INYO COUNTY BEHAVIORAL HEALTH

Mental Health Services Act
FY 2019-2020 Annual Update

POSTED FOR PUBLIC COMMENT
April 27, 2020 through May 26, 2020

The MHSA FY 2019-2020 Annual Update is available for public review and comment from April 27, 2020 through May 26, 2020. 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, June 1, 2020.

Public Hearing Information:
Monday, June 1, 2020 at 10:00 am
Behavioral Health Advisory Board Meeting

If appropriate, the Public Hearing will be held in-person at:
Bishop Wellness Center, 586 Central Avenue, Bishop, CA 93514

The Public Hearing will also be held via live online conferencing.
A few days prior to the event, please call or email us for the details about accessing the meeting online.

Comments or Questions? Please contact:
Gail Zwier
MHSA Annual Update Feedback
Inyo County Behavioral Health
162 J Grove Street, Bishop, CA 93514
Phone: (760) 873-6533; Fax: (760) 873-3277
gzwier@inyocounty.us

Thank you!

MHSA FY 2019-2020 Annual Update

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 2019/2020 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.

ICHHS-BH routinely discusses and obtains input on the utilization of MHSA funds with key stakeholders and partners in quarterly Quality Improvement Committee (QIC) meetings, MHSA consumer meetings, and the Behavioral Health Board (BHB). As part of the monthly BHB meetings, members discuss each of the programs' statistics and accomplishments. This discussion is often done in narrative form. ICHHS-BH looks 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. ICHHS-BH also discusses 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 occurs on an ongoing basis, as opposed to a one-time function.

ICHHS-BH also discusses the MHSA plan as part of the HHS Leadership Team, which includes managers and supervisors from Child Welfare, Aging 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 hospitals, schools, and criminal justice entities.

Finally, ICHHS-BH has an ongoing discussion with regional partners as part of the CPP. Many of the challenges and opportunities that the county faces are linked to the geographic isolation as a "frontier county." This is especially true as we plan around our crisis intervention services and the need to access higher levels of care. This year, there was a collaborative effort with Kern County to plan for our needs for access to a Crisis Stabilization Unit, especially as it applies to youth as well as adults.

With this information, ICHHS-BH was able to review the unique needs of the community and make sure that the programs supported through MHSA funds are well designed for this county. The overall goals of MHSA are still valid and provided an excellent guide for maintaining MHSA services in FY 2019-2020.

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, ICHHS-BH provided basic education regarding mental health policy; program

planning and implementation; monitoring and quality improvement; evaluation; and fiscal and budget components.

The MHSA FY 2019/2020 Annual Update was developed and approved by the BHB after reviewing data on current programs; analyzing community needs based on stakeholder input; and determining the most effective way to further meet the needs of the 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, ICHHS-BH obtained input from clients on ideas for maintaining and enhancing the Wellness Centers in both Bishop and Lone Pine. These meetings are attended in Bishop by consumers including consumers who are homeless; consumers who are older adults; consumers who are transition age youth. In Lone Pine, the stakeholder group consists of persons who have been homeless as well as adults and adults with children.

The Annual Update built upon the information obtained during the planning process for the most recent Three-Year Program and Expenditure 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 include 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 2019/2020 Annual Update and Evaluation Report has been posted for a 30-day public review and comment period from April 27, 2020- May 26, 2020 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 2019/2020 Annual Update has been distributed to all members of the Behavioral Health

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 June 1, 2020 at 10 am. The meeting will be held virtually via zoom and if appropriate, at the Bishop Wellness Center at 586 Central St., Bishop, CA 93514.

Substantive Recommendations and Changes

Input on the MHSA FY 2019/2020 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 COMPONENT

CSS Program Description, Data, and 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. ICHHS-BH offers a "whatever it takes" service approach in helping individuals achieve their goals. This approach has allowed 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. ICHHS-BH 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 Centers.

a. Full Service Partnership Program and Wellness Centers

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 a number of 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 or have provided temporary shelter in the local hotels. 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 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 GED, smoking cessation, gardening, and "Positive Affirmations" to persons at the wellness center facilitated by Behavioral Health staff members. Stakeholders groups were also held monthly 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 multiple persons, including 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. A handful of 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 have expanded this strategy through a combination of funds, including funds received under the Mental Health Block Grant (MHBG), MediCal matching fund where appropriate as well as the 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.

Full Service Partners (FSPs)

We spend an average cost of around $20, 000 per FSP. FSPs receive 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. Our FSP's have identified as homeless, veterans, Adults or Older Adults, Caucasian, Latinx and Native American.

Unduplicated Wellness Center Visitors per month

The highest number of visits occurs in the winter months and is linked with inclement weather. During these months, visitors come to the Wellness Center on a daily basis. The lowest number occurred when the Wellness Center reduced hours for re-tooling of the program offerings. There were an additional handful of visitors per month in Lone Pine.

b. CSS Outreach and Engagement Activities

We 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.

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 was 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. We provided ongoing outreach and engagement within their homes plus additional participants received outreach as part of the bimonthly community dinner that is attended by the Outreach Nurse.

c. General System Development Program

CSS continues to provide the opportunity to develop our service delivery model and build transformational programs and services. As in 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, multiple consumers volunteer at the local Salvation Army and several more are involved in seasonal bell-ringing. These "stigma-busting" activities have allowed consumers to gain skills, meet new people, and cultivate a positive presence in the community.

CSS Program Challenges and Mitigation Efforts

Fiscal year 18/19 was a time of change for the CSS wellness center strategies. In December 2018 the MHSA Wellness Center Manager retired. She had been with the program since its inception and had been dedicated to guiding the Wellness Centers using peer voice and choice. During a four month gap in leadership, the wellness center staff was challenged to continue to provide wellness center oversight as well as implementing the Strengths model case management to engage persons with complex care needs, including homelessness. A new MHSA Coordinator stepped into the position in April and brought expertise in the use of the Strengths model and began evaluating further implementation of this model in our community.

As a CSS program, we are also challenged to move from peer volunteers to employment of peers. While we have identified a small number of viable candidates, we have continued to struggle with how best to move persons into the county workforce positions. We will continue to look for ways to accomplish this, including through employment through Community Based Organizations.

A further challenge continues to be the prominence of substance use and co-occurring disorders in our persons who attend the wellness centers and who may be chronically homeless. In combination with a significant housing shortage, it has been difficult to identify permanent housing options. While we can provide assistance during the day and more temporary housing options, we will continue to prioritize more long term options as part of a county-wide effort to address the issues.

Finally an 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 continue to 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 CSS Program Changes anticipated in FY 2019/2020

While no significant changes to CSS are anticipated in this fiscal year, we will continue to look for collaborative opportunities through No Place Like Home (NPLH) and other community strategies to address the issues of homelessness and the need for complex care strategies tailored to our community.

PREVENTION AND EARLY INTERVENTION COMPONENT

PEI funding categories include Prevention, Early Intervention, Outreach, Access/Linkage, Stigma Reduction, and Suicide Prevention.

PEI Program Descriptions, Data, and Outcomes

A. Prevention Programs

1. Friendly Visitor / Elder Outreach 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:

   a) 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 18/19, the program provided services to around 16 seniors at a cost of approximately $2890 per person served. A total of approximately 431 visits were provided with 38% of these hours 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.

   b) 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 or to Behavioral Health for ongoing treatment, as appropriate.

In the past year, outreach visits were made to 5 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.

B. Early Intervention Programs

2. Parent-Child Interaction Therapy (PCIT) Community Collaboration: PCIT is an evidence-based practice which utilizes a specially equipped treatment room to train parents in parenting and behavioral management skills. PCIT provides families with very direct and individualized parenting skills that are developed through a process in which parents receive instruction through an earpiece that is linked to a therapist/intern. The therapist/intern, from behind a one-way mirror, observes interactions between the parent and child, adult coaches the development of relationship enhancement techniques, and gives behavioral interventions for how to respond to difficult parent/child situations. Each training session lasts about 1 hour; occurs for approximately 15-20 weekly visits; and shows very strong outcomes for both parents and children. Staff may provide in-home support to generalize the skills learned in the home setting, including replacement skills.

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 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.

We have kept the program going 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 7 additional families with this intervention. The approximate cost per family served under PCIT is around $2000.

We propose to continue the contract with the certified trainer in 19/20 in order to maintain PCIT services.

3. Families Intensive Response Strengthening Team (FIRST): In 18/19 we used PEI funds to support families participating in the FIRST program. 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 17 families under the FIRST strategy. A majority of the families were from the north part of the county but there was also representation from southern Inyo. The families were American Indian, Caucasian and Latinx. The MHSA portion of the costs was $328,500 for an approximate cost of $21,900 per family.

   Outcomes
   Outcomes were collected via a tool measuring protective factors that includes Child Development, Parenting Knowledge, Concrete Resources, Parent Resilience, and Social Connections. The greatest category of protective factors increase was Parent Resilience, increasing by an average of 9 points or 18%. Of the families who graduated from FIRST, the average protective factor increase

was 67 points or almost 30%. Of the families who terminated early from FIRST, the average total protective factor increase was 14 points or 6%. Our greatest family decrease was -18 points for a family still in the program. We often see this decrease early on as the family becomes more open to reporting their challenges. Our greatest family increase was 97 points.

For FY 19/20 we have proposed to continue to fund the FIRST program at the current level to ensure staffing capacity. We will continue to evaluate whether this program could be restructured to provide billable services with licensed clinician supervision and oversight.

4. School-Based Early Intervention – North Star Counseling: In FY18/19 we proposed funding additional school-based services through North Star Counseling. North Star had been a provider for around 5 years and had been reorganized to come under the supervision of Inyo County Superintendent of Schools during the end of the 17/18 school year. It is the sole source of low cost/no cost school-based early intervention counseling services in the schools in Inyo County. Only two of the six very small school districts in Inyo have any school counselors in the schools at all. Inyo HHS-BH provides some school-based services for youth who meet medical necessity for MediCal EPSDT but there was an expressed need for early intervention services as well as other types of PEI services for other students who do not fit these criteria. Using a two year contract, the PEI funds were used to partially support these expanded school-based early intervention services for youth and families throughout the County. The program included 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 developed a work plan in conjunction with Behavioral Health. The funds were to be used for personnel costs, training, and project implementation and evaluation costs over two fiscal years.

   During FY 18/19, we provided early intervention services and suicide prevention to students and teachers through the County. Approximately 60% of the FY 18/19 funds were expended. ICHHS-BH leadership met with ICOE staff to express concern regarding the model of employing practicum and intern status providers at North Star with distance supervision. It was proposed that PEI funds for 19/20 be designated to employ a licensed clinician to provide supervision and oversight in order to increase capacity. Further supervision and training opportunities were to be made available to North Star staff to support professional growth and address the complexity of cases even at the early intervention level.

C. Outreach Program

5. Latinx Outreach Program: In 18/19 we continued to use a Spanish-speaking Licensed Clinical Social Worker (LCSW) to provide outreach and prevention services to the underserved Latino population. The LCSW position again 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 provided a 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 over the past year.

   In FY 19/20, we will continue to provide these outreach services and will look for additional strategies.

D. Stigma Reduction Program

6. CalMHSA Stigma Reduction Program: 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 2019.

   In FY 19/20 we propose to increase consumer/ stakeholder involvement in planning efforts and expand events in connection with Mental Health Awareness.

E. Suicide Prevention Program

7. CalMHSA Suicide Prevention Program: ICHHS-BH has participated in funding statewide suicide prevention efforts through CalMHSA. We also continue to employ a retired annuitant to provide suicide prevention training in our jail and to our staff as part of crisis intervention. In addition, North Star counseling will provide suicide awareness using the ASSIST model.

PEI Program Challenges and Mitigation Efforts

Prevention Programs: 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.

Outreach and Early Intervention Programs: 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.

Significant PEI Program Changes anticipated in FY 2019/2020

No significant changes are anticipated in FY 19/20.

INNOVATION COMPONENT

INN Project Description, Data, and Outcomes

A. Community Care Collaboration Project

Our original Inyo County Community Care Collaborative (CCC) innovation plan 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 were able to improve outcomes for our clients and improve access to primary care services. In essence, we were able to create a health home for individuals that included enhanced care coordination and aspects of whole person care.

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 funded a full-time Administrative Analyst position to collect, track, and analyze outcome data based on a quality improvement model. The CCC team also included HHS Specialists who encouraged and supported wellness through assistance with housing, benefits, and the development of a strengths model plan to identify goals and aspirations.

While all new consumers are encouraged to access to primary care, the target population were behavioral health consumers with serious health conditions who were actively 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 was designed to address the following:

- Identified individuals with a severe mental illness and complex care issue who did not have an identified primary care physician, or did not routinely use primary care services, and linked them to the appropriate provider/health clinic/healer/alternative health care in the community.
  Outcome: 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.

- Collected 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 allowed for the reconciliation of medications between ICHHS-BH and NIHRHC. A work flow was tested and developed to allow for the sharing of this information between the two entities to best coordinate the medication needs. Outcome: This work flow was overly cumbersome and included faxing of documents between providers. We continue to look for more streamlined ways to communicate as this is very personnel intensive. We now gain more information over the phone and enter the information in the electronic health record whenever possible. .

- Clients and staff worked together to develop health and wellness activities to support clients to improve their health. These activities included developing walking groups, nutrition and cooking groups, and mindfulness. There has also been smoking cessation groups 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 trained peer supporters to assist with health goals and to accompany consumers to medical appointments to provide support and another "listening ear." We have struggled to maintain a peer in this role. Over the last year, we began implementation of Common Ground to provide peer support for communication with the providers around personal medicine.

The original project has become part of our overall system of care and in the last two years, the Coordinated Care project has been spread to the jail/re-entry population.

Inyo County HHS under our Public Health Division has been responsible for the provision of jail health services in the Inyo County Jail. ICHHS-BH had always provided a minimal level of BH services in the jail, mostly to connect persons with substance use disorder treatment and to address mental health crisis. As such, ICHHS-BH has been more aware of the treatment and re-entry needs of the inmates. With the advent of AB109 and the Stepping Up Initiative, we were positioned to look at the high percentage of persons with a mental health condition within our jail. We began to serve persons in the jail who evidence mental health conditions as well as health conditions and to focus on the specific needs of persons with severe mental illness in transitioning back into the community. 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.

We continued weekly care coordination meetings with a 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 provided outreach and engagement and makes a recommendation for continued services. The Re-Entry Coordinator looked 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 was 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 18/19, 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 18/19, persons with severe mental health symptoms accessed transition services at Progress House. Additional persons received assistance to link with further health care including persons who were linked for intensive case management and medication services, other persons who were referred to Toiyabe Indian Health Services and some who were linked to physical health care for complex medical issues. Another addition in FY 18/19 was implementation of a medication assisted treatment (MAT) through our NIHRHC and the emergency department. This service became available for persons as they re-entered the community and finally, has also been started with persons in the jail.

Our CCC project, partially funded by INN funds, represents Inyo's success in implementing Coordinated Care, in two different setting in our community. The CCC will continue in both our clinic and our jail/re-entry settings. This type of Coordinated Care allows for further integration of behavioral health and physical health care while also continuing our commitment to the recovery principles fundamental to a transformed system.

The collection of outcome data continues to be a challenge due to difficulties in data sharing across our systems. The best scenario would include an electronic health record that could be shared without duplicate entry between our behavioral health and physical health system. While with consent, we are able to coordinate much of our care through phone contact and faxed record sharing, it is not efficient at this time.

B. INN Funds Reversion Plan: An Innovation reversion plan was submitted and approved by the Oversight and Accountability Commission in accordance with AB114 and began on 1-1-2019. This plan was submitted as part of the Cohort Two for the Innovations Technology Suite. Inyo County was not able to move forward with this project as we did not have adequate staffing capacity to support the plan. We decided to "fail fast" in order to avoid further costs. We withdrew from the project on June 30, 2019 and will hold off on the identification of a new project at this time.

C. Verification of Reversion Amount: This reversion amount will be clarified in discussion with the MHSOAC.

WORKFORCE EDUCATION AND TRAINING COMPONENT

The initial Workforce Education and Training (WET) funds were fully and successfully expended in FY 17/18.

In FY 18/19, we transferred approximately $7,600 to complete the implementation of the strengths model to include training of our Residential Caregiver staff at Progress House.

In FY 19/20, we do not plan to transfer funds to WET, but will revisit capacity building for midlevel providers as well as development of peer support in our next three year plan.

CAPITAL FACILITIES & TECHNOLOGICAL NEEDS COMPONENT

The initial Capital Facilities/Technological Needs (CFTN) projects have been fully and successfully implemented.

No money was transferred in FY 18/19, although we had considered purchase of our Lone Pine Wellness Center site. This purchase may be addressed in the next MHSA Three-Year Plan.

In FY 19/20, we propose to transfer funds into TN to begin taking steps toward the upgrade of the Cerner Anasazi product to the proposed Millennium product that will increase capacity for a more fully integrated electronic health record.

PRUDENT RESERVE

By the end of FY 19/20, we propose to transfer funds from the Prudent Reserve into CSS as required by the Prudent Reserve Assessment that was submitted to the state in June 2019.

MHSA FY 19/20 BUDGET DOCUMENTS – FINAL

See the next pages for the final MHSA FY 19/20 Budget documents.

FY 2019/2020 Mental Health Services Act Annual Update
Funding Summary

County: Inyo Date: 4/27/20

All MHSA funds are managed via "first in, first out." Older funds will be expended first.	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 2019/2020 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$ 2,137,264	$ 47,005				
2. Estimated New FY 2019/2020 Funding	1,464,505	366,126	96,349			
3. Transfer in FY 2019/2020[a/]	$ (57,102)				$ 57,102	$ -
4. Access Local Prudent Reserve in FY 2019/2020	$ 252,209					$ (252,209)
5. Estimated Available Funding for FY 2019/2020	$ 3,796,876	$ 413,131	$ 96,349		$ 57,102	
B. Estimated FY 2019/2020 MHSA Expenditures[b/]	$ 1,389,395	$ 409,606	$ 26,000		$ 57,102	
C. Estimated FY 2019/2020 Unspent Fund Balance	$ 2,407,481	$ 3,526	$ 70,349		$ -	

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2019	$ 668,926
2. Contributions to the Local Prudent Reserve in FY 2019/2020	
3. Distributions from the Local Prudent Reserve in FY 2019/2020	$ (252,209)
4. Estimated Local Prudent Reserve Balance on June 30, 2020	$ 416,717

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.

b/ All MHSA funds are spent via "first in, first out."

FY 2019/2020 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: Inyo Date: 4/22/20

All MHSA funds are managed via "first in, first out." Older funds will be expended first.	Fiscal Year 2019/2020					
	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. CSS System Transformation (FSP)	$ 982,176	$ 982,176				
2.						
3.						
4.						
5.						
Non-FSP Programs						
6. General System Development	$ 279,038	$ 279,038				
7. Outreach and Engagement	$ 69,759	$ 69,759				
8.						
9.						
10.						
CSS Administration	$ 58,422	58,422				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	$ 1,389,395	$ 1,389,395	$ -	$ -	$ -	$ -
FSP Programs as Percent of Total	70.7%					

FY 2019/2020 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Inyo Date: 4/22/20

All MHSA funds are managed via "first in, first out." Older funds will be expended first.	Fiscal Year 2019/2020					
	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 *Note type of program: Prevention (P); Early Intervention (EI); Outreach (O); Access (A); Stigma Reduction (SR); Suicide Prevention (SP)*						
1. Friendly Visitor & Elder Outreach (P/O)	$ 50,000	$ 50,000				
2. PCIT Community Collaboration (EI)	$ 15,000	$ 15,000				
3. FIRST/Wraparound (EI)	$ 250,000	$ 250,000				
4. North Star Counseling (EI)	$ 55,000	$ 55,000				
5. Latinx PEI Program (O/SR)	$ 15,000	$ 15,000				
PEI Administration	$ 14,606	$ 14,606				
PEI Assigned Funds (CalMHSA Projects)	$ 10,000	$ 10,000				
Total PEI Program Estimated Expenditures	$ 409,606	$ 409,606				

FY 2019/2020 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: Inyo Date: 4/17/20

All MHSA funds are managed via "first in, first out." Older funds will be expended first.	Fiscal Year 2019/2020					
	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 Program						
1. Tech Suite (Final Year)	$ 26,000	$ 26,000				
INN Administration						
Total INN Program Estimated Expenditures	$ 26,000	$ 26,000				

FY 2019/2020 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: Inyo Date: 4/17/20

All MHSA funds are managed via "first in, first out." Older funds will be expended first.	Fiscal Year 2019/2020					
	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 *No WET programs at this time*						
WET Administration						
Total WET Program Estimated Expenditures						

FY 2019/2020 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: Inyo Date: 4/27/20

All MHSA funds are managed via "first in, first out." Older funds will be expended first.	Fiscal Year 2019/2020					
	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 *Note type of program: Capital Facilities (CF) or Technological Needs (TN)*						
1. Electronic Health Record IT Upgrade (TN)	$ 57,102	$ 57,102				
CFTN Administration						
Total CFTN Program Estimated Expenditures	$ 57,102	$ 57,102				