MODOC COUNTY BEHAVIORAL HEALTH

Mental Health Services Act
FY 2016-2017 Annual Update

POSTED FOR PUBLIC COMMENT
March 3, 2017 through April 2, 2017

The MHSA FY 2016-2017 Annual Update is available for public review and comment from March 3, 2017 through April 2, 2017. We welcome your feedback via phone, in person, or in writing. Comments may also be made during the Public Hearing to be held on Monday, April 3, 2017.

Public Hearing Information:
Monday, April 3, 2017 at 4:00 pm
Modoc County Health Services
Large Conference Room
441 N. Main Street, Alturas, CA 96101

Comments or Questions? Please contact:
Karen Stockton
MHSA Annual Update Feedback
Modoc County Behavioral Health
441 North Main Street, Alturas, CA 96101
Phone: (530) 233-6312; Fax: (530) 233-6339
karenstockton@co.modoc.ca.us

Thank you!

MHSA COMMUNITY PROGRAM PLANNING

Community Program Planning Process

In addition to MHSA-specific activities, the 2016 County Health Needs Assessment (CHNA) focus groups were held in Alturas on February 17, 2016; in Adin on February 18, 2016; and in Cedarville on February 19, 2016. The 2016 County Health Needs Assessment (CHNA) results identified mental health and drug use treatment as a top priority when addressing serious health needs and issues in our community. Increasing veterans' access to mental health services was also identified as a priority.

MHSA-specific activities in the planning process included two community focus groups, where participants were provided with education on the purposes of the MHSA and the current MHSA activities, as well as encouraged to offer insight and suggestion on how to enhance our efforts to meet the needs of unserved, underserved at-risk individuals with serious mental illness.

Focus groups were held in Newell on September 28, 2016 and in Adin on November 9, 2016. Input was also obtained at an Advisory Board public hearing in Alturas on October 26, 2016. In addition, 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.

Special outreach was extended to Sunrays of Hope (a peer owned and operated wellness and recovery center) and to the Big Valley Joint Unified School District, the Modoc County Office of Education, the Senior Resource Center, Modoc Medical Center, and Southern Cascades Emergency Medical Services to gain key-informant stakeholder input into our process.

Stakeholders and Meaningful Input

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 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, key leaders from the Hispanic, Native American and veterans' communities provided input, using a culturally competent consultant with strong connections to those communities.

LOCAL REVIEW PROCESS

30-Day Posting Period and Circulation Methods

This proposed MHSA FY 2016/2017 Annual Update has been posted for a 30-day public review and comment period from March 3 – April 2, 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 Annual Update 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 Annual Update has also been sent electronically to the Community Partnership Group/partner agencies and other stakeholders.

Public Hearing Information

A public hearing will be conducted on Monday, April 3, 2017, at 4:00 pm at 441 N. Main Street, Alturas, CA 96101, as part of a special Behavioral Health Advisory Board meeting.

Substantive Recommendations and Changes

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

MHSA Program Component
COMMUNITY SERVICES AND SUPPORTS

CSS Program Description and 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; wellness and recovery action planning; case management services; individual and group mental health services; crisis services; linkages to needed services; and housing support.

Our target populations include:

1. Children (ages 0-17) 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 Achievements in FY 2015/2016

MCBH successfully recruited a licensed Marriage and Family Therapist (LMFT), which has helped to expand our capacity for the provision of therapy, as well as expanding our range of

expertise for service provision for consumers with co-occurring mental health and substance use disorders.

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 2016/2017, 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 plan to participate in the Training of Trainers curriculum for the Peer Core Competencies. If Sunrays members successfully complete the Peer Core Competency Training of Trainers, then those members will be able to participate as trainers in Peer Core Competency training for consumers and family members in Modoc County.

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
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
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
CSS Clients (FY 2015-16)
By Gender

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

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

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

Challenges and Mitigation Efforts

We remain understaffed in nursing services. At this point, the plan is to write new job descriptions at higher pay ranges, creating additional nursing classifications, allowing for movement up a career pathway with the completion of additional training and licensure (e.g., from an LVN to an RN). If we are able to secure support from county administration and the Board of Supervisors, it is hoped that implementing increased salaries and a career pathway will assist in our efforts to recruit nurses to MCBH.

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 most recent 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 or two. The Leadership Team has developed a draft organization chart to address the needs, with one new position recently filled through promotion from the Specialist III level to the Program Manager level. Additional changes to mitigate the need will be pursued and will require writing new job descriptions and going through a formal county review and approval process.

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.

The inability to adequately collect, process and interpret data for outcomes measurement remains a barrier. We have 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 test 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 testing the eBHS registry that we will have finally found an affordable, effective, user friendly system to measure outcomes at both the consumer/client level and program level.

Significant Changes from Previous Fiscal Year

Successful recruitment of an LMFT near the end of FY 2015/2016 has relieved some of the pressure on therapists and rehab specialists attempting to meet the needs of consumers while understaffed. Consumers are experiencing fewer delays in scheduling assessments and ongoing appointments.

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.

MHSA Program Component
PREVENTION AND EARLY INTERVENTION

PEI Program Descriptions and 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: We have identified the following programs for the Prevention component:

1) **40 Development Assets** program coordinates training, outreach, and education on the Search Institute's 40 Developmental Assets, in order to support our community-wide effort to build child, youth, family, school, and community assets – assets that provide the building blocks of healthy development that help young people grow up healthy, caring, and responsible. Key elements of the program include:

- Part-time staff to provide outreach and engagement with schools, public and private agencies, faith-based organizations, civic organizations, recreational organizations, and others;
- Training for partners willing to participate in asset building, including training in Spanish and specific outreach to Hispanic and Native American groups and communities to identify culturally specific asset building activities;
- Training on individual assets and their power to affect youth development;
- Use of the Search Institute's 40 Developmental Assets survey in area schools to identify asset strengths and deficits;
- Activities to identify assets that need strengthened and strategies to improve assets in young people;
- Public education campaign, including media, to educate the general public on the 40 Developmental Assets, and strategies anyone can use to assist in the effort to improve individual, family and community assets;
- Continued operation of the Prevention Collaborative to support and encourage asset development;
- Expanded outreach to identify isolated or high risk young people and individuals/communities that can be brought together to support asset development in high risk youth.

The Modoc County Prevention Collaborative has remained the lead multi-agency body for planning and implementing activities designed to build and support child, youth and community assets. Community outreach and education regarding the 40 Development Assets occurred through advertisements in local newspaper and other print media, distribution of information regarding the power of asset building in youth *(e.g., the more assets a youth has, the less likely the youth is to start using alcohol or other drugs, drop out of school, get into legal trouble, etc.)* at three Health Fairs *(Modoc Medical Center, Big Valley Medical Center, and Ft. Bidwell Tribal Clinic),*

the Behavioral Health Open House, and 150 light pole banners on Main Street in Alturas promoting the 40 Assets. The banners were displayed for a total of six weeks in February and March, 2016.

One specific activity designed to promote a number of identified internal assets is the Behavioral Health staff presentation of the evidence-based Life Skills Training (LST) curriculum in two elementary schools. The internal assets targeted by LST include positive values *(caring/helping others and responsibility)*, social competencies *(planning/decision making, interpersonal competence – empathy, sensitivity and friendship skills, resistance skills – resisting negative peer pressure and dangerous situations, and peaceful conflict resolution)*, and positive identity *(self-esteem and personal power – young person feels s/he has some control over "things that happen to me.")*.

Other programs and activities promoting development and strengthening of assets in youth include, but are not limited to:

- Sponsoring two groups of youth (high school and middle school) from area schools to participate in the REACH Conference in Butte County, which strives to promote interpersonal and internal values like *bonding to school and community, equality and social justice, cultural competence, empathy and respect.*
- Behavioral Health and Public Health collaborative sponsorship and facilitation of Teen Health Coalitions at Modoc High School and Modoc Middle School to train peer educators, promoting youth developing through promotion of an empowerment asset *(youth as resources).* Peer educators are trained as trainers for their own age group, or younger children, in suicide prevention, substance use prevention, STD prevention, the value and power of developmental assets, and other topics impacting youth development.

2) **<u>Primary Intervention Program, Grades K-6</u>**: 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 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.

3) **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.

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

1) <u>Trauma-focused Cognitive Behavioral Therapy (TF-CBT)</u>: 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.

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

The MCBH "ReachOut" project will be implemented, with two primary goals: Increase recognition of early signs of mental illness; and Stigma and discrimination reduction. Strategies to address the goals include:

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) MCBH will implement a modified media campaign designed to educate the community on early signs of mental illness, and to promote the reduction of stigma and discrimination. 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:

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.

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

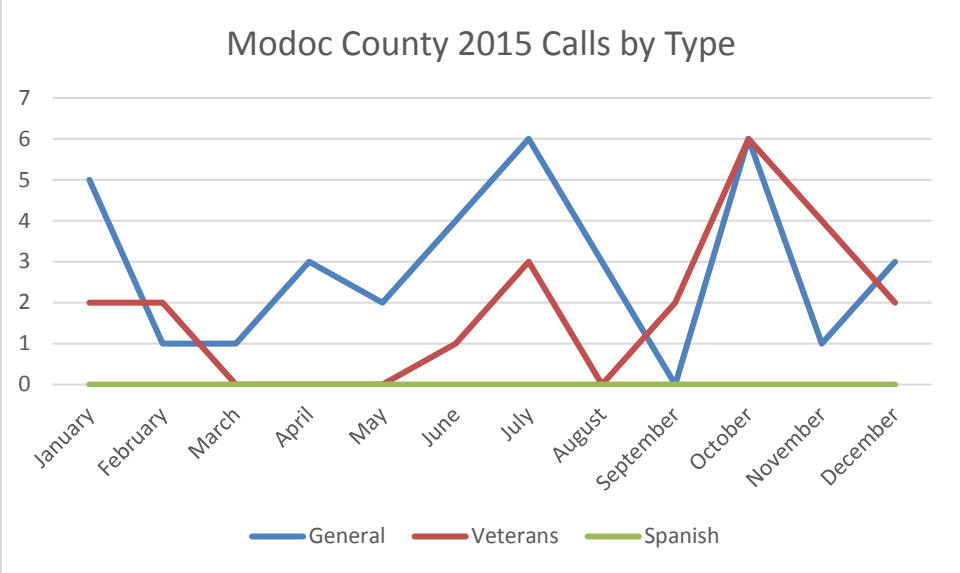
1) They met with consumers at Sunrays of Hope Wellness Center, provided Each Mind Matters materials, t-shirts, buttons and pamphlets, and provided suggestions for how consumers can actively participate in spreading the suicide prevention message.
2) Each Mind Matters staff visited businesses and shared 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


Modoc County 2015 Calls by Type
7
6
5
4
3
2
1
0
January
February
March
April
May
June
July
August
September
October
November
December
General
Veterans
Spanish

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.

Challenges and Mitigation Efforts

Staffing issues in very small counties continue to be the 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 plan to hire 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.

Significant Changes from Previous Fiscal Year

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 and to extend the program to the Big Valley Joint School District. 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 a more comprehensive PEI program called Behavioral Tiered Supports for Prevention and Early Intervention Program for grades K -12 and provides for that includes Positive Behavior Intervention Supports and a Multi-Tiered System of Support.

MHSA Program Component
INNOVATION

County: **Modoc**
Date Submitted: **DRAFT 03/02/17**

Project Name: **electronic Behavioral Health Solutions (eBHS) and Feedback Informed Treatment Implementation (FIT)**

I. Project Overview

1. Primary Problem

Modoc County proposes to increase the quality of behavioral health services they provide by enhancing their ability to collect, improve and analyze client data and to use it in a meaningful way for client improvement. Located in the most northern corner of California, Modoc county is a small, rural county, serving clients in a vast geographical region. Aware that the use of data in clinical practice has been shown to significantly improve client outcomes, Modoc County has long been looking for an innovative and cost effective solution to some of the most common challenges small counties face related to purchasing and using data systems: cost effectiveness, sustained implementation support and training of clinicians.

The cost of data systems often exceeds small county budgets. As Modoc County has learned, most common data systems, such as electronic health records, have high costs attached and are not easily customizable, which means that the only data systems available to small counties do not address the county's unique needs. Additionally, database vendors provide neither implementation support nor support in developing clinical dashboards and evaluation outcomes reports, often resulting data initiatives slowly fading away or never getting off the ground. Lastly, even if data systems are flexible and the implementation support is robust and sustained, training on how to interpret outcomes graphs and clinical data is often lacking and clinicians are left to figure this part out on their own.

2. What Has Been Done Elsewhere to Address Your Primary Problem?

Among the challenges faced by Modoc County, the External Quality Review Organization (EQRO) report for FY 15-16 highlighted the need for technology that will allow the county to address the Performance Improvement Plans developed by Modoc, as well as some areas of current ambiguity. An increased ability to analyze data would allow Modoc County to better understand areas of overutilization and other areas of concern, such as a low retention rate in services as well as a lack of clinical or functional outcomes. In order to address some of these concerns, Modoc has spent the past five years in multiple Plan-Do-Study-Act (PDSA) cycles to determine a system that not only can meet the unique data analytic needs of small counties, but also can be implemented successfully.

In exploring these challenges, Modoc County has reached the conclusion that any data system they purchase and use must meet multiple data needs, including day-to day clinical dashboards, population management data, and aggregate outcomes reporting for internal and

external stakeholders. This data system would help alleviate several of the challenges in Modoc, as well as pinpoint and allow for data analysis and improved system response.

3. The Proposed Project

Through the innovation proposed here, Modoc County would bring three effective strategies together to improve client outcomes. This three-pronged approach was developed by the California Institute for Behavioral Health Solutions as a way to increase the success of data collection initiatives. This approach has not yet been tested in a county system. If awarded Innovation funding, Modoc would be the first county to utilize it for system-wide data collection and client outcome tracking and improvement.

The proposed approach includes: 1) a uniquely flexible, cost-efficient web-based data system; 2) a robust implementation method; 3) training on use of data in clinical practice. Each component is believed to be equally essential. However, one or several of the components are often missing in data collection initiatives, resulting in a lack of access to real-time data, a lack of sustainability due to poor or missing implementation support, or lack of training on how to interpret data graphs and tables, all of which result in data not being used to its full extent to improve practice.

4. Innovative Component

Although each of the three components in and of themselves may not constitute an innovation, it is the combination of these three components that makes it innovative for this project. Equal attention to these three components will result in staff and clinicians knowing how to effectively navigate the data system, understanding how to interpret outcomes data in clinical dashboards, and sustaining use of data long-term so that it becomes a natural part of clinical practice. The ultimate goal of the project is a sustained improvement in client outcomes.

The three-pronged approach:

a) <u>The Data System</u>: The data system that will be part of the innovation is called electronic Behavioral Health Solutions (eBHS). eBHS is a flexible, cost-efficient web-based platform that enables custom development of reports including clinical dashboards, aggregate outcomes reports, and population management reports. In this innovation, clinical dashboards will be developed based on clearly defined clinical outcomes. Clinicians will be administering two types of outcomes measures: 1). A Global Functioning Measure; 2.) Treat-to-Target measures. Each client will be administered the same Global Functioning Measure (the OQ measures) which will be collected at intake, every six months, and at discharge. In addition, clinicians will select Treat-to-Target measures based on the client's clinical diagnoses. Examples of Treat-to-Target measures include the PHQ-9 (for Depression) and the GAD-7 (for Anxiety). The Treat-to-Target data collection interval will be determined by the clinician and can be as often as each session, weekly, or monthly. Treat-to-Target data will also be collected at intake and discharge. In addition, because eBHS allows for custom data report development, the staff will be engaged in a collaborative process to customize

the clinical dashboard template. This dashboard will include real time data results from the Global Functioning Measure and the Treat-to-Target measures as well as metrics identified by the clinical team to be crucial in tracking client progress (i.e. medications, chronic physical illness, and substance use disorder information). The collaborative process of having clinical staff participate in the development of the clinical dashboard serves two purposes: 1) to ensure that clinical dashboards are meaningful; 2) to actively engage the staff in the implementation from the beginning to the end in order to ensure the best possible outcomes. In addition to the use of clinical dashboards in daily practice, eBHS will also be set up to aggregate pre- and post-outcomes data. Pre- and post-data will be assessed using a paired samples T-Test and Cohen *d* effect size estimate to allow a review of program effectiveness. Different filtering options will be designed included the ability to run outcomes data based on common demographics categories, such as race, gender, age, etc.

b) The Implementation Protocol: The Community Development Team model (CDT) is based on implementation science and was developed by CIBHS in 2006. The CDT model includes clearly defined steps for Pre-implementation, Implementation, and Sustainability. 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 what is essentially a paradigm shift: using data in real time to guide clinical practice. The CDT also includes peer-to-peer learning between different sites implementing the approach. Modoc county will participate in peer-to-peer monthly calls with clinical and implementation staff from other counties to share learning, challenges, and barriers. The CDT Model also has a research base showing successful outcomes (Chamberlain, et al., 2008; Saldana & Chamberlain, 2012; Sosna & Marsenich, 2006).

c) Data Interpretation Training: In addition to engaging in pre-implementation, implementation, and sustainability activities, staff who will be using eBHS will also receive specific training on how to interpret and use clinical outcomes data with clients to inform practice. Feedback Informed Treatment(FIT) is an evidence-based approach to using clinical data in practice. FIT "involves routinely and formally soliciting feedback from consumers regarding the therapeutic alliance and outcomes of care and using the resulting information to inform and tailor service delivery" (2012, International Center for Clinical Excellence). In this innovation, the training on using eBHS will be integrated with the Feedback Informed Treatment training. By integrating these trainings eBHS will be presented as a clinical tool rather than a database. This shift is especially important since using data in practice will be new to the staff. Before going live with the use of eBHS, concerns of each staff will be addressed, included challenges and anxiety around databases and technology.

5. Learning Goals / Project Aims

Goal 1: Increase clinician use of real-time data analytics. This innovation project aims to learn if IITD will result in clinicians using data to guide practice. The goal is that clinicians will incorporate review of data as a natural and integral part of service delivery. IITD will assist clinicians to find benefit in data review and come to see it as necessary to their work with clients. IITD provides a very user-friendly daily-use client dashboard that will make data very accessible to clinicians. The IITD training not only shows clinicians how to access this data, but also how to interpret it in clinician useful language, then use it for treatment planning. Research shows that the in-session regular use of client informed data increases client retention in services and improves outcomes (Miller, 2011). Therefore, this innovation of a real-time client dashboard that is accessible and useful to clinicians will also improve client retention and outcomes.

Goal 2: Implement system wide administrative use of data analytics. Modoc and other small counties have minimal opportunity for analyzing their data to better understanding treatment and outcomes. IITD will train in the use of analytics within eBHS to monitor outcomes. This innovation will help Modoc County better understand what may be impacting areas of concern throughout their system. This innovation has the potential to be used in an integrated manner with all areas of whole-person health, so that multiple factors can be analyzed for their impact on consumer care. IITD is uniquely capable of system implementation due to the inclusion of the CDT model, which as described above, has research that supports its effectiveness for system implementation and sustainability.

Miller, S. D. (2011). Psychometrics of the ORS and SRS. Results from RCTs and Meta-analyses of Routine Outcome Monitoring & Feedback. The Available Evidence. Chicago, IL. http://www. slideshare.net/scottdmiller/measures-and-feedback-january-2011

6. Evaluation or Learning Plan

Approach to learn if Goal 1 was met:

- **Increase clinician use of data**: A survey of current use of "data" (defined below) by identified group of clinicians ("Initial Users") to be trained in IITD will be compared with a follow-up survey 6 and 12 months post training. The pre- and follow-up survey will be compared with actual data entry into current EHR (pre) and eBHS (follow up)
- **Data collection Methods:**
    A. Participants: A group of clinicians: "Initial Users" identified by Modoc County to be trained in IITD.
    B. What data: A survey of current use of data, EHR, eBHS
        1. "Outcomes data" defined as any objective measure of symptomology given pre-treatment. For clients who complete, number of post treatment measures (this can include physical, mental health, or functional measures). Specific measures currently being considered: PHQ-9, GAD-7, OQ, YOQ
        2. "Client feedback data" defined as any verbal or written measure of client's perception of treatment progress

3. "Data use" defined as an Initial Users reviewing outcomes and client feedback to alter treatment each session
4. Fidelity measure will be created by the IITD utilizing the fidelity measures from the FIT materials (Feedback Readiness Index and Fidelity Measure (FRIFM)) in collaboration with Modoc County clinical supervisors. This survey will measure clinician fidelity to data use.

C. Data collection: Fidelity measures with Initial Users. Data collected from current EHR and eBHS.
D. Method: (1) The Fidelity Measure will be completed prior to training by Initial Users identified by Modoc County. Follow up fidelity measures will be completed at regular intervals post training, as recommended by FIT and in collaboration with Modoc. The initial fidelity measure will be completed at the IITD training for clinicians, as a baseline measures. Follow up fidelity measures will be distributed via email as a fillable form. Participants will be reminded to complete form weekly until it is completed. The de-identified data from the Fidelity Measures will be used in the administrative and clinical calls to work through barriers. (2) Total number of outcome data measures will be collected initially from the current EHR (as baseline). Follow up number of outcome measures will be collected from eBHS as part of the IITD initiative at 6 and 12 months, which were chosen to indicate initial break through learning then sustainable use.
E. Analysis: Survey and outcome data use will be aggregated as pre and post, and analyzed using SPSS.

Approach to learn if Goal 2 was met:

- **Implement system wide administrative use of data analytics:** Completion of implementation checklist. Administrative fidelity checklist (FRIFM) will be administered pre (baseline), and monthly.
- **Data collection Methods:**
  A. Participants: Pre-selected administrators, chosen by Modoc County. CIBHS IITD training staff (checklist)
  B. What data: Implementation checklist. Administration FRIFM as developed by FIT to measure fidelity.
  C. Data collection: An implementation checklist from the CDT will be followed by CIBHS staff and agreed upon by Modoc administrative participants. The Administrative FRIFM from FIT will be administered monthly.
  D. Method: 1.) CIBHS will develop a checklist of the steps to implementation based on the CDT model, and as informed by implementation science and NIRN. The steps of this checklist will be marked completed by CIBHS at completion of each step, and as agreed by Modoc. 2.) The Administrative FRIFM developed by FIT will be administered during pre-implementation (date to be determined). This checklist will be used monthly during administrative calls to inform barriers and growth in administrative use of data.
  E. Analysis: Checklist- counted and compared to 95% completion. FRIFM will be continually used throughout the process and will be graphed to indicate growth. Final result will be compared with FIT standards of effective implementation

7. Contracting

The Administrative Team will meet regularly with the CiBHS Team, in person and via Webinar for project coordination of the implementation and evaluation. The 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 progress. Staff will be constantly working in partnership with CiBHS Team throughout the implementation and evaluation of the project. Most of the Modoc County Behavioral Health staff time will be in-kind funding to supplement the Innovation Funds allocated. Our contract covers regulatory HIPAA requirements. Since we will be implementing internally, we are required to ensure we meet all regulatory requirements.

II. Additional Information for Regulatory Requirements

1) Certifications

Innovative Project proposals submitted for approval by the MHSOAC must include documentation of all of the following:

a) *Adoption by County Board of Supervisors.*
b) *Certification by the County mental health director that the County has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act (MHSA).*
c) *Certification by the County mental health director and by the County auditor-controller that the County has complied with any fiscal accountability requirements, and that all expenditures are consistent with the requirements of the MHSA.*
d) *Documentation that the source of INN funds is 5% of the County's PEI allocation and 5% of the CSS allocation.*

These certifications will be added prior to submission to the MHSOAC.

2) Community Program Planning

Overview

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 in March 2015) and the FY 15-16 and FY16-17 Plan Updates. Further, as a very small county, it builds upon stakeholder input from multiple collaborative initiatives that involve all the same stakeholders/partners as described in collaborative section of this proposal.

This planning process was comprehensive and 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); Innovation; Workforce Education and Training (WET); and Capital Facilities/Technological Needs (CFTN) and more recently in the Plan Updates the new Innovation Component Proposal. In addition, we provided basic education regarding mental health policy; program planning and implementation; monitoring and quality improvement; evaluation; and fiscal and budget components. We have discussed the purpose and requirements of the MHSA Innovation Component in our stakeholder and Advisory Board Meetings. We have distributed the guidelines to the stakeholders and have posted them on our website.

For the planning process for the FY 2014/15-2017/18 Three-Year Plan, we sought input from stakeholders regularly at our Behavioral Health Advisory Board Meetings (1/15/14, 2/19/14, 3/19/14, 5/21/14, 6/18/14, 9/17/14, 10/29/14, 11/19/14), Modoc County Prevention Collaborative meetings on 8/26/14, 9/23/14 and 1/20/15, Collaborative Treatment Courts Steering Committee meetings (8/21/14, 10/16/14 and 12/11/14), and the Community Corrections Partnership monthly meetings. Our Native American Veteran Consultant conducted key informant interviews with Native American tribal leaders and veterans. We conducted focus groups and stakeholder meetings at various locations in the community. A focus group was conducted with consumers and family members at Sunrays of Hope

(1/21/15), with agency and community stakeholders (1/28/15) and clinical staff (1/29/15). Our prevention coordinator conducted one-on-one interviews with school personnel.

In 2014, as a component of the CPP, we obtained input from community stakeholders and conducted outreach to the unserved and underserved through collection of MHSA surveys. We collected survey information from adults (22), family members (46), and school personnel (26) to obtain their perspective on needs and issues for adults, children, and families in our community. Across all stakeholder groups including consumers, we received completed surveys from 94 individuals. Survey distribution and meeting announcements sought inclusive stakeholder input including veterans, persons from the LGBTQ community, Hispanics, Native Americans, and persons with lived experience.

Consumers and family members were involved in many settings, 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, Veteran's Services office, 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.

Stakeholder Involvement

Modoc County staff have been exploring solutions to our need for real time data to use in planning treatment, integration of care, and to measure outcomes for several years. Throughout the process, we have sought consumer and family member input through a variety of stakeholder meetings including the BH Quality Improvement Committee, Advisory Board Meetings, and interdisciplinary and inter-agency collaborative meetings (Collaborative Courts, Community Corrections Partnership (CCP) and JAG Grant collaborative meetings) and plan to continue to do so. We have engaged stakeholders, both consumers, other departments, and primary care clinics to discuss solutions and pilot test products through integrative care pilots.

Further, we are currently engaging in collaborative projects through the CCP resources, JAG Grant, and a County Medical Services (CMSP) Grant Proposal to enhance integration of care across agencies and are discussing the feasibility of use of eBHS to measure outcomes and/or exchange information as allowed by 42CFR and HIPAA to coordinate care. Modoc County Behavioral Health will continue to seek feedback and maintain regular interface with the multiple agencies involved with delivering quality services to our community through one-on-one staff contact, advisory and collaborative meetings.

Our plan is to seek stakeholder feedback as we implement this innovation project and to incorporate this feedback as a part of our evaluation plan and decision-making process. Implementation of this proposal is system wide and we believe, should it be successful, stakeholder discussion would include additional phases and expansion of the elements to meet current needs and requirements. Funding for continuation of the project for basic system, if evaluated as successful by stakeholders, would become part of the general system support budgeting and allocation process.

Modoc County Behavioral Health will continue regular interface with the multiple agencies involved with delivering quality services to our community through collaborative meetings and through one-on-one staff contact.

30-Day Public Comment Period and Public Hearing

This proposed Innovation Plan will be posted for a 30-day public review and comment period from March 3, 2017 – April 2, 2017. An electronic copy will be available online at hs.co.modoc.ca.us. Hard copies of the document will be 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 Innovation Plan will be distributed to all members of the Behavioral Health Advisory Board; consumers (on request); staff (on request); and Sunrays of Hope Wellness Center. The Plan will also be sent electronically to the Community Partnership Group/partner agencies and other stakeholders.

A public hearing will be conducted on April 3, 2017, 4 PM, at 441 N. Main Street, Alturas, CA, as part of a special Behavioral Health Advisory Board.

3) Primary Purpose

The primary purpose of this proposal is to increase the data analytics capabilities of Modoc County, and to determine how to assist other small counties in the adoption of data analytics. A secondary purpose is to impact the quality and retention of services, including better outcomes through real-time data use by clinicians and consumers in consumer-driven treatment planning and monitoring progress towards wellness and recovery. Several key characteristics of Modoc County determined our selection of this particular primary purpose. Located in the most northern corner of California, Modoc county is a small, rural county, serving clients in a vast geographical region. With increased needs for use of data to improve behavioral health practice, Modoc County faces particular challenges related to purchasing and using data systems. These challenges mean that any data system used must meet multiple data needs, including day-to day clinical dashboards, population management data, and aggregate outcomes reporting for internal and external stakeholders. Aware that the use of data in clinical practice has been shown to significantly improve client outcomes, Modoc county has long been looking for an innovative and cost effective solution that meets several criteria: Cost Effectiveness: The cost of data systems often exceeds small county budgets, so that the only data systems available to small counties can't be customized to the county's unique needs due to the high cost of customization. In addition, database vendors provide neither implementation support nor support in developing clinical dashboards and evaluation outcomes reports. They also do not provide training on how to interpret data results. The approach that was selected here addresses each of these barriers.

4) MHSA Innovative Project Category

This project will introduce a new mental health practice or approach by addressing three areas that are often lacking in behavioral health: A flexible data system, Implementation planning and sustained support, and training on how to interpret data graphs and use this information on how to guide treatment. This innovation combines components that have not been previously applied together in behavioral health practice, to ensure successful and sustained implementation of the use of a data analytics to view clinical dashboards and using data to guide practice.

5) Population

Modoc County is a small, remote county that lies in the northeastern corner of California, bordering Oregon to the north and Nevada to the east. According to 2013 U.S. Census Bureau estimates, the population in Modoc County is just over 9,100, compared to a 2010 Census of just over 9,600, indicating that the population in Modoc County continues to decrease. Modoc County has only one incorporated city, Alturas, the County Seat, with a population of just over 2,600 people. 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 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 age 30-39 in particular have migrated out of the area, pulled by academic and employment opportunities elsewhere. The unemployment rate in Modoc County in 2013 was 11.7%; the state unemployment rate was 8.9% for that same year. Modoc's unemployment rate has been consistently higher than the state's rate since 1990. (Source: CA EDD Monthly Labor Force Data for Counties, Annual Average 2013; Data Not Seasonally Adjusted.)

Modoc County has one of the lowest median incomes of households in the state at $37,482 in 2012, compared to $61,400 in California the same year. The county has a high percentage of population living under the poverty level (19.9%), above the statewide average of 15.3%. (Source: 2012 American Community Survey.)

Approximately 6% of the county population are under 5 years of age; 18% are ages 6-19; and 56% are ages 20-64. Almost 20% of the county population is over 65 years of age; that percentage is twice as much as the statewide older adult population. Females represent 49% of the population. 84% of Modoc County residents identify themselves as Caucasian; 14% are Hispanic; and American Indians comprise about 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. (Source: US Census 2010.) 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 1,160 veterans, which represent 15% of the population. (Source: 2012 American Community Survey.)

Modoc County has a dispersed population, far from urban services and supports. The poverty rate in the county is somewhat higher than statewide, and a difficult employment picture has led many residents in their employment years to leave the county. A higher number than average of older adults presents special challenges. The county has significant populations of Hispanic and Native American residents.

6) MHSA General Standards

a) Community Collaboration: The proposed project is the end result of several years of stakeholder input and collaboration among County Policy Makers, Agency Directors, and Department Heads, and direct service staff, consumers and their family members. Agencies within the County have a long history of collaboration; beginning with the Modoc County Collaborative in the 1990's which brought schools together with social service, public and behavioral health service providers and other agencies. Leadership and staff from each of the county agencies meet regularly as teams to plan, leverage resources, and deliver services to meet shared and individual project deliverables.

In 2005 Modoc County Behavioral Health began holding regular MHSA stakeholder meetings. Collaborative partners routinely make their trainings (cultural competence, childhood asset training, healthy beginnings, medication assisted treatment, motivational interviewing, critical incident management, etc.) available to other agencies or partner together to share staff expertise and/or the cost of bringing trainers to the county. Currently the Modoc County courts have several collaborative justice projects including a delinquency prevention court, a family wellness court and a drug treatment court. Leadership and staff from each of the county agencies meet regularly as teams to plan, leverage resources, and deliver services to meet shared and individual project deliverables.

Modoc Community Corrections Partnership (CCP) was formed as an advisory committee for the implementation of SB678. In 2011, as a result of Modoc County receiving AB109 funds, the CCP's role was expanded to develop an implementation plan for 2011 public safety realignment. Committee representatives include the Director of Health Services, and the Deputy Directors of Public Health and Behavioral Health, the Chief of the Alturas Police Department, 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 With AB109 funds, the CCP implemented various treatment services and programs in the jail. The services include: mental health and substance use disorder individual and group counseling and parenting and life skills classes, all utilizing evidence based programs. We are regularly involved in numerous collaborative projects that require us to identify barriers and to discuss better ways to provide relevant consumer- and family-driven,

"wrap-around," holistic services in a culturally competent manner. Ongoing team and other stakeholder meetings, focus groups, key informant interviews, and public hearings inform our planning process.

Over the years, the depth and quality of the agencies commitment to collaboration is demonstrated by an increased ability to effectively provide integrated, holistic services for the people who need our services. The collaborative has continued to commit in-kind resources, and to seek other funding, to ensure individuals in our target population are engaged in individually designed, culturally competent, and trauma-informed services. Further, we have collaboratively developed a Continuum of Care services that addresses the special needs of our target population with an emphasis on those who have behavioral health needs and are also involved in the criminal justice system (see attached). The Continuum of Care services include: jail services, access to primary care, housing options, intensive probation officer case management, transportation, legal services, work and/or meaning full activity, peer support, Promotores, etc. to maximize access and promote health and service equity for those most impacted by Proposition 47, with an emphasis on the needs of Native Americans and Hispanics. Our collaborative partnership is very important to us. The Continuum of Care Clinical Team is coordinated by our Behavioral Health clinical director.

Working collaboratively is a fundamental value in our community. We are very aware that the quality of our collaborative partnerships is a strength in our small, isolated community where our limited resources and distance from other services makes is vital to shared successful outcomes. This proposal addresses, and is based upon, our partnerships' shared perceptions of unmet needs and barriers to fostering 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 to collaboratively measure outcomes. We are hoping that the implementation of eBHS will address this barrier not only for the individuals in the public mental health system and in our electronic health record, but also for those are not and may still need access and linkage to the system and/or who need prevention and/or early intervention services. Currently, we have minimal outcome data available in Anasazi (EHR) that is limited to enrolled clients in the Modoc County Behavioral Health System.

b) Cultural Competence: Equal Access: eBHS is designed to track client data for all clients served and to allow clinicians to engage each client in data review discussions to assess progress. The data collected will be both from standardized assessment tools and from data identified by the client or agency. Individualized goal statements can be incorporated in dashboards allowing clients to customize their report themselves. Due to the highly flexible and individualizable format of eBHS, culturally relevant outcomes can be customized for the major groups represented in Modoc (Native American, Latino, elderly, veteran, Caucasian). For example, given these differing potential population cultures, aspects of spirituality can be explored and documented, medical needs can be in close collaboration, and/or issues relating to PTSD can be addressed. Due to this innovation inherently using technology, IITD training will include ways to meet individual consumer needs such as a discomfort with using technology (for example, using a paper and pencil version of the test for an elderly

consumer who is uncomfortable using a tablet and client portal) and using translated instruments for those consumers speaking Spanish. Disparities: eBHS allows program staff to filter data by race, ethnicity, gender, etc. Continual monitoring of data is possible because eBHS gives data in real time. This will allow administrators to determine whether underserved populations are being reached, allowing timely brainstorming and potential reallocation of resources to meet the populations' needs, such as remote accessibility.

- The MHP has a Supervisor, Clinician and peer who speak Spanish. The MHP, in collaboration with Public Health (PH) and Partnership Health Plan (PHP), is planning to expand services to the Adin and Newell communities to make services more accessible to the underserved populations in outlying areas. Further we have received County Medical Services Program (SMSP) funds to hire a community health worker (Promotores) to provide outreach and linkage for the underserved Hispanic population as a primary target.
- The proposed innovation, eBHS, as a web-based system is easily transportable with a connected device, such as a tablet, and a means for connection, such as a portable hotspot. This will allow clinicians to continue real-time data collection and analysis with the client in-vivo, rather than having to wait for a follow up appointment. Conceptually, with integrated systems, this innovation will allow for a traveling practitioner (from a PHN to a case manager or social worker) to present multiple levels of consumer information to the consumer (such as health related, medication related, treatment related as allowed by HIPAA and 42CFR). This is particularly relevant to the cultural needs specific to Modoc county given the rural and disparate aspects of the population, as well as potential difficulties with travel given elderly, disabled, or low SES.

c) Client-Driven: This innovation includes training in Feedback Informed treatment (FIT), which has been shown to increase client retention in services and improved outcomes. FIT was originally developed following research showing high dropout rates among behavioral health clients. Research shows that the alliance between clinician and client significantly affects the client retention and treatment outcomes. The FIT model was developed to highlight the importance of client driven treatment by collecting regular client feedback on alliance, the client's thoughts on treatment, as well as treatment outcomes. The FIT training includes how to create a culture of feedback within systems and within sessions, so clinicians and clients are comfortable giving and receiving feedback that will improve client care. Furthermore, the IITD innovation is unique in offering analyzed data quickly in session, in a readable format, so that clinician and client can determine on a regular (preferably weekly) basis if the treatment is impacting outcomes and the treatment itself is comfortable for the client.

Research indicates that this regular use of client-driven data is impactful both for retention and improved outcomes.

d) Family-Driven: The importance of including family in treatment cannot be over emphasized. While this innovation isn't inherently a family-driven process, it is easily adaptable to family driven treatment, which is compatible with the cultural needs of Modoc County. Youth and elderly treatment generally requires the cooperation of family, and many cultures prefer the inclusion of family in treatment. Because of this innovation's unique transportability and flexibility for capturing data outcomes important to the consumer, practitioners at any level can bring the innovation to the home where the consumer determines what and who will be best for their wellness and recovery. This level of transportability insures that the client and family have control over who participates in session, rather than the treatment barriers or providers determining family involvement.

e) Wellness, Recovery, and Resilience-Focused: The innovation is flexible in compiling meaningful outcomes for the consumer, including functional outcomes such as education, employment, medication, and health. Each clinician and consumer can develop meaningful wellness and recovery goals, and build on client strength and protective factors

f) Integrated Service Experience for Clients and Families: This is an exciting potential of this particular innovation. Modoc County already has a fully integrated Behavioral Health system with Public Health nursing, social workers, case managers, probation, and other services providers working closely. With the data analytic capabilities of this innovation, all areas can contribute to the wellness outcomes of a consumer, at the consumer's behest and within regulatory ability. The goals of this innovation plan are to sustainably implement this data analytic system throughout the administration in such a way that integration may become a natural component of ongoing consumer care.

7) Continuity of Care for Individuals with Serious Mental Illness

This project does not provide a discrete service; rather the goal is to improve client, clinician, and administrative use to real-time data to improve access to and delivery of quality care. Data analytic tools such as eBHS are used regularly in primary care settings to manage populations to: (1) provide the right care, (2) at the right time, (3) in the right amount. Mental health practitioners are not as aware of these tools, nor have we had them available to us in the Behavioral Health field. Tools such as these promote both continuity of care and integration of care as a part of the system design. Continuity of care is also promoted through the use of client dashboards as their own data is available to them, real-time, for planning their care and through the potential to add a client portal.

8) INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement

a) Explain how you plan to ensure that the Project evaluation is culturally competent.

As outlined above, there are substantial Native American, Spanish speaking, elderly and veteran subsets to the population in Modoc. The current data system does not adequately allow for analysis of whether and how Modoc is serving these populations. With this innovation, not only will the system be capable of analytics that will determine outreach results, retention, and outcomes with this population, but also the training with IITD considers ways to adapt the unique needs of populations. Such adaptations may include translated measures, the use of reading the material to consumers rather than expecting them to be able to read themselves, the use of paper measures to match the comfort level of the consumer, and outcome foci important to each consumer.

b) Explain how you plan to ensure meaningful stakeholder participation in the evaluation.

Regarding stakeholder involvement, because eBHS is uniquely flexible stakeholders can request changes in the data collected and analyzed based on stakeholder needs. For example, if a specific funding source is being tapped, eBHS can be easily configured to capture the data needed for that funding source. Furthermore, the analytics capabilities as a system allows stakeholders to determine the ways that Modoc is capturing and addressing outcomes in any desired area within regulatory guidelines.

9) Deciding Whether and How to Continue the Project Without INN Funds

Throughout the process, we will be assessing the effectiveness of the approach and making modifications/changes/additions to eBHS and the implementation process related to the feedback through staff, partners, and consumers. If eBHS is judged to be effective, the ongoing cost of the access to eBHS will be covered by realignment, MHSA CSS administrative costs, etc. If it is not effective, as determined by stakeholders, through the evaluation process review, plans will be made for how to better meet our data analytics needs. By that time, changes in the State or Federal outcome reporting systems may have changed in such a way to impact our needs as technology is changing so rapidly. Regardless, we need to be able to have access, for client-clinician partnership and real-time access to data for treatment planning, the ability to measure outcomes for quality improvement, and to transfer data/outcomes to OAC and other State or Federal oversight entities.

10) Communication and Dissemination Plan

a) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties?

We plan to disseminate information through a collaborative evaluation process, report findings to the Behavioral Health Advisory Board and Staff, attach a summary of findings to the Annual Plan update and report findings to the County Behavioral Health Directors Association (CBHDA) as is appropriate. As we are working with the California Institute of Behavioral Health Solutions for implementation and evaluation of this project, they will also have access to our evaluation data to share with other counties who are considering the use of eBHS.

b) How will program participants or other stakeholders be involved in communication efforts?

Since we will be involving clients and other stakeholders in the use of eBHS (data analytics tool or registry) they will be informed regarding the outcome of this project regularly. Our hope is that as they become involved they will also share with their peers and/or colleagues.

c) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

Data analytics for behavioral health; population management; behavioral health registries; mental health population management tools; real-time access to client data for treatment planning

11)Timeline

a) Specify the total timeframe (duration) of the INN Project: 4 Years

b) Specify the expected start date and end date of your INN Project:
Start Date: 05/01/2017 End Date: 04/30/2021

c) Include a timeline that specifies key activities and milestones and a brief explanation of how the project's timeframe will allow sufficient time for
   1) Development and refinement of the new or changed approach;
      a. Month 0-3
         i. CDT Checklist
         ii. Identify Implementation team, Begin implementation work
      b. Month 3-6
         i. Identify measures, work with eCenter for licensing or addition to eBHS as needed
         ii. Prep Supervisors for Clinician's training needs (barriers and solutions)
         iii. Identify and prep clinicians
         iv. Set up training date for eBHS
         v. Set up training date for FIT
         vi. Complete trainings (at approximately 6 month mark)
         vii. Measure baseline data for evaluation of INN Project
      c. Month 6-12
         i. Clinical Consultation calls
         ii. Administrative Consultation calls
         iii. Ongoing Fidelity checks for Evaluation
      d. Year 1
         i. "Breakthrough learning" evaluation of fidelity
         ii. PDSA for challenges in attaining fidelity
         iii. Continue Clinical and Administrative calls
      e. Year 1-1.5
         i. Continue monthly calls and fidelity monitoring
      f. Year 1.5
         i. "Sustained Learning" evaluation of fidelity
         ii. PDSA for challenges in attaining fidelity
         iii. Continue Clinical and Administrative calls
      g. Year 1.5-2
         i. Continue monthly calls and monitoring
         ii. Adding additional measures at this time (as needed)
         iii. Adding additional systems at this time (as needed)
      h. Year 2-2.5
         i. Set up Sustainability Plan to titrate off CIBHS support toward local support
         ii. Ongoing clinical consultation
         iii.
   2) Evaluation of the INN Project; (Starting approximately Year 3)
      a. Evaluation begins from the beginning of IITD with CDT checklist
      b. Evaluation continues with eBHS then FIT training (baseline Fidelity)

c. Evaluation monthly ongoing (through year 2.5)
d. Mid-eval at 6 months to determine "break through learning (approximately year 1)
e. 12 month evaluation to determine sustainability/needs (approximately year 1.5)
f. Writing up evaluation (Collaboration with CIBHS; 3-6 months for completion)

3) Decision-making, including meaningful involvement of stakeholders, about whether and how to continue the Project;
   a. After 6 and 12 month evaluation (year 1 and 1.5)
   b. Feedback on final draft evaluation
   c. Sustainability plan development and implementation
4) Communication of results and lessons learned.
   a. Sustainability Plan
   b. Eval results
   c. Approximately year 3.5 – 4

12)INN Project Budget and Source of Expenditures

The next three sections identify how the MHSA funds are being utilized:

a) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
b) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)
c) BUDGET CONTEXT (If MHSA funds are being leveraged with other funding sources)

A. Budget Narrative

Personnel costs from Innovation funds are for 0.1 FTE Clinical Director, 0.1 MHSA Coordinator, and 0.25FTE administrative assistant to administer the Project. The In-kind personnel costs are to cover the cost for staff training implementation of eBHS. The indirect operating costs are in-kind. The non-reoccurring equipment includes 4 Surface Pro computers and 4 Tablets for direct use of eBHS with consumers for collaborative treatment planning and direct data entry and for access outside of the main office. The other non-reoccurring cost is to cover the cost to add enhancement tools to eBHS to customize it for ongoing measures and population management measures. Additionally, as PEI projects and/or innovative practices and subpopulations are added, it will likely be necessary to add relevant enhancements. Currently our electronic health record will only accommodate registered clients. The non-reoccurring costs (except for the equipment) for enhancements will be paid through the contract with CiBHS for the eBHS. Evaluation costs are included in the Consultant Costs/Contract with CiBHS.

B. New Innovative Project Budget by FISCAL YEAR (FY)*							
EXPENDITURES							
		FY 16-17	**FY 17-18**	**FY 18-19**	**FY 19-20**	**FY 20-21**	**Total**
PERSONNEL COSTS (salaries, wages, benefits)							
1.	Salaries – INN funds	21,303	21,303	21,303	21,303	n/a	85,212
	Salaries – In-kind	83,222	83,222	41,611	41,611	n/a	249,666
2.	Direct Costs						
3.	Indirect Costs						
4.	**Total Personnel Costs**	**104,525**	**104,525**	**62,914**	**62,914**	**n/a**	**334,878**
OPERATING COSTS							
5.	Direct Costs						
6.	Indirect Costs – In Kind	16,320	22,399	13,934	9,134	n/a	61,787
7.	**Total Operating Costs**	**16,320**	**22,399**	**13,934**	**9,134**	**n/a**	**61,787**
NON-RECURRING COSTS (equipment, technology)							
8.	System set up and configuration		50,000	45,000			95,000
9.	Equipment	10,000					10,000
10.	**Total Non-recurring costs**	**10,000**	**50,000**	**45,000**			**105,000**
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)							
11.	Direct Costs: up to 30 users	39,771	25,522	22,522	19,522	n/a	107,337
12.	Indirect Costs	8,912	8,912	8,912	8,912	n/a	35,648
13.	**Total Operating Costs**	**48,683**	**34,434**	**31,434**	**28,434**	**n/a**	**142,985**
OTHER EXPENDITURES							
14. N/A							
15.							
16.							

BUDGET TOTALS	**FY 16-17**	**FY 17-18**	**FY 18-19**	**FY 19-20**	**FY 20-21**	**Total**
Personnel	104,525	104,525	62,914	62,914	n/a	334,878
Direct Costs	39,771	25,522	22,522	19,522	n/a	107,337
Indirect Costs	25,232	31,311	22,846	18,046	n/a	97,435
Non-recurring costs	10,000	50,000	45,000			105,000
Other Expenditures	0	0	0	0	0	0
					TOTAL INNOVATION BUDGET	**644,650**

Total Project Costs:

Innovation Funds:	$333,197.00
In-kind* Funds:	$311,453.00
Total Innovation Budget	$644,650.00

*In-kind funds from 1991 Realignment, Federal Financial Participation or Behavioral Health Subaccount as allocated by Cost Report

MHSA Program Component
WORKFORCE EDUCATION AND TRAINING

WET Program Description and Outcomes
The MCBH Workforce Education and Training (WET) program provides training components, career pathways, and financial incentive programs to staff, volunteers, clients, and family members, through the following project:

Financial Incentive Programs
We continue to fund licensing supervision for intern MSWs. The interns and our recently licensed Spanish-speaking LCSW are approved for the loan assumption benefits.

Challenges and Mitigation Efforts
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.

Significant Changes from Previous Fiscal Year
There are no significant changes to the MHSA WET Program in this fiscal year.

MHSA Program Component
CAPITAL FACILITIES/TECHNOLOGY

CFTN Program Description and Outcomes
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 also testing a new integrated healthcare client registry 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.

Challenges and Mitigation Efforts
Capital Facilities: Our major barrier to acquire CF is financial. Our strategy to mitigate is to consider a lease-to-own option or to modify the scope of the project.

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.

Status of 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.

Significant Changes from Previous Fiscal Year
We have allocated resources to CF to explore lease-to-own options for building our infrastructure and supporting 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 and/or TN for the Implementation of eBHS to promote improved consumer access to real-time data for joint treatment planning with their clinician.

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

County: **MODOC** Date: 3/3/17

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	**Prevention and Early Intervention**	**Innovation**	**Workforce Education and Training**	**Capital Facilities and Technological Needs**	**Prudent Reserve**
A. Estimated FY 2016/2017 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	848,331	796,387	244,351	132,179	519,011	
2. Estimated New FY 2016/2017 Funding	1,415,766	353,947	93,144			
3. Transfer in FY 2016/2017[a/]	(100,000)					100,000
4. Access Local Prudent Reserve in FY 2016/2017						0
5. Estimated Available Funding for FY 2016/2017	2,164,097	1,150,334	337,495	132,179	519,011	
B. Estimated FY 2016/2017 MHSA Expenditures	1,147,392	556,368	79,986	101,000	137,472	
C. Estimated FY 2016/2017 Unspent Fund Balance	1,016,705	593,966	257,509	31,179	381,539	

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2016	451,709
2. Contributions to the Local Prudent Reserve in FY 2016/2017	100,000
3. Distributions from the Local Prudent Reserve in FY 2016/2017	0
4. Estimated Local Prudent Reserve Balance on June 30, 2017	551,709

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

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

County: **MODOC** Date: 3/3/17

	Fiscal Year 2016/2017					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. System Transformation (FSP)	585,170	585,170				
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%)	312,091	312,091				
2. Outreach and Engagement (20%)	78,023	78,023				
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	172,109	172,109				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	1,147,392	1,147,392	0	0	0	0
FSP Programs as Percent of Total	51.0%					

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

County: MODOC Date: 3/3/17

	Fiscal Year 2016/2017					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Community Asset-Building (Child & Family)	40,000	40,000				
2. Primary Intervention (Children, Grades K-6)	200,000	200,000				
3. Nurturing Families	49,073	49,073				
4.	0					
5.	0					
PEI Programs - Early Intervention						
6. Trauma-Focused CBT/Trauma Informed Care	130,000	130,000				
7. Public Health PEI Program	20,000	20,000				
8.	0					
9.	0					
10.	0					
PEI Programs - Outreach and Stigma Reduction						
11. ReachOut	18,080	18,080				
12. PEI Coordinator	35,000	35,000				
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	49,215	49,215				
PEI Assigned Funds	15,000	15,000				
Total PEI Program Estimated Expenditures	556,368	556,368	0	0	0	0

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

County: MODOC Date: 3/3/17

	Fiscal Year 2016/2017					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. CIBHS eBHS Project	79,986	79,986				
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	0	0				
Total INN Program Estimated Expenditures	79,986	79,986	0	0	0	0

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

County: MODOC Date: 3/3/17

	Fiscal Year 2016/2017					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Financial Incentive Programs	90,900	90,900				
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					
WET Administration	10,100	10,100				
Total WET Program Estimated Expenditures	101,000	101,000	0	0	0	0

FY 2015/16 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: MODOC Date: 3/3/17

	Fiscal Year 2015/16					
	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. Lease-to-Own Project	30,000	30,000				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Consumer Access Expansion	12,322	12,322				
12. EHR and Health Registry	95,150	95,150				
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	137,472	137,472	0	0	0	0