I.E. PsychPartners: Public-Private Collaboration to Transform Emergency Psychiatric Services
INNOVATIVE PROJECT PLAN DESCRIPTION
Optional Template

County: Riverside Date Submitted 08/31/2017 (DRAFT)

Project Name: I.E. PsychPartners: Public-Private Collaboration to Transform Emergency Psychiatric Services

PLEASE NOTE: USING THIS TEMPLATE IS **OPTIONAL**. It is being provided as a technical assistance tool to staff who wish to make use of it.

An "Innovative Project" means "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" (*California Code of Regulations, Title 9, Sect. 3200.184*). Each Innovative Project "shall have an end date that is not more than five years from the start date of the Innovative Project" (*CCR, Title 9, Sect. 3910.010*). Counties shall expend Innovation Funds for a specific Innovative Project "only after the Mental Health Services Oversight and Accountability Commission approves the funds for that Innovative Project" (*CCR, Title 9, Sect. 3905*).

The goal of this template is to assist County staff in preparing materials that will adequately explain the purpose, justification, design, implementation plan, evaluation plan, and succession plan of an Innovation Project proposal to key stakeholders, including local and State decision-makers, as well as interested members of the general public.

General regulatory requirements for Innovative Projects can be found at CCR, Title 9, Sect. 3910. Regulatory requirements for the Innovation (INN) Component of the 3-Year Program and Expenditure Plan & Annual Update can be found at CCR, Title 9, Sect. 3930. In some cases, the items contained in this **OPTIONAL** template may be ***more specific or detailed*** than those required by the regulations; you may skip any questions or sections you wish.

The template is organized as follows. Part I, Project Overview steps through a series of questions designed to identify what the County has identified as a critical problem it wishes to address via an Innovative Project, the steps the County has taken to identify an innovative strategy or approach to address that critical problem; how it intends to implement the innovative strategy or approach; what it hopes to learn and how those learning objectives relate the innovative strategy or approach to the critical problem it has identified; how it intends to address the learning objectives; and how the County intends to address any transition for affected stakeholders at the end of the time-limited project.

Part II, Additional Information for Regulatory Requirements, poses a series of questions that relate to specific regulatory requirements, either for the proposal or for subsequent reports.

I. Project Overview

1) Primary Problem

a) 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.

The primary problem that this project addresses is the lack of knowledge in treatment of Emergency Department (ED) consumers who are in need of behavioral healthcare. Research on this topic revealed limited available information on solutions to combat ED wait times and the quality of care administered to consumers in mental distress.

The nation's dwindling mental health resources are contributing significantly to increased wait times and longer emergency department stays for patients having psychiatric emergencies, including children. Three-quarters of emergency physicians responding to a poll report seeing patients at least once a shift who require hospitalization for psychiatric treatment; almost one-quarter (21 percent) say they have patients waiting two to five days for in-patient beds (Llyod, 2016).

A 2016 American College of Emergency Physicians report states that:

- Almost half (48 percent) of respondents reported psychiatric patients are held (or "boarded") in their emergency department waiting for an in-patient bed one or more times a day.
- More than half (57 percent) reported increased wait times and boarding for children with psychiatric illnesses.
- Only 16.9 percent reported having a psychiatrist on call to respond to psychiatric emergencies in the emergency department.
- More than 11 percent reported having no one on call to respond to psychiatric emergencies.
- More than 10 percent reported having 6 to 10 patients waiting for inpatient psychiatric beds on their last shift.

ER psychiatric assessments are often inadequate, and when treatment is provided, it is generally no more than medication. This is because psychiatrists are not available in all emergency rooms, and ER staff members are often not trained in psychiatry (Alakeson, 2010).

The Hospital Association of Southern California's ad hoc committee, Ambulance Patient Offload Delay taskforce, has noted an increase in the number of patients requiring behavioral treatment in hospital EDs. Often, these patients are not actively accessing psychiatric care in other parts of the public behavioral health system, and/or other parts of the system of care. Additionally, the EDs are not equipped to provide the time-intensive treatment needed by these patients.

In the Inland Empire this issue is magnified due to rapid population growth and limited resources. This project will use a regional, two-county, collaboration in partnership with a public entity to address the need for insight on a combined method of embedded psychiatric crisis trained staff, the creation of order sets, ED staff training, and telepsychiatry. The working collaborative would include Riverside University Health System – Behavioral Health (RUHS-BH), San Bernardino County Department of Behavioral Health (SBCDBH), the Hospital Association of Southern California (HASC), and local hospitals.

b) 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.

In 2004, the people of the State of California declared the following: Behavioral health conditions are "extremely common; they affect almost every family in California. They affect people from every background and occur at any age. In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children — between 5% and 9%. Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year. People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of [physical] disabilities" (Mental Health Services Act, 2004). In the intervening thirteen years, progress has been made, but Californians seeking emergency behavioral health care continue to face one of the most complex care coordination for treatment and management systems in the United States' health care system. Over the past 40 years, cost saving measures have resulted in services for behavioral health patients shifting away from inpatient/hospital beds to outpatient and community-based behavioral health services. As of 2006, inpatient beds have been reduced to less than 50,000 nationwide (Wiler, 2014). Paradoxically, as hospitals are decreasing the number of inpatient beds, the outpatient capacity to provide psychiatric stabilization services in times of crisis has not kept pace and EDs are seeing increasing numbers of patients who need emergency behavioral health services.

Combined, Riverside and San Bernardino counties create a geographical region that is identified as the Inland Empire – the U.S. Census views the region as a metropolitan entity. The United States Census Bureau ranks the Inland Empire thirteenth in the nation's most populous areas; conversely, the region consists of two counties, each providing their own unique systems of care. The area is unique, consisting of urban, rural, and frontier populations covering a large geographic area. In 2013, the United States Census Bureau reported the Inland Empire first in poverty amongst metropolitan areas. The region also has a high homelessness rate. According to the Substance Abuse and Mental Health Services Administration, 20 to 25% of the homeless population in the United States suffers from some form of severe mental illness. These economic and social factors increase the use of county hospital EDs as a frontline of contact for consumers with mental health needs; consumers whose care is not easily defined by county lines.

The decision to prioritize the I.E. Psych Partnership arose as a response to community feedback. Additionally, a review of the literature regarding mental health consumers report their experience in EDs revealed feelings of humiliation and perceptions of a lack of expertise related to mental health concerns (Clarke, 2014). EDs staff have indicated feeling challenged by caring for individuals with mental health needs, a frustration exacerbated by hopelessness from the "revolving door" nature of psychiatric patients in the ED, resulting in apathy instead of empathy (Clarke, 2014). Primary health care providers have identified barriers to a greater partnership between primary and mental health care that includes the "extreme separation" between the allied professions, the difficulty in connecting a patient to mental health care when the need has not yet risen to a crisis state, a lack of knowledge of resources and mental health system navigation, and a lack of partnership between the professionals involved leaving the primary care physician to be excluded from the mental health care planning (Primary Care Medical Providers Attitudes Regarding Mental and Behavioral Medicine, 2012). Government agencies and hospital administrators recognize the importance of improving the quality of behavioral health care delivered in EDs (Wiler, 2014). The Centers for Medicare and Medicaid Services (CMS) include several measurements that evaluate patient length of stay and psychiatric boarding times while the patient is being treated in the ED. Of those metrics mentioned, behavioral health patients' boarding times, defined in wait times in emergency rooms, represent a significant concern for health care professionals, administrators, and regulators (Wiler, 2014).

EDs, by design, are created to address emergency health services targeted for physical health conditions such as heart attacks, strokes, and physical trauma. Specialty behavioral healthcare and treatment consultations are not currently a mandated component in emergency care. Emergency departments will medically assess any individual that walks; but without this mandate, a standardized model for providing emergency psychiatric care does not exist. Each individual hospital, or hospital group, is left to individually create its own model, usually without the assistance of a public behavioral health system or its regional neighboring hospitals. The development of regional order sets within

the EDs, similar to other consultative services, would create a streamlined standard of care for the overall benefit of individuals seeking psychiatric emergency care.

The I.E. Psych Partners project seeks to increase and improve the interagency collaboration between large systems to effect local EDs that have identified behavioral health consumers as contributing to overcrowding in the EDs and utilizes a high-cost, acute setting, impacting the EDs' capacity and throughput by increased wait times for non-trauma patients. Some common organizational barriers to interagency collaboration within healthcare, that this project will seek to improve, include but are not limited to:

- Lack of knowledge and appreciation of the roles of other healthcare professionals
- Stigma associated with mental health consumers seeking care in EDs and lack of education on managing consumers in mental health distress
- Lack of outcomes research on system wide collaboration efforts, to include a lack of data sharing between healthcare agencies
- Financial constraints that prevent inventive thinking within existing healthcare organizations
- Legal issues concerning scope of practice and liability between large healthcare agencies, to include unease with sharing in clinical decision-making
- Lack of understanding of reimbursement structures for both physical and mental/behavioral health procedures
- Lack of trust in the collaborative process

2) What Has Been Done Elsewhere To Address Your Primary Problem?

"A mental health practice or approach that has already demonstrated its effectiveness is not eligible for funding as an Innovative Project unless the County provides documentation about how and why the County is adapting the practice or approach… (*CCR, Title 9, Sect. 3910(b)*).

The Commission expects a County to show evidence that they have made a good-faith effort to establish that the approach contained within their proposed project either has not been demonstrated to be effective in mental health or is meaningfully adapted from an approach that has been demonstrated to be effective. Describe the efforts have you made to investigate existing models or approaches close to what you're proposing (e.g., literature reviews, internet searches, or direct inquiries to/with other counties). Have you identified gaps in the literature or existing practice that your project would seek to address?

a) Describe the methods you have used to identify and review relevant published literature regarding existing practices or approaches. What have you found? Are there existing evidence-based models relevant to the problem you wish to address? If so, what limitations to those models apply to your circumstances?

An intense review of scholarly articles, journals, books, studies, and internet sources concluded there was no resolve in the issue of extended wait times and inadequate care for psychiatric consumers in hospital EDs. Furthermore, there were no existing evidence-based models with the proposed collaborative effort. There were articles and research that focused on the topic but no particular practices or approaches to resolve the regional issue.

The local government collaboration and hospital association involvement has never been attempted – this is what makes this project innovative – creating an opportunity for learning practices and approaches that have not been learned in other programs.

RUHS-BH's REACH program is in place to increase access and quality to mental health services; yet, there is no current interagency collaboration that would increase access and ensure an equal level of quality throughout the region. Also, staff of this program are not embedded in the hospital to bridge the culture of the ED.

RUHS-BH REACH

Over the past two decades, Riverside has seen a significant population increase that has led to a greater examination of our psychiatric emergency rooms that were built when our county census was much smaller. With a trend toward voluntary care and a decrease in funding for involuntary beds, we looked to developing earlier interventions and hospital diversion programs. We have developed our Crisis System of Care to include mobile crisis teams that serve hospital EDs and law enforcement, Crisis Stabilization Units that provide an less than 24 hour, monitored treatment facility for voluntary consumers not needing an acute inpatient intervention, and Crisis Residential Units that provide up to a 2 week stay in a voluntary setting where the consumer can receive intensive services in a home-like atmosphere. Palo Alto, our most remote community hospital in Blythe, has access to telepsychiatry. Though these programs have significantly enhanced the options to crisis care, they have not relieved the region of a continued demand.

All Riverside County hospital emergency departments are offered the option to have professional staff apply for 5150 authorization and receive related mental health training in mental health crisis and law. In addition, a 5150 Committee, comprised of key department staff and system of care representatives was formed to problem solve training and access to emergency mental health care. Our Desert Region, one of the most impacted areas of our county, has developed problem solving relationships between the behavioral health regional administrator, Desert hospital administrations, and local law enforcement to improve outcomes for residents in mental health crisis.

As part of Riverside's Crisis System of Care, mobile crisis response teams were formed as a resource for EDs serving patients in mental health crisis. These teams are called Regional Emergency Assessment at Community Hospital (REACH) teams. From December 2014 through December 2016, REACH teams responded to 2,394 ED requests. The comparison of reported consumer need with ED requests for psychiatric support demonstrates that only a small percentage of psychiatric services in an emergency department are being addressed.

Obstacles to underutilization are not fully clear, but some emerging variables should be considered. REACH does not serve our most remote hospital, Palo Verde, in Blythe, due to distance and an inability to meet adequate response times. REACH only operates from 12:00 pm to 10:00 pm during regular business hours. REACH is an "outside" county agency responding to primarily private run, community hospitals; EDs are typically staffed by close knit medical teams that often face a great deal of practice scrutiny. Therefore, EDs may be reluctant to utilize an "outside" source to meet their needs, especially with a service population that has been particularly critical of their ED experience.

Woriking with HASC and SBCDBH, this proposed public-private collaborative project will eliminate the issues of the aforementioned programs. Streamlining the hospital process regionally, educating emergency Department staff, and developing a reciprocal partnership will create a network of services and increase the quality of care.

b) Describe the methods you have used to identify and review existing, related practices in other counties, states or countries. What have you found? If there are existing practices addressing similar problems, have they been evaluated? What limitations to those examples apply to your circumstances?

To identify and review existing related practices, research was conducted and meetings were held. The conclusion was that there was no regional, two-county, collaborations with a public entity addressing this issue. Also, there were no programs that included telepsychiatry and embedded hospital ED staff.

3) The Proposed Project

Describe the Innovative Project you are proposing. Note that the "project" might consist of a process (e.g. figuring out how to bring stakeholders together; or adaptation of an administrative/management strategy from outside of the

Mental Health field), the development of a new or adapted intervention or approach, or the implementation and/or outcomes evaluation of a new or adapted intervention. See CCR, Title 9, Sect. 3910(d).

Include sufficient details so that a reader without prior knowledge of the model or approach you are proposing can understand the relationship between the primary problem you identified and the potential solution you seek to test. You may wish to identify how you plan to implement the project, the relevant participants/roles, 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.

The proposed project seeks to shape system-wide transformative change by modifying the ways in which the hospital system interacts with the public behavioral health system in the care of patients seeking psychiatric emergency services in hospital emergency departments. The focus of this project will be to construct a collaborative infrastructure to increase the quality of services, which includes better outcomes, by introducing a two county (regional) approach to the management and organization of county level behavioral health services into a regional service network.

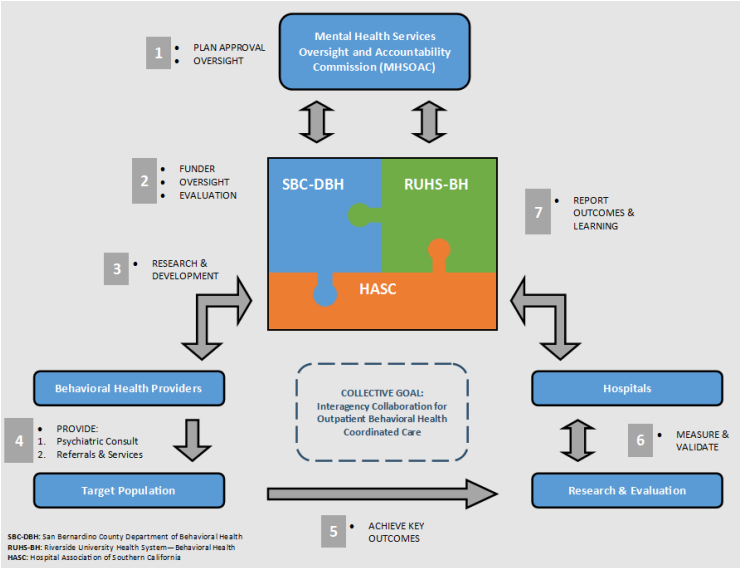
The project will provide funding for the following:

1) Multi-disciplinary, team-based psychiatric consultations, via telemedicine, in emergency rooms that currently lack this resource through telemedicine. The treating physician will now have the ability to request a psychiatric consultation in emergency rooms where this specialty does not currently exist. Additionally, for hospitals that require equipment to utilize this consultation, funding will purchase the capital equipment required.

2) The innovative component to the consultation is the addition of a behavioral health consulting professional to join the psychiatric specialist and emergency room treating physician in order to overcome the lack of information that may make it more difficult for the physicians during consultation. This includes information such as:
   a) Medication History
   b) Outpatient treatment history and management by a psychiatrist
   c) Previous discharge care plans
   d) Family and social supports
   e) Linkages to important program and outpatient services that assist the consumer
   f) Education on management of a consumer experiencing a mental health crisis

3) Construction of a standardized psychiatric workflow for the region's emergency departments to use, to include policy, procedures, and Order Sets: predefined templates that provide support in making clinical decisions that standardize and expedite the ordering process for psychiatric treatment in the ED

4) Creation of a regional training program that will continuously inform area hospitals of behavioral health resources available through San Bernardino and Riverside County's behavioral health systems, provide in-services on de-escalation strategies and techniques, and general behavioral health trainings to reduce the stigma and discrimination of psychiatric patients.



b) Identify which of the three approaches specified in CCR, Title 9, Sect. 3910(a) the project will implement (introduces a practice or approach that is new to the overall mental health system; makes a change to an existing practice in the field of mental health; or applies to the mental health system a promising community-driven practice approach that has been successful in non-mental health contexts or settings).

Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

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

By bringing consultative resources to the treating physician in the emergency department, this project is focused on the elimination of barriers that exist between the public and private healthcare systems. This collaboration will produce a new system that empowers the ED doctors and staff to develop tools, such as standardized order sets for enhanced consultation and medical decision-making that improves the continuum of care for behavioral health consumers. Part of this collaborative process will include the introduction of a regional training model that will allow the region to share best practices, increase awareness of behavioral health services within the region, and provide behavioral health trainings to decrease the stigma and discrimination associated with mental illness.

The counties have identified that the use of interactive videoconferencing (telehealth technology) is the best place to begin to achieve the interconnectivity between the various disconnected, or fragmented, services that currently exist. Telehealth technology is an existing and established practice within the medical health field and has been in use since the early 2000s and the use of telehealth technology in the ED has been successfully used to provide real-time case consultation for other physical health specialty fields, such as, cardiology and neurology. The reasons for uses of telehealth range from time and cost savings to lack of resources in rural areas. ED telepsychiatry programs appear to

provide quick and specialized care to patients with the risk of psychiatric emergencies and have the potential to assist in reducing crowding in EDs and lowering costs (Willliams, 2009). Even with the widespread acceptance of telepsychiatry and telemedicine as a means of delivering behavioral health services in the ED two issues have prevented widespread implementation: financial stability of telepsychiatry in the ED and the lack of published data and/or metrics of the existing telepsychiatry programs.

Currently, there are no projects of this scope within the Inland Empire. Our region's hospitals continue to receive an increased number of individuals in crisis who are suffering from behavioral health and substance use disorder issues to their EDs. These consumers usually require time intensive services that EDs are unable to provide. By creating a regional service network, regional hospitals and EDs would become part of a coordinated effort to find the best services available to address the needs of our shared consumers. This project would further expand on the integrated caremodel by developing a collaboration framework between primary care providers, hospital EDs, and county behavioral health departments in order to provide the most effective treatment plans for consumers with multiple ongoing healthcare needs. Using telehealth technology, the collaborative agencies will create an interagency treatment team that includes a psychiatrist and specialized behavioral health case managers available 24 hours a day 7 days a week within EDs in Riverside and San Bernardino Counties.

Funding will be provided by RUHS-BH and SBCDBH through the Mental Health Service Act (MHSA) as part of the Act's Innovation component.

4) Innovative Component

Describe the key elements or approach(es) that will be new, changed, or adapted in your project (potentially including project development, implementation or evaluation). What are you doing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

a) If you are adapting an existing mental health model or approach, describe how your approach adds to or modifies specific aspects of that existing approach and why you believe these to be important aspects to examine. If you are applying an approach or practice from outside of mental health or that is entirely new, what key aspects of that approach or practice do you regard as innovative in mental health, and why?

This innovation project plan proposes to implement a new regional approach to transforming psychiatric crisis response in emergency departments across two large counties. The regional collaborative partnership will implement several key innovative components to bring about systems change. The key components include:

1) Building a broad collaborative infrastructure between two County Mental Health Plans and regional hospital emergency departments utilizing a trusted relationship with HASC to enact change at a systems level. This collaborative will support developing a shared responsibility and accountability for improving the regions capacity to provide quality psychiatric care in hospital emergency departments.

2) Developing regional training tailored to improving the capacity of ED staff to respond to persons in psychiatric crisis. Training goals will include: increasing knowledge of de-escalation techniques; improving ability to provide quality crisis intervention; increasing understanding of behavioral health care as a broader concept; decreasing stigma associated with presenting in an emergency room with a mental health need.

3) Utilizing embedded staff in emergency departments and where appropriate telehealth technology to increase the communication and collaboration between hospital EDs and County Mental Health Plans. Comparisons will be made between employing two types of mental health staff to learn about the potential for utilizing paraprofessional staff as opposed to licensed clinical staff.

5) Learning Goals / Project Aims

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the spread of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the spread 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?
b) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

There is no maximum number of learning goals required, but we suggest at least two. Goals might revolve around understanding processes, testing hypotheses, or achieving specific outcomes.

1) To determine if regional capacity for responding to psychiatric crisis in hospital emergency departments can be increased, by developing a collaborative care process between County MHPs and local hospitals at the systems level. It is expected that collaborating agencies will develop implementation plans and meet regularly to communicate and support new practices. The transformed system will be expected to have developed joint ownership and a commitment to shared accountability for processes and practices that best support mental well-being in emergency departments. One product of this collaborative process will be the development of a standardized psychiatric workflow for use in hospital emergency departments. This standardized workflow will include policy, procedures, and pre-defined templates that provide support in making clinical decisions that standardized and expedite the ordering process for psychiatric treatment in the ED (i.e. order sets).

2) To determine if access to outpatient care following an ED crisis encounter can be increased by integrating behavioral health staff into the emergency department; and to compare the results of utilizing two different types of staff, licensed clinical staff compared to peer specialist staff.

3) To determine if wait times in the ED can be decreased by utilizing the standardized ED collaborative care. It is expected that more readily available psychiatric consultants and behavioral health staff to support case management and linkage to outpatient services will decrease “boarding” of clients in the ED and reduce the wait for services in the ED.

4) To determine if regional training improves ED staff capacity to respond to psychiatric crisis in the emergency room. In addition to training in de-escalation techniques and quality crisis interventions, it is expected that behavioral health staff working within the emergency department will have an impact on other ED staff views and beliefs about behavioral health.

6) 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. What observable consequences do you expect to follow from your project’s implementation? How do they relate to the project’s objectives? What else could cause these observables to change, and how will you distinguish between the impact of your project and these potential alternative explanations?

The greater the number of specific learning goals you seek to assess, generally, the larger the number of measurements (e.g., your “sample size”) required to be able to distinguish between alternative explanations for the pattern of outcomes you obtain.

In formulating your data collection and analysis plan, we suggest that you consider the following categories, where applicable:

a) Who are the target participants and/or data sources (e.g., who you plan to survey to or interview, from whom are you collecting data); How will they be recruited or acquired?
b) What is the data to be collected? Describe specific measures, performance indicators, or type of qualitative data. This can include information or measures related to project implementation, process, outcomes, broader impact, and/or effective dissemination. Please provide examples.
c) What is the method for collecting data (e.g. interviews with clinicians, focus groups with family members, ethnographic observation by two evaluators, surveys completed by clients, analysis of encounter or assessment data)?
d) How is the method administered (e.g., during an encounter, for an intervention group and a comparison group, for the same individuals pre and post intervention)?
e) What is the *preliminary* plan for how the data will be entered and analyzed?

The target participants for this innovation project are individuals presenting with a psychiatric crisis in local hospital EDs. Project measurement will include both quantitative and qualitative data collection. Proposed project measurement for each learning goal is as follows:

1) System transformation into a collaborative care model. The establishments of standardized workflows will be measured by collecting from the hospital EDs the policies, collaborative processes and protocols (order sets) developed as a result of this project. Both survey data and qualitative data from collaborative care meetings will be utilized to measure staff perceptions and buy-in to collaborative care. Participation and commitment to the collaboration will be measured with a Net Promoter Score Study. In addition a survey tool will be used to measure the extent to which hospital EDs have incorporated the jointly developed care collaboration practices.

2) Increasing access to outpatient care following an ED encounter. Data from the initial ED encounter will be collected on an ED contact form which will be used to match clients to outpatient service data extracted from electronic health records. This will provide the data necessary to understand aspects of the ED encounter (encounter disposition), collect client demographics and provide enough identifying information to match clients to determine outpatient service usage. Outcomes on linkage and access will be compared for two types of staff to understand any differences in outcomes when utilizing peers or licensed clinical staff.

3) Decreasing wait time in the ED. Data on time of admission, time of crisis service ED contact, and time of discharge from the ED will be recorded on the ED encounter form to examine wait time to care and overall length of stay in the ED. Baseline data on average ED wait times for clients in need of psychiatric care prior to program implementation will be need to be collected prior to program implementation to provide the appropriate comparison data.

4) Improving ED staff capacity to respond to Psychiatric Crisis in EDs. Pre to post survey results from regional trainings will be used to measure gains in EDs staff understanding of de-escalation techniques and crisis intervention. In addition ED staff stigma towards those with behavioral health needs will be surveyed periodically to measure the impact of embedding behavioral health staff into the ED resulting in a culture shift in the ED. Attitudes and stigma among care providing ED staff will also be measured.

7) Contracting

It is expected that this project will be contracted to HASC via sole source agreement or Memorandum of Understanding (MOU). RUHS-BH and SBCDBH will work collaboratively with HASC and the EDs participating in this project to develop, gather, and evaluate the data collected.

II. Additional Information for Regulatory Requirements

1) Certifications

Innovative Project proposals submitted for approval by the MHSOAC must include documented evidence of County Board of Supervisors review and approval as well as certain certifications. Additionally, we ask that you explain how you have obtained or waived the necessity for human subjects review, such as by your County Institutional Review Board.

a) Adoption by County Board of Supervisors. Please present evidence to demonstrate that your County Board of Supervisors has approved the proposed project. Evidence may include explicit approval as a stand-alone proposal or as part of a Three-Year Plan or Annual Update; or inclusion of funding authority in your departmental budget. If your project has not been reviewed in one of these ways by your Board of Supervisors, please explain how and when you expect to obtain approval prior to your intended start date.

Once the Innovation Project is approved by the MHSOAC, County Board of Supervisors approval will be sought prior to funds expenditure and implementation. If the timing of this Innovation Project coincides with the submittal of the County MHSA 3-Year Program and Expenditure Plan then the approval will be included when the MHSA Plan is submitted to the County Board of Supervisors. If the timing is earlier than the expected MHSA 3-Year Plan submittal than independent Board of Supervisor approval will be requested prior to funds expenditure and implementation.

b) Certification by the County mental health director that the County has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act (MHSA). Welfare and Institutions Code (WIC) 5847(b)(8) specifies that each Three-Year Plan and Annual Update must include "Certification by the county behavioral health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements."

Mental Health Director Certification form will be signed and attached after 30-day posting period.

c) Certification by the County mental health director and by the County auditor-controller if necessary that the County has complied with any fiscal accountability requirements, and that all expenditures are consistent with the requirements of the MHSA. WIC 5847(b)(9) specifies that each Three-Year Plan and Annual Update must include "Certification by the county behavioral health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act."

Of particular concern to the Commission is evidence that the County has satisfied any fiscal accountability reporting requirements to DHCS and the MHSOAC, such as submission of required Annual Revenue and Expenditure Reports or an explanation as to when any outstanding ARERs will be completed and filed.

County Certification will be signed and attached after 30-day posting period.

d) Documentation that the source of INN funds is 5% of the County's PEI allocation and 5% of the CSS allocation.

Riverside County adheres to MHSA Regulations utilizing the MHSA allocation of 80% of CSS and 20% of PEI. Five percent (5%) of each of these components is then dedicated to the Innovation Component. Documentation will be submitted after 30-day posting period.

2) Community Program Planning

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

Include a brief description of the training the county provided to community planning participants regarding the specific purposes and MHSA requirements for INN Projects.

Riverside University Health System – Behavioral Health (RUHS-BH) conducts an on-going continuous planning process year round. This includes eliciting feedback and informed decision making through subject matter experts that comprise the MHSA System of Care planning committees. MHSA staff also provide monthly updates to the Behavioral Health Commission as they act as advisory body on all aspects of MHSA planning. The planning process includes four committees by age span: Childrens, Transition Age Youth Collaborative, Adult, and Older Adults. There are several other cross-collaborative committees that advise the Department on certain specialty areas such as Criminal Justice, Cultural Competency/Ethnic Disparities, and the Consumer Wellness Coalition that lend ethnic-specific, consumer, and family member perspectives to the planning process. The participants involved organizations, and public agencies. Participants were representatives of underserved communities as well as persons serving those same communities. The MHSA Administrator and other RUHS-BH staff have been responsible for informing the various stakeholders regarding the purpose, scope, and limitation of Innovation Projects.

The decision to prioritize the I.E. Psych Partnership arose as a response to community feedback. Consumers, family advocates, neighboring county officials, and hospital association, all expressed urgency in finding a solution to extended wait times, outpatient follow-up care, protocols, and crisis response for psychiatric ED visits. Feedback was gathered and shared between RUHS-BH, SBCDBH, and HASC. The three collaborative organizations then worked with local hospitals to devise a planned approach. The plan was then presented at community meetings, commission meetings, and cultural competency meetings, for consumer and family advocate feedback and suggestions.

Hospital research and evaluation was conducted on the effectiveness of order sets in medical settings. It was concluded that order sets reduce the wait times for ED medical patients by having the ability to begin treatment prior to hospital admittance. Due to this conclusion the project will work to create psychiatric order sets.

Also, while researching the effectiveness of behavioral health nurses, it was discovered that there is a nursing shortage in Riverside County. In an effort to combat this issue, this project will employee varying levels of staff (licensed therapists, peers, etc.) in areas where the nursing shortage is prevalent. Consumer feedback has stated that peer support is an extremely effective tool for individuals in psychiatric crisis; this project will test that theory.

3) Primary Purpose

Select one of the following as the primary purpose of your project. (I.e. the overarching purpose that most closely aligns with the need or challenge described in Item 1 (The Service Need).

a) Increase access to mental health services to underserved groups
b) Increase the quality of mental health services, including measurable outcomes
c) Promote interagency collaboration related to mental health services, supports, or outcomes
d) Increase access to mental health services

Promote interagency collaboration related to mental health services, supports, or outcomes

4) MHSA Innovative Project Category

Which MHSA Innovation definition best applies to your new INN Project (select one):

a) Introduces a new mental health practice or approach
b) Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community
c) Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

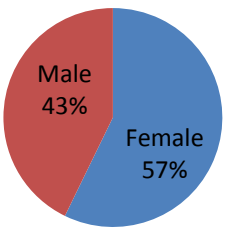
5) Population (if applicable)

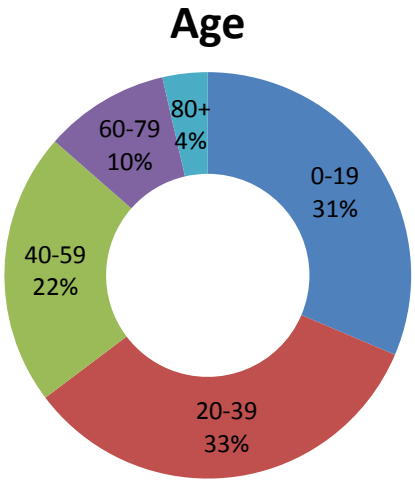
a) If your project includes direct services to mental health consumers, family members, or individuals at risk of serious mental illness/serious emotional disturbance, please estimate number of individuals expected to be served annually. How are you estimating this number?

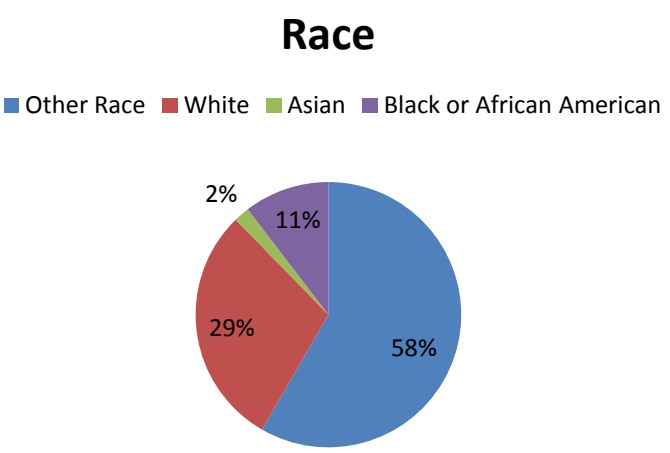
Direct services to behavioral health consumers will be included in the project. Due to the vast difference between emergency departments in Riverside County an estimate that encompasses the different regions is not possible. Additionally, baseline data will be gathered in the first few months of the project to determine the number of expected clients served annually. For reference, 2015 Office of Statewide Health Planning and Development hospital ED reports for Riverside County calculate over 30,000 consumer visits in which the primary diagnosis is mental disorder.

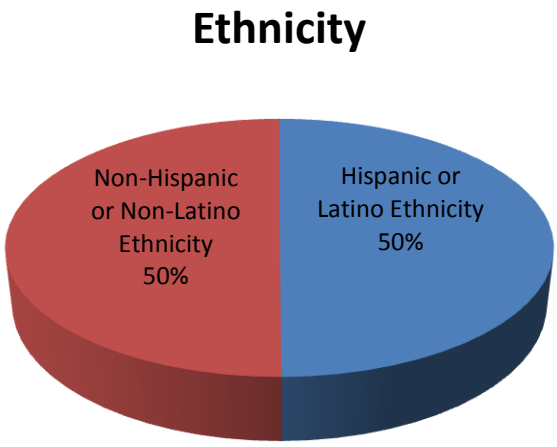
b) Describe the population to be served, including relevant demographic information such as age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate. In some circumstances, demographic information for individuals served is a reporting requirement for the Annual Innovative Project Report and Final Innovative Project Report.

Population to be served includes all Riverside County residents who access the ED for behavioral health crisis. Data from a 2015 Office of Statewide Health Planning and Development report states that the population served at Riverside County's highest volume ED is as follows:









c) Does the project plan to serve a focal population, e.g., providing specialized services for a target group, or having eligibility criteria that must be met? If so, please explain.

The project plans to serve all individuals who enter participating Riverside County EDs for behavioral health crisis.

6) MHSA General Standards

Using specific examples, briefly describe how your INN Project reflects and is consistent with all potentially applicable MHSA General Standards 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 standard could not apply to your INN Project, please explain why.

Every three years Riverside County is required to develop a new Program and Expenditure (3YPE) Plan for MHSA. The 3YPE outlines and updates the programs and services to be funded by MHSA and allows for a new three-year budget plan to be created. It also allows the County an opportunity to re-evaluate programs and analyze performance outcomes to ensure the services being funded by MHSA are effective.

MHSA regulations require counties to provide community stakeholders with an update to the MHSA 3YPE on an annual basis. Therefore Riverside County engages community stakeholders by providing them with an update to the programs being funded in the 3YPE. The community process allows stakeholders the opportunity to provide feedback from their unique perspective about the programs and services being funded through MHSA.

Once the Draft FY17/18-19/20 3YPE is completed, it must be posted for public review a minimum of 30 days. During the 30-day posting period the County will accept community feedback on the 3YPE and document the input accordingly. Following the posting period the Department calls upon the Riverside County Behavioral Health Commission (BHC) to hold a Public Hearing so they may receive face-to-face feedback on the content of the 3YPE.

Following the Public Hearing the BHC reviews all public comments and recommends any substantive changes that have been identified which need to be made to the Plan. Once the Plan is finalized it must be approved and adopted by the Riverside County Board of Supervisors and then sent to the State Mental Health Services and Accountability Commission within 30 days.

In addition, MHSA also holds community focus groups to help identify problems, determine need, and create solutions.

a) Community Collaboration

Multiple community partners were involved in the stakeholder process. Also this project is a regional collaborative, involving two counties (Riverside and San Bernardino), and a public-private collaborative with the inclusion of the Hospital Association of Southern California. Hospitals throughout two counties will also be working with the project to recruit and employ embedded hospital staff.

b) Cultural Competency

RUHS-BH's Cultural Competency team will be involved with the project to ensure compliance standards and ensure that cultural and linguistic needs are met. RUHS-BH has various culturally diverse task forces throughout the county, including but not limited to:

- Cultural Competency Reducing Disparities
- Community Advocacy for Gender & Sexuality Issues/ LGBTQ Task Force
- African American Family Wellness Advisory Group
- Spirituality Initiative
- Asian American Task Force

c) Client-Driven

Stakeholder feedback was reviewed during the formation of the project. This feedback was the motivating factor that initiated project conception. Clients will have the opportunity to submit feedback post services. Also, feedback forms will be collected from the public prior to the public hearing.

d) Family-Driven

Stakeholder feedback, including feedback from families and caregivers, was reviewed during the formation to this project. Also, feedback forms will be collected from the public prior to the public hearing.

e) Wellness, Recovery, and Resilience-Focused

Following the ED visit, consumers will have follow-up consultations and referrals to various resources – dependent upon their individual diagnosis. The goal is to connect the consumer with a sustainable treatment plan within the community, decreasing the need to access hospital EDs.

f) Integrated Service Experience for Clients and Families

A focal point of the project is to link the consumers (and their families) to culturally appropriate services within the community. This service will increase understanding and awareness of behavioral health disorders, outpatient services, knowledge of how to access services, as well as how to navigate the system of care.

7) Continuity of Care for Individuals with Serious Mental Illness

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 when the project ends.

Yes, individual with serious mental illness will receive services from this proposed innovative project. Clients who receive care through this project will continue to receive care when the project ends via the emergency departments. Upon completion of the proposed project participating EDs would continue to provide the service they provide.

8) INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement.

a) Explain how you plan to ensure that the Project evaluation is culturally competent.

Note: this is not a required element of the initial INN Project Plan description but is a mandatory component of the INN Final Report. We therefore advise considering a strategy for cultural competence early in the planning process. An example of cultural competence in an evaluation framework would be vetting evaluation methods and/or outcomes with any targeted ethnic/racial/linguistic minority groups.

b) Explain how you plan to ensure meaningful stakeholder participation in the evaluation.

Note that the mere involvement of participants and/or stakeholders as participants (e.g. participants of the interview, focus group, or survey component of an evaluation) is not sufficient. Participants and/or stakeholders must contribute in some meaningful way to project evaluation, such as evaluation planning, implementation and analysis. Examples of stakeholder involvement include hiring peer/client evaluation support staff, or convening an evaluation advisory group composed of diverse community members that weighs in at different stages of the evaluation.

See Section I.6 Evaluation Plan

9) Deciding Whether and How to Continue the Project Without INN Funds

Briefly describe how the County will decide whether and how to continue the INN Project, or elements of the Project, without INN Funds following project completion. For example, if the evaluation does (or does not) indicate that the service or approach is effective, what are the next steps?

The decision to continue this project will depend on the project outcomes, funding and stakeholder feedback. If the project is deemed successful, funding could come from MHSA program expansion n order to deliver services to all EDs with blended funding in partnership with HASC serving as the financial intermediary for hospitals sustaining interagency collaboration, potential cost savings, and return-on-investment for hospitals. Continued funding may only require minimal Behavioral Health staff to provide supportive services. Additionally, this project presents the option to explore partnership with the local health plans for applicable clients.

10) 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?

Project outcomes related to this project will be disseminated to stakeholders in Riverside County via its various committees and task forces. Upon completion, a final report presentation will be held at a Commission meeting.

b) How will program participants or other stakeholders be involved in communication efforts?

A list of interested participants and stakeholders will be developed and included in any communication efforts made. Additionally regular program updates will be provided during the robust stakeholder process already in place.

c) 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.

Regional collaboration; behavioral health in emergency departments; public-private collaboration; county partnership; emergency care

11) Timeline

a) Specify the total timeframe (duration) of the INN Project: Years 5 Months 0

b) Specify the expected start date and end date of your INN Project: Start Date 01/01/2018 End Date 12/31/2022

Because this project is under conditional approval, the expected start date will be within 60 days of Riverside County Board of Supervisor's approval.

Note: Please allow processing time for approval following official submission of the INN Project Description.

c) Include a timeline that specifies key activities and milestones and a brief explanation of how the project's timeframe will allow sufficient time for

i. Development and refinement of the new or changed approach;

ii. Evaluation of the INN Project;

iii. Decision-making, including meaningful involvement of stakeholders, about whether and how to continue the Project;

iv. Communication of results and lessons learned.

The project is expected to consist of four (4) phases. The phases are:

Phase 1: The first six to nine months will consist of the development of policies and procedures; hiring and training of staff; the procurement of any equipment necessary; the recruitment and bidding of a telepshych contractor; the creation of the evaluation methodology; and gathering baseline data

Phase 2: Full implementation of project is expected to be approximately 3.5 years. Implementation will occur during this phase with select hospitals. Telepsych consultations and care coordination will occur in the ED. Modifications will be made to the project as learning occurs. Evaluation efforts will start within six months of the start of the project and continue throughout the project.

Phase 3: Replication of implementation will occur in additional hospitals.

Phase 4: During the last 9 months of the project, designated staff will evaluate all of the data collected and make a determination of the projects success.

It is anticipated that this timeline will provide an adequate opportunity to measure the project's success. Data will be collected throughout the implementation of the project and analysis of progress towards the learning goals completed. This will allow for modification to the project as the learning occurs.

Citations

Lloyd, J., (2016). Waits for care and hospital beds growing dramatically for psychiatric emergency patients. American College of Emergency Physicians.

Alakeson, V., Pande, N., Ludwg, M., (2010). A plan to reduce emergency room boarding of psychiatric patients. Health Affairs, 29(9) 1637-1642.

Clarke, D., Usick, R., Sanderson, A., Giles-Smith, L., Baker, J., (2014). Emergency department staff attitudes towards mental health consumers: a literature review and thematic content analysis. International Journal of Mental Health Nursing, 23(3) 273-284.

Wiler, J.L. et al., (2014). Care of the psychiatric patient in the emergency department – a literature review. American College of Emergency Physicians.

Williams, M., Pfeffer, M., Boyle, J., Hilty, D., (2009). Telepsychiatry in the emergency department: overview and case studies. California HealthCare Foundation.

12) 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)

BUDGET CONTEXT (If MHSA funds are being leveraged with other funding sources)

A. Budget Narrative:

Personnel expenditures consist of:

- Behavioral Health Nurse – 12 FTE. These nurses (or other hospital staff where shortages occur) will be embedded in hospitals throughout the county to be the first line of contact for ED consumers in psychiatric crisis.
- Office Assistant - 0.5 FTE
- IT Database Administrator - 0.1 FTE
- Data Analyst - 1.0 FTE
- Nurse Educator - 0.5 FTE. This educator will train hospital staff on interaction with ED consumers in psychiatric crisis. This will include de-escalation techniques as well as other methods.
- HASC Project Manager - 0.5 FTE
- HASC Data Analyst - 0.5 FTE
- HASC Administrative Assistant - 0.5 FTE
- HASC Contracts Specialist - 0.5 FTE

Direct operating costs consist of rent, communications, insurance, maintenance, supplies, travel, and utilities. Indirect operating costs consist of program contingency. The operating costs will keep the program active in various hospitals throughout the county.

Non-recurring costs consist of computer and office equipment for HASC staff.

Consultant costs consist of telepsychiatry consultants to treat ED patients virtually and program evaluation.

Other expenditures consist of program administration.

In the first year of the project, there will be six months dedicated to preparation; therefore, personnel expenditures, operating costs, and telepsychiatry are at 50%. Years 2-5 show a fully active project.

B. New Innovative Project Budget By FISCAL YEAR (FY)*

EXPENDITURES							
PERSONNEL COSTs (salaries, wages, benefits)		**FY 18**	**FY 1819**	**FY 1920**	**FY 2021**	**FY 2122**	**Total**
1.	Salaries	1,043,946	2,087,892	2,150,528	2,215,044	2,281,496	9,778,906
2.	Direct Costs						
3.	Indirect Costs						
4.	Total Personnel Costs	1,043,946	2,087,892	2,150,528	2,215,044	2,281,496	9,778,906
OPERATING COSTs		**FY 18**	**FY 1819**	**FY 1920**	**FY 2021**	**FY 2122**	**Total**
5.	Direct Costs	184,757	357,514	368,090	378,983	390,202	1,679,546
6.	Indirect Costs	88,129	176,257	181,545	186,991	192,601	825,523
7.	Total Operating Costs	272,886	533,772	549,635	565,974	582,803	2,505,069

NON RECURRING COSTS (equipment, technology)		**FY 18**	**FY 1819**	**FY 1920**	**FY 2021**	**FY 2122**	**Total**
8.	Start Up Cost	44,064					44,064
9.							
10	Total Non-recurring costs	44,064					44,064
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY 18**	**FY 1819**	**FY 1920**	**FY 2021**	**FY 2122**	**Total**
11	Direct Costs - Telepsychiatry	650,000	1,300,000	1,300,000	1,300,000	1,300,000	5,850,000
12	Indirect Costs - Evaluation	14,000	14,000	15,000	15,000	17,000	75,000
13	Total Operating Costs	664,000	1,314,000	1,315,000	1,315,000	1,317,000	5,925,000

OTHER EXPENDITURES (please explain in budget narrative)	**FY 18**	**FY 1819**	**FY 1920**	**FY 2021**	**FY 2122**	**Total**
14.Progam Administration	47,028	94,056	96,878	99,784	102,778	440,523
15.						
16. Total Other expenditures	47,028	94,056	96,878	99,784	102,778	440,524

BUDGET TOTALS						
Personnel	1,043,946	2,087,892	2,150,528	2,215,044	2,281,496	9,778,906
Direct Costs (add lines 2, 5 and 11 from above)	834,757	1,657,514	1,668,090	1,678,983	1,690,202	7,529,546
Indirect Costs (add lines 3, 6 and 12 from above)	102,129	190,257	196,545	201,991	209,601	900,523
Non-recurring costs (line 10)	44,064					44,064
Other Expenditures (line 16)	47,028	94,056	96,878	99,784	102,778	440,524
TOTAL INNOVATION BUDGET	2,071,924	4,029,719	4,112,041	4,195,802	4,284,077	18,693,563

INNOVATIVE PROJECT PLAN DESCRIPTION – Optional Template

C. ***Expenditures By Funding Source and FISCAL YEAR (FY)***

Administration:

A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding**	**FY 18**	**FY 1819**	**FY 1920**	**FY 2021**	**FY 2122**	**Total**
1.	Innovative MHSA Funds	47,028	94,056	96,878	99,784	102,778	440,524
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**						

Evaluation:

B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18**	**FY 1819**	**FY 1920**	**FY 2021**	**FY 2122**	**Total**
1.	Innovative MHSA Funds	14,000	14,000	15,000	15,000	17,000	75,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**						

TOTAL:

C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18**	**FY 1819**	**FY 1920**	**FY 2021**	**FY 2122**	**Total**
1.	Innovative MHSA Funds	2,071,924	4,029,719	4,112,041	4,195,802	4,284,077	18,693,563
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**						

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