MHSA COMMUNITY PROGRAM PLANNING

Community Program Planning Process

The Inyo County Health and Human Services-Behavioral Health (ICHHS-BH) Community Program Planning (CPP) process for the development of the MHSA FY 2018/2019 Annual Update built upon the planning process for most recent MHSA Three-Year Plan and Annual Updates. This planning process was comprehensive and included input from over **200** consumers and family members, providers, and community members.

We 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 MHSA consumer meetings, and the Behavioral Health Advisory Board. As part of our monthly Advisory Board meetings, we discuss each of the programs' statistics and accomplishments. This discussion is often done in narrative form. We look for opportunities to be involved in and contribute to the community by working with other programs such as Public Health and Prevention in their efforts. We also discuss ongoing challenges including capacity and staffing issues, crisis and access to hospitals and transportation, homelessness and lack of affordable housing, criminal justice involvement, use of the residential facility, and mental health awareness and stigma within the community. The CPP happens on an ongoing basis, as opposed to a one-time focus group.

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, and HHS Administration, as well as Behavioral Health (including Substance Use Disorder services). The MHSA Annual Update was also discussed in partner meetings with the local hospital, schools, and criminal justice entities.

Finally, we have an ongoing discussion with our regional partners as part of the CPP. Many of the challenges and opportunities that we face are linked to our geographic isolation as a "frontier county." In working with Mono and Alpine, as well as with Kern as a neighboring county, we can create strategies that best meet our unique communities while staying true to the principles and goals of the Act.

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 MHSA are still valid and provide an excellent guide for maintaining our MHSA services in FY 2018/2019.

Components addressed by the planning process included Community Services and Supports (CSS); Prevention and Early Intervention (PEI); and Workforce Education and Training (WET). 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 FY 2018/2019 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 Annual Update 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 the Annual Update and the strategies to maintain services.

Stakeholders and Meaningful Input

Several different stakeholders were involved in the CPP process and input was obtained through a variety of ways including stakeholder focus groups, surveys, key informant interviews and partner meetings. 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 at least once per month. 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 Annual Update built upon the information obtained during the planning process for the most recent Three-Year Plan, which included collecting 160 surveys on access, community concerns, and mental health needs. The CPP for the Three-Year Plan also incorporated interviews with key educational stakeholders, to better understand training needs, target populations, and issues around stigma.

In addition, the CPP included input from ongoing child and adult staff meetings in behavioral health services as well as multidisciplinary partner meetings. The multiple agencies involved with children's services includes Child Welfare, Juvenile Probation, Toiyabe Family Services, and the schools. The multiple agencies involved with adult services include Adult Protective Services, Employment and Eligibility, Probation, Law Enforcement and the hospitals.

LOCAL REVIEW PROCESS

30-Day Posting Period and Circulation Methods

This proposed MHSA FY 2018/2019 Annual Update has been posted for a 30-day public review and comment period from April 22 - May 22, 2019. 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 MHSA FY 2018/2019 Annual Update has been distributed to all members of the Behavioral Health Advisory Board; consumer groups; staff; Wellness Centers (Bishop and Lone Pine); and partner agencies. The Annual Update is also available to stakeholders upon request.

Public Hearing Information

A public hearing for the Annual Update review and comments will be conducted on Thursday, May 23, 2019 at 10:00 am. The meeting will be held at Progress House at 536 N. Second St., Bishop, CA 93514.

Substantive Recommendations and Changes

Input on the MHSA FY 2018-2019 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).

COMMUNITY SERVICES AND SUPPORTS

All Ages/Populations

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 approach 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.

A. Wellness Centers Strategy

This CSS Program includes comprehensive assessment services, including a strengths assessment approach; personal recovery 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. In the last year, we have served 17 adults/older adults who identified as "homeless." 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 will often extend the hours of the wellness centers through the lunch hour to make sure that persons have a cool/warm place to be. On occasion, we have linked persons to temporary shelter provided by the Salvation Army. We have also successfully provided targeted outreach to several 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. Implementing a strengths model, we are taking more of services out into the field, using the community as a resource. We have become aware of persons with mental illness who have ended up incarcerated often due to a combination of mental illness and substance abuse. We have used the wellness centers as a place to connect as they re-enter the community. This can mean offering an array of services including assistance with housing,

employment and physical healthcare including more recently linkage to medication assisted treatment (MAT). At times, persons also need transitional living as they re-enter the community and are able to benefit from a combination of supports to meet their needs.

We provided ongoing peer-facilitated groups at the wellness center in Bishop, including Addiction and Recovery, Journaling, Art, Nutrition, Blanket-making, and Wellness Walking. We also provide groups such as money management, smoking cessation, gardening, and "Positive Affirmations" to persons at the wellness center facilitated by Behavioral Health staff members. Stakeholders groups were also held weekly to ensure consumer input.

Shower and kitchen facilities are available at both the lone Pine and the Bishop site, with laundry services also available in Bishop. These facilities expand the scope of available services. Consumers also take an active part in providing welcoming, sign in and phone support for the wellness center as well as providing help with cleaning and light maintenance. Consumers have been able to develop work skills through their involvement at the wellness center. The development of these skills has led to employment opportunities for a few of the consumers. Consumers are also able to earn incentive cards as well as to develop a sense of ownership and pride in the facility. A small group of consumers who choose homelessness find socialization and support at the wellness centers. In addition, as we implement the Strengths Model, we will look for opportunities to use the Strengths Assessments and Personal Recovery Plan to encourage consumers to work on self-identified goals and aspirations based on their own strengths. In this model, there is an opportunity join consumer in re-discovery and re-claiming of their lives.

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 (4) 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 four transition age youth/young adults with severe mental illness who had spent time incarcerated in our local jail and have spent time in homelessness. In addition, we have served persons who are living within the community who need 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 stays for 18 persons, including 2 veterans. In addition to mental illness, many of the persons served in this way have evidenced co-occurring addiction issues, may have been veterans or at least spent some time in the military, and/or may have had experienced significant adverse childhood events.

As a continued effort to focus on work/volunteer experience to increase transition readiness, consumers contribute to providing reception services at the wellness center sites. At least six consumers have participated in providing welcoming and one consumer has now functioned in this role on a more long-term basis, showing skills to become a peer supporter. We worked with our partners in the HHS Prevention programs to identify events that needed some volunteer assistance including health fairs, community runs and other community events. In addition, we looked at ways to employ peers to support improvement projects at Progress House and to accompany residents on medical visits. We continue to look for ways to increase the effectiveness of this strategy through the implementation of recovery principles.

We are expanded this strategy through a combination of funds, including funds received under the Mental Health Block Grant (MHBG), as well as MHSA funds. We will continue to use a social worker working out of the Employment and Eligibility division to assist with these services. The social worker will educate persons who receive social security benefits or general assistance about the opportunities to be involved in work experience. He will identify ways to assist with minimizing the impact of symptoms by helping to identify strengths, best work environments, and need for accommodation. He will also provide support for employees and education of employers. He will also make consumers aware of housing opportunities and will assist in identifying resources to aid in obtaining a stable living environment.

We also continue 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 treats anxiety and depression related to trauma issue as well as provides family support. This year, there was an increased need expressed around youth impacted by DACA (or the Dream Act). The contracted therapist has worked to advocate for youth and to provide support services. Approximately 10 youth were served through this CSS strategy along with outreach to at least 50 additional persons.

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 in Pahrump, few persons are willing or able to engage in this service. A limited 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 several isolated older adults who live in this community as well as checking in with adults or youth and family who have been identified with mental illness. Persons often evidence co-occurring addiction issues as well as related health conditions. The Nurse also participates in a bi-monthly community potluck that serves to connect with residents effectively. The Nurse has further been trained as a certified Mental Health First Aid trainer and has scheduled to provide this training for interested persons in the community.

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

	Youth (<16 years)	TAY (16-25 years)	Adult (26-59 years)	Older Adult (> 59 years)	Total
Caucasian	1	3	13 (1 veteran)	9 (1 veteran)	26
Native American	0	0	1	1	2
Latino	0	2	3	0	5
Total	1	5	17	10	33

Average Cost per FSP = $23,857 It is a combination of intensive services that might include transitional living at Progress House, participation in the Wellness Center array of services, coordination with health care needs and a variety of "whatever it takes" to address behavioral health needs.

Unduplicated Wellness Center Visitors by Age Group

	Youth (<16 years)	TAY (16-25 years)	Adult (26-59 years)	Older Adult (> 59 years)	Total
Bishop	4	27	121	16	168
Lone Pine	0	0	14	2	16

Number of Youth served through Latino Outreach: 3 families (14 persons) received counseling services at a rate of 143.21 per person. An additional 45 families received at least one outreach connection.

Persons receiving targeted outreach and engagement in South East County (underserved population): 12 persons received ongoing outreach and engagement within their homes plus around 26 additional participants received outreach as part of the bimonthly community dinner that is attended by the Outreach Nurse.

B. Neurofeedback/brain training

At the very end of the 17/18 fiscal year, we developed a small contract with a local provider of a neurofeedback/ brain training intervention. As this contract was implemented at the end of the year, we propose to continue this contract for 18/19.We will test the use of this strategy with a select group from this population as well as a select number of consumers who have evidenced severe mental illness.

Challenges and Mitigation Efforts

FY 2017/2018 was our fourth full year at the Wellness Center site in Bishop. We continue to have a small group of Transition Age adults, some of them who are homeless or are "couch surfing", who access the Wellness Center. Several of these young adults have substance use disorders, often as a result of childhood trauma and abuse. A number of these persons have been incarcerated due to this substance abuse. We continue to struggle to address these persons with co-occurring mental illness and substance abuse. While often mandated by the Court to participate in counseling services, both substance abuse and mental health, these young adults

may have difficulty engaging in “talk therapy.” We continue to be welcoming and try to engage the young adults in harm reduction strategies while maintaining a safe and welcoming environment for all participants.

Another area of continued concern is in assistance to the transition population of persons with severe mental illness from adult to older adult and the definition of “older adult” imposed on this age group (over 59). We have been successful in helping to address some of the health conditions of adults through coordinated care but now struggle to find an adequate number of appropriate living situations for adults over 60 who continue to need residential support. We work closely with partners in Aging services to access housing and other support and to problem-solve around specific needs.

Significant Changes from Previous Fiscal Year

In FY 2018/2019, we will begin the implementation of the software, Common Ground, to improve communication between clients and our psychiatric staff. CommonGround software allows the client to develop an “appointment report” just prior to meeting with their provider. Via a confidential workstation, the client enters into the software their wellness concerns and goals; symptoms; current medications and any concerns, such as side effects; additional service needs; and a specific goal for the appointment. Staff are available to help clients navigate the software, if needed. When the provider and client meet, they use the report to make shared decisions about the client’s treatment, which results in improved medication compliance and better outcomes.

No other significant changes to CSS are anticipated in this fiscal year.

PREVENTION AND EARLY INTERVENTION

Prevention Programs

PEI Prevention Programs – Descriptions and Outcomes

Elder Outreach Program/ Friendly Visitor (FV) Program

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 strategies consist of two related components along the continuum from prevention to early intervention with seniors:

The 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 part-time Program Services Assistants, one in the northern part of the county and one in the southern part of the county. The meal delivery staff 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.

In 17/18, the program provided services to 31 seniors at a cost of approximately $1,450 per person served. A total of approximately 1565 hours were provided with 49% of these hours provided in south county and 28% provided in southeast county, our most underserved areas of the County. A PHQ2 is used as an initial screen with a PHQ9 used to follow up on those found to be “at risk” from the PHQ2 responses. As might be expected, complex medical issues, including pain, fatigue, and insomnia were reported by a majority of participants.

The PEI also partially 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 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 17 older adults. 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.

PEI Prevention Programs – Challenges and Mitigation Efforts

As reported in earlier plans, we continue to struggle with challenges of finding appropriate transitional housing for older adults as they begin to evidence health challenges as well as mental illness. Moving forward, we continue to investigate housing alternatives and funding such as No Place Like Home that may offer opportunities to assist in funding housing for seniors with mental health and physical health challenges. In addition, we will continue to investigate the viability of using a regional approach to address residential or other housing needs. We also continue to educate the community around the need for a community system of care solution to address this need.

PEI Prevention Programs – Significant Changes

No significant changes from previous year's plan.

PREVENTION AND EARLY INTERVENTION

Early Intervention Programs

PEI Early Intervention Programs – Descriptions and Outcomes

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

Our Child and Family Program Chief had been 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.

PCIT is a highly effective program and the families show improved outcomes because 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.

Due to the retirement of the certified trainer for PCIT in May, 2017 and the turnover of an additional therapist, we were concerned regarding our ability to continue with a PCIT strategy. In 17/18, we kept the program going minimally by hiring a retired annuitant in the specific role of providing PCIT training and supervision to our Child and Family staff as well as interested partners. We have served two additional families with this intervention. The approximate cost per family served under PCIT is $6, 5361.

We propose to continue the contract with the certified trainer in 18/19 in order to maintain our PCIT services.

B. Latino Outreach and Early Intervention Services

In 17/18, we employed a Spanish-speaking Licensed Clinical Social Worker (LCSW) to provide early intervention services to the underserved Latino population. In 17/18, the LCSW position

provided outreach to several community groups including to Team Inyo, a consortium of prevention programs and to several school events. As part of this strategy, a community survey was developed to look at the whether the Latino population was aware of mental health resources and to identify the places where this population may seek support. As a result of this survey, the LCSW began an early intervention psychoeducational series of groups for Spanish-speaking women to increase level of support and to address issues of anxiety and trauma issues. This service has been offered at our clinic site and has been attended by 15 women over the past year.

C. Families Intensive Response Strengthening Team (FIRST)

In 17/18 implemented the use of some CSS funds to support families participating in our around program, FIRST. As part of our overall ICHHS Children's System of Care, the FIRST program employs a wraparound model in working with families with youth at risk of placement in a high level of out of home placement as well as families in need of intensive services as a means of building protective factors. This approach allowed us to include an intervention strategy for our work with "at risk" families and we are able to strengthen these families using a child/family team model. Our team consists of a supervisor who had worked extensively in a drug court program who could lead the team encouraging home-based support, a Parent Partner, a Social worker and two HHS Specialists. We also pull in resources from the Behavioral Health Child and Family program, our Substance Use Disorder program; First Five program as well as other agencies to intensively support the families. As the result of this expansion, we have served families with younger children. We are continuing to look for ways to expand the successful wraparound and home-based services as we plan to more fully implement the Continuum of Care Reform. Due to the blended funding strategy, we served 16 families under the FIRST strategy. Results suggested an increase of 61% in Protective Factors as measured on the Family Development Matrix. The largest increase was seen on the factors of Child Development Services and Parent Knowledge of Child Development. In 18/19, we propose to continue our partial funding of this effective strategy. The MHSA portion of the costs was $251,682 for an approximate cost of $15,730 per family.

PEI Early Intervention Programs – Challenges and Mitigation Efforts

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 were able to hire our previously certified trainer in PCIT to provide training and supervision in PCIT to interns and HHS Specialists as well as persons in the FIRST program and others from partner agencies. This approach will continue to be used to mitigate the loss of the strategy due to staff turnover.

In FY 2018/2019, we propose to address the need for school-based early intervention services through the support of the North Star Counseling Center. This strategy will allow North Star to hire an additional intern to provide early intervention services, such as one to one and group counseling, as well as presentations on topics to create increased mental health awareness and decrease stigma.

PEI Early Intervention Programs – Significant Changes

The following change from the previous plan is proposed: We will fund additional school-based services by providing funding support to North Star Counseling. This year, we will pursue a contract with NorthStar counseling for school-based counseling for early intervention services. North Star Counseling came under the supervision of Inyo County Superintendent of Schools during the 17/18 school year. It is the sole source of low cost/no cost school-based early intervention counseling services for students that do not meet the medical necessity criteria for Medi-Cal services. The PEI funds will be used to partially support expanded school-based early intervention services for youth and families throughout the County. The program will include individual and group counseling for students and families as well as projects targeting suicide prevention and stigma reduction for all school districts throughout the County. ICSOS North Star will develop a work plan in conjunction with Behavioral Health and will report back the necessary tracking and outcome data on a quarterly basis. The funds will be used for personnel costs, training, and project implementation and evaluation costs over the next two fiscal years. The use of this strategy will be proposed for the FY 18/19 and 19/20 updates to the MHSA PEI Plan.

PREVENTION AND EARLY INTERVENTION

Outreach / Suicide Prevention / Stigma Reduction

PEI Programs – Descriptions and Outcomes

A. Outreach

ICHHS-BH has participated in funding statewide outreach efforts through CalMHSA. In addition, we have provided three Mental Health First Aid (MHFA) classes. We have trained an additional 30 community members in MHFA.

B. Suicide Prevention

ICHHS-BH has participated in funding statewide suicide prevention efforts through CalMHSA. We also employed a retired annuitant to provide suicide prevention training in our jail, our Juvenile Center and to our staff as part of crisis intervention.

C. Stigma Reduction

ICHHS-BH has participated in funding statewide stigma reduction through CalMHSA for events such as Directing Change and Each Mind Matters. In addition, we have addressed issues of stigma through consumer participation as volunteers in community events such as health fairs, "trunk or treat," and fun runs. Wellness Center visitors and Progress House residents have also organized and participated in food drives for the local food banks. We again held two kite-flying events during Mental Health Awareness month in 2018.

PEI CalMHSA Programs – Significant Changes from Previous Fiscal Year

Outreach: We propose to provide at least three (3) MHFA trainings per year to the community, including at least one per year in south county. In addition, we propose to fund the North Star counseling staff to be involved in outreach efforts to students in the high schools.

Suicide Prevention: In this three-year plan, we propose to provide training in the ASSIST model to school counselors and staff.

Stigma Reduction: We propose to fund North Star counseling staff to join the Child and Family team in participation in Directing Change.

INNOVATION
Community Care Collaborative

INN Programs – Descriptions and Outcomes

A. Community Care Collaboration Project

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 partially funding a one full-time Administrative Analyst position to collect, track, and analyze outcome data based on a quality improvement model. While all new consumers entering services assisted to link with a primary care physician, the target population is now behavioral health consumers with serious health conditions who are also enrolled and receiving services at the Northern Inyo Hospital Rural Health Clinic (NIHRHC). We currently coordinate care for approximately 70 individuals to improve health outcomes.

The Coordinated Care Collaborative addressed the following:

- Identifies individuals who do not have an identified primary care physician, or routinely use primary care services, and links 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, nearly all admitted persons have primary care services.

- Collecting 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 other risks 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. This work flow continues to be rather cumbersome and includes faxing of documents between providers. We continue to look for more streamlined ways to communicate.

- 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 trained peer supporters to assist with health goals and to accompany consumers to medical appointments to provide support and another "listening ear."

- 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.

In the last two years, the Coordinated Care project has continued to be spread to the jail/re-entry population. As part of the Stepping Up Initiative, we are aware of the persons with a mental health condition within our jail. We serve 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. Our tracking of the number of persons on psychotropic medication proportionate to the total number of inmate population suggests that 25%-34% of inmates have a mental health condition, often in conjunction with a substance use disorder. Approximately 50 unduplicated persons receive this service per year.

We have continued weekly care coordination meetings with the Behavioral Health nurse, the Corrections Nurse, a Behavioral Health Counselor, the Re-entry Coordinator, and the Deputy HHS Director of the Behavioral Health Division. A coordination plan was discussed for each inmate and the team would make sure that there was ongoing care coordination between the Psychiatrist and the Health Officer and that communication was maintained. The Behavioral Counselor provides outreach and engagement and makes a recommendation for continued services. The Re-Entry Coordinator looks at ongoing needs in the community such as housing, employment, and access to benefits such as Medi-Cal.

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. In FY 17/18, 43 inmates on psychotropic medication were released back into the community. The Corrections Nurse provided medication to the inmates upon release or made arrangements for persons to connect with Behavioral Health for ongoing services and/or to their

primary care physician for treatment of ongoing medical conditions. In FY 17/18, six persons with severe mental health symptoms accessed transition services at Progress House. An additional 28 persons received assistance to link with further health care including seven persons who were linked for intensive case management and medication services, six persons who were referred to Toiyabe Indian Health Services and around 15 more who were linked to physical health care for complex medical issues.

B. INN Funds Reversion Plan

An Innovations reversion plan has been submitted and approved by the Oversight and Accountability Commission in accordance with AB114. This plan was submitted as part of the Cohort 2 for the Innovations Technology Suite. It is attached to this document as Attachment I and includes the budget documents.

INN Program – Challenges and Mitigation Efforts

The Challenge of this Innovation Program continues to be in the lack of a shared electronic record in which to communicate across systems between health/jail health and behavioral health, including both mental health and the physical health for persons with complex needs. One way that we have found to mitigate this challenge, at least for those person identified in the criminal justice setting as having these complex needs, is to begin the re-entry process at the time of incarceration and to develop teams that bridge the transition. Thus a behavioral health nurse supervisor oversees jail health as well as behavioral health nurses. The Psychiatrist in the jail works with the corrections nurse as well as the supervising behavioral health nurse. The behavioral health nurses, in turn, coordinate services for identified behavioral health needs as well as physical health care. In addition, as the community moves to a greater openness to Medication Assisted Treatment (MAT) and the treatment of addiction as a public health issue, we can move further toward a true integrated care and recovery model.

INN Program – Significant Changes from Previous Fiscal Year

This Innovation project will be completed during FY 18/19.

As mentioned above, see Attachment I for the AB 114 Innovations Reversion Plan This plan includes the time period through June 30, 2020 as well as continuing through June 30, 2021 as the Innovation Project.

WORKFORCE EDUCATION AND TRAINING (WET)

NOTE: The initial ICHHS-BH WET funds have been fully and successfully implemented. We are proposing to transfer $30, 000 from CSS funds into Workforce Education and training to be used to continue the implementation of the evidence-based strengths model to include training of staff and peers around supported employment models and other strengths-related interventions. In addition, we propose that funds be used to train the trainer model around Mental Health First Aid.

CAPITAL FACILITIES/TECHNOLOGY

NOTE: The initial ICHHS-BH Capital Facilities/Technological Needs (CFTN) projects have been fully and successfully implemented. This year we are proposing to transfer $90,000 into the CTFN to be used as partial funding to purchase the property that includes the Lone Pine Wellness Center. Currently, we are renting half of a duplex in a home-like setting on this property. The funds would go to offset a portion of the purchase of the entire duplex. Funds from other sources, including social services and probation, would be used to pay for the rest of the purchase and to allow for renovation. The purchase of the duplex will allow for a closer access to an array of services and allow for further hours for the wellness center. In addition, there will be the possibility of extended hours and/or access to the showers and cooking capability of the wellness center which is currently limited by staffing capabilities.

Budgets:

FY 2018/2019 Mental Health Services Act Annual Update

Funding Summary

County: **INYO COUNTY** Date: 4/18/19

	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 2018/2019 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	2,146,950	220,360				
2. Estimated New FY 2018/2019 Funding	1,421,849	355,462	93,543			
3. Transfer in FY 2018/2019[a/]	(120,000)			30,000	90,000	
4. Access Local Prudent Reserve in FY 2018/2019						
5. Estimated Available Funding for FY 2018/2019	3,448,799	575,822	93,543	30,000		
B. Estimated FY 2018/2019 MHSA Expenditures	1,158,047	10,000	93,543	30,000		
G. Estimated FY 2018/2019 Unspent Fund Balance	2,290,752	565,822				

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2018	831,442
2. Contributions to the Local Prudent Reserve in FY 2018/2019	
3. Distributions from the Local Prudent Reserve in FY 2018/2019	
4. Estimated Local Prudent Reserve Balance on June 30, 2019	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 2018/2019 Mental Health Services Act Annual Update

Community Services and Supports (CSS) Funding

County: **INYO COUNTY** Date: 4/18/19

	Fiscal Year 2018/2019					
	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)	596,570	596,570				
Non-FSP Programs						
1. General System Development (80%)	364,960	364,960				
2. Outreach and Engagement (20%)	91,240	91,240				
CSS Administration	105,277	105,277				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	1,158,047	1,158,047				
FSP Programs as Percent of Total	51.5%					

Prevention and Early Intervention (PEI) Funding

County: **INYO COUNTY** Date: 4/18/19

	Fiscal Year 2018/2019					
	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. Friendly Visitor /Elder Outreach	114,585	114,585				
PEI Programs - Early Intervention						
6. PCIT Community Collaboration	61,700	61,700				
7. FIRST Program	132,213	132,213				
8. North Star Counseling	100,000	100,000				
PEI Programs - Outreach / Suicide Prevention / Stigma Reduction						
11. Mental Health First Aid	0	0				
12. Latino Outreach	52,885	52,885				
PEI Administration	15,425	15,425				
PEI Assigned Funds (CalMHSA)	10,000	10,000				
Total PEI Program Estimated Expenditures	486,808	486,808				

FY 2018/2019 Mental Health Services Act Annual Update

Innovations (INN) Funding

County: **INYO COUNTY** Date: 4/18/19

	Fiscal Year 2018/2019					
	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)	93,543	93,543				
INN Administration						
Total INN Program Estimated Expenditures	93,543	93,543				

Note: Innovations Approved Reversion Plan, including budget documents is attached in its' entirety as Attachment I.

FY 2018/2019 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: **INYO COUNTY** Date: 4/18/19

	Fiscal Year 2018/2019					
	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. Fundamental Training Program	30,000	30,000				
WET Administration						
Total WET Program Estimated Expenditures	30,000	30,000				

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Capital Facilities/Technological Needs (CFTN) Funding

County: **INYO COUNTY** Date: 4/18/19

		Fiscal Year 2018/2019					
		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.	*South County Wellness Center*		90,000				
2.							
3.							
4.							
5.							
CFTN Programs - Technological Needs Projects							
6.	*No programs at this time*						
7.							
8.							
9.							
10.							
CFTN Administration							
Total CFTN Program Estimated Expenditures							