INYO COUNTY BEHAVIORAL HEALTH

Mental Health Services Act
FY 2015-2016 Annual Update

POSTED FOR PUBLIC COMMENT
March 9, 2016 through April 10, 2016

The MHSA FY 2015-2016 Annual Update is available for public review and comment from March 9, 2016 through April 10, 2016. 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 11, 2016.

Public Hearing Information:
Monday, April 11, 2016 at 10:00 am
Behavioral Health Advisory Board Meeting
Bishop Wellness Center
586 Central Avenue, Bishop, CA 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:** 03/09/16 – 04/10/16

Date: March 7, 2016 **Date of Public Hearing:** Monday, April 11, 2016

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 data 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 2015-2016 Annual Update. Include the dates of meetings and other planning activities; describe methods used to obtain stakeholder input.*

The Inyo County Health and Human Services- Behavioral Health (ICHHS-BH) Community Program Planning (CPP) process for the development of the MHSA FY 2015-2016 Annual Update built upon the planning process for the MHSA Three-Year Plan. This planning process

was comprehensive and has included input from over 100 consumers and family members, providers, and community members. We developed a short satisfaction survey regarding the components of the Plan and also asked for priorities and alternative ideas as well. We received surveys from 40 persons.

The Annual Update included stakeholder meetings at both of our Wellness Center sites and at Progress House. A variety of stakeholders participated in these meetings. In addition, there are a number of consumers, family members, and other stakeholders who provide ongoing input into our MHSA services and activities. We also routinely discuss and obtain input on the utilization of MHSA funds with our key stakeholders and partners in our quarterly Quality Improvement Committee (QIC) meetings, our bi-monthly MHSA consumer meetings, and the Behavioral Health Advisory Board. We also discuss the MHSA plan as part of our HHS leadership team which includes managers and supervisors from Child Welfare, Senior programs, Employment and Eligibility, Prevention, Public Health, HHS Administration as well as Behavioral Health (including Substance Use Disorder services). The MHSA plan was also discussed in partner meetings with the local hospital, schools and criminal justice.

With this information, we were able to review the unique needs of our community and make sure that the programs supported through MHSA funds are well designed for our county. The overall goals of the MHSA are still valid and provide an excellent guide for maintaining our MHSA services in FY 2015-2016.

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.

The MHSA 2015-2016 Annual Update was developed and approved by the Behavioral 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. All stakeholder groups are in full support of this MHSA annual update and the strategies to maintain 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. In Lone Pine, the stakeholder group consists of 2 persons who are homeless and 3-5 other Caucasian adult consumers.

The CPP also included input from ongoing child and adult staff meetings in behavioral health services, the multiple agencies involved with children's services, including Child Welfare, Juvenile Probation, Toiyabe Family Services, and the schools.

A critical entity in the planning process is the Behavioral Health Advisory Board. The Behavioral Health Advisory Board consists of two adult consumers; two family members of adult child/community members; 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.

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 FY 2015-2016 Annual Update has been posted for a 30-day public review and comment period from March 9, 2016 to April 10, 2016. 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 11, 2016 at 10 a.m., at the Bishop Wellness Center at 586 Central Avenue, Bishop, CA 93514. The public hearing will be held in conjunction with the Behavioral 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 FY 2015-2016 Annual Update 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). 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. The strategies are part of the larger system/continuum of care. We offer a "whatever it takes" service approach in helping individuals achieve their goals. This has allowed us the transformative flexibility to meet the person "where they are." 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 the principles of empowerment, self-determination, 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. It is critical that the wellness centers are centrally-located within the community in a comfortable setting. Our bilingual workers provide targeted outreach to the Latino population both within the schools and the community settings to build trust and to offer support in the wellness center.

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. Often persons who are homeless will be guided by partners or even community members to come to the wellness centers for support. Several persons have reported that they had been steered to the wellness centers by the local church, law enforcement, social services, or the hospital. We have also received calls from these partners letting us know about persons they have referred to the wellness center or persons for whom they have concerns. During times of more extreme hot or cold or otherwise inclement weather, persons are especially engaged at the wellness centers. We have provided more intensive outreach to persons during times of inclement weather, either extreme heat in the summer or cold during the winter. For example, we have received calls from our local grocery store about persons that they have observed as homeless and seeking respite from the elements within the store. We have successfully provided targeted outreach to a number of these persons and have engaged with them in the community, even if they are initially unwilling to come even to the wellness centers. Wellness center workers have patiently and persistently provided outreach over time to build trust with persons who have been very distrustful and distressed in their illness. Over many months, a person who was homeless in the elements, medically compromised and very ill was engaged; first with finally accepting food, then a sleeping bag, then showers, and finally shelter and willingness to address critical health issues. The worker was trusted to "stand guard" over belongings so that the person could have a shower at a local eatery. This slow process has been successful in the engagement of persons who are homeless and very ill.

We provided ongoing peer-facilitated groups at the Wellness Center in Bishop including Addiction and Recovery, Journaling, Art, Nutrition, Tai Chi, Blanket-making, and Wellness Walking. We also provide groups such as money management, smoking cessation, gardening, and dialectical behavioral therapy to persons at the wellness center facilitated by Behavioral Health staff members. In addition, our Transition Age Youth (TAY) 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. We anticipate a move to our new wellness center in Bishop by the end of March 2016. This site offers an opportunity to provide more extensive offerings such as a kitchen facility, showers (including an ADA shower), and laundry facility. This type of service has proven to be very effective in the engagement of persons who might not otherwise come to the facility. The new location is centrally located and is within close proximity (3-5 blocks) to our clinic, social services, Progress House, the city park, and four community-based organizations offering assistance. The two separate structures will allow us to offer a separate space for TAY as well as a space to provide some support services provided by our mental health nurses.

Another important component of the CSS plan is in the provision of respite and transitional housing for Full Service Partners (FSPs) as needed. We continue to purchase four beds at Progress House, an Adult Residential Facility. We have used these beds for persons with severe mental illness who are transitioning out of acute care, incarceration or who are homeless. We have provided transition services for three transition age youth with severe mental illness who had spent time incarcerated in our local jail. All three young adults have been able to make significant progress while at Progress House, two moving back into the community. Two of the three persons were Native American and one person was Caucasian. 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 have provided respite services for at least 25 adults. An example of this type of respite was with a Latino young adult experiencing serious family conflict and safety risks due to mental health symptoms. Without intervention, this young adult was likely to be hospitalized or incarcerated. After a period of respite, this young adult, who was extremely motivated to work, was able to manage symptoms in order to become employed and to move to a community setting. We continue to look for ways to increase the effectiveness of this strategy through the implementation of recovery principles. This year we added a Supervising Nurse as part of the administrative oversight at Progress House to help to ensure that health conditions and medication assistance is addressed.

We have also continued to offer Latino Outreach through both the wellness center sites and within the community. A contracted bilingual therapist, also employed by the schools, provides mental health services to Latino youth and their families. These youth and families may be hesitant to come into the traditional clinic especially if there are immigration issues. The therapist is able to treat anxiety and depression related to trauma issue as well as the provision of family support. A bilingual Latina employee at the wellness center also provides outreach to the underserved population and is able to serve as an advocate for Spanish-speaking persons with mental illness that are struggling to navigate the systems of support. Approximately 26 youth are served through this CSS strategy.

A specific strategy has been needed to address the needs of our isolated southeastern area of the County, the Death Valley area, closer to Nevada population centers than to Inyo towns. While there is a contract with a mental health provider for youth in Pahrump, few persons are willing or

able to engage in this service. A small amount of telemedicine is also available for persons engaged in services. A strategy of using a Mental Health Nurse to outreach and engage with persons with mental illness in this part of the county has been most useful. The Nurse has provided services to three families, two transition age youth (one Native American TAY and one Caucasian TAY with co-occurring developmental disabilities), two adults, and eight older adults. Persons often evidence co-occurring addiction issues as well as related health conditions. The Nurse also participates in a monthly community potluck that serves as a way to connect with residents effectively.

The 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.

The following represents our persons served under CSS strategies:

FSPs Ethnicity by Age Group

	TAY	Adult	Older Adult	Total
Caucasian	2	13	9	24
Native American		2		2
Latino	3	2		5
Total	5	17	9	33

Average Cost per FSP = $29,819

Wellness Center visitors by Age Group

TAY	Adult	Older Adult	Total
21	97	8	126

Number of Youth served through Latino Outreach: 26

Persons receiving targeted outreach and engagement in South East County (underserved population): 15

Approximate cost per person served $6,235.

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

While we successfully purchased a property in Bishop as our new wellness center site, renovations have taken longer to accomplish than anticipated. Another challenge that we have identified is the need to offer transition housing services for Older Adult FSP's. While we can use our transitional housing at Progress House to accomplish a certain amount of these services, there are an increasing number of "Older Adults" who need this support, often persons with co-occurring disorders. We continue to look for community-defined ways to address this challenge.

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

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 youth and TAY in the Native American and Latino populations, and we will look for ways to partner with our local tribes to accomplish this effort. We will extend CSS strategies for youth to include participation in the wraparound services offered as a collaborative effort with Child Welfare, Juvenile Probation, First Five, and Prevention. Youth with more severe mental health needs who may be at risk for out-of-home care, have been identified to participate in these services.

MHSA Program Component
PREVENTION AND EARLY INTERVENTION

1. Provide a program description (must include number of clients served, age, race/ethnicity, and cost per person; separate data for Prevention and Early Intervention, if possible). Include achievements and notable performance outcomes.

Prevention

A. Elder Outreach and Friendly Visitor Program

Elder Outreach: Our community has a large proportion of seniors. This PEI program has been helpful at identifying at-risk seniors who begin to exhibit signs of depression, prescription drug abuse, isolation, and other conditions related to the aging population. This Older Adult PEI Program has provided outreach and engagement, early mental health screening, and prevention services 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 Elder Outreach Program funds a mental health nurse to provide screening, referral and linkage, and support services to prevent the exacerbation of mental health conditions. The program, utilizing a Behavioral Health Nurse, offers comprehensive assessment services to those older adults at risk of developing mental health problems that may interfere with their ability to remain independent in the community. The Nurse then links 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. 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.

The role of the Behavioral Health Nurse is first to provide the initial assessment, including a PHQ 9 measure of depression, to potential candidates for prevention services such as the Friendly Visitor Program or Healthy Ideas. A member of the Adult Services team will further involve the Behavioral Health Nurse when intervention may be warranted, especially if any suicidal ideation is noted.

The Behavioral Health Nurse collaborates 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 Nurse also provides 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 a Friendly Visitor (see below) or to Behavioral Health for ongoing treatment, as appropriate.

In the past year, outreach visits were made to 79 older adults. This results in a cost of $1304 per individual. 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 provide care coordination/case management as additional support to the Older Adult PEI program.

Friendly Visitor (FV) Program has been implemented to provide prevention services to isolated seniors who have evidenced symptoms of depression and are living alone in the community. We have funded two par- time Program Services Assistants, one in the northern part of the county and one in the southern part of the county. Meals on Wheels drivers identify seniors who evidence symptoms of depression and/or anxiety and who might benefit from a visitor. The visitor, who may also be a senior, develops a plan with the senior to address the depression and prevent further exacerbation of symptoms. The program has provided services to 25 seniors at a cost of approximately $554 per individual. Although a formal evaluation of the program has not occurred, participants have reported a satisfaction with the services and a lessening of symptoms as evidenced by the following comments:

"We have lots in common as we are both Veterans. He has helped me through the Veterans Administration (VA) system to get the help I need and now I am getting someone to help clean my house. Some days I have been so depressed and when he comes, I don't feel so lonely."

"FV has been wonderful. I am blind and when he comes, he will read to me. I truly enjoy his company."

"I miss Bud (FV). He is dependable, the visits are great and I enjoy his company."

"We talk politics. I truly enjoy him and his company. This is a wonderful program and I really like him visiting me."

"Through this program, FV helped me get out of myself and brought me up. I don't feel so lonely and isolated anymore."

"I was in the doldrums and now I feel more motivated"

It is our plan to implement further outcome indicators including satisfaction surveys and pre/post PHQ9s.

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.

Early Intervention

B. 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, Inyo County Health and Human Services – Behavioral Health (ICHHS-BH) offers PCIT at two (2) locations in the county: our mental health clinic in Bishop and within the community in Lone Pine. Eight families were served at the Bishop clinic and two families were seen in Lone Pine. The ICHHS-BH 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 ICHHS-BH 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 ten additional families with this intervention, including two Native American; four Hispanic; and four Caucasian families. Of the six court-referred families involved in PCIT, five were reunified satisfactorily. It is our plan moving forward to implement a more formal outcome measure such as the Parent Stress Index to quantify results.

The approximate cost per family served under PCIT is $10,268

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

A continuing 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 are again providing training in PCIT to interns in Behavioral Health, wraparound, and in the substance use disorder program, as well as with HHS Specialists in these programs and in Child Welfare.

In the area of Elder Outreach, we had intended to continue the provision of the Healthy Ideas strategy as part of our continuum of care. We have experienced the retirement of one of the nurses trained in the Healthy Ideas strategy and the hiring of a new nurse for this position who has not had the opportunity for this training. In addition, we have lost our volunteer for Healthy Ideas and have experienced turnover within the Adult Services programs as well. We hope to continue the Healthy Ideas program in the near future.

We continue to have one Behavioral Health nurse vacancy, but continue to provide the Elder Outreach, newsletter, etc.

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

New Early Intervention Strategy

A. Families Intensive Response Strengthening Team (FIRST): This year, we are expanding our collaborative services using a wraparound model to additional families beyond those with youth at risk of placement in a high level of out of home placement. Using an early intervention strategy, we are able to strengthen families who are at high risk. We are able to pull in resources from the First Five program and Substance Use Prevention programs, as well as other agencies to intensively support the families. As the result of this expansion, we are able to serve families with younger children. One example was the work with a family where both parents of an infant evidenced a serious mental illness. We were able to support a healthy bonding and attachment process for this infant. We are also looking for ways to expand the successful wraparound and home-based services as we plan to more fully implement the Pathways to Mental Health program and Continuum of Care Reform.

MHSA Program Component
INNOVATION

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

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 ICHHS-BH. 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 Nurse 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 target population has been behavioral health consumers who are also enrolled and receiving services at the Northern Inyo Hospital Rural Health Clinic (NIHRHC), and currently includes approximately 85 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 addresses 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. It is now part of our admission process to assess whether each person has a primary care physician and to link that person with care if it is not in place. As a result of these efforts, approximately 90% of our admitted consumers have a primary care physician.

- 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, carbon monoxide 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 ICHHS-BH 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, and mindfulness. There is also a smoking cessation group offered at the Bishop Wellness Center. 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 peer 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 tracked population health data as well as tracking data on each consumer who has been identified as needing more intensive care coordination. Approximately 40 consumers receive more intensive coordination.

- Late in FY 14/15, we began to "spread" this approach to target persons in the jail who evidence mental health conditions as well as health conditions. We track all persons who are receiving psychotropic medication to treat a mental health condition or who have been identified as needing this type of treatment. Approximately 25-30 persons have been served to date. We have established weekly care coordination meetings with the behavioral health nurses, the jail nurse, an addictions counselor, the re-entry coordinator, and the behavioral health director. A majority of persons in this population have co-occurring substance abuse disorders and several of these persons have health conditions as a result. Most of the persons in this population have not received any consistent primary care or behavioral health treatment. The goal of this coordination is not only to treat and stabilize mental health and health conditions during incarceration but also to support the continued treatment during re-entry back into the community.

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

One of the ongoing challenges is in staff vacancies and turnover both in primary health as well as in behavioral health. A champion for the project at NIHRHC took another position within the hospital and as a result, it is difficult to maintain the medication reconciliation and tracking of costs. The behavioral health nurses are also pulled in many directions and struggle to keep up with the medication reconciliation as well during vacancies. In addition, one of the Peer Supporters moved on to employment (a good outcome) and another moved out of the area. One strategy to mitigate the impact of this situation is to continue to look for ways to build peer and other natural supports. 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.

Another ongoing barrier is found in the difficulty in developing a registry or a more efficient way to share communication, while maintaining privacy and security requirements, when electronic health records (E.H.R.) are not compatible. Each system has purchased their own E.H.R. to meet their own state requirements. We have not identified a way to address this barrier that does not include a great amount of duplicate entry. Partners at Northern Inyo Hospital, Toiyabe Indian Health Project and Inyo County HHS are participating in a Rural Health Network (RHN) planning grant to look for small ways to begin address this barrier.

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

No significant changes are anticipated to the original Innovation Plan. As described above, we are beginning to apply the coordinated care model to the jail and re-entry services population, as appropriate. Further, we have identified the need to coordinate care more effectively with Toiyabe Indian Health Project to address the needs of the Native American persons in our communities.

A future strategy may be 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 (WET) Coordination: Since the original WET Plan was approved, ICHHS-BH has developed contracts with various learning providers to deliver trainings to consumers, family members, Behavioral Health staff, 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. 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. Our behavioral health nurses will also participate in a psychiatric nurse conference to increase knowledge around mental health and related health conditions.
2) We have also identified a critical 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 support an on-line addiction counselor certification through University of the Pacific and related practicum/intern support. A cohort of 25 students from HHS and Probation will participate in the certification classes. We will also help to support the evidence-based strategy of Moral Reconation Treatment (MRT). We will include a day of training targeting trauma informed care as an important component of this strategy.
3) We will participate in the small county technical assistance around wellness centers and building peer support. We will visit other wellness centers and increase knowledge around psychosocial rehabilitation and immersion.
4) 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 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 National Alliance for the Mentally Ill (NAMI) Peer2Peer 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 Peer2Peer 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 California Association of Social Rehabilitation Agencies, 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. We will also continue to encourage consumers to identify mental health topics of interest for our "Q2" meetings and include consumers and family members in several of these meetings.

Financial Incentives: We participate in the Mental Health Loan Assumption Program, which offers two to three employees with master's degree in social work, 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 staff. We have one bilingual Latina employee who is pursuing her attainment is Licensed Clinical Social Worker (LCSW). She has quickly filled her caseload with Latino/Latina youth and families as the community is made aware of her services and consumers refer other family or friends. In addition, we are challenged to recruit and hire Native American providers, especially to serve youth and families. While we work closely with Toiyabe Indian Health Project, we continue to also serve a significant number of Native American youth within our core services. We have recently hired two Native American HHS Specialists to provide services focusing on youth or TAY. We also 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.

Another area of challenge is in the hiring of our licensed psychotherapy staff and behavioral health nurses. Several of our licensed staff will reach retirement age in the next 2-5 years and it is important to develop a strategy for succession planning. We are looking for ways to attract

interns to our county. Through the Regional WET program, we have been able to avail ourselves of a Roving Clinical Supervisor. Three interns from Behavioral Health as well as one intern employed by another provider have received distance clinical supervision and have made progress in achieving the requisite hours towards licensing as LCSWs or other master's level licensure. A nurse shortage also continues to be a challenge which we have not yet been able to fully address successfully. We continue to have one full time vacancy in this program.

Finally, we are challenged to provide psychiatry services. While we currently have an excellent experienced "in person" psychiatrist, we struggle to meet current need, let alone the need to address succession planning. As with many other counties, we are looking at the need to move forward with tele-psychiatry to address the shortage in psychiatry.

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.

The most significant change is in the additional effort to increase our county expertise in the area of co-occurring disorders through the provision of addiction certification coursework. As a small county it is important that the overall workforce is knowledgeable and trained to identify and provide interventions that meet the needs of persons with mental illness or co-occurring disorders. We must use each and every service provider, across agencies to accomplish this in our community.

MHSA Program Component
CAPITAL FACILITIES/TECHNOLOGY

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

ICHHS-BH chose to utilize the bulk of CFTN funding for a system-wide IT upgrade to achieve an Integrated Information Systems Infrastructure. ICHHS-BH initially implemented ShareCare™, a product of The Echo Group. An Electronic Health Record system is in place, including clinical assessments and progress notes. We also input the treatment plan into the record although a paper copy of the treatment plan is maintained due to signature requirements not addressed in the current system. Electronic prescriptions and medication monitoring are also components of this IT system, as well as lab orders and results. We have also explored ways to take a next step toward a more integrated health record by attempting to record health conditions and reconcile medication across primary health and health.

We have now come to a crossroads with our system due to the necessity to either upgrade the system to the ECHO VHR (Virtual Health Record) product or to find a product that better meets federal meaningful use as well as California requirements. We have moved forward to perform a cost/benefit analysis of the Kings View/Anasazi product to ascertain whether it will better meet the needs of the county around both meaningful use and outcome tracking. (see discussion below) .

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 as well as Progress House. These funds will be used to meet Americans with Disabilities Act (ADA) requirements and to create a more welcoming environment.

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

While ICHHS-BH 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, ICHHS-BH must continue to use many "work-arounds" in order to address deficiencies in the product. ICHHS-BH 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. While ICHHS-BH has explored the Virtual Health Record (VHR), we have not been satisfied that problems with the product have been adequately addressed or that ICHHS-BH will be able to obtain data necessary for QI purposes. We have been over-reliant on paper-based processes for outcomes tracking and quality-assurance monitoring. An initial cost/benefit analysis of the Kings View/ Anasazi product has suggested that this product may better meet our needs. The Anasazi product is supported and "hosted" by Kings View. This "hosting" mitigates the shortage of IT persons available in a small county. To date, only one other California County has implemented the VHR and twenty-two counties have implemented the Kings View/ Anasazi product. ICHHS-BH would also benefit from shared reports and data between the counties. In addition, Kings View provides tele-psychiatry services. Tele-psychiatry has become a way to mitigate the identified need for additional psychiatry services both now and into the future. It will be advantageous to use an E.H.R. product that is also used and familiar to the provider of the tele-psychiatry services. Funds transferred from CSS are proposed to meet this one-time implementation. This strategy will allow us to benefit from the experience and support provided

by this vendor as well as to have a streamlined method to compare our programs with other small counties.

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

ICHHS-BH had delayed implementation of the VHR to investigate whether the product would address the problems identified in the ShareCare product and to provide a cost/benefit analysis between this product and the Kings View/ Anasazi product to inform the decision.

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

The probable change is vendor is described above. The remainder of CTFN funds, however, are proposed for remodeling needs on the newly purchased wellness center and for transition beds at Progress House.

FY 2015/16 Mental Health Services Act Annual Update
Funding Summary

County: **INYO** Date: 3/7/16

	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 2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	972,742	305,477	401,089	270,114	202,990	
2. Estimated New FY 2015/16 Funding	1,092,601	273,150	71,882			
3. Transfer in FY 2015/16[a/]	(202,293)				202,293	0
4. Access Local Prudent Reserve in FY 2015/16	0					0
5. Estimated Available Funding for FY 2015/16	1,863,050	578,627	472,971	270,114	405,283	
B. Estimated FY 2015/16 MHSA Expenditures	1,118,432	248,273	142,746	94,600	405,283	
C. Estimated FY 2015/16 Unspent Fund Balance	744,618	330,354	330,225	175,514	0	

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2015	499,148
2. Contributions to the Local Prudent Reserve in FY 2015/16	0
3. Distributions from the Local Prudent Reserve in FY 2015/16	0
4. Estimated Local Prudent Reserve Balance on June 30, 2016	499,148

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 2015/16 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: **INYO** Date: 3/1/16

	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. General System Development (80%)	304,214	304,214				
2. Outreach and Engagement (20%)	76,053	76,053				
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	1,118,432	1,118,432	0	0	0	0
FSP Programs as Percent of Total	51.0%					

FY 2015/16 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: INYO Date: 3/1/16

	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	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 2015/16 Mental Health Services Act Annual Update
Innovation (INN) Funding

County: INYO Date: 3/1/16

	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 2015/16 Mental Health Services Act Annual Update
Workforce Education and Training (WET) Funding

County: INYO Date: 3/1/16

	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					
Total WET Program Estimated Expenditures	94,600	94,600	0	0	0	0

FY 2015/16 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: INYO Date: 3/1/16

	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	155,283	155,283				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Kingsview IT Setup	250,000	250,000				
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	405,283	405,283	0	0	0	0