MHSA FY 2013/2014 Annual Update
COUNTY CERTIFICATION

County: **INYO COUNTY MENTAL HEALTH**

County Mental Health Director	**Project Lead**
Name: Gail Zwier, Ph.D.	Name: Gail Zwier, Ph.D.
Telephone Number: (760) 873-6533	Telephone Number: (760) 873-6533
E-mail: gzwier@inyocounty.us	E-mail: gzwier@inyocounty.us
Mailing Address: 162 J Grove Street, Bishop, CA 93515	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and non-supplantation requirements.

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on _____XX_____.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached FY 2013/14 annual update are true and correct.

Mental Health Director/Designee (PRINT)	Signature	Date

MHSA FY 2013/2014 Annual Update
FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Inyo

- ❑ Three-Year Program and Expenditure Plan
- X Annual Update
- ❑ Annual Revenue and Expenditure Report

County Mental Health Director	County Auditor-Controller
Name: Gail Zwier, Ph.D.	Name: Amy Shepherd
Telephone: (760) 873-6533	Telephone: (760) 878-0343
E-mail: gzwier@inyocounty.us	E-mail: ashepherd@inyocounty.us
Mental Health Department Mailing Address: 162 J Grove Street, Bishop, CA 93515	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update, OR Annual Review and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for other counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/report is true and correct to the best of my knowledge.

_____ _____

Mental Health Director/Designee (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, XX, the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated XX for the fiscal year ended June 30, XX. I further certify that for the fiscal year ended June 30, XX, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/report is true and correct to the best of my knowledge.

_____ _____

County Auditor-Controller (PRINT) Signature Date

[1]Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

MHSOAC Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (02/14/2013)

MHSA Community Program Planning and Local Review Process

County: INYO **30-day Public Comment period dates:** 12-19-13 to 1-20-14

Date: 12-18-13 **Date of Public Hearing:** 1-20-14

Instructions: Utilizing the following format, we will provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this annual update per Title 9 of the California Code of Regulations, Sections 3300 and 3315.

Community Program Planning

1. *Briefly describe the Community Program Planning (CPP) Process for development of all components included in the FY 2013/14 annual update/update. Include the methods used to obtain stakeholder input.*

The Inyo County Behavioral Health (ICBH) community planning process for the FY 2013/14 Annual Update was comprised of two focus groups, a stakeholder survey, key informant interviews and a public review and comment period. Input was obtained from over 85 consumers, family members, providers, and community members. Components addressed by the planning process included Community Services and Supports (CSS); Prevention and Early Intervention (PEI); Innovation; Workforce Education and Training (WET); and Capital Facilities/Technological Needs (CFTN); in addition, we provided basic education regarding mental health policy; program planning and implementation; monitoring and quality improvement; evaluation; and fiscal and budget components.

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

We also developed a survey that focused on the components of the MHSA that we have implemented. This MHSA Survey captured stakeholder perception of current services and suggestions for alternative programs. The survey was administered to clients, family members, staff, providers, and partner agencies. We received 49 responses to the survey. Due to the low number of responses from partner agencies, the survey was re-sent to partners with one additional survey received. We then gathered input from partners through key informant interviews. This included interviews with personnel from Toiyabe Family Services, Rural Health Clinic, Northern Inyo Hospital Emergency Department, Probation, Social Services and Law Enforcement as related to CSS. Partners voiced support for the wellness centers as well as the access to Progress House for transitional residential treatment services for Full Service Partners. In addition, partners in Social Services and Senior Services assisted with the plan to expand the Elder Outreach PEI component and the adoption of the Healthy IDEAS program, an Evidence-based program to address Depression in Older Adults.

We further developed a survey to obtain information from stakeholders for the Innovation component of MHSA. The Innovation funds are to be used for one of the following purposes: to increase access to underserved groups; to increase quality of services, including better outcomes; to promote interagency collaboration; or to increase overall access to services. The Innovation funding is intended to be used for project that will contribute to "learning" and will offer an opportunity to "try out" new approaches in the community. The Innovation (INN) survey allowed us to obtain input from individuals attending focus groups, as well as individuals who were unable to attend an organized event. Input was obtained through meetings and presentations, and distributed INN surveys. In addition, clients who are currently receiving mental health services were invited to complete an INN survey. Community stakeholder meetings were held which included a brief explanation of the INN funding; meeting participants were asked to complete the INN survey. We

collected a total of thirty (30) Innovation surveys; 20% of respondents were persons with lived experience. The planning process for developing this Innovation project reflects the results of the feedback and survey results.

The Annual Update was developed and approved by the Mental Health Advisory Board after reviewing data on our current programs, analyzing community needs based on stakeholder input, and determining the most effective way to further meet the needs of our unserved/underserved populations. In addition, the MHSA FY 2013/14 Annual Update was shared at staff meetings and at wellness center stakeholder meetings to obtain additional input and feedback on services.

The draft Annual Update has been distributed county-wide for 30 days. A public hearing will be held at the close of the 30-day review period. Substantive recommendations obtained through the public review and comment process will be incorporated into the Annual Update prior to submitting the document to the County Board of Supervisors for review. A copy of the final Annual Update, including documentation of BOS approval, will be submitted to the State Mental Health Services Oversight and Accountability Commission (MHSOAC).

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

A number of different stakeholders were involved in the CPP process. Input was obtained from clients who utilize services at the Wellness Centers, including the homeless population. The Wellness Centers are consumer-run programs where adults come together, facilitate classes, attend activities, and have a formal meeting each week. Through these regularly scheduled meetings, we obtained input from clients on ideas for maintaining and enhancing our Wellness Centers in both Bishop and Lone Pine. These meetings are attended in Bishop by consumers including 3-6 consumers who are homeless, 2 consumers who are Hispanic, 2 consumers who are older adults, 2 consumers who are transition age youth and approximately 5 other adult Caucasian consumers. In Lone Pine the stakeholder group consists of 2 persons who are homeless and 3-5 other Caucasian adult consumers.

In addition, we obtained input from members of the MHSA Leadership/Business Analysis Committee, which is comprised of MHSA staff, consumers, the Behavioral Health Director, Health and Human Services fiscal and management staff, program staff in Behavioral Health, Quality Improvement Committee members, and others involved in the delivery of MHSA services. The CPP also included input from child and adult staff meetings in mental health services, the multiple agencies involved with children's services, and the Mental Health Advisory Board. The Mental Health Advisory Board consists of an older adult consumer, an adult consumer, a family member of an adult child/community member, the Patient's Rights Advocate (former consumer and volunteer), a Hispanic adult volunteer, a Hispanic consumer advocate and a member of the Board of Supervisors. Five to 10 consumers also participate regularly at the Advisory Board meetings.

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

3. *If consolidating programs or eliminating a program/project, include how the stakeholders were involved and had the opportunity to participate in the decision to eliminate the program/project.*

We do not anticipate eliminating any MHSA programs in FY 13/14.

Local Review Process

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

This proposed MHSA Annual Update has been posted for a 30-day public review and comment period from December 19 2013 to January 20, 2014. An electronic copy is available online on the Inyo County website. Hard copies of the document are available in the Bishop Behavioral Health Clinic; Bishop Social Services office; Health and Human Services Administrative office; Health and Human Services, Lone Pine office; and at all county libraries, including the Bishop, Big Pine, Independence, Lone Pine, Furnace Creek, and Shoshone branches. In addition, a hard copy of the proposed Annual Update has been distributed to all members of the Mental Health Advisory Board; consumer groups; staff; Wellness Centers (Bishop and Lone Pine); and with partner agencies.

A public hearing is scheduled for January 20, 2014 at 10 am at the Progress House location. The public hearing will be held in conjunction with the Mental Health Advisory Board meeting.

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

Input on the MHSA FY 2013/2014 Annual Update will be reviewed and incorporated into the final document, as appropriate, prior to submitting to the County Board of Supervisors and the State MHSOAC.

MHSA Program Component
COMMUNITY SERVICES AND SUPPORTS

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

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

The CSS Program includes comprehensive assessment services; wellness and recovery action planning; case management services; individual and group mental health services; crisis services; peer-led self-help/support groups; education and employment support; anti-stigma events; linkages to needed services; and housing support. Our Adult and Older Adult Wellness Centers (located in Bishop and Lone Pine) provide adults and older adults with necessary services and supports in a welcoming environment.

Our ongoing peer-facilitated groups include Addiction and Recovery, Journaling, Art, Nutrition, Tai Chi, and Wellness Walking. As consumers express an interest, we encourage them to bring the topic to the weekly stakeholder group . We also provide two support groups, one to Transition Age women and one to Adult women, in collaboration with Wild Iris, our local domestic violence agency and a men's support group. These groups have been well attended. In the last year we have provided two NAMI Peer2Peer classes to increase our capacity to provide peer support and increase skills in group facilitation We have also instituted a Dialectical Behavior Therapy (DBT) group and a focus on mindfulness, a Daily Living skills group with related activities, and a Medicine Wheel group co-facilitated by Behavioral Health staff. In addition, our Transition Age Youth program provides opportunities for youth to participate in age-appropriate activities. The TAY youth utilize the Wellness Center in Bishop once a week, meeting together to socialize, listen to guest speakers, and develop leadership skills.

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

There are currently 29 persons who are Full Service Partners:

- Children: two youth who are both Latino
- Transition Age Youth: four TAY, one Latino and three Caucasian
- Adults: 16 adults; three Latino, two Native American, and 11 Caucasian
- Older Adults: seven, all Caucasian

Approximately 115 individuals, including 24 homeless persons, were served through the Wellness Centers. The race/ethnicity of the participants was as follows: 16 Latinos, seven Native Americans, three "other" race and 89 Caucasians. In addition, 33 Spanish-speaking persons were provided outreach and community-based services through our MHSA contracted bilingual therapist and community worker.

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 food drives, 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, 3-5 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.

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

Our biggest challenge has been in locating a more adequate site for the Bishop Wellness Center. We have limited group and cooking space, no laundry or shower facilities, limited parking and no garden space at our current location. This has impacted some of our engagement strategies to attract persons to the wellness center. We have worked diligently to meet these challenges through use of other community facilities and organizations to meet these needs. We refer persons to a local church for showers and organize laundry excursions at our local laundry mat. We use our residential facility, at times, for group offerings. We have become part of the community gardening project to access a plot for our garden. We look forward to successfully securing a more suitable location.

Another challenge is in how to further address the mental health needs of our most isolated population in the southeastern portion of our county, especially the youth. While we have once again secured a contract with a provider in neighboring Pahrump Nevada and have continued the use of teleconferencing to provide psychotherapy and medication services, there is an ongoing unmet need. Circumstances change regularly that impact the willingness of providers to contract in that area. To mitigate these circumstances, we will support the employment of a part time therapeutic aide to work within the community and at the school site with youth in need of these support services.

3. List any significant changes for FY 2013/14, if applicable.

No significant changes to the CSS Program are anticipated in this fiscal year, only expansion of support to underserved youth in southeast part of the County.

MHSA Program Component
PREVENTION AND EARLY INTERVENTION

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

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

Parent-Child Interaction Therapy (PCIT) Community Collaboration

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

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

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

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

Older Adult PEI Services

Our community has a large number of individuals who are retired. This PEI program has been helpful at identifying at-risk seniors who begin to exhibit symptoms of depression, prescription abuse, isolation, and other

mental health conditions related to the aging population. The Older Adult PEI Program has provided early mental health screening and intervention to older adults who had been receiving services in the community and through county resources. This program also trains agency partners to recognize the signs and symptoms of mental illness in older adults.

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

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

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

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

PCIT Strategy: The challenge here is twofold. First, it can be challenging to keep families engaged to "complete" the entire PCIT program. Families see positive behavior change and do not complete the entire course of treatment in PCIT. Second, it is challenging to keep adequate clinical staff trained in the strategy. Contracted providers do not have openings or adequate time to participate consistently in the training and supervision. To mitigate this challenge, we have trained unlicensed staff to provide support services to reinforce PCIT. This support ensures that the gains seen in treatment are reinforced and generalized across settings and outside of the therapy room.

Older Adult Strategy: The challenge is to increase the capacity to outreach to and support older adults when the Mental Health Nurses face competing duties that entail triage skills and can be more "immediate". To mitigate this challenge, we have collaborated with Health and Human Services partners in the Senior Program to create a position that will recruit, train and support a small group of volunteers to provide these outreach services to seniors. We will further train and support volunteers in the Healthy IDEAS strategy. This will provide an evidence-based model to identify and offer early intervention around issues of depression in seniors.

3. List any significant changes for FY 2013/14, if applicable.
No significant changes to the PEI Program are anticipated in this fiscal year, only the expansion of the Older Adult strategy.

New/Revised Program Description
INNOVATION

☒ **Completely New Program**
☐ **Revised Previously Approved Program**

Program Number/Name: Coordinated Care Collaborative (CCC)
Date: September 1, 2013

Select **one** of the following purposes that most closely corresponds to the Innovation's learning goal.

☐ Increase access to underserved groups
☐ Increase the quality of services, including better outcomes
☒ Promote interagency collaboration
☐ Increase access to services

1. Describe why your selected primary purpose for Innovation is most relevant to your learning goal and why this primary purpose is a priority for your county.

The Inyo County Community Care Collaborative (CCC) was selected 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. Inyo County is a small, rural county which meets the definition of a frontier county. The general population is 18,478. The county covers 10,180 square miles. In Inyo County, there are 1.8 persons per square mile, while statewide there are 239 persons per square mile.

We have a high proportion of persons who are older adults (19.5%), compared to California (11.7%). Our small, rural county is comprised of 65.7% white, non-Hispanic; 20.1% Mexican /Hispanic; and 12.4% Native American. The other race/ethnicity groups each represent fewer than 3% of the population.

Increasing access to and coordination with primary care services for our clients with a serious mental illness is a high priority for ICBH. By coordinating and co-locating health and mental health services, we will be able to improve outcomes for our clients and improve access to primary care services. The vision of Inyo County Behavioral Health (ICBH) is to build and support healthy futures in which people with a serious mental illness (SMI) are able to achieve health, wellness, and recovery through the development of integrated health care services and identification of a person-centered health care home. To achieve this vision, this Innovation project will develop strategies to integrate health care, mental health, and substance use services to improve health outcomes for our clients.

The Innovation Project funding will support the development of a CCC Team by funding one full-time Nurse position (1.0 FTE) to coordinate and integrate health and wellness activities for behavioral health clients who are enrolled and receiving services at the Northern Inyo Hospital Rural Health Clinic (NIHRHC), Southern Inyo Rural Health clinic and/or the Toiyabe Indian Health Project (TIHP). The CCC team will identify clients receiving behavioral health services and help link them to health services in the community. These individuals will work with the NIHRHC and TIHP to improve health outcomes for CCC clients.

The goal of the CCC will build and support healthy outcomes in which adults ages 18 and older with a serious mental illness (SMI) are able to achieve health, wellness, and recovery through the

development of a person-centered health care home. Each individual with an SMI who is served by CCC will have access to a range of effective health services, supports, and resources to promote wellness, manage illnesses, and improve overall health outcomes.

CCC will help link individuals and their families to needed services, including substance use services in the community. A number of key health outcomes will be collected and routinely reported to clients, staff, and providers to demonstrate improved health indicators.

The CCC Team will coordinate health and behavioral health services for our identified adult clients, and develop strategies for reconciling medications between health and mental health services. In addition, we will develop an Individual Wellness Report for CCC clients. In addition, the CCC Team will offer wellness activities at each of the sites, offering smoking cessation classes, yoga, meditation, nutrition, and other wellness activities to promote healthy outcomes. These services will be developed to coordinate with existing services at the two health centers and ensure that services are culturally appropriate to meet the needs of the persons with a mental health disorder who are receiving services at one of these two health centers.

The Coordinated Care Collaborative will address the following:

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

- Collect basic health information, including lab work, on individuals to help understand each person's current health indicators. Staff will work with the individual to understand their health indicators (e.g., height, weight, body mass index, A1c and risk for diabetes, hypertension/blood pressure, cholesterol, and lung functioning). These health indicators will be 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.

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

2. *Describe the INN Program, the issue and learning goal it addresses, and the expected learning outcomes.*

The CCC Innovation Project will provide the foundation for integrating health and behavioral health care services through enhanced communication, shared tracking of client health indicators, and supportive services to improve wellness and manage chronic illness. Currently, the Behavioral Health clinic and the two Rural/Indian Health Clinics share a number of patients, but do not routinely share information on patients served, reconcile medications across providers, discuss health indicators and services received, or measure health indicators over time. This project will provide the opportunity to support these health care entities, as well as develop relationships with healer and/or alternative medicine providers in the community, to communicate, share strategies for sharing information, and develop shared health indicators to improve health outcomes for clients.

CCC Team members will talk with behavioral health clients about their need for primary care, identify current providers, and/or link each individual to a primary provider/health clinic/ healer/alternative medicine provider of their choice. The CCC Team will collect a core set of information on health, mental health, and substance use to establish a baseline. The Behavioral Health Nurse will collect some core health information, including height, weight, Body Mass Index (BMI), blood pressure, and Carbon Monoxide level, using a standardized CO 2 monitor. This information will be collected at baseline and every six (6) months to enable us to evaluate progress over time.

The CCC team will also collect social outcomes measures including education level, employment, arrest history, alcohol and drug use, social connectedness, and mental health indicators (depression, functioning, activities of daily living). A modified National Outcomes Measures Questionnaire will be used to collect this information. This information will be collected at baseline and every six (6) months to enable us to evaluate progress over time.

Once linked to a primary care provider, each client will receive a physical and have baseline lab work completed. The lab work will establish a baseline of health indicators for each client, which will be used by the CCC team to identify any health risk factors, and develop wellness goals for each individual. The Lab work will provide information on hypertension, cholesterol, diabetes, thyroid functioning, and other key health factors which lead to chronic health conditions. Lab work will be collected at baseline and every twelve (12) months to enable us to evaluate progress over time.

The key health indicators will be complied into Individual Wellness Reports and given to each client, Behavioral Health staff, and the Primary Care provider every six months. For each health indicator, the report will show areas of "normal" range, "at risk" for developing a chronic health condition, and "meets criteria" for a chronic health condition (e.g., BMI > 25; Blood Pressure > 140, etc.). These reports will provide a road map for developing strategies and goals for supporting the client to reduce their weight, blood pressure, and other indicators of a chronic health condition. Over time, clients and staff will learn how to improve health, make healthy choices in food and exercise, and be supported to manage their health.

Key outcomes for clients include: 1) identification of persons who need primary care and link them to services, 2) collect health information and share with the client, staff, and primary care to develop health and wellness goals; 3) support access to health, mental health, and substance use services; 4) improve clients' health indicators and manage chronic health conditions by offering wellness activities. System outcomes include: 1) improved coordination between primary care and behavioral health services; 2) development of the capacity to collect and share health data on key health indicators with clients, behavioral health staff, and primary care; and 3) develop and implement the capacity to measure client health outcomes and improve chronic health conditions over time. All persons who receive integrated services will benefit from an enhanced, collaborative, person-centered behavioral health care system.

The CCC Team will also continue to develop classes at the Wellness Center and at each health clinic to provide the skills to make healthy lifestyle changes. For example, classes on nutrition, healthy cooking to reduce calories, and walking groups will be offered. In addition, classes in medication, yoga, relaxation, and social connections will be offered by staff or other persons in the program. Together, the CCC Team and clients will celebrate successes and improved health.

<u>State how the Innovation meets the definition of Innovation to create positive change.</u>

The CCC Team will be innovative and contribute to learning by improving services to clients, linking clients to primary care services, and developing skills to better understand chronic illness and how to improve their health outcomes.

The Behavioral Health staff and the CCC Team will work closely with the two Health Clinics in the county to improve coordination of care, share information on clients, and understand services delivered by each agency. For example, we will hold a weekly phone call so nurses and staff from each agency can share information on medications prescribed, plans for managing adherence to medications, and strategies to improve health outcomes.

In addition, we will share the Individual Wellness Reports with clients, behavioral health staff, and primary care staff, to help identify at risk and/or chronic health conditions, identify goals to addressing these conditions, and share progress over time. This innovative method of sharing health indicators with the team will promote healthy outcomes for clients, help them to improve their health, and receive support and skills to make healthy choices. In addition, we will examine the cost-effectiveness of this project in helping keep clients improve their health indicators. The CCC Project will help provide a model for other small counties on how to share health information, reconcile medications, develop shared goals, and offer healthy activities to support wellness for high risk clients.

3. *Include a description of how the project supports and is consistent with the applicable General Standards as set forth in CCR, Title 9, Section 3320.*

The CCC Project supports and is consistent with the General Standards of the MHSA as follows:

<u>Community Collaboration</u>
Initiates, supports, and expands collaboration and linkages, especially connections with systems, organizations, healers and practitioners not traditionally defined as a part of mental health care cultural competence. Demonstrates cultural competency and capacity to reduce disparities in access to mental health services and to improve outcomes.

The CCC Team will develop strategies and outcomes for enhancing communication between behavioral health and the two health clinics in the county. This will help improve services for clients, as well as improve service coordination by reconciling medications and developing shared treatment goals.
The shared Individual Wellness Reports will improve communication between providers, has the opportunity to integrate alternative health practitioners and healers in the community, and will fully support clients to plan strategies to improve their health outcomes. The Individual Wellness Reports will clearly show progress toward improved health outcomes, and create the opportunity to celebrate success and identify opportunities for needed supportive services. This innovative approach will help promote healthy outcomes and improve chronic health conditions.

4. *Describe the population to be served, number of clients to be served annually, and demographic information including age, gender, race, ethnicity, and language spoken.*

The Health Integration Project will focus on adults who are 18 years of age, and older who are living independently. We expect to serve 60 unduplicated clients each year. We estimate the following demographics for these clients:

- 12% Native American; 65% Caucasian; 20% Hispanic; 3% Other
- 35% male and 65% female

- 85% adults (18-59); 15% older adult (60+)

5. *Describe the total timeframe of the program. In your description include key actions and milestones related to assessing your Innovation and communicating results and lessons learned. Provide a brief explanation of why this timeline will allow sufficient time for the desired learning to occur and to demonstrate the feasibility of replicating the Innovation.*

We took the initial steps towards readiness for implementation in September 2013. We have had meetings with representatives from the local Rural Health Clinic and Indian Health Clinic to discuss options for coordinating services between Primary Care and Mental Health. We are optimistic that we will be able to begin co-locating staff within six months of the start of the project.

This timeframe will allow the opportunity to train staff and develop an evaluation component to evaluate services to individuals.

Full implementation, with early identification, referral, and linkage processes developed, will occur within three (3) months of funding. We anticipate that this project will extend through 2016. We will utilize the final three months of the project to conduct the concluding components of the evaluation activities, analyze the data, and develop a final report. The timeframe for this project will provide the opportunity to collect data, analyze it, and demonstrate the feasibility of replicating these HIP outcomes and integrated services in other communities.

6. *Describe how you plan to measure the results, impacts, and lessons learned from your Innovation, with a focus on what is new or changed. Include in your description the expected outcomes of the Innovation program, how you will measure these outcomes, and how you will determine which elements of the Innovation Program contributed to successful outcomes. Include in your description how the perspectives of stakeholders will be included in assessing and communicating results.*

The CCC Team will collect health and behavioral health indicators on each client admitted to the HIP Team. This will include an intake packet for the Primary Care indicators and an assessment packet for the mental health, drug and alcohol, and social connectedness indicators.

Once linked to a primary care provider, each client will receive a physical and have baseline lab work completed. The lab work will establish a baseline of health indicators for each client, which will be used by the CCC Team to identify any health risk factors, and develop wellness goals for each individual. The lab work will provide information on blood pressure (hypertension), heart disease and cholesterol, Fasting Plasma Glucose and diabetes, weight and Body Mass Index (BMI), and other key health factors which are known to lead to chronic health conditions. Lab work will be collected at baseline and every twelve (12) months to enable us to evaluate progress over time. We will also collect information on lung health by using a Carbon Monoxide Monitor. This instrument is valuable in providing information on the impact of smoking on the body, and provides positive feedback once the individual stops smoking.

The key health indicators will be compiled into Individual Wellness Reports and given to each client, Behavioral Health staff, and the Primary Care provider every six months. For each health indicator, the report will show areas of "normal" range, "at risk" for developing a chronic health condition, and "meets criteria" for a chronic health condition (e.g., BMI > 25; Blood Pressure > 140, etc.). These reports will provide a road map for developing strategies and goals for

reducing weight, blood pressure, and other indicators of a chronic health condition. Over time, clients and staff will learn how to improve health, make more healthy choices in selecting meals and exercise, and the team will support them to manage their health.

In addition, the Behavioral Health Case Managers will gather outcome data to measure progress on mental health and drug and alcohol indicators. These will include the client's self-report on areas of dealing with everyday life (e.g., I deal effectively with daily problems; I am getting along with my family); violence and trauma; housing; education; employment; criminal justice; and social connectedness.

Key outcomes for clients include: 1) identification of persons who need primary care and are linked to services, 2) identification of persons who need substance use services and are linked to services; 3) identification of persons who need mental health services and are linked to services 4) improvement in key health indicators, including BMI, Weight, Breath CO, Fasting Glucose, and Cholesterol. 5) involvement in wellness activities to improve management of health indicators. System outcomes include: 1) improved coordination between primary care and behavioral health services; 2) development of the capacity to collect and share health data on key health indicators with clients, behavioral health staff, and primary care; and 3) develop and implement the capacity to measure client health outcomes and improve chronic health conditions over time. All persons who receive integrated services will benefit from an enhanced, collaborative, person-centered behavioral health care system.

The evaluation team will produce Individual Wellness Reports for each client to provide information on these key health indicators. Behavioral Health staff will meet with the client to review their health indicators, identify wellness and mental health goals to work on, and share the information with the primary care provider. This approach will provide the opportunity to have all team members work together to identify chronic health conditions and risk factors, identify measurable goals, and improve communication, collaboration, and services to improve outcomes for each client.

The data reports and other written information on the activities associated with the project will also be shared with stakeholders. Their input will be requested and documented throughout the project. The data will provide valuable information on how to support individuals to improve health outcomes. It will help to document lessons learned and how best to engage clients and the support systems to help them make healthy choices, remain living in the community, and effectively manage their symptoms. Obtaining satisfaction surveys annually from clients will provide important information on individual perceptions of the value and outcomes of the services and activities.

7. *If applicable, provide a list of resources to be leveraged.*

Leveraging of resources is not applicable to the Care Coordination Collaborative Project. However, we plan to utilize Medi-Cal funding to support the services, whenever possible.

8. *Please provide projected expenditures by each fiscal year during the program time frame, including both the current and future funding years. Please also describe briefly the logic for this budget: how your proposed expenditures will allow you to test your model and meet your learning and communication goals.*

Care Coordination Collaborative Project budget for three years is $322,600. The CCC

Innovation Project will provide the foundation for integrating health and behavioral health care services through enhanced communication, shared tracking of client health indicators, and supportive services to improve client's health and manage chronic illness. Currently, the Behavioral Health clinic and the two Rural/Indian Health Clinics share a number of patients, but do not routinely share information on patients served, reconcile medications across providers, discuss health indicators and services received, or measure health outcomes over time. Beginning with our Rural Health clinic, this project will provide the opportunity to support these health care entities, as well as develop relationships with local healers and/or alternative medicine providers in the community, to communicate, develop strategies for sharing information, and develop shared health indicators to improve health outcomes for clients.

9. Provide an estimated annual program budget.

INNOVATION PROJECT NEW ANNUAL PROGRAM BUDGET					
A. EXPENDITURES					
	Type of Expenditure	**County Mental Health Department**	**Other Governmental Agencies**	**Community Mental Health Contract Providers/CBO's**	**Total**
1.	Personnel	$105,500			$105,500
2.	Operating Expenditures	$2,100			$2,100
3.	Non-recurring Expenditures	$8000			$8000
4.	Contracts (Training Consultant Contracts)				
5.	Work Plan Management	$10,000			$10,000
6.	Other Expenditures(Admin)				
	Operating Reserve				
	Total Proposed Expenditures				
B. REVENUES					
1.	New Revenues				
	a. Medi-Cal (FFP only)	$18,000			$18,000
	b. State General Funds				
	c. Other Revenues				
	Total Revenues				
C. TOTAL FUNDING REQUESTED					**$107,600**

D. BUDGET NARRATIVE

It is anticipated that the Care Coordination Collaborative Project will be funded for $322,600 over 3 years. Funds will be used primarily to support the mental health nurse who will be co-located in primary care locations. The Nurse position will bill MediCal when appropriate. Funds will also be used to support wellness activities for consumers. In addition, funds will be used to offset costs of data collection, tracking and outcomes monitoring.

MHSA Program Component
WORKFORCE EDUCATION AND TRAINING

1. Provide a brief program description.

Since the original WET Plan was approved, ICBH has developed contracts with various learning providers to deliver trainings to clients, family members, staff from Behavioral Health, members of the Mental Health Advisory Board, and partner agencies. Training topics include psychosocial rehabilitation skills, the recovery model, motivational interviewing, and delivering comprehensive services for promoting wellness and recovery. Cultural competency and team building has also been a focus of our trainings. In addition, we have implemented evidence-based models such as Aggression Replacement Training (ART) and wraparound services. Our training partners include *Essential Learning*, a website which offers online courses, staff ethics and regulations compliance training, and an array of clinical skills building courses that also fulfill continuing education requirements for licensed behavioral health professionals. We have purchased a bulk subscription package for our organization that makes these exemplary courses available to staff. As an added training component, we have provided staff and consumers with technical software training to enhance the skill set of staff and consumers/family members who work or volunteer for Inyo County.

In addition, we have developed a NAMI Peer-to-Peer Training program to consumers to develop skills for Coach, Parent Partner, or Peer Mentor positions with Inyo County. Some of the topics included in the curriculum are: wellness management and recovery; promoting resiliency skills in Transition Age Youth; putting recovery skills into practice; embracing wellness in all aspects of care; providing peer support; and creating a recovery-based mental health services plan. To date, ten (10) consumers have graduated from the Peer-to-Peer Training and are developing activity groups to lead at our Wellness Centers. Further, we provided the NAMI Family Support Group training. Four family members completed this course and have provided a family support group. We continue to look for ways to increase participation in this group.

In the coming fiscal years, we will identify regional and statewide trainings – such as those offered through NAMI and CASRA – for staff, clients, family members, and other stakeholders to enhance their understanding of the recovery model, promote effective service delivery, increase cultural competency, promote leadership and team building, and learn other essential skills. We will also identify evidence-based strategies to address gaps in our systems of care. To support consumer and family member training, we will develop and maintain a mental health information library; this library will allow consumers and family members to borrow publications and DVDs on mental health, the recovery model, cultural competency, and other mental health related information.

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

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

3. List any significant changes for FY 2013/14, if applicable.

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

MHSA Program Component
CAPITAL FACILITIES/TECHNOLOGY

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

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

The balance of CFTN funding that may be used for Capital Facilities is limited, but utilization of the funds for remodeling the Wellness Center in Bishop may be implemented when a new location is found. Planning for these funds may begin in FY 13/14.

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

While ICBH has been able to utilize the ShareCare product to successfully produce a claim and has moved forward in the full use of the product to produce an electronic health record, ICBH must continue to use "work arounds" in order to address deficiencies in the product. ICBH will need to implement a newer product in the next year, the Virtual Health Record (VHR) or a similar product in order to meet "meaningful use" standards. ICBH has chosen to delay this implementation of the VHR due to continued deficiencies in the product as well as cost.

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

ICBH has delayed implementation of the VHR until next fiscal year to allow for sufficient time to address implementation challenges.

4. *List any significant changes for FY 2013/14, if applicable.*

No significant changes to the CFTN Program are anticipated in this fiscal year unless a wellness center facility is located for purchase and requires use of these funds. In this case, an amendment would be made to the plan.

County: **INYO** Date: **4/17/2013**

	MHSA Funding					
	CSS	**WET***	**CFTN**	**PEI**	**INN**	**Local Prudent Reserve**
A. Estimated FY 2013/14 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$996,629	$391,177	$0	$348,102	$325,083	
2. Estimated New FY 2013/14 Funding	$1,044,834			$261,208	$68,739	
3. Transfer in FY 2013/14[a/]	$0	$0				
4. Access Local Prudent Reserve in FY 2013/14	$0			$0		
5. Estimated Available Funding for FY 2013/14	$2,041,463	$391,177	$0	$609,310	$393,822	
B. Estimated FY 2013/14 Expenditures	$786,828	$13,815	$0	$257,630	$107,533	
FY 2013/14 Contingency Funding	$1,254,635	$377,362	$0	$351,680	$286,289	

[a/]Per 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.

***WET Funds revert in 2017 and 2018.**

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2013	$391,782
2. Contributions to the Local Prudent Reserve in FY 2013/14	$0
3. Distributions from Local Prudent Reserve in FY 2013/14	$0
4. Estimated Local Prudent Reserve Balance on June 30, 2014	$391,782

Xx ADD Budget Summary (Excel)