INYO COUNTY BEHAVIORAL HEALTH

Mental Health Services Act
FY 2014–2017 Three-Year
Program and Expenditure Plan

POSTED FOR PUBLIC COMMENT
March 26, 2015 through April 26, 2015

The MHSA FY 14/15-16/17 Three-Year Plan and Supplement are available for public review and comment from March 26, 2015 through April 26, 2015. We welcome your feedback via phone, in person, or in writing. Comments may also be made during the Public Hearing to be held on Monday, April 27, 2015.

Public Hearing Information:
Monday, April 27, 2015, 10:00 am
Mental Health Advisory Board Meeting
536 N. Second Street, Bishop, California 93514

Comments or Questions? Please contact:
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Thank you!

MHSA Community Program Planning and Local Review Process

County: INYO **30-day Public Comment period dates:** 03/26/15 – 04/26/15

Date: 03/23/15 **Date of Public Hearing:** Monday, April 27, 2015

COUNTY DEMOGRAPHICS AND DESCRIPTION

Inyo County contains astounding natural diversity. It includes Owens Valley and parts of Death Valley and is located between the Sierra Nevada Mountains and the White Mountains along the California/Nevada border. Inyo County offers scenic views and multiple opportunities for outdoor sports enthusiasts in diverse landscapes. Inyo County encompasses both the lowest point in the U.S., Death Valley, and the highest point in the lower 48 states, Mount Whitney. It is the second largest county in California with 10,140 square miles and has one of the smallest population bases in the state with 18,546 people.

A majority of Inyo County's population identifies as Euro-American, with a significant minority identifying as American Indian. Based on the 2010 census, 66% identify as white alone; 19% identify with Hispanic or Latino origin. Given the Hispanic population, Spanish is a threshold language for service. 13% identify as American Indian; 2% identify as Asian; and less than 1% identify as African American. 4% of people identify with 2 or more races. The federally-recognized Native American nations in Inyo County are the Bishop Paiute Tribe, Big Pine Paiute Tribe of the Owens Valley, Fort Independence Reservation, Lone Pine Paiute Shoshone Reservation, and Timbisha Shoshone Tribe. The Timbisha Shoshone Tribe, located in Death Valley National Park, is the only tribe located inside a national park in the US. The ethnic composition of Inyo County testifies to the rich heritage of Native American tribes in California and the recent history of the colonization of the Western United States. To meet the needs of the Native American population there is a Federally Qualified Heath Care facility, Toiyabe, that includes mental health and addiction serves as part of their family service offerings.

The composition of the Inyo population by age according to the same 2010 census is also informative to the planning process. While 5% of the population is under the age of 5 and 21% is under the age of 18; 26% of persons are over 60, with 19% over 65 and 9% over 70. This suggests a planning process with an in-depth look at the needs of older adults who are spread throughout the vast expanse of the County and as such are more vulnerable to isolation and complex challenges to access care. In addition, a "frontier" culture and an accompanying independent nature necessitated an approach that lends well to these factors.

The rural nature and location of Inyo County somewhat limits residents' access to urban centers and to services like healthcare. Most residents live in the northern area of Inyo County around its main population center, Bishop, and the closest urban area to Bishop is roughly 200 miles away, a 4-hour drive. Transportation is limited to motor vehicles and minimal air service. Another unique feature of Inyo County is the structure of land ownership. Federal agencies manage 92% of the land. The City of Los Angeles owns 3.9% of the land for the purpose of maintaining water rights. The State of California owns 2.4%, and private landowners own a mere 1.7% of the land in Inyo County. The configuration of land ownership and management along with other factors influences the economy and restricts the development of the region.

Economic conditions in Inyo County impose hardships on many families and individuals due to the combination of a high cost of living and limited work availability. Inyo County relies heavily on tourism and government services to support the economy. Many available jobs are in the service industry or are seasonal. Employee turnover rate is high. The median household income, based on the American Community Survey and in 2011 inflation-adjusted dollars, is $49,571, compared with $70,231 at the state level. According to the US Bureau of Labor Statistics, the unemployment rate in Inyo County in the last year averaged 8.95%, lower than the state rate but higher than the US rate. In addition, in 2000 19% of people in Inyo County had a disability, which can play a role in employment status and income level even though it does not contribute to the unemployment rate. 35% of households in Inyo County have Social Security income, and 5% have Supplemental Security Income. A total of 12% of households in the last year received some form of assistance like cash assistance or food stamps. The percentage of the total population of Inyo County living below the poverty level increased from 11% in 2003 to 12% in 2011, a trend further demonstrated in later paragraphs.

The low average education level in Inyo County also affects many individuals' employment opportunities and earnings. 40% of people 25 and older have no more than a high school education, and only 23% have a Bachelor's degree or higher. In terms of education level, the composition of Inyo County has shifted slightly in a positive direction in the last decade, however, as 89% of people 25 and older in 2011 graduated high school or higher compared with 82% in 2000.

Difficult economic conditions and limited opportunities can have disproportionate effects on children, families with young children, older adults, and other disadvantaged persons and can play an indirect role in substance abuse issues in communities. Roughly 18% of children 0-18 live below the federal poverty level, which increased from 14% in 2003. 24% of children under 5 live below the poverty level, up from 20% in 2000. 29% of families with children under five only live in poverty, compared with 14% at the state level. Significantly, 82% of single female parent families with children under 5 in Inyo County are in poverty, while the percentage at the state level is 38%. Of adults 65 years and older, 7% are in poverty. This information offers a fuller picture of people in greatest need in Inyo County and is critical, considering the importance of the earliest years of a child's life to optimal child development and lifelong health.

In sum, low education levels, low household income, high costs of housing, food, and fuel, and the remote location of Inyo County communities compound to place high stresses on families and individuals in Inyo County and on disadvantaged people in particular.

COMMUNITY PROGRAM PLANNING

Provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this annual update per Title 9 of the California Code of Regulations, Sections 3300 and 3315.

1. *Briefly describe the Community Program Planning (CPP) Process for development of all components included in the FY 2014-2017 Three Year Plan. Include the dates of meetings and other planning activities; describe methods used to obtain stakeholder input.*

The Inyo County Behavioral Health (ICBH) Community Program Planning (CPP) process for the development of the MHSA FY 2014/15-2017/18 Three-Year Plan was comprised of focus groups with consumers, a focus group with a NAMI family support group; a number of ongoing

partner meetings; a stakeholder survey; and key informant interviews. Input was obtained from over 150 consumers and family members, providers, and community members. Components addressed by the planning process included Community Services and Supports (CSS); Prevention and Early Intervention (PEI); Workforce Education and Training (WET); and Capital Facilities/Technological Needs (CFTN); in addition, we provided basic education regarding mental health policy; program planning and implementation; monitoring and quality improvement; evaluation; and fiscal and budget components.

We held two focus groups at our wellness center sites in October 2014. One focus group targeted our consumers and family members in the Bishop area, and the second obtained input from consumers and family members in the Lone Pine area. A brief history of the Mental Health Services Act was provided and the current MHSA-funded programs were reviewed. Participants were given the opportunity to discuss the current service system and offer suggestions for future funding activities. They were given an opportunity to indicate what areas they would like to prioritize.

Partner meetings:

- Community Corrections Partnership
- MHSA HHS Leadership Team
- Wrap Around Collaborative
- Inyo County Placement Team
- Crisis Services Collaborative

We also developed a survey regarding youth and one regarding adults that focused on the potential mental health issues identified in the County. The survey was administered to clients, family members, staff, providers, and partner agencies. We received a total of 65 responses to the survey. The results of the surveys are included as Attachment A. We then gathered input from partners through key informant interviews, which included interviews with personnel from Toiyabe Family Services, Rural Health Clinic, Northern Inyo Hospital Emergency Department, Probation, Social Services and Law Enforcement, as related to CSS. Partners voiced strong support for the wellness centers as well as the access to Progress House for transitional residential treatment services for Full Service Partners. In addition, partners in Social Services and Senior Services assisted with the plan to expand the Elder Outreach PEI component and the adoption of the Healthy IDEAS program, an Evidence-based program to address Depression in Older Adults. We also developed a survey to obtain information from stakeholders for the PEI older adult component of MHSA; the results of this survey are included as Attachment B.

The MHSA 2014-2017 Plan was developed and approved by the Mental Health Advisory Board after reviewing data on our current programs, analyzing community needs based on stakeholder input, and determining the most effective way to further meet the needs of our unserved/underserved populations. In addition, the MHSA was shared at staff meetings and at wellness center stakeholder meetings to obtain additional input and feedback on services.

2. *Identify the stakeholders involved in the Community Program Planning (CPP) Process (e.g., agency affiliation, populations represented, ages, race/ethnicity, client/family member affiliation, primary languages spoken, etc.). Include how stakeholder involvement was meaningful.*

A number of different stakeholders were involved in the CPP process. Input was obtained from clients who utilize services at the Wellness Centers, including the homeless population. The

Wellness Centers are consumer-run programs where adults come together, facilitate classes, attend activities, and have a formal meeting each week. Through these regularly scheduled meetings, we obtained input from clients on ideas for maintaining and enhancing our Wellness Centers in both Bishop and Lone Pine. These meetings are attended in Bishop by consumers including 3-6 consumers who are homeless, 2 consumers who are Hispanic, 2 consumers who are older adults, 2 consumers who are transition age youth, and approximately 5 other adult Caucasian consumers. Of special note was the strong voice of the consumers around the importance of the Wellness Centers. Several of the persons who have less stable living arrangements rely on the Wellness Center to access resources that meet basic needs and for a sense of belonging. These members have voiced a strong prioritization of a permanent Wellness Center site that is centrally located. In Lone Pine, the stakeholder group consists of 2 persons who are homeless and 3-5 other Caucasian adult consumers.

As part of a larger integrated Health and Human Services (HHS) agency, the HHS Management team has been an important entity in the planning process to identify both critical needs and strategies to meet the needs of the under-served populations. In addition, we obtained input from members of the MHSA Leadership/Business Analysis Committee, which is comprised of MHSA staff; the Behavioral Health Director; Health and Human Services fiscal and management staff; program staff in Behavioral Health; Quality Improvement Committee members; and others involved in the delivery of MHSA services.

The CPP also included input from ongoing child and adult staff meetings in mental health services, the multiple agencies involved with children's services, including Child Welfare, Juvenile Probation, Toiyabe Family Services, and the schools. This input included a special focus on the Wraparound approach as a viable alternative to group home or out-of-county placement.

Further community partner input was obtained, especially in regards to the adult population, from the crisis services partnerships and the Community Corrections Partnership. This opportunity allowed us to closely look at our response to mental health crisis and alternatives to hospitalization and incarceration.

To address the needs of the older adult population, we looked to partners in our Eastern Sierra Agency on Aging and adult social services team. This area of focus is critical to meet the needs of the significant number of older adults living in our geographically-expansive county. We have especially focused on the needs of the isolated older adults, including those in the south eastern part of our county.

A critical entity in the planning process is the Behavioral Health Advisory Board. The Behavioral Health Advisory Board consists of an older adult consumer; two adult consumers; a family member of an adult child/community member; the Patient's Rights Advocate (former consumer and volunteer); a Hispanic consumer advocate; and a member of the Board of Supervisors. Five to 10 consumers also participate regularly at the Advisory Board meetings.

All stakeholder groups and boards are in full support of this MHSA Annual Update.

LOCAL REVIEW PROCESS

1. *Describe methods used to circulate, for the purpose of public comment, the annual update. Provide information on the public hearing held by the local mental health board after the close of the 30 day review.*

This proposed MHSA Annual Update has been posted for a 30-day public review and comment period from March 26 to April 26, 2015. An electronic copy is available online on the Inyo County website (http://www.inyocounty.us/MHSA). Hard copies of the document are available in the Bishop Behavioral Health Clinic; Bishop Social Services office; Health and Human Services Administrative office; Health and Human Services, Lone Pine office; and at all county libraries, including the Bishop, Big Pine, Independence, Lone Pine, Furnace Creek, and Shoshone branches. In addition, a hard copy of the proposed Annual Update has been distributed to all members of the Mental Health Advisory Board; consumer groups; staff; Wellness Centers (Bishop and Lone Pine); and with partner agencies. The Annual Update is also available to stakeholders upon request.

A public hearing is scheduled for Monday, April 27, 2015 at 536 N. Second St, Bishop, California 93514 at 10:00 a.m. The public hearing will be held in conjunction with the Mental Health Advisory Board meeting.

2. *Include summary of substantive recommendations received during the stakeholder review and public hearing, and responses to those comments. Include a description of any substantive changes made to the annual update that was circulated. Indicate if no substantive comments were received.*

Input on the MHSA Three-Year Plan will be reviewed and incorporated into the final document, as appropriate, prior to submitting to the County Board of Supervisors and the California Mental Health Services Oversight and Accountability Commission (MHSOAC).

MHSA Program Component
COMMUNITY SERVICES AND SUPPORTS

1. ***Provide a program description (must include number of clients served, age, race/ethnicity, cost per client). Include achievements and notable performance outcomes.***

The MHSA CSS System Transformation program provides services to all ages [children (ages 0-17); transition age youth (ages 16-25); adults (ages 18-59); older adults (ages 60+)]; all genders; and all races/ethnicities. We offer a "whatever it takes" service approach in helping individuals achieve their goals. Services for all populations help reduce ethnic disparities, offer peer support, and promote values-driven, evidence-based practices to address each individual's unique needs and mental health. These services emphasize wellness, recovery, and resiliency and offer integrated services for clients of all ages and their families. Services are delivered in a timely manner and are sensitive to the cultural needs of each individual. The wellness centers are often the first "accepted door" into the System of Care by persons who do not recognize that they have a mental illness. Referrals to "check out the wellness center" come from many directions throughout the community including social services, health care providers, faith-based organizations, and law enforcement, to name a few. Our bilingual workers also provide targeted outreach to the Latino population both within the schools and the community settings.

The CSS Program includes comprehensive assessment services; wellness and recovery action planning; case management services; individual and group mental health services; crisis services; peer-led self-help/support groups; education and employment support; anti-stigma events; linkages to needed services; and housing support. Our Adult and Older Adult Wellness Centers (located in Bishop and Lone Pine) provide adults and older adults with necessary services and supports in a welcoming environment. Our ongoing peer-facilitated groups include Addiction and Recovery, Journaling, Art, Nutrition, Tai Chi, and Wellness Walking. As consumers express an interest, we encourage them to bring the topic to the weekly stakeholder group. We also provide two support groups, one to Transition Age women and one to Adult women, in collaboration with Wild Iris, our local domestic violence agency and a men's support group. These groups have been well attended. In the last year, we have provided two NAMI Peer2Peer classes to increase our capacity to provide peer support and increase skills in group facilitation. We also have provided two Mental Health First Aid classes at the wellness center sites. We have continued a Dialectical Behavior Therapy (DBT) group and a focus on mindfulness and a Daily Living skills group with related activities. In addition, our Transition Age Youth program provides opportunities for youth to participate in age-appropriate activities. The TAY youth utilize the Wellness Center in Bishop once a week, meeting together to socialize, listen to guest speakers, and develop leadership skills.

Our Wellness Center staff members also assist consumers to access and meet food and shelter needs, and physical health care needs as well as other behavioral health services. In addition, we provide volunteers with employment readiness experience at the wellness centers. This experience includes reception, statistics reporting, operation of office equipment as well as the group facilitation. We also assist consumers to access further education at our Community College.

Another important component of the CSS plan is in the provision of respite and transitional housing for FSPs as needed. We have continued to purchase four beds at Progress House, an

Adult Residential Facility. We have used this for persons with severe mental illness who are transitioning out of an IMD or from being in jail or who are homeless. In addition, we have served persons who are living within the community who are in need of a respite due to a mental health crisis. We have been able to keep persons within our community and to assist them to successfully transition back into the community through this strategy. We continue to look for ways to increase the effectiveness of this strategy through the implementation of recovery principles. We also use this opportunity to assist consumers to access medical care and develop wellness plans while they are in the transitional housing at Progress House. We have added a Supervising Behavioral Health Nurse position to coordinate care for the residents and to focus on wellness in such areas as meals, exercise and medication assistance.

CSS programs continue to provide the opportunity to change our service delivery model and build transformational programs and services. Over the past years, staff and consumers have worked together to build a community service program to give back to the community and reduce stigma. Consumers have conducted multiple food drives, assisted with relief efforts for fire victims, helped with park clean-up, visited older adults in a skilled nursing facility, volunteered for community events, and made blankets for the Hospice program. In addition, 3 to 5 consumers volunteer at the local Salvation Army and several more are involved in seasonal bell-ringing. These "stigma-busting" activities have allowed consumers to gain skills, meet new people, and cultivate a positive presence in the community.

CSS Data

The tables below show the number of CSS clients served, by age and race/ethnicity. They also show the total dollars and dollars per client.

CSS Clients by Age
FY 13/14

	0 - 15 years	16 - 25 years	26 - 59 years	60+ years	Total
# Clients	65	51	158	66	340
% Clients	19.1%	15.0%	46.5%	19.4%	100.0%

CSS Clients by Race/Ethnicity
FY 13/14

	Caucasian	Hispanic	Black/ African American	Asian/ Pacific Islander	American Indian/ Alaskan Native	Other/ Unknown	Total
# Clients	230	45	0	1	39	25	340
% Clients	67.6%	13.2%	0.0%	0.3%	11.5%	7.4%	100.0%

CSS Clients by Gender
FY 13/14

	Male	Female	Total
# Clients	159	181	340
% Clients	46.8%	53.2%	100.0%

CSS Dollars per Client
FY 13/14

Total Dollars	$ 656,953
Total Clients	340
Avg. Dollars/Client	$ 1,932

There are currently 32 persons who are Full Service Partners:

- Children: one youth who is Latino
- Transition Age Youth: five TAY
- Adults:19: four Latino, one Native American, 14 Caucasian
- Older Adults: seven, all Caucasian

Approximately 182 individuals, including 44 homeless persons, were served through the Wellness Centers. In addition, 33 Spanish-speaking persons were provided outreach and community-based services through our MHSA contracted bilingual therapist and community worker.

2. Describe any challenges or barriers, and strategies to mitigate.

Our largest barrier to our CSS implementation has been the difficulty in finding a permanent Wellness Center site in Bishop. We are now able to address this issue through the purchase of an existing house, as outlined below.

3. List any significant changes from previous fiscal year, if applicable.

The most significant change in this Fiscal Year is the purchase of a permanent Wellness Center site in Bishop. With FY 14/15 CSS funding, we have purchased a house that is located within a short walk from our Bishop clinic and Progress House, as well as other services and supports. This site has a both a main house and a smaller "back house." We are hoping to use the space to more easily provide for separate space for TAY population, as well as space to address needs for cooking, laundry, showers, and visits with the nurse. Additional CSS and CFTN funding will cover the remodeling expenses that will allow us to create a welcoming environment for our clients.

While we are not planning to make any other significant changes to our overall CSS program, we continue to test changes that will increase the effectiveness of the strategies implemented. These strategies address such areas as co-occurring substance use, coordinating physical health care and assisting persons with re-entry into the community from the legal justice system.

We will also continue to look for ways to extend FSP services especially to TAY in the Native American and Latino populations, and we will look for ways to partner with our local tribes to accomplish this effort.

MHSA Program Component
PREVENTION AND EARLY INTERVENTION

1. ***Provide a program description (must include number of clients served, age, race/ethnicity). Include achievements and notable performance outcomes.***

Prevention and Early Intervention (PEI) dollars currently funds two (2) PEI Programs: 1) PCIT Community Collaboration and 2) Older Adult PEI Services.

1. Parent-Child Interaction Therapy (PCIT) Community Collaboration

Several of our staff have been trained and certified to offer Parent-Child Interaction Therapy (PCIT), an evidence-based intensive parent-training program which has been found to be effective for families with aggressive, defiant, and non-compliant children; families with parents who have limited parenting skills; and families who have experienced domestic violence and/or child abuse. PCIT focuses on promoting positive parent-child relationships and interactions, while teaching parents effective parenting skills. PCIT has been shown to be an effective treatment program for children ages 2-7 years. This program has been adapted as an intervention for many different types of families (child welfare population, at-risk families, adoptive families, foster families, and other languages including Spanish).

PCIT teaches families individualized parenting skills that are developed through a process in which parents directly receive instruction through an earpiece that is linked to a therapist. The therapist, behind a one-way mirror and/or via a live camera feed, observes interactions between the parent and child, coaches the development of relationship enhancing techniques, and gives behavioral interventions for responding to difficult parent-child situations. Sessions last about one hour, occur over 18-20 weekly visits, and show very strong outcomes for both parents and children.

Currently, ICBH offers PCIT at two (2) locations in the county: our mental health clinic in Bishop and within the community in Lone Pine. The ICBH Youth and Family Program Chief is certified to provide supervision in PCIT. Our PCIT Community Collaborative program continues to work to expand PCIT delivery in the public mental health system and into the community. We had previously also trained four (4) local mental health clinicians in PCIT, targeting both ICBH staff and personnel from local community-based organizations. We wish to expand our services, especially to the Lone Pine area. This past year, we began training a bilingual Spanish intern in order to expand our capacity to offer PCIT services in Spanish to meet the needs of the underserved Latino community. We have continued to utilize case managers and our Perinatal Program Addictions Counselor to reinforce the PCIT skills. While these unlicensed staff members do not provide the actual PCIT strategy, they use the "language" of PCIT to offer parent coaching and support within the home. This approach has reinforced the skills learned in the PCIT sessions.

PCIT is a highly effective program and the families show improved outcomes as a result of this intensive parenting program. In addition, the children and their siblings show improved behavior (positive social interactions, following directions, reduction in acting out behavior) as a result of the program. We have served five additional families with this intervention, including 2 Native American; 1 blended Native America and Caucasian; and 2 Caucasian families. An additional 2 CPS involved families were reunited upon completion of PCIT.

2. Older Adult PEI Services

Our community has a large number of individuals who are retired. This PEI program has been helpful at identifying at-risk seniors who begin to exhibit symptoms of depression, prescription abuse, isolation, and other mental health conditions related to the aging population. The Older Adult PEI Program has provided early mental health screening and intervention to older adults who had been receiving services in the community and through county resources. This program also trains agency partners to recognize the signs and symptoms of mental illness in older adults.

The Older Adult Prevention and Early Intervention Program partially funds two Nurse positions to support prevention and early intervention activities throughout the county in order to identify older adults who need mental health services. The program, utilizing Behavioral Health Nurses, offers comprehensive assessment services to those older adults experiencing mental health problems that may interfere with their ability to remain independent in the community. The Nurses then link these individuals to resources within the community, including County Behavioral Health services. This program offers service alternatives for older adults who have been unserved and underserved in this community, including those in the isolated southeastern portion of the County. Services are voluntary and client-directed, strength-based, employ wellness and recovery principles, address both immediate and long-term needs of program members, and are delivered in a timely manner that is sensitive to the cultural needs of the population served.

In the past year the Behavioral Health RNs as part of the Older Adult team received training in the Healthy Ideas Program. This is an evidenced based practice to identify and address depressive symptoms. The role of the Behavioral Health Nurse is to provide the initial assessment, including a PHQ 9 measure of depression, to potential candidates for the Healthy Ideas strategy. A member of the Adult Services team, including a volunteer, implements Healthy Ideas and involves the Behavioral Health RN when further intervention is warranted, especially if any suicidal ideation is noted.

The Behavioral Health RNs collaborate closely with other agencies that provide services to this population, including In-Home Supportive Services, Adult Protective Services, Eastern Sierra Area Agency on Aging, local physicians, Public Health, nursing homes, home health agencies, and the home delivery meals program. All agencies receive training to help them recognize signs and symptoms of mental illness in older adults.

The Behavioral Health RNs also provide services to older adults who are at risk of hospitalization or institutionalization and who may be homeless or isolated. These positions offer prevention and early intervention services to older adults in community settings that are the natural gathering places for older adults, such as our Senior Center sites in the community sites of Bishop, Big Pine, Independence, Lone Pine, and Tecopa. Older adults who need additional services are referred to Behavioral Health for ongoing treatment, as appropriate. Twenty-seven older adults were served through this strategy. Ten of the older adults reside in the southeastern part of the county, 5 reside in Lone Pine and the remainder of the persons reside in the Bishop area. Therefore, this strategy again targets the more isolated parts of the county. One Native American and one Hispanic older adult have been served with the remainder being Caucasian. PEI funding also has allowed us to contract with an older adult services clinician to be available to provide additional support to the Older Adult PEI program.

The Behavioral Health RNs also provide a quarterly newsletter which addresses a wellness topic. This newsletter is distributed to the various senior centers and other agencies and has been well received.

2. Describe any challenges or barriers, and strategies to mitigate.

The classic barrier for Inyo County is the small number of staff and the issues caused when staff vacancies occur. In a small county, all vacancies are "key" and have an impact on service delivery and strategy implementation. We have our bilingual intern going out on maternity leave which will impact PCIT for a few months. We also have two Behavioral Health RN vacancies, but continue to provide the Elder Outreach, newsletter, etc.

3. List any significant changes from previous fiscal year, if applicable.

Based on input from consumers and community partners, this year we are implementing a further component to the continuum of care offered to older adults. We are employing two part time "personal services assistants" (PSAs) to implement the Friendly Visitor program. One PSA will work out of the Bishop area and one will work out of the Lone Pine area with isolated older adults at risk for depression. The Friendly Visitor provides outreach to the home and interaction with the older adult, involving them in activities of interest and engaging them to reduce isolation. These identified adults are at risk, not only due to isolation, but also due to complicating health and mental health conditions. The Friendly Visitor will add a further prevention component to the older adult continuum of care, and will pass along observations, concerns, and need for further linkage or intervention.

In addition, we are planning to redefine and expand our Wraparound services as a PEI strategy to better meet the needs of families. We will offer wrap round services to children and families who would benefit from early intervention to avoid risk of out of home placement. The newly targeted families may meet one of the following criteria: 1) Families with at least one parent who evidences a severe mental illness, or 2) Families with younger children involved in the Child Welfare system. We will use this evidence-based strategy to increase the current number of families served by at least 10 additional youth. Youth may be eligible under EPSDT and may include underserved families in the Latino, Native American and/or veteran population. A respite component will also be a part of this strategy.

MHSA Program Component
INNOVATION

1. ***Provide a program description (must include number of clients served, age, race/ethnicity, cost per person). Include achievements and notable performance outcomes.***

The Innovation component was approved in July 2014. The Inyo County Community Care Collaborative (CCC) was implemented to improve coordination of care with primary health care services for adults, ages 18 and older, with a serious mental illness. Persons with a serious mental illness are more likely to have chronic health conditions, and have shortened life spans by up to 25 years, compared to the general population. Increasing access to and coordination with primary care services for our clients with a serious mental illness is a high priority for ICBH. By coordinating and co-locating health and mental health services, we are able to improve outcomes for our clients and improve access to primary care services.

The Innovation Project funding supported the development of a CCC Team by partially funding one full-time Behavioral Health RN position (1.0 FTE) to coordinate and integrate health and wellness activities for behavioral health clients and one full-time Administrative Analyst position to collect, track, and analyze outcome and cost data based on a quality improvement model. The initial target population has been mental health consumers who are also enrolled and receiving services at the Northern Inyo Hospital Rural Health Clinic (NIHRHC), and currently includes approximately 90 persons. The CCC team identifies clients who receive behavioral health services and help link them to health services in the community. These individuals work with the NIHRHC to improve health outcomes for CCC clients.

The Coordinated Care Collaborative address the following:

- Identify individuals who do not have an identified primary care physician, or routinely use primary care services, and link them to the appropriate provider/health clinic/healer/alternative health care in the community.

- Collect basic health information, including lab work, on individuals to help understand each person's current health indicators. Staff work with the individual to understand their health indicators (e.g., height, weight, body mass index, A1c and risk for diabetes, CO monitor results, hypertension/blood pressure, cholesterol, and lung functioning). These health indicators are used to inform both the individual and staff on high risk health factors, and allow them to work together with the health clinic to identify goals on improving their health and wellness.

- Participating clients allow for the reconciliation of medications between ICBH and NIHRHC. A work flow has been tested and developed to allow for the sharing of this information between the two entities to best coordinate the medication needs.

- Clients and staff work together to develop health and wellness activities to support clients to improve their health. These activities include developing walking groups, nutrition and cooking groups, relaxation, meditation, and yoga. Wellness information is also offered to CCC clients, to provide support and information to help individuals make healthy choices. These activities help the team provide supportive services which will lead to positive outcomes.

- Peer Support has been recognized to be an important component of the coordinated care approach. We have begun to train per supporters to assist with health goals and to accompany consumers to medical appointments to provide support and another "listening ear." To date, we have trained three (3) peer supporters and one is actively involved in providing this service.

- We have collected and are tracking outcome data both as applies to the individuals and in the area of population health, on such factors as costs and hospitalizations.

2. Describe any challenges or barriers, and strategies to mitigate.

The ongoing challenge is in how to mitigate the impact of staff changes and vacancies on the CCC team of key members of the team. One strategy to mitigate the impact of this situation is to continue to look for ways to build peer and other natural support. Another strategy is to set up work flows that can be used by numerous staff and thus to "institutionalize" the gains made and the process of continuing to improve the strategies.

3. List any significant changes from previous fiscal year, if applicable.

No significant changes are anticipated to the original Innovation Plan. We are moving to applying the coordinated care model to the jail and re-entry services population, as appropriate.

A future strategy is to also look at ways to coordinate care for veterans. This focus will push us further in the development of strategies to address care when services are outside of the area. Distance strategies, such as telemedicine, will be developed to address this challenge.

MHSA Program Component
WORKFORCE EDUCATION AND TRAINING

1. Provide a program description. Include achievements.

Workforce Education and Training Coordination: Since the original WET Plan was approved, ICBH has developed contracts with various learning providers to deliver trainings to clients, family members, staff from Behavioral Health, members of the Mental Health Advisory Board, and partner agencies. Training topics include psychosocial rehabilitation skills, the recovery model, motivational interviewing, and delivering comprehensive services for promoting wellness and recovery. Cultural competency and team building has also been a focus of our trainings. In addition, we have implemented evidence-based models such as Aggression Replacement Training (ART) and wraparound services.

In the last year, our efforts to effectively coordinate care have also underlined the following training and workplace development needs:

1) As consumers have identified co-occurring medical needs and complications, we have found that we would benefit from an on-line resource such as "Up to Date" to provide our psychiatrist and nurses with information regarding medical conditions, medications, drugs, side effects, and accompanying research.
2) We have also identified a need for further training as related to the co-occurrence of mental illness and substance use disorders. It is critical to implement effective strategies to treat or mitigate the impact of substances on recovery and wellness. We propose to offer up to 10 staff, including peer supporters on-line addiction counselor certification and related practicum/intern support.
3) Finally, we have seen the need to offer training for partners in law enforcement, probation and other first responders. We propose to implement a Crisis Intervention Training (CIT) strategy, using persons with lived experience to share stories.

Fundamental Learning Program**:** Our training partners include *Relias*, an online training system which offers courses in confidentiality, ethics, and regulations, as well as an array of clinical skills building courses that also fulfill continuing education requirements for licensed behavioral health professionals. We have purchased a bulk subscription package for our organization that makes these exemplary courses available to staff. As an added training component, we have provided staff and consumers with technical software training to enhance the skill set of staff and consumers/family members who work or volunteer for Inyo County.

Consumer Pathways Program: We have developed a NAMI Peer-to-Peer Training program to consumers to develop skills for Coach, Parent Partner, or Peer Mentor positions with Inyo County. Some of the topics included in the curriculum are: wellness management and recovery; promoting resiliency skills in Transition Age Youth; putting recovery skills into practice; embracing wellness in all aspects of care; providing peer support; and creating a recovery-based mental health services plan. To date, fifteen (15) consumers have graduated from the Peer-to-Peer Training and are developing activity groups to lead at our Wellness Centers. As part of our efforts to develop a Peer Supporter program, we have developed a training that includes not only Peer2Peer, but also training in Motivational Interviewing and development of Wellness Recovery Action Plans (WRAP). Further we have trained an additional five persons to be certified facilitators of Mental Health First Aid (MHFA). Facilitators include two persons with lived experience, one Spanish-speaking, and one family member. Also included is

representation from the faith community and the health care community. MHFA has been provided to an additional 40 persons in the last year, including at least 15 persons with lived experience.

In the coming fiscal years, we will continue to identify regional and statewide trainings – such as those offered through NAMI and CASRA – for staff, clients, family members, and other stakeholders to enhance their understanding of the recovery model, promote effective service delivery, increase cultural competency, promote leadership and team building, and learn other essential skills. We will work to identify evidence-based strategies to address gaps in our systems of care, including crisis response (CIT), dual-diagnosis/co-occurring disorders treatment, and MHFA. To support consumer and family member training, we will develop and maintain a mental health information library at the Bishop Wellness Center. This library will allow consumers and family members to borrow publications and DVDs on mental health, the recovery model, cultural competency, and other mental health related information.

Financial Incentives: We participate in the Mental Health Loan Assumption Program, which offers two to three ASW employees, including a bi-lingual intern, support to pay back school loans for "hard to fill" positions. Due to bargaining agreements with local labor groups, we have not been able to offer tuition reimbursement to date. We continue to look for ways to offer this strategy.

2. ***Describe any challenges or barriers, and strategies to mitigate. Identify shortages in personnel, if any.***

We continue to face the challenge of recruiting bilingual, bicultural staff. We are mitigating the challenge to recruit Native American staff by focusing our efforts on supporting Toiyabe Family Support services through shared training and collaborative teams. We continue to look for ways to identify TAY to participate as part of the Human Services Certificate program at our community college as well as in other Peer Supporter roles. We look forward to expanding our training capacity and opportunities for both staff and consumers

While we participate in the Mental Health Loan Assumption Program, we have not been able to offer tuition reimbursement to date, due to bargaining agreements with local labor groups. We continue to look for ways to offer this strategy.

3. ***List any significant changes from previous fiscal year, if applicable.***

No significant changes are anticipated to the WET program in this fiscal year.

MHSA Program Component
CAPITAL FACILITIES/TECHNOLOGY

1. ***Provide a program description. Include achievements.***

ICBH chose to utilize the bulk of CFTN funding for a system-wide IT upgrade to achieve an Integrated Information Systems Infrastructure. ICBH implemented ShareCare™, a product of The Echo Group. An Electronic Health Record system is in place, including clinical assessments and progress notes. Electronic prescriptions and medication monitoring are components of the new IT system, as well as lab orders and results.

The balance of CFTN funding that may be used for Capital Facilities is limited, but the funds will be used for remodeling needs for the newly-purchased Wellness Center in Bishop. These funds will be used to meet ADA requirements and to create a more welcoming environment.

2. ***Describe any challenges or barriers, and strategies to mitigate.***

While ICBH has been able to utilize the ShareCare product to successfully produce a claim and has moved forward in the full use of the product to produce an electronic health record, ICBH must continue to use "work-arounds" in order to address deficiencies in the product. ICBH has fully implemented the clinical record portion for both mental health and SUD documentation with the product restrictions, which include an inability to sign the record electronically ICBH will implement a newer product in the next year, the Virtual Health Record (VHR), in order to meet "meaningful use" standards. ICBH had chosen to delay this implementation of the VHR due to continued deficiencies in the product, as well as the cost. To date, one other California County has implemented the VHR. ICBH will implement the product in tandem with Mono County Behavioral Health in order to manage cost of training and to benefit from the support of regional learning about this product.

3. ***Describe if the county is meeting/met benchmarks and goals, or provide the reasons for delays to implementation.***

ICBH has delayed implementation of the VHR until this fiscal year to allow for sufficient time to address implementation challenges of the product and to address product "bugs."

4. ***List any significant changes from previous fiscal year, if applicable.***

No significant changes are anticipated to the CFTN component in this fiscal year.

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: **INYO** Date: 3/20/15

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2014/15 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	1,404,427	271,038	462,400	356,114	142,895	
2. Estimated New FY2014/15 Funding	1,040,572	260,143	68,459			
3. Transfer in FY2014/15[a/]	(202,014)			0	85,000	117,014
4. Access Local Prudent Reserve in FY2014/15	0	0				0
5. Estimated Available Funding for FY2014/15	2,242,985	531,180	530,858	356,114	227,895	
B. Estimated FY2014/15 MHSA Expenditures	1,270,242	225,703	129,769	86,000	118,505	
C. Estimated FY2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	972,742	305,477	401,089	270,114	109,390	
2. Estimated New FY2015/16 Funding	1,092,601	273,150	71,882			
3. Transfer in FY2015/16[a/]	(202,293)			0	55,000	147,293
4. Access Local Prudent Reserve in FY2015/16	0	0				0
5. Estimated Available Funding for FY2015/16	1,863,050	578,628	472,971	270,114	164,390	
D. Estimated FY2015/16 Expenditures	1,118,431	248,273	142,746	94,600	164,390	
E. Estimated FY2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	744,619	330,355	330,225	175,514	0	
2. Estimated New FY2016/17 Funding	1,147,231	286,808	75,476			
3. Transfer in FY2016/17[a/]	(210,001)			0	25,000	185,001
4. Access Local Prudent Reserve in FY2016/17		0				0
5. Estimated Available Funding for FY2016/17	1,681,849	617,162	405,701	175,514	25,000	
F. Estimated FY2016/17 Expenditures	1,286,195	273,100	185,570	104,060	25,000	
G. Estimated FY2016/17 Unspent Fund Balance	395,654	344,062	220,131	71,454	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2014	382,134
2. Contributions to the Local Prudent Reserve in FY 2014/15	117,014
3. Distributions from the Local Prudent Reserve in FY 2014/15	0
4. Estimated Local Prudent Reserve Balance on June 30, 2015	499,148
5. Contributions to the Local Prudent Reserve in FY 2015/16	147,293
6. Distributions from the Local Prudent Reserve in FY 2015/16	0
7. Estimated Local Prudent Reserve Balance on June 30, 2016	646,441
8. Contributions to the Local Prudent Reserve in FY 2016/17	185,001
9. Distributions from the Local Prudent Reserve in FY 2016/17	0
10. Estimated Local Prudent Reserve Balance on June 30, 2017	831,442

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: **INYO** Date: 3/20/15

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. System Transformation (FSP)	499,935	499,935				
2. Wellness Center purchase (FSP)	147,889	147,889				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. System Transformation (Non-FSP)	333,290	333,290				
2. Wellness Center purchase (Non-FSP)	142,089	142,089				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	147,040	147,040				
CSS MHSA Housing Program Assigned Funds	0	0				
Total CSS Program Estimated Expenditures	1,270,242	1,270,242	0	0	0	0
FSP Programs as Percent of Total	51.0%					

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: **INYO** Date: 3/20/15

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. System Transformation (FSP)	570,400	570,400				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. System Transformation (Non-FSP)	380,267	380,267				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	167,765	167,765				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	1,118,431	1,118,431	0	0	0	0
FSP Programs as Percent of Total	51.0%					

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: **INYO** Date: 3/20/15

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. System Transformation (FSP)	655,959	655,959				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. System Transformation (Non-FSP)	437,306	437,306				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	192,929	192,929				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	1,286,195	1,286,195	0	0	0	0
FSP Programs as Percent of Total	51.0%					

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: **INYO** Date: 3/11/15

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Older Adult PEI Program	71,096	71,096				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. PCIT Community Collaboration	40,627	40,627				
12. Wraparound for Youth	91,410	91,410				
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	22,570	22,570				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	225,703	225,703	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: **INYO** Date: 3/11/15

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Older Adult PEI Program	78,206	78,206				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. PCIT Community Collaboration	44,689	44,689				
12. Wraparound for Youth	100,551	100,551				
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	24,827	24,827				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	248,273	248,273	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: **INYO** Date: 3/11/15

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Older Adult PEI Program	86,027	86,027				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. PCIT Community Collaboration	49,158	49,158				
12. Wraparound for Youth	110,606	110,606				
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	27,310	27,310				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	273,100	273,100	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: **INYO** Date: 3/11/15

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Community Care Collaborative (CCC)	117,972	117,972				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	11,797	11,797				
Total INN Program Estimated Expenditures	129,769	129,769	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: **INYO** Date: 3/11/15

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Community Care Collaborative (CCC)	129,769	129,769				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	12,977	12,977				
Total INN Program Estimated Expenditures	142,746	142,746	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: **INYO** Date: 3/11/15

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. NEW Innovation Plan TBD	168,700	168,700				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	16,870	16,870				
Total INN Program Estimated Expenditures	185,570	185,570	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: **INYO** Date: 3/11/15

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET Coordination	10,000	10,000				
2. Fundamental Learning Program	36,000	36,000				
3. Consumer Pathways	15,000	15,000				
4. Financial Incentives	25,000	25,000				
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0	0				
Total WET Program Estimated Expenditures	86,000	86,000	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: **INYO** Date: 3/11/15

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET Coordination	11,000	11,000				
2. Fundamental Learning Program	39,600	39,600				
3. Consumer Pathways	16,500	16,500				
4. Financial Incentives	27,500	27,500				
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0	0				
Total WET Program Estimated Expenditures	94,600	94,600	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: **INYO** Date: 3/11/15

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET Coordination	12,100	12,100				
2. Fundamental Learning Program	43,560	43,560				
3. Consumer Pathways	18,150	18,150				
4. Financial Incentives	30,250	30,250				
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0	0				
Total WET Program Estimated Expenditures	104,060	104,060	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: **INYO** Date: 3/20/15

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Wellness Center/Progress House Remodel	27,347	27,347				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. VHR & Telemedicine Implementation	91,158	91,158				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	118,505	118,505	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: **INYO** Date: 3/20/15

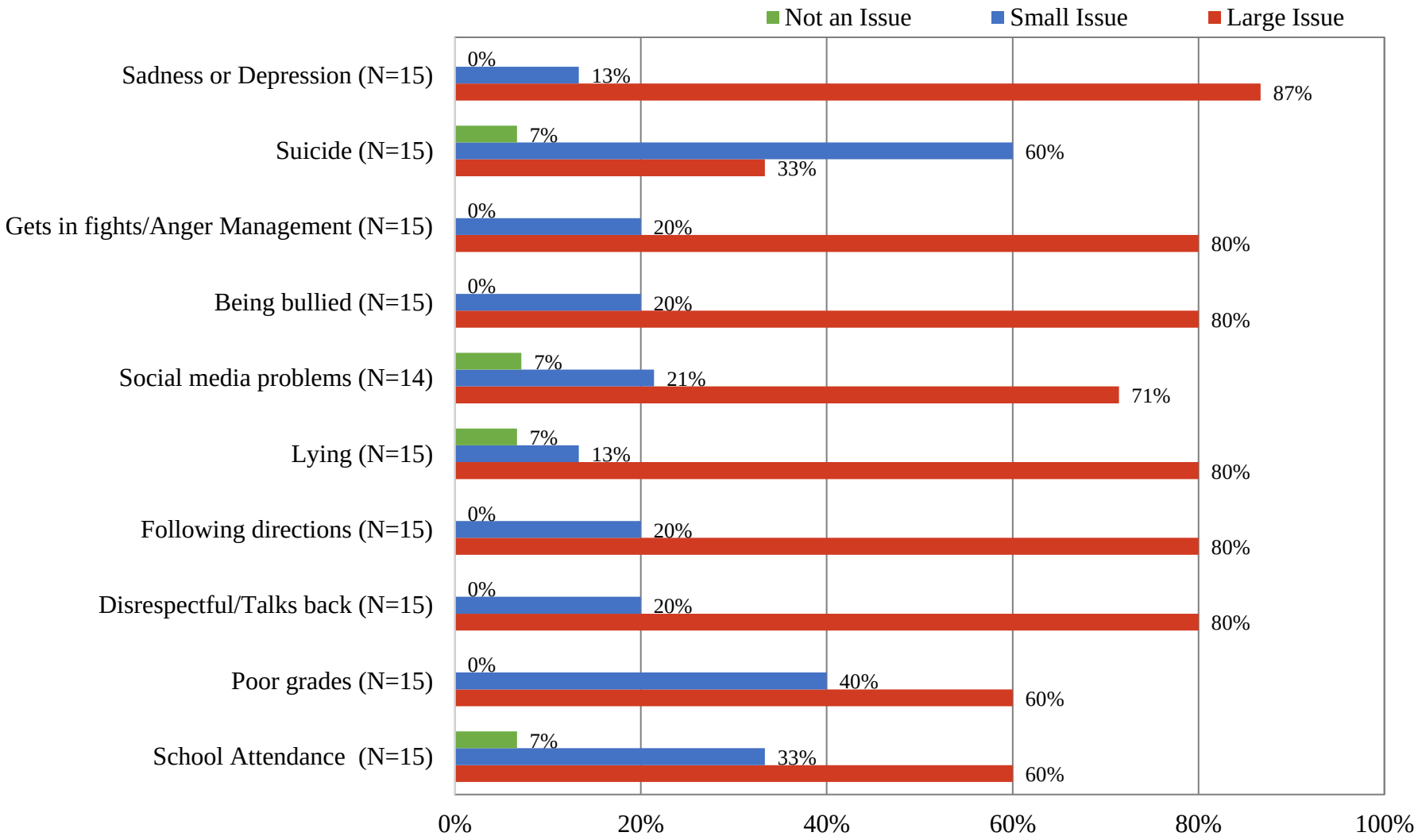
	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Wellness Center/Progress House Remodel	109,390	109,390				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. VHR & Telemedicine Implementation	55,000	55,000				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	164,390	164,390	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

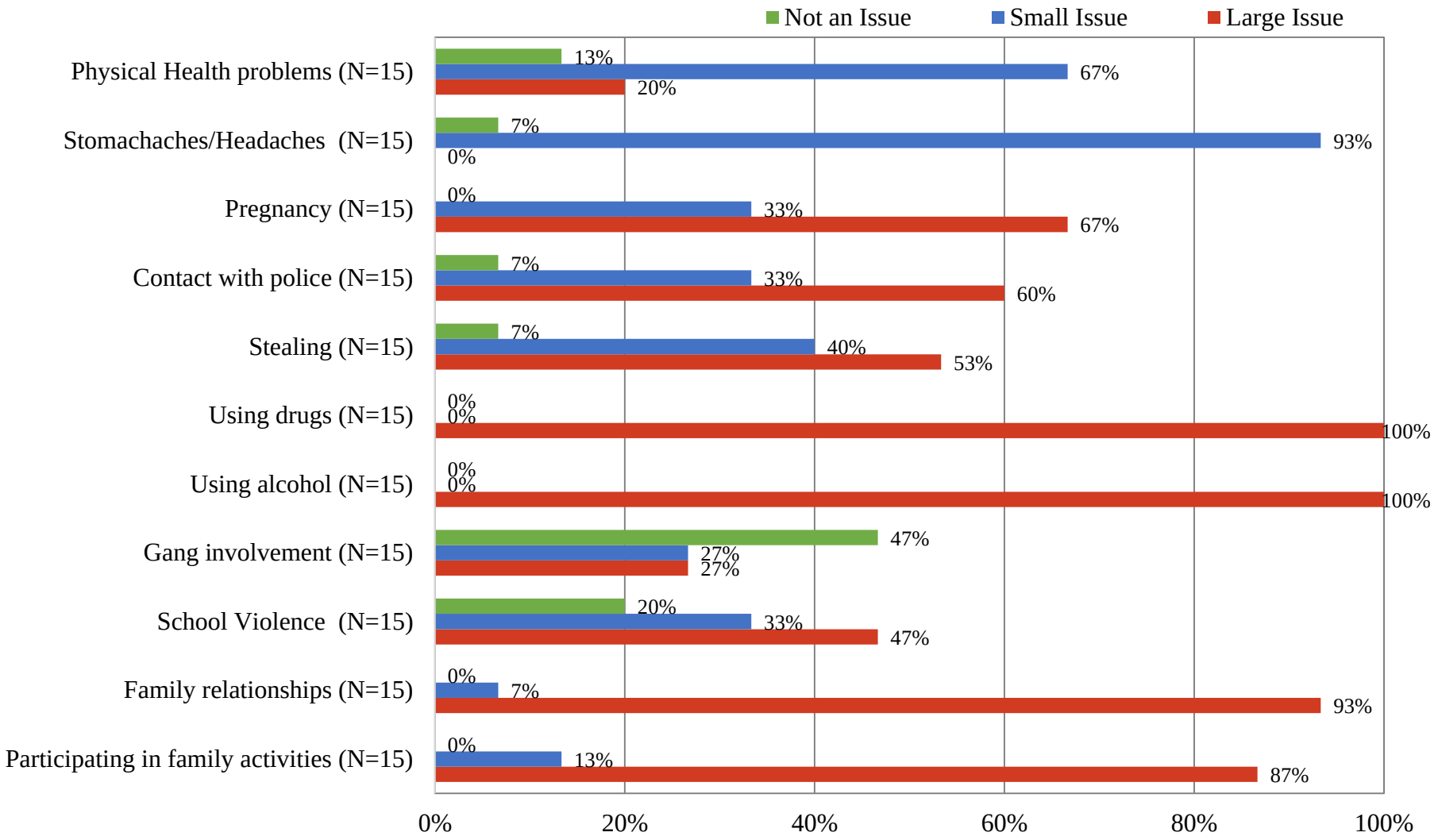
County: **INYO** Date: 3/20/15

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. VHR & Telemedicine Implementation	25,000	25,000				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	25,000	25,000	0	0	0	0

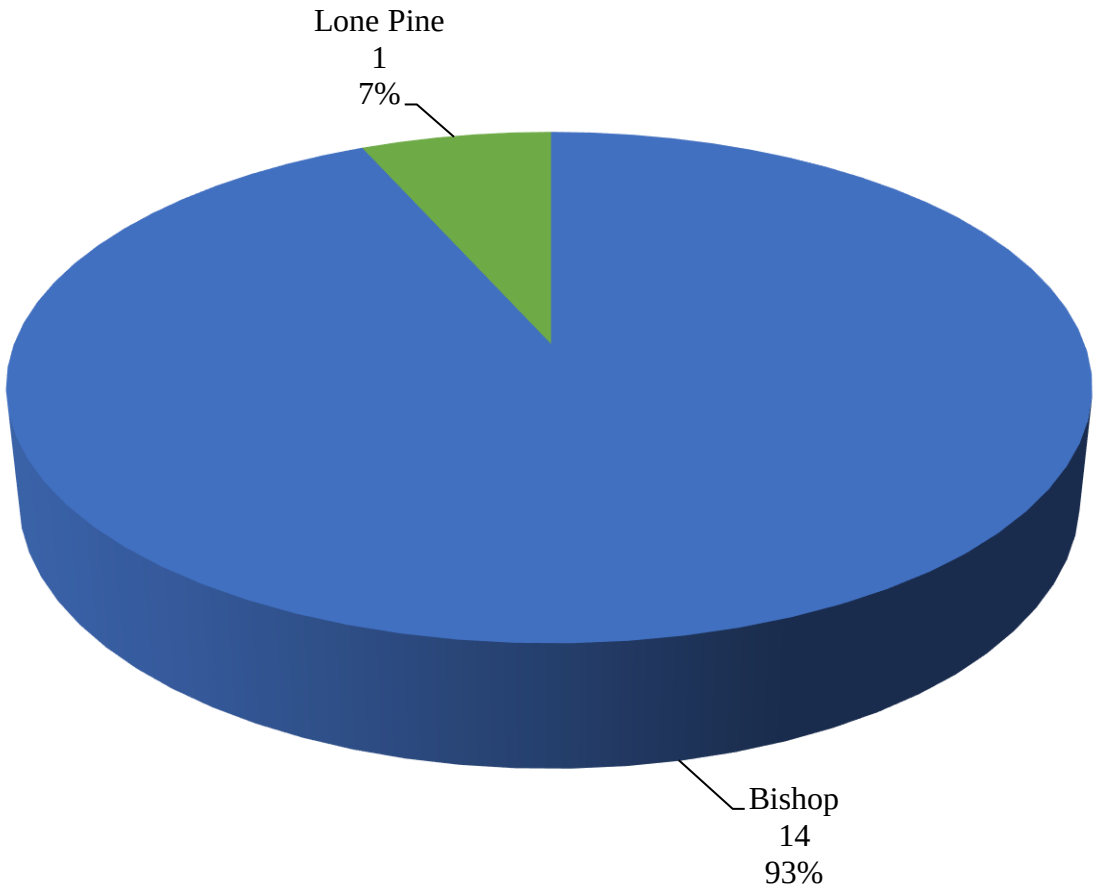
Inyo County Mental Health
MHSA Family Survey Results
Children/Youth Issues
2015



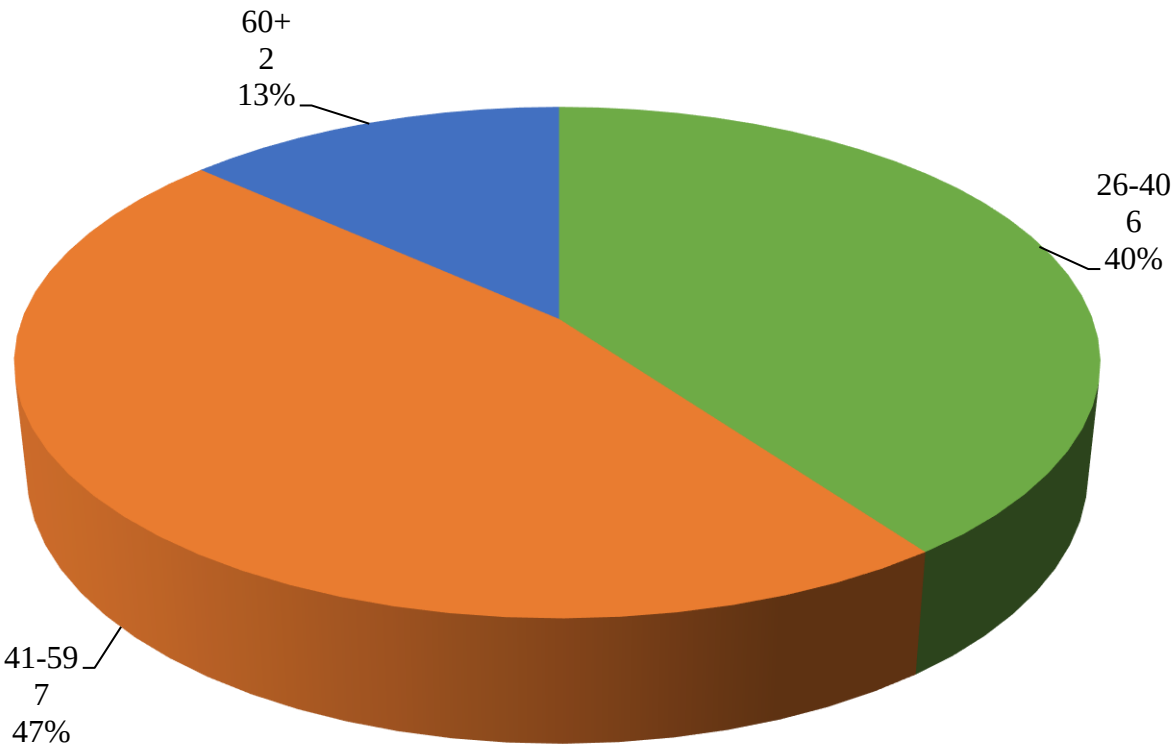
Inyo County Mental Health
MHSA Family Survey Results
Children/Youth Issues
2015



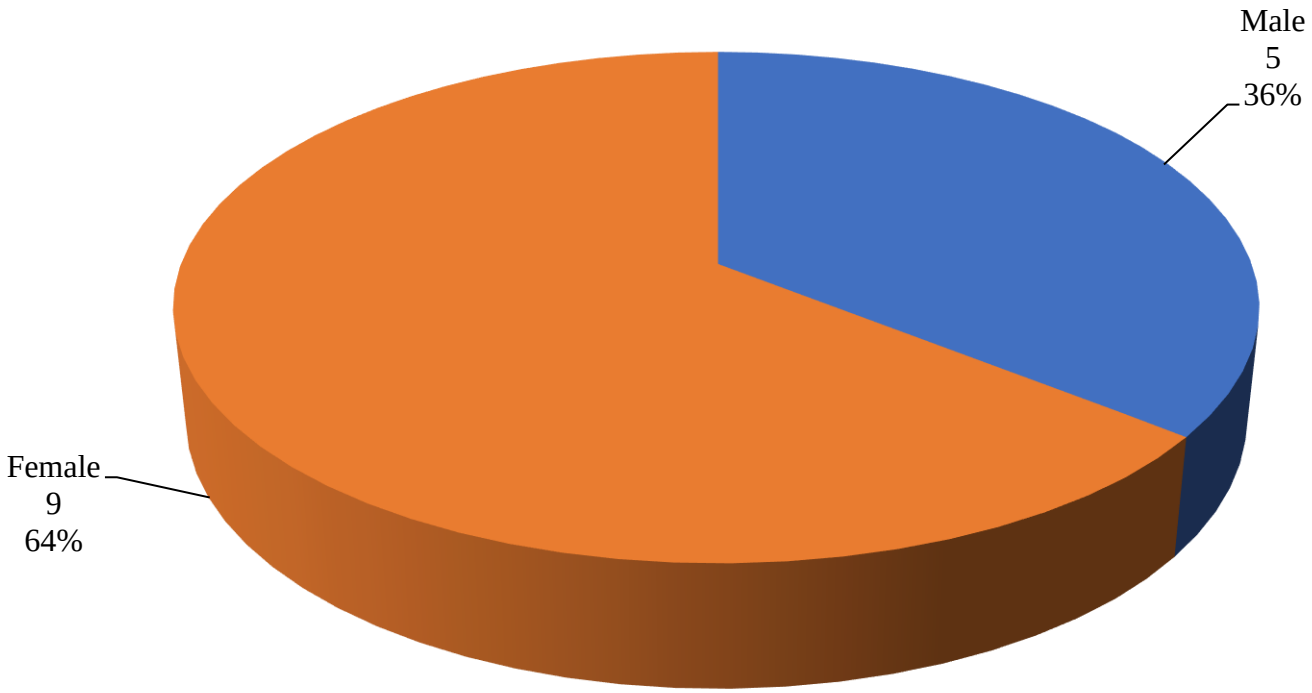
Inyo County Mental Health
MHSA Family Survey Results
2015
Region (N=14)



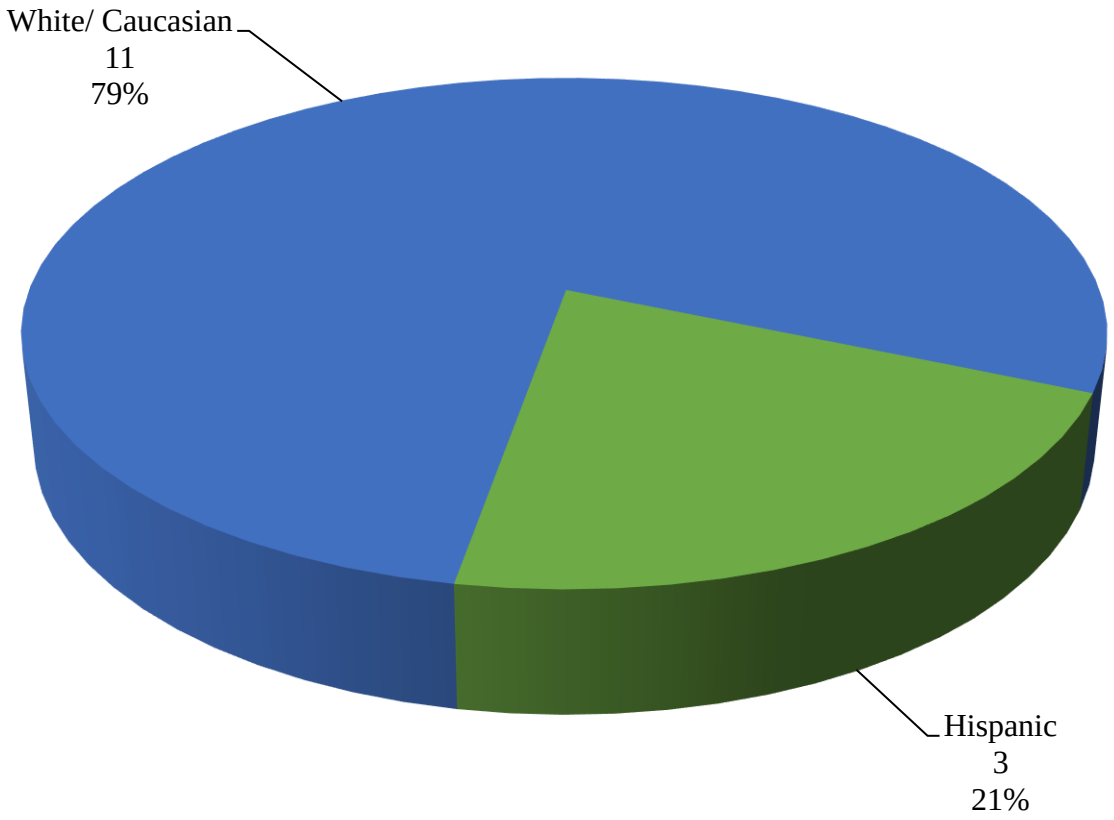
Inyo County Mental Health
MHSA Family Survey Results
2015
Age (N=15)



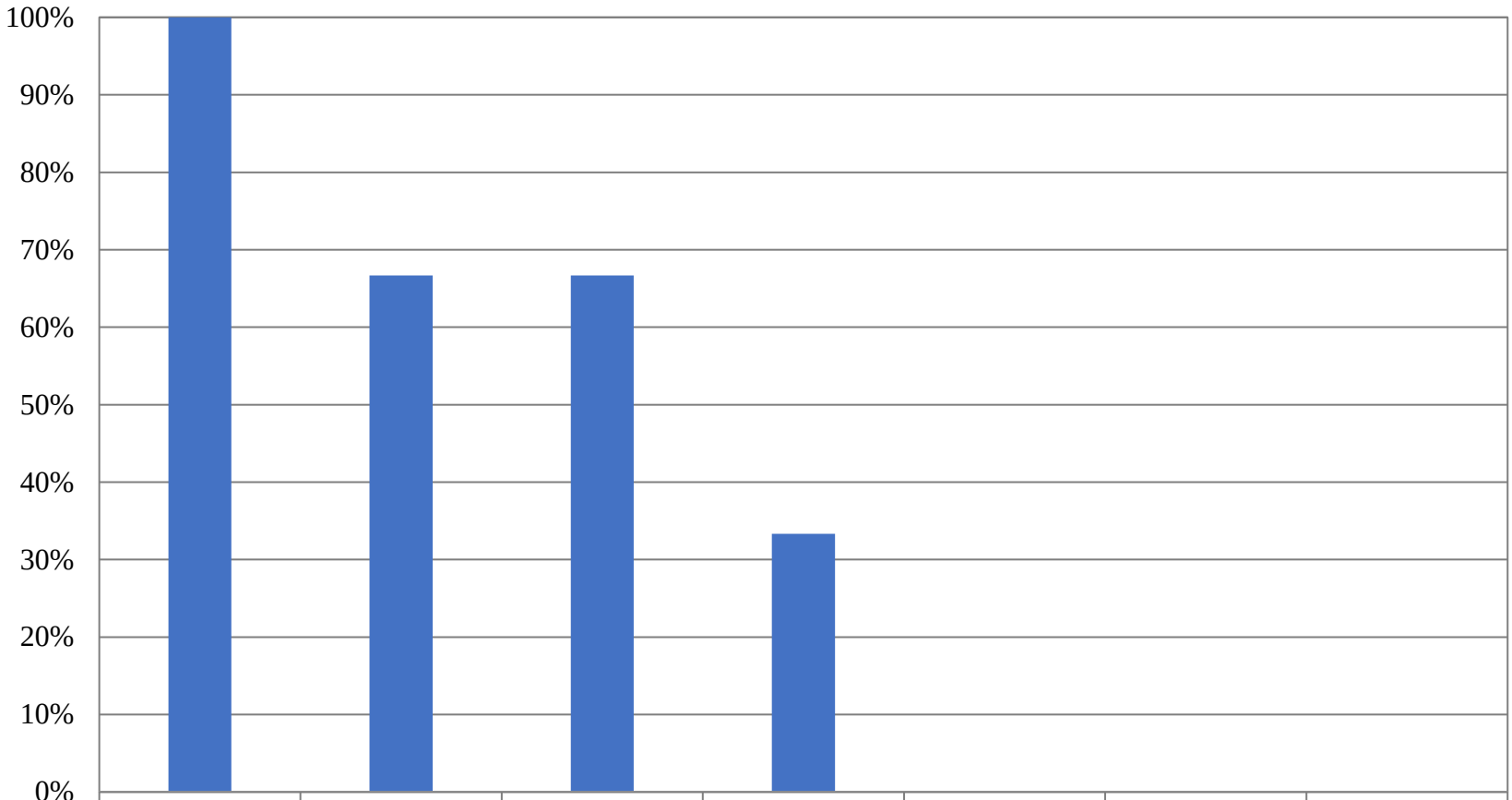
Inyo County Mental Health
MHSA Family Survey Results
2015
Gender (N=14)



Inyo County Mental Health
MHSA Family Survey Results
2015
Race/Ethnicity (N=14)

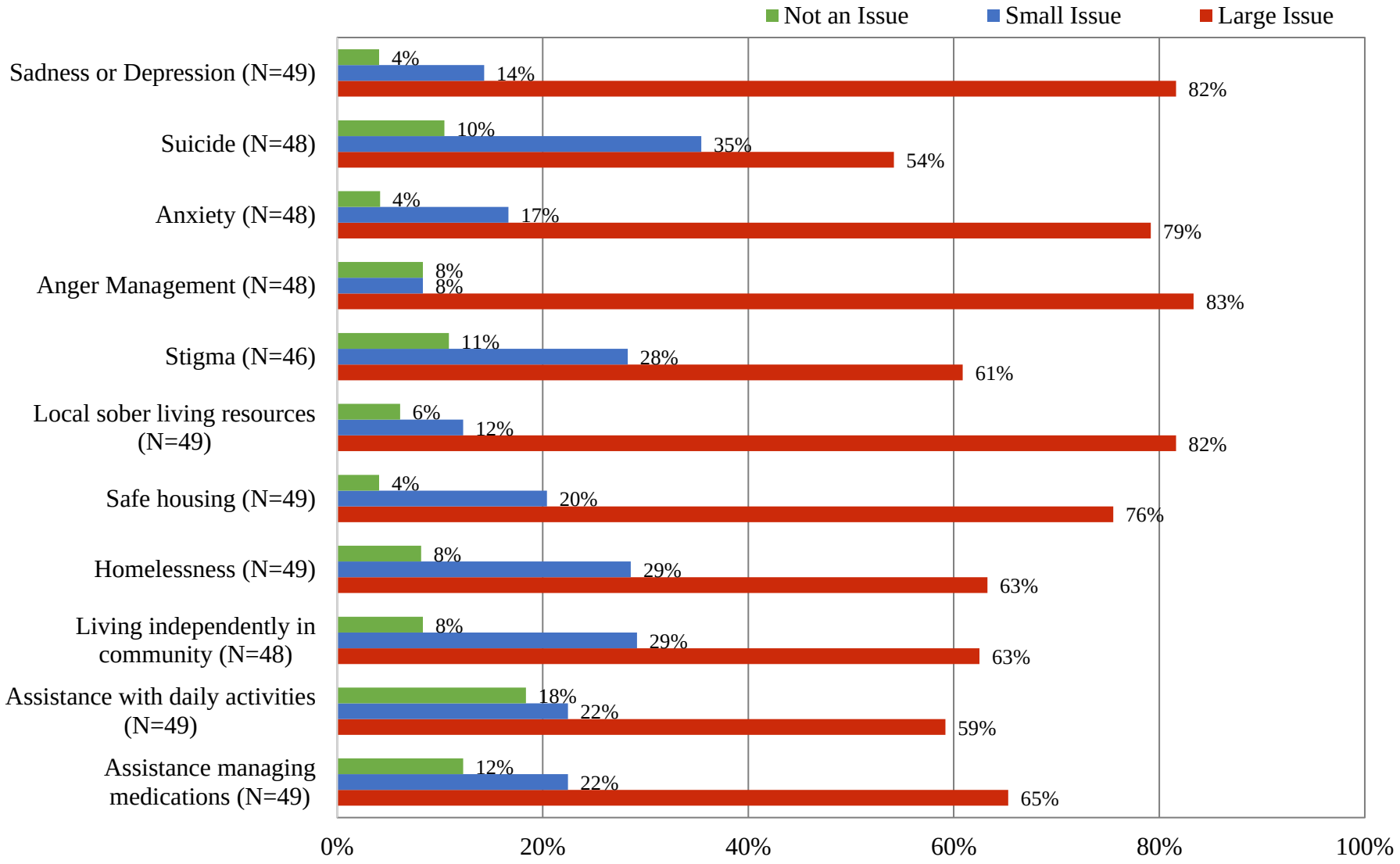


Inyo County Mental Health
MHSA Family Survey Results
2015
Has your family used any Mental Health services in the past year?
(Respondents may choose multiple responses)

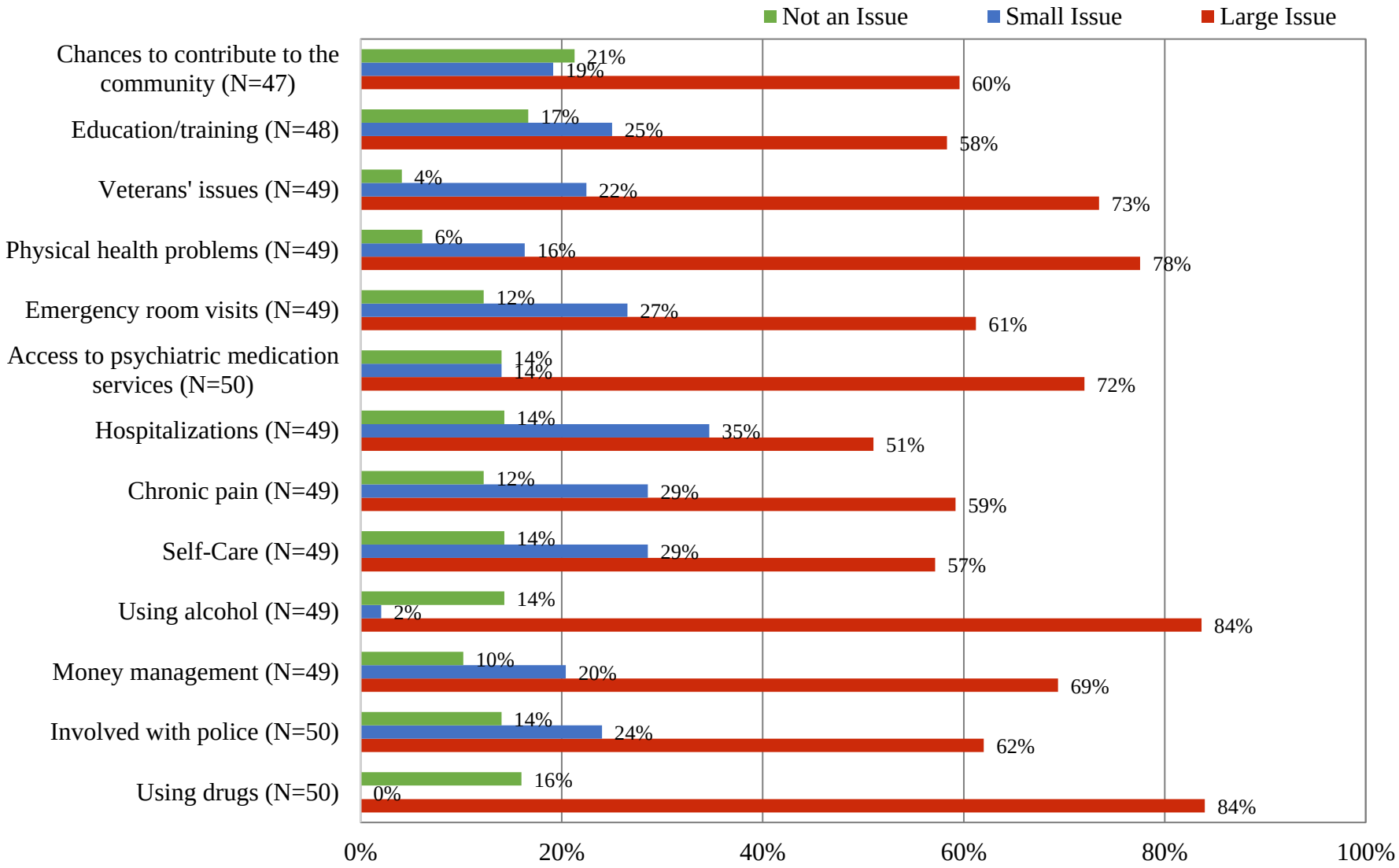


	Mental Health Counseling	Crisis Services	Medication/ Telepsychiatry	Case Management Services	Substance Use Treatment	Wellness Center Services	Total Respondents
# Respondents	3	2	2	1	0	0	3
% Respondents	100.0%	66.7%	66.7%	33.3%	0.0%	0.0%	100.0%

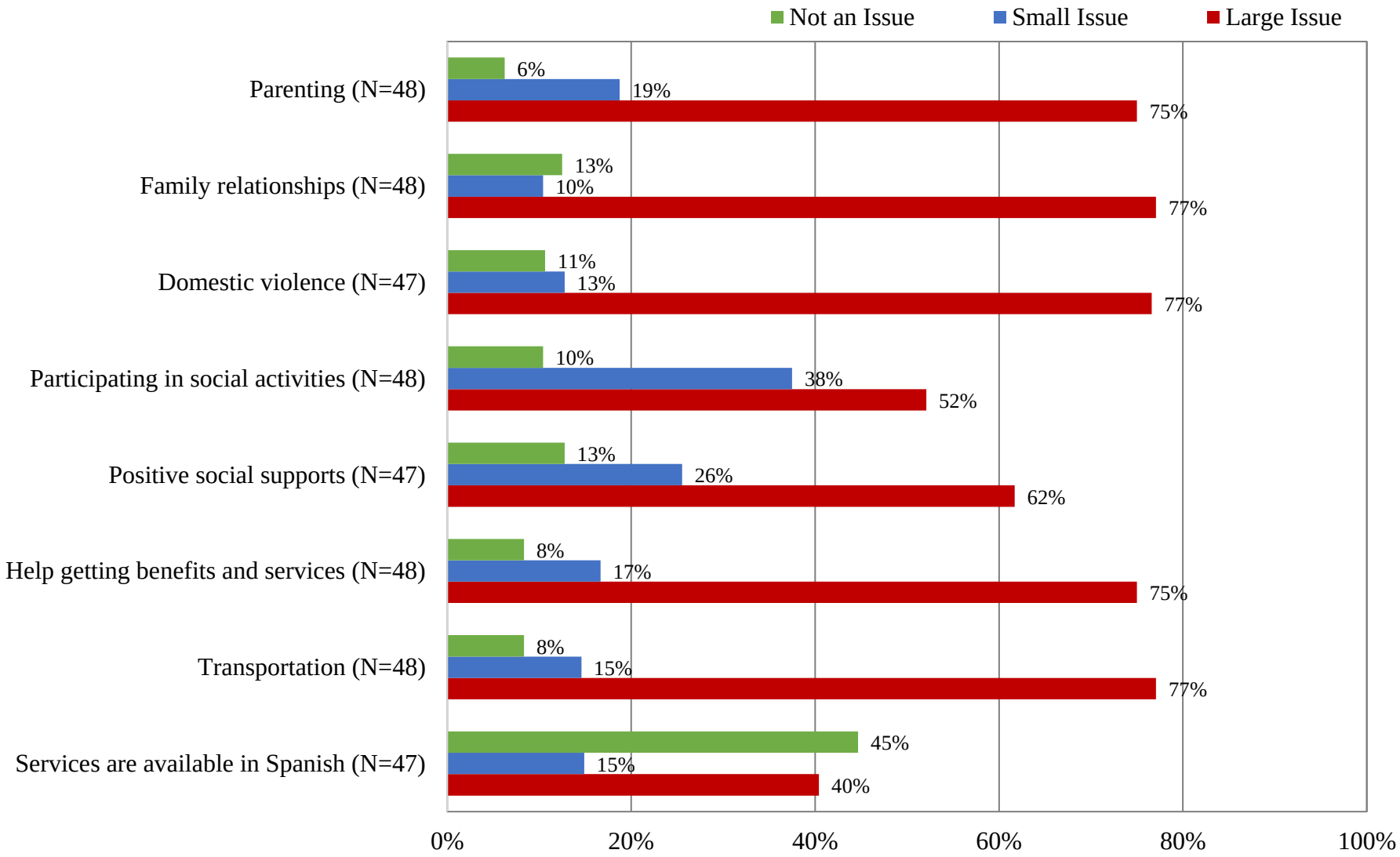
Inyo County Mental Health
MHSA Adult Survey Results
Adult Issues
2015



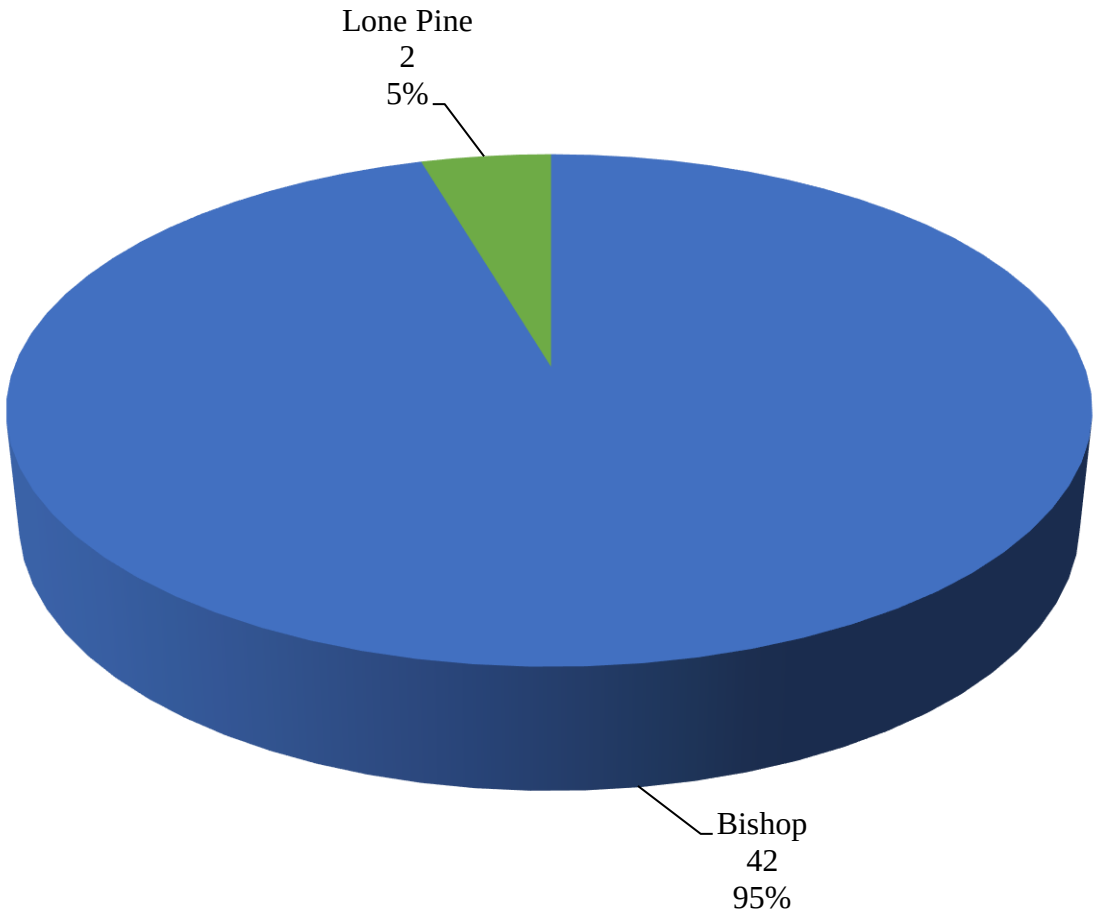
Inyo County Mental Health
MHSA Adult Survey Results
Adult Issues
2015



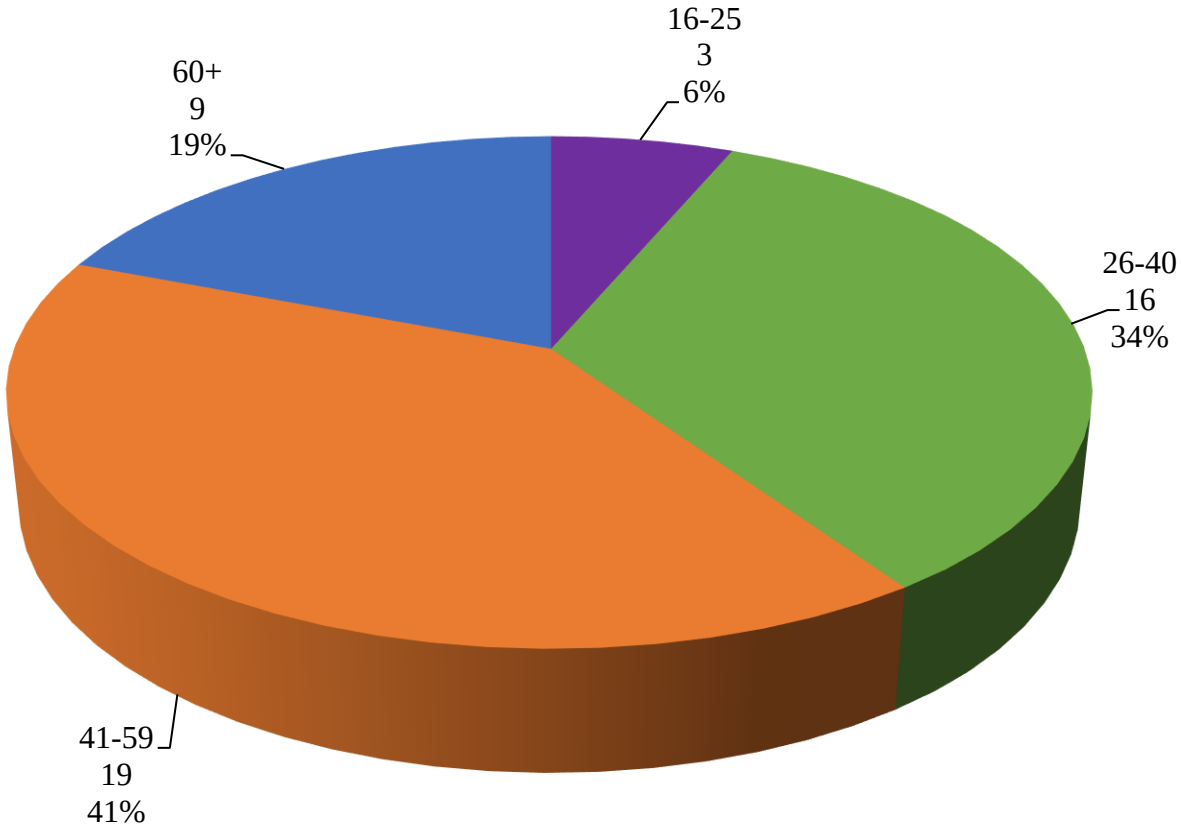
Inyo County Mental Health
MHSA Adult Survey Results
Adult Issues
2015



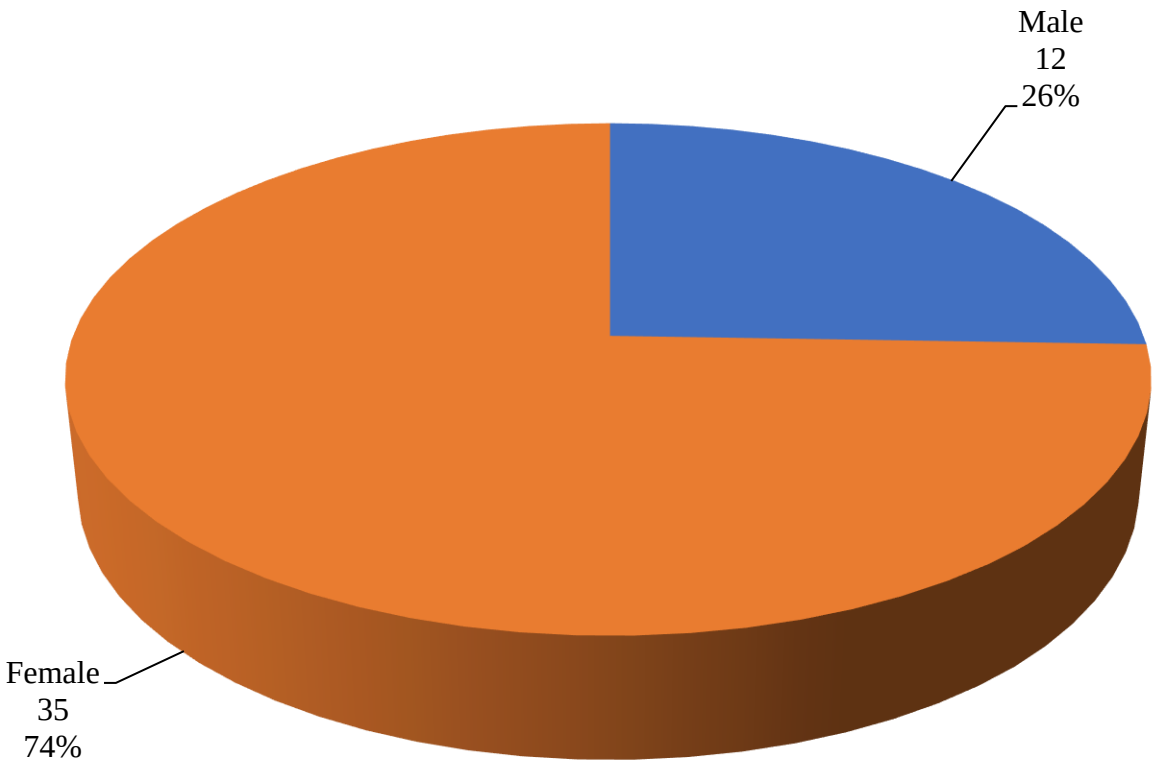
Inyo County Mental Health
MHSA Adult Survey Results
2015
Region (N=44)



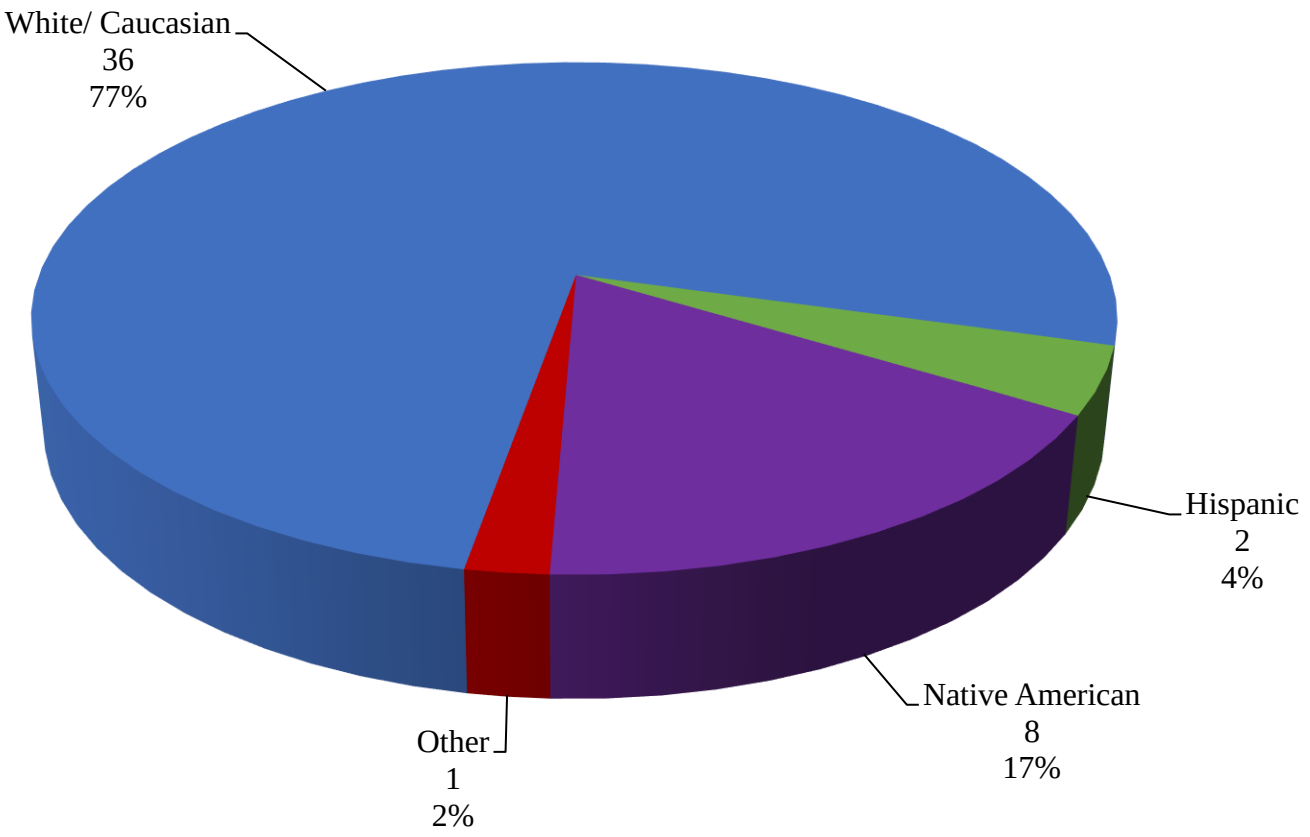
Inyo County Mental Health
MHSA Adult Survey Results
2015
Age (N=47)



Inyo County Mental Health
MHSA Adult Survey Results
2015
Gender (N=47)



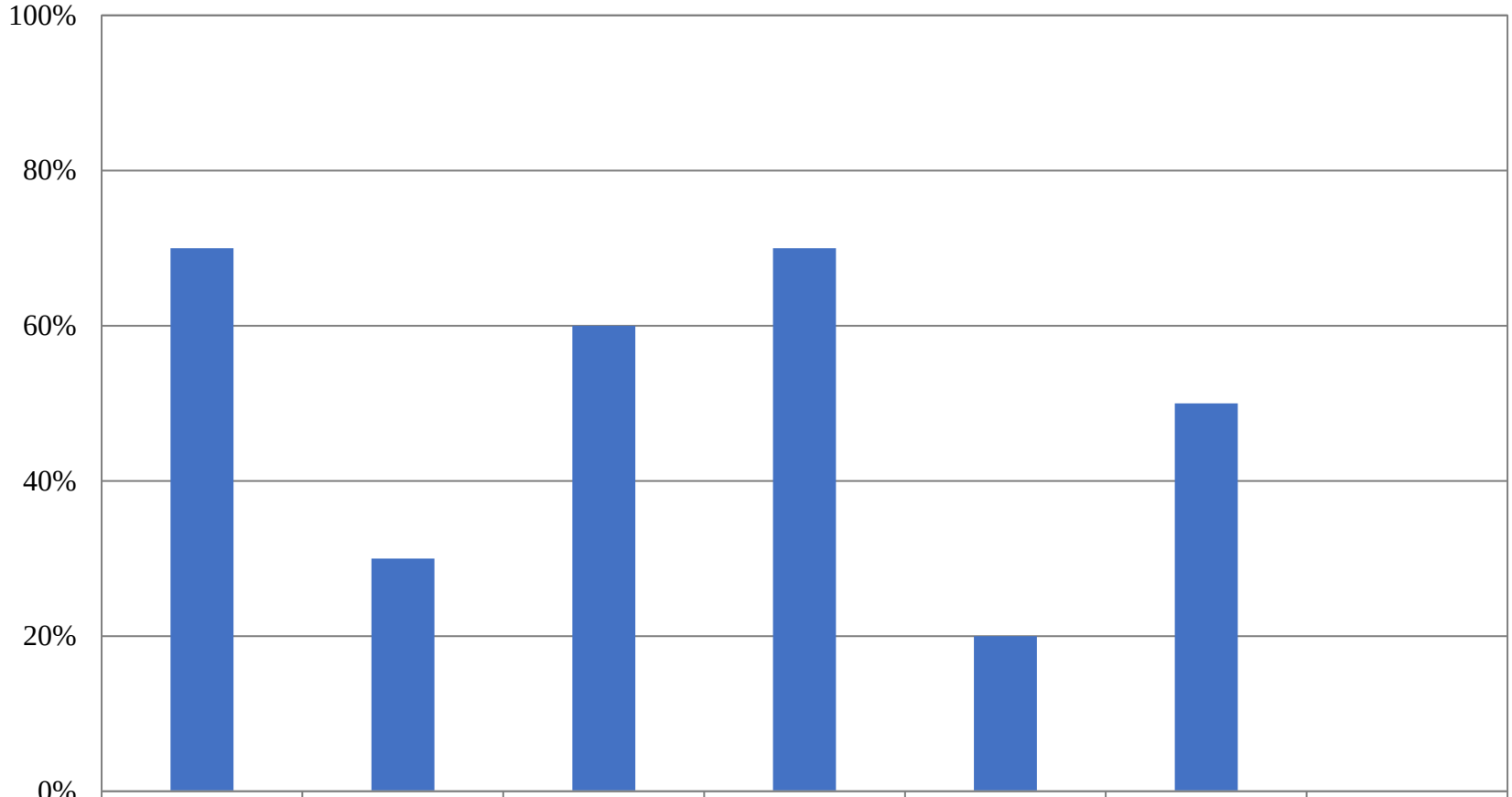
Inyo County Mental Health
MHSA Adult Survey Results
2015
Race/Ethnicity (N=47)



Inyo County Mental Health
MHSA Adult Survey Results
2015

Which Mental Health services have you used in the past year?

(Respondents may choose multiple responses)

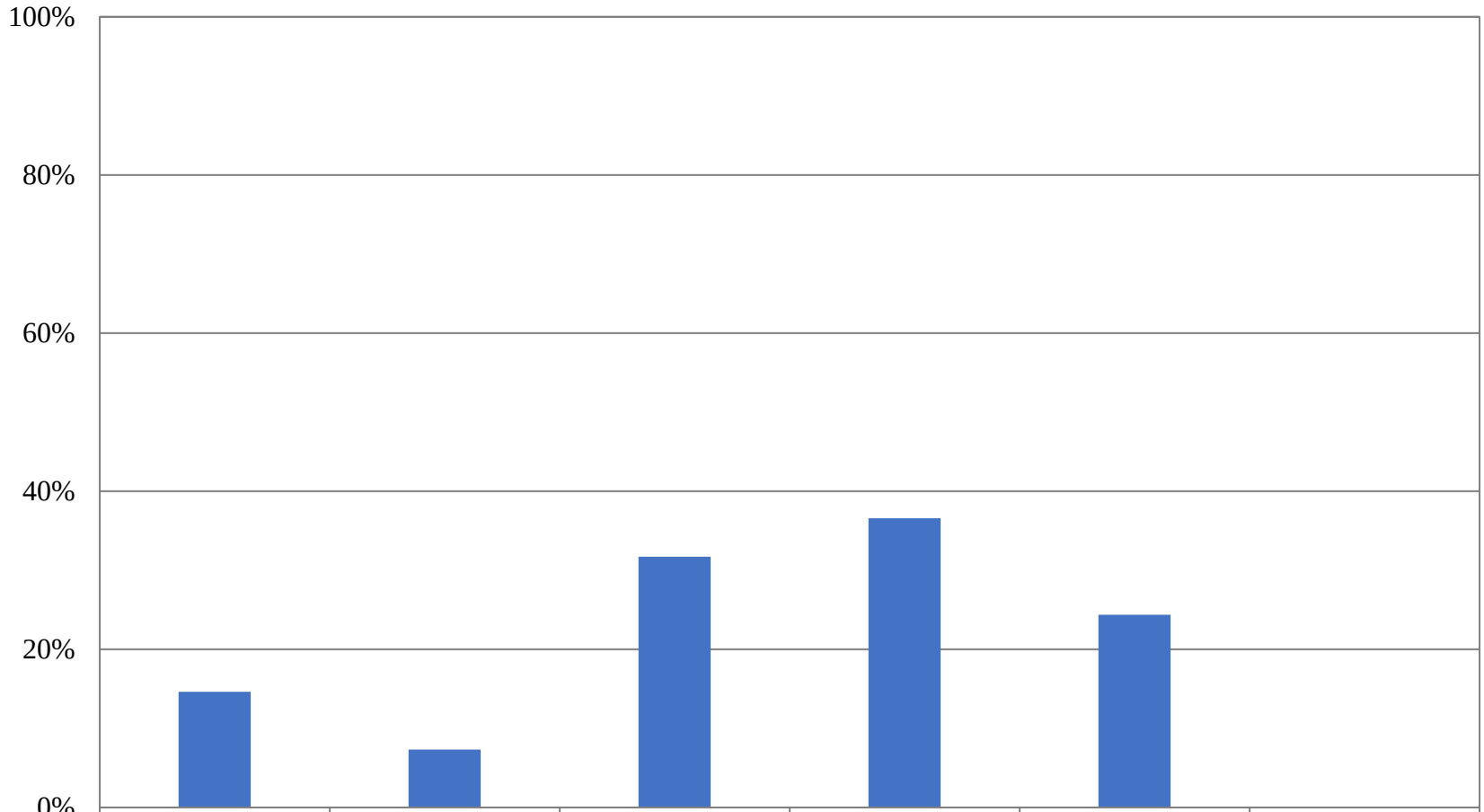


	Mental Health Counseling	Crisis Services	Medication/ Telepsychiatry	Case Management Services	Substance Use Treatment	Wellness Center Services	Total Respondents
# Respondents	7	3	6	7	2	5	10
% Respondents	70%	30%	60%	70%	20%	50%	100%

Inyo County Mental Health
MHSA Adult Survey Results
2015

Which of the following best describes your role in the community?

(Respondents may choose multiple responses)



	Client/Consumer	Family member of a client/consumer	Allied agency staff	Mental Health staff	Community member	Total Respondents
# Respondents	6	3	13	15	10	41
% Respondents	15%	7%	32%	37%	24%	100%

Older Adult Survey Results

Category	Not an Issue	Small Issue	Medium Issue	Large Issue	Rank
Isolation	5 11%	3 7%	8 18%	29 64%	1
Physical Health problems	4 9%	4 9%	10 22%	27 60%	2
Transportation	8 19%	2 5%	10 23%	23 53%	3
Sadness or depression	6 14%	6 14%	7 17%	23 55%	4
Chronic pain	7 16%	3 7%	15 33%	20 44%	5
Anxiety	3 7%	9 20%	15 34%	17 39%	6
Hospitalizations	6 14%	6 14%	14 33%	17 40%	7
Emergency Room visits	10 23%	3 7%	13 30%	17 40%	8
Assist. with daily activities	8 19%	9 21%	10 23%	16 37%	9
Assist. managing medications	10 23%	9 20%	9 20%	16 36%	10
Household Chores	9 20%	8 18%	12 27%	15 34%	11
Safe Housing	9 20%	10 22%	11 24%	15 33%	12
Living independently	10 22%	7 16%	14 31%	14 31%	13
Participating in social activities	9 21%	9 21%	11 26%	14 33%	14
Misuse of prescription drugs	14 32%	5 11%	11 25%	14 32%	15
Family relationships	8 18%	6 14%	17 39%	13 30%	16
Self-Care (personal care)	9 20%	6 14%	18 41%	11 25%	17
Benefits and Services	14 32%	7 16%	12 27%	11 25%	18
Stigma	10 24%	11 27%	9 22%	11 27%	19
Using alcohol	17 39%	7 16%	11 25%	9 20%	20
Education/Training	3 9%	12 35%	11 32%	8 24%	21
Homelessness	10 23%	11 25%	16 36%	7 16%	22
Employment	12 27%	12 27%	13 30%	7 16%	23
Anger Management	11 26%	13 31%	13 31%	5 12%	24
Domestic Violence	14 32%	12 27%	13 30%	5 11%	25
Suicide	14 32%	13 30%	13 30%	4 9%	26
Other	4 50%	0%	0%	4 50%	27
Average Percent	**29%**	**23%**	**35%**	**43%**	

Race/Ethnicity	
White/Caucasian	37
Hispanic	3
Black/African American	
Native American	1
Asian	
Other	
No Answer	4

Gender		Age Group	
Female	31	18-40	10
Male	11	41-59	15
Other		60+	20
No Answer	3	No Answer	

Town	
Bishop	20
Big Pine	1
Independence	1
Lone Pine	
No Answer	23

Use of Behavioral Health Services	
Mental Health Treatment	16
Wellness Center	13
Medications	11
Crisis	6
Substance Abuse	4
Case Management/Social Work	9
Other	3
None of These	17

Role in the Community	
Client/Consumer of BH Services	16
Family member of Client/consumer	7
Allied agency staff	8
Behavioral Health Staff	12
Agency working specifically with older adults	4
Community member	17
Other	2

Older Adult Issues Write in Answers
Getting meals if cannot or not able to leave home
Government harasses me. They like to see me dead
Local cops, with fractured logic, in a greed motivated, profit generated, and in a militaristic society
I hope they don't raise the rent again. When I moved in it was $175.00 per month now its $325.00
Mentors
Isolation from Family and hearing problems, so don't join group activities.
Help with call to Doctors when they have a hard time understanding
Fears: end of life prepardness, contact persons, money; not enough to live on these days.
Children playing too many video games.
Obtain enough support for all the above-physical/emotional when falls through the cracks of programs which only address limited short term issues. Also money/repare management with declining memory/dementia issues and lack of family/friend support available
PTSD

Use of BH Services- Write in Answers
Counseling
Out of County Counseling
Help with Heart Monitor

Role in Community Write in Answers
Peer Support Volunteer
Volunteering