Kings County Behavioral Health Innovation Plan: Multiple Organization Shared Telepsychiatry (MOST) Project

September 2018

Table of Contents

Introduction....3
What Has Been Done Elsewhere To Address Your Primary Problem....4
Proposed Innovation Project....5
Care Coordination....6
Facility....7
Learning Component....9
Evaluation/Learning Plan....9
Contracting Evaluation....13
Certification....13
Community Planning....14
Primary Purpose....16
Innovation Project Category....16
Population....16
Cultural Competency/Humility....16
MHSA Standards/Values....18
Continuity of Care for Individuals with Serious Mental Illness....20
Project Evaluation, Cultural Competency and Meaning Stakeholder Involvement....22
Outcomes....23
Communication and Dissemination....24
Timeline....25
Budget Narrative....31
Budget....36
Appendix/Letters of Support....39

Introduction

At Kings County Behavioral Health (KCBH), we believe that peers and family members are the heart and soul of recovery. Without them we lose the joy of community and the wisdom of those who have walked the road to wellness before. Working with peers and family members, KCBH is pursuing a wellness and recovery model of treatment and is striving to spread this approach to all aspects of behavioral health care in our county.

As we strive to move our system of care to a wellness and recovery model, it has become clear that one of the last vestiges of a medical model that remains is traditional psychiatric care. Currently, all psychiatric care in our system is provided using the medical model, without a wellness and recovery approach supported by peers and family members. Psychiatric care is provided by only one contracted provider and it does not include any peer support services. KCBH has identified the need for more psychiatric care in Kings County and the need to align the expansion of services with the wellness and recovery model of care.

Kings County is a small rural county with a population of nearly 150,000 people. Our county has the challenging combination of a high poverty rate and a high rate of serious mental illness. Nineteen percent (19%) of residents live in poverty and 38% are Medi-Cal eligible. The rate of serious mental illness in adults is the second highest in California, at 6.9%, and a rate of 8.0% for children. The rates of serious mental illness among adults and children in households with incomes below 200% of the poverty level are higher, at 7.9% and 8.9%, respectively. In addition, despite having one of the highest rates of serious mental illness, Kings County, like other rural California counties, has few psychiatrists. There are only two psychiatrists working in our county who serve Medi-Cal eligible consumers, offering just 68 hours of service per week to adults and children in a combination of in-person and telepsychiatric care. These psychiatrists work for a single mental health service provider. In our county, the average wait time to see a psychiatrist for an initial appointment is 25.6 business days.

These challenges are exacerbated in the more remote areas of Kings County, such as the community of Avenal, which is a 37-mile drive or a daylong round-trip bus ride to where psychiatric services are available, in Hanford. The dearth of psychiatric treatment hours and the fact that they are supplied by a single provider poses an ongoing structural challenge to offering mental health services to all qualified residents of the county. We have found that this lack of psychiatric services has led many people with serious mental illness to be served in hospital emergency departments or the county jail.

A well-known solution for expansion of psychiatric services in areas with too few psychiatrists is telepsychiatry: secure two-way audiovisual communication between a psychiatrist in a distant location and a local consumer in a designated private room, supported by additional staff on site. Kings County Behavioral Health plan to shift telepsychiatry care from a strictly medical

model to one that is focused on wellness and recovery, with consumer and family staffed support.

The Mental Health Services Act (MHSA) three year planning process for Kings County identified the need for additional psychiatric services which would increase access for underserved populations, reduce long wait times and allow for services to be accessed at the community level. The limited access to timely care and the current medical model, which excludes vital peer and family support, hinders the effectiveness of psychiatric care and provides a barrier to full engagement in services. By creating a peer and family member staffed Multiple Organization Shared Telepsychiatry (M.O.S.T.) psychiatric care facility, we seek to explore two significant issues as we strive to change the model of telepsychiatry through this innovation project.

> ONE: *Can a shared tele-psychiatry program that includes peer and family member as part of the treatment team help transform psychiatric services to a wellness and recovery based system of care with improved outcomes for consumers?*
>
> TWO: *Can sharing of tele-psychiatric services with multiple service providers (including community-based providers) improve coordination of care and outcomes of program participants?*

What Has Been Done Elsewhere To Address Your Primary Problem?

Many counties in the state have opted to implement telepsychiatry as a means to address psychiatric care shortages. A number of the superior region counties collaborated to share telepsychiatric services but, to date, we were unable to find any county that was providing psychiatric services with peer and family members as employed members of the treatment team, or where telepsychiatry was being shared between direct service providers and the county.

In response to our inquiry, the Mental Health Services and Oversight and Accountability Commission (MHSOAC) reported in January 2018 that they did not have a record of any innovation plan that had provided and evaluated shared telepsychiatry among a county and its providers, nor any that were using employed peer and family member staff.

We then made inquiries with several similar counties who had established telepsychiatry service to see if they shared any of their resources with providers or if they had a peer component. We engaged Tulare, Mono, Alpine, Colusa, and Madera Counties, all of whom have or had telepsychiatry services, but they were not shared with their providers and none had utilized a peer component. To more fully review telepsychiatry in its existing model, we communicated directly with several psychiatrists who provide services using Telepsychiatry. We toured and observed the telepsychiatry program in Madera County, and we communicated

with several telepsychiatric technology providers. Our current and only psychiatric provider, Kings View Counseling Services, does not share their resources or have peers involved in the psychiatric services. We made inquiries through Fleet and Family Services at Naval Air Station-Lemoore, and they reported that they have psychiatric services at the base hospital but only for active duty personnel (and do not share it with the families who reside on base) and there is no peer aspect. Adventist Health, our local hospital, does not employ a psychiatrist at this time and representatives reported that primary care providers prescribe all psychiatric medications. At the conclusion of this review of services throughout the state, we were not able to identify a telepsychiatry or any psychiatric program in California where the county shares the resource with other providers, or has peer and family members as employed members of the treatment team.

The Proposed Innovation Project

Kings County is seeking to develop the Multiple Organization Shared Telepsychiatry (MOST) Program under its Innovation Plan. The MOST Program, under the Innovation Plan will make changes to an existing practice in the field of mental health as required in California Code of Regulations, Title 9, Section 3910(a).

Kings County Behavioral Health seeks to create shared telepsychiatric suites in multiple sites within Kings County, accessible by multiple service providers, centered on a strong employed peer and family member component to improve timely service delivery and quality of care. These service providers would include the following providers in Kings County: the Department of Public Health, Mental Health Systems, Inc., Aspiranet, Inc., Kings View Counseling Services, and the Kings County Behavioral Health Department. We seek to transform the traditional medical model of our system of care into one that is wellness and recovery oriented by providing peer and family staffed telepsychiatric services available to multiple service providers.

We propose not simply to offer telepsychiatry, but to establish a program to enable mental health service providers and county departments to offer shared telepsychiatry services to their consumers in suites that are used by multiple organizations and are centrally managed and staffed by the county behavioral health department.

If not for this project, these organizations would not be able to offer telepsychiatry until years from now, if at all. Moreover, our research shows no indication that shared telepsychiatry services accessible to multiple county departments and contracted mental health providers has ever been done before in any California County and none are staffed by peer and family who are employed by the county.

This project will establish telepsychiatry suites in three cities, to be managed by Kings County Behavioral Health. Local organizations will be able to request telepsychiatric services for their clients, and we will schedule their appointments. Kings County Behavioral Health will provide

on-site staff support for the telepsychiatrists. Paid, trained peer support specialists or patient peer support specialist will be co-located with telepsychiatry suites. Ideally, peers trained and certified under Senate Bill 906 (once approved) will allow the peers to bill Medi-Cal for up to 50% of their work. Peers will provide the patients with transportation, if needed. They will assist consumers in navigating psychiatric care, teaching consumers how to advocate for themselves, and advocating on behalf of the consumers. Trained peers will meet with each consumer prior to their psychiatric appointment to ensure that the consumer can express any concerns, challenges, or issues with the psychiatric technician and/or psychiatrist. If necessary and appropriate, with the consumer's consent, a peer may sit in session with the consumer to increase their comfort level and provide support. An additional benefit of this project is that it is simple and highly replicable for other California counties. This will provide another avenue for the system to include peers, parent peers and/or persons with lived experience into the system of care to make it more wellness and recovery oriented. This model will likely improve consumer outcomes, reduce stigma around psychiatric services, increase engagement, and assist with retention of participants. The model goes beyond counties sharing resources, but counties and their local providers sharing limited resources which address limitations based on cost, capacity, geography, etc. in a recovery and wellness based model of care.

The MOST program will strive to serve **128** unduplicated individuals in its first year. With half of those being children/youth.

In the second year of the program, with an additional site and hours of care the program shall strive to render services to 64 new/unduplicated individuals, **192** individuals total for the second year.

In the final/third year of the program, with the addition of a third site and hours, 64 new individuals shall be served, allowing over the three years for the program to have served **256** more residents of Kings County through psychiatric care, and the expansion of these services.

Care Coordination

The mental health service providers who will utilize the telepsychiatry suites use the same Electronic Health Record (EHR) system provided by Kings County Behavioral Health. This ensures timely access to shared records. The psychiatrist shall also utilize the same shared EHR. The EHR includes a medication feature, which enables prescriptions to be sent electronically to pharmacies.

Before appointments with the psychiatrists can be scheduled, the consumers will first be evaluated by a licensed clinician or clinical intern/trainee under the supervision of a licensed clinician to ensure the consumer has a diagnosis necessitating psychiatric support. A Medi-Cal billable assessment will be completed and submitted for the psychiatrists review prior to the psychiatric appointment.

Consumers who are Medi-Cal eligible or have no health insurance and meet medical necessity for outpatient mental health services will be provided with a psychiatric appointment. Consumers who do not meet medical necessity referred to the appropriate provider in their network. If a consumer may is not Medi-Cal eligible they not have applied for Medi-Cal coverage and if that is the case they will be connected to the Human Services Agency for enrollment. If the consumer is an undocumented individual, they will be enrolled in the Full Service Partnership program, or another MHSA-funded program to ensure access to psychiatric care and medication treatment.

If a referring agency is a community mental health provider, that agency will complete the assessment utilizing their clinicians. The assessment will then be available in the shared EHR that is used by the county and its providers. Any consumer who has not been assessed by a referring agency who provides mental health assessments, such as the Health Department, will be assessed by the Kings County Behavioral Health Department through its own team of clinicians within two-business days after the referral. This program will reduce the wait time for eligible consumers to be seen for a psychiatric appointment from the current wait time of 25.6 days to within five to seven business days of the completed assessment and referral. The MOST program will also make use of an Urgent Condition process which will allow consumers who are at risk of psychiatric hospitalization without immediate intervention to access care within two business days.

Facility

The initial telepsychiatry suite space is available in empty space already leased in the Kings County Behavioral Health building. All other planned locations in the remote rural communities are owned and operated by the County of Kings.

Hanford: The initial MOST space in Hanford is an existing 1,521 sq./ft. county operated office space that has an open lobby which will house the bilingual Office Assistant/Receptionist. This staff person will be responsible for scheduling appointments, making reminder calls and following up with consumers. The suite offers two office spaces (one for the Peer Navigator and one for the Parent Peer Navigator) located adjacent to the waiting area. There is one office available for the psychiatric nurse or psychiatric technician. There will be one medical room (which is also a confidential space) for any health screening, vital check, or administration of medication. There is a secured/locked room next to the nurse's office which will be used as a medication room. This room will have restricted access and will also be the space where certain medications will be stored in accordance with regulations. Most medications will be prescribed by the Psychiatrist, and filled at various local pharmacies where consumers fill their prescriptions. Only selected medications will be stored on site (those requiring injection). The medication rooms will have refrigeration available for medications. The medication rooms will be established in accordance with California Code of Regulations, Title 22, and Section 73361

for records and California Code of Regulations, Title 9, Section 1810.435 (3) for storage of medication. The medication rooms will be secured using electronic locks and limited access to only designated medical staff and compliance officer.

Additional features include two large rooms for telepsychiatric services, including equipment. There is space within the room that allows the psych-tech assisting with the session to document instructions from the Psychiatrist and coordinate the session. The space is also large enough to allow for the peer support to sit in, should that be the desire of the consumer. Lastly, there is a large room, with soothing lighting that can be used by any consumer who may be in need of some quieter space, or whom may be agitated and benefit from a calm and private setting.

The initial location is in the office complex which houses Behavioral Health and is located across the walkway from the children's Full Service Partnership provider and is also across the walkway from Mental Health Services, Inc., the our contracted Assertive Community Treatment Team office. This proximity will assist our highest need and highest risk adult and child consumers by being located very close to their treatment providers. The MOST psychiatric suite is located 200 yards from the County's Day Reporting Center, for consumers who are reporting to probation. The location is less than a mile from the peer run Oak Wellness Center and is located in office space that has a much less conspicuous and stigmatizing appearance.

Directly adjacent to the MOST suite is a Quest Diagnostic Lab. This location, directly next to the telepsychiatric suite, allows for patients who are referred for any blood draws and/or lab work to a location within the same complex, increasing access. Proximity and connivance should increase follow through with doctor's instructions. Quest provides services for Medi-Cal beneficiaries. This also reduces challenges of performing such work on site or storing of samples.

Avenal: The second phase, which will include services in Avenal, shall eventually be housed in a new county One-Stop building that will be constructed and the telepsychiatric suite within that building designed specific to the needs of the MOST program. The new One Stop shall house Behavioral Health services (including a MOST Suite), Human Services, and Public Health. The Behavioral Health portions of the space and areas for telepsychiatry will be customized and allow for a secure medication room. If there are delays in the completion of the construction, the department already has contingency plans to utilize the County's Public Health building in Avenal to roll out phase two and provide services until the One Stop is completed. Both these venues are county owned and operated and meet the needs of the County and requirements for telepsychiatry services. The intended location and the contingency location house other support services and providers.

Corcoran: The third and final location for phase three shall be located in the County's Public Health building in Corcoran, where services by the county and other providers are already

rendered. This location is a county owned and operated location. Additional designs for the location will be detailed based on learning from the Hanford site and Avenal site that will include co-location with other services and providers.

The MOST program's staff will eventually operate out of all three sites, ensuring continuity of the team at the various locations. As the project expands, there will be a need for additional hours for a psychiatric technician. Thus, a part-time psychiatric technician will been implemented into the team, who will work primarily out of the satellite sites. This ensures continuity of care and continuity of the treatment team.

Learning Component

This project will deepen shared understanding by measuring the extent to which it achieves the following outcomes/ learning questions:

> ***ONE:*** *Can a telepsychiatry program that included a peer and family component as part of the treatment team help transform psychiatric services that are based on a medical model to a wellness and recovery based system of care?*
>
> ***TWO:*** *Can sharing of telepsychiatric services with other local services providers (including community-based providers) improve coordination of care and outcomes of program participants*?

Evaluation/Learning Plan

These two learning goals can be measured and evaluated by the following aspects of the program.

ONE: *Can a telepsychiatry program that includes a peer and family component as part of the treatment team help to transform psychiatric services that are based on a medical model to a wellness and recovery model?*

OUTCOME 1: Improve perceived value of peer involvement in psychiatric care among consumers, providers, and psychiatrists.

- In order to develop a baseline for consumer, staff and psychiatrist's perceptions of the value of peer involvement in psychiatric treatment, these participants will be surveyed at the on-set of the program and then each year until the end of the program. Changes in perception will be tracked and will provide a quantitative source of data with measurement of change in perception over time. If there are changes, these surveys will document the

correlation between peer employment in psychiatric care and the perception that services are being provided through a wellness and recovery model rather than the medical model of practice.

- The treatment providers who provide the referral and non-psychiatric services will also be surveyed to see how they perceive the inclusion of peers and family in the rendering of psychiatric care for their consumers, and if attitudes change over time.

OUTCOME 2: Consumers will self-report they believe they are meeting their own wellness and recovery goals. This consumer report from the MOST program will be compared to our existing telepsychiatric services in Kings County which are operated without peers or parent peers employed for the psychiatric services.

- Consumers participating in the MOST program will self-report if the telepsychiatric services are helping them to meet their wellness and recovery goals. These responses will be measured on surveys, including testimonials, provided during interviews to develop qualitative data and will characterize the actual participant's experience, looking for themes in the participant responses.

- Family members of consumers will also be surveyed to identify if and how the peer and parent peer's psychiatric support work impacted their loved one and the family in accessing or navigating psychiatric care, and engaging in services effectively.

OUTCOME 3: No-shows for MOST telepsychiatric appointments are lower than rates compared to the existing telepsychiatric services in county, as a result of this project's strong peer support component/care coordination. This will be compared to the existing medical model group to observe any differences between the two models.

- The goals of reducing no-show rates to telepsychiatric appointments as a result of the MOST program can be compared to a similar existing program within Kings County. The MOST program predicts that the project's strong peer and family component can reduce no-show rates, and be measured against the comparison group. Tracking no-show rates for the current 68 hours of telepsychiatric services offered via Kings View will be compared to the rates for the MOST program's consumer rates to determine if the use of the peer to provide support, education, engagement, and advocacy yields a lower no-show rate than one without. Surveys will also be conducted with consumers/family members to measure how much, if any, they perceive the peer support has assisted their treatment. For the qualitative aspect,

consumer interviews shall be conducted to ascertain if the peer support was a factor in their "show" as well as what specifically assisted them (follow-ups, advocacy, moral support, etc.).

OUTCOME 4: Transform the telepsychiatric services from a medical model to a wellness and recovery-based model of care.

- *Consumer satisfaction and perception surveys shall be completed by participants in the existing/current psychiatric system and by the MOST program participants. The survey will determine how participants rate their experience, and if the peer aspect did or did not play a role, and if they feel they received the traditional medical model of care or care based on a wellness and recovery approach.*

TWO: *Can sharing of telepsychiatric services with other local service providers (including community-based providers) improve coordination of care and outcomes of program participants*?

OUTCOME 1: Consumers are able to transition to a lower level of care as a result of better care coordination. This will be achieved through comparison with an existing services group that receive psychiatric services without peers and through a single provider.

- Using our shared electronic health record, the project shall track and measure how many MOST consumers transitioned to a lower level of care (either through the frequency of psychiatric appointments change in programs, as well as transitioning to lower systems of care) compared to those in the comparison group.

OUTCOME 2: Wait times to see psychiatrists for initial and follow-up appointments are reduced compared to current wait times.

- Currently, the existing psychiatric services provided in Kings County by Kings View Counseling Services, a contracted provider, all psychiatric services in the county. In January of 2018, Kings View served 428 unduplicated individuals. There are only 68 hours of services a week (272 hours of care a month) for psychiatry. These limited hours of service is due to limited capacity and costs for the current provider to contract with a psychiatrist. This results in current wait times of 25.6 days to access a psychiatrist. Having an existing and separate program allows for a comparison group to be established throughout this evaluation and project.

- The increase in access can be measured quantitatively through tracking the length of time from referral to the initial appointment in the shared EHR. The project will be able to examine current standards, and then the changes occur each year. With the shared telepsychiatric services located at several county locations demonstrating a reduction in wait time to access, this provides a model of shared services and locations for improving access and reducing wait times. It will also demonstrate how often consumers can access care (as often with psychiatric treatment medications do need to be adjusted).

OUTCOME 3: Number of mental illness crisis hospitalizations reduced for participants in the MOST program.

- Lowering the number of mental illness crisis hospitalizations is an objective of this project. This is something that is measurable. This would be a quantitative review of historical, current and future data. Looking at the existing data prior to the inception of the program, and then assessing how the additional hours, more timely access, and shared/coordinated care has resulted in the reduction of the number of crisis hospitalizations or not by consumers in the MOST Program. This would be compared to those receiving services in the comparison group. The data would be available through the shared EHR, as well as specific tracking to crisis hospitalizations before and after the inception of the program.

OUTCOME 4: Number of individuals seen by hospital emergency departments for mental illness reduced over the term of the project.

- Some of the variables to consumers accessing services at the highest level or at the most costly level include a lack of local resources, lack or limited access to appropriate care, the effectiveness of the care in engaging the consumer, and also coordination of care for consumers. A comparison of existing and future data can provide a quantifiable assessment of the MOST program's ability to yield lower numbers of emergency department visits for mental illness by connecting consumers to services sooner, and providing follow up coordination of care for those at risk of emergency department visits due to a lack of appropriate care. Working with our local hospital and emergency department (ED), ED visits for mental health can be tracked and compared to those who are received services or have not been able to access appropriate care. The number of ED admissions for crisis is documented by the county's only hospital (Adventist Health). The data is currently tracked by the hospital and shared with the County through the current Whole Person

Care initiative. This existing data source would be shared with the evaluation team.

OUTCOME 5: Number of individuals with mental illness who return to jail reduced as a result of participation in the MOST program.

- Access to timely, coordinated person centered psychiatric care may decrease the number of individuals with mental illness who reenter jail. Working with the Kings County Sheriff's Department, as well as the contracted in-custody health provider, NaphCare, those entering custody can be identified. Consumers can be identified through assessments or existing records if they are an existing consumer or have a mental illness, if they have received services previously for a mental illness and if the cause of their entry into the jail are associated to mental health. This data is already collected by the jail and can be monitored and compared with data in our EHR over the course of the program, the data should show whether the availability of additional Telepsychiatry services and the shared resource by providers is resulting in a lower number of consumers reentering the jail due to an issue caused by untreated or undertreated mental illness or those who have previously been involved with the jail (highest level of care, and not one that is based on wellness and recovery).

The increased access to services, more timely services, improved care coordination and system transformation may be replicated within other small, and/or rural portions of counties that currently have telepsychiatric services. This project may establish a model for opening up their services to other community providers so that a higher quality of care can be provided through shared health records and shared resources. By collaborating and sharing a key but often costly or limited resource, providers can improve care and work to move consumers to more appropriate levels of care based on their individual needs.

Contracting Evaluation

Kings County Behavioral Health will contract with an external evaluator (a third party) through a Request for Proposal to provide an independent evaluation of the MOST program. This will help to measure and determine if the project met its innovative learning goals and how the project performed. Based on the results, this information can be shared and replicated with other counties.

The MOST project will allocate a total of $120,000 for the evaluation component. This will be an allocation of a maximum of $40,000 per year for an independent evaluator to develop some of the rubrics, surveys and interview questions, conduct the qualitative aspects of the measures,

and compile and evaluate the raw data that shall be collected for the purpose of evaluating the project. This would be appropriate for the scope of an evaluator. Kings County has used this similar approach on two previous Innovation Plans, as well as evaluated other programs. The cost a similar range that the county has funded for other innovation and similar project evaluations in Kings.

Certification

The MOST Innovation plan that is being submitted to the MHSOAC was a part of Kings County's MHSA Three Year Plan for 2017-2020. The innovation plan was developed in conjunction with the overall plan and as such has already fulfilled all the requirements for institutional reviews. Kings County submitted the concept paper initially with the 2017-2020 MHSA Three Year Plan.

The plan was initially approved by the MHSA steering committee. It was then posted for a 30-day public comment period. In that time the posting was available at all local libraries, the department's website, as well as notices that ran for seven days in the local newspaper. During that time, a public hearing was held (January 22, 2018). The overall plan which including the MOST Innovation Plan project was presented and the plan was approved by the Kings County Behavioral Health Advisory Board on January 22, 2018. The Kings County Board of Supervisors approved the MHSA Plan (that included the Innovation component) on January 23, 2018.

The Kings County Behavioral Health Director, Lisa Lewis, PhD, then certified the approved plan along with the County's Auditor and submitted to the MHSOAC on February 6, 2018. The current MHSA plan has been posted to the department's website since January 31, 2018.

Kings County submitted its Annual MHSA Revenue and Expenditure Report (ARER) for FY 2016/17 on January 29, 2018 and continues to strive to submit its required reporting in a timely manner.

Community Planning

The MOST Project was part of the County's MHSA Three Year Plan development.

The MHSA planning process utilized twelve key informant interviews which included stakeholders from the community; Consumer/Family Members, Owens Valley Career Development Center, Santa Rosa Rancheria Tribal Social Services, Executive Director of a local Substance Use Disorder provider, Kings Community Action Organization, one of the Mental Health Plan contracted providers, two school district Assistant Superintendents of Special Services, the Kings County Veterans Service Officer and their Veteran Services representatives, the Public Guardian, a member of Kings County Board of Supervisors, Assistant Director for the Kings County Human Services Agency (Child Welfare Services), a local School Resource Officer, and the Deputy Director of Public Health.

There were also three community focus groups (including two in rural and predominantly Latino communities). Two of those meetings were facilitated in mostly in Spanish.

A steering committee of 23 members was also assembled to participate and met on three different occasions (over 24 hours total) in an effort to review the current MHSA plan, review the needs assessment and develop the new MHSA Three Year Plan, which included the MOST project under the Innovation Plan. The steering committee including members of the Behavioral Health leadership, County department leadership (Human Services-Child Welfare, Probation Department, Sheriff's Department, Public Health, Public Guardian, Kings County Veteran Services Office), Kings County Office of Education (SELPA Director), as well as community members representing local Native American communities (via Owens Valley Career Development Center and the Santa Rosa Rancheria Tribal Social Services), consumers and peers, local hospital, faith communities, African American community, and the Behavioral Health Advisory Board.

The final MHSA Three Year plan was developed by the stakeholder steering committee. The stakeholders identified the need for additional psychiatric services and that such services would be imperative to support several new initiatives in the Three Year Plan. The initiatives would seek to reduce services being rendered at the highest level (hospital emergency departments and criminal justice institutions) due to the lack of timely access to psychiatric care or care coordination. The steering committee identified the need for more psychiatric services to meet the demands, but to also improve service delivery and to support many other efforts to provide services at the community level (instead of jails and hospitals). The sharing of an expensive and scarce resource is a way to increase access, expand services, coordinate care, and move consumers to the level of care that met their own goals. Telepsychiatry allows for the challenges of schedule, location and geography to be reduced if not eliminated.

Fifty-one (51%) percent of Kings County's population is Latino, and, of those, over 30% are Spanish speaking. In addition to having a majority Latino population, Kings County has close to 13,000 Veterans who reside in this small rural county. Additionally, Kings County is home to the Tachi-Yokut tribe (at Santa Rosa Rancheria). Kings County made an effort to ensure individuals who are from those communities, work in those communities or whom represent those underserved, unserved, or inappropriately served communities were involved in the planning process from the key informant interviews, community meetings in their communities and also represented on the steering committee.

There was input during the planning process as well from the transition age youth (TAY) who were members of the then current Innovation Project (Youth Researching Resiliency). The youth who have been involved with participatory action research assessing the current system of care in Kings County for TAY provided some of their findings, research and recommendations. This ensured a robust voice of local TAY in the planning process.

Kings County contracted with Resource Development Associates (RDA) to assist in the development and completion of the Three Year Plan. RDA assisted Kings County with its two previous MHSA Three Year plans, and is the evaluator on the recently completed Innovation Plan. RDA conducted the needs assessment and stakeholder interviews, as well as facilitated the steering committee meetings. As part of its work, RDA provided education and resources on MHSA, the various regulations related to MHSA, criteria for the various funding components, and what can and cannot be supported by various MHSA Plans.

The MOST Program, which was included in the 2017-2020 MSHA Three Year Plan, successfully completed an initial 30-day public comment process without any challenges or feedback for changes to the Innovation Plan.

Kings County performed additional stakeholder focus groups for this project. On June 19, 2018, Kings County conducted a focus group with the Family Support Group. A focus group with consumers of psychiatric services was held at the Oak Wellness Center on June 20, 2018. Additionally, a Public Hearing was held on June 25, 2018 with the Kings County Behavioral Health Advisory Board. These efforts were made so that actual stakeholders, service users, and peers could be engaged and provide input as called forth in Title 9 California Code of Regulations 3315.

Kings County performed a Study Session for the Kings County Board of Supervisors (BOS) on June 26, 2018. The full plan, which has been submitted, to the MHSOAC was presented to the BOS. The BOS was satisfied with the update and opted not to have the plan submitted for re-approval.

Primary Purpose

The MOST Program is to increase the quality of telepsychiatric care from one that is based on a medical model to one that is based on a peer staffed wellness and recovery model.

Innovative Project Category

The MOST Program best fits with the innovation definition of *"Making a change to an existing practice that has not yet been demonstrated to be effective, including but not limited to, adaption for new setting, population or community"*. Our efforts to transform psychiatric care to a wellness and recovery-based model through the inclusion of peers on the treatment team is new and innovative. Sharing of the resource with other community partners allows for better collaboration of care. These types of efforts have never been implemented. The initial implementation will demonstrate effectiveness with clear outcomes compared to a comparison group.

Population

The focus of this project shall be all Medi-Cal eligible consumers who are in need of psychiatric treatment services. The goal of the program is to seek to provide psychiatric services to those who may be engaged in care, but may have barriers that prevent access to psychiatric care. At the end of the three years, the project seeks to have expanded psychiatric services through the shared telepsychiatric suites to an additional 256 residents of Kings County.

Cultural Competency/Humility

Kings County Behavioral Health seeks to be responsive to all persons being served. Cultural Humility is a vital aspect of all services rendered by Kings County Behavioral Health.

It is this deep commitment to cultural humility which led to the realization that psychiatric services provided without a strong peer or family component is missing the deep knowledge of lived experience and leaves consumers to navigate these experiences alone. We seek to provide connections and information through peer support to all consumers.

Additionally, this commitment to cultural competency and humility is reflected in the trainings that are offered throughout the county. These efforts ensure all service providers adhere to Culturally and Linguistically Appropriate Service (CLAS) standards, as well as develop programs and services that are responsive to the communities they serve with input from those communities.

Kings County has had a heavy involvement with cultural competency and cultural humility efforts. Its seasoned Ethnic Service Manager (ESM) serves on the County Behavioral Health Directors Association (CBHDA) Cultural Competency, Equity & Social Justice Committee (CCESJ) executive committee and is one of the Central Region's CCESJ Committee Co-Chairs. The Kings County EMS is one of only three EMS's statewide selected to be part of the AB 470 workgroup. This workgroup addresses the area of cultural competency/humility and has provided support on several early California Reducing Disparities Projects through the California Mental Health Services Authority. Kings County has often been commended in its Tri-Annual Reviews for its efforts in being culturally responsive and engaging communities.

The MOST project is seeking to ensure services are available to our most vulnerable and underserved communities. The sharing of telepsychiatric services in the planned locations (Hanford, Avenal and Corcoran) ensure services are being taken to our culturally and geographically isolated communities. Our efforts to staff the program with bilingual and bi-cultural staff and peers highlight our awareness of some previous barriers to care. It is the intention of Kings County to leverage its outreach and education efforts as well as its Cultural Ambassador program (which is based on a *Promotores de Salud* model) to engage the community and providers to ensure the services can be rendered in the most culturally

responsive and non-stigmatizing way. The Promotores model uses lay community health workers who are trained on various health related topics to provide grass roots education on those topics in Spanish to Latino and Spanish speaking communities.

Research has shown greater stigma around medication and psychiatric care among Latinos. Leveraging other resources such as a Promotores modeled program can improve engagement with certain populations. Utilizing lay community health workers from the community also increases the credibility of the dissemination of the information to the community. The Promotores model has been shown as an effective tool in increasing the health literacy of rural and mono-lingual Latino communities. This effort is sought to normalize mental health treatment, including use of medication treatment.

It is essential that our MOST team is bilingual and bicultural, as 51% of Kings County is Latino. 36% of Kings County residents have reported speaking Spanish at home and 42% of these individuals indicate that they speak English "less than very well."

Kings County Behavioral Health provides mental health services to the unserved and underserved populations of Latinos, Native Americans and Veterans who are unable to be served by other programs. Our county has significant populations of all three groups. It was noted that we have a Latino majority, as well as large monolingual Spanish speaking population. Kings County is home to the Santa Rosa Rancheria. The types of services that are available to local Native American populations are very limited, and often require residents to travel to other counties to be able to access psychiatric care. Lastly, Kings County, while a small county, has over 13,000 Veterans. Some of these veterans are not eligible for services at the Veteran Administration (VA) in Fresno, and services at the Naval Hospital at NAS Lemoore are restricted to only active duty military personnel. Others who may be eligible for VA services are unable to access the services from the VA hospital in Fresno due to distance (a minimum of 35 miles, and 45min drive and transportation challenges). We can offer them telepsychiatry services through trained staff who have an understanding of cultural humility as it relates to veterans as well as wellness and recovery.

Ensuring the Receptionist, Psychiatric Technician, Peer Support, and those who provide the services are bilingual is a commitment to that understanding of cultural responsiveness, to those who are bi-cultural. We are committed to and practice supporting on-going efforts to address understanding of culturally responsive efforts. These have and will continue to be addressed through various trainings, such as: *Another Kind of Valor* (for working with Veterans and their families) and facilitated by a licensed clinician who is also a veteran. *Historical Trauma* training for those working with Native Americans (which we have coordinated in collaboration with the Santa Rosa Rancheria Tribal Social Services Department in previous years), the County's Cultural Ambassador program (which will use a *Promotores* model approach to address stigma and mental health awareness in Spanish speaking Latino

communities), as well as other future efforts which will include ethno-psychopharmacology for providers and families. Past efforts have included trainings for those working with foster youth through the California Youth Connection. We also have partnered with an area LGBTQ Center (The Source) to provide an array of trainings and support focused properly serving LGBTQ youth, adults and older adults who may access the MOST program.

MHSA Standards/Values

The MOST project speaks to all five of the MHSA values. We believe this is demonstrated below.

Community Collaboration- The MOST project seeks to collaborate with multiple providers in the County to ensure timely access to the appropriate level of care for Medi-Cal eligible residents. As mentioned earlier, most local providers do not have the funding or the capacity to contract for their own psychiatric services, thus allowing for many to fall through the cracks or defaulting to more restrictive, costly, higher levels of care which not always effective. The sharing of very limited and costly resources through this project shall expand and enhance the continuum of care.
Integrated Service Experience- The MOST program will allow for consumers and their families to access the appropriate level of care in a timely manner, while maintaining their current behavioral health provider. If a consumer is receiving services and in need of psychiatric care they would now be referred through the existing network of care, and do not have to seek services outside the existing network. The coordination of care is also improved through the use of the same shared EHR. This is improving access, as well as joining efforts to ensure engagement, and close vital gaps in our current system of care. Shared records and joint care coordination can expedite services and ensure all providers of care to that consumer are aware of the consumer's goals and can support that effort. The inclusion of peers is a means to ensure that we are integrating the vital consumer experience, wisdom and perspective in provision of care. This will be transformational in how services are provided in the future.
Client and Family Service Driven- In the past, telepsychiatric services were implemented in the traditional medical model. However, the MOST project will be to developing telepsychiatric services based on the wellness and recovery model of care. The inclusion of fulltime peer positions in the program ensures that those with lived experience can support consumers, assist consumers in advocating their needs, and change the approach of

service delivery from a directive to a shared vision of the individual consumer's wellness goals.
Focus on Recovery and Wellness-The inclusion of Peer Support in the MOST program and the telepsychiatric services shall improve the consumer and family member experience, especially during what may be their initial entry into the behavioral health system and/or with the psychiatric aspect of care. The lived experience of peers may improve consumer engagement and provide positive role models for wellness and recovery. Peers can assist the consumer is voicing their goals, as well as advocating for the needs of the consumer and/or the family. Peers in this program will be trained and ultimately certified under SB 906 standards, thus making such positions sustainable and allow for greater growth of peer involvement in the behavioral health system. Should SB 906 not be available as a funding/revenue option as anticipated, positions can be supported through the Community Supports and Services (CSS) plans. Peers will serve in a role of a peer support, of a case manager, and as an advocate for the consumer and their families. This will increase the input and involvement of the consumer and their family in not just their care coordination but also in the transformation of the system of care.
Cultural Competence/ Humility As mentioned earlier, understanding and factoring each individual's culture is the cornerstone in how we operate. We understand the diversity in our county and have planned for the implementation of this program to be conducted in a manner that will ensure cultural humility. The inclusion of Peers (persons with lived experience) helps us look at each case individually. Having staff that are bilingual and bicultural in this program is another step in an effort to better support, respond and engage our consumers. Understanding that one-eighth of our population are veterans and/or family members of veterans allows us to respond to their specific needs. We have developed and supported training that helps us better serve and understand our various populations and communities. Collaborating with providers and faith communities who assist specific underserved populations is part of how we render services. We strive to make broader efforts to continually engage, educate and support our diverse communities and establish programs to demonstrate our commitment to ensuring the MOST program is culturally responsive. Lastly, seeking to place telepsychiatric suites in communities that are traditionally underserved and/or inappropriately served speaks to the effort to address the needs of

our community. This program embeds the culture of those with lived experience into services.

Continuity of Care for Individuals with Serious Mental Illness

The MOST program is focused on members of our community with serious mental illness. The program will allow us to launch an effort to expand telepsychiatric services so to increase timely and necessary access to those in greatest need for such services. The coordination of care through this shared resource will allow for the full spectrum of services to be available to individuals. The MOST program will reduce the dependence on the highest level and most costly levels of care (jail and hospitals) for treatment by expanding access to such care in the community. The MOST program will initially share its suite with:

Aspiranet	Offers Full-Service Partnership (FSP) / Wraparound services for children and youth, located in the same building complex as the planned MOST Suite that will house Kings County Behavioral Health's Hanford telepsychiatry suite.
Mental Health Systems, Inc.	Mental Health Systems, Inc. has been identified as the provider of Assertive Community Assessment Team (ACT) services. Mental Health Systems will provide intensive daily engagement using a team approach and an array of integrated services to meet consumer needs. The Hanford MOST suite is located in the same office complex that will house the ACT team, and is less than 50 yards apart. Majority of their ACT teams work will be in the field.
Kings County Public Health Department	A health clinic, located a half-mile from the Hanford telepsychiatry suite, will send people in mental health crisis to the telepsychiatry suite for care, e.g., women suffering from perinatal mood and anxiety disorder. This Department has additional clinics in Avenal, Corcoran, Kettleman City and Lemoore, which will also be able to send patients to our telepsychiatry suites in Avenal and Corcoran in later phases of the program.
Kings County Sheriff's Department	A re-entry program will use telepsychiatry to facilitate the continued psychiatric medication/care of participating adults during and after their re-entry process.

Kings View Counseling Services	Offers the only existing psychiatry services in the county, but more are needed, including for crisis response. The crisis response role of these services will benefit our continuum of care, especially in rural areas where access to care is very limited. Those over flow urgent condition consumers will be referred to the MOST program to reduce wait times.

This program and supporting components will address the needs of the most serious cases in Kings County and support wellness and recovery efforts.

Once the project is implemented, we will have yearly outcome measures and data to evaluate the effectiveness of the model and the outcomes and perceptions of consumers. This data and outcome driven project will then allow KCBH to modify programs and services to be more effective and engaging and make decisions based on actual measures versus conjecture. It allows Kings County Behavioral Health to work with consumers to identify their own wellness and recovery goals, which may include lower levels of care.

The MOST program has being developed with the specific intention of sustainability by the third year. This project will not be dependent on the Innovation funds by the completion of the project. It is our hope to transition to Medi-Cal Federal Financial Participation (FFP) for these services over the program's three years to ensure the long-term sustainability of this service will continue after the completion of the Innovation Plan funding.

Utilizing Medi-Cal FFP will provide our path to sustainability. This innovation plan allows the program to be initiated and to assess its effectiveness, while shifting to a sustainable model early in the program's life cycle. This approach of availing the program to Medi-Cal FFP reimbursement during the project ensures the program can be sustainable, and will also provide us with the ability to project future revenue and opportunities for expansion. The program needs initial capital and time to incubate until it can meet the requirements to effectively draw down other funding revenues.

With the potential of peers being able to bill for services under SB-906, the positions in the MOST program would generate revenue (Psychiatrist, Psychiatric Tech, and Peer) and allow it to be self-sustaining. Should SB-906 not be successful, the peer positions would be funded in the future through other funding (including MHSA). Specifically, peers could be funded through portions of the Community Support and Services Plans, as well as cost savings of other budget units, with a reduction in hospitalization.

A contingency plan will include utilizing the cost savings from less crisis hospitalizations, and transitions to lower levels of care, to be used to support future expansion, or enhancement of the program.

By phase two (year two), with the program being established and to being able to generate revenue through Medi-Cal FFP, the Department would begin explore additional funding. This could include other federal reimbursement, such as criminal justice funding for some participants, and/or funding that could allow for expansions and/or additional specialization of the MOST program.

Project Evaluation, Cultural Competency and Meaningful Stakeholder Involvement

As noted throughout this plan and demonstrated in the Cultural Competency section of this plan, cultural competency/humility is imperative for this program to be successful. There are several key and basic steps to be taken to ensure that the evaluation adheres to cultural competency standards. We shall ensure all evaluation material is viable in the county's threshold language (Spanish) and, if there are additional consumers who need translation of materials in order to participate in the evaluation, we shall coordinate those resources. The evaluator shall adhere to CLAS standards and, as such, have personnel/resources who can translate forms, communicate with consumers, and capture the perception/experiences of the consumers or contract with translation and interpreter services.

Translation of materials shall be completed by a certified translation service, per county policy and best practice. Interpreters may be used when performing consumer interviews to ensure participation, but they will not be family members interpreting. The Kings County Cultural Humility Taskforce will review materials to be used in the evaluation to ensure all relevant demographics are captured; the materials are responsive to the target population and come from a cultural humility approach. Forms/tools may be reviewed by the county's Cultural Humility Taskforce to provide feedback and recommendation to ensure the tools promote cultural humility and appropriate language standards.

Peer involvement is central in this project. From the on-set, peers will be part of the treatment team. Consumers will provide feedback and guidance from their own experiences. Annually, outcomes and evaluations will be formally presented to the Kings County Behavioral Health Advisory Board, which will include family members of consumers, consumers and peers, who will be able to provide direct feedback and input as part of an evaluation sub-committee/workgroup.

Outcomes

It is the hypothesis of the County that sharing of telepsychiatric services with a strong peer component will improve care and change the system to a wellness and recovery based model of care. Should, at the conclusion of the project, the data not support that hypothesis, telepsychiatric services will continue but would be provided in the more traditional model, until

we ascertain what prevented the improved care or system change. Based on the potential to have peers bill Medi-Cal for their services that would remain, as we work to identify why it did not change the system. The value of lived experience would not be removed from the system. It may not be expanded, if not yielding the initial outcome, but it would not be eliminated.

However, if the project demonstrates better care coordination through the shared resource, the County will expand to more communities to set up shared telepsychiatric suites. Kings County Behavioral Health will also work to apply this collaborative approach to more of its other programs.

Additionally, if the use of peers as part of treatment can be demonstrated to be a more effective model and change the service to one that is driven by wellness and recovery, then the county will change the practices within other similar psychiatric care programs to include peers within the treatment team. The project can also demonstrate through data supported evidence the viable role that Peers can and do serve in the overall system of care, and promote greater peer inclusion within the system of care.

Communication & Dissemination

Throughout and upon completion of the project, Kings County will share the findings to date and final recommendations in several ways.

It will provide an annual and final project study session to the Kings County Board of Supervisors to demonstrate how the funds were spent and how the program has supplied a successful approach to psychiatric care. Similar annual and final presentations reports shall be presented to the Behavioral Health Advisory Board. Kings County would also seek to gather all of its mental health providers at the end of the project to share and inform them of the success the program has had and initiate dialog on how peers can be incorporated into other aspects of the care coordination.

To ensure information was reaching the consumers and community, the final outcomes would be shared with various support groups, as well as local outreach and education programs, where the approach can be shared with consumers. Kings County will seek out to utilize both local and regional press to share how, through this Innovation Plan, it was able to change how services were rendered and improve services for consumers.

Kings County will coordinate with its evaluator opportunities to present at conferences, such as the NAMI California Conference, California Association of Mental Health Peer Run Organizations, a CBHDA/CiBHS Policy forum or other professional conferences to share its findings. This would increase the number of consumers, peers, advocates and providers who could learn of a new system change approach to care.

Lastly, we would seek to share the information with the MHSOAC through its county spotlight.

Consumers and peers will be essential in sharing the successes of the project. Peers and consumers will be provided with information as mentioned and encouraged to share it with other peers, families, and support groups. Having consumers and peer staff conduct panels at conferences, NAMI gatherings or to professional groups where their testimony, in a structured manner, would work to dispel biases and stigma associated with mental health care. The County would seek opportunities for peers to share this approach with students in the Psychiatric Technician program at West Hills College, as well as local primary care providers and health care providers. In addition to the Kings County Behavioral Health Advisory Board, local coalitions such a Kings Partnership for Prevention would also be great venues for local stakeholders and peers to share the successes of the program. Peer groups, NAMI, family support group, peer workers, etc. would also be able to access the reports and presentations from our website where they could explore opportunities to pilot similar efforts.

Five Phrases Summarizing M.O.S.T. Project

- **Shared Telepsychiatric services**
- **Peer Support Tele-psychiatry**
- **Psychiatric care coordination**
- **Wellness and recovery in telepsychiatry**
- **Peers in treatment teams**

The following five (5) phrases would summarize this project if someone were searching a database, archive or internet search engine:

Timeline

The MOST program will operate for three years (or 36 months). Timeline will be broken into 12 three-monthly quarters.

In the ideal situation, the project would coincide with a fiscal year. However, due to circumstances beyond its control, Kings County is seeking to have the program begin rendering services January 1, 2019. We would seek to conduct pre-implementation phase as soon as the plan is approved, implementing the program.

Pre-Implementation Phase (from approval to January 1, 2019).

- Purchase telepsychiatric equipment.
- Contract with psychiatrists to provide the telepsychiatrist (via a sole source authorization).
- Begin recruitment for existing positions within the County's system.
    - Hire positions needed for the MOST program.
- Issue a Request for Proposal for an Evaluator and complete the contracting prior to start of services.
- Develop peer navigator positions with the County's Human Resource Department.
- Through a Request for Application or Request for Qualification, begin recruiting for peer navigator and parent peer navigator.
    - Complete contracting with peer professionals (2 peers each working 20hrs a week).
- Establish protocols for care coordination (multi-disciplinary teams, consents and shared releases of information, schedules, referral process).
- Coordinate trainings prior to commencement of services.
    - Trainings on HIPAA, billing, cultural humility, medication, wellness and recovery, documentation, and best practices in telepsychiatry.

Initiate. January 1, 2019 Quarter 1.

Begin first phase of telepsychiatry out of the suite located at 460 Kings County Drive in Hanford.

- Monday and Wednesdays for children and TAY.
- Tuesday and Thursday for adults.
- Outreach and education on referral process to all other providers and/or possible referring agencies.
- Evaluators begin collecting initial perception surveys, establishing baselines and benchmarks.
    - Begin collecting all consumer data.

  - Enroll participants into the evaluation.

April 1, 2019 Quarter 2

- Complete the training for the MOST staff.
- Review the first quarter of care coordination with participating service providers.
- Review billing and address any changes to ensure appropriate billing.
- Complete the initial baseline data for the program.

July 1, 2019 Quarter 3

- Have the positions of peers/parent peer and any others approved by the Board of Supervisors and have those contractors become fulltime county employees for second year/phase two that will increase their hours by another day.
- Begin Medi-Cal certification for satellite in Avenal for Phase 2.
  - Initially, the Avenal MOST suite may be in a shared building with Public Health, until the completion of a new county One Stop that will house the telepsychiatry services in the future.
- Review referrals, protocols and care coordination thus far with providers sharing resource.

October 1, 2019 Quarter 4

- Complete recruitment for Peers (2 FTEs) and any other positions.
- Continue training for treatment team.
- Establish schedule for Phase Two in Avenal.
  - One day for children and TAY.
  - One day for adults.
- Conduct community outreach, education and medication literacy for primarily Spanish speaking residents of Avenal.
  - Utilize current outreach team, as well as other programs such as Cultural Ambassador.
  - Address issues of stigma around medication and mental health.
  - Address cultural barriers prior to rendering of services in Avenal.

- Coordinate access to pharmacy and medication. If local pharmacy not available, establish agreement with a pharmacy outside of the city and a courier service to deliver medications to consumers.
- Begin efforts to request an additional psychiatrist to provide 16 hours of service for the Avenal Suite.

PHASE 2: January 1, 2020 Quarter 5

- Begin providing two days of tele-psychiatry service in Avenal (one day for children and TAY and one day for Adults).
- Work on completion of the first year of data, and report.
- Prepare year one report for the OAC.
- Begin evaluation and development of baseline data for services in Avenal
- Continue to evaluate the program suite in Hanford.
- Continuous training of program staff.
- Continue quarterly meetings with all service providers to assess the coordination of care.
- Begin engagement with West Hills College on training students for Telepsychiatry, working with populations and peers to grow the local workforce pool trained in Wellness and Recovery.
- Begin work with human resources and Behavioral Health fiscal team based on projected Medi-Cal revenues for an additional two peers and psychiatric technician to support phase three (with those covering the Avenal Suite and Corcoran Suite). Phase 3 will provide four days of service in Hanford and four days at satellite sites (two days in Avenal and two days in Corcoran).
    - Include positions in the FY 2020/2021 budget.
- Apply for Medi-Cal certification for the Avenal One-Stop and also Corcoran satellite location.

April 1, 2020 Quarter 6

- Review the Medi-Cal revenues and plan for transition to fully bill Medi-Cal.

- Continue to have quarterly care coordination assessment meetings to identify challenges, and opportunities for improvement.

July 1, 2020 Quarter 7

- Begin recruiting for additional staff.
    - 1 FTE Psychiatric Technician.
    - This additional staff will cover the Avenal Suite 2 times a week and eventually two days at the Corcoran location. This is needed as the existing psychiatric technician will be rendering direct services four days a week at the Hanford location and unable to be at the other locations.
- Begin outreach, education and medication literacy for residents of Corcoran prior to rendering the MOST program.
- Evaluate the Medi-Cal revenues to date and projections for the rest of the Fiscal Year.
- Begin exploring other funding streams, such as Tri-Care for military families and veterans.

October 1, 2020 Quarter 8

- Establish any necessary agreements with pharmacies in Corcoran, and or courier services if medications have to be delivered to consumers or to the tele-psychiatry suite in Corcoran.
- Hire and train additional staff (if the demand warrants it and Medi-Cal funding supports the expansion).
- Establish the service schedule for Corcoran.
- Recruit and contract with a psychiatrist for two days (16hrs) of service at Corcoran site.
- Continue to conduct outreach and engagement with local community.

PHASE 3: January 1, 2021 Quarter 9

- Complete year two reports and evaluation.
- Submit report to the OAC.

- Begin providing services two days a week in Corcoran (with one day for adults and one for children and youth).
- Continue to provide services twice a week in Avenal (one day for adults one day for children/youth).
- Continue to provide services four times a week in Hanford (two days for adults and two days for children/youth).
- Begin data collection and participant evaluations of consumers in Corcoran.
- Continue to have quarterly care coordination meetings for system improvement.

April 1, 2021 Quarter 10

- Continue to monitor revenues from Medi-Cal, identify any trends or opportunities for continued sustainability.
- Be fully funded by Medi-Cal and/or other funding revenues not associated with the Innovation Plan.
- Continue to explore options of becoming a Tri-Care provider.
- Begin collaboration with County Admin on additional funding that may allow for expansion of days, hours or locations.

July 1, 2021 Quarter 11

- Begin assessment and comparison of the project to the existing service.
- Begin to assess two years of data and evaluation as well as the last six months.
- Review the primary goals of the program plan and see if successful.
    - If successful, begin working on plan to disseminate the information.
- Explore options through non-Innovation funds to expand services, if demand requires.
- Explore a future suite in Lemoore, if revenues from Medi-Cal or other sustainable streams are available.
- Compile recommendations based on data on how to change other programs within the county's system of care to implement successful aspects of the MOST Program.

October 1, 2021 Quarter 12

- Begin completion of the final report and evaluation of the program using 2.5 years of program reports and data.

- Expand hours of services based on demand, if necessary, at any of the existing locations.
- Begin plans for moving all telepsychiatry services in the county to include peer involvement (if the program measures and outcomes are successful).
- Prepare final report.
    - Final Report to be submitted to the OAC.
    - The Kings County BOS.
    - Kings County Behavioral Health Advisory Board.
    - Local press and media.
    - Other viable outlets for sharing the lessons learned.

CONCLUSION

- Based on final outcomes, if supported by the hypothesis:
    - Seek out and share with local media;
    - Utilized consumers and peers to promote the approach;
    - Explore opportunities to present project at conferences, summits, and other professional venues;
    - Begin implementing peer component into the existing (control group) telepsychiatric programs; and
    - Share or assist any other counties or providers who may seek to implement similar collaboration and/or peer components in their telepsychiatric services.

Budget Narrative

This Innovation Plan, if approved, shall meet the expenditure of funds that would be subject to revisions under assembly bill (AB) 114. This Innovation project shall be implemented under Innovation funding from Fiscal Year (FY) 2010/11 through 2016/17. Based on the county's Annual Revenue and Expenditure Reports (ARER), the available funding for this Innovation Plan is $1,663,631.

Fiscal Year (FY)	Innovation Funding
FY 2010-11	$127,786

FY 2011-12	$0.00
FY 2012-13	$182,585
FY 2013-14	$254,599
FY 2014-15	$361,361
FY 2015-16	$300,063
FY 2016-17	$377,404
Interest	$59,833
TOTAL	**$1,663,631**

For this project, Kings County is limiting use of Innovation funding for the direct services of the program, and will leverage other and existing resources to limit the impact on the Innovation funds.

The project will cost $2,138,631 over three years. We are seeking approval from the MHSOAC for $1,663,631 of Innovation funding. The difference will be made up through revenues generated through a Medi-Cal FFP and MHSA CSS funds in the final year.

Treatment Team/Personnel

- ***Psychiatrist:*** It is the intent of Kings County Behavioral Health to contract directly with experienced and quality psychiatrists. The use of telepsychiatry will address part of the shortage of psychiatrists in the region. This program has the ability to contract with psychiatrists who are familiar with telepsychiatry and who have established histories of quality service delivery. Kings County has also examined third party telepsychiatric services and sought input from other counties on providers they would recommend (including Colusa County, Alpine County, and Madera County). In the initial phase, there will be one psychiatrist providing two days (16hrs a week) to adults. A second psychiatrist will provide two days of care (16hrs a week) to children. Initially, the four days shall be at the Hanford location.

- ***Peer Support Specialist/Parent Peer Support Specialist.*** This program shall have both a Peer Support Specialist and a Parent Peer Support Specialist (for children), to provide the peer component of the program. The Peers will initially be part-time contracted workers working 20 hours, until the job classification of Peer Support Specialist can be developed, approved and established within the County's system. Once that is achieved and additional days are needed with phase two, the Peers will be fulltime county employees (that will allow them to provide 32 hours of direct services and eight (8) hours of other non-telepsychiatric services). Peers would be examples of resilience and recovery to new consumers and to the overall system of care. The Peers will be required to have specialized training as peers and meet the Peer Certification criteria called forth in SB 906. Peers shall receive training to ensure understanding of

pharmacology, confidentiality, cultural humility, best practices and case management services. Peers will have their own designated workspace to allow for completion of their duties. The Peers would be bilingual (Spanish), to meet the county's threshold language needs. As part of the recruitment, screening and hiring process, bilingual speaking skills will be evaluated.

Peers would provide advocacy to consumers and their families during psychiatric appointments and will sit in on psychiatric appointments, if requested.

The MOST program shall seek out peers with lived experience.

Peers/Parent Peer Support Specialist shall have at least six months of lived experience, have worked as a peer in some peer support setting for at least one year, and either meet the SB 906 peer certification criteria or completion of thirty (30) or more credit/contact hours approved by the U.S. Psychiatric Rehabilitation Association, Certified Psychiatric Rehabilitation Practitioner course, certification, or transcripts.

The Parent Peer Support Specialist does not have to have a child currently receiving services to be eligible for employment, but rather the lived experience.

Kings County would evaluate any peer applicant who may have prior criminal justice involvement the same as it does with other employees who perform similar duties in similar classifications. Criteria will be developed with the County's Human Resource Department as part of the creation of county job classification.

Additional training, such as Mental Health First Aid, Applied Suicide Intervention Skills Training (ASIST), SafeTALK, ethnopsychopharmacology, cultural humility (Health Equity & Multicultural Diversity Training) and other skills will be offered by the County.

Once these become county positions, peers shall have access to the health benefits provided by the county to all employees to assist in their on-going wellness efforts, as well as the county's Employee Assistance Program (EAP), which can also be utilized to assist their own on-going wellness and mitigate challenges they may face. The team will be supervised by a Behavioral Health Program Manager, who will regularly meet with contractors/staff. Kings County Behavioral Health is a supportive and accommodating work environment.

Initially, contracted Peers will work a maximum of 20hours a week. By phase two and three, Peers will work up to forty hours a week. Each will have two days of clinic hours, where they will meet with consumers, providing orientation to new consumers and their families, sitting in on sessions, and possibly providing transportation. One peer will be assigned to adults and a Parent Peer to children/parents. In the first year, the peers

will have two days (16 hours) of direct services, and four hours a week without seeing consumers in the clinic. The hours will be used for training, case staffing, care coordination, documentation, outreach, linkage and evaluation participation. As the program moves into phase two, they will have 24 hours of clinic work (with an additional day in Avenal) and two days providing other support services, care coordination, etc.

By phase three in the third year, the Peers would have four days of clinic work (two days in Hanford, one in Avenal and one in Corcoran) with a day of office work, staff meetings, training, and other coordination.

The salaries proposed for Peers would be higher than those for the same position in other area/neighboring counties.

- ***Psychiatric Technician:*** Apart from the contracted psychiatrists, the treatment team will include a psychiatric technician (to take vital statistics, send prescriptions to pharmacies and administer certain forms of medications).

  The local West Hills College-Lemoore has a fully functioning Psychiatric Technician program, thus making it easier to recruit from a pool of bilingual and local Psychiatric Technicians. Under California Professional Code Section 45002(a*) Psychiatric Technicians have direct responsibility for administering or implementing specific therapeutic procedures, techniques, treatments, or medications with the aim of enabling recipients or patients to make optimal use of their therapeutic regime.* Professional Code Section 45021 and 4502.2 allow for a Psychiatric Technician to administer medication by hypodermic injection when prescribed by a physician or surgeon and withdraw blood.

  Psychiatric Technicians are able to bill Medi-Cal at the same rates as the psychiatrist for the services they will provide in the MOST program, which will provide revenues to support and sustain the program.

  Initially, the psychiatric technician may be a contracted position until a position is developed and established by the County's Human Resource Department for the County. The possibility of utilizing other health positions may allow the Department to hire a psychiatric technician from the initiation of the project with existing job classifications. The position shall require candidates to be able to speak Spanish (and will be evaluated by the Human Resource Department as part of the screening and hiring process and shall meet other county established criteria for such a role).

  Psychiatric Technician will provide four days (32 hours of direct services) with an additional day a week used for staffing, trainings, documentation, etc.

For phase two and three of the project, an additional (second) Psychiatric Technician will be needed and may be hired as a contractor or as an additional FTE based on revenues that are generated under Medi-Cal and subject to demand.

- ***Office Assistant/Support Staff****:* The MOST Suite will have its own office assistant. This will be one FTE specifically for the MOST Suite in Hanford. The position will require the office assistant to be bilingual in Spanish, to ensure effective communication and interaction with consumers and family members. The office assistant shall assist consumers, as well as the peers and psychiatric technician, with scheduling appointments, processing referrals, and conducting reminder calls.

Salaries

*2 Contracted Psychiatris*t The projected cost for two contracted psychiatrists working a total of 32hrs a week will be $307,200 for the initial year. The cost would increase for the second and third year due to increased hours, for a total 48hrs a week. The projected cost for the psychiatrists would be $460,800 for each of the final two years. Total for the project is $1,228,800.
2 FTE Peer/Parent Peer. These positions would start out, as mentioned, as contracted positions and, by year two, become fulltime county positions. In the first year, the program shall contract with peer and parent peer a maximum of total of $50,000. This will initially be for 20hrs a week (at a rate of $20 per hour). The cost of two full time employees (FTE) would be $98,000 ($49,000 per peer FTE position). This salary will be for year two and three of the project. Each of these positions would be in the range of $16-17.00 per hour. Total of $ 246,000 for the project.
1 FTE Psychiatric Technician- The cost for the initial year will be $73,000 for a contracted psychiatric technician working 40hrs a week. By the second year, we seek to have the Psychiatric Technician be a FTE with the county at the same rate. Total of $ 219,000 for three years.
Part-Time Contracted Psychiatric Technician. This would be via a contractor and have projected $41,000 to cover the costs of a part-time psychiatric technician working up to 24hrs a week. The cost for the part-time Psychiatric Technician would not start until year two. The total project cost for a part-time Psychiatric Technician $ 82,000.
1 FTE Office Assistant- is $36,000 a year for a project total of $108,000.

Operating Expenditures and Non-Recurring Expenditures

Direct Operating Cost- for this project, main operating cost is related to information and technology. Specifically, to costs for our own county technology support for the suites and costs for various internet connection and rates necessary to operate telepsychiatric services. This funding will also cover licensing costs for the EHR for additional staff. This is estimated at $5,200 per year for a total of $15,600.

Non-Recurring Expenditures

Telepsychiatric Equipment- an estimated $10,000 for the telepsychiatric equipment is needed for the three suites and the providing psychiatrists. There is an additional $10,000 projected for the furniture, to ensure all the suites have proper workstations and waiting areas. These shall be one-time initial costs to allow for the roll out of the program. Total $20,000.
Consultation Cost- Allocation of $10,000 for work with consultants to provide technical assistance to ensure medication storage meets all state and federal safety, security and oversight requirements. Once this process is established and training is completed, the need will not continue for technical assistance and can be shifted to our own quality assurance team.
Computer/Technology- One-time expense projected at $5,000 to secure smart phones, laptop and other necessary technology for the treatment team.

Consultation Costs

Evaluation- We have allocated up to $40,000 per year for an independent third party evaluator. Based on experience with evaluators for similar size programs, we have found that the amount allocated will be competitive and will meet the needs of an evaluator. In total, $120,000 will be allocated to evaluate over the duration of this program.

The projected cost of the program is $2,138,631 for the three years. The total Innovation funding for this project is $1,663,631. We are seeking to offset the cost of the project by utilizing Medi-Cal FFP funds in years two and three and anticipate developing $325,000 in revenues, which will ensure that the cost of the program is covered.

We anticipate the program to cost approximately $754,000 annually, once fully operational. The program will be sustainable by the end of the Innovation term, through revenue

opportunities through Medi-Cal Federal Financial Participation (FFP) in the area of $325,000 during this project. The estimated amount is low, but there is potential for higher revenues as the program and services become established. Additionally, the county will utilize MHSA funding and/or cost savings from other programs to offset the $150,000 difference between the FFP funded portion of the MOST program and the actual cost of the program in the future. The MOST program will be a sustainable program for the County.

Budget

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 18/19**	**FY 19/20**	**FY 20/21**			**TOTAL**
1.	Salaries	**$466,200**	**$708,800**	**$708,800**			**$1,883,800**
2.	Direct Costs						
3.	Indirect Costs						
4.	Total Personnel Costs	**$466,200**	**$708,800**	**$708,800**			**$1,883,800**
OPERATING COSTS		**FY 18/19**	**FY 19/20**	**FY 20/21**			**TOTAL**
5.	Direct Costs	**$5,200**	**$5,200**	**$5,200**			**$15,600**
6.	Indirect Costs						
7.	Total Operating Costs	**$5,200**	**$5,200**	**$5,200**			**$15,600**
NON RECURRING COSTS (equipment, technology)		**FY 18/19**	**FY 19/20**	**FY 20/21**			**TOTAL**
8.	**Telepsychiatric Equipment**	**$10,000**					**$10,000**
9.	**Telepsychiatric Suite Furniture**	**$10,000**					**$10,000**
10.	**Staff Technology**	**$5,000**					**$5,000**
11.	Total Non-recurring costs	**$25,000**					**$25,000**

CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 18/19**	**FY 19/20**	**FY 20/21**			**TOTAL**
12.	Direct Costs	**$50,000**	**$40,000**	**$40,000**			**$130,000**
13.	Indirect Costs						
14.	Total Consultant Costs	**$50,000**	**$40,000**	**$40,000**			**$130,000**
OTHER EXPENDITURES (please explain in budget narrative)							**TOTAL**
15.							
16.							
17.	Total Other Expenditures						
BUDGET TOTALS							
Personnel (line 1)		**$466,200**	**$708,800**	**$708,800**			**$1,883,800**
Direct Costs (add lines 2, 5 and 12 from above)		**$55,200**	**$45,200**	**$45,200**			**$145,600**
Indirect Costs (add lines 3, 6 and 11 from above)							
Non-recurring costs (line 11)		**$25,000**					**$25,000**
Other Expenditures (line 15)							
TOTAL INNOVATION BUDGET		**$546,400**	**$754,000**	**$754,000**			**$2,054,400**

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures <u>for ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18/19**	**FY 19/20**	**FY 20/21**			**TOTAL**

1.	Innovative MHSA Funds	0	0	0			0
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**						
EVALUATION:							
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18/19**	**FY 19/20**	**FY 20/21**			**TOTAL**
1.	Innovative MHSA Funds	**$40,000**	**$40,000**	**$40,000**			**$120,000**
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**	**$40,000**	**$40,000**	**$40,000**			**$120,000**
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18/19**	**FY 19/20**	**FY 20/21**			**TOTAL**
1.	Innovative MHSA Funds	**$546,400**	**$753,000**	**$364,231**			**$1,663,631**
2.	Federal Financial Participation	**$75,000**	**$100,000**	**$150,000**			**$325,000**
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding* (MHSA-CSS)			**$150,000**			**$150,000**
6.	**Total Proposed Expenditures**	**$621,400**	**$853,000**	**$664,231**			**$2,138,631**

*If "Other funding" is included, please explain.							

Appendix/ Letters of Support