

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:

Data to be Collected

- 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.

Methods

- 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 S+B)	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