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**