



TUOLUMNE COUNTY BEHAVIORAL HEALTH
MENTAL HEALTH SERVICES ACT (MHSA):
ANNUAL UPDATE FY 2016 - 2017



WELLNESS • RECOVERY • RESILIENCE

Draft Posted for Public Review & Comment Period from Friday
November 4, 2016 through 5:00PM Monday December 5, 2016

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MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION¹

County/City : Tuolumne County

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

<p style="text-align: center;">Local Mental Health Director</p> <p>Name: Rita Austin, LCSW</p> <p>Telephone Number: (209) 533-6265</p> <p>E-Mail: laustin@co.tuolumne.ca.us</p>	<p style="text-align: center;">County Auditor-Controller/City Financial Officer</p> <p>Name: Deborah Bautista</p> <p>Telephone Number: (209) 533-5551</p> <p>E-Mail: dbautista@co.tuolumne.ca.us</p>
<p>Local Mental Health Mailing Address:</p> <p>2 South Green Street, Sonora, CA 95370</p>	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report, or Update to the Annual Plan, 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 other counties in future years.

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

Rita Austin, LCSW
Local Mental Health Director (PRINT)

Signature **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 MHSAs distributions were recorded as

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION¹

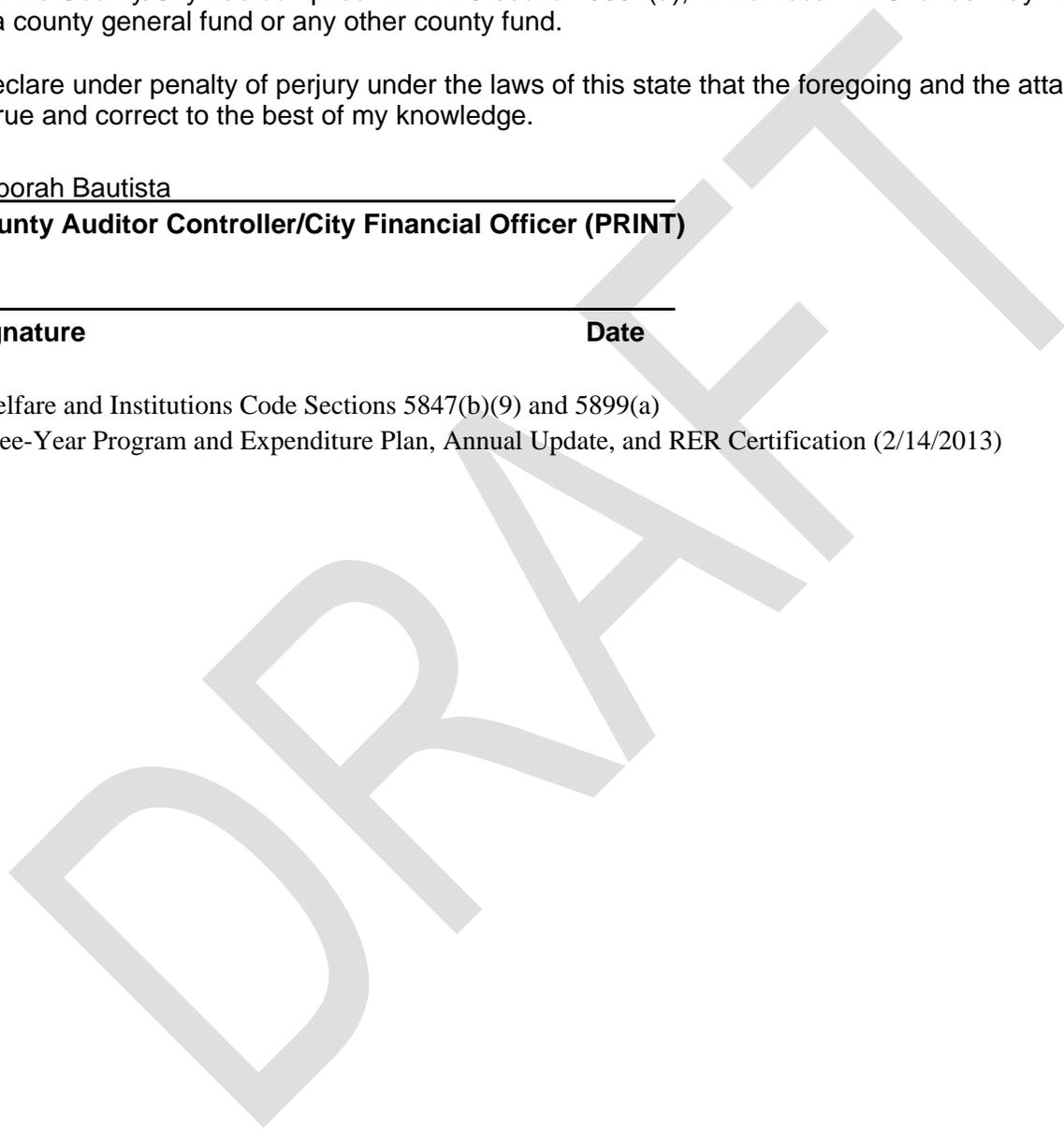
revenues in the local MHS Fund; that County/City MHSAs expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Deborah Bautista
County Auditor Controller/City Financial Officer (PRINT)

Signature **Date**

¹Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (2/14/2013)



Introduction:

In November, 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA) which became law on January 1, 2005. The Act imposed one percent taxation on individual income exceeding \$1 million. The MHSA is a unified, statewide initiative to provide improved care for individuals living with a mental illness and to outline a methodology to the plan of care and delivery of mental health services. All services were determined to be provided within a set of MHSA core values.

Annual Update Requirements:

The intent of the MHSA Annual Update is to provide the public a projection for Fiscal Year 2016/2017 regarding each of the components within MHSA. In accordance with MHSA regulations, County Mental Health Departments are required to submit a program and expenditure plan and update it on an annual basis, based on the estimates provided by the state and in accordance with established stakeholder engagement and planning requirements (Welfare & Institutions Code, Section 5847). This update provides a progress report of TCBH MHSA activities from Fiscal Years 2014/2015 and 2015/2016 as well as an overview of current or proposed MHSA programs planned for Fiscal Year 2016/2017.

Tuolumne County Background:



Tuolumne County, with a population of 53,709, is located in the central Sierra Nevada, roughly 95 miles South of Sacramento and approximately 135 miles East of San Francisco. The county stretches from the Central Valley in the West to the Eastern crest of the Sierra Nevada Mountains. The county includes the Northern portion of Yosemite National Park, has a total of 2,221 square miles, and the elevation ranges from 300 feet to more than 12,000 feet.

County Demographics:

- 80.8 % Caucasian
- 11.8% Hispanic/Latino
- 3.5% Reporting 2 or More Races/Ethnicities
- 2.0% African American
- 2.3% American Indian
- 1.3% Asian
- 0.2% Pacific Islander
- 24.2% Over 65 Years Old
- 5,268 Veterans
- 69.3% Homeownership Rate
- \$48,493 Median Household Income, 2010-2014
- 14.3% Live Below Poverty Level

County Challenges:

- Tuolumne County has a federal designation as a Mental Health Professional Shortage Area (MHPSA). MHPSA's are noted to have a shortage of clinical psychologists, clinical social workers, psychiatric nurse specialists, marriage and family therapists, and/or psychiatrists.
- Remote areas face transportation challenges, leading to increased isolation for residents.
- Increased potential for stigma and delay in seeking mental health services due to rural location.
- Tuolumne County has a higher concentration of persons aged 65 and older (Increase of 2% from 2014 to 2015 census estimates).
- Factors that adversely affect low income residents living in Tuolumne County include lack of affordable housing, food insecurity, and limited availability of affordable medical and dental services.

Sources: 2015 Tuolumne County QuickFacts from US Census Bureau

Community Planning Process

The Community Planning Process (CPP) to develop the MHSA FY 2016/2017 Annual Update uses the MHSA Three-Year Program & Expenditure Plan FY 2014 – 2017, as well as all past plans and annual updates, as a foundation. Over the past several years, the planning process has been comprehensive and has included diverse stakeholder input through surveys, meetings and focus groups. The CPP for this update began in February, 2016 with internal discussions amongst TCBHD staff. With cross-functional representation from internal groups, current plans and existing programs were reviewed and data from the last CPP process was considered. Stakeholders who have consistently participated in the CPP include:

- Tuolumne County Mental Health Advisory Board
- Enrichment Center staff and peers
- Tuolumne County Behavioral Health Staff
- Tuolumne County Superintendent of Schools, as well as individual district school staff and counselors
- California Highway Patrol
- Community agencies such as Amador Tuolumne Community Action Agency; Catholic Charities and Center for A Non-Violent Community
- Tuolumne County Probation Department

Using information from previous plans, TCBHD determined that the current MHSA programs and services were on track. Comprehensive stakeholder feedback is planned for the MHSA Three-Year Program & Expenditure Plan FY 2017 – 2020. Surveys, focus groups, key informant interviews and other data collection are being planned to thoroughly review current and proposed MHSA offerings to ensure that the mental health and wellness needs of Tuolumne County residents are being met.

30-Day Review Process:

A draft of the MHSA Annual Update FY2016-2017 is being posted for a public review and comment period of 30 days starting Friday November 4, 2016 through Monday, December 5, 2016 at 5:00pm. To

review the plan, and other MHSA documents, follow this link to Tuolumne County Network of Care website:

<http://tuolumne.networkofcare.org/mh/content.aspx?id=353>

The MHSA Annual Update FY2016-2017 will also be announced and made available for public review via the following methods:

- Printed copies will be available:
 - i. Main branch of Tuolumne County Library, 480 Greenley Road, Sonora
 - ii. Tuolumne County Behavioral Health, 105 Hospital Rd, Sonora
 - iii. Tuolumne County Board of Supervisors Chambers, 2 South Green St, Sonora
 - iv. The David Lambert Center, 347 W. Jackson St, Sonora
 - v. Tuolumne County Enrichment Center, 101 Hospital Rd, Sonora
- Legal notice to be submitted to the local newspaper regarding the availability of the Annual Update and the date of Public Hearing

Interested persons may provide written comments during this public comment period. Comments can be submitted to:

Tuolumne County Behavioral Health Department

Attn: Kristi Conforti, MHSA Coordinator
2 South Green St
Sonora, CA 95370
209-533-6262

kconforti@co.tuolumne.ca.us

Public Hearing

As per Welfare and Institutions Code (WIC) Section 5848, the Tuolumne County Mental Health Board will conduct a Public Hearing at the close of the 30 day comment period for the purpose of receiving further public comment on the MHSA Annual Update FY2016-2017. The Public Hearing will be held on December 7, 2016 at 4:00 pm at the Tuolumne County Behavioral Health Department located at 105 Hospital Road, Sonora, CA in the Community Conference Room. Once held, any comments received from the public hearing will be reviewed and added to the public comments section of this document. (See Attachment: *Public Hearing Announcement*)

Review and Approval by the Board of Supervisors

As required by Welfare and Institutions Code Section 5847, the final plan and budget will be reviewed for approval by the Tuolumne County Board of Supervisors, currently scheduled for Tuesday, December 20, 2016.

MHSA PROGRESS REPORT BY COMPONENT:

Following are Tuolumne County Behavioral Health Department's progress reports by component: Community Support Services (CSS), Prevention and Early Intervention (PEI), Workforce Education and Training (WET), Innovation (INN), and Capital Facilities and Technological Needs (CF/TN). Progress reports for MHSA Housing and SB82, Mental Health Triage, are also included.

Note: This plan includes estimates of cost per client for the CSS and PEI program components for 2014/2015 and 2015/2016 as per Welfare & Institutions Code 5847. The cost per client numbers are estimated with the following clarification: These are an approximation only and should not be utilized for any benchmark for services provided or as any minimum or maximum amounts to be spent. These numbers can be affected by a variety of factors including but not limited to: salaries of staff delivering services, established case rates, other insurance billing, variable cost of living and other program expenses. In a very general way, one may draw the conclusion that some services are more costly; for example, an FSP client who is receiving intensive individual services, and receiving assistance with housing and other expenses will reflect a significantly higher cost than a client who attends groups at the Enrichment Center. Also, outreach services through PEI are intended to potentially engage a client in community programs and services and may not include behavioral health. These amounts are provided for provided for informational purposes only.

Community Support Services (CSS)

Community Support Services (CSS) supports efforts to provide Outreach and Engagement, System Development and Full Service Partnership (FSP). Outreach and Engagement and System Development services refer to activities that utilize a recovery and resiliency model that centers around the consumer, and targets un-served and under-served severely mentally ill residents. The Full Service Partnership program is voluntary and provides a broad range of supports to accelerate client recovery.

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. For FY 16/17 a transfer of \$100,000 will be moved from CSS to Prudent Reserve.

CSS supports have become key in TCBHD's effort to maintain recovery of clients within the community. Since the implementation of MHSA, Lanterman Petris Short (LPS) conservatorships have been reduced by 50%. There are currently 17 LPS clients compared 32 in 2008. This is attributed to CSS programs and services including FSP. Pilot programs funded through alternative sources are uncovering a growing need for FSP services. The SOAR Collaborative program (see page 12), has identified numerous clients on early release from incarceration that require CSS services. These developments are in coordination with an increased partnership with Probation and law enforcement agencies with the goal to consider becoming a Stepping Up county and utilizing intervention strategies such as the Sequential Intercept Model.

Given these systems changes and growth, TCBHD has identified a need for MHSA clinical management and program outcome oversight. Reorganizing programs to fully optimize utilization and

systems coordination in the clinical arena are crucial to program successes and improved community services. New for FY 16/17 is the addition of a clinical program supervision position to oversee all CSS outcome driven services. This position will provide clinical program direction and recommendations associated with responses to outcome data analysis of FSP clients as well as other CSS services to evaluate success of programs. There will also be a coordination and development of staff to work with more resistant and challenging populations such as those exposed to intensive judicial experiences. Further work in the support of skills development and utilization of Peer Specialists in the treatment team and in community integration is also planned.

New for CSS in FY 16/17 is a community outreach program which places a Behavioral Health Clinician in the community working with various community agencies, other county departments. Partners in this program include Tuolumne County Public Health and Jamestown Family Resource Center (JFRC). The clinician is available on-site a Public Health to provide support to PH clients who are experiencing a crisis type situation. Other supports provided include:

- Enhanced “Home” visiting: Known as *Bright Beginnings*, this outreach activity focuses on families with children 0-5 living in the home. The clinician works with parents to provide brief intervention supports, mental health education information, developmental assessments/screenings, and referrals and linkages.
- Education Groups & Supports: Support groups offered at JFRC to help youth to work with emotions including: *Beating the Blues – How to manage feelings of sadness* and *Stay Focused - coping with distraction & high energy*.
- Parent Education: Research with stakeholders in the community showed 59% of parents surveyed were interested in learning more about *Effective and Positive Discipline*. Based on that feedback, a course outline is being developed and this will be the first series in several to help parents in the community

Full Service Partnerships (FSP)

The Tuolumne County Full Service Partnership (FSP) was designed for individuals requiring the highest level of care and service necessary to avoid the potential of more restrictive care. The program provides comprehensive, one on one mental health services for those who have been diagnosed with a severe mental illness. Clients are referred from various sources and, if they meet criteria, are assigned to a specific FSP Case Manager. Criteria for FSP are: Homeless or at risk of homelessness; Diagnosed with a serious mental illness; Recent hospitalization or emergency intervention; Receiving public mental health services; Willingness to partner in the program. The FSP program fosters client driven services and supports by promoting a team approach and partnership between the client, the provider and the client’s family if possible. Specific to the FSP program are: a low staff to client ratio, 24/7 crisis access and intensive and individualized supports. FSP clients may receive assistance with housing, employment, food and education in addition to access to mental health services as well as integrated treatment for those living with more than one diagnosed condition.

In FY 14/15 a total of 48 individuals were enrolled in and received FSP services with an estimated annual cost per client at approximately \$10,220.

A total of 60 clients received FSP services in some capacity in FY 15/16 with an estimated annual cost per client of approximately \$8,176. This reduction in cost may be attributable to the effective use of the Peer Specialist team members which were assigned in FY 15/16 to work more directly with the treatment and case management team to support clients.

A key improvement in the FSP program has been the increase in the number of children and TAY clients supported through FSP services. In FY 14/15, we did not have any data for these age categories and in FY 15/16 we reported 16% of FSP clients fall into the 0 to 24 age range.

TCBHD is currently not able to report on all quality of life indicators as a systems challenge has been identified. Training and monitoring changes are underway to assure the check/balance on completing the required Partnership Assessment Form (PAF), Key Event Tracking (KET), and 3M forms are finalized.

Challenges:

One challenge encountered during the past year was the absence of one of the Full Time FSP Case Managers due to serious illness. This had an impact on the FSP team, and there were some adjustments made to how staffing was handled during this time.

Changes and Improvements:

New for FY 16/17 is the addition of two FSP Peer Specialists and one part-time FSP Case Manager. Based on increasing field services and demands, the program will be funding the purchase of 2 new vehicles to support additional staff and clients in the program as well as a new transport van to bring groups of clients to the Enrichment Center, and to other scheduled recreational activities. TCBHD is also considering the lease or rental of residential housing units to provide much needed affordable housing to FSP clients with limited income.

To model new approaches and maximize MHSA supports grant funding was received from Centene Foundation for Quality Healthcare. In February, 2016 California Institute for Behavioral Health Services (CIBHS) acted as the primary for the grant and partnered with TCBHD, Tuolumne County Probation Department, Tuolumne County Sheriff/Jail, Amador Tuolumne Community Action Agency (ATCAA) and Behavioral Interventions (BI) to address the issue of improving healthcare in rural communities. The Tuolumne County SOAR Collaborative (TSC) was developed to target individuals coming out of incarceration or hospitalization and assist them in procuring social security, disability benefits. Transitional housing is also available through the grant. MHSA is providing in-kind contributions via a part time Peer Specialist dedicated to assisting clients in applying for benefits, and supervisory support from the MHSA Programs Coordinator. The SOAR program has helped to address the influx of new clients coming into the MHSA Benefits and Resource Coordinator due to AB109 and early release from incarceration. This has been the foundation for supporting ongoing efforts for this unique population. Following the TSC lead, a new focus in FY 16/17 is that of FSP Case Management supports targeted to serve persons with mental illness involved in the criminal justice system and/or being released from incarceration. A dedicated Case Manager and Peer Specialist will work as a subset of the current FSP program to address the needs of clients who are part of AB109, on probation, Incompetent to Stand Trial (IST) or have a criminal justice history that is impacting their recovery success. This new facet of the FSP program will support sustainability of the successful implementation of the TSC SOAR program.

Peer Support Services

TCBHD encourages wellness and recovery by providing peer supported environments for clients to learn from others who have experience living with a mental illness. Peer-run environments stimulate socialization, encourage wellness and recovery and provide an atmosphere that fosters independent

functioning. Two such programs, the Enrichment Center and the David Lambert Center are supported through MHSA.

The Enrichment Center (EC) helps peers to build coping skills and encourages activities for mental and physical wellness. There are numerous support groups that are all facilitated by peer volunteers: Mental Health and Addictions; Bipolar and Depression; Peers Helping Peers; Working with Emotions; and Trauma Recovery/Post Traumatic Stress Disorder (PTSD). Each of these groups hosts an average of 2 to 8 participants. (See Attachment: Enrichment Center Calendar of Events). In addition to group support, the center allows peers a safe and comfortable place for socialization, as well as access to computers, printers, laundry and shower facilities and direct contact to FSP case managers. New programs and activities introduced in FY 16/17 include peer support groups for the following: Eating Disorder; Homeless; 180 Group to support those coming out of incarceration; and the College Readiness to support peers going through the Psychosocial Rehabilitation Certification at Columbia College. Attendance growth at the EC can be attributed to increased promotional efforts, as well as the Affordable Care Act, Medi-Cal expansion and an updated reporting and tracking system for peer visitors.

In FY 14/15, the Enrichment Center served an average of 194 unduplicated clients per quarter for an estimated annual cost of \$187 per person.

In FY 15/16, the Enrichment Center served an average of 270 unduplicated clients per quarter for an estimated annual cost of \$191 per person.

The Lambert Center is a community drop in center that caters to homeless individuals and is staffed completely by volunteers, some with lived experience. The center focuses on outreach to the homeless population by offering food and basic necessities as well as a place for socialization and emotional support. Guests have access to computers and printers and they are provided with referrals to various resources if they are in need of services.

The David Lambert Center saw an average of 213 unduplicated visits per quarter in FY 14/15 for an estimated annual cost per person of \$49.

In FY 15/16, the David Lambert Center served an average of 239 unduplicated visits per quarter for an estimated annual cost per person of \$44

A Benefits Specialist is on site in the Enrichment Center to assist individuals in applying for, and obtaining, public benefits such as Medi-Cal and Supplemental Security Income (SSI). Due to the volume of individuals seeking assistance and because the program has been so successful, TCBHD sought external funding to supplement the Benefits Specialist function to assist more clients.

Benefits Specialist services were utilized by 1,412 people in FY 14/15 for an estimated annual cost per client is \$42.

In FY 15/16, a total of 1,210 people received Benefits Specialist assistance for an estimated annual cost per client of \$54

New for FY16/17 is the expansion of the Peer Specialist role. A partnership between BH and Columbia Junior College is being explored to possibly hold peer support groups on campus and increase outreach to transitional youth and other college students.

Crisis Services and Mental Health Triage (SB 82)

TCBHD provides Phone and Walk-in Services through the Crisis Access and Intervention Program (CAIP). CAIP workers perform mental health crisis interventions for persons who come to the walk-in independently or as referred by the Emergency Department or law enforcement. The crisis team consists of a specialized group of clinicians and behavioral health workers who are available to respond to crisis prevention or emergency support and referral services. Supports provided through the CAIP have resulted in a 21% reduction in hospitalizations of clients utilizing this service from FY 14/15 to FY 15/16.

Services provided by staff include:

- Telephone and face-to-face intervention
- Assistance in connecting to community resources
- Follow-up appointments and reminders
- 5150 evaluations and arrangements for hospitalization if needed
- On-site evaluations and services at Tuolumne County Jail

Upon research of quality improvement issues reported by staff and clients, the demand for immediate services and rapid response to multiple and complex needs, periods of stabilization has become evident. To enhance the availability of FSP services, the reassignment of CAIP related activities into more intensive supports will allow for a brief intensive model of FSP services. The focus will be on entry into the FSP system as well as a planned strategy for stepping up and out of these intensive services. As a result of redirecting CAIP staff to these FSP intervention opportunities, increases can occur to the supports and resources required for stabilization over brief periods. CAIP workers assigned to FSP will be linked with the full team and will be available to better coordinate initial treatment planning and supports necessary for success of FSP participants.

New for FY 16/17 are changes to the hours of on-site support at TCBHD as well as an expansion of services via an on-site clinician at Sonora Regional Medical Center (SRMC) for additional afterhours support. Data shows that the annual number of people using the walk-in services during the graveyard shift (11pm to 8am) is minimal:

Actual values for the three-year study for the 11 pm – 8 am shift:

	Face to Face contact	Telephone contacts
FY 13-14	16	55
FY 14-15	45	77
FY 15-16	32	87

Currently, Walk-in operations are 24 hours a day, 7 days a week with a planned change in the program to enhance service systems and opportunities. On a projected start date of Sunday, December 11, 2016, walk-In service hours will be accessible only from 8am to 10pm weekdays and from 10am to 7pm on weekends with closure on holiday. Phone support will still be available 24/7. As face to face contacts have remained very low over the past 3 years, the need to have a walk-in staff available after

hours is not proven. Meanwhile, demand for rapid response and supports for pre and post hospitalization have increased.

A component of the planned change is to utilize a crisis support phone line to serve clients calling after hours and to have face to face services routed through the on-site clinician at SRMC. The assigned clinician, as a mobile outreach, will be available for response to the housing programs if necessary and will be knowledgeable of the clients in the FSP service system. Additionally, Peer Specialist supports are also in development to provide after-hours response to support FSP client on a 24/7 basis.

Crisis response continues through SB82 funding to work with hospital and law enforcement personnel to refine the processes used to reach out to clients in crisis and reduce involuntary hospitalization. This has provided the foundation for efforts to implement a sequential intercept model to institutionalize a process to redirect persons with mental illness away from the judicial system and into treatment.

In FY 14/15, the CAIP served 1631 unduplicated individuals at an average annual cost of \$352 per client.

In FY 15/16, the CAIP served 1519 unduplicated individuals at an average annual cost of \$333 per client.

Prevention and Early Intervention (PEI)

Prevention and Early Intervention (PEI) strategies are meant to prevent a mental challenge from occurring by providing information and resources to the community. PEI is also designed to intervene early to keep a mental illness from reaching a severe level. The following programs are planned to continue through FY 16/17.

Early Childhood Nurturing Parenting Education Program

Nurturing Parenting is a priority intervention, universal prevention program that is a multi-level parenting and family support strategy to prevent severe behavioral, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents. This program has consistently been implemented by a team from TCBHD and through a contract with Infant/Child Enrichment Services (ICES). These services target parents in stressed families including: pregnant and parenting teens; special needs; poverty communities; substance abuse; abuse and/or neglect; domestic violence; social isolation; lack of basic needs; homelessness. The program utilizes the Nurturing Parenting and Parents in Recovery curriculum with the Adult Adolescent Parenting Inventory (AAPI) evaluation tool which measures parent progress, as well as, assuring the program is meeting the desired outcomes. The AAPI assesses skills in five domains: Expectations of Children; Empathy; Discipline; Family Roles; and Power and Independence. The scores range from 1-10, with 1-3 being high risk, 4-7 medium risk, and 8-10 low risk. During both FY 14/15 and FY 15/16 participants consistently improved their AAPI post test scores by a minimum of 80% resulting in a clearer understanding of children's behaviors, alternatives to physical punishment and more confidence in their parenting skills.

Services provided in FY 14/15 include:

- 38 adults, 62 children participated in Nurturing Parenting and Parents in Recovery classes.

- 25 adults and 27 children received home visits with staff using appropriate Nurturing Parenting curriculum.
- 9 Community events were attended including the ICES Children's Fair, YES Partnership and Head Start Meet & Greet.

Services provided in FY 15/16 include:

- 34 adults, 70 children participated in Nurturing Parenting and Parents in Recovery classes.
- 21 adults and 29 children received home visits with staff using appropriate Nurturing Parenting curriculum.
- 10 Community events were attended including the ICES Children's Fair, Family Fiesta Night and Social Services Consortia.

In FY 14/15 there were 152 individuals served through the program with an estimated annual cost per person for this program is approximately \$690.

In FY 15/16 there were 154 individuals served through the program with an estimated annual cost per person for this program is approximately \$681.

This PEI contract is funded 75% towards Prevention and 25% towards Early Intervention.

The Social Emotional Learning Foundations (SELF) Program

TCBHD contracts with First Five, which administers the Social Emotional Learning Foundations (SELF) program, in promoting the social and emotional development of young children ages 0 through 5. This Early Intervention program utilizes an Early Childhood Education (ECE) specialist to provide on-site training, consultation and materials to preschools in the community. An indirect outcome of this program is that other students in the pre-school classes benefit greatly from the positive behaviors learned by children receiving services.

In FY 14/15, a total of 19 children received targeted consultation to improve social skills and 73% of those children showed improvement in at least two positive behavior domains. Also throughout the year, ten teachers were supported by the ECE. The estimated annual cost per person for this program is approximately \$344.

In FY 15/16, a total of 15 children received targeted consultation to improve social skills and 100% of those children showed improvement in at least one positive behavior domain. There were three preschools and 9 teachers that received training and supports and 100% of the schools reported successful implementation of the program. The estimated annual cost per person for this program is approximately \$416.

Bullying Prevention Program

TCBHD contracts with The Center for A Non Violent Community's (CNVC) Bullying Prevention to provide programs to elementary and high school students to reduce school based violence. With an emphasis on mental health stigma reduction, prevention educators engage students in lessons and

activities which increase empathy for the bullying victim, the person exhibiting bullying behaviors, as well as the bystander. Strategies are then provided for victims and bystanders to remain safe.

In FY 15/16 the annual Anti-Bullying summit coordinated by Tuolumne County Superintendent of Schools Office (TCSOS) was re-evaluated and counselors, educators, parents and administrators all agreed to change the target age of the summit from 6th – 9th grade to a focus on 2nd grade students and to revamp the entire program and call it *The Friendship Conference*. Approximately 465 students attended the event with representatives from CNVC, TCBHD, TCSOS, ATCAA, Friday Night Live and more. CNVC focused on Empathy and use puppets to educate students on understanding feelings and how to gain empathy for others. The 2nd Annual Friendship Conference is scheduled for February, 2017.

Services provided in FY 14/15 include the following:

- More than 955 students attended Bullying Prevention workshops, assemblies, and community informational programs at 8 local elementary, charter, and high schools.
- 80% of students in the Tuolumne County Summer Recreation program reported that they had been bullied, or had seen someone bullied at school.

Approximately 955 students, faculty and parents participated in a bullying prevention activity for an estimated annual cost of \$32 per person.

Services provided in FY 15/16 include the following:

- More than 925 students, staff and parents participated in Bullying Prevention workshops, assemblies, and community informational programs at 7 local elementary and high schools.
- Bullying prevention and awareness information was presented to more than 25 individuals living with a mental health challenge at the Tuolumne County Enrichment Center.

Approximately 925 students, faculty, parents and community members participated in a bullying prevention activity for an estimated annual cost of \$33 per person.

This PEI contract is funded 100% towards Prevention.

Suicide Prevention Program

The Amador Tuolumne Community Action Agency (ATCAA) provides the Suicide Prevention services for TCBHD. The goal of the program is to provide a variety of community-wide trainings, education and information to open dialogue and raise awareness about risk factors, protective factors and warning signs of suicide. A community education campaign was implemented to continue to build awareness of suicide, educate the community about suicide, encourage the community to act to address suicide and to reduce the stigma around depression and suicide. Through trainings, meetings and community involvement, ATCAA continues to strengthen awareness of suicide in Tuolumne County. The partnership with community advocates and work to coordinate with state level resources continues to bring Suicide Prevention activities to the forefront.

The following activities took place in FY 14/15:

- Nearly 700 people attended a community outreach event, or received suicide prevention and awareness materials.
- 203 community members successfully completed either safeTALK (Tell Ask Listen and KeepSafe) or ASIST (Applied Suicide Intervention Skills Training) with 95% of participants reporting that they felt “Well prepared to Mostly prepared” to talk with someone experiencing suicidal thoughts.
- Completed required training to offer ASIST II training to the community in FY 15/16.

The following activities took place in FY 15/16:

- More than 625 people attended a community outreach event, or received suicide prevention and awareness materials.
- 189 community members successfully completed Mental Health First Aid (MHFA), safeTALK (Tell Ask Listen and KeepSafe), ASIST (Applied Suicide Intervention Skills Training) or ASIST II, with 100% of participants reporting that they felt “Well prepared to Mostly prepared” to help someone experiencing suicidal thoughts.
- Successful training of 4 YMHA trainers to provide much needed YMHA training in the community. 56 participants were trained with 100% reporting that they “Strongly Agree” that would be able to recognize the signs, reach out to, and assist a young person who may be dealing with a mental health crisis.
- More than 3,000 Know The Signs suicide awareness tent cards provided to willing Pharmacies throughout Tuolumne County for distribution in prescription medicine bags.
- Survivors of Suicide loss support group established to provide a place for family and friends to process emotions in a safe and supportive environment.

The Suicide Prevention Task Force (SPTF) continues to play a large role in gathering and disseminating information, addressing the needs of the community and supporting organizations seeking funds for suicide prevention activities. The SPTF is currently updating a 5-year plan to provide a roadmap of goals, methods and implementation of trainings, programs and supports to make Tuolumne County a suicide safer community.

FY 15/16 plans include YMHA training for inmates in the Sierra Conservation Center as well as *The Council* and *Girls Circle* programs specifically for Tuolumne County Probation which provide a resiliency developing support group for young men and women. Also, plans to build a strong partnership with Columbia College are in place as they have recently hired a full time Mental Health Coordinator. Plans include annual trainings at the college for MHFA and safeTALK with other trainings being considered as well.

In FY 14/15, there were 996 people who attended training, an event, received information, or attended a presentation about the program resulting in an estimated cost per person of \$75.

In FY 15/16, approximately 870 people attended training, an event, received information, or attended a presentation about the program resulting in an estimated cost per person of \$86.

This PEI contract is funded 100% towards Prevention training and programs.

CAFÉ: Connections and Awareness for Elders

TCBHD has contracted with Catholic Charities to provide outreach and engagement services to Tuolumne County's older adult population. The purpose of this program has been to engage those individuals, aged 65 or older, that are isolated, lonely, and under-served. Engagement strategies include offering in-home visits for socialization, counseling, activities, resources and referrals to TCBHD or other community agencies.

In FY 14/15 the program struggled with only 22 Senior peers receiving home visits, socialization and other supports, only 1 notable outreach event and a lack of reporting the number of volunteers in the program. These challenges were reportedly due to numerous staffing changes resulting in a lack of organization and tracking in the program.

FY 15/16 showed progress with the following activities reported:

- 35 Senior peers received home visits, socialization and other supports.
- 17 volunteers were actively involved in providing supports to the elderly.
- Successful planning and implementation of the Annual Elder Abuse Awareness Conference with 197 attendees.

For FY 16/17, Catholic Charities will be implementing a new tracking tool to provide measurable outcome data to show the impact of the program on the Senior Peers who are receiving supports. They continue to plan activities and strategies to reach older adults including: providing information at community meetings; attending multi-disciplinary team meetings; and working closely with County departments and community agencies.

In FY 14/15 approximately 192 individuals received services, training or information about the CAFÉ program. The estimated annual cost per person is \$282.

In FY 15/16 There were 249 individuals who received services, training or other information about elder abuse awareness and the CAFÉ program for an estimated annual cost per person \$198.

This PEI contract is funded 100% towards Prevention.

Latino Outreach

Beginning in FY 14/15, TCBHD contracted with Amador Tuolumne Community Action Agency (ATCAA) to provide prevention and early intervention services to the Latino community in Tuolumne County. The program consists of two Promotores de Salud (Promoters of Health) who provide mental health education, outreach and support. The Promotores are from the Latino community themselves and have succeeded in building relationships and trust with their peers. They focus on breaking down barriers to accessing services, such as transportation, culture, language, stigma, and mistrust of behavioral health services.

The Promotores program has reached hundreds of unserved and underserved individuals. The primary challenge with their supports is in relation to health care insurance coverage. The majority of Latinos in our community are undocumented and therefore only qualify for Emergency Medi-Cal supports. For the few with private insurance, mental health counseling is not covered forcing families to pay for services, an expense often not seen as a priority. They are addressing this challenge by providing

mental health and wellness education, support, awareness and tools to live healthier, more connected lives. This is evident in the grass roots creation of a support group that grew from monthly presentations to the Spanish Speaking Parent Advisory Committee. A core group of women began to meet after each presentation to talk. The group began to provide encouragement and support to each other and it became so popular, participants decided to meet twice each month.

In FY 14/15 approximately 145 individuals received services, training or information for an estimated annual cost per person of \$282.

In FY 15/16, 249 individuals received training, information or services through the Promotores de Salud for an annual cost per client of approximately \$62.

70% of this program is funded towards Early Intervention services and the remaining 30% is funded towards Prevention activities.

Native American Outreach and Engagement:

The Tuolumne Me-Wuk Indian Health Clinic (TMIHC) has provided outreach and engagement services targeting Native American youth and their families. By offering programs designed to engage the participants in healthy activities, and offering opportunities to connect with their Native American culture, the program encourages activities such as sweat lodges and cultural-specific trainings. Participants benefit from specific services and supports that honor the culture, beliefs and spirituality of Native American traditions. New for FY 16/17, TMIHC has identified a counselor to be dedicated to the Tuolumne County Law and Justice Center currently scheduled to open in January 2017. The site will include a juvenile detention facility to which this counselor will be assigned.

Services provided in FY 14/15 include:

- 315 individuals participated in monthly sweat lodge ceremonies. These ceremonies are increasing in popularity and participants are sharing their spiritual growth and challenges with the group.
- 17 youth and their families received Individual Education Plan (IEP) assistance
- 24 Native American inmates in the jail received supports
- 5 community informational events were presented to cover topics such as recovery from addictions and Native Traditions.

Services provided in FY 15/16 include:

- 213 individuals participated in monthly sweat lodge ceremonies.
- 4 youth and their families received Individual Education Plan (IEP) assistance
- 390 community members attended Talking Circles and Drug/Alcohol informational sessions (this service was provided through collaboration with Mewuya).
- 40 visits were made to Native American inmates at the jail.
- 4 community informational events were presented to cover topics such as integration of Native traditions and culture.

Promotion of spiritual and healing practices among Native Americans in recovery continues as the primary focus of this program. Sweat Lodge Ceremonies, Native Circle and other special events are scheduled throughout the year to provide culturally sensitive services to the community.

New for FY 16/17 is the continued partnership with Mewuya to expand the availability of services of Native American to the community.

In FY 14/15 an estimated 356 people received supports through this program for an estimated annual cost per person for this program is approximately \$84.

In FY 15/16 an estimated 611 people received supports through this program for an estimated annual cost per person for this program is approximately \$49.

This PEI contract is funded 100% towards Prevention.

Fostering Healthy Activities in Non-Traditional Settings

Beginning in FY 15/16, TCBHD contracted with the Jamestown Family Resource Center (JFRC) in Fostering Health Activities in a Non-Traditional setting. Jamestown Elementary School staff was already implementing the evidence based practice of Positive Behavior Intervention and Support (PBIS), and our goal was to support that program and to help the school to fully implement a Trauma Informed approach in working with students and their families.

FY 15/16 was to be a building year with the focus on implementing trauma informed principles and to fully train a “trauma team” consisting of 9 staff, including 4 teachers. Reaching out to and working with high risk students such as those experiencing homelessness, or living in the foster care system or other out-of-home placement was the primary goal. The success of the program in its first year is astounding:

- 48% of the entire Jamestown Elementary School staff received training on Trauma Informed Behavior.
- 88% of teachers on staff received the training.
- 88% of high risk students in Grades 4 - 8, showed improved GPA by .5 in English Language Arts.
- 63% of high risk students in Grades 4 - 8 showed improved GPA by .5 in Math.

In addition, there was a reduction in every measurable area of consequence during the school year:

Consequence	14/15 School Year	15/16 School Year	Change
After School Detention	121	105	-13%
Lunch Detention	164	153	-7%
Loss of Recess	28	20	-29%
Principal Referral	41	36	-12%
Suspension	39	23	-41%

The plan for FY 16/17 is to continue to work to get all staff fully trained in trauma awareness and building resiliency in students. Since the goal is to foster healthy activities, students need to be inspired to come to school, stay in class all day, and not be sent out of class due to inappropriate behaviors. Teachers and staff must be able to recognize the signs of trauma, the impact of that trauma on student behaviors and learning and they need to be able to implement strategies to respond and support resiliency.

During the FY15/16 school year, 58 “at risk” students were served; 23 school personnel received trauma informed training; and 9 teachers received follow up trauma response coaching. The estimated annual cost per person is approximately \$388.00n and this PEI contract was funded 100% towards Early Intervention.

PEI Statewide Plans Program:

Three statewide projects are implemented through the California Mental Health Services Authority (CaMHSA):

- Suicide Prevention – To significantly impact information about suicide prevention
- Student Mental Health initiative –To provide grants to educational institutions
- Stigma and Discrimination Reduction – To reduce sigma and discrimination against people living with mental illness

In FY 14/15, Tuolumne County received customized “Happy and Healthy Families Start Here” fotonovela series. The fotonovela is a traditional print medium found in Hispanic and Latino cultures and are similar in format to a comic book. This series of brochures was offered with both English and Spanish in each book and addressed issues relating to mental health and stigma reduction within the Latino community.

In FY 15/16, more than 425 students at Columbia Elementary and Belleview Elementary were reached through the Walk in Our Shoes program. The students attended a play addressing stigma reduction by highlighting the struggles of students experiencing various mental health challenges. (*See Attachment: Tuolumne County Fotonovela*)

TCBHD plans continued participation in the annual funding of PEI Statewide Plans at a contribution rate of 5% of local PEI funds. This will allow for continuation of existing and successful PEI programs to prevent suicide, reduce stigma and discrimination, and to improve student mental health.

Innovation (INN)

Current Project:

TCBH's Innovation Project titled "Wellness: One Mind, One Body" (INN02) was approved on April 1, 2014, by the Board of Supervisors as an update to the MHS FY 13/14 Annual Update. The project was updated through the MHS Annual Update FY 15/16 and approved by the Board of Supervisors on November 17, 2015.

The purpose of the project is to increase the quality of services, including better outcomes for those individuals served by TCBH who have difficulty accessing physical health and oral health care, have chronic medical issues, or who do not have access to regular primary health care or regular oral health care.

The project introduced collaboration between behavioral health and various non-mental health and oral health disciplines. TCBH is learning whether this model of coordinated care planning, which includes behavioral health, primary care and oral health care, improves the overall physical health, oral health, and quality of life for participants.

The interim report, included as an appendix to the Annual Update includes information on: learning to date; progress and changes in the collaboration; transition to the HART program; progress and outcomes in learning for oral health care; physical health care; and self-care management. Also included is information on challenges to the project, learning, and implementation of changes. (See *Attachments: INN Interim Report; Spread Planner; HART Clients PCP; HART Clients Calls Received; HART Clients All Services; HART Clients No Show; HART Clients Crisis Services*)

Potential New Project:

The recent retirement of the TCBHD full time Psychiatrist has resulted in discussions and ongoing interviews with various stakeholders about how to fill this gap. Stakeholders include clients, staff, community members, key behavioral health leaders in other counties, several regional health care centers, managed care plan partners, as well as a representative of a NP University Training Program. Recruitment of psychiatrists to rural counties is problematic, and TCBHD is seeking other less costly, but fully acceptable, solutions. In the meantime, the county continues to utilize a psychiatric on staff, who is available one day per week, and in addition, a Telepsychiatry service is being used.

Demand for medication support services is greater than resources available. An option under consideration is utilizing a "physician extender", such as a Psychiatric Mental Health Nurse Practitioner (PMHNP), however, recruitment is an issue. Another possibility is to secure the support of a University Nurse Practitioner (NP) Training Program to place a student PMHNP who would be precepted by a local Psychiatrist while in the program.

The question raised is whether it's possible to increase access to psychiatric providers in our underserved community through a coordinated effort of a collective regional group (3 or 4 counties, a regional/local health center, a managed care plan), with the support of a University Training Program to place, and guide, the training of a student PMHNP. The ideal solution would be to recruit the student PMHNP to remain permanently in the region/county to provide medication support services. The goal would be not only to provide a sustainable program with access to medications for our clients that truly supports integrated and community healthcare with an emphasis on development of self-management

skills and total health orientation, but also to utilize the PMHNP to serve as a preceptor for any future student NP recruits to the region.

The department will continue to pursue, and possibly develop, this into a new Innovation Project. There are many aspects in the development phase of this project, therefore more data, research and information are required prior to launching a new proposal.

Workforce Education and Training (WET)

Ongoing trainings are provided to staff, as well as to interested community members, annually through various online opportunities, on-site at TCBHD, throughout the community and via individualized off-site training offerings.

FY 14/15 offerings included: *Trauma Focused Cognitive Behavioral Therapy; Law and Ethics for Health Care Providers; Culturally Sensitive Intake Assessment and Treatment; Best Practices in Serving LGBTQ Clients;* and the *Elder Abuse Awareness Conference (EAC)*. Through WET Central Region funds, 3 TCBHD staff members received financial assistance through the Mental Health Loan Appreciation Program (MHLAP); 5 received clinical supervision through the Roving Supervisors program; and 1 took advantage of an online Hybrid Masters Social Work (MSW) program through California State University Stanislaus.

In FY 15/16, TCBHD launched a new Workforce Needs Assessment survey revealing 70% of persons working for the department report a personal connection with mental health by reporting that they themselves identify as a peer, or as a family member of a peer. This is a substantial increase from the 2008 assessment which reported less than 10% of staff identifying this way. This development is likely related to increased efforts in the reduction of stigma related to mental illness as well as a concerted effort to hire persons with lived experience.

Trainings provided in FY 15/16 included: *Motivational Interviewing; Interpreter training for Interpreters and Providers; Trauma Focused Cognitive Behavioral Therapy; Seeking Safety; Co-Occurring Disorders; EAC; Youth Mental Health First Aid (YMHFA); and Trauma Informed Practice*. Three TCBHD clinical staff received compensation through the MHLAP tuition assistance program; 5 received clinical supervision through the Roving Supervisors; and 2 staff were enrolled in the online Hybrid MSW program. Also, through WET Central Region Marriage Family Therapist (MFT) Stipend program, a license eligible individual completed the required one year of service commitment for TCBHD.

To further support TCBHD staff, as well as private therapists in the community, TCBHD provides Continuing Education Units (CEUs). Trainings where CEUs are offered must meet strict criteria and must involve a cultural aspect to meet Cultural Competency Plan requirements. TCBHD is willing to provide CEU's as they are critical for licensed individuals to maintain their certification.

A key objective for FY 15/16 was to provide peer employees with the tools they need to allow them to be successful in a peer-run environment. A partnership with Mental Health America of Northern

California (NorCalMHA) provided trainings to staff, volunteers and peers interested in entering the workforce. TCBHD provided trainings in 15/16 such as : *Welfare Recovery Action Plan (WRAP)*; *Group Facilitation 101*; and *Recovery 101*. Peer Trainings will continue in FY 16/17 with scheduled trainings including: *Confidentiality, Off Duty Conduct and Ethics & Boundaries*; *Victim Witness Elder Abuse Awareness*; *Self Care & Stress Management*; *Recovery Coaching*; and *Trauma Informed Practices*. Also new for FY 16/17 is support of peers to complete the *Psycho Social Rehabilitation certification* program through Columbia College. WET funds will pay for tuition and books for 6 students to complete this two year program commitment.

Also in FY 15/16, TCBHD extended a one-time grant of WET funds to HealthLitNow, a non-profit organization dedicated to educating elementary and high school students about healthcare literacy and providing them with information and resources about healthcare career opportunities in our community. Also known as “The Career Pathways Project” the program for 7th - 9th grade students was presented to 13 schools and reached approximately 850 students. More than 30% of students reported having an increased interest in a career in a healthcare occupation after completing the workshop.

Planned community trainings for FY 16/17 include *the EAC*; *Trauma Informed Practice Conference* and numerous suicide awareness trainings. WET Central Region has scheduled *Utilizing Data in Public Mental Health*; *Mental Health First Aid Train the Trainer*; *UC Davis Leadership Train the Trainer*; and *Clinical Supervisor* training. TCBHD staff will also be attending trainings such as: *Mindfulness*; *Crisis Management*; *Culture of the Client/Culture of the Family*; *Transgender 101*; and *Working with Veterans*.

Original MHSAs funding allocated to WET has been exhausted. For FY 16/17, a transfer in the amount of \$200,000 from CSS to WET will take place in order to continue training efforts to TCBHD staff and community.

Capital Facilities and Technological Needs (CFTN)

TCBHD continued to address needed expansion in several areas.

Renovation of the former Long Term Care facility, located next to the Tuolumne County Behavioral Health building on Hospital Road is complete. The building was transformed through a partnership between TCBHD and Child Welfare Services (CWS). The front portion of the building houses the new *Children & Family Visitation Center* including offices for CWS staff as well as several family visitation rooms and a community room where families and caregivers can support each other. To strengthen the children’s system of care, TCBHD moved a children’s therapist to a renovated office within the footprint of the Behavioral Health building. This allows the therapist to provide outreach to children in the foster care system, including those who have been placed out of county. The back portion of the building is called, *MHSA Administration*, and houses FSP program staff as well as MHSA administrative staff. The space provides a centralized located for the complete FSP team including Case Managers, Peer Specialists, Interns and the Program Supervisor.

CFTN funds were also used to support technology needs such as new computers, printers and phones for the new offices.

Perimeter fencing around the TCBHD campus is still in process. There is one more phase of fencing required to secure the parking lot area. This portion of the fencing will include a security gate to be locked after hours, only accessible by county staff with badge access.

Permanent Supportive Housing

TCBHD continues to support two residential housing structures and residents at both the Washington Street and Cabrini House. These locations continue to receive supportive services and assistance. Residents are thriving and the units continue to remain occupied 100% of the time, with an ever growing waiting list of eligible clients in need of housing.

As reported in the MHSAs Annual Update FY 15/16, AB 1929, passed in January 2015 and allowed Tuolumne County Behavioral Health to request MHSAs housing funds, in the amount of \$11,792.96 to be returned from the California Housing Finance Agency (CALHFA).

This update includes a request pursuant to the State of California, Health and Human Services Agency Department of Healthcare Services MHSUDS Information Notice No. 16-025. The Information Notice informed counties of the end of the program and release of unencumbered funds dedicated to MHSAs Housing Program. Because the MHSAs Housing Program is expiring, Cal-HFA must release any remaining MHSAs funds to counties by November 30, 2016.

As reported in the MHSAs Annual Update for FY 15/16, TCBH received unencumbered funds in the amount of \$11,792.96. Tuolumne County Behavioral Health and stakeholder groups have determined that any **future unencumbered or disencumbered funds** dedicated to the MHSAs Housing program should be released and returned to Tuolumne County Behavioral Health Housing, Inc. (TCBHH).

Allowable use of these funds include provision of housing services to residents of Tuolumne County with severe mental illness and can include rental assistance, security deposits, utility deposits, or other move-in cost assistance. Based on the obvious demands for more supportive housing, these funds are being allocated to assist Full Service Partnership clients to move from current supportive housing units to their own permanent housing. The moves foster independent living and allows supportive housing placement to others in need.

(See Attachments: MHSAs Housing Fund Release AND Attachment A to Inf. Notice 16-025)

FY 2016/17 Mental Health Services Act Annual Update Funding Summary

County: Tuolumne County

Date: 10/6/16

	MHSA Funding					
	A Community Services and Supports	B Prevention and Early Intervention	C Innovation	D Workforce Education and Training	E Capital Facilities and Technological Needs	F Prudent Reserve
A. Estimated FY 2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	2,916,093	452,831	309,431	39,754	219,329	
2. Estimated New FY 2016/17 Funding	1,968,238	391,545	130,515			
3. Transfer in FY 2016/17 ^{a/}	(300,000)			200,000		100,000
4. Access Local Prudent Reserve in FY 2016/17						
5. Estimated Available Funding for FY 2016/17	4,584,331	844,376	439,946	239,754	219,329	
B. Estimated FY 2016/17 MHSA Expenditures - net	2,614,485	456,983	156,074	135,680	148,185	
G. Estimated FY 2016/17 Unspent Fund Balance	1,969,846	387,393	283,872	104,074	71,144	
H. Estimated Local Prudent Reserve Balance						
1. Estimated Local Prudent Reserve Balance on June 30, 2016		406,901				
2. Contributions to the Local Prudent Reserve in FY 2016/17		100,000				
3. Distributions from the Local Prudent Reserve in FY 2016/17		0				
4. Estimated Local Prudent Reserve Balance on June 30, 2017		506,901				

*** Note *** Interest in amount of **\$30,724** is in Prudent Reserve but reflected as part of the CSS balance

a/ Pursuant to Welfare and Institutions Code Section 58922(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 2016/17 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding**

County Tuolumne County

Date: 10/6/16

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. FSP	1,385,221	1,181,359	203,862			
2.	0					
3.	0					
4.	0					
5.	0					
Non-FSP Programs						
1. 24 hr Walk-in Clinic	947,236	789,625	157,611			
2. Peer Coordination (EC)	313,339	313,339				
3. Lambert Center (O&E)	42,100	42,100				
4. Mobile Crisis Outreach	25,000	25,000				
5. Benefits Development	69,523	69,523				
6. Promotion & Community Ed Activities	50,361	50,361				
7. SOAR	45,097	45,097				
8.	0					
9.	0					
CSS Administration	41,132	41,132				
CSS MHSA Housing Program Assigned Funds	56,949	56,949				
Total CSS Program Estimated Expenditures	2,975,958	2,614,485	361,473	0	0	0
FSP Programs as Percent of Total	47%					

**FY 2016/17 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding**

County: Tuolumne County

Date: 10/6/16

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Suicide Prevention & Stigma Reduction	75,000	75,000				
2. Older Adults, Latino, & Native American O&E	105,000	105,000				
3. School Based Violence Prevention	30,000	30,000				
4.	0					
5.	0					
PEI Programs - Early Intervention						
11. Early Childhood Project	115,000	115,000				
12. Jamestown Family Resource Center	35,000	35,000				
13.	0					
14.	0					
15.	0					
PEI Administration	71,983	71,983				
PEI Assigned Funds	25,000	25,000				
Total PEI Program Estimated Expenditures	456,983	456,983	0	0	0	0

**FY 2016/17 Mental Health Services Act Annual Update
Innovations (INN) Funding**

County: Tuolumne County

Date: 10/6/16

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Wellness: One Mind, One Body	143,422	136,074	7,348			
2.	0					
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					
20.	0					
INN Administration	20,000	20,000				
Total INN Program Estimated Expenditures	163,422	156,074	7,348	0	0	0

**FY 2016/17 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding**

County: Tuolumne County

Date: 10/6/16

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Staffing Support & Training	113,256	113,256				
2. Mental Health Loan Appreciation Program	10,000	10,000				
3.	0	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					
20.	0					
WET Administration	12,424	12,424				
Total WET Program Estimated Expenditures	135,680	135,680	0	0	0	0

**FY 2016/17 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding**

County: Tuolumne County

Date: 10/6/16

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. MHS Admin Center	120,000	120,000				
2. Enrichment Center	10,000	10,000				
3. FSP & Walk-in Facility	5,000	5,000				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Computers	13,185	13,185				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	148,185	148,185	0	0	0	0



Tuolumne County Behavioral Health Department

MENTAL HEALTH SERVICES ACT (MHSA): **NOTICE OF 30-DAY PUBLIC COMMENT PERIOD and NOTICE OF PUBLIC HEARING**

MHSA Annual Update FY 2016-2017

To all interested stakeholders, Tuolumne County Behavioral Health, in accordance with the Mental Health Services Act (MHSA), is publishing this **Notice of 30-Day Public Comment Period and Notice of Public Hearing** regarding the above-entitled document.

- I. **The public review and comment period begins Friday November 4, 2016 and ends at 5:00 p.m. on Monday December 5, 2016.** Interested persons may provide written comments during this public comment period. Written comments and/or questions should be addressed to TCBHD, Attn: Kristi Conforti, MHSA Coordinator, 2 South Green St, Sonora, CA 95370. Please use the public comment form.
- II. **A Public Hearing will be held by the Tuolumne County Mental Health Board on Wednesday December 7, 2016, at 4:00 p.m.,** at the Behavioral Health Department, 105 Hospital Rd., Sonora, CA, for the purpose of receiving further public comment on the MHSA Annual Update FY 16/17.
- III. **To review the MHSA Annual Update FY 2016-2017** or other MHSA documents via Internet, follow this link to the Tuolumne County Network of Care website:
<http://tuolumne.networkofcare.org/mh/content.aspx?id=353>
- IV. Printed copies of the MHSA Annual Update FY 2016-2017 are available to read in the public waiting areas of the following locations during regular business hours:
 - Tuolumne County Behavioral Health, 105 Hospital Rd, Sonora.
 - Main branch of Tuolumne County Library, 480 Greenley Road, Sonora
 - Tuolumne County Administrator Office, 2 South Green St, Sonora
 - The David Lambert Center, 347 W. Jackson St, Sonora
 - Tuolumne County Enrichment Center, 102 Hospital Rd, Sonora

To obtain a copy by mail, or to request additional information, call the MHSA Coordinator at (209) 533-6262.

**Tuolumne County Behavioral Health
Mental Health Services Act (MHSA)
Annual Update FY 2016-2017**

30 Day Public Comment Form
Dates of Posting: November 4, 2016 to 5:00pm on December 5, 2016

PERSONAL INFORMATION	
Name: _____	
Agency/Organization: _____	
Phone Number: _____	E-mail Address: _____
Mailing Address: _____	
YOUR ROLE IN THE MENTAL HEALTH SYSTEM	
<input type="checkbox"/> Client/Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Education <input type="checkbox"/> Social Services	<input type="checkbox"/> Service Provider <input type="checkbox"/> Law Enforcement/Criminal Justice <input type="checkbox"/> Probation <input type="checkbox"/> Other (specify) _____
COMMENTS:	

All Electronic Comments and Inquiries Regarding the Annual Update FY 2016-2017 should be sent to:
Email address: KConforti@co.tuolumne.ca.us

Written Comments may be submitted by mail to:
Kristi Conforti, MHSA Coordinator, Tuolumne County Behavioral Health: 2 South Green St, Sonora, CA 95370
All Comments Must Be Received by: 5:00 P.M., Monday December 5, 2016

**A Public Hearing on the Mental Health Services Act (MHSA) Annual Update FY 2016-2017 will be held on
Wednesday December 7 at 4:00pm.** The meeting will convene at: Tuolumne County Behavioral Health
Department, 105 Hospital Road, Sonora, California

Public Comments Received and Actions Taken:

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DRAFT

Attachments

- **PUBLIC HEARING ANNOUNCEMENT**
- **ENRICHMENT CENTER CALENDAR OF EVENTS**
- **FOTONOVELA**
- **INN02 INTERIM REPORT**
- **SPREAD PLANNER**
- **GRAPHS: HART CLIENTS PCP; HART CLIENTS CALLS RECEIVED; HART CLIENTS ALL SERVICES; HART CLIENTS NO SHOW; HART CLIENTS CRISIS SERVICES**
- **MHSA HOUSING FUND RELEASE**
- **ATTACHMENT A TO INF. NOTICE 16-025**

DRAFT

PUBLIC HEARING NOTICE

Tuolumne County Behavioral Health Department has posted a draft copy of the Mental Health Services Act (MHSA) Annual Update Fiscal Year (FY) 2016/2017. This annual update provides information on current MHSA activities, as well as a review of MHSA services provided in FY 14/15 and FY 15/16. As of Friday, November 4th, the document has been posted on the following websites:

Tuolumne County Behavioral Health Department (www.tuolumnecounty.ca.gov)
TC Network of Care (<http://tuolumne.networkof-care.org/mh/content.aspx?id=353>)

The document will be available for a 30 day public comment period starting on Friday, November 4th through 5:00pm on Monday, December 5th.

A public hearing will then be held on Wednesday, December 7th, at 4:00pm, at the Tuolumne County Behavioral Health Department located at 105 Hospital Road, Sonora, California. Tuolumne County residents are encouraged to attend this public hearing. As required by Welfare and Institutions Code Section 5847, the final plan and budget will be reviewed for approval by the Tuolumne County Board of Supervisors, currently scheduled for Tuesday, December 20, 2016. Once approved by the Board, the document will be submitted to the California Department of Mental Health.

For questions or additional information, please contact:
Kristi Conforti, MHSA Programs Coordinator
Office phone 209- 533-6245
e-mail @ kconforti@co.tuolumne.ca.us

Publication Date: November 4, 2016
The Union Democrat, Sonora, CA 95370



FEBRUARY 2016

TUOLUMNE COUNTY ENRICHMENT CENTER 101 HOSPITAL RD. SONORA, CA 95370

Monday	Tuesday	Wednesday	Thursday	Friday
9-10 Men and Women 1 10-11 Pride: Boundaries 11-12 Seeds of Hope Grief Group/Recreation 1-2 Mental Health Addictions	8-2 Laundry 2 11-2 Movie Day 12:30-1:30 AA 1:45-3:00 Bipolar and	EC CLOSED 3 Community Training 	8-3 Showers 4 10-12 Art / Game Day 11-12 Eating Disorder Support Group 12-1 Peers Helping Peers 2-3 Trauma Recovery/PTSD	9-11 Karaoke/ Gardening 5 9:30-12 Smile Keepers 11-12 Red Road 12:30-1:30 Dealing with Life Issues
9-10 Men and Women 8 10-11 Pride: Interacting with Others 11-12 Honky Tonk 1-2 Mental Health & Addictions	8-2 Laundry 9 11-2 Movie Day 12:30-1:30 AA 1:45-3:00 Bipolar and Depression	9-10 Men and Women 10 10-11 Pride: Origins of Valentine's Day 11-12 Fun & Healthy Eating 12-1 Homeless Community Group 12:30-2 Working With Emotions	8-3 Showers 11 10-12 Art / Game Day 11-12 Eating Disorder Support Group 12-1 Peers Helping Peers 2-3 Trauma Recovery/PTSD	9-11 Karaoke/Gardening 12  Valentine's Day Potluck 12:30-1:30 Dealing with Life Issues
EC CLOSED 15  President's Day	8-2 Laundry 16 11-2 Movie Day 12:30-1:30 AA 1:45-3:00 Bipolar and Depression	9-10 Men and Women 17 10-11 Pride: Meditation 11-12 : Fun and Healthy Eating 12-1 Homeless Community Group 12:30-2 Working With Emotions	8-3 Showers 18 10-12 Art / Game Day 11-12 Eating Disorder Support Group 12-1 Peers Helping Peers 2-3 Trauma Recovery/PTSD	9-11 Karaoke/ Gardening 19 11-12 Information Session: Peer Support and  Psychosocial Rehabilitation Certificate Program 12:30-1:30 Dealing with Life Issues
9-10 Men and Women 22 10-11 Pride: NAMI Presentation w/ John Leamy 11-12 Music/ Recreation 1-2 Mental Health & Addictions	EC CLOSED 23 Staff Training  6:30-8:15 ML Survivors of Suicide Loss	9-10 Men and Women 25 10-10:45 Pride: Current Events 11-12 Willie Todd & Friends  12-1 Homeless Community Group 12:30-2 Working With Emotions	8-3 Showers 26 10-12 Art / Game Day 11-12 Eating Disorder Group 12-1 Peers Helping Peers 2-3 Trauma Recovery/PTSD	9-11 Karaoke/Gardening 26 9:30-12 Smile Keepers 11-12 Red Road 12:30-1:30 Dealing with Life Issues
9-10 Men and Women 29 10-11 Pride: Tea Time  11-12 Seeds of Hope Grief Group/Recreation 1-2 Mental Health & Addictions	COMPUTERS: Monday 8-9, 12-4 Tuesday 8-4 Wednesday 8-9, 12-4 Thursday 8-4	SHOWERS: Monday 12-3 Wednesday 12-3 Thursday 8-3 Friday 12-3	LAUNDRY: Tuesday 8-2 ~Laundry and Shower Supplies provided~	



Phone: 533-6695
Fax: 533-7113

COMMUNITY CENTER FOR WELLNESS AND RECOVERY

Monday-Friday
8:00 a.m.
to 4:00 p.m.

www.facebook.com/TuolumneCountyEnrichmentCenter



Healthy & Happy Families Start Here

A GUIDE FOR PARENTS AND CHILDREN TO EXPLORE TOGETHER



INCLUDES:

- A spiritual leader's advice for mental wellness
- Helpful tips for talking & listening to one another
- Fun games & activities for the whole family



California's Mental Health Movement

Una Familia Feliz y Saludable Comienza Aquí

UNA GUÍA DE APRENDIZAJE PARA PADRES E HIJOS



INCLUYE:

- Consejos de un líder espiritual acerca del bienestar mental
- Consejos útiles para hablar y escucharse unos a otros
- Actividades y juegos divertidos para toda la familia



Movimiento de Salud Mental de California

If you or someone you know needs help,
there are resources available to assist you.



**National Suicide
Prevention Lifeline**

www.SuicidePreventionLifeline.org
1-800-273-TALK (8255)

The National Suicide Prevention
Lifeline provides free and confidential
emotional support to people in
suicidal crisis or emotional distress
24 hours a day, 7 days a week.

TO SEARCH FOR MORE LOCAL
SERVICES ONLINE, VISIT:
www.California.NetworkofCare.org

For local services in Tuolumne County:



Tuolumne County Behavioral Health Department

105 Hospital Road
Sonora, CA 95370

For General Information call our Business Line: 209-533-6245

If you or someone you know is in crisis, call our 24/7 Crisis Line:
209-533-7000

**Amador Tuolumne Community Action Agency-
Promotores de Salud**

For General Information call our Business Line: 209-533-0361

Si usted o alguien quien conoce necesita ayuda,
existen recursos disponibles para asistirle.



**La Red Nacional de Prevención
del Suicidio**

www.SuicidePreventionLifeline.org/

gethelp/Spanish

1-888-628-9454

La Red Nacional de Prevención del Suicidio brinda
un apoyo emocional, confidencial y gratuito las 24
horas al día, 7 días a la semana para personas que
estén sufriendo un trastorno emocional o estén
pasando por una crisis de suicidio.

PARA ENCONTRAR SERVICIOS
LOCALES EN LINEA, VISITE:
www.California.NetworkofCare.org
(Red de Atención de La Salud Mental -
sitios web en español)

Para servicios en el Condado de Tuolumne:



El Departamento de Salud Mental del Condado de Tuolumne

105 Hospital Road
Sonora, CA 95370

Para información general llame al: 209-533-6245

Si usted o alguien que conoce está en crisis, llame a nuestra línea de
crisis 24/7 al: 209-533-7000

ATCAA Promotores de Salud

Para información general llame al: 209-533-0361

INN-02 Project: “Wellness: One Mind, One Body” – ANNUAL UPDATE (Interim Report) FY 16/17

Background:

The Innovation Project: “Wellness: One Mind, One Body” (INN02) was approved on April 1, 2014, by the Board of Supervisors as an update to the MHSa FY 13/14 Annual Update. The project was revised through the MHSa FY 2015/2016 Annual Update, and approved by the Board of Supervisors on November 17, 2015.

The purpose of the project is to increase the quality of services, including better outcomes for those individuals served by TCBH who have difficulty accessing physical health and oral health care, have chronic medical issues, or who do not have access to regular primary health care or regular oral health care.

The project contributes to learning by intending to make a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community. It has been TCBH’s intention to pilot and test to determine whether coordinated care planning that is inclusive of behavioral health, primary care and oral health care information and measures its success in improving overall physical health, oral health and quality of life for clients.

By introducing collaboration between behavioral health and various non-mental health and oral health disciplines, the physical health and oral health outcomes of TCBH clients may be improved. TCBH wants to learn whether or not an innovative integrated approach to behavioral health and physical and oral healthcare will empower consumers to access health care, dental care and also influence clients to manage their self-care more effectively.

The issue(s) being addressed by this innovation include identifying what changes are needed to establish multiagency communication, thereby creating better workflow(s) for coordinated physical, oral and behavioral healthcare, and also promote the client’s self-management of same, as well as to establish a clinical information “system”, using limited resources in this rural county.

Time Frames:

The project includes four phases:

1. Approximately 12 to 15 months (March 1, 2014 through May 31, 2015) – this phase had two components - Technical Assistance and Training, and Designation of Staff for Project
2. Approximately 24 months (June 1, 2015 through May 31, 2017) – focus on implementation of the learnings from the Care Coordination Collaborative, instituting those changes.
3. Approximately 12 months (June 1, 2017 through May 31, 2018) - includes evaluating and monitoring the changes implemented during Phase One and Two.

4. Approximately 6 Months (April 1, 2018 through November 30, 2018) will involve analysis of the outcomes from the first three phases, measuring successes (or lack of success) in the learning objective(s).

With this update, however, the following adjustments in the phases is being made:

1. Completed December 2014, ahead of schedule;
2. Started January 2015 with the development of the Innovation Spread Plan to spread initial learnings and track progress of same, the implementation of the Healthcare Access Resource Team (“HART”), and addition of the Oral Healthcare Component introduced October 2015. This phase may be shorter than expected, since the learnings for the project are more evident in reporting. This Phase may end approximately December 2016.
3. Starts approximately January 2017 - evaluating and monitoring changes in Phase One & Two, has some overlap with Phase Two, and a part of the evaluation occurs with this report.
4. Starts approximately July 2017.

Reporting Periods:

Project reporting has occurred and will occur as follows:

1. The MHSA 2015/2016 Annual Update included a report of progress for the period from March 2014 through June 30, 2015. This update also included a revision to the Program Description for the project, to include oral healthcare because it is part of a person’s overall wellness. This report covered all of Phase One of the project and introduced Phase Two.
2. The MHSA 2016/2017 Annual Update includes a report of progress for the period from January 2015 through December 2015. Data for the project is being reported for this time frame (Calendar Year). This report includes how the learnings have been implemented, changes instituted, and adjustments made as a result of the revised project. It appears the Phases have been shortened due to earlier results of outcomes and learnings.
3. The MHSA 2017/2018 Annual Update will include the period January through December 2016, evaluating the outcomes from CY 2016, and comparing the outcomes between CY 2015 and CY 2016. Phase Three will be well underway with this report, and an estimated date of the closure of the project, and plan for sustaining the project under another funding source.

Progress To Date:

The “Wellness: One Mind, One Body” Innovation Project was submitted for the improvement of Integration of Health Care and Self-Management development as a 4 year planning and implementation process. The first step in the process was the acceptance into the Coordinated Care Collaborative for Integrated Care to develop an understanding of systems structure, support and direction to assure a quality improvement program and systems structure to support the necessary relationships and change the culture of care within the behavioral health

and physical health care arenas. At the conclusion of a Learning Collaborative on systems structure for integrated care from July 2013 through December of 2014, efforts to sustain the learned processes and spread the practice as a core principle and value were continued under the ongoing Innovation Project (INN02) for assuring that intervention and recovery model of services was reflective of a commitment to health care self-management and integration.

With the conclusion of the technical assistance/training portion of the project (the CCC Learning Collaborative), TCBHD held a series of meetings (from January 2015 to May 2015) to undertake efforts to sustain the learned processes and to spread the practice as a core principle and value. An "Innovation Spread Plan" (See ***Attachment 1 in appendices titled "Spread planner"***) was developed based upon the initial learnings of the Learning Collaborative on systems structure for integrated care; various activities or elements of management were to be spread into the system with team building supported through innovation. Through numerous components of the concept of self-management as they relate to health choices in mind and body, the value of having a detailed care coordination for persons with complex medical and physical conditions required a distinct work plan and effort to assure institutional internalization. The Innovation Spread Plan now serves as the guide and monitoring tool to evaluate and plan for ongoing efforts toward that goal. Significant updates to progress at a minimum of 6 months are established to determine status of the systems changes.

By April of 2015, a number of issues had been identified that impacted institutionalization of the process. The lead peer liaison who had worked on the project was no longer with the organization, the loss of the faculty leadership from the CCC Learning Collaborative reduced to level of attention and meeting frequency dedicated to the project, key administrative staff and coordination had reduced. This resulted in recognition that, though concepts and efforts were continued and staff throughout the agency were utilizing the care coordinator, many protocols and processes were underdeveloped for a systems wide change and the integrity of the effort was being compromised by capacity challenges and multiple areas of ongoing training needs.

Initial re-evaluation was conducted with the team of the Behavioral Health Director, Program Supervisor and Care Coordinator with the decision to assign additional staffing to support transition and clinical needs, re-establishment of a peer liaison to support the education and direction of self-management and WRAP development, and assure clear processes to better integrate and maximize appropriate service utilization. Further, Quality Improvement coordination was brought in for support in consultation and tracking as this function had previously been supported through the CCC Learning Collaborative and did not get established at the end of the collaborative to assure quality improvement measures continued. Specific planning addressing the spread plan are identified/evaluated within the work plan to best track specific planning efforts.

In Phase Two, the Healthcare Access Resource Team (HART) program was created to potentially sustain the project. The team consists of a Psychiatric Technician, a Behavioral Health Worker, and a Community Liaison. One of the important learnings thus far has been that participants have needed help in navigating both health and oral health care needs as part of their self-management. HART staff developed a "Health Care Self-Management Resource Map" to assist clients in self-management of physical and oral health care. Training peers with lived experience who are already in recovery to teach participants how to access the broader health system has been an important aspect of improvement outcomes for those participants.

Understanding what community resources are available, how the community is organized, how to use informal social networks, etc., help a client to organize their own health/oral health care.

The peer liaison position was re-established to support the education and direction of client self-management and WRAP (Wellness Recovery Action Plan) development.

The following is a copy of the Flyer that is used to communicate with clients the intent of the “HART” program:

H.A.R.T. WORKSHOP*



HELP WITH:

- FINDING A DOCTOR
- “MY HEALTH INFO” CARDS
- WRAP (WELLNESS RECOVERY ACTION PLAN)
- PATIENT PORTALS

WEDNESDAY 2-3
ENRICHMENT CENTER

NEED A PRIMARY CARE DOCTOR AND DON'T KNOW HOW TO START?

ALWAYS WANTED TO KNOW ABOUT THE WRAP AND HOW TO FILL IT OUT?

FILL OUT A “MY HEALTH INFO” CARD AND ALWAYS HAVE ALL YOUR MEDICAL INFORMATION IN A HANDY WALLET SIZED FORMAT

DID YOU KNOW YOU CAN GET YOUR MEDICAL INFORMATION FROM YOUR DOCTOR'S OFFICE...MEDICATIONS...APPOINTMENTS...TEST RESULTS- ALL FROM ANY COMPUTER?

*Please bring a list of all current medications, including dosage and times of day taken

In addition to the HART Program and Workshops, access to the Sonora Regional Medical Center's Project HOPE (Health, Outreach, Prevention and Education) is also now available to participants, and is being used to provide another means of obtaining primary care services for clients. The Project HOPE Van is available to clients on Mondays and Fridays, from 9:00 a.m. to 3:30 p.m., and is parked adjacent to a Wal-Mart Store in Sonora. On the fourth Friday of the month, the Project HOPE Health Van is parked at another social service agency in Sonora, but

clients have access to that location. A Family Nurse Practitioner is the “on board” medical practitioner. Clients can receive episodic care services, physicals, check-ups, blood pressure checks, minor, non-invasive testing and prescription orders. The client tracks the medical and oral health care information on their personal “My Health Info” wallet card.

The revised INN02 Program Description that was approved in the MHSA Annual Update FY 15/16 in November 2015 included the addition of oral healthcare as part of the One Mind, One Body approach. The Smile Keepers Oral Health Project was implemented and provides dental health education and treatment services to adults who attend The Enrichment Center, a day program for peers who are clients with TCBH or are homeless drop in clients. This component of the project started in early Fall 2015.

The Smile Keepers staff includes an RDHAP and an RDA to provide education and patient services. These services are provided twice per month. Clients can track their oral health care information on the “My Health Info” wallet sized card.

One additional aspect of protecting and providing for continuity of participants has included the team’s work in the area of readying participants for discharge through planning strategy, therefore Phase Two now also includes institutionalizing integrated discharge planning. TCBH will report more on that aspect of Phase Two in the report to be submitted in the MHSA 2017/2018 Annual Update.

Progress and Outcomes in Learning – the Oral Health Care Component

The Smile Keepers provide the oral health care component of the Innovation Project. Based upon the indicators selected by the collaborative team, Smile Keepers has produced the outcomes data as follows. However, not only do HART clients participate in the oral health care component of the project, but many other clients have started to become involved in their oral health care as well. Approximately 25 adult clients arrive on any given day when Smile Keepers is present at the Enrichment Center. Many of them receive transportation to come to the Enrichment Center. Not all adults come regularly and there is inconsistent attendance. Group education is provided on a variety of topics, followed by one on one work with the clients, which can include oral screening, professional dental cleanings, oral hygiene instruction, fluoride varnish treatment and distribution of dental supplies. Clients can track their oral health care treatment on the “My Health Info” card.

The following includes the learning objectives for the oral health care component, and data is provided for the period 8/2/2015 through 6/30/2016:

- Pre/post measures of oral care outcomes AND Improved self-esteem because of improved oral care:

The Smile Keepers Team started the evaluation process with a literacy-heavy pre- and post-test which did NOT work for the clients. The purpose was to determine what improvements the client experienced as a result of attending educational sessions and receiving patient services (oral health evaluations and dental cleaning). After observing for a time, the team switched to a direct feedback strategy. The client is presented with a simple set of questions pre and post service, which can be initiated orally in a conversation setting. This has been more realistic and workable for this group.

The pre-test was conducted (orally) during a group activity/discussion about maintaining lifetime oral health. The group was asked about their belief in the importance of good oral health and overall health and if they were interested in learning about taking care of their teeth.

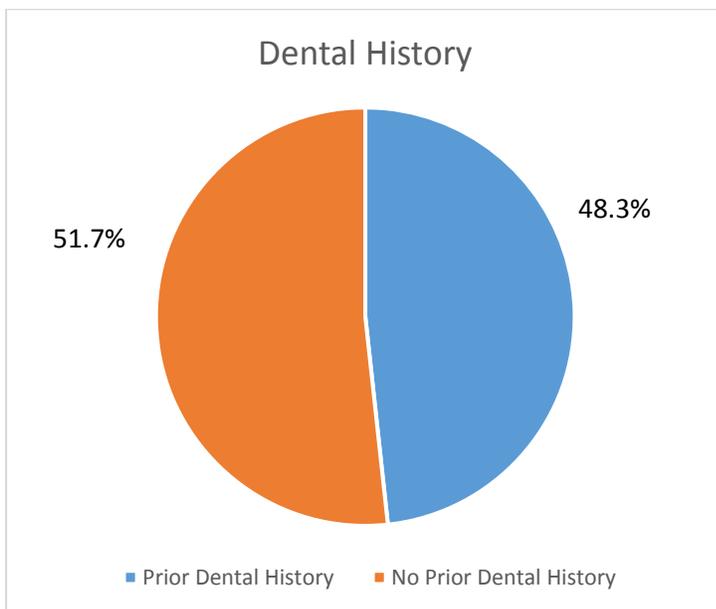
Education events were conducted, and as a post-test, participants were asked if the information was helpful. 100% of the participants reported that it was helpful.

- Improved self-care management as a result of the model of service delivery for the oral health care component:

During the period of measurement (Nine months of the 15/16 fiscal year), a total of 29 adults received individual oral health evaluations. Of the 29, six received a second evaluation, and 2 received a third evaluation.

- Client has designated Oral Care Services:

For the 29 adults treated in the program, 15 of them could not provide information on when their last dental visit was. For those that could, it ranged from fifteen years to the current year, with the average being 4 years.



Increased Access to Oral Care Services:

Prior to the implementation of this project, the clients attending the Enrichment Center or Lambert Drop-in Center had little to no access to oral care education or referral to services. Staff provide the services to the clients twice per month, on Fridays, from 9am to Noon. As mentioned earlier, approximately 25 adults arrive on any given day. The Smile Keepers staff serve the adults who arrive that day. Appointment cards are given for upcoming cleaning appointments.

A total of 11 Group Education Events were held during the time period. Attendance at the group events ranged from 15 to 44, with an average of 25 per session.

- 5 adults were assisted with making a dental appointment at a clinic for an immediate oral health issue such as toothache, broken tooth, swelling, etc. Recently, a patient with severe dental infection was evaluated and as a result was sent to the local clinical for immediate physical health care. The patient ended up having surgery to relieve swelling and infection and was very grateful that Smile Keepers was available to them at the Enrichment Center. Patients with a regular dentist were not given a referral if they were receiving current dental care.
- 8 adults received dental cleaning, with 3 of these receiving a second cleaning during the time period. Many patients have no teeth, or have dentures, and do not require professional dental cleanings. Education on good oral health is still very important for patients with dentures or no teeth. They are provided oral care and denture care via gum tissue checks and cleaning of dentures for patients. Patients receive dental cleaning every 3 months if needed, even if a patient has received a cleaning at a dentist, since Medi-Cal will only cover 1 dental cleaning per year.

Progress and Outcomes of Learning – The Physical Health Care Component

Measuring the progress of the learning and outcomes for the participants was initially a challenge since the addition of Quality Improvement Staff (time allotted to the project) had to wait until new staff could be hired. One of the learnings has been that while indicators were initially developed to measure outcomes and learning, the level of difficulty in capturing and tracking the data wasn't anticipated. In this small county, the QI Analyst has to support multiple data needs in not only the Mental Health Plan/Services, but also for the MHSA programs. Perhaps a "less aggressive" approach may have helped. However, the number of indicators has now been decreased to a more reasonable level, but still will allow evaluation of the outcomes for the project.

The numbers of those participating in HART have ranged from 18 to 22 for CY 2015. Data reports are included as an addendum to this report, as appendices at the end of the Interim Report/Annual Update. The following Indicators were reviewed, and will be compared with 2016 data when it becomes available:

"CLIENT HAS A DESIGNATED PRIMARY CARE PHYSICIAN"

When comparing the number of clients with and without a Primary Care Physician in 2014 and 2015, there was significant improvement from 2014 to 2015. A total of 20 participants were compared as follows:

- During CY 2014:
 - 35% of participants had a PCP
 - 65% of participants did NOT have a PCP
- During CY 2015:
 - 55% of participants had a PCP
 - 45% of participants did NOT have a PCP

This data clearly shows that the partnership and integrated approach is beginning to have an impact on the number of participants who now have an active PCP. This can be considered one indicator of success of the project. (See **Attachment 2 HART Clients PCP**)

“REDUCED USE OF BEHAVIORAL HEALTH SERVICES”

For this indicator, we are evaluating several measures.

The first is the number of behavioral health calls received from participants in the project. Unfortunately, we don't have data for 2014, but we have collected data for CY 2015, and will be able to compare that data with CY 2016 in the final report (See **Attachment 3, HART Clients Calls Received by Month**). Some observations of the data collected include:

- The number of calls decreases during the summer months, and then increases dramatically during October, then begins to decrease.
- If October is excluded, overall, there is a continual decrease in the calls coming from HART participants, which may mean that the integrated approach is working.

Another method we are using to evaluate whether or not HART participants have a decreased use of Behavioral Health Services is to look at the number of services accessed overall. The total number of services for all HART clients per month for CY 2015 has been tracked and evaluated. (See **Attachment 4, HART Clients All Services**). The data reveals the following:

- With the beginning of CY 2015, the number of services for all HART clients is lower and then trends gradually higher toward the end of the year. The number of services drops in December 2015, but there are many reasons for this, including the holidays arriving, clients being with family, friends, and supports.
- The increase in the number of services being received by the HART clients isn't necessarily a negative – the Analyst attributes it to more involvement in their treatment and recovery, such as partnering as an FSP.

“INCREASED LEVEL OF ENJOYMENT, HOPEFULNESS, SATISFACTION WITH CARE”

To evaluate whether or not HART clients are “satisfied with their care”, we thought we should include data on “no shows” for these participants. The assumption here is that if the client is satisfied with care, and they are managing their own care in an improved way, perhaps they would have fewer incidents of “no show” than other clients. Therefore, we have included the total number of “No Show” appointments per month for all HART clients in CY 2014 and CY 2015. We will be comparing this data with the 2016 numbers when they become available – to determine whether or not there is a continued decline in the number of no shows for the participants. (See **Attachment 5, HART Clients No Shows**).

- Given the consistent number of participants (18-22), the number of “no show” appointments has decreased dramatically from CY 2014 to CY 2015. There is a spike of “no show” in December 2015, likely a seasonal variation, which is typical at that time of year.

“DECREASE IN ACUTE CRISIS VISITS”

In evaluating the Indicator “Decreased Use of Crisis Services” for the project, we compared the total number of HART clients that used Crisis Services in CY 2014 with CY 2015. There is a dramatic decrease in crisis services used by HART clients in CY 2015 when compared to the previous year.

It was also noted that of those HART Participants, 75% of them did NOT use crisis services in CY 2015 – this is also informative. We may be able to imply that the decrease in use of crisis services is due to the increased learnings by participants about self-care management, and with the development of WRAP plans by participants, these clients have more in their recovery “tool kit” that allows them to make different choices and to seek out other supports and services when needed (rather than a crisis visit) (see **Attachment 6, HART Clients Crisis Services**).

Challenges to the Innovation (INN02) Project, HART, and Learnings to Date:

There have been some challenges to HART all along the way, but those challenges have contributed to learning in many ways. The Collaborative Partners/Team have had to make adjustments and adapt to those challenges/changes as they have occurred, and the Team has found the “Spread Planner” the best way to spread the changes. For this report, some of those challenges or learnings are listed by category or description, below:

1. Strengthening Health/Oral Health Screening and Self-Identification of Comorbid Conditions at Intake, Annual and at Change: Early in Phase Two, the need to develop a screening tool at first contact and during unplanned service contacts was realized. The team implemented a “Medical Information Survey” for staff to use, staff received orientation to same, and the HART Workshop groups were initiated and conducted by the Peer Liaison.
2. Decreased Involvement by Primary Care Partner: There have been some serious challenges during Phase Two of the project. One of the primary partners in the integration effort that provided primary health care had to scale back their involvement due to the intensity of some of the issues encountered with the coordination of the client’s care. Services are still being coordinated, however, the level of staff dedication in a primary care clinic was realized to not be feasible. This outcome has been important to understanding planning needs around innovative integrative approaches. The intensity factor is important in future PCP involvement.
3. Bi-Directional Releases of Information and Access to Records: While Bi-directional ROI is now accomplished via a new electronic health record form, another learning, to date, is the need to rely on the “Patient Portal” as a point of records access, as well as education of clients, to better have real-time access to (their) records. This has also been found to be a component of improving self-management in health care/oral healthcare. The Peer Specialist member of HART has an important role in educating and assisting persons with access to their health records. It also incorporates the concept of WRAP (Wellness Recovery Action Planning). This has become one aspect of adaptation and has, it is hoped, helped to empower consumer access to health care, dental care, and to influence clients to manage their self-care more effectively.

4. Data Driven Population Management: It was identified early in Phase Two that quality improvement assignment had not adequately been established in preparation for evaluating outcomes and monitoring the success of implementation of the project. With the recruitment and hiring of qualified QI Coordinator and QI Analyst, the collection and evaluation of data is underway.
5. Coordination of Care with the Managed Care Plans, Development and Maintenance of a Referral and Consultation Model: The team identified the need to develop a Managed Care Plan and Behavioral Health Administrative Policy regarding the development of referral processes and resource management. This has been accomplished and monitoring/evaluation of same will determine if this is successful. The Managed Care Care Coordinators are being trained and now meet monthly for care coordination related to referrals.
6. Client Completing Paperwork: – A challenge for the oral care partner has been that many of the clients that come to them won't try to access care on their own because of the paperwork involved. These barriers include low literacy, physical effects of medication, such as hand tremors, and overall comprehension difficulty. A learning has been to provide staff to assist Clients to complete the paperwork to access care.
7. Sporadic Attendance for Oral Care – Another challenge for our oral care partner has been to address the issue of sporadic attendance. As a result, the Smile Keepers team initiated making appointments with patients for their next visit. This has worked well, with patients appearing more comfortable with the appointment scheduling. Many patients need time to mentally prepare for an appointment. One very artistic and creative patient was asked to create an appointment card template for the Smile Keepers Program.
8. Medications & Oral Care: Our oral care partner, Smile Keepers, has observed that many medications cause mouth dryness, which can lead to unique oral health issues. An additional observation is that persistence in oral health prevention/hygiene can be hampered by medication that has a sedative effect. The team is monitoring this factor.
9. Homelessness – hygiene (hand washing and tooth brushing and flossing) is very challenging for those who do not have access to running water or who live outdoors. The oral care team offers handwashing demonstrations on many occasions. Participants are given a kit with a new nail brush, hand lotion and hand sanitizer. Smile Keepers also provides a mini hand massage and fingernail inspection after the handwashing demonstrations. This gesture is meant to provide a pathway to building trust and comfort for patients in the dental setting.
10. Multi-agency Communication: The managed care company involved in the collaborative has remained active, and TCBH continuously seeks to improve and enhance care coordination with the managed care system. Quarterly meetings with the collaborative partners are occurring.

11. Special Supports: Care management and transportation supports have been offered to get clients to behavioral health appointments. This is considered a successful and useful support to the participants in HART.

The Collaborative Team is working during Phase Two of the project on building a plan of sustainability for the “Wellness: One Mind, One Body” Innovation Project. This will include evaluating possible funding opportunities through leveraging of resources, using data management of outcomes related to psychiatric hospitalizations, population management evaluation as related to Medi-Cal billing. Presentation materials will be developed in order to do outreach to Primary Care physicians for standardization of integrated care. During Phase Three of the project, the team is planning to develop and provide a sustainability plan and outcomes success to the Board of Supervisors to support necessary staffing and/or resource development.

Early evaluation and outcomes, and the learning from that, have thus far demonstrated that changing this small county’s approach to coordinated care planning (including behavioral health, primary care and oral health care) is achieving success for clients. One of the best outcomes is the realization that there is a need to enhance the peer system for coordination and self-management skills building. TCBH looks forward to the MHSA Three Year Program and Expenditure Plan coming in FY 17/18 which will have more information on the progress of peer system enhancement.

The MHA Innovation Plan was submitted for the improvement of Integration of Health Care and Self-Management development as a 4 year planning and implementation process. The first step in the process was the acceptance into the Coordinated Care Collaborative for Integrated Care to develop an understanding of systems structure, support and direction to assure a quality improvement program and systems structure to support the necessary relationships and change the culture of care within the behavioral health and physical health care arenas. At the conclusion of a Learning Collaborative on systems structure for integrated care from July 2013 through December of 2014, efforts to sustain the learned processes and spread the practice as a core principle and value were continued under the ongoing Innovation plan for assuring that intervention and recovery model of services was reflective of a commitment to health care self-management and integration. From the learning, various activities or elements of management were to be spread into the system with team building supported through Innovation. Though numerous components of the concept of self-management related to health choices in mind and body, the value of having a detailed care coordination for persons with complex medical and physical conditions required a distinct workplan and effort to assure institutional internalization. The Spread Plan serves as the guide and monitoring tool to evaluate and plan for ongoing efforts toward that goal. Significant updates to progress at a minimum of 6 months are established to determine status of the systems changes.

By April of 2015, a number of issues had been identified that impacted institutionalization of the process. The lead peer liaison who had worked on the project was no longer with the organization, the loss of the faculty leadership from the CCC Learning Collaborative reduced to level of attention and meeting frequency dedicated to the project, key administrative staff and coordination had reduced. This resulted in recognition that, though concepts and efforts were continued and staff throughout the agency were utilizing the care coordinator, many protocols and processes were underdeveloped for a systems wide change and the integrity of the effort was being compromised by capacity challenges and multiple areas of ongoing training needs. Initial re-evaluation occurred with the team of the Director, Program Supervisor and Care Coordinator with the decision to assign additional staffing to support transition and clinical needs, re-establishment of a peer liaison to support the education and direction of self-management and WRAP development, and assure clear processes to better integrate and maximize appropriate serve utilization. Further, Quality Improvement coordination was brought in for support in consultation and tracking as this function had previously been supported through the CCC and did not get established at the end of the collaborative to assure quality improvement measures continued. Specific planning addressing the spread plan are identified/evaluated within the workplan to best track specific planning efforts.

Changes to be Spread	Spread to Whom	Spread Timeline	Who is Responsible?	Details of How?(Including communication plans)
Initiation of bi-directional release of information to Managed Care Plans, Physicians and support systems at first contact or continuation of treatment to optimize and assure orientation of total health care in	Behavioral Health consumers- including those receiving MH, dual-diagnosis, SUD Primary Care Physicians	February 2015 for BH and Mathiesen staff training. June 2015 for community partners and PCPs.	Intake and triage staff at BHD, annually BH staff providing ongoing services Medical Records Supervisor to direct and establish procedure for Electronic Records staff to FAX to PCPs and MCPs	<ul style="list-style-type: none"> • Ask about PCP, check for MCP and support systems at intake/triage for all consumers entering systems – (training commenced as of Nov. 2014) to emphasize total health care model and resources • Bi-directional ROI now accomplished via new E.H.R. Form.* • information/ training related to peer

recovery.			BH Care Coordinators	support and self-management skills to peer liaisons to support self-advocacy and use of resources including MCP case management is now ongoing with CAHAN.**
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Review of status:

5/3/15 Meeting- Review of efforts and challenges associated with assurance of obtaining releases of information. A number of cues and training have been provided to improve assurance of ROI including screening tools with ROI cues, assessment in the EHR system with a check to request ROI, however this has not appeared to have impact and expected change. Plan: Assure protocols are written and reviewed with all staff for various points of expected offer to complete ROI. Reinforce training related to the impact of co-occurring disorders and symptoms that mimic behavioral issues that may be physical in nature. Meet in staff teams for discussion and ideas for support.

10/11/16 – * Bi-directional ROI now is being accomplished through the new Electronic Health Record Form. Staff trained to same.

**Information & training related to peer support and self-management skills to peer liaisons to support self-advocacy and use of resources included MCP case management is now ongoing with CAHAN.

Changes to be Spread	Spread to Whom	Spread Timeline	Who is Responsible?	Details of How? (Including communication plans)
Behavioral Health Record Management for Medical Reconciliation and diagnosis updates with BH and PCP, including lab results and medication reconciliation	MH, SUD providers internal to BH. Electronic Medical Records Staff MCPs PCPs Consumers	Ongoing – first evaluation of status 6/2014	Established as of 12/2014: Care Coordinators for both SUD and MH for primary point of monitoring PCPs – Implementation of Patient Portals Consumer: My Health Info wallet card use for personal management of same	<ul style="list-style-type: none"> • Establish procedures and protocols to assure timely sharing and updates of medications and/or diagnosis from all provider groups.* • Establish mechanism to assure that emergency services are identified and shared among care providers. • Establish a tracking system to identify use of emergency services.

Review of Status:

5/3/15 – Monthly meetings with the Care Coordinator and Mathiesen Clinic continue, however challenges occur due to the increase in caseload to the care coordinator resulting in delayed responses between the two agencies on the Behavioral Health side. Quarterly meetings with Administration are addressing issues as they arise with problem solving efforts. Coordination with other PCPs is occurring however not with the shared care planning levels occurring with the PCP and PA staff at Mathiesen. Reconciliation and improved communication is resulting in improvement in locating and referring persons without MDs or in need of specialists. Tracking of measures needs to occur to assess the success of this project – thus meeting with the Care Coordinator and QI Coordinator to establish internal and sustainable measures has been set up. FSP Liaisons need to be identified for support and assignment to the integrated care project.

10/11/16 – * The establishment of procedures and protocols to assure timely sharing and updates of medications and/or diagnosis from all provider groups is still needed.

Changes to be Spread	Spread to Whom	Spread Timeline	Who is Responsible?	Details of How?(Including communication plans)
Strengthen health screening and self-identification of comorbid conditions at intake, annual and at change in health to identify need for referral to intensified coordination of care	Target group: Identified persons with barriers in treatment or risk of complex health care compromise, e.g., dual physical and MH/SUD issues. Referral Options from: Consumers Peer Liaisons PCPs	June 2015	Utilization Reviewer, Quality Assurance Manager/IT and clinical management staff to assure current Assessment and tools adequate to identify key qualifiers for care. Staffing at intake and annual assessments accurately screen and document health care issues. Peer liaisons – establish and maintain individual and group services for use of WRAP and My Health Info wallet cards.	<ul style="list-style-type: none"> ● Review of current assessment and annual processes and implement any necessary changes to assessment document.* ● Re-training of all BH staff to assure comprehensive understanding and communication of integrated self-management and care.** ● Ongoing training modules for peer liaison staff, weekly meetings to support incorporation of total health care into self-management and personal care.*** ● Use of PCP Patient Portals

5/3/2015 Screening tool at first contact and during unplanned service contacts with BHWs with cues for referral opportunities and ROIs was developed to better identify resources needs during initial system decision making and promote . Full activation of Health Questionnaire at intake – limited to MD?

10/11/2016 - *A Medical Information Survey is completed.

**Orientation is now provided at All-Staff trainings

***H.A.R.T. Workshop Groups are conducted by the Peer Liaison

Changes to be Spread	Spread to Whom	Spread Timeline	Who is Responsible?	Details of How?(Including communication plans)
Use of a data-driven population management system to assure identification of persons requiring intensified care coordination is sustained, monitored for population management.	Quality Management Program for BH Care Coordinator	By June 2015	Updated Medication Management Review (Med UR) to include annual baseline lab assurance. Quality Improvement Coordinator for evaluation of identification and appropriate service development with ongoing data for success of identification and assignment. Care Coordinator for development of self-management planning and coordination with care teams.	<ul style="list-style-type: none"> • Establish quarterly data monitoring to assess success of implementation and usage.* • Notify MCP of MH Specialty services upon identification of co-occurring conditions to optimize resources (MD, case management, etc.) and access to care – Care coordinator responsibility.** • For intake, ongoing service or annual assessment activities: Any staff assigned for evaluation and referral for care coordination based on health care indicators utilize referral processes.***

Review of Status:

5/2/15: As identified, Quality Improvement assignment not adequately established in preparation, the care coordinator and the QI Coordinator to take lead role in determining clinical values and tools for tracking. The Physician Homepage has been activated and is an ideal tool for medication reconciliation however Care Coordinator indicated she was not alerted/trained or had access issues. This to be reviewed with program supervisor and care coordinator to optimize access.

10/11/16: *Not happening yet.

**Yes, this is now occurring.

***Yes, this is now occurring

Changes to be Spread	Spread to Whom	Spread Timeline	Who is Responsible?	Details of How?(Including communication plans)
Coordination of Care with the Managed Care Plans; Development and maintenance of a referral and consultation model.	BHD in coordination with Anthem Blue Cross and California Health and Wellness	Calif H&W: (First meeting 12/2014 completed) March 2015 Anthem: Sept. 2015	Director Clinical Supervisors Care Coordinators: both MH and SUD Quality Management staff Managed Care Plan case managers and supervisors	<ul style="list-style-type: none"> • MCP and BH administrative policy development of referral processes and resource management * • Training of Care Coordinators and establishment of monthly care coordination meeting related to referral** • Ongoing review of access to care and referral***

Review of Status:

Meetings/trainings – On Dec. 18, a team from Ca H& W came and provided training, inclusive of AOD staff. There are many resources that seem to be offered, however notification and training to staff beyond this meeting does not appear to be happening. Plan: Director to coordinate with Ca H&W, Reina Hudson, to see about information brochure or cards for quick reference and access. Care Coordinator reports that the assigned staff from Ca H&W have been working closely on a number of beneficiaries to optimize care and resource management. A meeting in March 2015 was scheduled but did not occur.

10/11/2016: * Yes, this has been accomplished with MR and MCP

**Training is occurring quarterly

***Yes, ongoing review with MR and MCP

Changes to be Spread	Spread to Whom	Spread Timeline	Who is Responsible?	Details of How?(Including communication plans)
Building a Plan of Sustainability with Community and Primary Health Care through data management support	County Administration Hospital system MCPs Community Based PCPs	June 2016	Behavioral Health: MHSA and M/C billing staff, Accounting Quality Management Program Staff including: Utilization Reviewer, Quality Improvement and Quality Assurance Clinical Supervisory Staff Director and HSA Administration MCPs: Anthem and Calif H&W	<ul style="list-style-type: none"> Assure plan development for funding opportunities and leveraging of resources through data management of outcomes related to psychiatric hospitalizations, population management evaluation as related to MediCal billing. Develop presentation and outreach to PCPs for standardization of integrated care. Provide/develop sustainability plan and outcomes success to Board of Supervisors to support necessary staffing and/or resource development.

Review of Status:

5/2015 – Though not initiated within the Innovation Program, the outreach service through SB82 in coordination with the ED and law enforcement is establishing possibilities in cost savings associated with excess use of emergency services and redirection to alternative resources. To be monitored and incorporated based on viability for sustained outreach process.

10/11/16: To be developed in Phase III of Project, after review of program and client level outcomes, and learning reviewed.

Changes to be Spread	Spread to Whom	Spread Timeline	Who is Responsible?	Details of How?(Including communication plans)
Enhancement of Peer System for Coordination and Self-Management skills building	Employed persons with lived experience Consumers BH Providers PCPs	Budget adoption 2015/16	MHSA Coordinator Human Resources BH Director and Administration	<ul style="list-style-type: none"> • Establish tier level of peer liaison system (I, II and Senior) within the County Personnel system for permanent benefitted positions and extra hire * • Maintain weekly meeting schedule for case planning and support. ** • Establish long term plan for MHSA Workforce Development and Training for peer providers *** • Monitor and implement MediCal billing upon establishment and approval of certification. + • Educate consumers, MCPs and providers on use and advantages of peer provider system. ^

Review of Status:

5/2/2015 Review: Establishment of In-Home liaison program second level of strategy. No current establishment of levels or HR process in place. Pending ongoing development with State efforts for certification. Needs process and protocol for assignment, referral and utilization of FSP level liaison.

10/11/16: *Peer staff positions were reclassified – there is now a Peer Specialist I, which is entry level and Peer Specialist II, which is based on education, training, work experience. No Senior Peer Specialist established to date.

** Peer Specialist meets regularly with clients, implemented the HART Workshop at the Enrichment Center.

***A new Program Specialist position will be managing peer trainings and taking advantage of offerings from NorCAL MHSA WISE Program as well as other peer training vendors. This position includes keeping up with legislation as it progresses (see below).

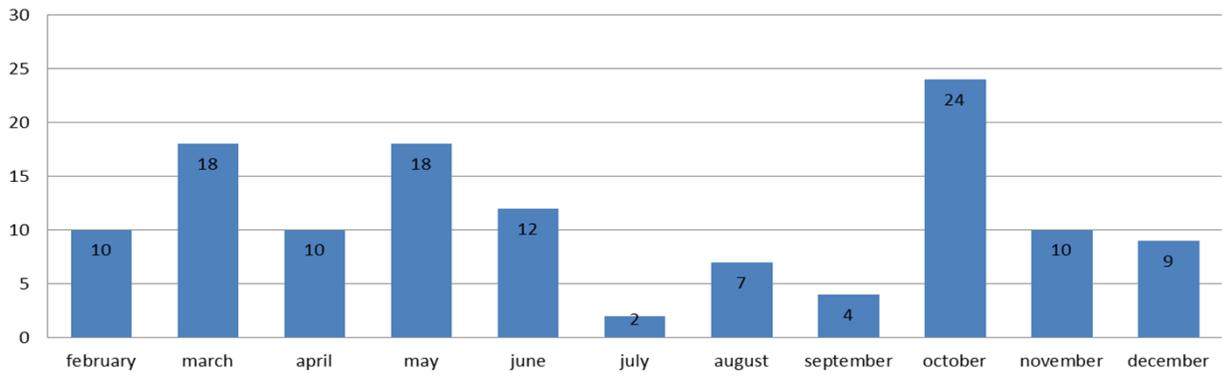
+ The statewide Peer Specialist Certification process has been put on hold while additional stakeholder and peer input is obtained.

^ A Peer Outreach initiative is under exploration through the CSS portion of MHSA.

Number of HART Clients with Primary Care Physicians by Calendar Year



BH Calls Received from HART Clients by Month for CY 2015



Total Number of Services for All HART Clients per Month



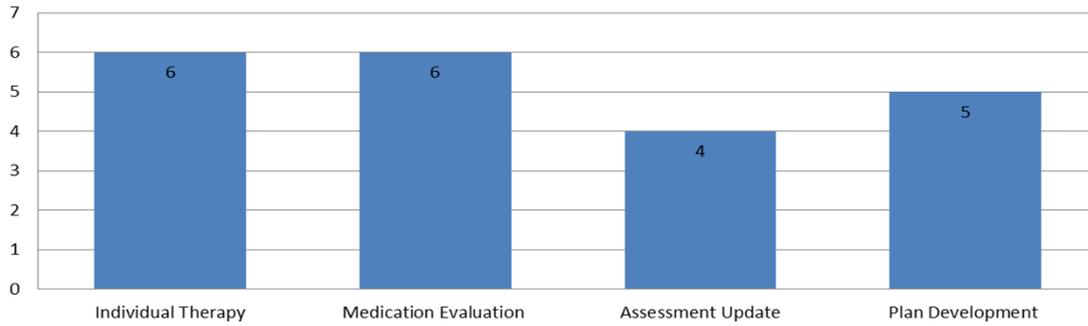
Series1	197	118	139	162	177	188	171	303	246	284	245	150
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Total Number of No Show Appointments per Month for All HART Clients CY 2015

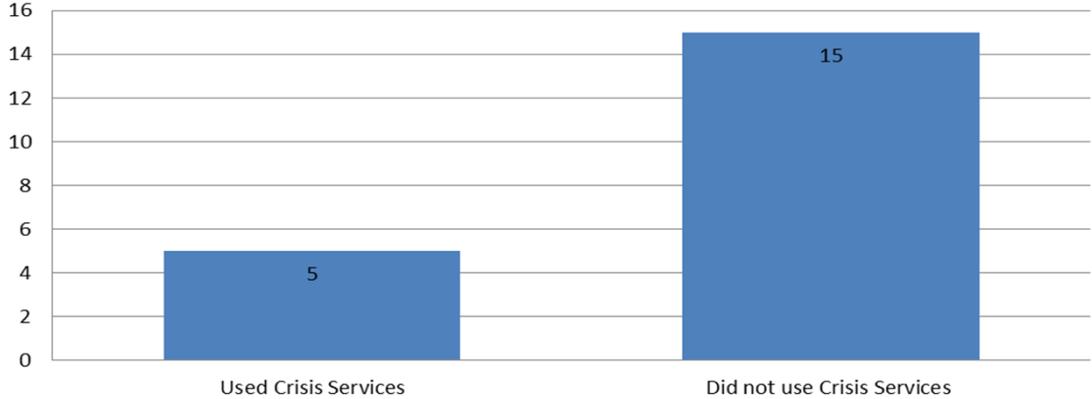


*note that higher no show rates are necessarily bad, it means they are more involved in their treatment, such as FSP

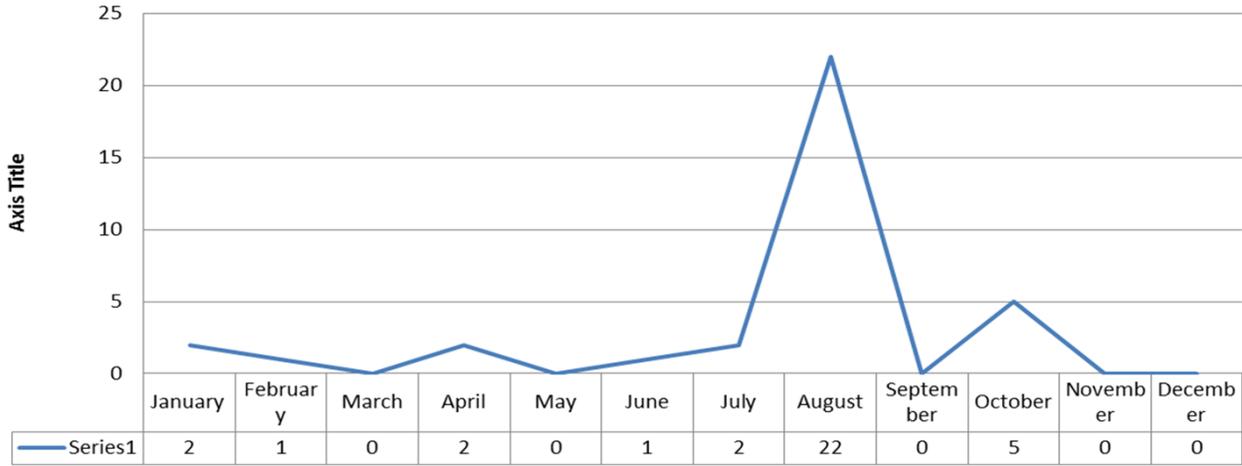
Service Type and Count for the Most No Show Appointments for All HART Clients CY 2015



Total Number of HART Clients that Used Crisis Services in CY 2015



Number of Crisis Services used by HART Clients by Month for CY 2015





Tuolumne County Behavioral Health Department

RITA AUSTIN, LCSW
Director

105 Hospital Road
Sonora, CA 95370
Main: (209) 533-6245
24 Hour Crisis: (209) 533-7000

Date: November 4, 2016

To: California Department of Health Care Services
Mental Health Services Division
MHSA Program and Fiscal Oversight Section
1500 Capitol Avenue, MS 2704
Sacramento, CA 95899-7413

Subject: Request to Release Unencumbered Mental Health Services Act (MHSA) Housing Program Funds Pursuant to State of California-Health and Human Services Agency Department of Healthcare Services MHSUDS Information Notice 16-025

Attachments:

- 1) Attachment A - MHSA Housing Loan Program Ongoing Annual MHSA Fund Release Authorization for Future Unencumbered Funds
- 2) Meeting Minutes of 12/20/2016, Tuolumne County Board of Supervisors

Per the instructions written within MHSUDS Information Notice 16-025, please find "ATTACHMENT A" which includes Tuolumne County's request of the release of all future unencumbered or disencumbered funds dedicated to the MHSA Housing Program, to be released and returned to Tuolumne County Behavioral Health Housing, Inc., (TCBHH), a 501(c)(3) organization.

Please also find attached, the Tuolumne County's Board of Supervisors Meeting Minutes from December 20, 2016. Please find said reference on _____ of the Board of Supervisors Meeting minutes, pertaining to the Board of Supervisors' motion of approval to release all future unencumbered funds.

Sincerely,

Rita Austin, LCSW
Tuolumne County Behavioral Health Director

MHSA HOUSING LOAN PROGRAM
ONGOING ANNUAL MHSA FUND RELEASE AUTHORIZATION FOR FUTURE
UNEUNCUMBERED FUNDS

City/County: _____

Until otherwise directed by City/County, and pursuant to Welfare and Institutions Code (W&I) Section 5892.5, City/County hereby request the annual release of MHSA funds in City/County’s CalHFA MHSA account (“Account”). Said Account may include deposits of unencumbered MHSA Housing funds, MHSA residual receipt loan payments, and accrued interest (collectively referred to as “Funds”). As of May 1st of each calendar year, please:

- Release and return all Funds to the City/County; OR**
- Release and assign all Funds to the CalHFA administered Local Government Special Needs Housing Program.**

On behalf of the City/County listed above, I hereby certify the following:

The City/County will use any released MHSA Funds returned to the City/County to provide housing assistance to the target populations identified in W&I Section 5600.3. Housing assistance means rental assistance or capitalized operating subsidies; security deposits, utility deposits, or other move-in cost assistance; utility payments; moving cost assistance; and capital funding to build or rehabilitate housing for homeless, mentally ill persons or mentally ill persons who are at risk of being homeless; and

The City/County will administer released and returned MHSA Funds in compliance with the requirements of the MHSA including, but not limited to, the following:

- The City/County will follow the stakeholder process identified in (W&I Section 5848), when determining the use of the funds;
- The City/County will include the use of the funds in the County’s Three-Year Program and Expenditure Plan or Annual Update, (W&I Section 5847);
- The City/County will account for the expenditure of those MHSA Funds in the City/County’s Annual Revenue and Expenditure Report (W&I Section 5899) Reporting will begin in the fiscal year when the MHSA Housing Program funds are returned to the City/County by CalHFA; and
- The City/County will expend the returned funds within three years of receipt or the funds will be subject to reversion. (W&I Section 5892 (h)).

By: _____ Date: _____

Name: _____ Title: _____

**MHSA HOUSING LOAN PROGRAM
ONGOING ANNUAL MHSA FUND RELEASE AUTHORIZATION FOR FUTURE
UNEUNCUMBERED FUNDS**

Make check payable to (if applicable): _____

Address: _____

Must attach evidence of City/County Board of Supervisors Approval



State of California Use Only:

REVIEWED BY:

**Department of Health Care Services
Agency**

California Housing Finance

Signature Date

Signature Date

Name

Name

Title

Title