MODOC COUNTY BEHAVIORAL HEALTH

Mental Health Services Act
FY 2017-18 through2019-20
Three-Year
Program and Expenditure Plan

POSTED FOR PUBLIC COMMENT
May 31, 2017 through June 30, 2017

The MHSA FY 17/18-19/20 Three-Year Plan is available for public review and comment from May 31, 2017 through June 30, 2017. The Plan is available online at hs.co.modoc.ca.us or in hardcopy upon request at the address are phone numbers listed below. Translation in Spanish will be available upon request. We welcome your feedback via phone, in person, or in writing. Comments may also be made during the Public Hearing to be held on Friday, June 30, 2017.

Public Hearing Information:
Friday, June 30, 2017 at 4:00 pm
Modoc County Health Services
Large Conference Room
441 N. Main Street, Alturas, CA 96101

Comments or Questions? Please contact:
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Thank you!

MHSA Community Program Planning and Local Review Process For MHSA 3 Year Plan FY 17/18-19/20

County: MODOC **30-day Public Comment period dates:** 5/31/17 – 6/30/17
Date: 5/31/17 **Date of Public Hearing:** Friday, June 30, 2017

COUNTY DEMOGRAPHICS AND DESCRIPTION

Modoc County is a small, remote county in the northeastern corner of California, bordering Oregon to the north and Nevada to the east. According to 2016 U.S. Census Bureau estimates, the population in Modoc County is believed to be 8,795, compared to a 2010 Census of 9,686, indicating that the population in Modoc county has decreased by 9.2%, continuing a downward trend from the loss of 7.4% in 2015. This stands in contrast to a population increase of 5.4% in California according to U.S. Census estimates in 2016 and 5.1% in 2015. (www.census.gov/quickfacts/table/PST045215/06049,06) Modoc County has only one incorporated city, Alturas, the County Seat, with a population of just over 2,600 people (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF). Major metropolitan areas are outside the county, or outside the state, 150-180 miles away. There are a number of small, rural communities located in the county. East of the Warner Mountains are Cedarville, Eagleville, and Fort Bidwell; in the northern part of the county are Davis Creek and New Pine Creek; to the west and northwest are Day, Canby, Newell/Tulelake, and Adin; and in the south, is Likely. The population of these unincorporated communities ranges from 800 to less than 60.

Historically, the local economy has been based on agriculture and forestry, with some recreation. There has been a major decline in forestry jobs over the last fifteen years and some decline in agriculture. Like other Northern California counties, individuals aged 30-39 in particular have migrated out of the area, pulled by academic and employment opportunities elsewhere. The unemployment rate in Modoc County in March 2017 was 9.7% compared to the unemployment rate for California of 5.1% (http://www.labormarketinfo.edd.ca.gov/file/lfmonth/countyur-400c.pdf). Modoc's unemployment rate has been consistently higher than the state's rate since 1990.

Modoc County has one of the lowest median incomes of households in the state at $37,860 in 2015, compared to $61,818 in California the same year. The county has a high percentage of population living under the poverty level (20.3%, standing above the statewide average of 15.3%) with a density of 2.5 people per mile (www.census.gov/quickfacts/table/PST045215/06049,06). More than 50% of students are receiving free or reduced lunches (Source: www.cde.ca.gov). The County Health Rankings & Roadmaps for 2016 identifies 31% of children living in poverty in Modoc County as compared to 23% in California.

Approximately 4% of the county population is under 5 years of age; 18% is ages 6-19; and 55% is ages 20-64. Nearly 23% of the county population is 65 years of age or older; that percentage is more than double the statewide older adult population of 11.4%. Females represent 49% of the population. 78% of Modoc County residents identify themselves as White; nearly 15% are Hispanic. American Indians comprise about 3.5% of residents, but are a significant voice in this community. Very small numbers of Asian/Pacific Islanders and African-Americans also live in

Modoc. (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF) It is estimated that about 13% of the population of Modoc County speaks a language other than English at home. Spanish is the only threshold language in Modoc County. There are an estimated 886 veterans, which represent about 10% of the population. (*Source: 2015 American Community Survey.)*

Modoc County is a rural, sparsely populated, isolated county of over 7,800 square miles. The County has been designated by legislation as a "Frontier county," which means that service delivery is hampered by the extremely low density of residents. Though density is sparse, Modoc County boasts scenic beauty and abundant natural resources. There are small towns, ranches, farmlands, lava beds, wildlife refuges, caverns, and forests within the borders of Modoc County.

An estimated 87% of persons in Modoc County aged 25 years or older have graduated from high school or have some college education (California rate is 82%), whereas those of the same age group with a bachelor's degree or graduate studies are an estimated 18% (California rate 31%) (www.census.gov/quickfacts/table/PST045215/06049,06). Though a higher percentage of individuals finish high school or attend college than the California average, those who earn a college, graduate, or professional degree are significantly less than the state average. This leaves Modoc County with a dearth of individuals possessing professional-level job training and skills.

While those who live in Modoc County enjoy all the advantages of rural living, they also face the challenges of a depressed rural economy, a geography that isolates them, and harsh winter weather often lasting into May, which causes further isolation. The sheer size and topography make it difficult for individuals and families to access needed support systems. The lengthy distances are further compounded by the fact that public transportation in the county is nearly nonexistent. Unemployment has caused many working age adults and families to leave the county while a higher than average number of older adults presents special challenges. The county has a significant population of Hispanic and Native American residents. Isolation, boredom and lack of access to gainful employment often contribute to individuals having too much down time and little incentive for achieving significant life goals.

COMMUNITY PROGRAM PLANNING

Provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this annual update per Title 9 of the California Code of Regulations, Sections 3300 and 3315.

1. *Briefly describe the Community Program Planning (CPP) Process for development of all components included in the FY 2017-2020 Three Year Plan. Include the dates of meetings and other planning activities; describe methods used to obtain stakeholder input.*

The Modoc County Behavioral Health (MCBH) Community Program Planning (CPP) process for the development of the MHSA FY 2017/18-2019/20 Three-Year Plan builds upon the initial planning process that started in 2005 for the development of our original Three-Year Plan and our Annual Updates. Over the past several years, this planning process has been comprehensive and has included the input of diverse stakeholders through one-on-one discussions, formal focus groups, stakeholder meetings, and surveys.

Components addressed by the planning process included Community Services and Supports (CSS); Prevention and Early Intervention (PEI) local and statewide; Innovation; Workforce

Education and Training (WET); and Capital Facilities/Technological Needs (CFTN). In addition, we provided basic education regarding mental health policy; program planning and implementation; monitoring and quality improvement; evaluation; and fiscal and budget components.

For the planning process for the FY 2017/18-2019/20 Three-Year Plan, we sought input from stakeholders regularly at our Behavioral Health Advisory Board Meetings (8/7/16, 9/21/16, 10/26/16, 1/18/17), Modoc County Prevention Collaborative meetings (1/24/17, 3/28/17, 4/25/17) and the Community Corrections Partnership monthly meetings. Special outreach was extended to school personnel from Modoc County Office of Education, Modoc Joint Unified School District, and Big Valley Joint Unified School District (3/27/17), Dependency Drug Treatment Court (5/1/17), and clinical staff (4/27/17). Our prevention program manager conducted one on one interviews with a family and consumer member from Sunrays of Hope, a peer owned and operated wellness and recovery center, (5/8/17), school personnel (5/8/17), Veterans Services, and other key community stakeholders, also reaching out to the Native American community.

Focus groups were held in Newell on September 28, 2016 and in Adin on November 9, 2016. Input will also be obtained at an Advisory Board public hearing in Alturas on June 19, 1917. Additional input was sought from the Community Corrections Partnership monthly meetings, particularly as we were planning the Continuum of Care for Behavioral Health consumers who are involved in the Criminal Justice System.

With this information, we were able to determine the unique needs of our community and develop an MHSA program that is well designed for our county. The overall goals of the MHSA are still valid and provide an excellent guide for maintaining and enhancing our MHSA services in FY 17/18-19/20.

We also reviewed data on our 43 Full Service Partnership (FSP) clients to ensure that FSP participants are achieving positive outcomes. Outcome and service utilization data is regularly reviewed by the clinical team to monitor clients' progress over time. This data has helped us to understand service utilization and evaluate client progress, and has been instrumental in our planning process to continually improve FSP services.

The proposed Three-Year Plan integrates stakeholder input, survey results, and service utilization data to analyze community issues and determine the most effective way to further meet the needs of our unserved/underserved populations. In addition, the MHSA Three-Year Plan planning, development, and evaluation activities were discussed with the following to obtain input and strategies for improving our service delivery system: Behavioral Health Advisory Board; Community Corrections Partnership; Cultural Competence Committee; Quality Improvement Committee; Katie A Team; Behavioral Health staff; Substance Use staff and AB109 service recipients.

All stakeholder groups and boards are in full support of this MHSA Three-Year Plan and the strategy to maintain and enhance services.

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

A number of different stakeholders were involved in the CPP process. Consumers and family members were involved in many formats, including through Sunrays of Hope, the consumer-operated, nonprofit Wellness Center. Consumers and/or family members also serve as members of the Behavioral Health Advisory Board, the Quality Improvement Committee and the Cultural Competence Committee. The following agencies/organizations have been represented in our CPP process: Public Health, Social Services, Probation, Modoc Superior Court (judges, Chief Clerk and Collaborative Treatment Courts Coordinator), District Attorney's Office, Sunrays of Hope consumer-operated wellness center, Living in Wellness Center in Adin, Modoc County Sheriff's Office, Alturas City Police, California Highway Patrol, Modoc County Office of Education, schools, TEACH, Inc. (non-profit), Modoc Crisis Center, Modoc Victim Witness program, Strong Family Health Center (formerly Modoc Indian Health Project), CalWORKs Welfare to Work Program, Ft. Bidwell Indian Tribe, and RISE (Resources for Indian Student Education).

Populations represented in the CPP process include Behavioral Health (mental health and substance use services) consumers, family members and staff (management, administrative, quality improvement and clinical), Native Americans, Hispanic residents, youth, transitional age youth, adults, older adults, veterans, and individuals whose primary language is either English or Spanish.

Modoc County Behavioral Health (MCBH) regularly interfaces with the multiple agencies involved with delivering quality services to our community through collaborative meetings and through one-on-one staff contact. In addition, MCBH reached out to key leaders from the Hispanic, Native American and veterans' communities to provide input.

Overall, the focus groups validated the input gained from prior individual and stakeholder discussions in collaborative meetings and key informant interviews. Outreach for focus groups, individual and stakeholder participation included encouraging veterans and persons who are LGBTQ to participate, although data related to veteran status and sexual identity was not collected during the process.

As expected in a geographically isolated frontier county, the perceived level of need was high overall. Common themes in the focus groups, collaborative meetings and key informant interviews included concern over the high levels of depression, anxiety, and anger issues. Other recurrent themes included the total absence of badly-needed safe, sober housing to address homelessness and transitional housing, and the lack of transportation, especially in the outlying areas of the county. There was strong support for training and certification of peers to assist with wellness and recovery, as well as support for clinician training to continue to build skills in the delivery of best practices. We also received validation, in general, for our individualized, client/family-focused service delivery plan, with some suggestions related to outreach and improving access to residents of the more isolated communities. Participants of focus groups expressed support for development and testing of the use of the web-based service delivery to assist with increasing access to services and peer to peer outreach and support.

LOCAL REVIEW PROCESS

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

This proposed MHSA FY 2017/18-2019/20 Three-Year Plan has been posted for a 30-day public review and comment period from May 31, 2017 through June 30, 2017. An electronic copy is available online at hs.co.modoc.ca.us. Hard copies of the document are available at the Behavioral Health clinic and in the lobbies of all frequently accessed public areas, including the Court House, County Administration, and the local library. In addition, hard copies of the proposed Three-Year Plan have been distributed to all members of the Behavioral Health Advisory Board; consumers (on request); staff (on request); and Sunrays of Hope Wellness Center. The Plan was also sent electronically to the Community Partnership Group/partner agencies and other stakeholders.

A public hearing will be conducted on Monday, June 30, 2017 at 4:00 pm, at Modoc County Health Services, 441 N. Main Street, Alturas, CA, in the large conference room.

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

Input on the MHSA Three-Year Plan will be reviewed and incorporated into the final document, as appropriate, prior to submitting to the County Board of Supervisors and the California Mental Health Services Oversight and Accountability Commission (MHSOAC).

MHSA Program Component
COMMUNITY SERVICES AND SUPPORTS

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

The MCBH CSS Program embraces a "whatever it takes" service approach in helping individuals achieve their goals. Services for all populations help reduce ethnic disparities, offer peer support, and promote values-driven, evidence-based practices to address each individual's unique needs, and support health and wellness. These services emphasize wellness, recovery and resiliency and offer integrated services for clients of all ages and their families. Services are delivered in a timely manner and are sensitive to the cultural needs of each individual.

Services included in the CSS Program are as follows:

- Outreach and Engagement. Services are provided, to the extent possible, through agreements with two neighboring counties (Lassen and Siskiyou); a consumer-operated drop-in center; collaboration with partner agencies and organizations to provide coordinated and/or integrated services in underserved areas; collaboration with organizations providing services to the Native American and Hispanic communities; and one-on-one contacts with individuals with serious mental illness, family members, community leaders, and school personnel.

- Full Service Partnerships. Services to include, but are not limited to, one-on-one intensive case management, housing support, transportation, advocacy, assistance navigating other health care and social service systems, child care, and socialization opportunities.

- Integrated Clinical Service Teams. Treatment teams are employed on an as-needed basis for individuals and families with mental health issues. Services include comprehensive assessments; individualized wellness and recovery action planning; case management services; individual and group mental health services; crisis services; linkages to needed services; and housing support.

- Continuum of Services Treatment. This continuums of care plans are designed to address the mental health and substance use disorder needs of children and youth, adults, and/or offenders. The Children and Youth Continuum of Care is designed in close collaboration with the educational system stakeholders. The Criminal Justice Continuum of Care is designed for offenders who have been arrested, charged with or convicted of a criminal offense and have a history of mental health or substance use disorders, with an emphasis on providing services to clients who are homeless and clients in the outlying area of the county post-release. The plan activates from the time of arrest through adjudication and release. The treatment team, comprised of all direct services providers, meets semi-monthly to review cases and look at all available service options to ensure that a client-focused/client-centered holistic approach is used. This is a collaborative system of care designed and delivered by the Community Corrections Partnership (CCP).

Our target populations include:

1. Children (ages 0-16) at risk of placement out of home (hospitals, juvenile justice system), and their families, especially children in Native American and Hispanic communities;
2. Transition Age Youth (ages 16-25) at risk of placement out of home (hospitals, criminal/juvenile justice systems), especially Native American and Hispanic youth;
3. Adults (ages 18-59) with serious mental illness and at risk of hospitalization, involvement in the criminal justice system, and/or homelessness; and
4. Older Adults (ages 60+) at risk of losing their independence and being institutionalized due to mental health problems, and especially those with co-occurring mental health and substance use disorders.

CSS Data for FY 2015/2016

The tables below show the number of CSS clients served, by age, race/ethnicity, and gender. It also shows the total dollars and dollars per client.

Figure 1 shows the total unduplicated number of clients served by the CSS program in FY 2015-16. As shown, there were 414 persons served with 19.6% children (0-15 years), 15.2% Transition Age Youth (16-25 years), 54.1% adults (26-59 years), and 11.1% older adults (60+ years).

Figure 1
CSS Clients (FY 2015-16)
By Age

0 - 15 years	81	19.6%
16 - 25 years	63	15.2%
26 - 59 years	224	54.1%
60+ years	46	11.1%
Total	414	100%

Figure 2 shows the race/ethnicity of those individuals served through CSS. Caucasians represent 75.8% of the client population; Hispanics 9.2%; and American Indians 10.4%. **Duplicated count: individuals can select more than one category for race/ethnicity.*

Figure 2
CSS Clients (FY 2015-16)
By Race/Ethnicity

Caucasian	314	75.8%
Hispanic	38	9.2%
African American	3	0.7%
Asian/Pacific Islander	2	0.5%
American Indian	43	10.4%
Other	5	1.2%
Unknown	9	2.2%
Total	414	100%

Figure 3 shows that females represent 60.1% of the CSS client population.

Figure 3
CSS Clients (FY 2015-16)
By Gender

Male	165	39.9%
Female	249	60.1%
Total	414	100%

Figure 4 shows that the average CSS client received $3,109 in services.

Figure 4
CSS Clients (FY 2015-16)
Dollars per Client

Total Dollars	$1,287,314
Total Clients	414
Avg. Dollars/Client	$3,109

Figure 5 shows the quarterly averages of the **duplicated** number of clients (23.5) served by the CSS program in FY 2015-16. There were 43 unduplicated FSP persons served with approximately 5% children (0-15 years), 16% Transition Age Youth (16-25 years), 53% adults (26-59 years), and 11% older adults (60+ years).

Figure 5
FSP Clients (FY 2015-16)
Age

0 - 15 years	2	5%
16 - 25 years	7	16 %
26 - 59 years	23	53%
60+ years	11	26%
Total	43	100.0%

Figure 6 shows that females represent approximately 63% of the FSP client population.

Figure 6
FSP Clients (FY 2015-16)
Gender

Male	16	37%
Female	27	63%
Total	43	100.0%

Figure 7 shows that of those served through FSP, three (3) individuals indicated identifying with Mexican American ethnicity and five (5) indicated that they identified with Native American heritage. Since individuals were able to select more than one category, the total number of clients is less than the total of the combined categories therefore the percentages are of the categories and add up to more than 100%. Thirty-nine (39) FSP persons (91%) served indicated they were not Hispanic/Mexican American. Caucasians represent 81% of the FSP client population; Hispanics 7%; and American Indians 12%. **Duplicated count: Individuals can select more than one category for race/ethnicity.*

Figure 7
FSP Clients (FY 2015-16)
By Race/Ethnicity

Caucasian	35*	81%*
Hispanic	3*	7%*
African American	0*	0%*
Asian/Pacific Islander	0*	0%*
American Indian	5*	12%*
Other/Unknown	2*	5%*
Total Unduplicated FSP persons served	43	105%*

Figure 8 shows that the average FSP client received $10,487 of FSP services.

Figure 8
FSP Clients (FY 2015-16)
Dollars per Client

Total Dollars	$ 450,940
Total Clients	43
Avg. Dollars/Client	$10,487

CSS Program Achievements

Modoc County continues to employ a collaborative model to strengthen outreach and engagement and service delivery to persons with serious emotional disturbance and serious mental illness in the unserved and underserved populations. We are utilizing a multi-agency response team on an as-needed basis to ensure that all community resources are available to assist individuals and families with mental health issues. The Community Corrections Partnership and Collaborative Treatment Courts Teams participate in the collaborative response team process for clients who we have in common.

We expanded outreach efforts to individuals and groups in the County who serve as potential identifiers and referral sources for unserved on underserved residents. Individual clinicians, or teams of direct service staff, scheduled and completed visits with a number of partner entities, including both hospitals, all primary care clinics, all dental clinics, the Modoc County Senior Center, the Veteran's Services office, Strong Family Health Center, and various partner County agencies. Outreach was also provided to clinics in neighboring communities in Siskiyou and Lassen Counties. Information was provided on the range of services available for children and adults, with particular emphasis on our collaborative service approach, FSP services and

intensive services available for youth, including Trauma-Focused CBT. Partners were encouraged to share their concerns, as well as ideas for improving or expanding services for individuals with serious mental illness. Various options for making referrals were provided, including business cards for all Behavioral Health clinical staff.

Several partners contacted through expanded outreach indicated they were pleasantly surprised by the array of services available through MCBH, and by the number of licensed therapists and Master's level interns employed by MCBH. Outreach efforts culminated with a well-publicized Behavioral Health Open House held from 10:00 am to 2:00 p.m. on June 17, 2016. A reporter from the *Modoc County Record* who attended the Open House published an article in the June 23rd edition of the newspaper describing the Behavioral Health array of integrated mental health and substance use services and how to access the services, as well as information on level of education, licensure, and/or certification of Behavioral Health staff.

MCBH management and supervisory staff investigated innovative options for improving outreach to underserved areas. Approval was granted through the Board of Partnership Health Plan of California to use Intergovernmental Transfer (IGT) funds to secure a mobile office for integrated Behavioral Health and Public Health services to be provided in outlying areas. After additional review and investigation, it was determined that the plan for a mobile office would be costlier than originally considered. However, the process of brainstorming outreach methods has led to additional avenues that will be pursued in FY 20/17/18, including collaborative approaches to travel and service delivery to outlying areas.

Sunrays of Hope, a consumer-operated, non-profit wellness center continues to be active in pursuing training opportunities to be provided locally for consumers and family members. Two members of Sunrays completed a Peer Core Competency Training, and participated in the Training of Trainers curriculum for the Peer Core Competencies. Those Sunrays members, who completed the Peer Core Competency Training of Trainers, are now able to participate as trainers in Peer Core Competency training for consumers and family members in Modoc County.

We have made significant progress in engaging consumers and family members on our Behavioral Health Advisory board, Quality Improvement Committee, and Cultural Competence Committees.

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

a. The Health Services Leadership Team (Director, BH and PH Deputy Directors, and the BH Clinical Director) identified a need for additional program management staffing. There were key administrative and program leadership functions that were not being adequately addressed. A similar conclusion was reached by the review team during the 2015/16 EQR. In addition, the Leadership Team took into consideration the need for succession planning since the Director and the BH Deputy Director both plan retirement within the coming year. The Leadership Team has developed a draft organization chart to address the needs, with one new position recently filled at the Program Manager level. In addition, a Clinician II was moved to a Clinician III and is a Supervisory position.

b. We have been unable to hire an on-site psychiatrist due to economy of scale issues, but we have been able to maintain stable telepsychiatry services, albeit at a high cost and added an additional day (3 days per week).

c. The need to increase outreach and engagement efforts in underserved areas remains a barrier and a priority. Since other Modoc County agencies and programs experience a similar need, we plan to pursue collaborative approaches to travel to outlying areas for service delivery. For instance, partnering with Public Health, Probation, Veteran's Service Office, CalWORKs, Child Welfare Services and other agencies who have clientele in those same underserved areas could reduce travel costs, while simultaneously improving opportunities for collaboration and integration of services. We are hoping to extend services to the Adin, and possibly Newell areas in the next couple of years.

d. Due to limited resources in the county, it continues to be a challenge to fully implement interagency collaborative teams. However, the interest and engagement of all stakeholders has been growing. Since the same players are involved frequently, we have been trying to maximize our time together and establish ways to convene meetings as needed for the more challenging situations. To the extent staffing levels have allowed, we have been trying to write grants and leverage existing resources for our collaborative efforts. Our Katie A, CCP, and Drug and Family Court collaborative teams have built a good foundation for our interagency collaborative team approach. Since our Behavioral Health integration and the addition of a Public Health nurse to the Behavioral Health team, we have built a strong, interdisciplinary core team to build upon as necessary.

e. As a community, over the last few years, we have experienced some significant traumatic events that resulted in an increased need for services. Our strategies included providing opportunities for debriefing, creating priority access as needed, and providing Crisis Intervention Training for law enforcement and other first responders. In addition, as a result of traumas within their community, Native Americans are faced with reestablishing a cohesive structure and leadership. We, along with other stakeholders, are in the throes of rebuilding our historically very strong ties with stakeholders and collaborators within the Native American community.

f. Implementation of Medi-Cal Managed care in the primary health care clinics, and Medi-Cal and Drug Medi-Cal expansion has created many challenges. Our strategies include staying current on each change; engaging with Partnership Health Plan and primary care providers to maximize opportunities for healthcare integration; engaging with other county colleagues to seek opportunities to provide regional services and create risk pools.

g. The inability to adequately collect, process and interpret data for outcomes measurement remains a barrier. We tested the use of a client registry, but the system tested did not adequately meet our needs. MCBH, along with Nevada County Behavioral Health, have been accepted by the California Institute for Behavioral Health Solutions (CIBHS) as the first Counties to implement the Electronic Behavioral Health System (eBHS), a more comprehensive and user-friendly registry, allowing for real-time information sharing across healthcare systems. We are hopeful as we move forward with implementation the eBHS registry that we will have finally found an affordable, effective, user friendly system to measure outcomes at the consumer/client level, program, and population levels. Our Innovation Plan for the implementation of eBHS was approved by the Mental Health Services Oversight and Accountability Commission on April 27, 2017.

3. *List any significant changes in Three-Year Plan, if applicable.*

We have created a Continuum of Care Partnership (CCP) continuum of care treatment team that works on applying for Medi-Cal, case management, housing, job skills and education and SUDS and mental health services.

We have filled a Program Manager position that reports to the Deputy Director. The new Program Manager will receive appropriate training and mentoring in order to assume responsibility for two programs, which includes leadership and administration of the Modoc County MHSA programs and processes.

Timeliness measures in our electronic health records (EHR) have been created to measure first contact to first assessment service, first contact to first psychiatric service, urgent condition (new crisis contact) to first follow-up service and first service after hospitalization. Our goal is to have our Electronic Behavioral Health Solutions (eBHS) offer monthly or quarterly reports on the timeliness measures.

We are working with the Northern Region Directors and Partnership Health Plan to develop a regional approach to implementation of Drug Medi-Cal.

We have worked to create a Prevention and Intervention Continuum of Care for children and youth in collaboration with our educational and other agency partners and plan to strengthen this collaborative partnership as a part of this plan.

MHSA Program Component
PREVENTION AND EARLY INTERVENTION

1. ***Provide a program description (include number of clients served, age, race/ethnicity, cost per person; try to separate data for Prevention and Early Intervention, if possible). Include achievements and notable performance outcomes.***

The new PEI regulations that became effective October 6, 2015, outline requirements for specific program categories for delivering PEI services: a) Prevention Program(s); b) Early Intervention Program(s); and c) Stigma and Discrimination Reduction Program(s); d) Outreach for Increasing Recognition of Early Signs of Mental Illness (a separate program, or a strategy within a program); e) Access and Linkage to Treatment strategy or program; and f) Improve Timely Access to Services for Underserved Populations strategy or program. In addition, counties may choose to deliver a Suicide Prevention Program. Below are descriptions of program/strategy funded under each category.

a. **Prevention:** The **Integrated Prevention Through Developmental Asset Building Program,** with the following strategies, was developed through our stakeholder process as our prevention component:
   1) **Primary Intervention Program, Grades K-6**: The Modoc County Office of Education (MCOE) operates this program through a Memorandum of Understanding. The Program is provided in three school districts under the auspices of MCOE: Modoc Joint Unified School District; Surprise Valley School District; and Tulelake School District. Educators in each district refer high-risk youth to the program, which is provided throughout the school year in each district. Key elements include:
      - Specific site selection, selection of program facilitators and program monitoring by MCOE;
      - Identification of school site in-kind resources to support the Primary Intervention Program;
      - Development of referral protocols for services at the classroom site, that are culturally competent and that identify children at risk of school failure for Primary Intervention Program services;
      - Development of parent involvement efforts to assure that parents/guardians and teaching staff support children's participation and growth in the Primary Intervention Program;
      - Development of referral protocols with Modoc County Mental Health for students and families who need more intensive services;
      - Administration of tracking and monitoring tools to determine effectiveness of the program.

      In school year 14/15, MCOE expanded the Primary Intervention Program from 10 weeks to 18-20 weeks, and from 30 minute sessions to 45 minute sessions in order to incorporate modeling of the skills learned, as well as student role play of the skills. With the expansion, outcomes were measured using the Walker Survey Instrument (WSI).

      The WSI is filled out by teachers for each student referred to the program prior to the start of the sessions (pre-test), as well as after completion (post-test). The teacher

records his/her assessment of the child's behavioral status in relation to each of 19 statements indicative of behavioral skills. The teachers rate the frequency of observed use of the skills on a five-point scale, with "1" indicating the student "never" uses the skill; "3," the student "sometimes" uses the skill; and "5," the student "frequently" uses the skill.

In school year 15-16, the Primary Intervention Program served 112 students in the 18-20-week program: 52 students from Tulelake Elementary School; 47 from Alturas Elementary School; and 13 students from Surprise Valley Elementary School.

Demographics – for youth receiving services in the Primary Intervention Program for FY 15-16:

Male: 67 clients
Female: 45 clients

White, not Hispanic: 68 clients
Hispanic/Latino: 34 clients
Native American: 4 clients
Multi-racial/Multi-ethnic: 6 clients

Ages 5-11: 108 clients
Ages 12-14: 4 clients

Student progress – Primary Intervention Program – 2015/16 School Year

When comparing the pre-WSI scores and the post WSI scores for each student, all three schools demonstrated improved behavioral skills for students completing the program. In addition, all three schools demonstrated an increase in improvement (student growth in demonstrated behavioral skills) in 2015/16 when compared to 2014/15.

Figure 5
Primary Intervention Program
Pre/Post-Measure Improvement (growth in the students' demonstrated behavioral skills)
For School Years 2014/15 and 2015/16

Elementary School	2014-15 School Year		2015-16 School Year	
Alturas Elementary School	n = 34	67% growth	n = 47	79% growth
Surprise Valley Elementary School	n = 12	25% growth	n = 13	42% growth
Tulelake Elementary School	n = 44	64% growth	n = 52	72% growth

In FY 2015-16, the Modoc County Behavioral Health agreement with MCOE provided $40,000 of MHSA-PEI funds to partially offset the costs of providing the Primary Intervention Program for the 112 children in the three elementary school sites.

2) **40 Developmental Assets**: In response to school personnel input and observations from stakeholders and individuals regarding a need to serve children at risk of, or suffering from, anger, anxiety or other mental health issue, a shift was made in the FY 2016/17 – 2018/19 from a focus on the 40 Developmental Assets program to the School Wide Positive Behavioral Intervention Services (SW-PBIS) program and the Capturing Kid's Heart (CKH) program. These evidence-based programs continue the focus on school climate change and asset development for youth begun with the 40 Developmental Assets program.

   School climate affects the maturation and achievement for all students, especially those with academic and behavior risk (e.g., disability, mental health, disadvantaged, language). Positive school climate has been linked to several important outcomes including increased student self-esteem and self-concept, decreased absenteeism, enhanced risk prevention, reduced behavioral problems and disciplinary actions and increased school completion. Establishing and maintaining a positive school climate benefits all students, including students with disabilities, English language learners, children and youth from economically disadvantaged families, and students from culturally and racially diverse groups (*Source: Sugai, G. Simonsen, B, Freeman, J, La Salle, T. (11/29/16).Technical Brief "Every Student Succeeds Act: Why School Climate Should Be One of Your Indicators," Center for Positive Behavioral Interventions and Supports, University of Connecticut*).

3) **Capturing Kid's Hearts (CKH),** developed and tested by the Flippen Group, was first offered through Modoc County Office of Education in FY 16-17 as an immersive participatory experience in character education. The goal is to capture kid's hearts in order to capture their minds. "Research shows that when students feel more connected to their school and staff, they achieve higher academic success and are less likely to have attendance, tardy or behavioral issues" (ghaps.org/content/capturing-kids-hearts).

   The area of interest in this program is mental health promotion for youth and teens. The outcomes measured are: problem behaviors, parent-student communication, self-efficacy, loneliness, and school connectedness.

   The program consists of behavioral contracts at school, at certain places in the school (gym, cafeteria, playground), and at home. It centers around school climate change by building positive relationships with peers, teachers, staff and family. Specific culturally competent strategies are developed by each school, each teacher and each home that are tailored to meet the needs of the students.

   The Healthy Kid's Survey will continue to give us trends in school connectedness to help evaluate the effectiveness of this program.

4) **School Wide Positive Behavioral Intervention Services (PBIS)**, is a school climate change program implemented by the Big Valley Joint Unified School System and being considered by Modoc County Office of Education. Grounded in the behavioral and prevention sciences, it emphasizes a three-tiered support system framework. Tier 1, the primary prevention level gives support in positive behavioral interventions and supports for all students. Tier 2 is targeted group support for some students who struggle at some level. Tier 3 is individual support for a few students (usually 1%-5%

of all students) and is provided by MCBH specialists and those best trained to support the students. These tiers, who they target and the prevention strategies are described below:

PBIS Multi-Tiered Support Systems		
Tier 1	Universal Supports, Primary Prevention	Preventing the development of new problem behaviors by implementing high quality learning environments for all students and staff and across all settings (i.e., school-wide, classroom, and non-classroom).
Tier 2	Targeted Supports, Secondary Prevention	Reducing the number of existing problem behaviors that are presenting high risk behaviors and/or not responsive to primary intervention practices by providing more focused, intensive and frequent small group-oriented responses in situations where problem behavior is likely.
Tier 3	Intensive Supports, Tertiary Prevention	Reducing the intensity and/or complexity of existing problem behavior that are resistant to and/or unlikely to be addressed by primary and secondary prevention efforts by providing most individualized responses to situations where problem behavior is likely.

The Healthy Kid's Survey will be used to measure the effectiveness of the PBIS program.

5) **The Nurturing Families Program** was first offered in FY 15-16 when it was chosen to replace the Strengthening Families Program (SFP), which is no longer available. The Nurturing Families Program is a labor-intensive program, requiring multiple facilitators. Facilitators may change from one 15-week session to the next, depending upon availability from partner agencies. The Program consists of fifteen weekly sessions; each session includes dinner, followed by skills-based groups. First, separate groups are scheduled for the youth, using the teen Nurturing curriculum ("It's All About Being a Teen: Developing Nurturing Values and Skills in Adolescents"), and for the parents, using the "Nurturing Parenting" curriculum. The separate groups are followed by a short group session for the families where all the parents and youth in the program participate. Facilitators in FY 15-16 included staff from Behavioral Health, Probation, juvenile court, Public Health and TEACH, Inc. (nonprofit). A Behavioral Health prevention staff member has been assigned to take the lead to coordinate the teams for facilitating each 15-week session, and to coordinate the planning time required for the teams to successfully present the Nurturing Families Program.

The Nurturing Families Program occurs wherever outreach activities identify the necessary 10-12 families willing to participate in each 15-week experiential education process. The program takes place in Alturas most frequently. If there are not

adequate numbers of families identified to provide the service in outlying communities, transportation to the program is provided.

Program Elements:

- Outreach and engagement to identify parents, and referring entities, for families needing and wanting additional family education and support;
- Engagement and expansion to identify and recruit facilitators from partner stakeholder agencies and other appropriate sources;
- Arranging for child care for children in the participating families who had children too young for the program;
- Arranging for transportation for families who indicated they would need a ride to the program;
- Arranging for family-style sit-down dinners as part of each cycle of the Nurturing Families Program. This has been accomplished in a variety of ways in the past, including take-out meals from local restaurants, hiring a cook with appropriate food-handlers' certificates, and relying on facilitators, with food-handler certificates, taking turns to provide meals. Our experience is that remaining flexible on "what works" increases the likelihood of coordinating a successful Nurturing Families cycle.

Recruitment of participant families for each cycle of the Nurturing Families Program tends to be difficult given our small population size. Six families (with a total of 7 teens) were recruited for the cycle that began in FY 2015-16. Four of the six families (total of 4 teens) graduated from the Nurturing Families Program in July, 2016.

Demographic and other data for the five adults in the four families completing the program include the following:

- 4 females (3 mothers and 1 legal guardian/family member); 1 male (boyfriend of a mother);
- 4 adults reported race/ethnicity as White/non-Hispanic; 1 reported Hispanic;
- Ages of adults ranged from 31 to 49, with 39 as the average age;
- 2 adults reported working part-time; 1 reported as disabled; 2 reported unemployed;
- 3 of the 5 adults reported experiencing childhood abuse. The abuse occurred within the family for 1 adult, outside the family for 1 adult, and 1 adult reported childhood abuse both within and outside the family.

Demographic data for the 4 youth enrolled in the program include:

- 2 males; 2 females;
- 1 Hispanic; 3 White/non-Hispanic;
- Ages ranged from 13 to 17, with 15.5 as the average age.

Outcomes were measured using pre- and post-measures completed by the parents/ guardians. The measuring tool, *Adult-Adolescent Parenting Inventory-2* (AAPI-2), results in a parenting profile that provides "risk scores" for five parenting constructs. "Risk Scores" ranged from 1 to 10 for each construct, with higher numbers indicated reduced risk. For each of the five constructs, a risk score of 1-3 indicated high risk, a score of 4-7 was medium risk, and 8-10 indicated low risk.

Table 6 includes both low and high score descriptions for each parenting construct, as well as the range of scores and the average score (pre- and post-) for each construct.

The constructs measured by the AAPI-2 include:

A. Appropriateness of parent's expectations;
B. Level of parent's empathy;
C. Parent's belief in value of corporal punishment vs. value of alternatives to corporal punishment;
D. Appropriateness of family roles; and
E. The extent to which parents value power-independence in their children.

Figure 6
Low and High Score Descriptions of Parenting Constructs
Range and Average of Pre- and Post-AAPI-2 Scores for Each Construct
Average Pre- and Post-Scores for All Constructs Combined

Parenting Construct	Low Score Description of Parenting Constructs	*Pre*-Measure Range/Ave.	*Post*-Measure Range/Ave.	High Score Description of Parenting Constructs
A. Expectations	**INAPPROPRIATE EXPECTATIONS** *Expectations exceed children's developmental capabilities. Lacks understanding of normal child development. Self-concept as a parent is easily threatened. Tends to be demanding and controlling.*	Range of Scores: 2 (high risk) to 7 (med. to low risk). **Average: 5.6 (Med. risk)**	Range of Scores: 4 (med. to high risk) to 7 (med. to low risk). **Average: 5.75 (Med. risk)**	**APPROPRIATE EXPECTATIONS** *Understands growth and development. Children allowed normal developmental behaviors. Self-concept as a caregiver is positive. Tends to be supportive of children.*
B. Empathy	**LOW LEVEL OF EMPATHY** *Fears spoiling children. Development needs of children not understood or valued. Children must act right and be good. Lacks nurturing skills. Unlikely to handle parenting stresses.*	Range of Scores: 5 (med. risk) to 7 (med. to low risk). **Average: 6.0 (Med. risk)**	Range of Scores: 4 (med. to high risk) to 10 (low risk). **Average: 6.75 (Med. Risk)**	**HIGH LEVEL OF EMPATHY** *Understands/values children's needs. Children are allowed to display normal behaviors for age. Nurture children and encourage positive growth. Communicates with children. Recognizes children's feelings*
C. Corporal Punishment	**STRONG BELIEF IN THE VALUE OF CORPORAL PUNISHMENT** *Hitting, spanking, slapping children is appropriate and required. Lacks knowledge of alternatives to corporal punishment. Disciplinarian, rigid. Tends to be controlling, authoritarian.*	Range of Scores: 3 (high risk) to 8 (low risk). **Average: 5.5 (Med. risk)**	Range of Scores: 4 (med. to high risk) to 10 (low risk). **Average: 6.25 (Med. risk)**	**VALUES ALTERNA-TIVES TO CORPORAL PUNISHMENT** *Understands and utilizes alternatives to physical force. Tends to be democratic in rule making. Rules for family, not just for children. Tends to have respect for children and their needs. Values mutual parent-child relationship.*
D. Family Roles	**REVERSES FAMILY ROLES** *Tends to use children to meet self-needs, as objects for adult gratification. Tends to treat children as confidant and peer. Expects children to make life better by providing love, assurance and comfort. Tends to exhibit low self-esteem, poor self-aware-ness, and poor social life.*	Range of Scores: 6 (med. risk) to 9 (low risk). **Average: 7.25 (Med. to Low risk)**	Range of Scores: 7 (med. to low risk) to 10 (low risk). **Average: 8.5 (Low risk)**	**APPROPRIATE FAMILY ROLES** *Tends to have needs met appropriately. Finds comfort, support, companionship from peers. Children allowed to express developmental needs. Takes ownership of behavior. Tends to feel worthwhile as a person, good awareness of self.*

E. Power - Independence	**RESTRICTS POWER-INDEPENDENCE** *Views children with power as threatening. Expects strict obedience to demands. Does not value negotiation or compromise to solve problems. Views independent thinking as disrespectful.*	Range of Scores: 3 (high risk) to 10 (low risk). **Average: 6.5 (Med. risk)**	Range of Scores: 5 (med.) to 8 (low risk). **Average: 7.25 (Med-Low risk)**	**VALUES POWER-INDEPENDENCE** *Values children's ability to problem solve. Encourages children to express views, yet expects cooperation. Empowers children to make good choices.*
Average Pre-test score on 5 constructs 6.17			**6.90 Average Post-test score on 5 constructs**	

Given the extremely small number of individuals included in data analysis, no conclusions can be drawn or inferences made about the Nurturing Parenting Program. As measured by the Pre- and Post- AAPI-2 scores for these adults, it can be noted that the average risk score for these parents/guardians improved for all five parenting constructs.

6) **Healthy Beginnings**: The target population for this program is from 0 – 5. Healthy Beginnings seeks to improve birth outcomes by providing access to direct health and social services for pregnant women whose chances of having a healthy baby are hampered by such risk factors as poverty, limited access to health care, poor nutrition, age, substance abuse, homelessness, domestic violence and more. The system also seeks to reach young children exhibiting developmental or behavioral issues that could hamper later school success. Through early intervention, many such issues can be dealt with prior to the child entering the formal school setting, thus improving opportunities for school success.

Healthy Beginnings continues to be a collaborative project between Behavioral Health and Public Health. The MCBH counselors have continuous dialogue with Public Health Nurses regarding Healthy Beginnings clients who require their services in order to facilitate case management and ensure timely access to care.

Promotores (Community Outreach Worker) – We plan to incorporate into our prevention program the use of Promotores to provide additional cultural and linguistic competence to engage and more effectively identify and serve the needs of our Hispanic community members.

There were 13 Healthy Beginnings clients who utilized Behavioral Health services during FY 15/16. There were a total of 25 Healthy Beginnings clients during this time frame. The primary caregiver of the family is screened for potential SUD and history of mental illness by the Public Health Nurse and then referred to Behavioral Health if there is a concern.

b. Early Intervention: We have identified the following program for the Early Intervention component:

1) **Trauma-focused Cognitive Behavioral Therapy (TF-CBT):** The target population for this program is children and youth ages 3 – 18. The goal of TF-

CBT is to help address the biopsychosocial needs of children with Post-Traumatic Stress Disorder (PTSD) or other problems related to traumatic life experience, and their parents or primary caregivers. TF-CBT is a model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioral therapy. Children and parents are provided knowledge and skills related to processing the trauma; managing distressing thoughts, feelings, and behaviors; and enhancing safety, parenting skills, and family communication.

TF-CBT treatment components include:

- Psychoeducation
- Parenting Skills
- Trauma Narrative
- Enhancing Future Safety and Development

We were able to look at data for 9 youth who received TF-CBT treatment services, as well as 10 parents/caregivers (3 of the 9 youth were siblings).

Demographic data for 9 children include:

- Sex – 5 girls and 4 boys
- Ages – Ranged from age 4 to age 14; Average age – 9.2 years
- Race/ethnicity – 8 youth were Caucasian; 1 was Native American

Demographic data for 10 parents/caregivers include:

- Sex – 7 women and 3 men
- Ages – Ranged from age 31 to 35; Average age – 32.3 years
- Race/ethnicity – 8 parents/caregivers were Caucasian; 1 was Native American; 1 was Hispanic

Treatment "Dose":

- Children received between 10 and 20 TF-CBT sessions, with 16.9 the average number of sessions the children received.
- Parents/Caregivers received between 6 and 21 sessions, with 11.1 the average number of sessions received.

Outcomes:

- Using the UCLA PTSD Index for DSMIV (PTSD Ri) at initial assessment, 5 of the nine children met criteria for Post-Traumatic Stress Disorder, and were treated using the TF-CBT curriculum.
    - After completing approximately half of the treatment process, 1 child terminated the treatment prematurely;
    - 3 children completed the treatment protocol, no longer met diagnostic criteria for PTSD and terminated successfully;
    - 1 child completed the TF-CBT treatment protocol, and no longer met criteria for PTSD. The child continues to receive mental health treatment from Modoc County Behavioral Health for other behavioral and mental health concerns.
- Using the UCLA PTSD Index at initial assessment, 4 of the children did not meet criteria for PTSD, although had some PTSD symptoms. They were treated using the TF-CBT curriculum.

- All four children completed treatment, no longer had anxiety symptoms that impacted functioning, and terminated successfully.

It is estimated that we will serve approximately 10 - 20 children and youth in this program per year at approximately $4,000/child for a total of $40,000 - $80,000 per year. It is anticipated that 80% of youth completing the TF-CBT treatment program will demonstrate improved outcomes using the above measures pre and post treatment.

c. Outreach for Increasing Recognition of Early Signs of Mental Illness, Linkage, and Stigma and Discrimination Reduction:

The MCBH "ReachOut" project will be integrated and infused throughout our system of care and as such, our Prevention and Early Intervention Programs. The three primary strategies are to: Increase recognition of early signs of mental illness; provide timely access and effective linkage; and reduce Stigma and discrimination through leveraging the Cal MHSA program strategies. Implementation is planned as follows:

1) MCBH and Sunrays of Hope will develop collaborative processes whereby staff/peer partners will jointly reach out to community groups (e.g., Rotary, sororities, Chamber of Commerce, schools, partner agencies, tribal entities) to schedule presentations/ meetings for the purpose of educating community members on: understanding mental illness; recognizing early signs of mental illness; and what they can do to help. Inclusion of MCBH staff and trained peers active in Sunrays of Hope will provide both a peer perspective and a professional perspective on recognizing early signs of mental illness.
2) Timely access and linkage strategies with be infused throughout the whole system of care and well as the prevention and early intervention programs and strategies by embedding it in our collaborative processes and procedures. Timeliness measures are incorporated and embedded in our electronic health recorded and eBHS and we plan to report them on a system-wide basis as a very small county.
3) Our Stigma and Discrimination Reduction Program with be delivered and evaluation through agreement with California Mental Health Services Authority (CalMHSA) as a part of the Statewide Program Plan. MCBH and SUDS will collaboratively leverage the Modoc funded by implementing a modified media campaign designed to educate the community on early signs of mental illness, and to promote the reduction of stigma and discrimination and to raise awareness of adverse effects of substance use to mental and physical well-being. The media campaign will include articles and ads in the local *Modoc County Record* newspaper, as well as flyers to be distributed to businesses, partner agencies, faith-based groups, and other venues.

d. Suicide Prevention:

We have entered into an agreement with CalMHSA to continue to fund the state-wide suicide prevention program and to provide additional support as our suicide prevention program. Due to very limited resources, with Board approval of this plan, MCBH will not provide a local-specific suicide prevention program. We will, however, continue to partner with statewide efforts through collaborative CalMHSA activities and Each Mind Matters media messages and infuse suicide prevention efforts into our system continuum of care.

On March 16, 2016, two members of the Each Mind Matters organization visited Modoc County:

1) They met with consumers at Sunrays of Hope Wellness Center, provided Each Mind Matters materials, t-shirts, buttons and pamphlets, and provided suggestions for how consumers can actively participate in spreading the suicide prevention message.
2) Each Mind Matters staff visited businesses and shared some materials. During their tour of local businesses, they entered a local restaurant where all wait staff were wearing Each Mind Matters t-shirts. The restaurant owner shared that his staff wear Each Mind Matters t-shirts on the same day once a week, which is how the business and the staff help promote suicide prevention on an ongoing basis.
3) Each Mind Matters staff attended the Behavioral Health Advisory Board to provide materials and information about statewide efforts to prevent suicide, and how Each Mind Matters is being incorporated into prevention efforts in Modoc County.

Each Mind Matters provided statistics on the number of Modoc County residents accessing the National Suicide Prevention Hotline, a phone number distributed through local efforts related to Each Mind Matters.

Below is the Modoc County National Suicide Prevention Hotline data for calendar years 2015 and 2016.

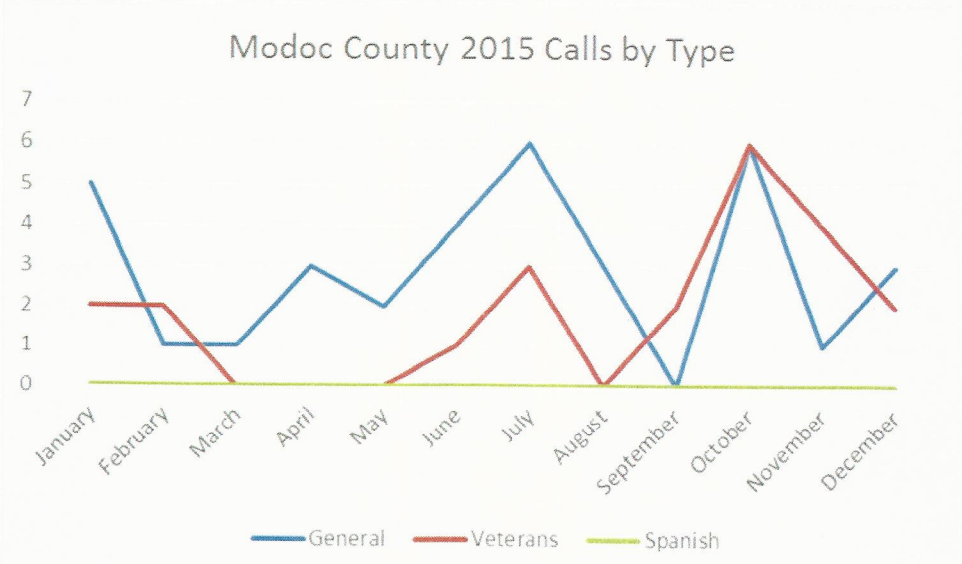
2015 Modoc County Calls to
The National Suicide Prevention Hotline

MODOC 2015	General	Veterans	Spanish	Total
January	5	2	0	7
February	1	2	0	3
March	1	0	0	1
April	3	0	0	3
May	2	0	0	2
June	4	1	0	5
July	6	3	0	9
August	3	0	0	3
September	0	2	0	2
October	6	6	0	12
November	1	4	0	5
December	3	2	0	5
	35	22	0	57

2016 Modoc County Calls to the National Suicide Prevention Hotline
(Partial Year)

2016	General	Veterans	Spanish	Total
January	7	0	0	7
February	3	0	0	3
March	0	0	0	0
April	4	0	0	4
May	6	2	0	8
	20	2	0	22

It was noted that there was a noticeable drop in numbers of calls to the suicide hotline from Modoc County in calendar year 2016, compared to calendar year 2015. During much of 2016, MCBH was short-staffed, which may have impacted the amount of time staff had available for on-going local outreach/education on the National Suicide Prevention Hotline.



Prevention Programs Summary

In the prevention programs overall, we anticipate that these PEI projects will result in positive community outcomes, specifically an improvement in children's assets in Modoc County, as measured by comparisons over time of the results from the Healthy Kids Survey. We expect that some children in grades K-12 will improve their functioning in school and social environments. We expect that some families will improve their ability to communicate, to reduce risky behaviors, and to function confidently in school and social settings.

1. ***Describe any challenges or barriers, and strategies to mitigate.***

We experienced some implementation challenges in the past couple of years in the 40 Developmental Assets Program. Due to school staffing capacity, we were not able to evaluate this program annually. Through collaboration with the schools, they have identified evidence based Capturing Healthy Hearts and School Wide Positive Behavioral Interventions and Supports (PBIS) programs as preventive interventions appropriate to the Modoc County population. We are collaborating to implement these programs at the school level, while providing individual and wrap-around services for students who enter Tier 3 of the PBIS program.

Staffing issues in very small counties continue to be a primary challenge. All employees take on multiple roles, wearing many hats. Economy of scale issues make it impossible to have staff that are dedicated solely to MHSA or to PEI. However, we have hired a part-time staff person to co-ordinate the PEI program to help expand our PEI program components and expand access to PEI strategies to the outlying areas of Adin and Newell.

Due to staffing and resource issues, we were unable to expend funds fully as budgeted which could result in some reversion of PEI funds. However, we are actively working with the State, our Association, and the MHSOAC to address the issues on behalf of all counties, and especially small counties through changes to regulations or the law to mitigate the potential impact.

2. ***List any significant changes in Three-Year Plan, if applicable.***

Significant changes to the PEI program are described above, to address the updates in the PEI regulations.

As a result of stakeholder feedback, the Primary Intervention Program (PIP) is being expanded this fiscal year to increase the number of hours and programs offered. This program has been identified by our educational partners as the highest priority need and evidence-based practice cluster that they would like to implement. The PIP will be folded into two PEI programs called Capturing Kid's Hearts, and Positive Behavior Intervention Supports, a multi-tiered system of support for a more comprehensive Prevention and Early Intervention Program for grades K -12.

Other changes are to collaborate with SUDS in community outreach media education and to target ages 0-5 through Healthy Beginnings.

We have increased our programming in the schools by offering therapy and case management within the school sites.

MHSA Program Component
INNOVATION

1. Provide a program description. Include achievements and notable performance outcomes.

Modoc County Innovations Project Overview
Electronic Behavioral Health Solutions (eBHS)
Innovations and Improvement Through Data (IITD)

Over the past five years, Modoc County has been participating in integrated care learning collaboratives that incorporated quality improvement (Plan, Do, Study, Act – PDSA) processes. Learning from the PDSA cycles included the following barriers and/or needs:

1) Electronic health records (EHRs) and State reporting systems do not adequately contribute to real time use of data for partnering with clients in treatment planning nor tracking adherence and use of evidence based practices nor are they useful for tracking individuals not formally admitted for services, therefore they are not useful for population management;

2) There is a critical need for a data analytic system to meet multiple data needs, including day-to-day clinical dashboards, population management data reports, and aggregate outcomes reporting for internal and external stakeholders. The data system should have the capacity to pinpoint and allow for data analysis and improved system response thus improving behavioral health care in this especially small "frontier" County;

3) Most counties have not been successful in spreading use of data analytics systems beyond special projects, much less for population management. Any system adopted needs to have a strong implementation process aimed at embedding the data analytics as a part of the clinical practice and easy to use with minimal information technology support;

4) The implementation process needs to engage and educate staff in practical, real-time use of data in treatment planning and tracking individual outcomes related to selection of and adherence to evidence-based or promising practices;

5) Once these are incorporated, the data analytics system should have the flexibility to allow for entry of individuals not registered in the EHR, have ability to accept data crosswalk from the EHR and/or other data systems, have data collection reminders, allow access for integrated care partners, and have potential for client portal capability in the future.

Through the innovation, Modoc County will bring three effective strategies together to improve client outcomes and manage the Behavioral Health population more proactively. This three-pronged approach was developed by the California Institute for Behavioral Health Solutions to increase the success of data collection initiatives. Now that Innovation funding has been awarded, **Modoc will be the first county to utilize it for system-wide data collection, client outcome tracking, population management, and quality improvement.** The approach includes: 1) a uniquely flexible, cost-efficient web-based data analytic system; 2) a strong implementation method; and 3) training on use of data in clinical practice. Each component is believed to be equally essential.

Equal attention to these three components will result in staff and clinicians knowing how to navigate the data system, add data for population management, understand how to interpret outcomes data in clinical dashboards, and sustain use of data long-term so it becomes a natural part of clinical practice and managed care. The ultimate goal of this innovative project is a sustained improvement in client outcomes. The three pronged approach will be as follows:

1. <u>The Data System</u>— electronic Behavioral Health Solutions (eBHS):

A flexible, cost-efficient web-based platform, eBHS enables custom development of reports including clinical dashboards, aggregate outcomes reports, and population management reports.

Clinical dashboards will be developed based on clearly defined clinical outcomes: 1) A Global Functioning Measure; 2) Treat-to-Target measures. Real time data will be used to engage the client and clinician in treatment to ensure the best possible outcomes. In addition, eBHS will be set up to aggregate pre and post outcomes data with filtering options providing the ability to collect data based on common demographics categories, such as race, gender, age, etc.

2. The Implementation Protocol:

We will use the Community Development Team model (CDT) based on implementation science and developed by CiBHS in 2006. Used in California to implement Evidence-Based Practices and Community-Defined practices, the CDT will be modified for this innovation to include specific pre-implementation activities related to the use of technology and preparation for using data in real time to guide clinical practice and population management. Modoc County will participate in peer-to-peer calls with clinical and implementation staff of other counties to share learning, challenges, and barriers.

3. Data Interpretation and Feedback Informed Treatment (FIT)Training:

The staff using eBHS will receive specific training on how to interpret and use clinical outcomes data with clients to inform practice. By integrating trainings of eBHS and FIT, eBHS will be presented as a clinical tool rather than a database. Further, the process will build capacity as a Managed Care Entity to use eBHS as a beneficiary/population management tool.

Learn and Improve

Modoc County aims to learn and improve client service through the implementation of a new population management/data analytics system in two areas:

Goal 1: Increase clinician use of real-time data analytics. The goal is that clinicians will incorporate review of data as a natural and integral part of service delivery through use of eBHS.

Goal 2: Implement system-wide administrative use of data analytics. Small counties have minimal opportunity to analyze their data to better understand treatment and outcomes, and for use in population management and prevention. This innovation will help Modoc County better understand what may be impacting areas of concern throughout their system as well as the potential to be used in an integrated manner with all areas of whole-person health and for proactive prevention and linkage to treatment. Modoc County would be, to our knowledge, the first county mental health plan in California to implement eBHS or other population management analytics tool system wide. Since we are a pilot county for eBHS, our intent is to make available our learning counties for their use. The initial implementation is intended to serve as a foundation for further proactive prevention population management and potential interface with other databases for upstream prevention and early intervention.

Community Program Planning

The Modoc County Behavioral Health (MCBH) Community Program Planning (CPP) process for the development of this Innovation Component Plan was based upon the three-year planning process for the FY 2014/15-2017/18 MHSA Plan (approved March 2015) and the FY 15-16 and FY 16-17 Plan Updates. The process was comprehensive and included the input of diverse stakeholders through one-on-one discussions, formal focus groups, stakeholder meetings, and surveys. The plan was posted 3/3/ - 4/2/17 for public comment and a Public Hearing was on 4/3/17. The Board of Supervisors approved the Plan on 4/11/17. It was approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) 4/27/17.

Primary Purpose

The purpose of this proposal is twofold: 1) to increase the data analytics capabilities of Modoc County and to determine how to assist other small counties in the adoption of data

analytics; and 2) to impact the quality and retention of services, including better outcomes through real-time data use by clinicians and consumers and proactive population management.

Innovative Project Category

This project will introduce a new mental health practice or approach by addressing three areas: A flexible data system, Implementation planning and sustained support, and training on how to interpret individual and population data and use this information to guide prevention and treatment.

Setting/Population

The fully integrated **Behavioral Health** team consists of 21.5 full time equivalent staff members (3 FTE Administration, Administrative Support 7 FTE, and 11.5 FTE Direct Services Staff – when fully staffed). Telemedicine is provided under contract for Psychiatry and prescribing of psychotropic medications. This BH team was responsible for the managed care of and service delivery to 531 unduplicated individuals in FY 15-16 (432 MH and 82 SUDS).

Community Collaboration

The proposed project comes from several years of stakeholder input and collaboration among County Policy Makers, Agency Directors and department Heads, direct service staff, consumers and their family members. Modoc Community Corrections Partnership (CCP) has representation including the Director of Health Services, the Deputy Directors of Public Health and Behavioral Health, the Alturas Police Department chief, the Modoc County Sheriff, District Attorney, Public Defender, Director of Social Services and the presiding court judge. Also included are directors and representatives of Community Based Organizations that provide direct services to the target population. Working collaboratively is a fundamental value in our community and the quality of our collaborative partnerships is a special strength in our small, isolated community. This proposal addresses our partnerships' shared perceptions of unmet needs and barriers to fostering prevention, wellness and recovery. One of the priority barriers identified is that we do not have a **shared data analytics system** to proactively manage the target population and collaboratively measure outcomes.

Evaluation

Evaluation is built into this innovation plan at every phase. Data will be collected by those trained in the use of eBHS pre and post training (6 and 12 months after training). It will include data from EHR, eBHS, quantitative and qualitative (client feedback data written or verbal). The Administrative Team will meet regularly with the CiBHS Team for project coordination. Staff will be constantly working in partnership with the CiBHS Team throughout life of the project. Project resources will be utilized primarily to pay for access to eBHS, for implementation of the use of eBHS data warehouse, and use of resulting data. We will have ongoing access to evaluation of the project.

Communication and Dissemination Plan

Information will be disseminated through a collaborative evaluation process, reporting findings to the BH Advisory Board and Staff, attaching a summary of findings to the Annual Plan update and reporting findings to CBHDA and the Small Counties Committee as appropriate. The CiBHS will share our evaluation data with other counties considering the use of eBHS or another population management system. Clients and other stakeholders will be involved in the use and evaluation of eBHS on an ongoing basis.

The full Innovations Component Plan is available upon request or an electronic copy is available online at hs.co.modoc.ca.us

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

This is a newly initiated program and will be updated in the MHSA Plan update for FY 18-19.

3. ***List any significant changes in Three-Year Plan, if applicable.***

No significant changes are anticipated at this time, however, if we build the system out beyond current work plan, additional resources may need to be approved and allocated as necessary.

MHSA Program Component
WORKFORCE EDUCATION AND TRAINING

1. Provide a program description. Include achievements.

The MCBH Workforce Education and Training (WET) program provides training components, career pathways, and financial incentive programs to staff, volunteers, clients, and family members.

WET Project Support
We continue to fund staff support to implement and coordinate training and related activities. As part of that effort, we identify ongoing staff education and training needs and pair them with training opportunities both locally and at a regional level.

Collaborative Partnership Training and TA
We continue to provide training for staff, consumers, and partner agencies both locally and at a regional level. A recent focus is training in the delivery of evidence-based practices and integration of care. We recently offered Crisis Intervention Training for law enforcement and other first responders in our county. We continue to provide funding for peer support training and plan to work with consumers to provide peer certification training as part of the Superior Region WET Collaborative.

Career Pathways
We were successful in hiring a staff member who has a Bachelor's degree in Social Work, with a career pathway to LCSW, with a commitment to provide reimbursement for educational expenses. We have also hired a nurse who is pursuing a nurse practitioner program, and a master's level psychology major who is enrolled in a Psychological Doctorate Program. We maintain outreach efforts to recruit consumers and family members interested in a career pathway in community mental health. We are also providing funding for three full-time staff member/identified consumer(s) to work toward certification as a substance use counselor in order to specialize in assisting clients with co-occurring mental health and substance use disorders.

Financial Incentive Programs
We continue to fund licensing supervision for our Spanish-speaking MSW and two other MSWs. All 3 MSWs are also approved for the loan assumption benefits. We recently developed policies to access tuition reimbursement and loan assumption benefits.

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

Our biggest challenge to utilizing WET funds has been the difficulty in recruiting staff and consumers, largely because of our very small population and remote location. In the last few years, we have made significant progress in this area, however this resulted in delays in expending the financial incentive program with staying consistent with the State financial incentive program payment schedules. Since the funds need to be expended by June 30, 3018, we are proposing to fund through an external entity a Modoc Public Mental Health Workforce Financial Incentive Program for any unencumbered funds as necessary.

3. List any significant changes in Three-Year Plan, if applicable.

Funding of an external entity a Modoc Public Mental Health Workforce Financial Incentive Program to avoid reversion of any unencumbered funds.

MHSA Program Component
CAPITAL FACILITIES/TECHNOLOGY

1. ***Provide a program description (must include number of clients served, age, race/ethnicity). Include achievements.***

We have made some progress related to evaluation of possible capital facilities (CF). However, due to the County's fiscal crisis, cash flow issues, and financing issues, our options are limited. The current level of funding is not adequate to purchase a facility outright, so we are pursuing alternate solutions, or modifying our objective of an integrated health and human services campus. We continue to explore long-term options and opportunities related to acquisition of an integrated administrative/services facility.

We have actively implemented the technology (TN) Program. We were the recipient of a grant from the California Tele-Health Network (coordinated by Connecting to Care) to provide new computers and equipment for Telemedicine. We have implemented our Electronic Health Record for Modoc County Behavioral Health, and are taking steps toward a goal of eliminating our paper client records for a fully electronic record. We continue to work closely with Kings View in implementation and billing processes. We are implementing a new integrated healthcare client registry/data analytics tool to facilitate better tracking of client outcomes and care integration with primary care. There is strong support to expand consumer access to the web and web-based delivered services. As a result, our technology plan includes acquiring tablets, smartphones, and Wi-Fi technology, and pilot ways to increase consumer access through the use of web-based services.

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

Capital Facilities (CF): Our major barrier to acquire CF is financial. Our strategy to mitigate is to pursue a purchase or lease-to-own option to expend or encumber the funds prior to June 30, 2018.

Technological Needs: Our key technology barrier to the expansion of the project, development of, and access to, web-based services is the band width and internet infrastructure in Modoc County. Internet speed is very slow where it is available and there are many areas with only satellite service available if at all. Our strategy at this point is to advocate for increased band width access for the county, work with California Telehealth Network to increase our access, and to identify ways to establish WIFI connections through hubs or mobile connections where available.

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

The goals for the CF project have not been met – see above. We plan to expand the TN project to meet consumer/family access to technology to support their wellness and recovery.

4. ***List any significant changes in Three-Year Plan, if applicable.***

We have allocated resources to CF to buy or lease-to-own the currently rented building to support our service delivery system. We plan to expand the TN project through the 1)

development of and access to web-based services for consumers/family members; and 2) purchase of tablets and/or smartphones for consumer use and improve access to services with priority for clients who are isolated and lack resources for access to the web. We also plan to expand data analytics through the Innovations Plan for the Implementation of eBHS to promote improved consumer access to real-time data for joint treatment planning with their clinician.

FY 2017-2018 Through FY 2019-2020 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: MODOC

Date: 05/31/17 draft

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2017/2018 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	1,016,705	593,966	257,509	212,755	536,586	
2. Estimated New FY2017/2018 Funding	1,387,451	346,868	91,281			
3. Transfer in FY2017/2018[a/]	(240,869)					240,869
4. Access Local Prudent Reserve in FY2017/2018	0	0				0
5. Estimated Available Funding for FY2017/2018	2,163,287	940,834	348,790	212,755	536,586	
B. Estimated FY2017/2018 MHSA Expenditures	1,262,131	605,000	105,737	212,755	536,586	
C. Estimated FY2018/2019 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	901,156	335,834	243,053	0	0	
2. Estimated New FY2018/2019 Funding	1,401,325	350,337	92,194			
3. Transfer in FY2018/2019[a/]	(248,447)					248,447
4. Access Local Prudent Reserve in FY2018/2019						0
5. Estimated Available Funding for FY2018/2019	2,054,034	686,171	335,247	0	0	
D. Estimated FY2018/2019 Expenditures	1,325,238	562,000	97,737	0	0	
E. Estimated FY2019/2020 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	728,797	124,171	237,510	0	0	
2. Estimated New FY2019/2020 Funding	1,415,338	353,840	93,116			
3. Transfer in FY2019/2020[a/]	(267,248)					267,248
4. Access Local Prudent Reserve in FY2019/2020	0	0				0
5. Estimated Available Funding for FY2019/2020	1,876,886	478,011	330,626	0	0	
F. Estimated FY2019/2020 Expenditures	1,391,500	529,000	49,737	0	0	
G. Estimated FY2019/2020 Unspent Fund Balance	485,387	(50,989)	280,889	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2017	551,709
2. Contributions to the Local Prudent Reserve in FY 2017/2018	240,869
3. Distributions from the Local Prudent Reserve in FY 2017/2018	0
4. Estimated Local Prudent Reserve Balance on June 30, 2018	792,578
5. Contributions to the Local Prudent Reserve in FY 2018/2019	248,447
6. Distributions from the Local Prudent Reserve in FY 2018/2019	0
7. Estimated Local Prudent Reserve Balance on June 30, 2019	1,041,024
8. Contributions to the Local Prudent Reserve in FY 2019/2020	267,248
9. Distributions from the Local Prudent Reserve in FY 2019/2020	0
10. Estimated Local Prudent Reserve Balance on June 30, 2020	1,308,273

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

FY 2017-2018 Through FY 2019-2020 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: MODOC

Date: 05/12/17 draft

	Fiscal Year 2017/2018					
	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. System Transformation (FSP)	732,036	732,036				
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					
Non-FSP Programs						
1. General System Development (80%)	272,620	272,620				
2. Outreach and Engagement (20%)	68,155	68,155				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	189,320	189,320				
CSS MHSA Housing Program Assigned Funds	0	0				
Total CSS Program Estimated Expenditures	1,262,131	1,262,131	0	0	0	0
FSP Programs as Percent of Total	58.0%					