Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Inyo

☒ Three-Year Program and Expenditure Plan
☐ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Gail Zwier, Ph.D	Name: Amy Shepherd
Telephone Number: 760-873-6533	Telephone Number: 760-878-0343
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Local Mental Health Mailing Address: 162 J Grove St. Bishop, CA 93514	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue 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 period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

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

Gail Zwier PhD — Local Mental Health Director (PRINT)

[signature] PhD — Signature — 4.3.18 — Date

I hereby certify that for the fiscal year ended June 30, _____, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated _____ for the fiscal year ended June 30,_____. I further certify that for the fiscal year ended June 30,_____, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City 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 if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Christie Martindale — County Auditor Controller / City Financial Officer (PRINT)

[signature] — Signature

7/13/2018 — Date

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

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Inyo

Local Mental Health Director	Program Lead
Name: Gail Zwier Ph.D	Name: Gail Zwier Ph.D
Telephone Number: 760-873-6533	Telephone Number: 760-873-6533
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County Mental Health Mailing Address: 162 J Grove St. Bishop, CA 93514	

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 nonsupplantation 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 4/3/18.

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 annual update are true and correct.

Gail Zwier, PhD
Local Mental Health Director/Designee (PRINT)

Signature

4.3.18
Date

County: Inyo

Date: 4.3.18

Inyo County HHS Behavioral Health

Mental Health Services Act
FY 2017/2018- 2019/2020
Program and Expenditure Plan

Posted For Public Comment

March 2, 2018 – April, 1 2018

The MHSA FY 17/18-19/20 Three-Year Plan and Supplement are available for public review and comment from March 2, 2018 through April 1, 2018. We welcome your feedback via phone, in person, or in writing. Comments may also be made during the Public Hearing to be held on Monday April 2, 2018.

Public Hearing Information:

Monday April 2, 2018, 10:00 am
536 N. Second St. Bishop, Ca 93514

Comments or Questions? Please Contact:

Gail Zwier
MHSA Three-Year Plan Feedback
Inyo County Behavioral Health
162 J Grove St., Bishop Ca 93514
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Thank You!

MHSA COMMUNITY PROGRAM PLANNING

County Demographics and Description

Inyo County contains astounding natural diversity. It includes Owens Valley and parts of Death Valley, and is located between the Sierra Nevada Mountains and the White Mountains along the California/Nevada border. Inyo County offers scenic views and multiple opportunities for outdoor sports enthusiasts in diverse landscapes. Inyo County encompasses both the lowest point in the U.S., Death Valley, and the highest point in the lower 48 states, Mount Whitney. It is the second largest county by area in California with 10,140 square miles; and, with a population of 18,546, Inyo has one of the smallest population densities in the state with only 1.8 persons per square mile. This is a fact that needs to be taken into account where there is any discussion of time/distance requirements for services. It can be termed a "frontier" county reflecting the challenges of being very isolated.

A majority of Inyo County's population identifies as Euro-American, with a significant minority identifying as American Indian. Based on the 2010 census, 66% identify as white alone; 19% identify with Hispanic or Latino origin. Given the Hispanic population, Spanish is a threshold language for service. 13% identify as American Indian; 2% identify as Asian; and less than 1% identify as African American. 4% of people identify with 2 or more races. The federally-recognized Native American nations in Inyo County are the Bishop Paiute Tribe, Big Pine Paiute Tribe of the Owens Valley, Fort Independence Reservation, Lone Pine Paiute Shoshone Reservation, and Timbisha Shoshone Tribe. The Timbisha Shoshone Tribe, located in Death Valley National Park, is the only tribe located inside a national park in the US. The ethnic composition of Inyo County testifies to the rich heritage of Native American tribes in California and the recent history of the colonization of the Western United States. To meet the needs of the Native American population, there is a Federally Qualified Heath Care facility, Toiyabe Indian Health Project, that includes mental health and addiction serves as part of their family service offerings to the American Indian population in Inyo.

The composition of the Inyo population by age according to the same 2010 census is also informative to the planning process. While 5% of the population is under the age of 5 and 21% is under the age of 18; 26% of persons are over 60, with 19% over 65 and 9% over 70. This suggests a planning process with an in-depth look at the needs of older adults who are spread throughout the vast expanse of the County and as such are more vulnerable to isolation and complex challenges to access care. In addition, a "frontier" culture and an accompanying independent nature necessitated an approach that lends well to these factors.

The rural nature and location of Inyo County somewhat limits residents' access to urban centers and to services like healthcare, especially specialized healthcare. Most residents live in the northern area of Inyo County around its main population center, Bishop, and the closest urban area to Bishop is roughly 200 miles away, a 4-hour drive. Transportation is limited to motor vehicles and minimal air service.

Another unique feature of Inyo County is the structure of land ownership. Federal agencies manage 92% of the land. The City of Los Angeles owns 3.9% of the land for the purpose of maintaining water rights. The State of California owns 2.4%, and private landowners own a

mere 1.7% of the land in Inyo County. The configuration of land ownership and management along with other factors influences the economy and restricts the development of the region.

Economic conditions in Inyo County may impose hardships on many families and individuals due to the combination of a high cost of living and limited work availability. Inyo County relies heavily on tourism and government services to support the economy. Many available jobs are in the service industry or are seasonal. It is difficult to find entry level jobs for persons with a disability. The median family income in Inyo County is slightly below the 60% marker of the median family income for California as a whole.

Inyo County also has significant strengths to address the challenges:

- There is a great opportunity for prevention and treatment strategies using the accessibility to diverse outdoor activities.
- There is both the necessity and opportunity to integrate services and work closely with partners to create cross agency systems of care.
- There are "natural helpers" who are highly committed to and invested in the community. While we struggle to attract an adequate number of professionals who want to come to this community, we have an incredible "natural resource" in the persons who are deeply connected to the community and want to raise their families here. These persons often have the necessary basic skills that can be developed into effective service provision.
- There is an opportunity for transformation of the whole system due to the small size and integrated services.

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 2017/18-2019/20 Three-Year Plan built upon the planning process for the previous MHSA Three-Year Plan and the most recent Annual Update. This planning process was comprehensive and included input from over 200 consumers and family members, providers, and community members.

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

We also discuss the MHSA plan as part of our HHS leadership team which includes managers and supervisors from Child Welfare, Senior programs, Employment and Eligibility, Prevention, Public Health, and HHS Administration, as well as Behavioral Health (including Substance Use Disorder services). The MHSA Three-Year Plan was also discussed in partner meetings with the local hospital, schools, and criminal justice entities.

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

With this information, we were able to review the unique needs of our community and make sure that the programs supported through MHSA funds are well designed for our county. The overall goals of MHSA are still valid and provide an excellent guide for maintaining our MHSA services in FY 2017/18 through 2019/20.

Components addressed by the planning process included Community Services and Supports (CSS); Prevention and Early Intervention (PEI); and Workforce Education and Training (WET). In addition, we provided basic education regarding mental health policy; program planning and implementation; monitoring and quality improvement; evaluation; and fiscal and budget components. Of note is the fact that it is difficult to parse out and to clearly discuss the different components of what is seen as an overall plan and system of care. This can be confusing to stakeholders. Inyo County Health and Human Services Behavioral Health Division has worked hard to transform the entire system as opposed to separating out MHSA from "business as usual". When we attempt to address only component programs, we rely on small numbers that do not have statistical significance. We have found it to be more powerful to tell the story as a narrative and an overall system exploration and change. We will continue to look for ways to be able to discuss outcomes in a meaningful way for our community.

The MHSA FY 2017/18-2019/20 Three-Year Plan 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 FY 2017/18-2019/20 Three-Year Plan 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 Three-Year Plan and the strategies to maintain services.

Stakeholder Participation

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

In addition, we used some targeted surveys and key informant interviews as part of the CPP process. Information was obtained in the following ways:

- Underserved Population in SE County: We collected 13 surveys from persons who attended a Community potluck or received an outreach visit in our South East county in in July 2017. The survey results suggest that due to the limited exposure to behavioral health services, there was not a clear knowledge of the services offered. In this community, there was interest expressed in telemedicine services, training in mental health awareness and suicide prevention, and anti-bullying strategies for the schools.

- Mental Health Awareness: To receive general input regarding mental healthcare in our community, we surveyed persons who accessed Social Services, received services from the Rural Health clinic in Bishop, or who attended a school meeting focused on the Latino population. We received 147 completed surveys. The survey looked at whether persons were aware of mental health services and how to access them in our community; whether they had experienced any mental health or substance use disorder symptoms; and what barriers they experienced or concerns they had about receiving services. Approximately two thirds of the respondents were aware of the services with a quarter of the respondents saying that they had received services from Behavioral Health. Half of the respondents reported that they had not experienced any problems related to mental health symptoms while a third experienced moderate symptoms and 12 percent reported severe symptoms. A smaller number of respondents reported difficulties related to substance abuse. Finally, we asked respondents about barriers or concerns about access to services. More than one in three worried about the cost of care although the majority of respondents received Medi-Cal benefits, and this was closely followed by a concern regarding how to access care and how to convince a loved one to receive services.

- School Mental Health and Early Intervention Services: While Behavioral Health provides services in each of the schools within the county, the services focus on youth with severe emotional disturbance and their families. School partners have long expressed a need for early intervention services to fill a gap between the support that can be provided by the school counselors and those services provided by Behavioral Health. While services were provided for several years through statewide PEI funds used to support North Star Counseling Services, there was a need expressed to restructure these services and to work to increase mental health awareness and reduce stigma. Two key informant interviews occurred with the Superintendent of Schools and two interviews occurred with four school counselors. Counseling services were identified as well as the need for training around suicide prevention, LGBTQ issues, and stigma reduction. In addition to these interviews, a survey was sent to school teachers and administrators.

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

LOCAL REVIEW PROCESS

30-Day Posting Period and Circulation Methods

This proposed MHSA FY 2017/18-2019/20 Three-Year Plan has been posted for a 30-day public review and comment period from March 2, 2018-April 1, 2018. 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 Three-Year Plan 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 MHSA FY 2017/18-2019/20 Three-Year Plan is also available to stakeholders upon request.

Public Hearing Information

A public hearing was conducted on April 2, 2018 at 10:00 am at 536 N. Second St., Bishop California, 93514 as a special meeting of the Behavioral Health Advisory Board meeting. There were 20 attendees at the public hearing as follows:
Age:
0-TAY 16-25
18-Adults 26-60
2- Older adults 61+

Ethnicity:
2- Native Americans
1-Hispanic
17-Cuacasian

The attendees offered strong support for the three year plan. Members of the Behavioral Health Advisory Board discussed meeting priority goals of decreasing stigma and addressing the needs of young people through the plan. The Behavioral Health Advisory Board approved the Plan.

Substantive Recommendations and Changes

Input on the MHSA FY 2017/18-2019/20 Three-Year Plan was reviewed prior to submitting to the County Board of Supervisors and the California Mental Health Services Oversight and Accountability Commission (MHSOAC). There were no substantive changes submitted.

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

A. Wellness Centers Strategy

This CSS Program includes comprehensive assessment services; 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. In the last year, we have served 24 adults/older adults who identified as "homeless." Several persons have reported that they had been steered to the wellness centers by the local church, law enforcement, social services, or the hospital. We have also received calls from these partners letting us know about persons they have referred to the wellness center or persons for whom they have concerns. During times of more extreme hot or cold or otherwise inclement weather, persons are especially engaged at the wellness centers. We will often extend the hours of the wellness centers through the lunch hour to make sure that persons have a cool/warm place to be. On occasion, we have linked persons to temporary shelter provided by the Salvation Army. We have also successfully provided targeted outreach to several persons and have engaged with them in the community, even if they are initially unwilling to come even to the wellness centers. Wellness center workers have patiently and persistently provided outreach over time to build trust with persons who have been very distrustful and distressed in their illness. We have become aware of persons with mental illness who have ended up incarcerated often due to a combination of mental illness and substance abuse. We have used the wellness centers as a place to connect as they re-enter the community. 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.

We moved to our 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 has offered 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 location is within the downtown area of Bishop 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 moved to a new wellness center site in Lone Pine in late spring of 2017. 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. We continue to offer cooking and showers 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 (4) beds at Progress House, an Adult Residential Facility. We have used these beds for persons with severe mental illness who are transitioning out of acute care, incarceration or who are homeless. We have provided transition services for four transition age youth/young adults with severe mental illness who had spent time incarcerated in our local jail and have spent time in homelessness. In addition, we have served persons who are living within the community who need a respite due to a mental health crisis. We have been able to keep persons within our community and to assist them to successfully transition back into the community through this strategy. We have provided respite services for at least 15 adults. In addition to mental illness, many of the persons served in this way have evidenced co-occurring addiction issues, may have been veterans or at least spent some time in the military, and/or may have had experienced significant adverse childhood events.

This year, we focused on work/volunteer experience to increase transition readiness. We continued to offer work experience in the provision of reception services at the wellness center sites. At least five persons participated in this work experience. We worked with our partners in the HHS Prevention programs to identify events that needed some volunteer assistance including health fairs, community runs and other community events. In addition, we looked at ways to employ peers to support improvement projects at Progress House and to accompany residents on

medical visits. We continue to look for ways to increase the effectiveness of this strategy through the implementation of recovery principles.

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

We also continue to offer Latino Outreach through both the wellness center sites and within the community. A contracted bilingual therapist, also employed by the schools, provides mental health services to Latino youth and their families. These youth and families may be hesitant to come into the traditional clinic especially if there are immigration issues. The therapist treats anxiety and depression related to trauma issue as well as provides family support. This year, there was an increased need expressed around youth impacted by DACA (or the Dream Act). The contracted therapist has worked to advocate for youth and to provide support services. Approximately 10 youth were served through this CSS strategy along with outreach to at least 50 additional persons.

This year, we are proposing to use a new hired Spanish-speaking Licensed Clinical Social Worker to provide additional services to Spanish-speaking women to address issues of anxiety and trauma. This service will be provided at the wellness center or other community site.

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

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

The following represents our persons served under CSS strategies:

FSPs Ethnicity by Age Group

	Youth (<16 years)	TAY (16-25 years)	Adult (26-59 years)	Older Adult (> 59 years)	Total
Caucasian	1	5	18 (2 veterans)	11 (1 veteran)	35
Native American	0	0	2	0	2
Latino	1	3	1	0	5
Total	2	8	21	11	42

Average Cost per FSP = $23, 053.. It is a combination of intensive services that might include transitional living at Progress House, participation in the Wellness Center array of services, coordination with health care needs and a variety of "whatever it takes" to address behavioral health needs.

Unduplicated Wellness Center Visitors by Age Group

	Youth (<16 years)	TAY (16-25 years)	Adult (26-59 years)	Older Adult (> 59 years)	Total
Bishop	4	33	161	56	254
Lone Pine	0	0	27	1	28

Number of Youth served through Latino Outreach: 15 families received counseling with an additional 50 families receiving some at least one outreach connection. The average cost is $158.31.

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 $3,456.

B. Families Intensive Response Strengthening Team (FIRST)

This year, we are proposing to identify additional youth in need of full service partnership (FSP) within our FIRST program. As part of our overall ICHHS Children's System of Care, the FIRST program employs a wraparound model in working with families with youth at risk of placement in a high level of out of home placement as well as families in need of intensive services as a means of building protective factors. This approach allowed us to include an intervention strategy for our work with "at risk" families and we are able to strengthen these families using a child/family team model. We hired a supervisor who had worked extensively in a drug court program who could lead the team encouraging home-based support. We also employ a Parent Partner, a Social worker and two HHS Specialists. We also pull in resources from the First Five program as well as other agencies to intensively support the families. As the result of this expansion, we have served families with younger children. We are continuing to look for ways to expand the successful wraparound and home-based services as we plan to more fully implement the Continuum of Care Reform. We are proposing to identify youth with emotional

disturbance as full service partners in order to provide "whatever it takes" to strengthen the family and to meet family goals.

Challenges and Mitigation Efforts

This was our third full year at the Wellness Center site in Bishop. We continue to have a group of Transition Age adults, some of them who are homeless or are "couch surfing", who access the Wellness Center. Several of these young adults have substance use disorders, often as a result of childhood trauma and abuse. A number of these persons have been incarcerated due to this substance abuse. We continue to struggle to address these persons with co-occurring mental illness and substance abuse. While often mandated by the Court to participate in counseling services, both substance abuse and mental health, these young adults may have difficulty engaging in "talk therapy". We continue to be welcoming and try to engage the young adults in harm reduction strategies while maintaining a safe and welcoming environment for all participants. We are proposing to explore the use of a neurofeedback/ brain training intervention through a contract with a local provider. We will test the use of this strategy with a select group from this population as well as a select number of adult consumers who have evidenced severe mental illness.

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

Significant Changes from Previous Fiscal Year

The changes that we are proposing in the CSS plan are 1) to increase the number of youth FSPs through identification from the FIRST program as well as from our Child and Family team; and 2) adding a provider of neurofeedback to test with select transition age youth and adults.

We continue to work 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; addressing the challenges related to treating dual-diagnosis clients, especially TAY; and focusing on adults with homelessness and employment issues.

PREVENTION AND EARLY INTERVENTION

Prevention Programs

PEI Prevention Program Descriptions and Outcomes

A. 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 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 48 older adults. This results in a cost of $567.63 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.

B. 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. The meal delivery staff identify seniors who evidence symptoms of depression and/or anxiety and who might benefit from a visitor. The visitor, who may also be a senior, develops a plan with the senior to address the depression and prevent further exacerbation of symptoms.
The program has provided services to 17 seniors at a cost of approximately $360.18. The average initial score on the PHQ9 was 11 with a range of 4 (very mild) to 23 (very severe) with four persons falling in this category. Five participants reported daily thoughts of "being better off dead". A majority of the participants (>75%) reported moderate to severe pain symptoms. The categories where persons reported the most daily difficulty were in "feeling tired" and "trouble with sleep". While there continue to be difficulty in obtaining "post" PHQ9s, participants surveyed report a high degree of satisfaction with the FV and a decrease in feelings of depression.

Challenges and Mitigation Efforts

We continue to struggle with having adequate nursing coverage as well as experiencing other staff turnover in Adult Social Services and the Aging program. This staffing issue 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

During the next three-year plan, we propose to add a prevention strategy targeted to youth. Health and Human Services Public Health and Prevention Division has provided prevention services for youth using braided funding from Substance Use Disorder funds, Tobacco Control funds, Women Infants Children (WIC) and various Child Abuse prevention services. In the last year, the Prevention team has expanded its mentoring program as well its use of outdoor programs to build protective factors. This year, we are proposing to expand the outdoor program to include youth who have been exposed to a high number of Adverse Childhood Experiences (high ACES scores). The correlation between high ACES scores and mental health symptoms and risk for substance use disorders has been well-documented. The use of this strategy will be proposed for the FY 18/19 and 19/20 updates to the MHSA PEI Plan.

PREVENTION AND EARLY INTERVENTION

Early Intervention Programs

PEI Early Intervention Program Descriptions and Outcomes

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

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

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

PCIT is a highly effective program and the families show improved outcomes because of this intensive parenting program. In addition, the children and their siblings show improved behavior (positive social interactions, following directions, reduction in acting out behavior) as a result of the program. We have served seven additional families with this intervention. The approximate cost per family served under PCIT is $5731.

Due to the retirement of the certified trainer for PCIT in May, 2017 and the turnover of an additional therapist, we have been concerned regarding our ability to continue with a PCIT strategy. We are proposing to hire the retired annuitant in the specific role of providing PCIT training and supervision to our Child and Family staff as well as interested partners. We are also proposing to identify mobile technology for use of PCIT in community and/or home settings.

B. Families Intensive Response Strengthening Team (FIRST)

As part of our HHS children's system of care, the FIRST program employs a wraparound model in working with families with youth at risk of placement in a high level of out of home placement as well as families in need of intensive services as a means of building protective factors. This approach allowed us to include an intervention strategy for our work with "at risk" families and we are able to strengthen these families using a child/family team model. We hired a supervisor who had worked extensively in a drug court program who could lead the team encouraging home-based support. We also employ a Parent Partner, a Social worker and two HHS Specialists. We also pull in resources from the First Five program as well as other agencies

to intensively support the families. As the result of this expansion, we have served families with younger children. We are continuing to look for ways to expand the successful wraparound and home-based services as we plan to more fully implement the Continuum of Care Reform.

In 2016/2017, we served nine families for a total of 27 family members served. The MHSA portion of the costs was $119,805 for an approximate cost of $13,333 per family. Of the nine families served: one family graduated, six families continued in the program, one family withdrew and one family's child voluntarily went to a higher level of care. We are have implemented pre/post assessment measures using the National 5 Protective Factors measure.

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. As proposed above, we will hire our previously certified trainer in PCIT to provide training and supervision in PCIT to interns and HHS Specialists as well as persons in the FIRST program and others from partner agencies. This will be used to mitigate the loss of the strategy due to staff turnover. In addition, we will address the need for school-based early intervention services through the support of the North Star Counseling Center. This will allow them to hire an additional intern to provide early intervention services such as one to one and group counseling as well as presentations on topics to create increased mental health awareness and decrease stigma.

Significant Changes from Previous Fiscal Year

The following changes from the previous plan are proposed: 1) We will hire a retired annuitant to provide training and supervision in PCIT in order to continue this strategy within our community. 2) We will fund additional school-based services by providing funding support to North Star Counseling.

PREVENTION AND EARLY INTERVENTION

Suicide Prevention Programs

PEI Suicide Prevention Program Description and Outcomes

ICHHS-BH has participated in funding statewide suicide prevention efforts through CalMHSA. In addition, our Program Chief who has expertise in suicide prevention and crisis intervention has provided crisis intervention training in the County jail, the Juvenile facility and with the schools as well as providing ongoing training to staff in behavioral health.

Significant Changes from Previous Fiscal Year

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

PREVENTION AND EARLY INTERVENTION

Outreach Programs

PEI Outreach Program Description and Outcomes

ICHHS-BH has participated in funding statewide outreach efforts through CalMHSA. In addition, we have provided four Mental Health First Aid (MHFA) classes, including one class in the southeastern part of the County to community members. We have trained an additional 35 community members in MHFA.

Significant Changes from Previous Fiscal Year

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

PREVENTION AND EARLY INTERVENTION

Stigma Reduction Programs

PEI Stigma Reduction Program Description and Outcomes

ICHHS-BH has participated in funding statewide stigma reduction through CalMHSA for events such as Directing Change and Each Mind Matters. In addition, we have addressed issues of stigma through consumer participation as volunteers in community events such as health fairs, "trunk or treat" and fun runs. Additionally, Wellness Center visitors and Progress House residents have organized and participated in food drives for the local food banks. We held two kite-flying events during Mental Health Awareness month in 2017.

Significant Changes from Previous Fiscal Year

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

INNOVATION
Community Care Collaborative

Innovation Program Description and Outcomes

Community Care Collaboration Project

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

The Innovation Project funding supported the development of a CCC Team by partially funding one full-time Behavioral Health Nurse position (1.0 FTE) to coordinate and integrate health and wellness activities for behavioral health clients and partially funding a one full-time Administrative Analyst position to collect, track, and analyze outcome data based on a quality improvement model. While all new consumers entering services assisted to link with a primary care physician, the target population is now behavioral health consumers with serious health conditions who are also enrolled and receiving services at the Northern Inyo Hospital Rural Health Clinic (NIHRHC). We currently coordinate care for 80 individuals to improve health outcomes.

The Coordinated Care Collaborative addressed the following:

- Identifies individuals who do not have an identified primary care physician, or routinely use primary care services, and links them to the appropriate provider/health clinic/healer/alternative health care in the community. It is now part of our admission process to assess whether each person has a primary care physician and to link that person with care if it is not in place. As a result of these efforts, nearly all admitted persons have primary care services.

- Collecting basic health information, including lab work, on individuals to help understand each person's current health indicators. Staff work with the individual to understand their health indicators (e.g., height, weight, body mass index, A1c and other risks for diabetes, carbon monoxide monitor results, hypertension/blood pressure, cholesterol, and lung functioning). These health indicators are used to inform both the individual and staff on high risk health factors, and allow them to work together with the health clinic to identify goals on improving their health and wellness.

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

providers. We continue to look for more streamlined ways to communicate.

- Clients and staff work together to develop health and wellness activities to support clients to improve their health. These activities include developing walking groups, nutrition and cooking groups, and mindfulness. There is also a smoking cessation group offered at the Bishop Wellness Center. Wellness information is also offered to CCC clients, to provide support and information to help individuals make healthy choices. These activities help the team provide supportive services which will lead to positive outcomes.

- Peer Support has been recognized to be an important component of the coordinated care approach. We have trained peer supporters to assist with health goals and to accompany consumers to medical appointments to provide support and another "listening ear."

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

In the last year the Coordinated Care project has continued to be spread to the jail/re-entry population. As part of the Stepping Up Initiative, we are aware of the persons with a mental health condition within our jail. We serve persons in the jail who evidence mental health conditions as well as health conditions. We track all persons who are receiving psychotropic medication to treat a mental health condition or who have been identified as needing this type of treatment. Our tracking of the number of persons on psychotropic medication proportionate to the total number of inmate population suggests that 25%-34% of inmates have a mental health condition, often in conjunction with a substance use disorder. Approximately 50-70 unduplicated persons received this service per year.

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

A majority of persons in this population have co-occurring substance abuse disorders and several of these persons have health conditions as a result. Most of the persons in this population have not received any consistent primary care or behavioral health treatment. The goal of this coordination is not only to treat and stabilize mental health and health conditions during incarceration but also to support the continued treatment during re-entry back into the community. In FY 16/17, 43 inmates on psychotropic medication were released back into the community. The Corrections Nurse provided medication to the inmates upon release or made arrangements for persons to connect with Behavioral Health for ongoing services and/or to their primary care physician for treatment of ongoing medical conditions. In FY 16/17, four persons with severe mental health symptoms accessed transition services at Progress House. During FY 17/18, a more formalized tracking system is being set up to track coordination efforts.

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, including with the administrative analysts. It is difficult to maintain the medication reconciliation and tracking of costs and outcomes. The behavioral health nurses are also pulled in many directions and struggle to keep up with the medication reconciliation as well during vacancies or absences. 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 project. This Innovation project will expire at the end of FY 2018/2019. ICHHS-BH will develop a new Innovation project at that time.

WORKFORCE EDUCATION AND TRAINING

WET Program Descriptions and Outcomes

A. 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 that includes the Social Services and Aging Division and the Public Health and Prevention Division. Partner agencies such as Probation and Toiyabe Indian Health Plan are also trained. Training topics include a broad range of family engagement, 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.

B. 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.

In FY 17/18, ICHHS-BH will form a Strengths Model Learning Collaborative with Alpine and Mono counties. This collaborative is a fundamental learning program using an innovative regional approach. It is a fundamental learning program in that it builds skills in keeping with the recovery principles as described below.

Strengths Model Overview: "The University of Kansas School of Social Welfare developed the Strengths Model in the mid1980s as a response to traditional deficit-oriented approaches in mental health. The Strengths Model is both a philosophy of practice and a set of tools and methods designed to enhance recovery. While the tools of the model (i.e. Strengths Assessments and Personal Recovery Plans) are used primarily by community-based direct service workers (e.g. case manager, care manager, care coordinator, community health worker, etc.), the principles of the model have agency-wide application.

The Strengths Model rests on six core principles [that provide both a philosophical base as well as day-to-day guidance for tasks and goals] (Rapp & Goscha, 2012):

- "Principle # 1: People with psychiatric disabilities can recover, reclaim and transform their lives;

- Principle #2: The focus is on an individual's strengths rather than deficits;
- Principle #3: The community is viewed as an oasis of resources;
- Principle #4: The client is the director of the helping process;
- Principle #5: The relationship is primary and essential; and
- Principle #6: The primary setting for our work is in the community."

The Strengths Model is also the curriculum that will be used to train staff. Learning sessions will be focused on recovery goals, engagement, and strengths assessment; group supervision and building recovery-oriented treatment plans from the strengths assessment; developing the personal recovery plan; and naturally-occurring resources and supporting independence from the system. This model is proven to improve outcomes in the areas of housing, employment, education, and increased community involvement. In Inyo County, our participation will include members of the adult services team including all Wellness Center staff, the three adult services clinicians, the Progress House Manager and the Nurse Supervisor as well as representation from the Outcomes and Evaluation team. While we would like to spread this training to our entire team, we are starting with 12 key staff to ensure fidelity to the model. It is our goal to "institutionalize this knowledge to result in spread to training the entire BH team as well as partners to utilize this model. We are implementing fidelity measures from the beginning and will be closely monitoring for system improvement.

What makes the Eastern Sierra Learning Collaborative innovative is the fact that the identification of needs and the planning and implementation of the Collaborative has all been county-driven and that it will also invite community partners to the learning sessions. The development of this Collaborative has been a regional grassroots effort; where other trainings may be grassroots, they are likely not regional and where they are regional, they are rarely grassroots.

As a result of this Innovation project, Inyo, Mono, and Alpine Counties will all have a common need met through a Collaborative that is specifically adapted to the remote, rural environment and includes both systems change and clinical change elements. Moreover, this Innovation project serves as a learning opportunity for how counties can improve their collaborative work and leverage resources to meet common county-identified needs. Finally, it serves as a way to learn more about working with other community partners and developing a common approach to serving clients across organizational boundaries.

In addition to the Strengths Collaborative described above, it is important to identify the strengths of the entire Behavioral Health team, including all front office and support staff as well as all program staff (including those who may not be directly involved in the Strengths Collaborative). We will be assessing team strengths through the Strengths Finder and will conduct a training opportunity and facilitated conversation with the Behavioral Health Director from Alpine County. In this way, we can further identify the strengths of our team and find ways to build on these strengths even as we work with consumers to build on their strengths. The strengths identified will further be used to create professional growth goals for employees. This is an excellent way to "grow" our workforce.

In FY 17/18, ICHHS-BH will also provide Crisis Intervention Training (CIT) for Law Enforcement partners, First Responders, and BH staff. We have long identified the need to increase skills of all first responders who respond to mental health crises. While we do not have the capacity to provide a separate crisis response team, it is important to increase skills and

awareness for all of the team. We will partner with Mono County to offer training to law enforcement including Sheriffs, Bishop Police Department and California Highway Patrol as well as Behavioral Health staff and all other interested partners.

C. 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. We offered two entry level temporary positions for persons with lived experience. One person provided general oversight of several Wellness Center activities both in Bishop and in Lone Pine. He also provided assistance with transport and support of medical appointment. Another person worked out of Progress House and provided assistance with improvement projects including painting and general repair. This year we are proposing to take these positions and make them permanent positions as HHS Specialists.

D. Financial Incentive Program

We participate in the Statewide 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.

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 have retired and we have been unable to recruit replacements. 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. Two of the interns have completed their hours and have become licensed clinical social workers. One of these recently licensed persons went to work in our local hospital and one moved to a position with the school. One of the other two has completed hours and will be preparing to take the licensure exam, the other will complete in the next year. We are proposing to add at least one intern in the next year and will explore a continued contract with a distance provider in future years if the need exists.

Finally, we are challenged to provide psychiatry services. While we currently have an excellent experienced "in person" psychiatrist, she is moving toward retirement. As with many other counties, we will move forward with tele-psychiatry to at least partially address the shortage in

psychiatry. We propose to look for incentives to attract another in-person psychiatrist, will work with partners in the area for a possible shared position, and will consider the use of a "head hunter" to assist with recruitment.

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

In FY 17/18, ICHHS-BH will form a Strengths Model Learning Collaborative with Alpine and Mono counties. Please see above description.

In FY 17/18, ICHHS-BH will provide CIT training in partnership with Mono County.

CAPITAL FACILITIES/TECHNOLOGY

Capital Facilities and Technology Projects

Capital Facilities funding was used for remodeling needs for the newly-purchased wellness center in Bishop. These funds helped to upgrade the facility to meet Americans with Disabilities Act (ADA) requirements and to create a more welcoming environment.

ICHHS-BH chose to utilize the bulk of CFTN funding for a system-wide IT upgrade to achieve an Integrated Information Systems Infrastructure. We began implementation of our new Cerner/ Kings View (KV) 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. Use of the Kings View product also positioned us to move forward on needed telemedicine services as we look towards the retirement of our long-term Psychiatrist within the County. We have implemented telemedicine for a block of four hours per week as we transition to this modality. In FY 17/18 we will be expanding telemedicine and teleconferencing capabilities to the jail and to the outlying communities. We will also use teleconferencing for participation in the Learning Collaborative as well as to access webinars and other training opportunities.

Challenges and Mitigation Efforts

As we have implemented our new electronic health record product, we 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. In addition, we have found that there is less direct access to raw data than was found in our last product. However, we are now able to receive reports on demographics, penetration rates and productivity through a report generated out of the system. This cuts down on the number of "excel spreadsheets" used to track basic data. It remains clear that the current product is a rather complex billing system and takes a very large investment of staff time to navigate. We will 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. We continue to explore ways to include outcomes data as part of our record. In FY 17/18, we will add the Milestones of Recovery (MORS) to our record as well as the mandated Child and Adolescent Needs and Strengths (CANS) and other measures. As an HHS Department of which Behavioral Health is a division, it is our ongoing goal to develop our HHS Outcomes and Evaluation team to look for ways to benchmark community-wide indicators of health and wellness.

Implementation Benchmarks and Delays

- All admissions transferred into KV system: June 2016
- All new admissions, treatment plans and progress notes into KV: July 2016
- New billing out of KV: September 2016
- Completed all assessments in KV: June 30, 2017
- Use of Electronic signature: implemented for all intakes: Delayed to September 2017, still in process for treatment plans.
- Use of reporting functions: increase through the fiscal year and beyond.

Significant Changes from Previous Fiscal Year

The CFTN funds have been fully expended.