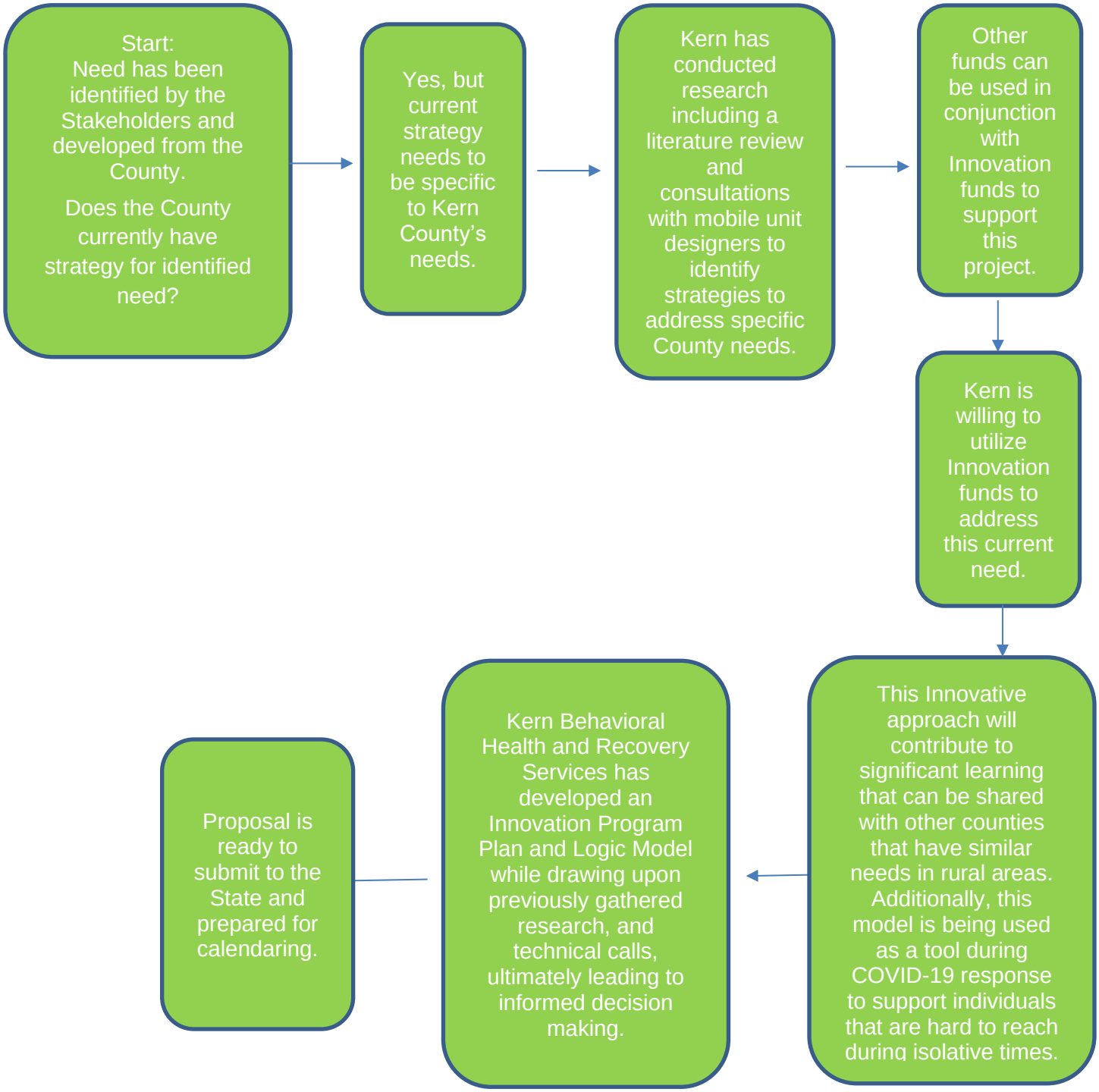
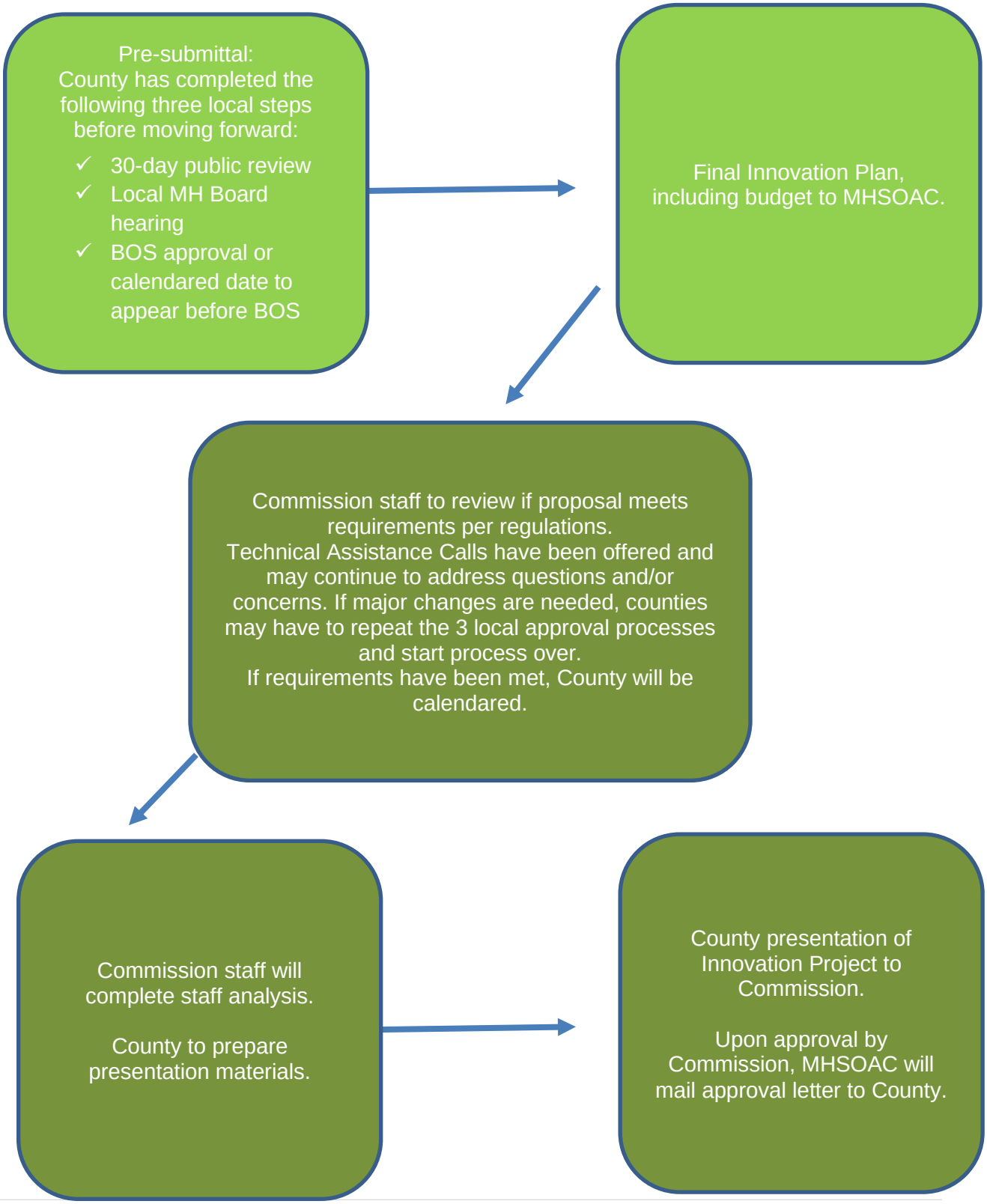
Innovation Proposal
“Mobile Clinic with Street Psychiatry”

BEHAVIORAL
HEALTH&RECOVERY
SERVICES

WELLNESS ON WHEELS FRAMEWORK DECISION TREE



INNOVATION REVIEW PROCESS



INNOVATIVE PROJECT PLAN RECOMMENDED TEMPLATE

COMPLETE APPLICATION CHECKLIST
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:
☐ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors. *(Refer to CCR Title9, Sections 3910-3935 for Innovation Regulations and Requirements)*
☐ Local Mental Health Board approval Approval Date:_2/28/2022_____
☐ Completed 30 day public comment period Comment Period: _12/17/2021-1/17/2022_____
☐ BOS approval date ☐ Approval Date:_3/1/2022_____ If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled:__n/a_____ *Note: For those Counties that require INN approval from MHSOAC prior to their County's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*
Desired Presentation Date for Commission: __3/24/2022_____ ***Note: Date requested above is not guaranteed until MHSOAC staff verifies <u>all requirements</u> have been met.***

TABLE OF CONTENTS

County Name: Kern Behavioral Health and Recovery Services

Date submitted: 11/18/2021

Project Title: Mobile Clinic with Street Psychiatry

Total amount requested: $8,774,095

Duration of project: 5 Years

Purpose of Document: The purpose of this document is to introduce the purpose, need, design, implementation plan, evaluation plan, and sustainability plan on this Innovation Project Plan.

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". This Innovation project will provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

☐Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention

☒Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population

☒Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system

☐Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

☒Increases access to mental health services to underserved groups

☒Increases the quality of mental health services, including measured outcomes

☒Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes

☐Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your County.

On Monday, March 16, 2020, the Kern County Administrative Officer (CAO) declared a local emergency and county operations moved to an essential-staffing only model related to the changing circumstances related to the novel coronavirus (COVID-19). This national public health emergency has changed project planning in significant ways. The most drastic and obvious change being that a "Walk-In Clinic" open access model for psychiatric and behavioral health appointments are not as available due to barriers presented by COVID-19. Additionally, the homeless crisis has expanded drastically and services for street psychiatry and substance use and recovery are needed more than ever.

Data from the National Center for Health Statistics reports in 2018, Opioid Overdoses ranged from 8-22 people for every 100,000 residents in Kern County. Additionally, 3,000-11,000+ Naloxone Units were approved per 100,000 residents to help aid in the fight against opioid overdose. Additionally, research from Research Triangle Institute noted that during the pandemic national regulations on alcohol policy were relaxed and on average frequency of drinking alcoholic beverages went up.

The Homeless Management Information System (HMIS) showed from March 2020-April 2021, the following information:

Basic Housing Information:

- 8,030 adult individuals in Kern needed support with Housing. Additionally, 1,432 of these individuals were classified as families or adults with children.
- 2,825 individuals identifying as youth needed support with Housing. Additionally, 17 of these youth/children did not have an identified adult or guardian.
- 43% of the individuals needing housing support identified has having mental health and/or substance use challenges.

Chronic Homeless Information:

- 10,779 individuals receiving support with Housing identified as homeless or at-risk of homelessness, 1,419 of those individuals identified as experiencing chronic homelessness with 223 of these individuals being classified as families or adults with children. Additionally, 17 of those identified as homeless or at-risk of homelessness were children.
- 12% of individuals identified as chronically homeless were identified as having a mental

health and/ or substance use challenge.

- Out of the total number of individuals that were reported homeless, a total of 6,794 individuals were created as clients within HUD's Homeless Management Information System (HMIS). This means that 6,794 individuals received some type of placement care, ranging from street outreach programs to emergency shelters to permanent supportive housing programs.

The current situation Kern finds itself in has brought forward a need for mobile services and a comprehensively trained street outreach team for people that are homeless and living on the streets with mental illness and substance use challenges. Kern County is widespread, 8,161 square miles, and there is an existing transportation challenge with outreach and service delivery within the County. This challenge has been brought to the County's attention through many different communication streams including the MHSA Stakeholder process. Amidst the pandemic of COVID-19, Kern is seeing even more challenges in outreach, education, access, assessment, and linkage to services. Individuals in our geographically isolated areas do not have the necessary transportation capabilities that are needed on a weekly basis for appointments and medication pickup. Stakeholders have been vocal and supportive in the last year of needing more mobile service delivery and outreach into the community. In addition to this, feedback regarding more outreach to Transitional Age Youth (TAY), youth, and Commercial Sexual Exploitation of Children (CSEC) has been voiced. At this time, developing an innovation program that alleviates this hardship is greatly needed. Prior to COVID-19, KernBHRS' efforts have increased to create more available services to unreached populations. Since then, we have learned what works best is taking services directly to our clients or potential clients in the community.

Additionally, Supervisor Mike Maggard, from Kern County's Board of Supervisors met with the Kern Behavioral Health and Recovery Services Department's (KernBHRS) Executive Team to expedite an initiative to respond to our local homeless and substance use crisis currently occurring in Kern County. Supervisor Maggard requested immediate action on the part of the Behavioral Health Department to assist in reaching some of the hardest to reach population in Kern County, those facing homelessness. KernBHRS with no existing funding available, shifted it's Full Service Partnership- Homeless Adult Team (HAT) to meet this immediate need. Under the HAT team, the Relational Stages of Outreach and Engagement Model (ROEM) was adopted under HAT's menu of services. The change began in March 2021 which included:

- Adding 4 hours a week of street psychiatry to the existing Homeless Adult Team.
- Pulling two existing underutilized vans to support with outreach.
- Reallocating 5 existing staff and a part time supervisor to the ROEM programming.
- Adding Joint response with street medicine.
- Training on the ROEM model.
- Creating a MOU for set aside shelter beds.
- Set aside Adult Residential, SLE and Hotel Rooms.
- Creating a direct connection into local Freise Hope Housing placement.

- Expanded Grave Disability Evaluations.

During the second month of programming, April 2021, the need was evident that more was needed. KernBHRS pulled more of its existing resources to assist in supporting ROEM, including:

- An additional van was identified in the department and reallocated for use for the ROEM team.
- An additional part time Peer Specialist was added to the staffing plan.
- An additional part time Substance Use Disorder Specialist was added to the staffing plan.
- A direct Substance Use Department Connection was created for immediate need.
- Joint response was created with KernBHRS' Homeless Outreach Team and provider Flood Ministries.
- Critical Time Intervention (CTI) Model was implemented, and staff trained.
- Relationship with law enforcement for appropriate response was created.

In the third month, May 2021, the following additional needs were identified and reallocated to the ROEM program:

- An additional van was identified in the department and reallocated for use for the ROEM team. Now totaling 5 vans allocated to the ROEM team.
- Additional residential beds were identified in the community and allocated for ROEM outreach.
- Increase law enforcement response.
- Added linkage with showers and other engagement services.
- Assistance with community conservatorships.

Our intent to expand the preliminary efforts of the ROEM team to include a fully operational team, Mobile Clinic with Street Psychiatry and response plan to Kern County's most underserved and vulnerable population, people that are homeless.

CORONAVIRUS RESPONSE

The safety of staff and clients is a top priority with which will be handled accordingly. When outreach occurs, KernBHRS will practice all CDC and public health recommendations for social distancing and safety protocols and larger groups will be controlled so that people will not accumulate in a condensed space. Sanitization of all surfaces and all protective materials will be used. Additionally, all behavioral health vehicles will be equipped with appropriate plexiglass outfitting to ensure safety in close proximity where distancing is not an option. Plexiglass fitting will be available for this Mobile Clinic with Street Psychiatry once acquired to assist in safety measures. Staff will wear all appropriate Personal Protective Equipment (PPE) and will provide masks and/or gloves to clients if needed. The maximum capacity of the van will be kept at a minimum. Further guidelines will be taken into consideration as the team sees fit and with the specific use of the vehicle in service delivery. This Mobile Clinic with Street Psychiatry will also have the ability to respond to requests

and participation in drive-thru outreach events or disaster response that have become a new norm during the time of the Pandemic.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) Provide a brief narrative overview description of the proposed project.

Kern County is proposing to purchase Mobile Clinics for Street Psychiatry and plans to use the ROEM model for specific engagement with those facing homelessness and experiencing mental health and/or substance use challenges. This effort to expand much needed support for those facing homelessness in Kern County will increase the street psychiatry services to a full-time psychiatrist and a mobile clinic unit to be placed in centralized locations close to homeless encampments. Current program piloted 4 hours of street psychiatry with our newly formed ROEM team who is attached to a current FSP team.

This Mobile Clinic with Street Psychiatry intends to apply a promising community driven approach that has been successful in the public health setting. This plan intends to combine public health's mobile health strategy with mental health services and outreach. This proposed project will fund 2 vehicles, a smaller Recreational Vehicle and a Large Minivan or Sprinter cargo type van. Both vehicles purchased for the Mobile Clinic with Street Psychiatry model will be customized to provide mobile medical unit, psychiatric and behavioral health services. The vehicles will support mobile, field-based, and outreach services to homeless individuals who are not engaging in traditional behavioral health services. The vehicles will also be used for general community outreach and disaster response as needed and requested.

Vehicle can/will be utilized for:

- Outreach to hard to serve populations experiencing homelessness or are at risk of homelessness.
- A focal point of the outreach model will include client choice and preferences to care, multiple options for care, culturally competent service, and person-centered approaches to treatment options and community resources.
- Provide whole person care and treatment, including: psychological, peer-led services, co-occurring treatment, and medical linkage.
- Mobile injection services during and after the pandemic. Doing so will establish safe practices for clients who need to be quarantined yet who require these vital services.
- Mobile prescription RX program to aid individuals in obtaining medication needs.
- Mobile psychiatric services including in person and telehealth services. This service will be valuable during and after the pandemic.
- Community based psychiatry programs, including specialized residency program rotations once the program is established and running.

- Nursing, psychiatric, behavioral health services (mental health and substance use) will be provided during disaster response operations.
- Partnership opportunities for outreach with other community agencies, including whole person care initiatives, primary care collaborations, and public health initiatives.
- Will be used for homeless outreach to provide much needed engagement, treatment and connection to vital resources, including housing.
- Services planned to be provided are detailed in the following groups:

    - Primary for Mobile Clinic and Street Psychiatry:
        - Individuals experiencing homelessness which include TAY, adults and families, older adults with mental health and substance use needs.

Additionally, the vehicles purchased aim to providing the following in either vehicle:

- Storage for mobile pop-up showers
- Primary care exam room
- Extended exam room (secondary space)
- Blood pressure machine
- Utility outfitting to provide basic vitals, height, weight, visual exam, space to walk back and forth, chair to sit and stand, stretch space, & a CPR kit for basic physical exam
- Handwashing station
- Lab draw equipment, small refrigerator, & Lab area in a double locked room for all Laboratory needs
- Sharps storage
- Solar Powered energy
- Powered Patio Awning with lighting
- Microwave, food refrigerator, & coffee and tea maker
- Toilet and sink
- Internet router with extender and cooling equipment
- Extra air conditioning capacity
- Wheelchair life and full ADA compliance
- Television, iPad, computer, docking station, & printer

Photos displayed below are examples of the Recreational Vehicle that will be purchased for the Mobile Clinic with Street Psychiatry Model:

Photos displayed below are examples of the Large Minivan or Sprinter cargo type van that will be purchased for the Mobile Clinic with Street Psychiatry Model:

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

The proposed Innovation Plan introduces a new practice and approach to Kern County's overall mental

health system, including, but not limited to, Full-Service Partnership (FSP) and Prevention and Early Intervention (PEI) service delivery to the County.

This Mobile Clinic with Street Psychiatry will have an emphasis on providing a preventative based approach by providing immediate access service delivery for individuals living on the streets, youth and others identified as at risk due to an inability to utilize traditional behavioral health services. Additionally, this Mobile Clinic with Street Psychiatry will be equipped to respond to collaborative events with county agencies to provide outreach and education on mental health services and supports from Kern Behavioral Health and Recovery Services (KernBHRS). This is the primary general criteria requirement that this proposal meets. In addition, this proposal makes a change to Kern's existing practice in the local mental health field by providing an immediate access to care approach to service delivery during a pandemic where people are more isolated or hard to reach and unable to use traditional behavioral health services to safety concerns and accessibility.

Additionally, KernBHRS notes that engaging with those facing homelessness or chronic homelessness can be extremely challenging. HUD cites, on average, it takes approximately 17 encounters with an individual living on the streets for him or her to engage in services. What makes this Mobile Clinic with Street Psychiatry so unique is that KernBHRS will use the ROEM model for engagement. The model is considered a best practice nationally. KernBHRS conducted extensive research into effective engagement techniques with individuals experiencing homelessness and found this model through the National Healthcare for the Homeless Council. The model focuses heavily on meeting individuals where they are in terms of engagement. Building relationships and trust overtime and involving the client in decision making processes for care. This plan applies a promising community driven approach that has been successful in other counties and throughout the nation, but is tailoring it specific to the need, current pandemic climate, and Kern's geographic region.

C) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

The Relational Stages of Outreach and Engagement Model (ROEM) is an approach from outside of our current organization and has successfully be shown to work specifically in engagement with people that are experiencing homelessness. Outreach and engagement are the processes of coming along side someone who is struggling with homelessness and related health and social concerns. Then sharing the journey in a way that leads to healing, wholeness and stability in the community. Outreach and engagement activities can be seen as a movement through four phases of relationship: approach, companionship, partnership, and mutuality.

Approach: The approach phase involves observation and introduction. It is helpful to spend time simply watching, to see how a person acts, how they relate to others, what kind of space they need, how they seem to be experiencing their environment and responding to the world. Careful observation helps us shape an introduction. We may simply pass by with a nod or greeting, the most minimal of neighborly acknowledgements. We may introduce ourselves in a general way, or with a more specific role with concern. The key is to begin generally as someone who cares and define our role more specifically as the relationship develops and trust builds between us.

Companionship: At its simplest, companionship means sharing a little of the journey with another, standing or sitting with them, walking a little ways with another, listening, and hearing a person's story. Perhaps it may include suggesting some possibilities to assist someone along the way, maybe going with them to some destination or arranging for another to accompany and help them.

Partnership: The partnership phase of outreach and engagement begins when we introduce the person to others who can help or assist. In partnering with others – case managers, medical providers, social service programs, family members – a widening circle of care is created upon which the individual can rely for support and care in various aspects of their lives.

Mutuality: In the phase of mutuality, we recognize one another as fellow citizens and community members. We continue to encourage the other in making use of appropriate resources for their journey and support the individual in becoming a stable part of the neighborhood and community. In time, it is recognized that the relationship has come to fruition and thus is brought to closure as appropriate.

Through the use of these four principles, the KernBHRS ROEM team will provide mobile street outreach, psychiatry, prescription RX program, linkage to behavioral health and substance use recovery care, linkage to medical care, and housing.

Kern has gathered research from Kern County Stakeholders that a mobile clinic is desired and will be greatly appreciated to meet a gap within the Mental Health Services System for the County. Below is a table of captured comments from past stakeholder meetings that provide support for mobile services.

Date:	Location of Stakeholder:	Direct Stakeholder Comments:
07/18/2019	27 Cougar Ct, Taft, CA 93268	• Resources such as transportation would help to connect clients to other resources, they are unable to get to. • Create more inclusion and awareness of community wide needs. Taft in general is incredibly underserved and we desperately need resources to improve the lives of our clients such as transportation.
07/24/2019	113 E. F St, Tehachapi, CA 93561	• Being in a rural community presents many unique problems such access to services due to transportation. • Transportation, SUD and Homeless Solutions for our community. • Transportation is a big concern, particularly in accessing services. • We need homeless shelter, SA programs, youth programs and suicide prevention programs. • Homeless access to services. • A homeless shelter would greatly benefit the homeless here and they could more easily be linked to MH services as needed.
7/25/2021	Westchester Training Room	• By getting the homeless off the streets.
08/16/2019	7054 Lake Isabella Blvd, Lake Isabella, CA 93240	• Mobile services will benefit our community. • Our community will benefit from mobile services. This will support children, homeless, and those without transportation.

Date:	Location of Stakeholder:	Direct Stakeholder Comments:
		• Programs to support children, homeless, and those without transportation would benefit our community. • Programs especially for the homeless. • Outreach to homeless. Try hosting a free picnic lunch at the park – hand out flyers in parking lots (Vons & markets) wherever they hang out. Emphasize – no obligation – then handouts with details of who to contact – where to go – a temporary office (or permanent place) where they can go.
09/10/2019	1400 N. Norma St, Ridgecrest, CA 93555	• Transportation is a struggle, and no one wants to go to Bakersfield for services. • Our community needs transportation. Ridgecrest residents are taken to Bakersfield with no transportation back to Ridgecrest. • Need infrastructure to help the homeless. • We have a lot of unused land in Ridgecrest, we should be using said land to build tiny home community for the homeless community.
09/17/2019	8787 Hall Rd, Lamont, CA 93241	• CSV should have cars to transport clients to their appointments.
10/03/2019	Arvin Collaborative at Grimmway Academy	• I would like to see mobile units that provide services to the community. • I would like to see transportation for families of low income/poverty. • In the Lamont area we only have one agency that serves the area for mental health. All others must travel into Bakersfield. • I would like to see more transportation services and awareness in our community.
10/15/2019	1003 Pebble Beach Dr, Bakersfield, CA 93309	• Our community needs transportation. • We need transportation.
10/16/2019	5121 Stockdale Hwy, Bakersfield, CA 93309	• More bed availability for homeless shelters; public access to showers; public access to laundry mat.
10/17/2019	2731 Nugget Ave, Lake Isabella, CA 93240	• I see a great number of students who cannot participate in extra-curricular activities due to lack of transportation. • We need adequate transportation for 5150 individuals. • Help limit homelessness. • Intense SUD for homeless. • Low barrier shelter for Lake Isabella area/ housing option for community.
10/18/2019	113 East F Street, Tehachapi, CA 93561	• Many in our community depend on transportation and do not receive it. • Transportation is needed in our community for Psych Services for kids and ADHS RX for our clients/patients. • We need transportation to get to Medical & Mental appointments along with child psychiatric services.
10/24/2019	131 E Las Flores Ave, Ridgecrest, CA	• We need transportation.

Date:	Location of Stakeholder:	Direct Stakeholder Comments:
	93555	• Improve coordination of services, transportation, preventive, early intervention. • Homeless shelter. • Less homeless.
11/21/2019	1600 E. Belle Terrace, Bakersfield, CA 93307	• Work to educate community and destigmatize homelessness. Many people assume that homeless are dirty, drugged out, lazy, criminals, etc. • It will help end the overrun of homeless in Kern County.
03/03/2020	Homeless Forum at Westchester Training Room	• Our community needs Mobile Teams. • Have funding available for MH professionals on-site at all homeless shelters • All homeless shelters need clinical staff onsite. • Stakeholders suggestions that would help promote recovery and increase the number of persons exiting homelessness: o Make them commit to services o Education at schools o Promotion (extensively) of services o Holding townhall meetings at various religious entities & colleges/schools. o Handle the situation individually o Bring services, treatment, follow up to where people are living. Lessening the process of screening, assessment and have more direct access to treatment. o Get rid of dual funding and assessments for mental health and substance use. Create dual diagnosis treatment. o Integrate 1 universal form for those assessed as homeless to use amongst Behavioral Health and providers/NGOs. o Reduce barriers to housing production – zonings, impact, regulations o Increase funding for permanent supportive housing o Fund case management services o Emphasize information o BHRS collaborating with homeless shelters more. o Easier access to care o Better & increased collaboration. o Measuring outcomes vs. output o Dignity presenting programs that influence and provide “coaches” or guides that can increase access to the available programs. o We need a complete overhaul of our health care system. I was raised in Canada. Universal healthcare does much for a healthier society all around. o Perhaps gather volunteers through MSW or SW who need therapy hours to provide onsite services. o Job skills opportunities o Programming that stays connected with clients building ongoing relationships throughout transition to housing or jobs for help & support to keep them on track.

Date:	Location of Stakeholder:	Direct Stakeholder Comments:
03/03/2020	Homeless Forum at Westchester Training Room (continued)	○ Programming that brings personal responsibility at any level a person is at, bringing self-value & self confidence that will lead to personal success. ○ Focus in promoting secure and stable homes. ○ The only factor I feel is being overlooked is medical detox. Opiate addicts need more options. ○ A way to get more people into recovery services and mental health treatment that uses ways to make the individual more accountable to receive treatment and services. • List of factors stakeholders listed as a contribution to the rise in the homeless population: ○ Drugs/Substance Abuse/Addition (12) ○ Mental Health (6) ○ Economic/financial factors (2) ○ Prop 47/57, AB 109 – lack of accountability (2) ○ Cost of living (2) ○ Laws that have no backbone/Criminal Justice reform (2) ○ Family dynamics ○ Early childhood development ○ Too many free services ○ Access to services; MH, SUD, medical ○ Red tape too many req'd assessments and documentation needed to get services. ○ SUD / lack of program & services ○ Foster Care system ○ Access to care ○ Untreated/undiagnosed mental health ○ Policy ○ Wealth disparity "A time when the rich are too rich, and the poor are too poor" ○ Serious complex trauma that has not been addressed ○ Complex issues that need skilled social workers to coordinate ○ Housing that has supportive services like mental health ○ Mental & social challenges ○ Lack of police intervention ○ Lack of support ○ Loss of jobs/lack of jobs & job skills training which can lead to depression or mental health issues. ○ The safety net system is overburdened and underfunded. ○ Insufficient emergency beds & permanent housing subsidies. ○ Divorce / family breakdown ○ Absence of God in people's lives ○ Available resources ignorance ○ No Access to detox (medical detox) services. ○ Lack of mental health services.
05/01/2020	Virtual Microsoft Teams Stakeholder meeting	• Those with mental health issues seem to be on the rise leading to unresolved homelessness.

Date:	Location of Stakeholder:	Direct Stakeholder Comments:
05/01/2020	Virtual Microsoft Teams Stakeholder meeting (continued)	• I think that Kern County needs to get serious about addressing the problem of homelessness as it relates to mental illness. • More homeless outreach and assistance with food, shelter and health services. • Homeless shelters • I don't really know what the solutions are, since it's hard to stay in contact with the homeless population and to keep them on track with treatment, but I think housing them in an area where services are offered could be a start. • Homeless people and TRANS AND QUEER homeless people need space to live. There are more empty houses in America than there are homeless people, and our city arrests them for trespassing and loitering when they have nowhere else to go. • Outdoors programs, children and youth programs that might include animals, programs at homeless shelters. • Offer mindfulness, meditation and yoga at the homeless shelter. • The homeless count increased by another 19% in 2020 we continue to need funding for street outreach and housing for those who are homeless or at-risk. • We need affordable housing. Not money thrown just at getting more staff to help the homeless but actual homes/placements. If we want to serve mentally ill clients and their family, we need to help meet their basic needs 1st. We need affordable housing plain and simple.
07/30/2020	Virtual Microsoft Teams Stakeholder meeting	• The mobile unit model would be easier for clients to access services and their needs to be met as well as it would be timely and financially efficient as transporting client's to different locations would be minimized. • More affordable placements for our clients. Maybe in the same model such as Haven Cottages and Green Gardens where clients could actually afford housing/apartments. More shelters for our ever-growing homeless population. • More outreach to the homeless who have drug addictions and MH problems.
08/26/2020	Virtual Microsoft Teams Stakeholder meeting	• Person to person connection with the mobile unit. • Our community could benefit from having an RV equipped with computers, printers, and drive it to rural areas • Voting Item: Mobile Service Unit: Are you in favor of launching a mobile curbside approach to providing programs and services to Transition Aged Youth (TAY) and Youth who are seeking or have fallen out of services due to COVID-19 or other factors? Yes: 26 No: 2 • Homeless population with SUD as they need a supportive environment while waiting for residential treatment.

Date:	Location of Stakeholder:	Direct Stakeholder Comments:
		• We ultimately need land for apartments/studio apartments/low cost housing to actually reduce homelessness. I truly believe that once a client's basic needs of food, shelter, & clothing are met, then we can get them to buy into our program and help lessen their mental health symptoms and substance abuse issues.
09/22/2020	Virtual Microsoft Teams Stakeholder Meeting	• I would like the funds to help members of our community who are homeless and suffer from mental health illness to be encouraged to participate in cleaning the community for a weekly paycheck as well as provide shelter in a safe and secure environment.
09/29/2020	Virtual Microsoft Teams Stakeholder Meeting	• Our community needs a Mobile Care Unit. • Increase showers for the homeless. • More programs to help our homeless population.
11/19/2020	Virtual Microsoft Teams Stakeholder Meeting	• More placement and housing for our clients in Kern County. I think it's awesome that some motels hotels have been used as placement during this pandemic. My concern is what happens after the pandemic to these people? I hope we can find some way to get permanent low income housing for them to prevent homelessness.

12/11/2020	Virtual Microsoft Teams Stakeholder Meeting	• Question: Please provide ideas on how you would aid in supporting those facing homelessness among the TAY (ages 16-25) population. What resources would you need in order to accomplish this?
		  • The Kern County Network for Children's Dream Center and Self Sufficiency Project are supporting TAY facing homelessness in the following ways: providing outreach (we work hand in hand with 211, homeless shelters, schools, county agencies, non-profit organizations, and homeless street outreach teams), housing assistance, and case management services to homeless youth; linking homeless youth to mental health and substance abuse treatment services; engaging TAY youth who are struggling and/or need support; helping TAY youth with building life and coping skills as well as research-based protective factors. Despite funding cuts that are on the horizon, we need to continue to receive MHSA funding so we can continue our work.
		  • Training and referral resources
		  • Info with available contacts/resources to provide to youth at release.
		  • Our team is planning on firsthand outreach to identify families needing our services. placing flyers around hotels, parks, trailer parks, lower-income communities.
		  • Reasonably priced housing options. There is a need to grow the availability of low income/starter housing in various areas of Kern County.
		  • Education to give to TAY regarding our new low barrier shelter on M Street and Brundage Lane Navigation Center.

Date:	Location of Stakeholder:	Direct Stakeholder Comments:
12/11/2020	Virtual Microsoft Teams Stakeholder Meeting (continued)	• Housing and Housing Vouchers • I would like to see TAY Sober Living services expanded from 90 days to 180 days. 90 days doesn't seem quite long enough, especially for homeless youth who have so much trauma to deal with. Additionally, it would be great if youth who successfully exit the program, then relapse, could re-enter and repeat the program at least once. Relapse happens frequently for TAY, especially given the negative impacts of COVID-19. TAY youth like the program so much, they tend to ask to return after relapse. When they are told that they can't, they don't want to go to other sober living programs and nearly always say, "If I can't go back to Third Tradition, I'll handle it on my own." • Homeless TAY are an underserved population. TAY youth associate being homeless, struggling with mental illness and/or substance abuse as stigmatizing. They need service providers who can meet them where they are at, help them to see that they are deserving of housing, worthy of employment, and that utilizing mental health and/or additional treatment services is not a needed, as much as they are a tool that they can use so they can achieve their goals and work toward their dreams. MHSA funds have made it possible for the KCNC Self Sufficiency Project to serve these youth and help them to improve outcomes.
01/28/2021	Virtual Microsoft Teams Stakeholder meeting	• Homeless individuals struggle with accessing remote services since phones are not a reliable method of communication for them.
02/01/2021	Virtual Microsoft Teams Stakeholder meeting	• And some of these categories I would’ve chosen two or three different areas. As in the area of town that we are most engaged in it would be not just Bakersfield but also the rural areas where we have small neighborhood churches there to bring hope and help and support to people nearby. Also, I wouldn’t just say it was the homeless or at risk of homeless as the largest area of need. We are also working with target populations of homeless youth, families and seniors who are definitely in need of support and help in these areas.
6/21/2021	Virtual Microsoft Teams Stakeholder meeting	• 100% of individuals that participated and voted were in favor of starting the Mobile Clinic with Street Psychiatry. • Explore ways of integrating basic needs services to pets and service animals of the targeted population for the mobile clinic. • Food, Water, Vaccination, other SPCA services • Possible collaboration with The Dream Center to provide services to TAY experiencing homelessness, may include using TAY from the Dream Center with lived experience for engagement.

Date:	Location of Stakeholder:	Direct Stakeholder Comments:
		• Expand current partnership with The Center for Sexuality and Gender Diversity to provide culturally competent services to LGBTIQ+ individuals facing homelessness.
9/8/2021	Virtual Microsoft Teams Stakeholder meeting	• Update given to stakeholders on draft Innovation Plan for the Mobile Clinic with Street Psychiatry. ○ No public comments were given

D) Estimate the number of individuals expected to be served annually and how you arrived at this number. (Insert chart waiting on disaster numbers.)

The estimate number of individuals that are expected to be served annually is broken down below. In calculating this estimate, the number of currently served individuals and outreach events were viewed and educated estimates were derived off of the available historical data.

	Approximate Unduplicated # to be Served Annually:
Service Delivery (Behavioral Health and Co-occurring Treatment)	50
Mobile Medical Services	10
IM Injections	10
Outreach	12,500
RX Medication Refills	10
Linkage to Medical Care	10
Distribution of Narcan	5
Disaster Response	50
Total # Served Annually	12,635

Additionally, it is important to mention that some of these numbers are true estimates. The service delivery category was estimated by looking at the prediction from the Kern County MHSA 3 Year Plan.

From our 3 Year Plan we estimate that we will serve 1,500 individuals through our Homeless Outreach Team, 740 individuals through our Homeless Adult Team, and 1,519 individuals through our Home to Stay Program for Fiscal Year 21/22. The Mobile Clinic with Street Psychiatry will be used to provide outreach, treatment service options and supports to a portion of the clients served by these teams.

Mobile nursing will be available on the Mobile Unit with Street Psychiatry for those that chose this treatment option. One of the measurable tasks from mobile nursing will be to provide intramuscular (IM) injections. Mobile medical unit averages about 200 intramuscular injections in a given month. In August 2020, 244 IM injections of psychotropic medications were given to clients. Due to the availability of the Mobile Clinic with Street Psychiatry, it is estimated from our Medical Services Team that of those individuals being served that will receive prescription RX support, 5% of those individuals will need IM injections from the Mobile Clinic with Street Psychiatry. IM support will become available once the Mobile Clinic with Street Psychiatry has been stably deployed and scheduling and use has been determined. The mobile nursing team will also be training to provide other medically necessary and appropriate care as needed. It is intended dependent on the need of individuals, approximately 10 individuals will be served for mobile medical services.

For general community outreach to the public, KernBHRS for most of Fiscal Year (FY) 19-20, despite reduction of in-person services and implementation of safety protocols due to COVID-19, KernBHRS was able to provide in-person outreach to 13,563 people within Kern County. Due to COVID-19 restrictions currently in place, KernBHRS estimates that general public community outreach can be provided with the use of the Mobile Clinic with Street Psychiatry to approximately 12,500 people within Kern County. This number is subject to change depending on the continued impact of the Pandemic. However, KernBHRS can commit to being equipped to provide outreach to 12,500 people in Kern County with this Mobile Clinic with Street Psychiatry model.

Lastly, disaster response is difficult to predict the approximate unduplicated number of individuals served annually by the Mobile Clinic with Street Psychiatry. Disaster response is typically unpredictable in nature. In FY 19-20 the Ridgecrest earthquake was the most significant disaster event that occurred in Kern County. It is estimated that at least 80 individuals were seen daily for mental health triaging. Within the total of two weeks following the Ridgecrest earthquake, it is estimated 830 individuals were served as part of the disaster response. The year prior FY 18-19, the KernBHRS Disaster Response Team responded to The Camp Fire in the community of Paradise in Butte County. The KernBHRS Team provided services for two weeks beginning Thanksgiving week to this devasted community. Two teams of 4 staff covered the AM and PM shifts for the local law enforcement officers. Due to the concern that Wildfires seem to occur more frequently as a consistent threat to Kern County and the State, as a whole, and the standards for Public Safety Power Shutoffs, KernBHRS estimates to serve around 50+ individuals annually through disaster response efforts with the Mobile Clinic with Street Psychiatry.

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

We expect the population to be served to be diverse in terms of race, ethnicity, sexual orientation, gender identity, and languages.

The chart below, illustrates the targeted populations that can be served with the Mobile Clinic with

Street Psychiatry. Not all of these services will be frequent but can be available if needed. Additionally, there might be additional needs outside of the ordinary projection below where the Mobile Clinic with Street Psychiatry may respond that are unique to the individuals served. The Mobile Clinic with Street Psychiatry is designed to be flexible support tool in the delivery of service. If the Mobile Clinic with Street Psychiatry is used within a year outside of the range listed on the following page, the additional uses will be reported in the Annual Plan by KernBHRS.

	Children	TAY	Adults	Older Adults
Service Delivery	X	X	X	X
Mobile Medical Services	X	X	X	X
IM Injections		X	X	X
Outreach	X	X	X	X
RX Medication Refills	X	X	X	X
Linkage to Medical Care	X	X	X	X
Distribution of Narcan	X	X	X	X
Disaster Response	X	X	X	X

Additionally, it is worth noting that information pulled from the HMIS reveals relevant demographic information that will be taken into account with staff planning, hiring and training:

- 1% of individuals needing housing support identify at Trans. Additionally, stakeholder comments supported more services to LGBTIQ+ individuals facing homelessness.
- The top 3 race & ethnicity demographics of individuals needing housing support are: White (66%), LatinX (36%) and Black/African American (27%). Additionally, Native American/Alaska Native and API populations also had significant demographic rates in Kern County.

The department requires at least 6 hours of cultural competency training for each KernBHRS staff. Additionally, the department makes in-person and online training readily available to help give staff quality culturally specific and sensitive training in working with diverse populations.

Primary populations that will use the Mobile Clinic with Street Psychiatry:

Individuals facing Homelessness Services

Priority use for the Mobile Clinic with Street Psychiatry will be given to individuals who are experiencing homelessness. This will include individuals who may be mono-lingual Spanish speaking. Appropriate bilingual staff will be available for service delivery. Additionally, services will be provided that are culturally appropriate.

TAY facing Homelessness Services

Priority use for the Mobile Clinic with Street Psychiatry will be given to services for youth who are homeless. This will include youth that are Spanish Speaking, as Spanish is Kern's threshold language. Appropriate bilingual staff will be available for service delivery.

Youth Identified as CSEC and Homelessness Services

Priority use of the Mobile Clinic with Street Psychiatry will also be given to services for youth who have been identified as commercial sexually exploited children (CSEC) and homeless. This population has been identified as a high-risk population with diverse challenges and needs. Spanish speaking staff as well as additional resources will be available to this population that is culturally responsive to their needs.

Additionally, for all three of these identified priority populations, KernBHRS has developed partnerships with The Center for Sexuality and Gender Diversity, Bakersfield American Indian Health Project, LatinX Taskforce of Kern County, and other culturally specific partnerships that can aid in linking individuals into culturally appropriate care when necessary.

Furthermore, KernBHRS currently has a well established Multi-Agency Integrated Services Team (MIST) which is categorized as a FSP program successfully serving the CSEC population in Kern County. Through the Mobile Clinic with Street Psychiatry, if a TAY facing homelessness is identified and additionally is identified as CSEC, they will be provided linkage opportunity to the MIST program.

Additional support services:

Street Psychiatry

Street Psychiatry will be the main focus of this Mobile Clinic. This will include the practice of providing mental health care directly to people experiencing homelessness. The individuals could be living on the streets, under bridges, in riverbeds, in parks, or other community-based places where other individuals facing homelessness live. Services provided could include: Psychiatric evaluations, medication management services, therapeutic interventions, 5150 evaluations, etc.

Mobile Medical Services

Additionally, the Mobile Clinic with Street Psychiatry will be equipped to be used as a mobile medical unit. The mobile medical portion of this model will include medical screenings, lab work, prescribing and refilling prescription medication, and Narcan distribution when available. Once these practices have been established with the Medical Services Team, mobile injections will be a second phase to roll out in service delivery. This service primarily will be available for adults as they have been identified as the largest group to utilize this service but will be equipped to serve any age. With this model, if a person has a higher level of medical care needed, the person will be linked to a partner larger mobile medical unit like Clinical Sierra Vista's Medical Street Outreach Team or Adventist Health Hospital's Mobile Medical RV Services.

General Public Outreach Community Support

Outreach and education can be provided to the public (all ages) with the use of the Mobile Clinic with Street Psychiatry. The Mobile Clinic with Street Psychiatry will be equipped with informational material and marketing products to assist in breaking the stigma associated with mental health and substance use recovery. Additionally, linkage, referrals, resources, and assessments can be provided as needed for each event the Mobile Clinic with Street Psychiatry attends. KernBHRS has a warehouse of

marketing collateral designed and available for many sub-populations throughout Kern County. All of the marketing collateral is available in both English and Spanish; however, Kern has invested in creating material to engage in other languages that are significantly represented in Kern County. In stock marketing collateral available in other languages are: Punjabi, Hindi, & Tagalog. Additionally, KernBHRS has inventory of marketing collateral that focuses outreach to children, TAY, adults, older adults, Spanish Speaking, LatinX, Black/ African American, Asian Pacific Islander, Native American & LGBTIQ+ demographics.

Disaster Response

Kern County disaster response team is certified in Critical Incident Stress Management (CISM) which allows Kern to respond to and assist in behavioral health response during a state of emergency. In the past, Kern has responded to the Paradise Fire and Trona Earthquake (both outside of Kern County) and to locally devasted areas that have left communities in despair due to traumas that have occurred by natural disaster or other cataclysmic events. The Mobile Clinic with Street Psychiatry would be equipped and available to use during emergency response times. The general population that is impacted due to the catastrophic event would be the targeted population. At times, emergency response is specific to a need in supporting first responders in their own behavioral health needs during a crisis or supporting victims exposed to trauma of the event.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

The Mobile Clinic with Street Psychiatry intends to be a continuously adaptable model with which Kern can effectively provide services to all individuals at risk of homelessness or currently are experiencing homelessness. The ROEM approach with the Mobile Clinic with Street Psychiatry looks to provide support in engaging Kern County's most underserved population as identified by our MHSA Stakeholder process. The ROEM engagement approach really focuses on meeting and individual where they are at, building a trustful relationship, and bridging a person into services and care in a more organic style. This project specifically takes a whole person care approach from outreach and engagement, linkage to community services and support, food and hygiene supplies, housing, substance use services, mental health services, and medical services that include, nursing, medication, and street psychiatry. These are all specific needs that have been identified in Kern County in aiding people facing homelessness. The Mobile Clinic with Street Psychiatry will be staffed with a psychiatrist, therapist, outreach workers, a peer or person with lived experience, substance use counselor, and bilingual staff. The model, if successful, has the potential to also provide a street psychiatry residency program and fellowship to continue the investment towards street psychiatry and outreach. With the changing dynamic of the coronavirus, this project aims to be adaptable for each population.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

KernBHRS has conducted extensive research on Mobile Clinics with Street Psychiatry in different capacities, utilizing a variety of sources including internet searches, news articles, and literature reviews. A summary of findings is as follows (References in Attachment A):

A study was found that used a time-lag design to evaluate the effectiveness of a Mobile Outreach and Crisis Services (MOCS) unit in remitting psychiatric symptomatology, improving global functioning, and decreasing homelessness in a population of homeless, severely mentally ill residing in a mid-sized urban center (Morris & Warnock, 2001). Using a time-lag study design, two groups of subjects--25 individuals before receiving services (control group) and 25 individuals after receiving services (experimental group)--were contrasted across outcome measures. The results indicate that a MOCS unit utilizing a Program for Assertive Community Treatment mode was effective in significantly decreasing psychiatric symptomatology, reducing homelessness, and increasing global functioning. If carefully implemented and interpreted, a time-lag design may be a means of providing valuable feedback and information in a timely manner. Although this model has differences from KernBHRS' proposal of Mobile care, what can be extracted from this article is that mobile response can aid in the reduction of psychiatric symptom and decreasing homelessness. These are both goals of KernBHRS with the Mobile Clinic with Street Psychiatry using the ROEM approach.

Another model worth mentioning is Project HELP which was established in New York City in 1982 as a mobile outreach unit providing crisis medical and psychiatric services to impaired homeless persons (Cohen, Putnam & Sullivan, 2006). The authors describe the demographic characteristics of the population served, the disposition of patients accepting treatment or shelter services, and the adaptation of the homeless to weather extremes. They discuss the difficulties in providing services to a population whose members are distrustful of authority and are unwilling to provide information about themselves. They conclude that the more disaffiliated members of the homeless population are, such as those served by Project HELP, need even more extensive services than the homeless who use some kind of existing sheltered care, and they suggest various kinds of services to meet their needs.

The takeaway from Project HELP is that an approach like the proposed Mobile Clinic with Street Psychiatry and the use of the ROEM approach can aid in successful outreach towards those facing homelessness. On average it takes 17 encounters with a person who is homeless to receive services, treatment or support. Building rapport with individuals is a key in the engagement and linkage into care. KernBHRS firmly believes that a successful engagement model is needed to create trust between individuals experiencing homelessness and any health care provider.

Youth homelessness is a substantial issue, and many youths experiencing homelessness have mental health issues as both a cause and consequence of homelessness. These youths face many barriers to receiving traditional mental health services, and as a result, only a few youths experiencing homelessness receive any form of mental health care. Mobile Phone-Based Intervention project aimed to develop and determine the feasibility and acceptability of engaging young adults (I.e., individuals aged 18-24 years) experiencing homelessness in a remotely delivered mental health intervention (Schueller et al., 2019). This intervention provided brief emotional support and coping skills, drawing from cognitive behavioral principles as an introduction into psychosocial support. The intervention was piloted in a homeless shelter network. A total of 35 young adults experiencing homelessness participated in a single-arm feasibility pilot trial. Participants received a mobile phone, a service and

data plan, and 1 month of support from a coach consisting of up to 3 brief phone sessions, text messaging, and mobile mental health apps. They evaluated feasibility by looking at completion of sessions as well as the overall program and acceptability with satisfaction ratings. They also collected clinical symptoms at baseline and the end of the 1-month support period. They used validity items to identify participants who might be responding inappropriately and thus only report satisfaction ratings and clinical outcomes from valid responses.

Most participants (20/35, 57%) completed all 3 of their phone sessions, with an average of 2.09 sessions (SD 1.22) completed by each participant. Participants sent an average of 15.06 text messages (SD 12.62) and received an average of 19.34 messages (SD 12.70). They found higher rates of satisfaction among the participants with valid responses, with 100% (23/23) of such participants indicating that they would recommend participation to someone else and 52% (12/23) reporting that they were very or extremely satisfied with their participation. Results found very little change from pre- to posttreatment on measures of depression (d=0.27), post-traumatic stress disorder (d=0.17), and emotion regulation (d=0.10).

This study demonstrated that it was feasible to engage homeless young adults in mental health services in this technology-based intervention with high rates of satisfaction. Technology and mobile efforts might be an important avenue to reach young adults experiencing homelessness, but additional work could explore proper interventions to deliver with such a platform. KernBHRS is hoping to implement efforts that can link youth with mobile service delivery to aid in their treatment and recovery.

Below are additional other successful Mobile Response Models:

HealthRIGHT 360's Clinic on Wheels: This San Francisco organization is a street-based model. It's staffed by a combination of medical providers and an outreach team. The mobile clinic has two complete exam rooms, a bathroom, and an elevator wheelchair lift. This program is a collaboration between nonprofit organizations, the private sector, and government to provide medical and mental health services.

Humboldt County Behavioral Health Triage Services: This program is a Mobile Response Team for youth and adults. Services include Crisis triage by phone or in person, crisis stabilization, short-term assistance and case management services, after care, and referrals for long-term assistance. In addition to this, provides education and training to the school system. Educates children on recognizing the signs and symptoms of behavioral health issues and how to respond. The response unit designed for adults incorporates a peer element.

Carlos Fernandez, M.D.'s published article, *Innovative Mobile Clinics Serving Children and Families of Riverside County with Limited Access to Behavioral Health Services (2017):* Clinical teams are comprised of two therapists serving on each mobile unit, with auxiliary support provided by a staff psychologist, mental health services supervisor, and psychiatry residents. The Clinical Team provides counseling, parenting classes, and consultation while on the mobile unit, periodically providing training for other mental health staff within Riverside University Health System Behavioral Health. Mobile units rotate throughout various school districts to increase mental health service accessibility. Patients are enrolled in the clinical programs through self-referral and school referrals. The mobile clinics participate in the National Alliance on Mental Health Illness events and mental health fairs. The

units are custom-built recreational vehicles, with a playroom and observation room, with a one-way mirror for observation of therapy sessions, which are monitored in real-time during parent child clinical treatment. Three principle therapy modalities are employed in the mobile units: 1) Parent-Child Interaction Therapy, 2) Trauma-Focused Cognitive Behavioral Therapy (CBT), and 3) Strong Kids group. Most of the clients reported receiving mental health services for the first time.

Marin Health and Human Services: The Mobile Crisis Team only operates Monday through Saturday from 1:00-9:00 p.m. This team is comprised of a licensed mental health practitioner and a peer provider. Referrals are submitted by schools, police departments, and family members. This team will have the capacity to initiate a 5150 if warranted or to offer crisis intervention, stabilization, and linkage to appropriate community-based services. In addition, the team will have the capacity to lift holds in certain circumstances.

McLean County's Center for Human Services (CHS): Collaboration with Community Health Care Clinic and Home Sweet Home Ministries. Once a month the clinic will provide primary care exams by a Community Health Care Clinic nurse practitioner, followed by an assessment by Home Sweet Home's outreach coordinator to see whether additional community support could assist the patient. Community Health Care Clinic staff provide medical exams and Home Sweet Home (HSH) staff make sure the patient is connected to human service agencies that can provide more assistance.

Orange County's Hurtt Family Health Clinic: Mobile clinic that began in 2000. The clinic provided healthcare services to homeless and uninsured. Program offers primarily medical services, but also provides dental services, laboratory services, and pharmacy services.

Alameda County Health Care for the Homeless Program: Program serves an estimated 160 homeless individuals every month. Mobile Unit is staffed by healthcare providers, including nurse practitioners and social workers. They offer primary care, counseling, and testing for sexually transmitted diseases.

Kitsap County's Peninsula Community Health Services: Program staffed by a community health worker, a licensed mental health counselor and a chemical dependency professional. Bus is parked in locations that are accessible by public transit. Clients are able to be seen as walk-ins or through appointments. The Community Health Worker helps the client navigate the insurance process and helps them obtain insurance if they do not currently have insurance. The bus has a chemical dependency professional and medication-assisted-therapy program (MAT). An important consideration this program has is that clients develop rapport with the public as they are the same staff each day.

Tulare County's CCS Mobile Unit Program: Program is a Mobile Unit with the capability to provide in-home services. Services include individual and family therapy, education and advocacy, peer support, medication support, health screenings, and Cal Fresh enrollment. Public health nurses administer screenings and assessments.

Kern's population is faced with a unique situation where the pandemic and size of Kern County is impacting service delivery and engagement. From the literature review, we have concluded that Kern's program will address a gap in the existing practice. This program will offer "meet them where they are" delivery system with a combination of outreach and engagement, and the usage of peers.

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) *What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?*

During the pandemic, KernBHRS has identified areas of need after shifting from our traditional delivery system to more telehealth based service delivery. With the pandemic the system of care has felt the impact of need with the current clientele. KernBHRS has made many shifts in service delivery since March 2020 when Kern County experienced its first shutdown. During this time, many MHSA programs experienced cancelations of group activities, face to face services, trainings, meetings to endorse social distancing standards. A majority of programs have received enhanced technological support to enable telehealth, virtual meeting platforms, and mobile internet and email capabilities. All programs supporting clients that have moved to virtual or telehealth means are limiting their face to face contact with clients to respect social distancing standards. In-person outreach and engagement is very limited. Therefore, social media and other marketing efforts will be taken into consideration to maximize exposure. Additionally, KernBHRS realizes that a sense of normalcy will eventually return to the County in how services are provided. KernBHRS is making additional efforts to provide face to face services in the field with people experiencing homelessness. We would like to make the shift from pandemic telehealth and virtual services to meeting the population facing homelessness with behavioral health and/ or substance use challenges in a safe outdoor environment using COVID safety standards by the CDC. This would include meeting people where they are at, which could include encampment sites, underpasses, riverbeds, public parks, etc.

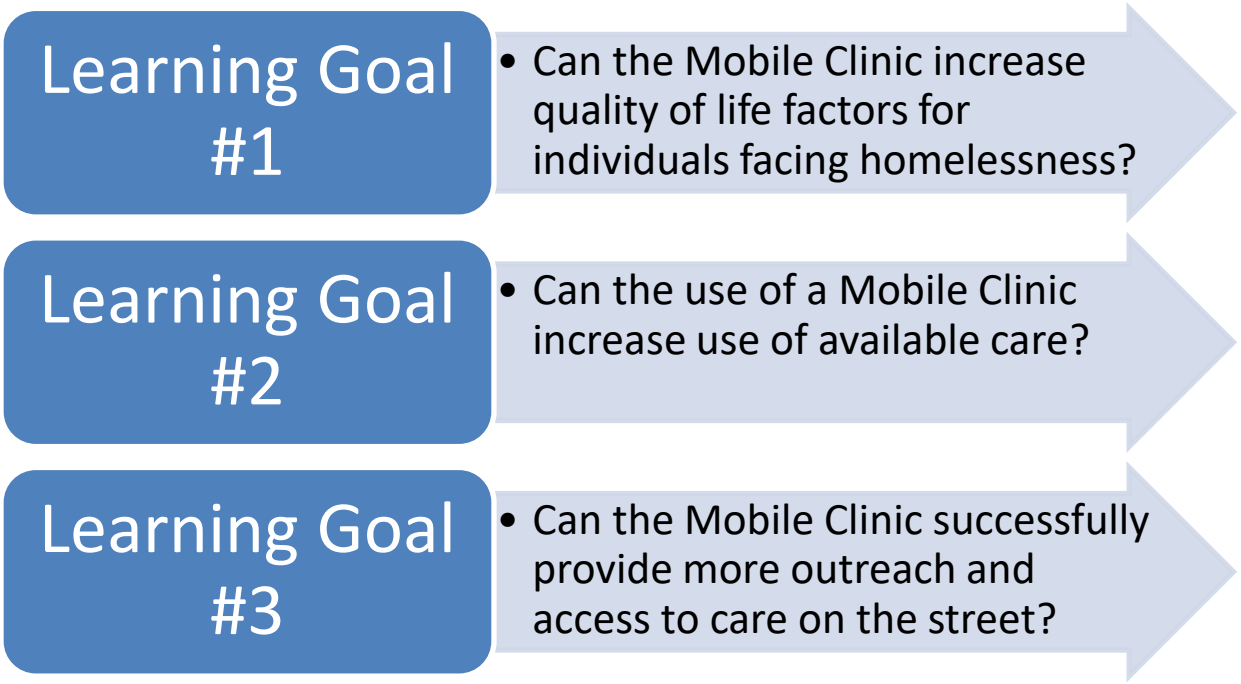
On the next two pages is a chart of the all of the changes that have occurred as a result to COVID-19 response of the department.

KernBHRS COVID-19 RESPONSE	CHANGES THAT HAVE OCCURRED:								
PROGRAM EXPERIENCING CHANGE	**Moved to Virtual Platform or Telehealth**	**Cancelled Group Activities**	**Reduction in Services or Partial/ Full Program Suspension**	**Cancellation of Events**	**Experienced Loss in Staffing**	**Enhanced Media Outreach**	**Expanded Services**	**Providing Linkage to Emergency Housing, Food & Resources**	**Decrease or Suspension of Outreach**
COMMUNITY SERVICES AND SUPPORTS (CSS)									
FULL SERVICE PARTNERSHIP (FSP)									
Adult Transition Team (ATT) /Homeless Adult Team(HAT)		X							
Adult Wraparound	X							X	
Assertive Community Treatment	X								
Multi-Agency Integrated Services Team (MIST)			X						
Transitional Age Youth (TAY)	X								
Wellness, Independence and Senior Enrichment	X	X		X					
Youth Wraparound	X						X		
GENERAL SYSTEM DEVELOPMENT (SD)									
Access & Assessment	X								
Adult Wraparound Core	X								
Consumer Family Learning Center (CFLC)	X		X						
Home to Stay			X						
Recovery and Wellness Center (RAWC)	X								
Self-Empowerment Team (SET)	X								
PREVENTION AND EARLY INTERVENTION (PEI)									
TRADITIONAL PEI									
Court Appointed Special Advocates (CASA)	X								
Crisis Hotline							X		
Foster Care Engagement	X								
Living Well	X		X						
Outreach & Education	X	X		X		X		X	
Prepare U			X						
Volunteer Senior Outreach Program (VSOP)	X							X	
Youth Brief Treatment	X								X

PREVENTION AND EARLY INTERVENTION (PEI)									
TRADITIONAL PEI									
Youth Juvenile Justice Engagement	X								
Freedom, Recovery and Empowerment with Dogs (FRED)	X	X				X			
Help Me Grow						X		X	
Risk Reduction Education and Engagement Accelerate Alternative Community Behavioral Health (REACH) Expansion	X								X
Suicide Prevention Outreach and Education (O&E)	X								X
Transitional Age Youth (TAY) Dual Recovery Program		X							
Transitional Age Youth (TAY) Self-Sufficiency Program (SSP)	X	X						X	
Yoga	X	X		X		X			
Zero Suicide					X				
INNOVATIONS									
Help @ Hand	X				X				X
Smart 911				X		X			
WET									
Clinical Internship	X								
Psychology Internship	X								
Training Enhancement	X	X		X					

Since these are the changes that have been noted since the pandemic started. KernBHRS would like to bring our services closer to our clientele, especially those with some of the highest care needs, like those experiencing homelessness. We would like to move in a direction to provide more face to face services, increase and expand service delivery in the field, provide enhanced linkage to auxiliary services, and provide more intensive outreach.

From the changes that have occurred and the impact from COVID-19 the following 3 learning goals pertaining to this project have been established:



B) *How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?*

As identified by Kern County Stakeholders, a Mobile Clinic with Street Psychiatry fills an existing gap in service delivery for those that are hard to reach for services including people who are homeless. The pandemic has only heightened this need. A Mobile Clinic with Street Psychiatry that can provide, psychiatric, and behavioral health services have been articulated as an additional need in Kern County. Additionally, on top of Street Psychiatry, KernBHRS has identified mobile medical unit, community outreach, and mobile disaster response as priorities for the department to grow in supporting the needs of existing clients and outreach to those that do not currently receive our services. All of these needs can be supported by this innovation plan and established learning goals.

Measuring the impact of the Mobile Clinic with Street Psychiatry on providing access and linkage to treatment will align with strategies for improving behavioral health services for underserved or hard to reach populations. Tracking the use of the Mobile Clinic with Street Psychiatry and reasoning for use will allow the local MHSA team to monitor if the Mobile Clinic increases outreach efforts and reduces stigma and discrimination associated with behavioral health treatment and substance use recovery. Gauging the success of this this model is a priority. Therefore, mobile service delivery will be monitored to analyze its improvement of behavioral health outcomes.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine

whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

Learning Goal #1

Can the Mobile Clinic increase quality of life factors for individuals facing homelessness?

Learning Goal #1 will measure if individuals who use the Mobile Clinic with Street Psychiatry increase their quality of life standards. Through the use of an outside evaluator, a satisfactory survey instrument will be created to measure qualitative and quantitative factors in an individuals overall quality of life after receiving care through the Mobile Clinic and/ or treatment.

The outside evaluator will measure overtime the user's satisfaction level of services and indicators that measure their quality of life standards after receiving care. Pre and post surveys would not be used in this case as it has been noted in current outreach efforts with the homeless population that asking many questions upfront in a survey format typically create a barrier towards engagement in the long run with the population. The satisfaction instrument will therefore measure factor's of the individuals quality of life after treatment and services have been provided.

Learning Goal #2

Can the use of a Mobile Clinic increase use of available care?

Learning Goal #2 will measure if the Mobile Clinic with Street Psychiatry will increase the use of available care from the behavioral health department. Measurements will track encounters of individuals on the streets experiencing homelessness and their willingness to engage and/or accept services. Flow data tracking through spreadsheets will allow this team to observe if individual encounters with individuals living on the street result in use of available care. This approach follows the principle of meeting people where they are to enhance their willingness to accept and participate in treatment options available and that are needed.

During the first year of operations using the Mobile Clinic in the field, a baseline will be set of the encounters with individuals experiencing homelessness and their utilization of available care options. This baseline report will be organized monthly and show utilization of services. In the second year of operation, reporting will continue and be compared to the prior year's data. This will show an increase or decrease in the use of available care options through the Mobile Clinic. Once

in the second year, this data comparison will continue against all previous years data to map increase or decrease in use of available care. Although this process will map both increases and decreases, the intended goal is to see an increase in use of available care options through the Mobile Clinic with Street Psychiatry.

Learning Goal #3

Can the Mobile Clinic successfully provide more outreach and access to care on the street?

Learning Goal #3 will measure the success in providing more outreach and access to care on the street. The Mobile Clinic with Street Psychiatry will measurement enhanced linkage to services including an increased willingness to take prescription medication, increase in successful housing, and decrease homelessness. Through our Electronic Health Record (EHR) KernBHRS will create a specific subunit to track use of prescription and IM medication provided through the Mobile Clinic. Through the EHR standardized reports can be pulled over a period of time which will show an increase or decrease in use of prescription or IM medication use. Like the above Learning Goal #1, a baseline will be set the first year using this standardized report and will be compared with all additional years moving forward to map the increased willingness to take prescription medication and/or IM injections through the Mobile Clinic.
Learning Goal #2 will also measure an increase in successful housing and a decrease in homelessness. This will be done through the use of the DCR. The assigned subunit for the Mobile Clinic will be updated for use in the DCR by being supported under the Homeless Adult Team which is a Full-Service Partnership team. The DCR will map successful housing placement and or decrease in homelessness. DCR reports are already being reviewed for our Full Services Partnership teams monthly with a quarterly review. The oversight over this process already exists and is successful so the Mobile Clinic will be an added team to review through this standardized approach. Over time, and in working with the housing team, KernBHRS will be able to map if the Mobile Clinic is successfully supporting individuals with housing and decreasing homelessness through the Mobile Clinic.

Additionally, through the use of flow data tracking, KernBHRS can track how many times the Mobile Clinic was dispatched into the field, how many times it was dispatched to public events, and how many times it responded to emergency disaster events. Additionally, the data that is tracked through the flow data tracking system includes how many people were approximately reached in each outreach activity.

Currently, KernBHRS monitors all outreach and education that occurs for the whole Mental Health Plan through the MHSA Team. A flow data tracker currently exists that will be updated to include when the Mobile Clinic with Street Psychiatry is slated to be used for outreach to the community.

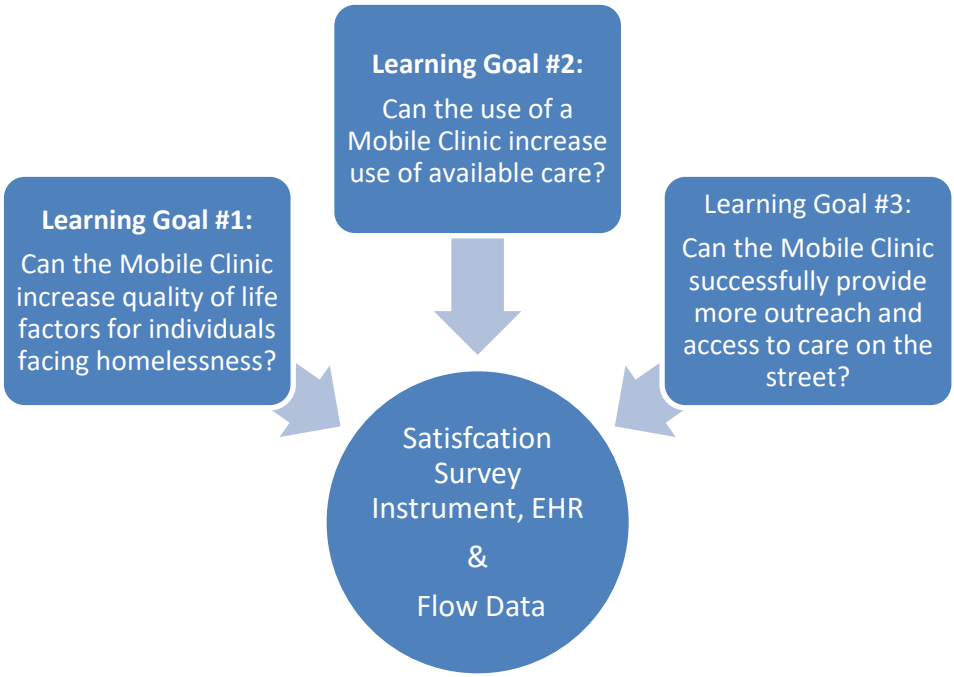
Information that will be collected is:

- Date and time of the event
- Location
- Target demographic audience for the outreach event
- Approximate number of individuals that were provided outreach and education on behavioral health and substance use recovery treatment and services.

Disaster response, similar to outreach tracking, will be monitored through the disaster coordinator. The Outreach and Education Team will monitor the following items with the use of the Mobile Clinic with Street Psychiatry for disaster response throughout the life of the project:

- Date and details of the Disaster
- Dates the Mobile Clinic with Street Psychiatry was used for Disaster Response
- Location or geographic area Mobile Clinic with Street Psychiatry responded to
- Approximate number of people Mobile Clinic with Street Psychiatry helped or provided support to

Like the other Learning Goals, in the first year that the Mobile Clinic is in operations, the first year data will create the baseline for mapping future success in outreach efforts using the Mobile Clinic with Street Psychiatry. Once the baseline is set for the first year using this standardized flow data tracking tool, it will be compared with all additional years moving forward to map the increase and success of the Mobile Clinic providing more outreach and support to the community and to individuals facing homelessness. The number of events will be tracked as well as the approximate number of people reached through those events.



Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

KernBHRS plans to contract out project evaluation to EVALCORP. EVALCORP is a leader in providing outcome evaluation support for MHSA in multiple counties. Kern currently uses EVALCORP for multiple projects including our Smart911 Innovation Plan.

EVALCORP has proven to successfully work with KernBHRS on complex projects including Innovation and have the experience necessary to support Kern County in the Mobile Clinic with Street Psychiatry projection evaluation to map outcome measurements and successes found through this model.

Once the project becomes operational, EVALCORP will map outcomes measures starting the first year of operations to help set the baseline for success. Through this process EVALCORP will manage all data throughout the year and provide and Annual Report of the progress found through the use of the Mobile Clinic with Street Psychiatry.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or underserved populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

Community Program Planning Process (CPPP) gives respective community members (stakeholders) the opportunity to provide feedback on how MHSA funding should be used within the scope of MHSA. It also provides a platform for stakeholders to share their thoughts on the effectiveness of current mental health programs.

CPPP is maintained on an annual schedule but occurs many times throughout the year. Meetings are held at different geographical locations. Currently all meetings are being held virtually due to COVID-19 restrictions. Meetings are conducted in English as well as the current threshold language for Kern (Spanish), in order to ensure that stakeholders reflect the diversity of Kern County and have had ample opportunity to participate and provide feedback. During the stakeholder process, KernBHRS collects self-disclosed demographic information from all participants that participate in the stakeholder process.

Since 7/18/2019, the MHSA Team has formally documented the initial need for mobile services. As mentioned in the section entitled ***Proposed Project Item C*** details of specific stakeholder feedback is available.

Data was collected from the period of 7/12/2019-9/8/2021, showing stakeholder support for mobile services. From the data, 22 different stakeholder meetings received feedback suggesting and recommending the need for mobile services and/ or transportation needs for clients. From the 24 different meetings, 10 of these stakeholder meetings were in different locations within Kern County. From the 10 meetings in different geographically areas, 8 meetings were in rural areas with unmet needs and 2 of the meetings were in the city limits of Bakersfield. Additionally, 6 meetings were held virtually. Additionally, besides geographic areas where stakeholder feedback was collected, feedback was also collected from other cultural and specific locations: The Center for Sexuality and Gender Diversity, Kern City 55+ Community, and the Homeless Collaborative. All three of these locations advocated for their intended audiences: those identifying as LGBTIQ+, Older Adults, and those facing or are at-risk of homelessness. On the following page is a map to help visualize the vast geographically need throughout Kern County for the Mobile Clinic with Street Psychiatry.

★= location of a Stakeholder meeting that was in support for the Mobile Unit/ Wellness on Wheels

Furthermore, during the stakeholder process, the MHSA Team requests demographic information from every stakeholder that participates in the public process. Demographic information is self-disclosed. Stakeholders have the option to decline participating in the demographic survey; however, it is encouraged to complete the survey to support the CPPP and matching the demographics of Kern's Stakeholders to those of Kern's clients.

On the next page is a chart of Collective Stakeholder Demographic Information from the 24 Stakeholder Meetings that occurred between 7/12/2019-9/8/2021 and supported the Mobile Clinic

with Street Psychiatry conceptual model.

Collective Stakeholder Demographic Information

1. Age Group:	
0-15	1
16-25	16
26-59	267
60 or older	55
Decline/ Did not submit a Survey	350
2. Gender Assigned at Birth:	
Male	58
Female	288
Decline/ Did not submit a Survey	343
3. Gender you currently identify with:	
Male	106
Female	249
Transgender	2
Genderqueer	4
Questioning or unsure	0
Other gender identity	1
Decline/ Did not submit a Survey	327
4. Veteran's Status:	
Yes, I am a veteran	11
No, I am not a veteran	263
Decline/ Did not submit a Survey	415
5. What is your primary language?	
English	263
Spanish	14
Both English and Spanish	38
Decline/ Did not submit a Survey	374
6. Disabilities:	
Vision	15
Hearing, or difficult understanding speech	9

Mental/Cognitive (excludes behavioral)	9
Mobility/Physical	6
Chronic Medical Illness (not limited to pain)	17
None	270
Decline/ Did not submit a Survey	363
7. What is your sexual orientation?	
Straight/Heterosexual	341
Gay/Lesbian	15
Bisexual	11
Questioning	1
Queer	7
Decline/ Did not submit a Survey	312
Other Sexual Orientation	2
8. What is your race?	
Asian	5
Native Hawaiian or other Pacific Islander	3
Black/African American	25
Latino/Hispanic	125
Tribal/Native American	7
White/Caucasian	172
Two or more races	124
Decline/ Did not submit a Survey	228
9. What is your ethnicity? *Note: Participants may select more than 1 answer	
African	16
Asian Indian/South Asian	3
Cambodian	0
Chinese	1
Eastern Europe	11
Korean	0
Middle Eastern	3
Vietnamese	0
European	62
Filipino	1
Japanese	0
Caribbean	1
Central American	20
Mexican/Mexican American/Chicano	104
Puerto Rican	1
South American	5
Two or more ethnicities	38

Decline/ Did not submit a Survey	287
Other	293

KernBHRS believes that Stakeholders represented within the 24 stakeholder meetings that were representative of support for the Mobile Clinic with Street Psychiatry are diverse. Furthermore, looking at the demographics make up of all attendees that opted to complete the demographics survey show people from many different walks of life. The demographic data shows people participated in the stakeholder process representing various age groups, genders, ethnic and culturally specific groups.

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration

KernBHRS will work in collaboration with Stakeholders to get feedback on appropriate locations or encampments for the Mobile Clinic with Street Psychiatry to do outreach. Additionally, KernBHRS will announce to stakeholders that the Mobile Clinic with Street Psychiatry will be available for outreach events when not in use by the ROEM team for homeless outreach. Feedback regarding program outcomes will be collected annually through the MHSA CPPP.

Community collaboration will occur through the outreach component of the model, for both general outreach and also street psychiatry and outreach. KernBHRS has developed a relationship with other mobile street outreach teams that provide medical care services and can co-locate when a need is identified with the medical response care teams. Many times, throughout the year, KernBHRS receives requests to participate in community outreach. Sometimes this is requested as a collaborative effort with other government departmental agencies, school districts, or annual awareness events. Examples of collaborative efforts with governmental departmental agencies in the past have included work with Public Health, Board of Supervisor initiatives, Department of Health Services, First 5, and work with Elected Officials. There are 48 school districts and 236 schools within Kern County. KernBHRS is available to work with all school districts to increase awareness of resources and services available for behavioral health and substance abuse services especially for children and families deemed high risk for homelessness. KernBHRS provides support for resource fairs, drive thru events, trainings, Back to School night, and health fairs with the schools. KernBHRS currently works with most Kern County School Districts to provide resources and education to students and educators. Additionally, KernBHRS routinely gets invited and involved with community annual awareness events like the Suicide Prevention Walk, National Alliance of Mental Illness (NAMI) Walk, Movie in the Park, College Fairs, Homeless Outreach Efforts, Prison Employee Awareness Fair, Geographic Health Fairs, El Tejon Tribe Pow Wow, Disability Fair, Veterans Stand Down Event, Good Neighbor Festival, Pride Fair, Recovery Conference, Men's Health Month, Homeless Center Carnival, Sikh Parade, Farmworker

Appreciation Resource Fair, Delano Block Party, and Multifaceted History of Blackness Event.

In responding to disaster response, KernBHRS typically collaborates with other federal and state departments and authorities depending on the severity and circumstances of the given disaster. KernBHRS intends to work closely with other governmental and community organizations to provide the most efficient and effective services needed in response to crisis or disaster response. In the past, KernBHRS has responded and worked with local law enforcement and the Red Cross for disaster response.

Additionally, below is a list of all agencies and actions that KernBHRS plans to work with in collaboration with the Mobile Clinic with Street Psychiatry. Many of these identified agencies already have working MOUs or existing partnerships with KernBHRS

- MOU for shelter beds at homeless shelters/ low barrier shelters
- MOUs with Adult Residential Facilities, SLE and Hotel Rooms
- Direct connection into local Freise Hope House placement
- Joint response With the Homeless Outreach Team and Flood Ministries (contracted provider for homeless outreach).
- Relationship with Law Enforcement for appropriate response.
- Linkage to public showers and other engagement services.
- Linkage to Clinical Sierra Visit's Medical Street Outreach Team
- Adventist Health Hospital's Medical Outreach Teams.
- The Center for Sexuality and Gender Diversity
- Bakersfield American Indian Health Project
- LatinX Taskforce of Kern County

Community Based Organizations are utilized when an individual is accepting third party assistance are ready to move into a safe housing environment, job training, and furthering their education. One CBO being utilized is Garden Pathways which is also a peer support/mentor program that offers parenting classes, job training, tattoo removal and working with individuals to get their needs met. With the working relationships with KernBHRS and CBOs, the options are endless when an individual is ready.
KernBHRS currently is working with the County's Homeless Collaborative. This Collaborative has recently restarted with an emphasis on wraparound approaches from community based organizations throughout the County. KernBHRS participates in this collaborative as a partner that can bring treatment options for behavioral health and substance use needs for those experiencing homelessness. Through this collaborative, KernBHRS can assist individuals encountered on this street with housing options and resources through the Homeless Collaborative's partners and through the Housing Authority.
Additionally, since the pandemic started, two new low barrier shelters have been established servicing those facing homelessness. KernBHRS has provided linkage and treatment staff at both of these low barrier shelters to encourage outreach, engagement and linkage options into care. These existing relationships will be leveraged to help identify people within the homeless population to provide a more robust whole person care approach.

B) Cultural Competency

All staff, including psychiatrists, nurses, substance use counselors, recovery specialists, peers/ those with lived experience, and aides, will be required to complete cultural competency training on an annual basis. Annually, KernBHRS staff will complete a minimum of 6 hours of cultural competency training. Bilingual staff will assist individuals who are more comfortable receiving services in Spanish. KernBHRS bilingual staff members are required to attend interpreter training, as to ensure continuity of care with Spanish-speaking populations. Additionally, KernBHRS utilizes a language line for interpretation services when needed for clients or community members.
KernBHRS has an array of marketing collateral and resources available in many different languages. The resources, brochures, and flyers that are taken by the community are in: English, Spanish, Punjabi, Hindi, or Tagalog. If an additional need for marketing material is needed in a specific language during the implementation of the Mobile Clinic with Street Psychiatry, KernBHRS has the ability to create marketing material in the requested language.

Stakeholder feedback in support for this Innovation project included feedback from groups representing: LGBTIQ+ individuals, Native American Populations, Spanish Speaking/ LatinX groups, African American/ Black, and from Veterans. Some specific interests for these groups and the use of the Mobile Clinic with Street Psychiatry were recorded. Most of the feedback was specific to outreach to certain geographically areas with higher density groups of certain cultural backgrounds.

Additionally, KernBHRS has a very robust training program that gives all of our staff access to live, instructor-led events and asynchronous, self-paced training modules. As of 6/2/21, there are 275 cultural competence course available in our Relias Training Program for the department. Some examples of trainings that are offered and may be applicable to training for the Mobile Clinic with Street Psychiatry are below:

Topic	**Training Title**
LGBTIQ+	Behavioral Health Services and the LGBTQ+ Community, Best Practices for Working with LGBTQ Children and Youth, Cultural Competence and Sensitivity in the LGBTQ Community – California, Substance Use Disorder Treatment and the LGBTQ Community
Latinx	How Social Distancing, Loneliness, and Insecurity Affect People Recovering from Mental Health and Substance Use Disorders and What to do to Help (Spanish Webinar),
Black/AA	Juneteenth Virtual Town
NA/AN	Advocacy for American Indian Health Equity in Kern County
API	Asian and Pacific Islander American Heritage Month Virtual Symposium

C) Client-Driven

KernBHRS believes peers and those with lived experience have a special role within our department. Their stories and journeys have inspired others and instilled hope in the journey of recovery. KernBHRS has invested in supporting the role of peers within the department. KernBHRS plans to hire 1 staff for the Mobile Clinic with Street Psychiatry that will be a peer with lived experience to assist in driving the Mobile Clinic with Street Psychiatry and supporting the team that

is scheduled to use the Mobile Clinic with Street Psychiatry. Lived experience for this position can be defined as having experience living with homelessness and/ or behavioral health and/ or substance use challenges. This peer can also provide outreach for each team or the department for clients that have missed appointments or are hard to reach. Additionally, with the current HAT and ROEM pilot that initially launched and will help to support the Mobile Clinics with Street Psychiatry, there is already 1 team member with lived experience that assists with outreach and engagement with individuals that are homeless.

If possible, peer recovery specialists will be included in the staffing during treatment when the Mobile Unit is being used for service delivery. Peer support is vital and will be implement from the initial engagement through treatment options. Individuals have setbacks, contemplate sobriety, and question their motivation for change. The peer works with a harm reduction approach and maintains consistent services to show commitment to building trust in the relationship. Peers have the background and understanding of truly "meeting the client where they are" and understanding the struggles of trust, stopping history of repeating itself, and the know of getting multiple chances to improve their current situation without judgement and encouragement. Peer to peer early intervention with needle exchange can show individuals that KernBHRS is not there to judge the decision to continue to use but help work toward using in a safe manner, which is key when working on building a trusting relationship for services. Substance Use Disorder (SUD) services in the local shelters and street outreach will be supported by the peer role. Daily street outreach for SUD services along with Behavioral Health services will be conducted for linkage and coordinated entry into the system of care.

Many people throughout the department have lived experience and use it in their treatment efforts. This will be a practice that KernBHRS and the Innovation plan will encourage with the use of the Mobile Clinic with Street Psychiatry in service delivery.

Additionally, clients will be provided with the opportunity to submit feedback through the stakeholder process or during public review of the Annual or 3 Year MHSA Plan.

D) Family-Driven

Family members are encouraged to participate in the services and recovery of individuals served. Families may also be referred to community services and to NAMI. KernBHRS believes that family has a vital role in supporting family members, especially family members that have suffered hardships like homelessness and challenges with behavioral health and recovery needs. KernBHRS will attempt to reconnect and include family in the treatment process, when applicable, and when family can be located, and after the individual facing homelessness is stabilized in treatment.

When the Mobile Clinic with Street Psychiatry is used for outreach, education, and engagement in the community, it is a family friendly practice. The outreach workers are trained to work with families to provide linkage, access to services, and basic resources in a dignified and informative way. KernBHRS' Outreach Team's mission is to reduce stigma and discrimination within the community in regard to seeking treatment for mental health and substance use recovery.

The Mobile Clinic with Street Psychiatry will be available to go to family and school resource fairs where outreach workers typically provide education and resources to family members, guardians, and circle of supports. The Mobile Clinic with Street Psychiatry can also be used in response to invitations from NAMI to participate in their planned family advocacy events.

E) Wellness, Recovery, and Resilience-Focused

Mobile Clinic with Street Psychiatry can be a valuable service for access and linkage to treatment. By using appropriate culturally competent outreach efforts, individuals can develop hope and wellness. The Mobile Clinic with Street Psychiatry can be an invaluable tool for homeless adults, youth and families.

The Mobile Unit's practice is based off the idea of supporting wellness, aiding in the process of recovery, and building resilience with the community and the people the Mobile Clinic with Street Psychiatry intends to serve. The Mobile Clinic with Street Psychiatry's philosophy is to be designed in a way that is extremely flexible so that it can be used in a multitude of ways for different populations and purposes within Kern County.

F) Integrated Service Experience for individuals and Families

At the individual's discretion, with the exception of youth, families can be invited to participate in their recovery process. The Mobile Clinic with Street Psychiatry is designed to assist client's in their recovery if their recovery includes their family. The Mobile Clinic with Street Psychiatry will be large enough to have family participate in treatment of the individual.

Additionally, marketing collateral and resources that will be in stock in the Mobile Clinic with Street Psychiatry to promote recovery from all stages in life which can appeal to families if they have multiple behavioral health and recovery challenges that the family unit may be experiencing. Some marketing material has thoughtfully been created to depict families in the process of recovery and healing so that clients and their families may identify more closely with services and how services can assist them on their treatment or recovery.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

KernBHRS considers cultural competence as a priority for all staff and the department as a whole. The benefit from annual training is evident through the care our clients receive. All staff assigned to this Innovation Project will be up to date on their required hours of cultural competence training.

KernBHRS' Stakeholders will have repeated access to voice their opinions in scheduled stakeholder meetings. Each meeting is publicly announced on the department website, through an invitation list or previous stakeholders, and social media pages. KernBHRS is also using the Behavioral Health Board and the Kern County Board of Supervisors to disseminate the

Stakeholders invitations. During quarantine under COVID these meetings have switched to a virtual platform.

Additionally, the MHSA coordinator and representative from the MHSA Team sit on the monthly Cultural Competence Resource Committee (CCRC). In the implementation of the program and the reporting of the project evaluation, if an issue arises regarding a cultural competence challenge or counsel is needed, this item can be brought to the CCRC for a formal review and recommendation. For instance, if a culturally significant group seems difficult to provide outreach to using the Mobile Clinic with Street Psychiatry, this challenge may be presented to the CCRC with requested review and recommendations of how to improve outreach.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.

After the term for this innovation ends, the County will compile all feedback from stakeholder meetings and data collected from outcome measurements to determine whether this innovation program was a complete success and should be continued through the FSP funding stream. If only some elements from the project were successful, then KernBHRS will take these ideas and continue funding them through a different program as permittable and with Stakeholder approval.

In preparation for the sustainability planning of this Innovation program, the tools used for outcome measurements are very similar to the tools used for FSP. FSP uses the DCR as an outcome measurement tool which is a proposed tool for this Innovation plan. If it is determined that this program is successful and has Stakeholder support to continue after the timeline of the Innovation program is completed, the program will merely move over to either the FSP funding source and continue as is. The Mobile Clinic with Street Psychiatry model and ROEM programming was designed to easily move over to either FSP funding if need be.

Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

The Mobile Clinic with Street Psychiatry is designed to provide supports in all service delivery areas and can and will be used for individuals that quality for Full-Service Partnership (FSP) services, which are individuals with some of the highest level of need. KernBHRS' intent is to have staff use the Mobile Clinic with Street Psychiatry to provide "meet them where they are at" services to individuals with the highest level of needs that are determined to be high risk.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) *How do you plan to disseminate information to Stakeholders within your County and (if applicable) to other counties? How will program participants or other Stakeholders be involved in communication efforts?*

Open communication to all Stakeholders is planned to be provided through regularly scheduled stakeholder meetings. Updates on the successes and challenges of the program will be communicated with all parties. A survey is given at the end of each stakeholder meeting to successfully gather feedback from every individual. Additionally, Stakeholders are able to communicate suggestions or opinions during the discussion portion of the meeting. Outcome measurement data and plans for improvement will be communicated with the public through annual updates and three-year plans. At the end of the Innovation project term a final Innovation Report will be written and posted on the KernBHRS website. Other counties are able to contact the Kern MHSA Team for information on the program directly through email or through stakeholder meetings. The MHSA Team has a public email that is used as a means for open door communication with the public for all inquiries and concerns.

Additionally, the MHSA Team provides a Quarterly report of findings from each stakeholder meeting. These reports once published are available in English and Spanish on the KernBHRS website. These quarterly reports aid in transparency of each Stakeholder meeting and the public comment that was collected. The Quarterly report also lists the self-disclosed demographics of those who attended the meeting. At the end of the Fiscal Year the Quarterly Reports are combined into an Annual Stakeholder Report on all combined findings and suggestions from the year worth of Stakeholder feedback.

B) *KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.*

- Mobile Unit
- Street Psychiatry
- ROEM
- Homelessness
- Disaster Response

TIMELINE

A) *Specify the expected start date and end date of your INN Project*

If KernBHRS received approval to implement this Innovation Project by the late fall, KernBHRS intends to implement the program approximately 1/1/2022. The project will run for a five-year term, with a projected end date of 12/31/2026.

B) *Specify the total timeframe (duration) of the INN Project*

As mentioned above the total timeframe and duration of the INN project is planned for a span of 5 years. The five years will start upon the first expense occurring for the program.

C) *Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.*

#	Project Timeline	Fiscal Year Quarter Achieved
1	Purchase, design and construction of the Mobile Unit	Q4
2	Hiring of staff	Q4
3	First Year Report on Innovation Plan completed and submitted	Q4
4	Annual Report and ARER will provide updates on Innovation Program	Q4
5	Procedure for Use of the Mobile Unit will be completed	Q5
6	Suggested scheduling for the Use of the Mobile Clinic with Street Psychiatry will be completed	Q6
7	Programming of Innovation Project and the Use of the Mobile Clinic with Street Psychiatry will begin	Q7
8	Outcome measurements will be collected	Q8
9	Annual Report and ARER will provide updates on Innovation Program	Q8
10	Outcome measurements will be collected	Q10
11	Outcome measurements will be collected	Q12
12	Annual or 3 Year Report and ARER will provide updates on Innovation Program	Q12
13	Outcome measurements will be collected	Q14
14	Outcome measurements will be collected	Q16
15	Annual or 3 Year Report and ARER will provide updates on Innovation Program	Q16
16	Outcome measurements will be collected	Q18
17	Determination of the sustainability of the Innovation Program will be determined	Q19
18	Outcome measurements will be collected	Q20
19	Annual Report and ARER will provide updates on Innovation Program	Q20

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) *BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)*

B) *BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)*

C) *BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources*

BUDGET NARRATIVE

The total budget for the 5-year project is estimated at a cost of $8,774,095 dollars. The budget includes expenditures for personnel cost, assets purchases, operational cost of both “services and supplies expense” and training expense, and indirect cost. Note that the $40,000 estimated cost for the primary care exam rooms, will be the exam rooms customized within the mobile units. The

following schedules show key aspects of the estimated cost of the proposed project:

Schedule 1:

Budget Cost by Category and Percentage			
Item	**Description**	**Total**	**Percentage**
1	Personnel Cost	$ 6,372,713	73%
2	Operating Cost	805,345	9%
3	Capital Assets	640,133	7%
4	Indirect Cost	955,907	11%
	Totals	**$ 8,774,098**	**100%**
Comment: The above schedule provides the percentage of each category expense of the total 5-year budget.			

Schedule 2:

Personnel Cost by Position								
Item	**Position**	**FTE**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1	Peer Support Specialist I/II/III	2	$ 171,497	$ 176,641	$ 181,941	$ 187,399	$ 193,021	$ 910,499
2	Psychiatry Time	1	450,000	463,500	477,405	491,727	506,479	2,389,111
3	Medical Assistant	1	78,886	81,253	83,690	86,201	88,787	418,817
4	Nurse	1	192,312	198,082	204,024	210,145	216,449	1,021,012
5	BH Recovery Specialist	1	133,053	137,045	141,156	145,391	149,753	706,398
6	BH Therapist	2	174,581	179,819	185,213	190,770	196,493	926,876
	Totals	**8**	**$ 1,200,329**	**$1,236,340**	**$1,273,429**	**$ 1,311,633**	**$1,350,982**	**$6,372,713**
Comment: the above schedule provides the personnel cost by position								

Schedule 3:

Purchase of Capital Assets & Technology								
Item	**Description**	**Qty**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1	Custom RV	1	$ 420,000					$ 420,000
2	Sprinter Van	1	150,000					150,000
3	Mobile Internet Router & Extender Equipment	1	7,133					7,133
4	Primary Care Exam Rooms	1	40,000					40,000
5	Laptops/Printers/Docking stations		15,000	2,000	2,000	2,000	2,000	23,000
	Totals	**4**	**$ 632,133**	**$ 2,000**	**$ 2,000**	**$ 2,000**	**$ 2,000**	**$ 640,133**
Comment: The above schedule provides the capital assets purchases. Except for the laptops, printers, and docking stations, the major capital assets will be purchased at the beginning of the project.								

Summary of Budget and Funding Schedule:

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
	PERSONNEL COSTS (Salaries, Wages, Benefits)	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Salaries, Personnel Expenditures, Including Salaries, Wages & Benefits	$1,200,329	$1,236,340	$1,273,429	$1,311,633	$1,350,982	$6,372,713
2.	Direct Costs						
3.	Indirect Costs						
4.	Total Personnel Costs	1,200,329	1,236,340	1,273,429	1,311,633	1,350,982	6,372,713
	OPERATING COSTS	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
5.	Direct Costs	172,500	118,250	121,950	120,686	121,959	655,345
6.	Indirect Costs						
7.	Total Operating Costs	172,500	118,250	121,950	120,686	121,959	655,345
	NON-RECURRING COSTS (Equipment, Technology)	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
8.	Non-recurring Costs	632,133	2,000	2,000	2,000	2,000	640,133
9.	Non-recurring Costs						
10.	Total Non-recurring Costs	632,133	2,000	2,000	2,000	2,000	640,133
	CONSULTANT COSTS/CONTRACTS (Clinical, Training, Facilitator, Evaluation)	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**

11.	Direct Costs	30,000	30,000	30,000	30,000	30,000	150,000
12.	Indirect Costs						
13.	Total Consultant Costs	30,000	30,000	30,000	30,000	30,000	150,000
OTHER EXPENDITURES (Please explain in budget narrative.)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
14.	Indirect Costs	180,049	185,451	191,014	196,745	202,648	955,907
15.							
16.	Total Other Expenditures	180,049	185,451	191,014	196,745	202,648	955,907
BUDGET TOTALS							
Personnel (line 1)		1,200,329	1,236,340	1,273,429	1,311,633	1,350,982	6,372,713
Direct Costs (add lines 2, 5 and 11 from above)		202,500	148,250	151,950	150,686	151,959	805,345
Indirect Costs (add lines 3, 6 and 12 from above)							
Non-recurring costs (line 10)		632,133	2,000	2,000	2,000	2,000	640,133
Other Expenditures (line 16)		180,049	185,451	191,014	196,745	202,648	955,907
TOTAL INNOVATION BUDGET		$2,215,011	$1,572,041	$1,618,393	$1,661,064	$1,707,588	$8,774,098

* For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION							
Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	$180,049	$185,451	$191,014	$196,745	$202,648	$955,907
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	180,049	185,451	191,014	196,745	202,648	955,907
EVALUATION							
Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	2,034,962	1,386,590	1,427,379	1,464,319	1,504,941	7,818,191
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other Funding*						
6.	**Total Proposed Evaluation**	2,034,962	1,386,590	1,427,379	1,464,319	1,504,941	7,818,191
TOTAL							
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 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	2,215,011	1,572,041	1,618,393	1,661,064	1,707,588	8,774,098
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**	$2,215,011	$1,572,041	$1,618,393	$1,661,064	$1,707,588	$8,774,098
*If “Other funding” is included, please explain:							

ATTACHMENT A

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Oversight & Accountability Commission

COMMISSION MEETING RECOMMENDATIONS

These recommendations for innovation plan presentations have been developed to support the dialogue between the Commission and the counties. Please note that the recommendations below regarding length, the County brief, PowerPoint presentation and presenter information are to ensure that counties and the Commission have ample opportunity to engage in a dialogue to gain a better understanding of the needs in the County, how the innovation plan meets those needs, why it is innovative and how will it be evaluated to support shared learning.

1. **Length of Presentation**
   a. County presentations should be no more than 10-15 minutes in length
   b. The Commission will have received the Innovation Project Plan as well as the Staff Analysis prior to the meeting
   c. The remaining time on the agenda is reserved for dialogue with the Commission and for public comment

2. **PowerPoint Presentation**
   a. Recommend bulleted slides to allow County to discuss and highlight project and dialogue
   b. Recommend 5 slides and include the following five (5) items:
      i. Presenting Problem/Need
      ii. Proposed Innovation Project to address need
      iii. What is innovative about the proposed Innovation Project? How will the proposed solution be evaluated (learning questions and outcomes)?
      iv. Innovation Budget
      v. If successful, how will Innovation Project be sustained?

3. **County Brief (optional)**
   a. Recommend 2-4 pages total and should include the following three (3) items:
      i. Summary of Innovation Plan / Project
      ii. Budget
      iii. Address any areas indicated in the Staff summary

4. **Presenters and Biographies**
   a. We request no more than a few (2-4) presenters per Innovation Project
      i. If the County wishes to bring more presenters, support may be provided during the public comment period
   b. Recommend biography consisting of brief 1-2 sentences for individuals presenting in front of the Commission
      i. Include specific names, titles, and areas of expertise in relation to Innovation Plan / Project

Note: *Due dates will be provided by Innovation Team upon Commission calendaring for the following items: Presenter Names, Biographies, County Brief, and PowerPoint presentation.*