients that are unconnected to behavioral health services and are currently being screened or hospitalized for a psychiatric emergency care.

The proposed modality of Telemental Health has evidence of being an effective means of interacting and connecting, especially with youth, due to their high levels of computer literacy. Interventions that have proven to be effective are derived from alternative delivery strategies such as internet based video or games (Christopher P. Siemer, BS, Joshua Fogel, Ph.D, and Benjamin W. Van Voorhees, MD, MPH, PMC 2012 Jan 1). An example of an effective internet based intervention is MoodGym (moodgym.anu.edu.au), which uses modules based on cognitive behavioral therapy (CBT) both to provide pertinent information and to directly address depressive symptoms in a youth population (Calear AL, Christensen H, Mackinnon A, Griffiths KM, O'Kearney R., Clin Psychol. 2009). 7 Cups is another example of a website providing "online emotional support service." There are many options for support: individual listeners (called 1-1 chats), group support chat rooms, individual therapy, forums, guided discussions and a feed feature. These web based interventions and services exemplify the various opportunities that are available when providing Telemental Health services. Technology and software allow for secure connections that ensure compliance with privacy standards and regulations.

The design of this innovation project would initiate services by screening clients in advance of discharge from designated inpatient and crisis stabilization units by an onsite case manager. The treatment team's recommendation for services upon discharge would be considered, as would be the appropriateness of Telemental Health (as opposed to existing treatment modalities) to meet these recommendations. Unconnected clients discharging from the hospital or crisis setting will continue to be offered services from current providers for transitional home based services and/or clinic based services with the additional option of Telemental Health services to ensure that there is follow-up and linkage to appropriate resources for continuity of care and lasting stability. The clients identified as being both reasonable candidates and amenable to Telemental Health will be provided necessary resources in order to access and participate in their follow-up sessions which when appropriate may be initiated while still in the

hospital or crisis service setting.

The identified clients will be educated and provided assistance with registration for Telemental Health services by the case manager while still in the psychiatric emergency setting. This would include completing consent forms for treatment, signing release of information documents, etc. Clients would be taught how to navigate the Telemental Health application by the case manager.

The case manager will help the client identify an appropriate device to utilize for service delivery. If client does not have access to an electronic device (i.e., computer or tablet) and necessary WiFi connection availability, technology will be provided to them. Clients will establish an agreed upon date and time for their follow-up session with the clinician. In some instances, the initial session may occur prior to their discharge from the facility.

Staffing will consist of 5 FTE Licensed or Licensed Eligible (minimum 1 bilingual) clinicians who will provide tele-therapy sessions and 3 FTE case managers who will conduct the initial screenings to determine the client's amenability and appropriateness for Telemental Health as well as offer on going collateral services and support. The clinicians and case managers will be trained on best practices, legal, HIPAA and ethics of Telemental Health to ensure competency with the modality (Higgins, R.-2016-Clinican Resources, Telehealth).

Projected target is linking 250 clients to Telemental Health services which includes screening, education on the device/application and therapeutic services through a clinician and any needed support through a case manager. It is estimated that 75 youth and 175 adults would be served annually.

4) Innovative Component

a) This Innovation project utilizes a known modality of Telemental Health in a new way that is focused on an identified subset of clients who experience psychiatric emergency relapses yet are not connected to traditional aftercare. The intent is to utilize Telemental Health to augment current behavioral health services in order to increase access and connection to follow up behavioral health treatment in a modality that meets the client's needs. This approach is hypothesized to achieve continuity of care for a population with high rates of recidivism in utilizing emergency crisis services.
b) Literature reviews reveal that Telemental Health is a current modality utilized worldwide, however, no current information is available about existing programs with the specificity of offering Telemental Health services to clients discharging from emergency psychiatric settings in order to increase access to follow up mental health treatment across various psychiatric needs. There are early studies investigating the use of Telemedicine to reduce readmission rates for groups of medically ill patients, but studies to date do not examine the use of Telemental Health to reduce readmission for psychiatric hospitalization/crisis services.
c) The use of Telemental Health is supported as a promising approach and solution to overcoming barriers that prevent clients from accessing behavioral health services upon discharge from a crisis service.

5) Learning Goals / Project Aims

a) To learn if Telemental Health will lead to increased engagement in outpatient behavioral health services for clients who access emergency services yet are not connected to outpatient care and are therefore at risk for a secondary emergency service.
b) To learn if Telemental Health decreases the utilization of the of crisis/hospital services within 30 days post-discharge.
c) To determine how Telemental Health meets specific needs or diminishes barriers to treatment for clients.
d) To determine which subpopulations (based upon age, gender, racial/ethnic, linguistic, diagnosis or cultural determinants) respond best to technology driven services.

6) Evaluation or Learning Plan

a) Youth and adults who are unconnected to services and receive care in a psychiatric hospital or crisis stabilization setting will be the target participants.

b) Data collection will include:

- Number of individuals screened for appropriateness of Telemental Health services and the number of individuals referred for the service
- Diagnosis, gender, ethnicity, and age of those utilizing Telemental Health services
- Recidivism rates for clients utilizing Telemental Health services (within 30 days post discharge of initial crisis service)
- Number of clients, and length of time, clients are assisted by the Telemental Health program

c) Data collection will be tasked to the program.

d) Data collected from the Telemental Health program will be compared to data from existing reports detailing outcomes for unconnected clients receiving psychiatric emergency services.

e) Existing data reports pertaining to this population and related outcomes will continue to be collected and reviewed.

f) The contract shall be monitored and evaluated in the following ways:

- Quarterly Status Reports by program.
- Data elements that will be tracked and monitored by the program.
- Independent evaluator will complete annual reports and final evaluation of effectiveness of the intervention.

7) Contracting

a) All contracts are handled through San Diego County's Department of Purchasing and Contracting (DPC), which processes more than $1 billion in public purchases and contracts each year. The County posts its requirements for goods and services on BuyNet, an online public system. Procurements will normally be posted on BuyNet under formal Request for Bid (RFB) or Request for Proposal (RFP) solicitations. The department's aim is sound procurement processes to acquire the highest quality goods and services at the best price.

b) Quality and regulatory compliance elements are included in each contract, specific to the funding source and purpose of the service. Proposals are selected in part on the basis of the offeror's plan to achieve best possible quality and compliance with all relevant regulations. A Contract Officer's Representative (COR) with Behavioral Health Services assumes responsibility for ongoing monitoring of the contract for compliance and outcomes, working with the DPC. Monitoring includes regular site visits, review of documentation, and oversight of applicable laws and regulations.

c) A percent of project funds is set aside for an evaluation contract with a qualified research organization.

d) Contractors will have a dedicated COR or Program Monitor from Behavioral Health Services who will develop a contract monitoring plan containing activities that will be conducted over each year on their Statement of Work (SOW).

e) There will be a minimum of four monitoring activities per contract year, including a minimum of one site visit, with subsequent visits, as needed, if identified problems/issues have not been resolved.

f) Monthly COR meetings and site visit activities include but are not limited to deliverables review, technical assistance and consultation, review of fiscal and claim documentation and annual inventory update, emergency planning documentation, corrective action plans, discussion of strengths and weaknesses of contractor's deliverable outcomes.

g) Regular review of SOW contract deliverables to determine contractor's performance in meeting contract objectives, review contractor exclusion/department/Medi-Cal Sanctions lists employee review process as well as a minimum of two in-depth invoice reviews.

8) Certifications

a) Board of Supervisors (BOS) authorization dated 4/25/2017.

b) Certification from the Behavioral Health Director will be included.

9) Community Program Planning

a) Twelve community forums were conducted county-wide to get community input and feedback regarding the Innovative project.

b) The Older Adult, Adult and Children, Family and Youth Councils were also solicited for input regarding the community's need.

c) After ideas for the Innovation Project was solidified, community members also participated in "conversation cafes" to discuss the proposed project and given opportunity to provide feedback on components needed.

10) Primary Purpose

Increase access to mental health services.

11) MHSA Innovative Project Category

Adapting an existing mental health practice for a new setting, population or community.

12) Population

a) Program aims to screen unconnected clients prior to discharge from psychiatric emergency settings. Based on the current need, the projected number of clients served annually will be 250 clients.

b) The population served will be youth (up to age 17 years old) and adults/older adults (18-60+ years old) who recently experienced a psychiatric emergency. The program is inclusive of any gender identity, race, ethnicity, sexual orientation or language.

c) Client in the subset mentioned above discharging from a crisis setting (San Diego County Psychiatric Hospital, Child and Adolescent Psychiatric Hospital, Crisis Stabilization Unit) that is not currently connected with a provider in the SOC will be eligible for this service.

13) MHSA General Standards

This project is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320.

Community Collaboration: The concept for this work plan was developed based on local stakeholder process for input on system needs over multiple years.

Cultural Competence: As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services to improve outcomes.

Client/Family Driven Mental Health System: This program includes the ongoing involvement of clients and family members in roles such as, but not limited to, implementation, evaluation, and future dissemination. Ultimately, the program strives to create healthier families in our community.

Wellness, Recovery and Resilience Focus: This program increases resilience and promotes discovery and wellness for parents with serious mental illness by increasing access to services. The goal is to strengthen the overall family to allow for a more stable and resilient family system with strength to sustain wellness.

Integrated Service Experience: This program encourages access to a full range of services provided by community resources, multiple agencies, programs and funding sources for family members.

14) Continuity of Care for Individuals with Serious Mental Illness

The program's target population will be individuals with serious mental illness (adults) and serious emotional disturbance (youth). Existing efforts to link unconnected clients to services post-discharge will continue when this project ends, and if the innovative component proves successful, efforts will be made to leverage alternative funding streams to provide continued service via the Telemental Health modality.

15) INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement.

a) The concept for this work plan was developed based on local stakeholder process for input on system needs. There was overwhelming feedback that Telemental Health service provision be easily accessible, particularly in rural areas. Telemental Health was identified as a viable option to support clients who have difficulty physically accessing services. The community forum participants also proposed partnership between Telemental Health and on-site support resulting in the incorporating of case managers.

b) As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to increase sensitivity to the barriers that these clients face with accessing follow-up mental health services to reduce recidivism. The barriers take into consideration cultural factors such as beliefs that create stigma regarding receiving behavioral health services, lack of resources for low socio-economic status client and unique impediments for clients with serious mental health needs.

16) Deciding Whether and How to Continue the Project Without INN Funds

Existing efforts to support unconnected clients receiving psychiatric emergency services will continue, however the outcome data from the innovation project will inform decisions regarding continued provision of Telemental Health service modality for this subpopulation.

17) Communication and Dissemination Plan

a) Information regarding the program, including outcomes, will be shared with stakeholders via the Behavioral Health Advisory Board, Children's System of Care Council, Adult System of Care Council, Behavioral Health Program Manager's meetings and presentations to various to partners/stakeholders (For example, CWS and Hospital Association).

b) The Children, Youth, and Family System of Care Council (CYF SOC Council) meets monthly and has an annual retreat to help set the Council's annual agenda for the year. The Council is made up of 24 voting members from a wide variety of constituencies including Public Government (Child Welfare, Public Health, Probation, Juvenile Court, Health and Human Services Administration, and the First 5 Commission), Education (Regular education representative for the 42 school districts in our county, Special Education, the School Boards, and the Special Education Local Planning Agencies), Private Sector (the Regional Center, Alcohol and Drug Contractors Association, Mental Health Contractors Association, San Diego Association of Local Governments, Fee for Service Provider Network, Managed Care Health Plans, and the local Academy of Pediatrics), as well as the Family and Youth Sector (Family and Youth Liaison, Caregiver of child/youth served by the system, and two youth served by the public Behavioral Health system). There are an equal number of attendees at the meeting who ask questions, give input, and follow the decision making of the Council. These stakeholders receive monthly updates and proposals to our MHSA plan and consider what is relevant and needed in the community. The INN-19 Telemental Health Clinic concept has been discussed in the past, but this year the CYF SOC Council picked it as a project that should receive high priority for inclusion in the MHSA Innovation efforts. This

proposal was specifically discussed by this group multiple times and a special MHSA subcommittee in February of 2017 and the groups decided to go forward with its recommendation unanimously.

18) Timeline

a) Total timeframe (duration) of the INN Project: 5 Years

b) Expected start date and end date: January 1, 2019 to June 30, 2023

19) INN Project Budget and Source of Expenditures

Cycle 4 INN - 19 Telemental Health

Innovative Project Budget by FISCAL YEAR (FY)

Budget	FY 18/19 (1/2 year)	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
Salaries & Benefits	$ 447,460	$ 894,920	$ 894,920	$ 894,920	$ 894,920	$ -	$ 4,027,140
Operating Cost	$ 107,177	$ 82,270	$ 82,270	$ 82,270	$ 82,270	$ -	$ 436,257
Indirect Cost	$ 67,848	$ 122,810	$ 122,810	$ 122,810	$ 122,810	$ -	$ 559,089
Annual Program Budget	$ 622,485	$ 1,100,000	$ 1,100,000	$ 1,100,000	$1,100,000	$ -	$ 5,022,486
Annual Evaluation Cost	**$ 23,089**	**$ 46,178**	**$ 46,178**	**$ 46,178**	**$ 46,178**	**$ 23,089**	**$ 230,890**
Total Project Budget	**$ 645,574**	**$ 1,146,178**	**$1,146,178**	**$1,146,178**	**$1,146,178**	**$ 23,089**	**$ 5,253,376**
Total Project Cost: $ 5,253,376						**Project Duration: 5 Years**	
S&B Rate to Annual Budget	72%	81%	81%	81%	81%	0%	80%
Operating Cost Rate to Annual Budget	17%	7%	7%	7%	7%	0%	9%
Indirect Rate based on Annual Budget	11%	11%	11%	11%	11%	0%	11%

County of San Diego — Telemental Health (INN 19)

PROJECTED SALARIES AND BENEFITS						
Position	FTE	Hourly Rate	Annual Salary	Benefits (25% of Salary)	Benefits (25% of Salary)	Total
Program Manager	1	$ 40.00	$ 83,200	$ 10.00	$ 20,800.00	$ 104,000
Office Assistant	1	$ 15.00	$ 31,200	$ 4	$ 7,800	$ 39,000
Licensed MH Clinician	5	$ 32.00	$ 332,800	$ 16.00	$ 166,400.00	$ 499,200
Case Manager	3	$ 27.00	$ 168,480	$ 13.50	$ 84,240.00	$ 252,720
Projected Total Salaries & Benefits						$ 894,920

PROJECTED OPERATING COST						
Operating Cost	FY 18/19 (Half Year)	FY 19/20 (Full Year)	FY 20/21 (Full Year)	FY 21/22 (Full Year)	FY 22/23 (Full Year)	Total
Building Rent and Leases	$ 12,500	$ 24,000	$ 24,000	$ 24,000	$ 24,000	$ 108,500
Furniture & Equipment	$ 5,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 45,000
Equipment Rent and Leases	$ 600	$ 1,200	$ 1,200	$ 1,200	$ 1,200	$ 5,400
Utilities	$ 3,000	$ 6,000	$ 6,000	$ 6,000	$ 6,000	$ 27,000
Telecommunication	$ 26,000	$ 26,000	$ 26,000	$ 26,000	$ 26,000	$ 130,000
Office Supplies	$ 900	$ 1,800	$ 1,800	$ 1,800	$ 1,800	$ 8,100
Travel	$ 1,500	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 13,500
Insurance	$ 1,200	$ 2,400	$ 2,400	$ 2,400	$ 2,400	$ 10,800
Interpreters	$ 1,500	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 13,500
Printing	$ 650	$ 1,200	$ 1,200	$ 1,200	$ 1,200	$ 5,450
Accounting/Audit/Legal Fees	$ 1,200	$ 2,400	$ 2,400	$ 2,400	$ 2,400	$ 10,800
Other Business Expense	$ 1,127	$ 1,270	$ 1,270	$ 1,270	$ 1,270	$ 6,207
Others: Start up	$ 52,000	$ -	$ -	$ -	$ -	$ 52,000
Projected Total Operating Cost	$ 107,177	$ 82,270	$ 82,270	$ 82,270	$ 82,270	$ 436,257

County: San Diego County **Total Funding Request**: $6,155,624

Project Name: ReST Recuperative Services Treatment **Duration:** Jan 1, 2018 – June 30, 2022

Project Overview

1. Primary Problem

In San Diego County, there are a subset of individuals who have severe mental illness (SMI), are homeless, and who utilize acute/emergency settings (emergency departments (ED), Short Term Acute Residential Treatment (START), Psychiatric Emergency Response Team (PERT), emergency psychiatric unit (EPU), and jail mental health services), but are not otherwise connected to outpatient mental health services – these individuals are considered "unconnected." Transitional Age Youth (TAY; 18-25 y/o) with SMI are particularly more vulnerable to homelessness and incarceration than their non-SMI counterparts. Multiple factors including inability to complete high school, lack of employment and individual living skills are compounded by the TAY's mental health symptoms.

San Diego County proposes to decrease the number of homeless and unconnected TAY to prevent these individuals from inappropriately returning to acute/emergency mental health services (ED, START, PERT, EPU and jail mental health services) by providing them with recuperative and habilitative mental health care. Individuals enrolled in ReST will be engaged in habilitation services and be connected to appropriate levels of care and housing to support ongoing recovery and wellness.

Background. According to the Office of National Drug Control Policy, approximately 30 percent of the chronically homeless population has a serious mental illness (SMI) that creates barriers to accessing and maintaining stable housing. These barriers could include the inability to participate in essential activities such as self-care, completing education, maintaining employment and household management (National Coalition for the Homeless, 2009). Individuals with SMI may also have difficulty maintaining social relationships which leads to social isolation, often times due to active symptoms and stigma of having a mental illness (Linz & Strum, 2013). Conversely, lack of housing options (short-term, bridge housing and permanent supportive housing) exacerbates mental health conditions and inhibits recovery and wellness. Additionally, the homeless in general, and the homeless with SMI, in particular, are more at risk for substance usage. These individuals may turn to substance usage as a way to cope with their circumstance of being homeless (National Coalition for the Homeless, 2009) and individuals with SMI may use substances to self-medicate their symptoms (Dualdiagnosis.org). Homelessness also affects incarceration rates. A national survey study found that 15% of inmates were homeless prior to incarceration, a rate that is 7.3 to 11.5 times the standardized estimate of 1.36% to 2.03% in the U.S. adult general population (Greenberg & Rosenheck, 2008). Furthermore, subgroups within the homeless population including individuals with SMI, veterans, and youth are particularly vulnerable to incarceration (National Health Care for the Homeless Council, 2013).

The Bazelon Center for Mental Health Law indicated that TAY with SMI are three times more likely to be involved in criminal activity than TAY without mental illness and have higher rates of substance abuse

than any other age groups with mental illness. In 2016, San Diego's Point In Time count indicated there were a total of 685 TAY who were homeless, with 459 TAY indicating that they were unsheltered. Additionally, the count indicated that 22.8% of homeless youth had mental health issues and 14.6% had substance abuse (2016 WeALLCount). In fiscal year 15/16, there were 196 unconnected TAY who self-identified as homeless that accessed acute/emergency mental health services. Among these individuals, there has been repeated inappropriate utilization of these acute/emergency mental health services due to the fact that they are unconnected to outpatient mental health services.

2. What Has Been Done Elsewhere To Address Your Primary Problem?

Recuperative Services. Traditionally in the medical field, recuperative care centers exist to assist clients discharged from an acute hospital who are homeless to continue their recovery. There are a large number of recuperative care centers around the U.S. that treat primarily physical health needs after an acute stay at a hospital. Recuperative care centers in the medical field have been proven effective in decreasing the number of hospital readmissions. In an observational study of Boston's Respite Care, Kertesz et al. (2009) analyzed three years' worth of administrative data and found that respite care significantly reduced the likelihood of a homeless patient being readmitted to a hospital within 90 days of discharge compared to those who were discharged to their own care or other planned care. While existing recuperative care centers will provide holistic care and may address issues of mental health and substance usage, in order to access these recuperative care centers, clients must have a primary medical issue. There appears to be a lack of recuperative centers specifically for individuals with SMI.

Arizona's Restart program appears to be the only program in the United States that provides short-term housing to individuals with SMI transitioning from hospitals and jails back to the community. The program's goal is "finding longer term housing, either through reconnection with family, Supportive Community Housing, or preparation for a treatment-oriented housing setting. Our teams also help members maintain their wellness through group interactions and 1:1 support with living skills, transportation, personal care support, and medication reminders." However, Arizona's Restart program is not focused on services or habilitation, but rather on housing.

Finding. The majority of recuperative services target clients with primary medical and physical health needs. These recuperative care centers have been effective in preventing hospital readmissions. There does not appear to be any programs that provide recuperative and habilitative services to clients with primary mental health needs. One program, the Arizona's Restart program, provides short term housing services (30-days) to persons with SMI who have transitioned from the hospital or jail setting; however, intensive recuperative and habilitative services are not provided akin to those in the medical recuperative care centers. Services provided at Arizona's Restart program appear to be a bridge to housing with supports and are focused on locating housing for its clients.

3. The Proposed Project

The proposed Recuperative Services Treatment (ReST) project is envisioned and designed to provide recuperative and habilitative mental health care services and housing support in an open housing development or residential site similar to Board and Care buildings for TAY clients. The target

population are TAY clients with SMI who 1) require habilitative services (e.g. managing symptoms, learning activities of daily living) post-discharge from acute care settings, 2) are homeless or at-risk of homelessness, 3) are unconnected to mental health treatment, and 4) have repeated utilization of inappropriate levels of care (e.g. acute/emergency care settings).

ReST will be an Enhanced Strength Based Case Management program with mental health services co-located at the housing site. Clients will be referred through acute/emergency settings (e.g. ED, START, PERT, EPU, jail mental health settings) and meet the criteria listed above.

The recuperative-care site will be a "home-like" environment in design and have a live-in resident manager as well as office space for staff, such as a Program Manager, Housing Specialist, Licensed Mental Health Clinician, Case Manager with AOD certification, Peer Support Specialists, and part time psychiatric consult and nurse practitioner, live-in housing manager, and cook. The program will provide screening, behavioral health assessment, individual and group counseling, medication management, case management, care coordination, peer and family support services, linkages to permanent housing and other needed resources. Medication Assisted Treatment (MAT) services will be available for individuals with a co-occurring substance usage disorder.

Although mental health services will be offered on-site, this program design is not that of a residential treatment facility. Clients will not "complete" treatment and will not graduate to a "step down" program. Instead, the services provided through ReST will be geared towards providing a different experience with mental health providers and to teach habilitative skills to engage and connect the TAY clients to ongoing appropriate levels of care, link them to housing, and provide them with enough skills (e.g. managing symptoms, activities of daily living, educational or employment skills) so that they will no longer inappropriately utilize acute/emergency care settings. Additionally, there will also be a "mentorship" component in which Peer Support Specialists will continue to work with clients after they have left ReST to ensure continuity and provide support 30-60 days post-completion of ReST.

4. Innovative Components

ReST is an adaptation from both the medical field's recuperative care centers that have been shown to reduce readmission to acute care settings and adds the following innovative approaches:

- The main innovation component of ReST is providing habilitative mental health services. Habilitation is defined as "the process of supplying a person with the means to develop maximum independence in activities of daily living (ADL) through education and/or treatment" (Mosby's Medical Dictionary, 2009). This habilitative component is adapted from the medical field's recuperative services. Clients will have time to stabilize, learn how to cope with their symptoms, learn ADL skills, and learn ways to access services appropriately.
- While ReST is not a residential treatment facility, it will have mental health services co-located onsite. The co-location of services is geared at providing clients with a different experience of mental health providers with the goal of successfully linking the clients to ongoing treatment, housing and preventing future, and inappropriate use of acute/emergency care settings.
- San Diego's proposed ReST project differs from the Arizona's Restart program by targeting a

specific age group (18-25 y/o) with the addition of co-location of recuperative and habilitative mental health services and MAT services which will also be provided to clients with co-occurring disorders.

- Using MAT to assist and support sobriety and recovery for individuals with co-occurring disorders. Untreated mental health conditions are often masked by the use of alcohol or other drugs in the form of self-medication in which clients medicate mental health symptoms by using alcohol and drugs (Foundations Recovery Network).
- Clients will have the opportunity for ongoing mentorship with ReST Peer Support Specialists for up to 60 days after leaving ReST to provide any support while client transitions to more permanent outpatient treatment.

5. Learning Goals / Project Aims

1) Decrease TAY's inappropriate utilization of acute care services and/or returning to jail, 2) Increase TAY's ability to manage their symptoms and improve their level of functioning and ability to live independently, and 3) Increase connection with an ongoing outpatient mental health program.

a) Does the use of a habilitation model demonstrate success in penetration and retention of TAY who are unconnected to treatment and have repeatedly utilize acute care, STARTs, EDs, PERT, EPU and jail mental health services?
b) Do TAY enrolled in ReST demonstrate an increase in engagement with treatment due to the co-location of mental health and support services?
c) Does ReST impact acute/emergency care (START, ED, PERT, EPU, and jail mental health services) recidivism?
d) Do TAY enrolled in ReST demonstrate an improvement of their symptoms or mental health condition?
e) Do TAY enrolled in ReST demonstrate an ability to stay connected to treatment during and post discharge?
f) Do TAY enrolled in ReST demonstrate a reduction of stigma associated with their symptoms or mental health condition?
g) Do TAY enrolled in ReST demonstrate an increase in knowledge of how to access behavioral health services and housing supports?

6. Evaluation of Learning Plan

To determine whether the learning goals listed above are met, the following approaches will be utilized. Some approaches will be universal to all of the learning goals, while others will be specific to particular learning goals.

Target participants are TAY with inappropriate and high utilization of acute care services. Behavioral Health Services Data from FY 15/16 (C0-19 Report) for unconnected clients will be analyzed to determine the TAY population that will be the focus of attention for the ReST program.

<u>Data to be Collected</u>

a) Demographic data, including but not limited to age, race, ethnicity, gender, sexuality, disability, veteran status, diagnosis, and primary language will be collected.
b) Client outcomes such as engagement in treatment, increased understanding of mental health, attaining educational and employment goals, increase in socialization, decrease in symptoms and negative behaviors, decrease in homelessness, and decrease in inappropriate and frequent utilization of acute/emergency care services.
c) The number of TAY returned to acute care hospitals, START, EPU, PERT and/or jail setting while enrolled in program will be tracked as well as information regarding number of clients returning to acute care hospitals, START, EPU, PERT and/or jail setting within 90 days, at 6 months and 12 months post-discharge from program.

Methods

a) One major tracking mechanism includes the usage of Cerner Community Behavioral Health (CCBH), an electronic health record system, which tracks demographics, diagnosis, and episodes in different levels of care including acute care hospitalization, START, EPU, PERT and jail mental health services. Baseline data will be collected for the previous 12-month and 24 month data from C0-19 report.
b) Current collaboration with the Sheriff and Probation will facilitate access to arrest data.
c) Focus groups, interviews and surveys will be administered to TAY clients Pre and Post discharge from the program. TAY clients will be administered the Milestones of Recovery Scale (MORS) or other TAY specific scales to determine level of care needed at intake, 30 days, 60 days and upon discharge.
d) Data will be analyzed and reported by the University of California, San Diego (UCSD). Other data collection methods will be used to determine engagement in treatment, reduction of stigma, and client satisfaction will be obtained via interviews and/or surveys that will be developed and analyzed by the UCSD research team.

7. Contracting

All contracts are handled through San Diego County's Department of Purchasing and Contracting (DPC), which processes more than $1 billion in public purchases and contracts each year. The County posts its requirements for goods and services on BuyNet, an online public bidding system. Procurements will normally be posted on BuyNet under formal Request for Proposal (RFP) solicitations. The department's aim is sound procurement processes to acquire the highest quality goods and services at the best price.

Quality and regulatory compliance elements are included in each contract, specific to the funding source and purpose of the service. Proposals are selected in part on the basis of the offeror's plan to achieve best possible quality and compliance with all relevant regulations. A Contract Officer's Representative (COR) with Behavioral Health Services assumes responsibility for ongoing monitoring of the contract for compliance and outcomes, working with the DPC. Monitoring includes regular site visits, review of documentation, and oversight of applicable laws and regulations.

Contractors will have a dedicated Program Monitor from Behavioral Health Services who will develop a

contract monitoring plan containing activities that will be conducted each year on their Statement of Work (SOW). Monthly Program Monitor meetings are routine.

There will be a minimum of four (4) monitoring activities per contract year, including a minimum of one (1) site visit, with subsequent visits, as needed, if identified issues have not been resolved.

Monthly COR meetings and site visit activities include but are not limited to deliverables review, technical assistance and consultation, review of fiscal and claim documentation and annual inventory update, emergency planning documentation, corrective action plans, discussion of strengths and weaknesses of contractor's deliverable outcomes.

There will be monthly review of SOW contract deliverables to determine contractor's performance in meeting contract objectives, review contractor exclusion/debarment/Medi-Cal Sanctions lists employee review process as well as a minimum of one (1) in depth invoice reviews annually.

Additional Information for Regulatory Requirements

1. **Certifications**

Board of Supervisors (BOS) authorization will be requested by 3/21/2017. Certification from the Behavioral Health Director will be included, Behavioral Health Services will provide Annual Revenue and Expenditure Reports as requested, and documentation will be provided by the County's PEI and CSS allocation.

2. **Community Program Planning**

Twelve (12) community forums were conducted county-wide to get community input and feedback regarding the Innovative project. The Older Adult, Adult and Children, Family and Youth Councils were also solicited for input regarding the community's need. Using the input from stakeholders, Behavioral Health Services (BHS) proposed preliminary ideas for the Innovation Project in "conversation cafes" in which community members participated in discussions around the proposed project and given the opportunity to provide feedback on components needed.

3. **Primary Purpose**

    a) Increased access to mental health services to underserved groups

4. **MHSA Innovative Project Category**

    a) Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

5. **Population**

The ReST Program intends to serve 15-17 individuals at any given time with each individual residing in the program for up to 90 days. Once clients have completed the program, they will continue to be supported through a mentorship program to ensure connection and sustained participation with

ongoing outpatient services. Based on the capacity of the program, the projected number of clients served annually will be between 48-60 individuals.

The target population are TAY clients with SMI who 1) require habilitative services (e.g. managing symptoms, learning activities of daily living) post-discharge from acute care settings, 2) are homeless or at-risk of homelessness, 3) are unconnected to mental health treatment, and 4) have repeated utilization of inappropriate levels of care (e.g. acute/emergency care settings). The ReST program is inclusive of any gender identity, race, ethnicity, sexual orientation or language.

6. MHSA General Standards

a) Community Collaboration

For community collaboration, local LPS hospitals, STARTs, jail mental health services, EDs, EPU, PERT, Sheriff and Probation Departments will be consulted and partnered with to ensure the most appropriate TAY individuals are referred and linked to the program.

b) Cultural Competency

As defined in the CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services to improve outcomes. To achieve this, service providers will be required to 1) participate in trauma informed care, 2) have working knowledge of TAY population and developmental needs, 3) have knowledge about the culture of homelessness, and 4) how to access an array of appropriate housing options for TAY.

c) Client-Driven

To ensure that services are client driven, the program will focus on the clients' goals and treatment planning will be a collaborative process between the clients and service providers. Clients' feedback and participation will be utilized to evaluate the program's outcomes and implement new policies, procedures and services, if needed.

d) Family-Driven

The program will also include clients' families (or other support network) with client consent to assist in the treatment planning, engagement of client and post-discharge connectedness to outpatient treatment so that services. Program can also assist clients in re-engaging with their families of origin if this is desired by the client.

e) Wellness, Recovery, and Resilience-Focused

This program strives to increase clients' ability to manage their symptoms and level of functioning through habilitative and recuperative mental health services to facilitate recovery and wellness post discharge from an acute setting. An Enhanced Strength Based Model of service will be the cornerstone of services to increase resiliency and recovery; thus decreasing episodes of in acute care settings or jail post discharge from the program.

f) Integrated Service Experience for Clients and Families

Program will provide care coordination with other specialties (physical health, substance use programs) to provide a full range of services/resources to increase the clients' ability to move forward towards their goals of wellness and recovery.

7. Continuity of Care for Individuals with Serious Mental Illness

The program by design is a short term, up to 90 day program aimed at providing recuperative and habilitative mental health services with co-location of service providers. TAY will be linked to appropriate levels of care (family health centers, outpatient mental health services, alcohol and drug services, Full Service Partnerships) for mental health services while the client is at ReST. Clients will also be linked to an array of housing services to ensure continuity of care once client is discharge from the program. The goal of ReST is to provide clients with a different experience with the mental health system to increase their connection to ongoing care. The intent is to continue the program pending successful outcomes and availability of funds. If the County is not able to continue with the program, clients will be referred to appropriate levels of care services directly from the acute care setting.

8. INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement.

a) Cultural Competence

Focus groups with the TAY population will be conducted. TAY Council and current TAY treatment providers will be also be consulted to address issues that are unique to the TAY population (e.g. stage of development, experience of first psychotic break).

b) Stakeholder participation

The TAY Council is a key stakeholder for this project. Through the TAY Council, a steering committee will be created to guide the program and development of its evaluation.

9. Deciding Whether and How to Continue the Project Without INN Funds

Part of the continual monitoring and evaluation of program's outcomes and achievements through the monitoring plan and based on lessons learned, the County will decide if the program will convert into another funding source. If the County is not able to continue with the program, clients enrolled in the program will be linked to other outpatient mental health services or to mental health services in primary care settings for continuation of services.

10. Communication and Dissemination Plan

To disseminate information to stakeholders, information regarding the program, including outcomes, will be shared via the Behavioral Health Advisory Board, Adult Council, Children's Council, TAY Council, Housing Council, the Cultural Competent Resource Team, Probation AB109 bi-monthly meetings and other pertinent community meetings, presentations to various programs/service providers and conferences. Program participants will also be given the opportunity to participate and share their experiences at stakeholder meetings, community forums and presentations to other services providers and/or conferences.

The following are keywords or phrases for this project: Mental Health Recuperative Care, Mental Health Habilitative Care, Mental Health Aftercare, Recuperative Bridge Housing, and Behavioral Health Recuperative Care

11. Timeline

a) Timeframe (duration) of the INN Project: 4 Years, 6 Months

b) Expected start date and end date: January 2018 Start Date; June 2022 End Date

Timeline that specifies key activities and milestones

I. January 1, 2018 – June 30, 2018: Start-up period to include identifying appropriate housing or residential site. Identify and meet with TAY Steering Committee to determine evaluation approach.
II. July 1, 2018 – December 31, 2018: Begin habilitative treatment services, begin evaluation design and development. Monthly TAY Steering Committee meetings begin with participation of BHS program monitor and UCSD research evaluators. Monthly meetings to be held to include Program Monitor, evaluation provided thereafter.
III. Monthly reports submitted and first annual report will be provided Fall 2019.

12) INN Project Budget and Source of Expenditures

The ReST team will consist of 1 FTE Program Manager, 1 FTE Licensed MH clinician, 1 FTE Case Manager with AOD certification, 1 FTE Housing Specialist, 2 FTE Peer Support Specialists, 1 FTE admin support/medical records, 1 FTE housing manager, 1 FTE cook, 0.5 FTE nurse practitioner, and 0.1 FTE psychiatric consult. See below for estimated personnel, operating and indirect costs.

* Operating costs include flex funds, maintenance, utilities, supplies, transportation, master-lease etc.

Position	Hourly Rate	Annual Salary (S)	Benefits (25% of S)	Operating (30% of S+B)	Indirect (15% of S+B+O)	**Fully Loaded**
Program Manager	$33.00	$68,640.00	$17,160.00	$25,740.00	$16,731.00	$128,271.00
Housing Specialist	$22.00	$45,760.00	$11,440.00	$17,160.00	$2,574.00	$76,934.00
FTE NP	$59.00	$61,360.00	$15,340.00	$23,010.00	$3,451.50	$103,161.50
FTE LMHC	$27.00	$56,160.00	$14,040.00	$21,060.00	$3,159.00	$94,419.00
FTE CM with AOD cert	$24.00	$49,920.00	$12,480.00	$18,720.00	$2,808.00	$83,928.00
FTE PSS	$18.00	$37,440.00	$9,360.00	$14,040.00	$2,106.00	$62,946.00
FTC PSS	$18.00	$37,440.00	$9,360.00	$14,040.00	$2,106.00	$62,946.00
Admin/medical records	$20.00	$41,600.00	$10,400.00	$15,600.00	$2,340.00	$69,940.00
Cook	$15.00	$31,200.00	$7,800.00	$11,700.00	$1,755.00	$52,455.00
Live-in Housing Manager	$24.50	$50,960.00	$12,740.00	$19,110.00	$2,866.50	$85,676.50
Psychiatric Consult	$200.00	$41,600.00				$41,600.00
Half Year:		$321,100.00		$90,090.00	$19,948.50	**$431,138.50**
Full Year:		$642,200.00		$180,180.00	$39,897.00	**$862,277.00**

Additional Costs:

Non Recurring Costs:	$26,000.00
Annual master lease for 20 units:	$360,000.00
Annual food budget at $15.8/day/client:	$75,000.00
Half Year Evaluation (5%):	$32,431.93
Full Year Evaluation (5%):	$64,863.85
Half Year Total:	**$707,070.43**
Full Year Total:	**$1,362,140.85**

Cycle 4 INN 21 ReST						
Innovative Project Budget by FISCAL YEAR (FY)						
BUDGET TOTALS	**FY 17/18 (Half)**	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**TOTAL**
Personnel	321,100.00	642,200.00	642,200.00	642,200.00	642,200.00	2,889,900.00
Direct Costs						
Indirect Costs	19,948.50	39,897.00	39,897.00	39,897.00	39,897.00	179,536.50
Operating Costs	307,590.00	615,180.00	615,180.00	615,180.00	615,180.00	2,768,310.00
Non Recurring Costs	26,000.00					26,000.00
Other Expenditures						
INNOVATION BUDGET						
Evaluation 5%	32,431.93	64,863.85	64,863.85	64,853.85	64,863.85	291,877.33
TOTAL	**707,070.43**	**1,362,140.85**	**1,362,140.85**	**1,362,130.85**	**1,362,140.85**	**6,155,623.83**

Innovative Project Plan Description

County: San Diego County **Total Funding Request**: $8,788,837

Project Name: ROAM Roaming Outpatient Access Mobile **Duration:** Jan 1, 2018 – June 30, 2022

Project Overview

1. Primary Problem

In San Diego County, factors such as history, culture, geography (rural) and building meaningful and trusting relationships have been identified as barriers to accessing mental health treatment for Native American communities. San Diego proposes to increase access and utilization of culturally competent mental health services Native American rural populations to decrease the effects of untreated mental health and co-occurring conditions through the use of two mobile mental health clinics, cultural brokers and incorporating complimentary traditional Native American healing practices in treatment and services.

Background. There are more Native American reservations in San Diego County than any other county in the United States (San Diego Native American), with some 5,300 individuals living on reservations, covering approximately 193 square miles. Many of these Native American communities do not have behavioral health services that are readily available and easily accessible. Although there are currently three (3) Indian Health centers and two (2) satellite clinics located on reservation land in San Diego County, many still live far away from services. In addition, while these clinics may provide varying levels of behavioral health services, the County of San Diego does not currently have any contracts specific to providing mental health treatment to individuals with severe mental illness (SMI).

All of the reservation land is located in rural San Diego. People living in rural areas are more likely to have significant mental health issues, including substance abuse (Rural Health Network). A study addressing substance abuse in rural America found that rural youth (ages 12 to 17) and transitional aged youth (TAY/18-25 y/o) have higher methamphetamine and alcohol use than urban youth; and the more rural and isolated an area is, the higher the usage rate (Lambert, Gale & Hartley, 2008).

San Diego's rural area residents have an overall higher rate of suicide than the rest of the county. In 2011, one (1) out of seven (7) rural adults required help for emotional/mental problems (Community Health Statistics (CHS)-Health Status Report Rural, 2012). In addition, national research indicates that suicide rates of Native American/Alaskan Native teens are 2 to 3 times higher than other youth (Mays, 2016) and Native Americans experience serious psychological distress 1.5 times more than the general public and PTSD over 2 times more than the general public (Mental Health America).

While there have been Prevention and Early Intervention (PEI) services provided to this community through the County's contract with the Dreamweaver Consortium member organizations, services are limited to prevention education (suicide prevention and stigma and discrimination reduction) and brief intervention (not longer than 6 sessions). The Dreamweaver Consortium member organizations have indicated a need for more mental health treatment services for Native Americans.

In a Native American community dialogue conducted at the Rincon offices of the Indian Health Council, representatives from various Native American communities within San Diego (n=34) were asked about their communities' behavioral health needs. The following are some points that were communicated during this community conversation:

a) Native Americans have the same behavioral health needs as other communities, but factors such as culture, history and geography serve as unique factors to consider.
b) Geographical isolation (many communities live in remote regions) makes it difficult to access services as they are not provided within the community; many members live on unpaved roads and some tribes are located many miles away from any services.
c) Culture is important and needs to be woven into all efforts – recognizing that some of these values are complex, contradictory and not always uniform.
d) Innovative and resource strategies include:
    - Incorporate Native American culture into treatment – arts, cultural initiatives and rites of passage, etc.
    - Use of technology, i.e. tele-mental health program for follow up appointments
    - Adopt a "no wrong door" approach, understanding that people may not come in for behavioral health services, even though that is one of their needs.
    - Promote recovery from a cultural perspective.

With much of San Diego's Native American population living in a geographically large rural area, Behavioral Health Services (BHS) concluded that the best method to improve access and utilization of mental health services is to develop two mobile mental health service units deployed to pre-determined locations (e.g. schools, community gathering areas) throughout designated San Diego's Native American Reservations. Additionally, to ensure we provide relevant and culturally competent services, employment of cultural brokers (e.g. tribal leaders, elders, and healers) will be critical to facilitate engagement, access and treatment services for the community and the treatment providers.

Participants in the BHS Community Engagement Forums this past year were invited to discuss this proposed project. They indicated that the project was needed and suggested the addition of community members with lived experience as they could help the mobile unit make the services more acceptable and reduce stigma. The participants also indicated that appropriate marketing could further help reduce stigma.

2. What Has Been Done Elsewhere To Address Your Primary Problem?

Mobile Clinics. The medical field has adopted the usage of mobile clinics to facilitate access to care. A literature review conducted by Harvard Medical School (2016) indicated that Mobile Health Clinics are effective in facilitating access to health care and are considered an effective intervention for physical health needs as well as the Mobile Health Clinics' success in providing preventative services for physical care and its ability to reach and treat underserved populations. This literature review listed the following as barriers to access to physical health care: transportation/geographic barriers, insurance status, legal status, financial costs, linguistic and cultural barriers, psychological barriers, perceived absence of patient-centered care, intimidation by healthcare settings, lack of healthcare providers, hours of operations and anonymity concerns. This literature review also identified a gap in the provision of focused mental health services (inclusive of diagnosis, treatment, follow-up, prevention

and early intervention) in a mobile clinic setting.

The usage of mobile clinics for mental health treatment is relatively new. Typically, when mental health "mobile units" are referenced, this term indicates service providers who are mobile; that is, individual or teams of individuals are deployed when needed to provide outreach, referrals or services in homes and in the community.

During the research phase, BHS identified a single program nationwide that has a Mental Health Mobile Clinic and serves rural communities. Tulare County has 2 Mobile Units that target individuals from rural communities. Phone calls to the two programs that provide the Mobile Unit services indicated that:

a) The North Unit only serves adults 18 years old and over. Services are provided through their mobile unit in conjunction with services provided through their home office. Clients are sometimes brought into the home office to participate in groups or other services. Typically only the case manager and therapist (with the driver) go out in the mobile unit. The psychiatrist has one "doctor day" in which he also goes into the community in the mobile unit.
b) The South Unit serves children between the ages of 2-11 years old and adults over the age of 25. Mobile services are provided in conjunction with services provided at their home office. They also have county nurses that provide physical health screenings and inoculations.
c) While Tulare County does have a Native American population, these programs do not specifically target this population and were unable to provide any data about whether any Native Americans are served through their program.

Cultural Brokers. The usage of cultural brokers to bridge the gap between mainstream medical model treatment and individual culturally diverse communities is not a new practice. Cultural brokers can serve as a cultural guide and mediator for both clients and providers. Cultural brokers can also "serve as a catalyst for change to assist health care providers and organizations in adapting policies and practices to the cultural context of patient populations and communities served" (National Center for Cultural Competence, 2011, p.3).

Current practices indicate that cultural brokers are used only when the provider has expressed frustration or difficulty with engaging the clients from different cultural groups in treatment or adhering to treatment. In some instances, cultural brokers simultaneously work directly with the providers and clients when they are called to action. In other instances, cultural brokers work with providers and clients independently as cultural experts or trusted community leader/member, respectively.

Finding. Mobile clinic use has been primarily and effectively focused on physical health, with mental health services limited to crisis intervention and screening (Harvard, 2016). The use of vehicular mobile clinics for comprehensive mental health services is currently only being utilized by Tulare County. However, the program is not completely mobile, and does not provide services to Native Americans. While cultural brokers have been used as a bridge between health and human service providers, there appears to be a lack of information and data about incorporating relevant culturally competent interventions and services in the mental health field for Native Americans.

3. The Proposed Project

The Roaming Outpatient Access Mobile (ROAM) program will consist of two fully mobile mental health clinics: one in the North Inland region and one in the East County region (areas that have the highest concentration of Native American reservation land). The ROAM program will operate Monday through Saturday 8:00am-6:00pm with client hours between 9:30am-4:30pm. Each Mobile unit will be staffed with a culturally competent Licensed Mental Health Clinician, psychiatrist (dual board certified), registered nurse, case manager with AOD certification, peer support specialist, family support specialist, cultural broker and support staff. The ROAM program will provide comprehensive services to children and youth with serious emotional disturbances, adults with serious mental illness (e.g. individual/group counseling, medication management, case management, peer and family support, care coordination, and prevention and services as well as Alcohol and Other Drug (AOD) screening, referral and linkage. The program will also apply and incorporate relevant cultural practices that are widely accepted and utilized by the Native American communities and are complimentary with traditional western treatment approaches. The target population will be children, youth, families, adults, and older adults of Native American descent living on the various Reservations across San Diego's rural areas. San Diego aims to increase the utilization of Mental Health services among the culturally diverse, and underserved Native American population to decrease the effects of untreated mental illness by outreaching and promoting engagement in services by integrating the provider team with local community leaders as cultural brokers.

The project will adapt the pre-existing practice of Tulare County, by testing mobile mental health clinics to the unique population and geography of San Diego by focusing on Native American individuals across all age groups living on reservation land. The project will also test engagement of cultural brokers as an embedded component of treatment to evaluate its efficacy in engaging and treating local Native American members as well as evaluating the efficacy of incorporating culturally competent services and traditional healing practices in the treatment model.

In addition, a sub-set of individuals with serious mental illness who have a co-occurring substance use disorder will be identified and provided with adjunct treatment and services such as Medication Assisted Treatment (MAT).

4. Innovative Components

The project takes an evidence-based approach, improving access to care by using vehicular clinics, and adds the following innovative approaches:

a) Staffing the mobile clinics with culturally competent clinicians and cultural brokers from the targeted communities. Contractors shall recruit, retain and employ individuals from the Native American communities.
b) Utilizing and incorporating culturally competent traditional Native American healing practices in treatment plan.
c) Using MAT to assist and support sobriety and recovery for individuals with co-occurring disorders. Untreated mental health conditions are often masked by the use of alcohol or other drugs in the form of self-medication in which clients medicate mental health symptoms by using alcohol and drugs (Foundations Recovery Network). MAT is a

recognized practice that is gaining traction in the Alcohol and Drug field, but much less so in the mental health field, although approximately 49% of adult clients with a serious mental illness have a co-occurring disorder of substance use (BHS Systemwide Annual Report F/Y 14-15).

d) The usage of tele-mental health in conjunction with, rather than in lieu of, in vivo services is a key factor in preventing any additional barriers to treatment and allow for further engagement. Tele-mental health capabilities would allow for follow up "visits" even when the mobile clinic is in a different area. Additionally, there may be a subset of clients who are unable or unwilling to physically come to the mobile clinic (e.g. actively psychotic individuals, who may benefit from tele-mental health technology.
e) GPS location services will be explored so clients and potential clients will have real time information as to where the mobile unit is.

5. Learning Goals / Project Aims

1) Improve access to and utilization of culturally competent mental health treatment and services; 2) Decrease the effects of untreated mental illness, and 3) Decrease behavioral health symptoms and improve level of functioning.

a) Will the use of a focused, dedicated culturally competent mental health mobile clinic improve access to and utilization of services for underserved Native American communities in rural San Diego?
b) Will the integration of cultural competent treatment practices and the use of the cultural brokers embedded within the program increase access and utilization of services and improve mental health treatment outcomes?
c) Will the use of MAT services for co-occurring diagnosed clients decrease substance use among Native American communities in rural San Diego?
d) Will the use of tele-mental health sustain engagement in treatment with clients in Native American communities in rural San Diego?

6. Evaluation of Learning Plan

Target participants are Native American children, TAY, adults, and older adults with severe emotional conditions (children/youth) or severe mental illness (TAY, adults and older adults). To determine whether the learning goals listed above were met, the following approaches will be utilized:

<u>Data to be Collected</u>

a) Demographics, including but not limited to age, race, ethnicity, gender, sexuality, disability, veteran status, diagnosis, and primary language will be collected.
b) Client satisfaction with integration of culturally competent services and cultural brokers.
c) Client outcomes such as engagement in treatment, decrease in symptoms and negative behaviors, increased understanding of mental health, attaining educational and employment goals, and increase in socialization.

<u>Methods</u>

a) Focus groups, interviews and surveys.
b) Surveys and outcome measures, including the Milestones of Recovery Scale (MORS) or another culturally competent measure will be conducted at intake, every 6 months and at discharge.
c) Two annual focus groups will be conducted.
d) Data will be entered into contracted data bases provided by University of California, San Diego (UCSD) and will be analyzed by the UCSD research team.

7. Contracting

All contracts are handled through San Diego County's Department of Purchasing and Contracting (DPC), which processes more than $1 billion in public purchases and contracts each year. The County posts its requirements for goods and services on BuyNet, an online public bidding system. Procurements will normally be posted on BuyNet under formal Request for Proposal (RFP) solicitations. The department's aim is sound procurement processes to acquire the highest quality goods and services at the best price.

Quality and regulatory compliance elements are included in each contract, specific to the funding source and purpose of the service. Proposals are selected in part on the basis of the offeror's plan to achieve best possible quality and compliance with all relevant regulations. A Contract Officer's Representative (COR) with Behavioral Health Services assumes responsibility for ongoing monitoring of the contract for compliance and outcomes, working with the DPC. Monitoring includes regular site visits, review of documentation, and oversight of applicable laws and regulations.

Contractors will have a dedicated Program Monitor from Behavioral Health Services who will develop a contract monitoring plan containing activities that will be conducted each year on their Statement of Work (SOW). Monthly Program Monitor meetings are routine.

There will be a minimum of four (4) monitoring activities per contract year, including a minimum of one (1) site visit, with subsequent visits, as needed, if identified issues have not been resolved.

Monthly COR meetings and site visit activities include but are not limited to deliverables review, technical assistance and consultation, review of fiscal and claim documentation and annual inventory update, emergency planning documentation, corrective action plans, discussion of strengths and weaknesses of contractor's deliverable outcomes.

There will be monthly review of SOW contract deliverables to determine contractor's performance in meeting contract objectives, review contractor exclusion/debarment/Medi-Cal Sanctions lists employee review process as well as a minimum of one (1) in depth invoice review annually.

Additional Information for Regulatory Requirements

1. Certifications

Board of Supervisors (BOS) authorization will be requested by 3/21/2017. Certification from the Behavioral Health Director will be included, Behavioral Health Services will provide Annual Revenue and Expenditure Reports as requested, and documentation will be provided by the County's PEI and CSS allocation.

2. Community Program Planning

Twelve (12) community forums were conducted county-wide to get community input and feedback regarding the Innovative project. The Older Adult, Adult and Children, Family and Youth Councils were also solicited for input regarding the community's need. Additionally, a Native American community dialogue was conducted to understand the needs of their community. After ideas for the Innovation Project was solidified, community members also participated in "conversation cafes" to discuss the proposed project and given opportunity to provide feedback on components needed.

3. Primary Purpose

a) Increased access and utilization of culturally competent mental health services to Native Americans in rural San Diego.

4. MHSA Innovative Project Category

b) Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community

5. Population

The ROAM program aims to serve approximately 60 to 70 individuals per unit who will receive ongoing services on an annual basis with a total of approximately 120 to 140 individuals receiving ongoing mental health services for both units. An additional estimate of 300 individuals will be screened for services per unit, with an approximate 600 individuals projected to be screened annually for both units. The ROAM program will target children and youth who have severe emotional conditions and TAY, adults, and older adults with a serious mental illness who may also have co-occurring substance use disorders.

6. MHSA General Standards

a) Community Collaboration

Collaborations will include the Southern California Tribal Chairmen's Association, Indian Health Council, Southern Indian Health Council and other partners in the Dreamweaver Consortium to ensure program's outcomes and goals are aligned with theirs as well as increase services to their constituents.

b) Cultural Competency

Contractor shall recruit, retain and employ Native American individuals and individuals from rural areas. Service providers with Native American experience will be sought, and all contracted staff will be required to participate in culturally competent training specific to Native Americans, to advance working knowledge and complimentary treatment practices with Native American communities. Service providers will embed in the treatment team cultural brokers and engage community leaders (e.g. tribal elders, healers) to build meaningful trusting relationships as well as build on connections previously established by the Dreamweaver Consortium. Culturally competent practices such as complimentary traditional healing practices will be incorporated into treatment and services. As defined in

CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services to improve mental health outcomes and quality of life improvement.

c) Client-Driven

Services will be culturally competent, client centered and clients will be the driver of their treatment plans and services.

d) Family-Driven

Family participation, involvement and collaboration will be sought to increase clients' support network to improve mental health outcomes.

e) Wellness, Recovery, and Resilience-Focused

Program aims to promote wellness and recovery within the Native American and rural populations focusing on mental health, client and families' resiliency to engage in treatment towards the goal of increased stability and ability to have productive lives.

f) Integrated Service Experience for Clients and Families

Providers will provide treatment and services in collaboration with the family with the clients consent to increase support and wellness, and use complimentary culturally competent healing practices to treat the person holistically within a spiritual, mental and physical health approach.

7. Continuity of Care for Individuals with Serious Mental Illness

Individuals enrolled in the program will receive an array of mental health services (described previously). The goal is to engage and provide clients with a different experience of the mental health system to increase their ability to participate in treatment with the goal of clinical stability. It is the intent of this program to continue pending successful outcomes and availability of funding. If the County is not able to continue with this program, Behavioral Health Services (BHS) will ensure clients are linked to the nearest Behavioral Health Services programs for continued mental health services. These may include linkages to Community Health Clinics, Indian Health Centers or BHS providers in the county.

8. INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement

Focus groups with the Native American population will be conducted to evaluate ongoing the ROAM program. Native American culture brokers will be sought to inform the evaluation team on the best approach to conduct the focus groups. Traditional cultures have a narrative style of communicating, telling a story to get to the point of interest. This may be useful with the Native American community. Short qualitative surveys or interviews about wellness or what has been helpful in an ethnographic style may be considered. BHS will seek the assistance of established Tribal Leaders, Elders and/or Culture Brokers to assist in the development of the evaluation.

9. Deciding Whether and How to Continue the Project Without INN Funds

The County will evaluate and determine if the program will be continued with another funding source

based on the programs outcomes and achievements demonstrated in the monitoring plan and evaluation results. All efforts will be made to ensure clients receiving treatment will be connected to outpatient mental health services as described in item 7 above.

10. Communication and Dissemination Plan

a) Information regarding the program, including outcomes, will be shared with stakeholders via the Behavioral Health Advisory Board, the Adult Council, Children's Council, Older Adult Council, TAY Council, Housing Council, the Cultural Competent Resource Team and other pertinent community meetings, presentations to various programs/service providers and conferences.
b) Forums will also be held with Southern California Tribal Chairmen's Association, Indian Health Council, Southern Indian Health Council and other Dreamweaver Consortium members and their constituents as well as at specific Tribal Council meetings at the designated Reservations or Native American community gatherings.
c) Program participants will be given the opportunity to share their experiences at stakeholder meetings, community forums and presentations to other services providers and conferences.

Keywords and phrases for the program include: Mental Health Mobile Unit, Native Americans Mental Health, Roaming Outpatient Access Mobile, and Behavioral Health Mobile Unit.

11. Timeline

a) Total timeframe (duration) of the INN Project: 4 Years, 6 Months

b) Expected start date and end date: Jan, 2018 Start Date June, 2022 End Date

c) Timeline that specifies key activities and milestones

I. January 1, 2018 – June 30, 2018: Start Up period to include: identifying appropriate mobile units and build out, hiring or staff, meetings to build relationships and request input from Native American leaders and elders on the implementation of ROAM, develop ROAM Steering Committee, culturally competent training.
II. July 1, 2018 to December 31, 2018: Begin treatment services, meetings with ROAM Steering Committee to determine evaluation approach and inform on ROAM progress. Monthly meetings to be held to include Program Monitor, evaluation provided thereafter.
III. Monthly reports submitted and first annual report will be provided Fall 2019.

12. INN Project Budget and Source of Expenditures

Each full ROAM team will consist of 0.5 FTE MD (dual board certified), 0.5 FTE registered nurse, 1 FTE Licensed MH clinician (dual filled as Program Manager), 1 FTE Peer Support Specialist (dual filled as driver), 1 FTE Family Support Specialist (dual filled as driver), 1 FTE cultural broker, and 1 FTE admin support/medical records. See below for estimated personnel, operating and indirect costs per each full team.

Position	Hourly Rate	Annual Salary (S)	Benefits (25% of S)	Operating (30% of S+B)	Indirect (15% of	**Fully Loaded**
Registered Nurse	$40.00	$41,600.00	$10,400.00	$15,600.00	$10,140.00	$77,740.00
LMCH/Program Manager	$35.00	$72,800.00	$18,200.00	$27,300.00	$17,745.00	$136,045.00
Case Manager	$24.00	$49,920.00	$12,480.00	$18,720.00	$12,168.00	$93,288.00
Peer Support Specialist/Driver	$20.00	$41,600.00	$10,400.00	$15,600.00	$10,140.00	$77,740.00
Peer Support Specialist/Driver	$20.00	$41,600.00	$10,400.00	$15,600.00	$10,140.00	$77,740.00
Cultural Broker	$25.00	$52,000.00	$13,000.00	$19,500.00	$12,675.00	$97,175.00
Admin/medical records	$22.00	$45,760.00	$11,440.00	$17,160.00	$11,154.00	$85,514.00
MD	$225.00	$234,000.00				$234,000.00
Half Year (per mobile clinic):		$332,800.00		$64,740.00	$42,081.00	**$439,621.00**
Full Year (per mobile clinic):		$665,600.00		$129,480.00	$84,162.00	**$879,242.00**

Additional Costs (per mobile clinic):

Non Recurring Costs (mobile vehicle):	$240,000.00
Half Year Evaluation (5%):	$21,981.05
Full Year Evaluation (5%):	$43,962.10
Total full year per mobile clinic:	**$963,583.10**
Total full year for 2 mobile clinics:	**$1,846,408.20**

Total Annual Cost for Both Mobile Clinics

Cycle 4 INN 20 ROAM						
Innovative Project Budget by FISCAL YEAR (FY)						
BUDGET TOTALS	**FY 17/18 (Half)**	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**TOTAL**
Personnel	665,600.00	1,331,200.00	1,331,200.00	1,331,200.00	1,331,200.00	5,990,400.00
Direct Costs						
Indirect Costs	84,162.00	168,324.00	168,324.00	168,324.00	168,324.00	757,458.00
Operating Costs	129,480.00	258,960.00	258,960.00	258,960.00	258,960.00	1,165,320.00
Non Recurring Costs	480,000.00					480,000.00
Other Expenditures						
INNOVATION BUDGET						
Evaluation 5%	43,962.10	87,924.20	87,924.20	87,924.20	87,924.20	395,658.90
TOTAL	**1,403,204.10**	**1,846,408.20**	**1,846,408.20**	**1,846,408.20**	**1,846,408.20**	**8,788,836.90**

County: San Diego County **Total Funding Request**: $8,836,362

Project Name: Medication Clinic **Duration:** July 1, 2018 – December 31, 2022

Project Overview

1. Primary Problem

The County of San Diego has roughly 3.2 million people, of which 750,000 are under the age of 18. The rate of significant mental illness for children and youth is conservatively estimated at 10%, so 75,000 are at risk for mental health problems that interfere with their development, school function, social relationships, and ability to succeed in our society.

The County of San Diego Behavioral Health Services division serves approximately 18,000 children and youth per year. Its current outpatient model provides for 13 sessions per person, with the option of an additional cycle of 13 sessions if a utilization review process deems the additional sessions necessary. The services offered are based on a Child Guidance Clinic model of individual therapy, conjoint therapy with caregivers, psychiatric medication assessments when indicated, medication follow up services, and group therapy in some locations, and case management for high basic needs families. Over the years, Therapeutic Behavioral Services, Wraparound Services, and Full Service Partnerships have been added to the service mix. There is access to emergency services through the Emergency Screening Unit, North County Behavioral Walk-In Clinic, and the Psychiatric Emergency Response Teams (affiliated with law enforcement). The in-patient psychiatric care is provided at 3 local psychiatric units.

This system of services has provided excellent, well regarded and highly-rated services for children, youth and families who are able to access this system. This system works well for those who have episodic, short-term mental health problems that can be managed with psychotherapy and medication treatments.

Some of these young people find that they can live stable lives with the assistance of psychotropic medications after receiving psychotherapy services, but our system of care through the organization provider network (Community Based Organizations) has limited capacity to provide medication-only services. Currently, these youth are referred to primary care doctors, fee-for-service psychiatrists or Federally Qualified Health Clinics for ongoing psychotropic medication support. Conditions that may require ongoing medication support include Attention Deficit Hyperactivity Disorder, Generalized Anxiety Disorder, Panic Disorder, Major Depression, and others. For children and youth with complex combinations of mental health problems (or with recognized complex mental disorders like Complex PTSD, Bipolar Disorder, Schizophrenia, Autism with aggression, ADHD plus mood dysregulation) it can be difficult to find a primary care doctor prepared to manage the medication treatment aspect of their care.

In addition, there are also children who are seen in other locations (primary care medical offices, specialty medical care offices) who do not receive specialty mental health care. These children may have complex Medical Illnesses (asthma, cancer, diabetes, gastrointestinal illnesses, and genetic abnormalities) and also have mental health needs. At present, these individual are not receiving

coordinated behavioral health services in the same location and in collaboration with the medical treatment.

This proposal attempts to address some of the above issues involving ongoing medication support for children and youth who continue to need medication services once their therapy sessions end.

2. What Has Been Done Elsewhere to Address Your Primary Problem?

We have done extensive literature searches, selected focus groups, interviews with Pediatric and Child Psychiatry Professional Organizations (AAP and AACAP local and nationally) and the broader community forums during the development of our Psychiatric Consultation for Primary Care (beginning in 2010 and continuing through 2016) efforts. These efforts resulted in our current program called "Smart Care" which offers telephone consultation to primary care physicians treating both children and adults with mental health problems in the primary care locations. This is a successful program for relatively uncomplicated clinical cases, but is not sufficient for treating long term, somewhat chronic, cases or for complex medical and mental health cases. The Washington State PAL program and the Massachusetts Child and Adolescent Psychiatric Access program have found the same situation- consultation is helpful, but not sufficient for complex mental health problems or for complex medical illness and mental health problems.

We have not found a similar program in this state or in the United States that has the flexibility, clinical expertise, and creativity to solve these difficulties.

3. The Proposed Project

The proposed project will establish a Psychotropic Medication Clinic staffed by expert Child and Adolescent Psychiatrists, Case Manager Clinicians, Psychiatric Nurses, and a Program manager to be run by a Community Based Organization under contract with the County of San Diego. These clinicians will provide medication support services to children and youth who have mental health problems that require medication treatment to support their function, safety, and reduce suffering so that they can participate in school, community activities, and in a rich home life. These psychiatrists will be mostly in one location, but will provide care in multiple settings.

a) Telepsychiatry to 2 locations per region (6 regions of the county- total of 12 sites) potentially in conjunction with primary care medical offices.
b) On-site psychiatric care in a Specialty Medical Office of Developmental and Behavioral Pediatricians who currently see children with complex medical problems.
c) On-site office-based psychiatric care for medication support at an office centrally located in the County. This service will not be timed limited, but will be provided as long as is needed by the client (eligibility will continue until the child/youth is 18 years of age.

In addition, other services will be provided that are not currently available in San Diego County as a part of a treatment clinic. These include:

a) Psychoeducational presentations about mental health problems, treatments, resources, medication side effects and effects. These presentations will be in the evenings and will offer on-site child care.

b) Resource fair for families- videos, books, pamphlets, website with resources and coming events.
c) Peer support groups- NAMI, ChADD.
d) Consultation to school personnel, Probation Staff, Child Welfare Staff, and Primary Care Offices for those children and youth involved in multiple systems.
e) Specialty Clinics for the medication management of Attention Deficit Hyperactivity Disorder and Anxiety Disorders.

It is hoped that this clinic will be seen as a "Center for Child Psychiatry" in our county, both for children, youth and their families, but also other clinicians and community partners.

The Medication Clinic will be involved in the following approach specified in CCR, Title 9, Sect. 3910(a): will change several existing practices in mental health.

1. Providing specialty medication support services to children and youth who are discharged from their organization provider (Community Based Organization) yet have needs too complex for Primary Care Clinicians.
2. Provide coordinated and co-located access to care for children and youth who access primary care in Developmental Pediatricians' Offices due to having complex medical needs. Most medically complicated children (those who have serious illnesses with complicated treatment) do not seek Specialty Psychiatric Care in the way non-medically ill people do. This project allows them to receive this level of care that is more sophisticated and intense than that available from Developmental Behavioral Pediatricians.
3. Telepsychiatry to multiple locations in the County for children and youth who do not have or have not accessed Specialty Psychiatric Care due to geographical distance, cultural reluctance, stigma, fear, or socioeconomic concerns.
4. Address workforce shortages by exploring telepsychiatry with psychiatry groups who may be outside of San Diego County (External Quality Review recommendation from FY15/16 review).
5. Psychoeducational evening programs to families on relevant topics with provided child care.
6. Resource Fairs for families to get videos, books, pamphlets and web-site access to information and resources.

We determined the need and best approach by holding multiple discussions with multiple different Organizational Provider (Community Based Organizations) personnel (Program Managers, Psychiatrists, Case Managers, Therapists), families approaching the youth's discharge date, pediatricians who were receiving referrals for children being discharged from organizational provider clinics, Developmental Behavioral Pediatricians, the Children Youth and Families System of Care (CYF-SOC) participants (annual planning and prioritizing meeting), the CYF-SOC Early Childhood Subcommittee members, the local American Academy of Pediatrics, and the San Diego Academy of Child and Adolescent Psychiatry. We also discussed the challenges (discharges from organizational provider clinics, medically complicated children with mental health needs, clinics that lose their psychiatric consultants and have no replacement for long periods of time) with the local organization that oversees the fee-for-service MediCal providers in terms of the availability of Psychiatrists on their panel.

4. **Innovative Components**

- On-site collaboration, psychiatric evaluations and treatment in Developmental Behavioral Pediatricians' office for medically complex youth
- Recognizes the value of longer-term, responsible psychiatric care for youth who have clinically stabilized but continue to require complex psychotropic medication regimens, particularly in light of recent legislative focus on psychotropic medication provision to Medi-Cal youth
- 12 Telepsychiatry sites in 6 regions for psychiatric consultation with efforts to place in a primary medical care office
- Psychoeducation programs at night for families, youth, other caregivers, educators on topics related to mental health problems, treatments, resources with available child care
- Resource fairs which provide access to books, articles, videos, pamphlets on relevant topics
- Consumer support meetings at the same location that services are provided (NAMI, ChADD, Bipolar Foundation)
- Temporary psychiatric coverage for programs that lose their psychiatric consultants and are having trouble recruiting
- Monitoring the medication treatments of children and youth who are not receiving services from an Organizational Provider Clinic

5. Learning Goals/Project Aims

The projects main goals are to see if a Medication Clinic can serve as a specialty program for children and youth who have been clinically stabilized by who require sophisticated psychiatric services sufficient to meet their ongoing complex prescribing needs. The main questions are:

a. Can an on-site psychiatrist work in close collaboration with Developmental Behavioral Pediatricians to provide integrated care to children and youth with complex medical and mental health problems?
    i. What does the working relationship need to be?
    ii. How will they communicate?
    iii. How can they safely provide intense medical and mental health care? Does this program intervention serve to better address interactions between psychotropic medications and medications provided for complex medical illness?
    iv. What are the health outcomes that each child and family seeks? Can this arrangement facilitate those outcomes (they will be different for each person and family)?
b. Can we potentiate the stability of youth by providing consistent, longer term relationships with a prescriber team?
c. Can we leverage psychiatrist outside our County via Telepsychiatry to expand our limited pool of prescribers available to serve our community's youth?
d. Can a stand-alone Medication Clinic be a stabilizing factor for children discharged from Organizational Provider Full Service Clinics and work with different schools,

therapists, primary care physicians, and group homes in a collaborative and integrated manner?

i. Can this clinic be seen by its users (children, youth, caregivers, teachers, other helpers) as a helpful support? A source of information and resource?

6. Evaluation of Learning Plan

1. Target Participants: Youth with complex, comorbid medical and psychiatric needs. Youth who have clinically stabilized but continue to require complex psychotropic medication regimens. Education will target youth and families who utilized psychotropic medication as well as System of Care practitioners to increase the workforce understanding of aforementioned issues.
2. What data is to be collected? For this component the County of San Diego will be using evaluators from UCSD to assist with the development of measures, the data collection, and data analysis. The UCSD group has years of experience doing System of Care assessments and implementation of change assessments.
3. The CYF-SOC presently completes a system of care evaluation and has a set of questions it uses. In collaboration with Developmental Behavioral Pediatricians, a questionnaire will be developed to identify the health outcome goals for each child seen and then subsequent questionnaire to find out if those goals have been reached. Lastly, the medical and mental health participants will be asked to respond to a questionnaire about integration of effort, ease of working together, communication, ways the arrangement has improved care and ways the arrangement has hindered care.

7. Contracting

The County has significant experience developing Requests for Proposals, overseeing contracts, and evaluating outcomes. This is the 4th set of Innovation projects the County is developing. The contracts are overseen by Behavioral Health Services Contracting Officer Representatives (CORs) and the process of contracting is seen by The County of San Diego Department of Purchasing and Contracting.

Additional Information for Regulatory Requirements

1. Certifications

a. Adoption by County Board of Supervisors by date (TBD)
b. Certification by the County Behavioral Health Director
c. Certification by the County Mental Health Director and by the County Auditor-Controller
d. Documentation that the source of INN funds is 5% of the County's PEI allocation and 5% of the CSS allocation

2. Community Planning

a. Twelve (12) community forums were conducted County-wide to get community input and feedback regarding the Innovation project
b. The Older Adult, Adult and Children, Family and youth Council were also solicited for input regarding the community's need

c. After ideas for the Innovation Project was solidified, community members also participated in "conversation cafes" to discuss the proposed project and given opportunity to provide feedback on components needs

3. Primary Purpose

a. Increase access to specialized psychiatric services to underserved groups

4. MHSA Innovative Project Category

a. Introduces a new mental health practice of approach for children and youth consisting of psychiatric medication-only services provided via Telepsychiatry to multiple regions of the County, medication support services located in Special Needs Pediatric Clinics, and medication support services in a central office location provided to children and youth who completed psychotherapy but still have an ongoing need for medication treatment.

5. Population

a. Number served-the estimate of children and youth to be served by direct services is 100 in the Developmental and Behavioral Pediatrics office, 300 in the Telepsychiatry Locations (approximately 25 children at each location), and 100 in the Medication Clinic itself. The average cost per person served is $3800/year (500 children/youth for $1,900,000).
b. Population is children/youth from approximately 3 years to 21 years of age who live anywhere in the County of San Diego and who are transitioning out of receiving Organizational Provider Mental Health services or who have complex medical needs and are served by the Developmental Behavioral Pediatricians. There is no limit as to race, ethnicity, gender orientation, geographic location, or language. The clinical and administrative data for these children and youth will be collected in the County of San Diego electronic medical record system so will be able to be gathered and reported.
c. Target groups- It is one of the purposes of this project to meet the mental health needs of medically ill children. These children's eligibility for service will be that they have a medical illness, a mental health illness, a developmental disorder, or significant family stress and disorder. It is expected that the children will have at least 2 of these qualifying characteristics and be seen in the Developmental Pediatrics office.

6. MHSA General Standards

a. Community Collaboration: The concept for this work plan was developed based on local stakeholder process for input on system needs over multiple years.
b. Cultural Competence: As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services to improve outcomes.

c. Client/Family Driven Mental Health System: This program includes the ongoing involvement of clients and family members in roles such as, but not limited to, implementation, evaluation, and future dissemination. Ultimately, the program strives to create healthier families in our community.
d. Wellness, Recovery and Resilience Focus: This program increases resilience and promotes discovery and wellness for parents with serious mental illness by increasing access to services. The goal is to strengthen the overall family to allow for a more stable and resilient family system with strength to sustain wellness.
e. Integrated Service Experience: This program encourages access to a full range of services provided by community resources, multiple agencies, programs and funding

7. Continuity of Care for Individuals with Serious Mental Illness

a. Individuals with serious mental illness will receive services from the proposed project. They are a specific focus as many of the consumers will have been discharged from Organizational Provider Clinics. There is not a limit on time or number of services received from the Medication Clinic, as long as medical necessity is met. At the end of the Innovations project, if this Medication Clinic concept proves successful, the fiscal support for the Clinic will be achieved by exploring utilization of EPSDT MediCal and Federal Participation funds.

8. INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement

a. Ensure cultural competence
b. Ensure meaningful stakeholder participation

9. Deciding Whether and How to Continue the Project Without INN Funds

a. Throughout the duration of the project, steps will be taken to review the effectiveness of the approach.
b. If effective, traditional EPSDT funding streams will be considered.

10. Communication and Dissemination Plan

a. Dissemination within your county
b. Involvement of program participants and other stakeholders
c. 5 keywords of phrases for this project to assist with search medication clinic, psychiatry,

11. Timeline

a. Specify the total timeframe (duration) of the INN Project 4.5 years allowing for a 6 month final evaluation period.
b. Expected start date and end date of INN project 7-1-18 through 12-31-22 for a total of 4.5 years

c. Key activities timeline and milestones
    i. New or changed approach
    ii. Evaluation of the INN Project
    iii. Decision making, meaningful involvement about continuation of project
    iv. Communication of results and lessons learned

12. INN Project Budget and Source of Expenditures

a. Budget by fiscal year and specific budget category
b. Budget context

position	hourly	Annual Salary (s)	Benefits (B) (25% of Salary)	Operating (O) (30% of S+B)	Indirect (I) (15% of S+B+O)	fully loaded
Admin Associate	$20.00	$41,600.00	$10,400.00	$15,600.00	$10,140.00	$77,740.00
Psychiatrist	$175.00	$364,000.00	$0.00	$109,200.00	$70,980.00	$544,180.00
Program Manager	$40.00	$83,200.00	$20,800.00	$31,200.00	$20,280.00	$155,480.00
Psych Nurse	$50.00	$104,000.00	$26,000.00	$39,000.00	$25,350.00	$194,350.00
LMHP	$38.00	$79,040.00	$19,760.00	$29,640.00	$19,266.00	$147,706.00
Psychiatrist	$175.00	$364,000.00	$0.00	$109,200.00	$70,980.00	$544,180.00
		$0.00	$0.00	$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00	$0.00	$0.00
Total:		$1,035,840.00	$76,960.00	$333,840.00	$216,996.00	$1,663,636.00

Operating expenses (rent, medications, equipment, business expenses)	$200,000.00
Evaluation (5% of total)	$100,000.00
	$1,963,636.00

Cycle 4 Innovation: Medication Clinic						
Innovation Project Budget by FISCAL YEAR (FY)						
Budget Totals	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23 (Half)**	**Total**
Personnel	$1,112,800	$1,112,800	$1,112,800	$1,112,800	$556,400	$5,007,600
Direct Costs						
Indirect Costs	$216,996	$216,996	$216,996	$216,996	$108,498	$976,482
Operating Costs	$333,840	$333,840	$333,840	$333,840	$166,920	$1,502,280
Non-Recurring Costs						
Other Expenditures	$200,000	$200,000	$200,000	$200,000	$100,000	$900,000
INNOVATION BUDGET						
Evaluation 5%	$100,000	$100,000	$100,000	$100,000	$50,000	$450,000
TOTAL	**$1,963,636**	**$1,963,636**	**$1,963,636**	**$1,963,636**	**$981,818**	**$8,836,362**