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