MHSA COMMUNITY PROGRAM PLANNING

Community Program Planning

The Inyo County Health and Human Services-Behavioral Health (ICHHS-BH) Community Program Planning (CPP) process for the development of the MHSA FY 2016/2017 Annual Update built upon the planning process for the most recent MHSA Three-Year Plan. This planning process was comprehensive and included input from over 100 consumers and family members, providers, and community members. We routinely discuss and obtain input on the utilization of MHSA funds with our key stakeholders and partners in our quarterly Quality Improvement Committee (QIC) meetings, our bi-monthly MHSA consumer meetings, and the Behavioral Health Advisory Board. We discuss the MHSA plan as part of our HHS leadership team which includes managers and supervisors from Child Welfare, Senior programs, Employment and Eligibility, Prevention, Public Health, and HHS Administration, as well as Behavioral Health (including Substance Use Disorder services). The MHSA Annual Update was also discussed in partner meetings with the local hospital, schools, and criminal justice entities.

With this information, we were able to review the unique needs of our community and make sure that the programs supported through MHSA funds are well designed for our county. The overall goals of the MHSA Three-Year Plan are still valid and provide an excellent guide for maintaining our MHSA services in FY 2016/2017.

Components addressed by the planning process included Community Services and Supports (CSS); Prevention and Early Intervention (PEI); Workforce Education and Training (WET); and Capital Facilities/Technological Needs (CFTN); in addition, we provided basic education regarding mental health policy; program planning and implementation; monitoring and quality improvement; evaluation; and fiscal and budget components.

The MHSA 2016/2017 Annual Update was developed and approved by the Behavioral Health Advisory Board after reviewing data on our current programs; analyzing community needs based on stakeholder input; and determining the most effective way to further meet the needs of our unserved/underserved populations. In addition, the MHSA was shared at staff meetings and at wellness center stakeholder meetings to obtain additional input and feedback on services. All stakeholder groups are in full support of this MHSA annual update and the strategies to maintain services.

Stakeholder Participation

Several 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 5-10 consumers who are homeless, 2 consumers who are Hispanic, 2 consumers who are older adults, 5 consumers who are transition age youth, and approximately 5 other adult Caucasian consumers. In Lone Pine, the stakeholder group consists of 2 persons who are homeless and 3-5 other Caucasian adult consumers.

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

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

LOCAL REVIEW PROCESS

30-Day Posting Period and Circulation Methods

This proposed MHSA FY 2016-2017 Annual Update has been posted for a 30-day public review and comment period from May 2, 2017- May 31, 2017. An electronic copy is available online on the Inyo County website (http://www.inyocounty.us/MHSA). Hard copies of the document are available in the Bishop Behavioral Health Clinic; Bishop Social Services office; Health and Human Services Administrative office; Health and Human Services, Lone Pine office; and at all county libraries, including the Bishop, Big Pine, Independence, Lone Pine, Furnace Creek, and Shoshone branches. In addition, a hard copy of the proposed Annual Update has been distributed to all members of the Behavioral Health Advisory Board; consumer groups; staff; Wellness Centers (Bishop and Lone Pine); and partner agencies. The Annual Update is also available to stakeholders upon request.

Public Hearing Information

A public hearing will be conducted on June 1, 2017 as part of a special Behavioral Health Advisory Board meeting.

Substantive Recommendations and Changes

Input on the MHSA FY 2016/2017 Annual Update will be reviewed and incorporated into the final document, as appropriate, prior to submitting to the County Board of Supervisors and the California Mental Health Services Oversight and Accountability Commission (MHSOAC).

COMMUNITY SERVICES AND SUPPORTS

All Ages/Populations

CSS Program Description 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. We offer a "whatever it takes" service approach in helping individuals achieve their goals. This has allowed us the transformative flexibility to meet the person "where they are." Services for all populations help reduce ethnic disparities; offer peer support; and promote values-driven, evidence-based practices to address each individual's unique needs and mental health. These services emphasize the principles of empowerment, self-determination, wellness, recovery, and resiliency and offer integrated services for clients of all ages and their families. Services are delivered in a timely manner and are sensitive to the cultural needs of each individual. The wellness centers are often the first "accepted door" into the System of Care by persons who do not recognize that they have a mental illness. It is critical that the wellness centers are centrally-located within the community in a comfortable setting. Our bilingual workers provide targeted outreach to the Latino population both within the schools and the community settings to build trust and to offer support in the wellness center.

The CSS Program includes comprehensive assessment services; wellness and recovery action planning; case management services; individual and group mental health services; crisis services; peer-led self-help/support groups; education and employment support; anti-stigma events; linkages to needed services; and housing support. Our Adult and Older Adult Wellness Centers (located in Bishop and Lone Pine) provide adults and older adults with necessary services and supports in a welcoming environment. Often persons who are homeless will be guided by partners or even community members to come to the wellness centers for support. Several persons have reported that they had been steered to the wellness centers by the local church, law enforcement, social services, or the hospital. We have also received calls from these partners letting us know about persons they have referred to the wellness center or persons for whom they have concerns. During times of more extreme hot or cold or otherwise inclement weather, persons are especially engaged at the wellness centers. We have provided more intensive outreach to persons during times of inclement weather, either extreme heat in the summer or cold during the winter. 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. We have also 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. At times, persons also need transitional living as they re-enter the community and are able to benefit from a combination of supports to meet their needs.

We provided ongoing peer-facilitated groups at the Wellness Center in Bishop including Addiction and Recovery, Journaling, Art, Nutrition, Blanket-making, and Wellness Walking. We also provide groups such as money management, smoking cessation, gardening, and

dialectical behavioral therapy to persons at the wellness center facilitated by Behavioral Health staff members. In addition, our Transition Age Youth (TAY) program provides opportunities for youth to participate in age-appropriate activities. The TAY youth utilize the Wellness Center in Bishop once a week, meeting together to socialize, listen to guest speakers, and develop leadership skills.

We moved to our new Wellness center site in Bishop in March 2016 after extensive renovations occurred at the site including constructing an ADA bathroom and shower facility in the back house. This site offers an opportunity to provide more extensive offerings such as a kitchen facility, and laundry facilities. This type of service has proven to be very effective in the engagement of persons who might not otherwise come to the facility. The new location is centrally located and is within close proximity (3-5 blocks) to our clinic, social services, Progress House (our Adult Residential facility), the city park, and four community-based organizations offering assistance. The two separate structures allow us to offer a separate space for Transition Age Youth as well as a space to provide some support services to be provided by our mental health nurses. Further, there is space for a significant garden between the two structures. Consumers participate in planting and caretaking of the garden and will in turn have the opportunity to cook with fresh vegetables, take vegetables with them, and to participate in entering vegetables at the fair as part of community inclusion. 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 are 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.

We also anticipate a move to a new Wellness Center site in Lone Pine as there was a change in ownership of the property. The new property is a duplex in the center of the town and within walking distance to the main resources including social services, school sites, and hospital. As a duplex site, this location will offer potential for co-location with other services and supports. It is our desire to use this new facility to continue to offer cooking, shower and laundry capabilities as well as to have a slightly bigger group room capability.

Another important component of the CSS plan is in the provision of respite and transitional housing for Full Service Partners (FSPs) as needed. We continue to purchase four beds at Progress House, an Adult Residential Facility. We have used these beds for persons with severe mental illness who are transitioning out of acute care, incarceration or who are homeless. We have provided transition services for 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 are in need of a respite due to a mental health crisis. We have been able to keep persons within our community and to assist them to successfully transition back into the community through this strategy. We have provided respite services for at least 17 adults. In addition to mental illness, many of the persons served in this way have evidenced co-occurring addiction issues, may have been veterans, and/or may have had experienced significant adverse childhood events. This year we are proposing to focus on some work/volunteer experience to increase transition readiness. We are working with our partners in the HHS Prevention programs to identify events that need some volunteer assistance including health fairs, community runs and other community events. In addition we will look at ways to employ peers to act as crew leaders to support improvement projects at Progress House and also 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 continued to also employ a Supervising Nurse as part of the administrative oversight at Progress House to help to ensure that health conditions and medication assistance is addressed.

We have also continued to offer Latino Outreach through both the wellness center sites and within the community. A contracted bilingual therapist, also employed by the schools, provides mental health services to Latino youth and their families. These youth and families may be hesitant to come into the traditional clinic especially if there are immigration issues. The therapist is able to treat anxiety and depression related to trauma issue as well as the provision of family support. A bilingual Latina employee at the wellness center also provides outreach to the underserved population and is able to serve as an advocate for Spanish-speaking persons with mental illness struggling to navigate the systems of support. Approximately 22 youth were served through this CSS strategy along with outreach to at least 55 additional persons.

A specific strategy has been needed to address the needs of our isolated southeastern area of the County, the Death Valley area, closer to Nevada population centers than to Inyo towns. While there is a contract with a mental health provider in Pahrump, few persons are willing or able to engage in this service. A small amount of telemedicine is also available for persons engaged in services. A strategy of using a Mental Health Nurse to outreach and engage with persons with mental illness in this part of the county has been most useful. The Nurse has provided services to several isolated older adults who live in this community as well as checking in with adults or youth and family who have been identified with mental illness. Persons often evidence co-occurring addiction issues as well as related health conditions. The Nurse also participates in a bi-monthly community potluck that serves to connect with residents effectively. The Nurse has further been trained as a certified Mental Health First Aid trainer and has scheduled to provide this training for interested persons in the community.

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

The following represents our persons served under CSS strategies:

FSPs Ethnicity by Age Group

	TAY	Adult	Older Adult	Total
Caucasian	3	11	9	23
Native American	0	2	0	2
Latino	3	2	0	5
Total	6	15	9	30

Average Cost per FSP = $32,224. This is the average cost per person of a combination of intensive services that might include transitional living at Progress House, participation in

Wellness Center array of services, coordination with health care needs and a variety of "whatever it takes" to address behavioral health needs.

Wellness Center visitors by Age Group (approximated)

TAY	Adult	Older Adult	Total
50	145	25	220

Number of Youth served through Latino Outreach: 22 families received counseling with an additional 55 families receiving some at least one outreach connection. Approximate cost is $98.77 per person.

Persons receiving targeted outreach and engagement in South East County (underserved population): 13 persons received ongoing outreach and engagement within their homes plus around 22 additional participants received outreach as part of the bimonthly community dinner that is attended by the Outreach Nurse. Approximate cost per person served with outreach to this isolated community is $3456.

Challenges and Mitigation Efforts

This was our first full year at the new Wellness Center site in Bishop and we were able to attract additional persons to the Wellness Center especially given inclement weather issues. We began to attract a group of Transition Age adults, some of them who were homeless or were "couch surfing". We were challenged to address persons with co-occurring mental illness and substance abuse. We have looked for effective ways to address these issues. We continue to be welcoming and try to engage the young adults in recovery while maintaining a safe and welcoming environment for all participants.

Another challenge continues to be 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 and now struggle to find an adequate number of appropriate living situations for adults over 60 who continue to need residential support. We work closely with partners in Aging services to access housing and other support and to problem-solve around specific needs.

Significant Changes from Previous Fiscal Year

We will not make significant changes in this third year update to the plan. Instead, we are working to refine a way to evaluate our overall outcomes as a system of care as opposed to looking at each small strategy individually. We are looking at the impact of our efforts as varying partners meet around initiatives such as re-entry coordination and criminal justice for persons with mental illness; taking next steps with integrated care with our physical health care partners; looking at school mental health needs and foster youth challenges; as well as focusing on adults and homelessness and employment issues.

PREVENTION AND EARLY INTERVENTION

Prevention Programs

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 Outreach Program funds a mental health nurse to provide screening, referral and linkage, and support services to prevent the exacerbation of mental health conditions. The program, utilizing a Behavioral Health Nurse, offers comprehensive assessment services to those older adults at risk of developing mental health problems that may interfere with their ability to remain independent in the community. The Nurse then links these individuals to resources within the community, including County Behavioral Health services. This program offers service alternatives for older adults who have been unserved and underserved in this community. Services are voluntary and client-directed, strength-based, employ wellness and recovery principles, address both immediate and long-term needs of program members, and are delivered in a timely manner that is sensitive to the cultural needs of the population served.

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

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

The Behavioral Health Nurse also provides services to older adults in community settings that are the natural gathering places for older adults, such as our Senior Center sites in the community sites of Bishop, Big Pine, Independence, Lone Pine, and Tecopa. Older adults who need additional services are referred to a Friendly Visitor (see below) or to Behavioral Health for ongoing treatment, as appropriate.

In the past year, outreach visits were made to 79 older adults. This results in a cost of $1304 per individual. This strategy again targets the more isolated parts of the county. One Native American and one Hispanic older adult have been served with the remainder being Caucasian. PEI funding also has allowed us to provide care coordination/case management as additional support to the Older Adult PEI program.

Friendly Visitor (FV) Program

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. Meals on Wheels drivers identify seniors who evidence symptoms of depression and/or anxiety and who might benefit from a visitor. The visitor, who may also be a senior, develops a plan with the senior to address the depression and prevent further exacerbation of symptoms. The program has provided services to 25 seniors at a cost of approximately $3139 per individual. Although a formal evaluation of the program has not occurred, participants have reported a high level of satisfaction with the services and a lessening of symptoms.

Challenges and Mitigation Efforts

We continue to struggle with having adequate nursing coverage as well as experiencing other staff turnover in Adult Social Services. This makes it difficult to implement evidence-based strategies with consistency. We also 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 will 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.

Significant Changes from Previous Fiscal Year

No significant changes noted.

PREVENTION AND EARLY INTERVENTION

Early Intervention Programs

Families Intensive Response Strengthening Team (FIRST)

In the last two years we expanded our collaborative services using a wraparound model to additional families beyond those with youth at risk of placement in a high level of out of home placement. This allowed us to include an early intervention strategy for our work with "at risk" families and we are able to strengthen these families using a child/family team model. We additionally hired a supervisor who had worked extensively in a drug court program who could lead the team encouraging home-based support. We additionally were able to pull in resources from the First Five program and Substance Use Prevention programs, as well as other agencies to intensively support the families. As the result of this expansion, we are able to serve families with younger children. We are also looking for ways to expand the successful wraparound and home-based services as we plan to more fully implement the Continuum of Care Reform.

In 2015/2016, we served 9 families for a total of 30 family members served. The MHSA portion of the costs was $201,760 for an approximate cost of $22,417 per family.

Parent-Child Interaction Therapy (PCIT) Community Collaboration

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

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

PCIT is a highly effective program and the families show improved outcomes because of this intensive parenting program. In addition, the children and their siblings show improved behavior (positive social interactions, following directions, reduction in acting out behavior) as a result of the program. We have served seven additional families with this intervention. Of the four court-referred families involved in PCIT, three were reunified satisfactorily.

The approximate cost per family served under PCIT is $7120.50.

Challenges and Mitigation Efforts

A continuing barrier for Inyo County is the small number of staff and the issues caused when staff vacancies occur. In a small county, all vacancies are "key" and have an impact on service delivery and strategy implementation. We are again providing training in PCIT to interns in Behavioral Health, wraparound, and in the substance use disorder program, as well as with HHS Specialists in these programs and in Child Welfare.

Significant Changes from Previous Fiscal Year

There are no significant changes in this strategy from the previous years.

INNOVATION

Community Care Collaborative

Community Care Collaboration Project

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

The Innovation Project funding supported the development of a CCC Team by partially funding one full-time Behavioral Health Nurse position (1.0 FTE) to coordinate and integrate health and wellness activities for behavioral health clients and partially funding a one full-time Administrative Analyst position to collect, track, and analyze outcome and cost data based on a quality improvement model. The initial target population has been behavioral health consumers who are also enrolled and receiving services at the Northern Inyo Hospital Rural Health Clinic (NIHRHC), and currently includes approximately 89 persons. The CCC team identifies clients who receive behavioral health services and help link them to health services in the community. These individuals work with the NIHRHC to improve health outcomes for CCC clients.

The Coordinated Care Collaborative addresses the following:

- Identifying individuals who do not have an identified primary care physician, or routinely use primary care services, and link them to the appropriate provider/health clinic/healer/alternative health care in the community. It is now part of our admission process to assess whether each person has a primary care physician and to link that person with care if it is not in place. As a result of these efforts, over 90% of admitted consumers have an identified primary care provider.
- Collecting basic health information, including lab work, on individuals to help understand each person's current health indicators. Staff work with the individual to understand their health indicators (e.g., height, weight, body mass index, A1c and risk for diabetes, carbon monoxide monitor results, hypertension/blood pressure, cholesterol, and lung functioning). These health indicators are used to inform both the individual and staff on high risk health factors, and allow them to work together with the health clinic to identify goals on improving their health and wellness.

- Participating clients allow for the reconciliation of medications between ICHHS-BH and NIHRHC. A work flow has been tested and developed to allow for the sharing of this information between the two entities to best coordinate the medication needs. This work flow continues to be rather cumbersome and includes faxing of documents between providers. We continue to look for more streamlined ways to communicate.

- Clients and staff work together to develop health and wellness activities to support clients to improve their health. These activities include developing walking groups, nutrition

and cooking groups, and mindfulness. There is also a smoking cessation group offered at the Bishop Wellness Center. Wellness information is also offered to CCC clients, to provide support and information to help individuals make healthy choices. These activities help the team provide supportive services which will lead to positive outcomes.

- Peer Support has been recognized to be an important component of the coordinated care approach. We have trained peer supporters to assist with health goals and to accompany consumers to medical appointments to provide support and another "listening ear." To date, we have trained five (5) peer supporters and one is actively involved in providing this service.

- We have collected and tracked population health data as well as tracking data on each consumer who has been identified as needing more intensive care coordination. Approximately 41 consumers receive more intensive coordination.

- Late in FY 14/15, we began to "spread" this approach to target persons in the jail who evidence mental health conditions as well as health conditions. We track all persons who are receiving psychotropic medication to treat a mental health condition or who have been identified as needing this type of treatment. Approximately 70 unduplicated persons have received this service. We have established weekly care coordination meetings with the behavioral health nurses, the jail nurse, an addictions counselor, the re-entry coordinator, and the behavioral health director. A majority of persons in this population have co-occurring substance abuse disorders and several of these persons have health conditions as a result. Most of the persons in this population have not received any consistent primary care or behavioral health treatment. The goal of this coordination is not only to treat and stabilize mental health and health conditions during incarceration but also to support the continued treatment during re-entry back into the community.

Challenges and Mitigation Efforts

One of the ongoing challenges is in staff vacancies and turnover both in primary health as well as in behavioral health. It is difficult to maintain the medication reconciliation and tracking of costs. The behavioral health nurses are also pulled in many directions and struggle to keep up with the medication reconciliation as well during vacancies. One strategy to mitigate the impact of this situation is to continue to look for ways to build peer and other natural supports. Another strategy is to set up work flows that can be used by numerous staff and thus to "institutionalize" the gains made and the process of continuing to improve the strategies.

Significant Changes from Previous Fiscal Year

No significant changes are anticipated to the original Innovation Plan. As described above, we have applied the coordinated care model to the jail and re-entry services population, as appropriate. Further, we identified the need to coordinate care more effectively with Toiyabe Indian Health Project to address the needs of the Native American persons in our communities and will continue to participate as part of the Rural Health Network to coordinate efforts. It is clear that distance strategies, such as telemedicine, are critically important to address our challenges of capacity.

WORKFORCE EDUCATION AND TRAINING

Workforce Education and Training (WET) Coordination

Since the original WET Plan was approved, ICHHS as a whole developed several contracts and strategies with various learning providers to deliver a broad range of trainings to benefit the workforce. In a small rural isolated community it has been an effective strategy to offer training that assists us to "grow our own" workforce from within our community from those dedicated to the community. We have offered training aimed at the development of consumers and family members. Behavioral Health staff members are trained separately and as part of the larger Health and Human Services staff including Child Welfare, Prevention, Employment and Eligibility and Eligibility, Public Health and Aging Services. Partner agencies such as Probation and Toiyabe Indian Health Plan are also trained. Training topics include a broad range of family engagement and child and family teaming, motivational interviewing, and delivering comprehensive services for promoting wellness and recovery. Team building and transformational change has also been a focus of our trainings.

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

1) We identified a critical need for further training as related to the co-occurrence of mental illness and substance use disorders. It is critical to implement effective strategies to treat or mitigate the impact of substances on recovery and wellness. We supported an on-line addiction counselor certification through University of the Pacific and related practicum/intern support. A cohort of 10 students from HHS and Probation completed the coursework and several have pursued practicum hours. We also helped to support the evidence-based strategy of Moral Reconation Treatment (MRT) including trauma-focused MRT. Six additional staff members participated in this training.
2) We participated in the small county technical assistance around wellness centers and building peer support. We visited another wellness centers and increase knowledge around psychosocial rehabilitation and immersion.
3) We have continued to see the need to offer training for partners in law enforcement, probation and other first responders and provided crisis response training for these partners. We also provided training in de-escalation for persons working at our community museums, libraries and at our child support services.
4) We trained an additional cohort of five persons in Mental Health First Aid facilitation and have offered several community trainings.

Fundamental Learning Program

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

Consumer Pathways Program

Our Wellness Center sites have offered the best training ground for consumers to gain volunteer and other work experience. As we have strived to make sure that groups and services offered at the wellness center sites are consumer driven and facilitated, we have had consumers act as reception staff, group facilitators and participate in the operation and care of the facility. As a result of these efforts, we are able to identify consumers who may act as peer supporters or who desire to develop other skills for use in the workforce. This year we have been able to recruit for two entry level positions that will transfer to permanent positions after an initial period.

Financial Incentive Program

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

Challenges and Mitigation Efforts

We continue to face the challenge of recruiting bilingual staff. We have one bilingual Latina employee who is pursuing her attainment is Licensed Clinical Social Worker (LCSW). She quickly filled her caseload with Latino/Latina youth and families as the community was made aware of her services and consumers refer other family or friends. We also continue to look for ways to identify TAY to participate as part of the Human Services Certificate program at our community college as well as in other Peer Supporter roles. We look forward to expanding our training capacity and opportunities for both staff and consumers.

Another area of challenge is in the hiring of our licensed psychotherapy staff and behavioral health nurses. Several of our licensed staff will reach retirement age in the next year and it is important to develop a strategy for succession planning. We are looking for ways to attract interns to our county. Through the Regional WET program, we have been able to avail ourselves of a Roving Clinical Supervisor. Three interns from Behavioral Health as well as one intern employed by another provider have received distance clinical supervision and have made progress in achieving the requisite hours towards licensing as LCSWs or other master's level licensure. A nurse shortage also continues to be a challenge which we have not yet been able to fully address.

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

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

Significant Changes from Previous Fiscal Year

The most significant change is in the additional effort to increase our county expertise in the area of co-occurring disorders through the provision of addiction certification coursework. As a small

county it is important that the overall workforce is knowledgeable and trained to identify and provide interventions that meet the needs of persons with mental illness or co-occurring disorders. We must use each and every service provider, across agencies to accomplish this in our community.

CAPITAL FACILITIES/TECHNOLOGY

Capital Facilities and Technology Projects

ICHHS-BH chose to utilize the bulk of CFTN funding for a system-wide IT upgrade to achieve an Integrated Information Systems Infrastructure. ICHHS-BH initially implemented ShareCare™, a product of The Echo Group. In FY 15/16, we had come to a crossroads with our system due to the necessity to either upgrade the system to the ECHO VHR (Virtual Health Record) product or to find a product that better meets federal meaningful use as well as California requirements. After we had performed a cost/benefit analysis, we chose the Cerner/ Kings View product as it better met the needs of the county around both meaningful use and outcome tracking. Use of the Kings View product also better positioned us to move forward on needed telemedicine services as we look towards the retirement of our long term Psychiatrist within the County.
We began implementation of our new Electronic Health Record system in July 2016. The implementation included, not only clinical assessments and progress notes but also treatment planning and the use of the client signature into the electronic record. Electronic prescriptions and medication monitoring are also components of this IT system, as well as lab orders and results. We have explored ways to take a next step toward a more integrated health record by attempting to record health conditions and reconcile medication across primary health and health.

CFTN funding that may be used for Capital Facilities was limited and the funds were used for remodeling needs for the newly-purchased Wellness Center in Bishop. These funds were used to meet Americans with Disabilities Act (ADA) requirements and to create a more welcoming environment.

Challenges and Mitigation Efforts

As we have implemented our new product, we have discovered the challenges inherent to the use of a new product including the understanding of the language and terminology for functions that might differ from the previous product. Thus, a request for a report might be called something different in the new product. As we have learned how to access these reports, we can then take advantage of data collected through KV and cut down on the number of reports generated through a "spread sheet" method.

We also continue to explore ways through use of our electronic record, as well as additional "add on products" to find ways to communicate cross systems such as some form of registry where there is not a requirement for duplicate entry.

Finally, we have also continued to explore the ways to further collect and track outcomes in a meaningful way. We see the need to collect a set of cross program measures to more fully tell the story of transformational change across a system of care as opposed to outcomes from a very small program or strategy. In fact, we have been developing our HHS analyst team to look for ways to benchmark community-wide indicators of health and wellness.

Implementation Benchmarks and Delays

- All admissions transferred into Kings View (KV) system: June 2016

- All new admissions, treatment plans and progress notes into KV: July 2016
- New billing out of KV: September 2016
- Use of Electronic signature: January 2017
- Use of reporting functions: increase through the fiscal year and beyond
- Complete all assessments in KV: June 30, 2017

Significant Changes from Previous Fiscal Year

No significant changes, CFTN funds remaining were proposed for continued use in the implementation of the electronic health record as well as to support the purchase of telemedicine equipment.

FY 2016/2017 Mental Health Services Act Annual Update
Funding Summary

County: INYO Date: 5/1/17

	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 2016/2017 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	1,679,308	433,449	86,025	249,620	83,619	
2. Estimated New FY 2016/2017 Funding	1,189,673	297,418	79,312	0	0	0
3. Transfer in FY 2016/2017[a/]	(210,001)				25,000	185,001
4. Access Local Prudent Reserve In FY 2016/2017	0					0
5. Estimated Available Funding for FY 2016/2017	2,658,980	730,867	165,337	249,620	108,619	
B. Estimated FY 2016/2017 MHSA Expenditures	966,731	439,639	165,337	104,060	108,619	
C. Estimated FY 2016/2017 Unspent Fund Balance	1,692,249	291,228	(0)	145,560	0	

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2016	646,441
2. Contributions to the Local Prudent Reserve in FY 2016/2017	185,001
3. Distributions from the Local Prudent Reserve in FY 2016/2017	0
74. Estimated Local Prudent Reserve Balance on June 30, 2016	831,442

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

FY 2016/2017 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: INYO

Date: 5/1/17

	Fiscal Year 2016/2017					
	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
A. Estimated FY 2016/2017 Funding						
1. System Transformation (FSP)	874,974	874,974				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. General System Development (80%)	34,987	34,987				
2. Outreach and Engagement (20%)	8,747	8,747				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	48,023	48,023				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	966,731	966,731	0	0	0	0
FSP Programs as Percent of Total	90.5%					

FY 2016/2017 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: INYO

Date: 5/1/17

	Fiscal Year 2016/2017					
	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
A. Estimated FY 2016/2017 Funding						
1. Older Adult PEI	55,408	55,408				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. PCIT Community Collaboration	71,205	71,205				
12. FIRST	179,921	179,921				
13. Latino Outreach	32,790	32,790				
14. Friendly Visitor	78,476	78,476				
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	21,839	21,839				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	439,639	439,639	0	0	0	0

FY 2016/2017 Mental Health Services Act Annual Update
Innovation (INN) Funding

County: INYO

Date: 5/1/17

	Fiscal Year 2016/2017					
	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
A. Estimated FY 2016/2017 Funding						
1. Community Care Collaborative (CCC)	148,803	148,803				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	16,534	16,534				
Total INN Program Estimated Expenditures	165,337	165,337	0	0	0	0

FY 2016/2017 Mental Health Services Act Annual Update
Workforce Education and Training (WET) Funding

County: INYO

Date: 5/1/17

	Fiscal Year 2016/2017					
	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
A. Estimated FY 2016/2017 Funding						
1. WET Coordination	12,100	12,100				
2. Fundamental Learning Program	43,560	43,560				
3. Consumer Pathways	18,150	18,150				
4. Financial Incentives	30,250	30,250				
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	104,060	104,060	0	0	0	0

FY 2016/2017 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: INYO Date: 5/1/17

	Fiscal Year 2016/2017					
	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
A. Estimated FY 2016/2017 Funding						
1. EHR Implementation	83,619	83,619				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.						
CFTN Programs - Technological Needs Projects						
11. Telemedicine Implementaton	25,000	25,000				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	108,619	108,619	0	0	0	0