TUOLUMNE COUNTY BEHAVIORAL HEALTH

Update to the MHSA FY 2013/2014 Annual Update -
NEW Innovation Project
(INN-02)

Wellness: One Mind, One Body

Approved by Tuolumne County Board of Supervisors on
Tuesday, April 1, 2014

Includes Modifications and Additions for Presentation to the
Mental Health Services Oversight and Accountability
Commission – May 2014

Table of Contents

1. Description of Community Program Planning and Local Review Processes……..3

2. Innovation Work Plan Narrative…….7
   a. Purpose of Proposed Innovation Project
   b. Reason for Selecting the Proposed Project
   c. Project Description – The Innovation, Issue(s) Addressed, Expected Outcome(s)
   d. Contribution to Learning
   e. Timeline for Project
   f. Project Measurement
   g. Leveraging Resources

3. Innovation Work Plan Budgets & Description……..17

4. Public Comment Notification……...23

5. Public Comment Form……...24

6. Summary of Public Comments Received, Including Summary of Changes Made…...…25

7. County Compliance Certification……..…….26

8. County Fiscal Accountability Certification……..….27

Tuolumne County Behavioral Health
Update to the MHSA FY 2013/14 Annual Update - New Innovation Project
Wellness: One Mind, One Body
February 2014

Description of the Community Program Planning and Local Review Processes

1. Briefly describe the Community Program Planning Process.

The Community Program Planning Process for Tuolumne County's Update to the MHSA FY 13/14 Annual Update for a new Innovation Project began as part of Tuolumne County Behavioral Health's (TCBH) MHSA Annual Update for FY 2013/2014. During the planning process for FY 2013/2014 Annual Update, specific input regarding a new Innovation project was received using a variety of methods and sources. Based upon the input received, it became apparent that there was a need to integrate behavioral and physical healthcare services to provide clients a more satisfactory health and mental health outcome.

The following means were used to gather stakeholder input during the community program planning process:

- MHSA Community forums were held on April 3 and April 10, 2013, with the purpose of discussing Mental Health Services Act programs, and soliciting input about a possible new Innovation project;
- In addition to the public community forums, a survey was distributed to those attending the forums. The survey added a specific question about a possible innovation project concept (coordinating care/integrating behavioral and physical healthcare for clients).
- The survey was also made available through an online survey tool.
- The annual update summary presentation and stakeholder survey were posted on the Network of Care site to facilitate a "Virtual Stakeholder Process".
- A large focus group was held with 36 peers attending the P.R.I.D.E. group (Peer Recovery: Independent Development and Empowerment), held at the peer-run Enrichment Center on March 27, 2013.

A total of 49 individuals participated in the in-person forums, and a total of 92 surveys were completed. (See Paragraph #2, below, for Stakeholder representation). The forums, survey, and focus groups included questions and discussion about a potential/possible new Innovation Project, as well as questions and discussion about current MHSA programs. There was a recurring theme involving the need to provide better and more coordinated physical healthcare with behavioral healthcare in order to give clients a more satisfactory health and mental health outcome.

In doing community program planning in TCBH, it is important to acknowledge that Tuolumne County's population differs significantly from most of the State. Tuolumne County is less racially and ethnically diverse than State averages. In 2011, the county's population was estimated to be 54,008, declining from 55,365 the previous year. Tuolumne County's median age is nearly twice the state average with 22% of residents over the age of 65, according to the United States Census Bureau. The county ethnic diversity is:

- 81.7% White
- 11.1% Hispanic
- 3.2% Multiracial
- 2.2% Black
- 2.2% American Indian
- 1.2% Asian
- 0.2% Pacific Islander

Tuolumne County is also less linguistically diverse, and has no threshold language. According to the Census, 92 % of the total population speaks "only English at home". Based on Census estimates, fewer than 400 individuals, county-wide, speak English "not well" or "not at all".

In evaluating the county's efforts to determine the ethnic diversity of the participants in the community program planning process (through the surveys, questionnaires, forums, etc.), the county realized it hadn't collected demographic data beyond identifying whether or not an individual was a client with lived mental health experience, a family member of a person with lived experience, or a general community member. The county's demographic data collection didn't identify the cultural, ethnic or racial diversity of the mental health consumers/clients who participated in the community program planning process. While the department was pleased with the return of the responses it had received during this round of community program planning, it became apparent that it would have to collect data on the ethnic diversity of respondents/participants in the future. This oversight was corrected with the community program planning process implemented for the MHSA Three Year Plan for FY 14/15, 15/16 and 16/17. Demographic/data collection questions on cultural, ethnic or racial diversity were added to the surveys, questionnaires, key informant interview form, focus group participant form, and sign in sheet(s) for community forums.

Moving forward with the planning process, and while utilizing the information and input received to this point, the Tuolumne County Medical Society was also engaged to provide their perception of the identified need for coordination/integrating behavioral and physical healthcare. The physicians indicated that they would like someone to consult with and refer clients to. The concept of an integrated approach to healthcare and behavioral healthcare was introduced, and as a result, Dr. Hope Ewing of the Matheisen Clinic, came forward to learn more.

Clients were also subsequently engaged through QI (Quality Improvement) committee participation to provide additional input and to elicit their thinking about the concept of integrated/coordinated medical care and behavioral healthcare, including their fears, concerns, etc. They provided input to staff about what they need, how they care about their health, and their perceptions of being treated poorly for their healthcare needs.

Unfortunately, there wasn't enough time to draw up a NEW Innovation Project to be included and approved as part of the MHSA FY 2013/14 Annual Update. Instead, using a summary of the stakeholder input compiled from the forums, surveys, focus group (s), staff crafted a brief concept statement proposing a new Innovation Project focusing on integration of behavioral care with healthcare. This brief statement was included in the MHSA FY 2013/14 Annual Update.

The Tuolumne County Board of Supervisors approved the MHSA Annual Update for FY 2013/14 on September 3, 2013, also giving its approval of the concept for the proposed Innovation Project, thereby giving the Behavioral Health staff the approval to go forward with drafting a Plan for a New Innovation Project. This is the plan now being presented.

2. Identify the stakeholder entities involved in Community Program Planning.

Stakeholders included at-large community members, mental health consumers/clients (persons with lived experience), family members, the local medical society, as well as representatives of a variety of local community based agencies and organizations that represent and/or serve diverse stakeholders. (The diverse stakeholders represented included Latinos, Native Americans, adults, children, older adults, and veterans). Because TCBH is an integrated Behavioral Health Department, county providers of alcohol and drug services were included as recipients and respondents to the county survey process, as well as invitations to the county forums. Representatives of education and law enforcement were invited to attend the community forum(s) as well as to complete the MHSA survey for stakeholder input. Alcohol and drug services clients were provided access to the virtual survey as well as printed copies of the survey. TCBH contracts with community providers of mental health services to children (through schools) in the community, and outreach to these families/participants was made by the agencies on behalf of TCBH. In reviewing the responses received from the various stakeholders, it was determined that in the future, more key informant interviews with Education and Law Enforcement would be conducted as part of future MHSA Community Program Planning in order to do a more thorough outreach to these stakeholders, and to receive their input. In addition, members of the Tuolumne County Behavioral Health Advisory Board, Tuolumne County MHSA and Quality Improvement Committee(s), and the local NAMI chapter were also stakeholder participants.

Community stakeholders are also involved in meaningful activities and decisions in community program planning through various venues. TCBH Quality Improvement Program includes an active Quality Improvement Council (QIC) which meets monthly, and includes representatives from mental health, alcohol and other drug services, family members, mental health clients, the local community cultural collaborative (representatives from the LGBTQ community, Native American community, education, public health service providers, the Latino community, the faith based community). The QIC reviews program planning, it's implementation, quality improvement initiatives (such as performance improvement through improved productivity, monitoring of client satisfaction results, performance improvement project(s) status/activities, etc.). In addition to the QIC, the Quality Management Committee meets twice monthly, and is charged with distributing the staff work and assignments needed to provide reports and input to the QIC. This committee also tracks/monitors issues for the QIC, providing QIC a monthly report of progress. The Behavioral Health Advisory Board also meets monthly, and those meetings include updates on existing quality improvement initiatives, data reporting, budget

updates, etc. The Behavioral Health Advisory Board includes representation from family members, client/consumers with lived mental health experience, a member of the Board of Supervisors, and at large community representatives. The Behavioral Health Advisory Board provides feedback to TCBH on mental health policy, programs/planning, monitoring of same, quality improvement project feedback, etc.

3. List the dates of the 30-day stakeholder review and public hearing.

The Update to the FY 13/14 Annual Update for a new Innovation Project titled "Wellness: One Mind, One Body" was posted and circulated for the required 30 day review and public comment period from Thursday February 13, 2014 to 5:00pm on Friday March 14, 2014 . The Tuolumne County Behavioral Health Advisory Board conducted a public hearing on the Monday, March 17, 2014 at 5:00pm. The Tuolumne County Board of Supervisors approved the Update to the FY 13/14 Annual Updated for the new Innovation Project on Tuesday April 1, 2014. Minutes from the Tuolumne County Board of Supervisors meeting of April 1, 2014 will be available on Tuolumne County's Website on May 6, 2014.

The Update to the FY 13/14 Annual Updated to include the new Innovation Project was posted on the Tuolumne County Mental/Behavioral Health Network of Care website (http://tuolumne.networkofcare.org/mh/content.aspx?id=353). After the close of the 30 day public review and comment period, the Tuolumne County Behavioral Health Advisory Board conducted the required Public Hearing as noted above. A Summary of any public comments is attached, including any substantive comments received.

Innovation Work Plan Narrative

Purpose of Proposed Innovation Project:

The purpose of the proposed Innovation project is to:

- Increase the quality of services, including better outcomes

Briefly describe the reason for selecting the above.

Based upon the comments and information obtained from participants in the community forums, focus group, and surveys, clients, family members and professionals are watching clients die sooner than they should. Many clients not only have a serious mental health and/or substance use disorder, but they also have chronic medical conditions. Medical services for this population are poorly coordinated and fragmented because of "siloed" care plans and treatment. Clients also rarely receive support to be active in their own care, or to engage in healthy behaviors.

There is an increasing body of research which shows that people with serious and persistent mental illness (SPMI) have health outcomes that are significantly worse than those of the general population. Deaths for this population occur on average 25 years earlier than those without SPMI. These individuals are more likely to have high blood pressure, heart disease, diabetes, or other serious medical issues. There are many reasons for the premature deaths noted for this population. Low medical follow up, high rates of tobacco use, high rates of alcohol and illicit substance use, poor diet and lack of exercise are a few reasons for premature death. And, not surprisingly, health care costs for individuals with mental health and substance abuse disorders who have multiple physical health conditions are significantly higher than that of the general population. These individuals are more likely to use an emergency room and to be hospitalized, yet often have been found to have difficulty accessing regular medical care.

Tuolumne County Behavioral Health (TCBH) wants to learn if using a coordinated approach to integrating behavioral health and physical healthcare will work for the clients served by this rural county. It is intended that clients will achieve not only improved health outcomes as a result of the project, but improved self-care as well. The Patient Protection and Affordable Care Act supports health home models of service delivery (which incorporate team based care, care coordination), but in a rural county such as Tuolumne, the structure of the service delivery will likely be slightly different. There are unique values and cultural issues embedded in the rural lifestyle and attitudes of the community. Persons tend to be isolated, a large older adult cohort (22% in Tuolumne County vs. California's 12%), lower higher education achievement, more limited access to technology due to signal restrictions or cable issues, and generally conservative in values and political orientation. Stigma related to mental health remains a substantial barrier as well.

Project Description: Describe the Innovation, the issue it addresses, and the expected outcome.

The Proposed New Innovation:

TCBH is proposing a new Innovation project that will focus on integrating behavioral health with physical health care through the coordination of the client's care. Collaboration with non-mental health care providers (including public health, physical healthcare, and holistic care) will be built using a combination of several similar approaches. The Care Collaboration Team will work together intensively, and ultimately, a service delivery model unique to Tuolumne County's needs will be developed. It is expected that the project will take between three to four years to achieve the learning objective(s). The project is being titled: "Wellness: One Mind, One Body". As the project name implies, the goal is to treat the whole person in order to achieve physical and emotional wellness. The issue(s) being addressed by this innovation include identifying what changes are needed to establish multiagency communication, thereby creating better workflow(s) for coordinated physical and behavioral healthcare, and also promote the client's self-management of same, as well as to establish a clinical information "system", using limited resources in this rural county.

The following outlines the proposed phases of the project. The time frame(s) for the phases and the timelines are estimates, due to the fact that adjustments may be necessary based upon the results of the periodic evaluation(s) being completed on the project. It should be noted that the budgets that are attached are based upon TCBH fiscal year, therefore the first budget is only for 4 months of FY 13/14, and then there are full 12 month budgets for each subsequent fiscal year, FY 14/15, 15/16, and 16/17. This represents a total of estimate of 40 months for the project, however, some flexibility is necessary in that it is possible that the project may go for the estimated 46 months. If that is the case, a partial FY budget for FY 17/18 may be required (but is NOT included with this plan). If that becomes necessary, TCBH will do an Update to the Innovation Project (Plan) for the purpose of requesting an additional budget for the FY 17/18.

Phase One of the project will take approximately 12 to 15 months (reflected as months "0" through "15" on the timeline, approximately March 1, 2014 through May 31, 2015). There are two components to Phase One:

- Technical Assistance and Training will occur through participation in a Care Coordination Collaborative through the California Institute for Mental Health (CiMH). This component of the project will focus on training, technical assistance from CiMH, and in building collaborations with identified partners, including: Tuolumne County Public Health; Tuolumne County Behavioral Health (Director, Supervisors, Peer Representation, etc.); the Mathiesen Memorial Health Clinic; the Tuolumne County Medical Society; the National Alliance for the Mentally Ill (NAMI Local Chapter); and California Health and Wellness. Additional partners may be identified during the training portion of the project. Communication between partners will occur the first year through a web based compatibility system, the cost of which is carried by CiMH. At the end of one year, the team will evaluate the effectiveness of this form of coordination and

determine if TCBH will continue to utilize this method going forward. (After the first year, the cost would then be absorbed by TCBH).

Training for all collaborative partners will be required and will include webinars for local on-site training, as well as multiple day courses that will be offered off-site in various locations. Occasionally, travel will be necessary for partners to receive the off-site training, sometimes at distant locations throughout California; therefore associated costs will be covered for hotel accommodations, travel reimbursement, etc. (These costs are funded under the project).

- Designation of Current TCBH Staff as the INN Project Client Care Coordinator. Simultaneously, a staff member from (TCBH) will be designated specifically to identify clients for participation in the innovation project. This individual will provide assistance to the client(s) in a variety of ways. This staff person will also assure the collection of data which will (ultimately) be used to monitor and measure the success of the project.

Based upon what is learned from the participation in the Care Coordination Collaborative, the team will identify the ways that multiple agencies can work together to coordinate mental health client care, as well as determine what individual and system changes can be made to improve the health status of the clients who may have complex, co-occurring conditions and who require coordinated services.

Phase Two of the project will take approximately 18 to 24 months (shown as months 12 through 36, dated January 1, 2015 through February 28, 2017) and will focus on implementation of the learnings from the Care Coordination Collaborative, including instituting those changes required to improve the health status of clients participating. It is expected that there will be some overlap between Phase One and Phase Two. Phase Two will take approximately two to two and one half years. Activities during early Phase One and as part of Phase Two will be to ensure that those clients who do not have a designated primary care provider are offered assistance in finding and establishing care with a provider that meets their insurance and health needs. Additionally, current clients who are stable and utilizing medication services only will be assisted in transitioning to receiving ongoing mental health medication support from their primary care doctor. This will involve opportunities for primary care doctors and nurses to consult with behavioral health staff to support the client's ongoing care and maintain stability.

Phase Three of the project will take approximately 12 months (shown as months 30 through 42, dated July 1, 2016 through August 31, 2017) and will include evaluating and monitoring the changes implemented during Phase One and Two. It is anticipated that the evaluation and review may result in further adjustments to the model during Phase Three.

Phase Four of the project will take approximately 6 to 8 months (shown as months 40 through 48, dated May 1, 2017 through February 28, 2018) and will involve analysis of the outcomes from the first three phases, measuring successes (or lack of success) in the learning objective(s).

During Phase Two and also during Phase Three of the project, there may be opportunities for onsite exchanges, where the behavioral health psychiatrist could spend one day a month in the

primary care clinic. Tuolumne County Behavioral Health is also exploring the possibility of utilizing a Mobile Health Van provided by Sonora Regional Medical Center to be parked at the Enrichment Center twice a month for health screening. (*The peer run/operated Enrichment Center is located adjacent the Tuolumne County Behavioral Health Department. The center offers peer supported groups, life skills training, computer access, laundry, showers, and other supports such as a benefits specialist, a seasonal garden, clothes closet, etc.)*

Barriers and Issues:

The community mental health challenge facing TCBH is to overcome long-term thinking that has become embedded within the Tuolumne County medical community and the general community at large regarding how mental health clients have received their physical/medical healthcare. By way of history, TCBH has only recently managed the outpatient aspect of behavioral health. Up until 5 years ago, outpatient mental health care in Tuolumne County was contracted out to and managed by a private company. At that time, Tuolumne County still operated a County General Hospital, which included an Inpatient Psychiatric Unit. The standard of practice was that when a client was struggling with their mental healthcare, they were admitted to the inpatient unit for mental healthcare issues. Often they also received treatment for any health or medical issues as well. With a high level of utilization of the psychiatric inpatient unit and/or emergency room services, coordinated physical healthcare was often overlooked. There was no operationalized venue for coordinating a client's mental health and physical healthcare beyond intermittent medication reconciliation when specific healthcare conditions were identified. Mental health related issues were not necessarily viewed as within the venue of the physical healthcare strategies toward overall wellbeing and vice versa. When the client was discharged from psychiatric facilities, the client's medical care was not an included component of the discharge planning and information, which potentially resulted in compromised or limited outcomes. This historical practice led to high cost, high end care, and a continuing negative cycle for the mental health client. The county has since closed the General Hospital, as well as the Inpatient Psychiatric Unit, but the historical attitudes and practices have remained ingrained within the medical, mental health and general community.

Expected Outcome:

This new Innovation project is intended to improve the health outcomes for those individuals served by TCBH who have difficulty accessing health care, have chronic medical issues, or who do not access regular primary health care. By introducing collaboration between behavioral health and various non-mental health disciplines as stated above, the health outcomes of TCBH clients may be improved. TCBH wants to learn whether or not an innovative integrated approach to behavioral health and physical healthcare will empower consumers to access health care, and also influence clients to manage their self-care more effectively.

The information gathered in the community program planning and review process (as mentioned earlier), supports the belief that there is not only a gap between the behavioral health care and the physical health care received by clients served by TCBH, but there is a lack of coordination of care and follow up. Additionally, State and Federal changes in health care management will have an impact on how service is delivered because the Patient Protection and Affordable Care

Act provides incentives and support for the integration of Mental Health/Substance Use Disorders and primary care services. This can benefit the clients served.

As stated earlier, a body of research has shown that Americans with mild, moderate, serious and severe mental health/substance use disorders have a substantially higher prevalence of chronic health conditions, as well as higher total healthcare expenditures. Because rural counties have fewer resources available to them, it is essential for Tuolumne County to learn whether or not a team or coordination of care model based upon multi-agency communication can be successful in providing its behavioral health clients with high quality mental/physical healthcare with improved health outcomes, as well as affordability, in mind.

TCBH is anticipating the outcomes expected from the project which will include developing a model of integrated physical/mental health care service delivery with effective coordination of services and interventions which result in improved health/mental health outcomes for the 'whole person' and the 'whole system'. Through the project, it is expected that there will be evolving significant roles for clients, parents and family members in the planning and the development of integrated services and any associated evaluation processes. TCBH would like to see a system that does not have to be "navigated" by the client/their family, but rather, a system that becomes seamless to them, where no road map is required to get the desired healthy outcome.

Contribution to Learning: Describe how this project contributes to learning.

The proposed project is intended to do the following:

- Make a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.

Many clients active to the Behavioral Health system not only have a serious mental health and/or substance use disorder, but also have chronic medical conditions as reported by the clients – though verification through medical records is not currently obtained as reflected during the chart utilization review process. Ultimately, medical services for this population are poorly coordinated and fragmented because of "siloed" care plans and treatment. Clients do not have documented support to be active in their own physical health care planning, or to engage in healthy behaviors through supportive activities and case management. A preliminary statistical review of persons open to the Behavioral Health Department who actually reported having a primary care provider was performed and reflected that 47% of persons had indicated that they had an active primary care provider. TCBH might possibly conclude: 1) clients are not accessing physical health care, 2) identification of primary care is not occurring, or 3) poor record keeping is resulting in under-identification of potential resource supports for optimal care.

TCBH has reviewed existing documented approaches (models) to coordination of mental health care and physical healthcare. TCBH has acknowledged challenges between physical health care and behavioral health care that have experienced long standing obstacles as described earlier, which have resulted in compromises to overall health of persons with mental illnesses.

We don't feel that we can use other documented approaches/models to integrating mental health care and physical healthcare because those approaches are not sufficient to meet our rural needs and differing attitudes. Some of the reasons why we need to try different approaches include:

1. The impact of stigma which results in a lack of disclosure of either a mental health diagnosis to the PCP or disclosure to mental health regarding their physical healthcare issues (or they may not realize the importance of this disclosure occurring, or its impact on their physical/mental health outcomes.)
2. There is no electronic system interoperability between rural physical health care clinics and behavioral health, therefore this method of communication is not available, and alternatives are needed to assure communication in integration.
3. Identification of co-occurring physical and mental health conditions and the lack of coordination of them mean that there is no management of the care between the providers.
4. PCP referral of their physical healthcare client to TCBH services has been referred to as a "black hole" phenomenon (described by the PCP's themselves). The PCP receives no feedback from TCBH regarding follow up.
5. Medication reconciliation between mental health and physical health care (PCP) are not in place and it's difficult to obtain with reliance on client self-report.

TCBH would like to try out a number of methods/approaches to address some or all of the above (and there are likely more that will come to light as the project is evaluated), in the following possible ways:

1. Creation of a collaborative team which includes representatives <u>not only from</u> behavioral health, physical health, public health, clients/patients of the physical health and behavioral health clinics, representatives from the local medical society, but also persons with lived mental health experience as well as providers from the MCP (managed care plans)._ This team will first be trained by CiMH as part of a Collaborative. This team differs from other mental health/physical health integration teams for several reasons:
    a. the team will include persons with lived mental health experience (as mentors) to the providers from the MCP's (Managed Care Plans) that the county will be working with;
    b. the roles, responsibilities and activities of the peer mentors and providers from the MCP will, with CiMH guidance, be designed by the team, and subsequently tested/refined, modified, and evaluated as part of the learning
2. Exploring system capabilities (electronic, paper) to determine how communication between different entities might occur.
3. Evaluate feasible alternatives to identification of co-occurring physical and mental health conditions, and determination of how management of same can be achieved.
4. Determine how receipt of referral and follow up occurs (or not), and evaluate how other models "encourage" pursuit of a PCP, and decided how that can be incorporated.

5. Utilize PDSA cycle to incrementally learn whether or not interventions proposed by the collaborative are working.

This project is also entirely consistent with and supports the MHSA principles and general standards in the following manner:

- Community Collaboration –The project is based on partnership and collaboration, specifically between the treatment teams for those served and health care and other related providers.
- Cultural Competence - Eliminating disparities in terms of equal access to services of equal quality is a key element to the project. The project will evaluate whether or not clients aren't accessing physical care because of communication issues, or possibly do not have a primary care physician because of cultural or language barriers, or whether or not tools used to communicate internally might need to be more unique to each person's racial/ethnic, cultural, or linguistic style, for example. Evaluating how the data itself is collected as it relates to each individual's racial/ethnic, cultural, or linguistic need, will be helpful to staff, and to the client, in assuring equal access to services of equal quality. The health indicators which will be utilized to reflect improvement, including BMI, BP/hypertension and Glucose, will be reviewed with specific racial/ethnic focus for the individual.
- Client Driven – A nurse coordinator (from behavioral health) works with each client who participates in the Innovation Project. The client has access to an assigned nurse coordinator to provide input and feedback. The client will also be the primary decision maker with their primary care physician in determining the client's desired health outcome (which will, hopefully, prove to affect improvement in the client's mental health status/outcome). Together, the nurse coordinator will work with the client to assure the client has a primary care physician, has appointments with the physician, and assures the information is properly documented in the behavioral health record. They also work together to determine what specific health indicators will be measured/collected as part of the project (and which will be included in the client's electronic record).
- Family Driven - The Innovation Project does not include families of children and youth with serious emotional disturbance. However, family members of persons with lived mental health experience will receive updates and reports as periodic evaluation of the ongoing Innovation Project occurs. Innovation Project updates will be presented to the Quality Council as well as the Behavioral Health Advisory Board, with ample opportunity for family members to provide input on evolving policy, procedures, service delivery, definition and determination of (future) outcomes, and future evaluation projects involving this Innovation.
- Wellness, resiliency and recovery focus – The fundamental purpose of the project is to further promote wellness and recovery among those consumers who participate. The project recognizes that physical and mental health are interlinked, and it will promote consumer wellbeing across both domains. Peer staff will reinforce this message, promoting a recovery orientated environment, reducing stigma and increasing the likelihood of participation by consumers in the project.

- Integrated service experience – At its foundation, this project supports the integration of mental health and physical health care for participants, supporting a holistic approach to wellness and service delivery.

There are several ways that this project will contribute to learning for TCBH staff, collaborators, clients, family members:

- Initiating, supporting and expanding collaboration from various non-mental health disciplines (such as public health, physical health, holistic practice) can improve the health outcomes of TCBH clients;
- A model of service delivery which integrates behavioral/physical healthcare through collaboration and communication will not only improve health outcomes for TCBH clients, but also influence clients to manage their self-care.

Timeline: Outline the timeline within which the project will operate:

Phase One (Month 1 through Month 12 (with flexibility to 15 months):

- Implementation Planning and Start Up (Months 1 through 6)
  - Identify any implementation partners who will support the project's activities;
  - Identify and meet with collaborators from non-mental health disciplines (Public Health, Physical Health, Local Medical Society, Holistic Practice/Clinic) to participate on the Care Coordination Collaborative Team
  - Register the Team with CiMH for participating in Care Coordination Collaborative, and participate in ongoing Learning Sessions
  - Identify TCBH Staff Member to be Designated for Project Care Coordinator
  - Team develops specific measureable project goals and objectives, an evaluation framework, any indicators, measurement tools/data collection protocol
  - Project Care Coordinator begins to identify clients to participate (those with chronic medical issues, no access to regular primary care physician, etc);
  - Set up follow up meeting(s) with stakeholders to review progress on the project.
  - Month 6, TCBH will make available an update on the project through the TCBH Newsletter, which can be shared with other counties through the Network of Care Website, or via CMHDA-MHSA Committee meeting distribution list.

- Early Implementation (Months 7 through 12) – Ramp Up
  - Team continues with regularly scheduled meetings, collaborative calls, lead calls, etc.
  - Team developed Measurement tool ready for use
  - Project Care Coordinator starts working with clients identified for participation;
    - Assists client to establish health and wellness goals
    - Assists client to obtain benefits, make appointments
    - Follows up on treatments recommended, labs, etc.
    - Assist clients receiving medication only services to transition to primary care physician for support
  - Initial data collection ("pre" measures)

- Data collection of any process measures
- Follow up meetings with stakeholders to review progress on the project.
- Month 12, TCBH will make available an update on the project through the TCBH Newsletter, which can be shared with other counties through the Network of Care Website, or via CMHDA-MHSA Committee meeting distribution list.

Phase Two (Approximately Month 12 through Approximately Month 36)

- Project Operations:
  - Team continues activities
  - Project Care Coordinator increases activities with clients, adds more clients
  - Monitor progress of activities, data collection, monitor improvements
  - Make Changes to the model as needed.

- Data Collection, Measures
  - Sufficient time will be needed to fully implement and evaluate Phase 2 and 3 of the project. Need to ensure participation by statistically meaningful number of consumers and time for measurable changes in wellness outcomes.

- Stakeholder Review – Follow up with stakeholders to review progress on the project.
- Month 24: TCBH will make available an update on the project through the monthly TCBH Newsletter, which can be shared with other counties through the Network of Care Website, or via CMHDA-MHSA Committee meetings

Phase Three (Approximately Month 30 through Approximately Month 42):

- The project activities and corresponding measurement will continue
- In Phase Three, additional strategies may need to be introduced, including additional training to incorporate broader wellness approaches regarding treatment and increased coordination with public health, physical health, holistic practices.
- Outcome data will be collected/analyzed/reported to both project participants (clients) as well as stakeholders. This data will be used to drive any project adjustments/changes.
- Month 36: TCBH will make available an update on the project through the monthly TCBH Newsletter, which can be shared with other counties through the Network of Care Website, or via CMHDA-MHSA Committee meetings.

Phase Four (Approximately Month 40 through Approximately Month 46)

- Evaluate successes and improvements, modify the model of service delivery and establish another funding stream if the model is successful. A complete project evaluation will be completed during the final 6 months of year 4. The Team will formulate final recommendations to the Department about whether or not and/or how to incorporate the project as an ongoing program, and funding sources. Evaluation results will be disseminated to the stakeholder community.
- A final report on the Project will be issued from TCBH Administration to the Board of Supervisors. The final report will include the evaluation results, and identify what

elements to continue beyond the Innovation funding. The final report will be shared with other counties through the Network of Care Website, via CMHDA-MHSA Committee meeting, and through Tuolumne County Board of Supervisor final presentation (to be shared on the County Website).

Project Measurement: Describe how the project will be reviewed and assessed.

The project will be reviewed and assessed for success at the client level, process/system level, and the community level. These levels will be used to determine success (or lack thereof) for the learning objectives:

- Improved health outcomes because of collaborative approach and coordination of behavioral/physical healthcare
- Improved self-care management as a result of the model of service delivery

Pre and post assessment of the following indicators will be necessary in order to determine the success of the learning through the innovative approach utilized. The data can be collected through various methods, which might include:

- Tracking forms used by Project Care Coordinator
- Tracking forms used by the Care Collaboration Team
- Consumer Perception Survey (MHSIP)
- Client self-administered survey (using a five point Likert Scale)
- Chart Review Which Uses a Screening Tool (electronically)
- Existing Utilization Data
- Survey Stakeholders

The following are client level indicators that can be measured:

- Client has a designated primary care physician
- Decrease in acute medical episodes
- Decrease in emergency room visits
- Reduced medical hospitalization
- Reduced use of behavioral health services
- Increased level of enjoyment, hopefulness, satisfaction with care
- Pre/post measures of physical health outcomes (weight, BMI, BP, glucose, lipids)
- Improved health related behaviors, such as decreased tobacco or drug use, increase in exercise, gardening, etc.
- Pre/Post assessment of mental health outcomes, such as: BASIS 24, including change in clinical symptoms; GAF; utilization of CAIP (Crisis, Access and Intervention Program); etc.

Process/system level indicators:

- Number of Clients shared with partners on Team
- Increased access to primary health care
- Decreased utilization of behavioral health services

- Pre/Post assessment of mental health outcomes, ie, BASIS 24, including change in clinical symptoms, GAF, utilization of CAIP (Crisis, Access and Intervention Program), etc.
- Improved client satisfaction (for those participating in the project)
- Decreased cost per client for care (behavioral healthcare or physical healthcare)

Community level indicators:

- Stakeholders express satisfaction with improvements
- Team members receive positive feedback from their cohorts

Leveraging Resources: Provide a list of resources expected to be leveraged.

Leveraging will occur through a variety of methods:

- Use of facilities for meetings and/or activities at the Enrichment Center, the Matheisen Clinic, Public Health
- Staff from non-mental health entities will be allowed to participate in the Care Collaborative at no cost to Behavioral Health Department
- Evaluation for this Innovation program will be provided through the combination of a Tuolumne County Behavioral Health Staff Analyst with contributions from the collaborative team at no additional cost to the Behavioral Health Department
- Affordable Care Act, Collaboration through Health Care Exchanges

Innovation Work Plan Description

The total number of clients to be served annually: **120 clients**

Population to be Served: **Adults SMI (Seriously Mentally Ill) with Co-occurring medical (See next page for Budget for FY 13/14)**

- **Budget Resources:** The following narrative identifies the expected sources of funding, as well as the amount of the annual Innovation Funds requested that the MHSOAC approve. Evaluation for this Innovation program will be provided through the combination of a Tuolumne County Behavioral Health Staff Analyst with contributions from the collaborative team at no additional cost to the Behavioral Health Department.

Fiscal Year 13/14 – 4 months:

- $54,492 – Total for Personnel and Operating Expenditures
- $30,507 – Total Revenues from Medi-Cal FFP and MHSA FSP/CSS Clients
- $23,986 – Total Innovation Funds Required for FY 13/14 – 4 Months of Operations

Fiscal Year 14/15 – 12 months:

- $134,727 – Total for Personnel and Operating Expenditures
- $91,520 – Total Revenues from Medi-Cal FFP and MHSA FSP/CSS Clients
- $43,207 – Total Innovation Funds Required for FY 14/15 – 12 Months of Operations

Fiscal Year 15/16 – 12 months:

- $134,727 – Total for Personnel and Operating Expenditures
- $91,520 – Total Revenues from Medi-Cal FFP and MHSA FSP/CSS Clients
- $43,207 – Total Innovation Funds Required for FY 15/16 – 12 Months of Operations

Fiscal Year 16/17 – 12 months:

- $134,727 – Total for Personnel and Operating Expenditures
- $91,520 – Total Revenues from Medi-Cal FFP and MHSA FSP/CSS Clients
- $43,207 – Total Innovation Funds Required for FY16/17 – 12 Months of Operations

TOTAL INNOVATION FUNDS REQUESTED FOR 40 MONTHS: **$153,607**

Innovation Projected Revenues and Expenditures

County: Tuolumne

Fiscal Year: 2013/14 - 4 mos

Work Plan #: INN 02

Work Plan Name: Wellness: One Mind, One Body

New Work Plan ☑

Expansion ☐

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	37,385			37,385
2. Operating Expenditures	17,108			17,108
3. Non-recurring expenditures	-			-
4. Training Consultant Contracts	-			-
5. Work Plan Management	-			-
6. Total Proposed Work Plan Expenditures	**54,492**	**-**	**-**	**54,492**
B. Revenues				
1. Existing Revenues				-
2. Additional Revenues				
a. Medi-Cal (FFP only)	21,485			21,485
b. MHSA FSP/CSS	9,021			9,021
c. Other Revenue				-
3. Total New Revenue	**30,507**	**-**	**-**	**30,507**
4. Total Revenues	**30,507**	**-**	**-**	**30,507**
C. Total Funding Requirements	**$ 23,986**	**$ -**	**$ -**	**$23,986**

Innovation Projected Revenues and Expenditures

County: Tuolumne

Fiscal Year: 2014/15

Work Plan #: INN 02

Work Plan Name: Wellness: One Mind, One Body

New Work Plan ☑

Expansion ☐

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	112,154			112,154
2. Operating Expenditures	22,573		-	22,573
3. Non-recurring expenditures	-		-	-
4. Training Consultant Contracts	-			-
5. Work Plan Management	-			-
6. Total Proposed Work Plan Expenditures	**134,727**	**-**	**-**	**134,727**
B. Revenues				
1. Existing Revenues				-
2. Additional Revenues				
a. Medi-Cal (FFP only)	64,455			64,455
b. MHSA FSP/CSS	27,064			27,064
c. Other Revenue				-
3. Total New Revenue	**91,520**	**-**	**-**	**91,520**
4. Total Revenues	**91,520**	**-**	**-**	**91,520**
C. Total Funding Requirements	**$ 43,207**	**$ -**	**$ -**	**$ 43,207**

Innovation Projected Revenues and Expenditures

County: Tuolumne

Fiscal Year: 2015/16

Work Plan #: INN 02

Work Plan Name: Wellness: One Mind, One Body

New Work Plan ☑

Expansion ☐

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	112,154			112,154
2. Operating Expenditures	22,573		-	22,573
3. Non-recurring expenditures	-			-
4. Training Consultant Contracts	-			-
5. Work Plan Management	-			-
6. Total Proposed Work Plan Expenditures	**134,727**	**-**	**-**	**134,727**
B. Revenues				
1. Existing Revenues				-
2. Additional Revenues				
a. Medi-Cal (FFP only)	64,455			64,455
b. MHSA FSP/CSS	27,064			27,064
c. Other Revenue				-
3. Total New Revenue	**91,520**	**-**	**-**	**91,520**
4. Total Revenues	**91,520**	**-**	**-**	**91,520**
C. Total Funding Requirements	**$ 43,207**	**$ -**	**$ -**	**$ 43,207**

Innovation Projected Revenues and Expenditures

County: Tuolumne

Fiscal Year: 2016/17

Work Plan #: INN 02

Work Plan Name: Wellness: One Mind, One Body

New Work Plan ☑

Expansion ☐

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	112,154			112,154
2. Operating Expenditures	22,573		-	22,573
3. Non-recurring expenditures	-			-
4. Training Consultant Contracts	-			-
5. Work Plan Management	-			-
6. Total Proposed Work Plan Expenditures	**134,727**	**-**	**-**	**134,727**
B. Revenues				
1. Existing Revenues				-
2. Additional Revenues				
a. Medi-Cal (FFP only)	64,455			64,455
b. MHSA FSP/CSS	27,064			27,064
c. Other Revenue				-
3. Total New Revenue	**91,520**	**-**	**-**	**91,520**
4. Total Revenues	**91,520**	**-**	**-**	**91,520**
C. Total Funding Requirements	**$ 43,207**	**$ -**	**$ -**	**$ 43,207**

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

Update to the FY13/14 Annual Update for the Purpose of Adding a New Innovation Project

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

I. **The public review and comment period begins Thursday, February 13, 2014 and ends at 5:00 p.m. on Friday, March 14, 2014.** Interested persons may provide written comments during this public comment period. Written comments and/or questions should be addressed to TCBH, Attn: Kristi Conforti, MHSA Coordinator, 2 South Green St, Sonora, CA 95370. Please use the public comment form.

II. **A Public Hearing will be held by the Tuolumne County Behavioral Health Advisory Board on Monday March 17th at 5:00pm at Tuolumne County Behavioral Health Department, 105 Hospital Road, Sonora, CA** for the purpose of receiving further public comment on the Update to the MHSA FY 13/14 Annual Update.

III. **To review the MHSA Update to the FY13/14 Annual Update for the Purpose of Adding a New Innovation Project** or other MHSA documents via Internet, follow this link to the Tuolumne County Mental/Behavioral Health website: http://tuolumne.networkofcare.org/mh/content.aspx?id=353

IV. Printed copies of the MHSA Update to the FY13/14 Annual Update for the Purpose of Adding a New Innovation Project are available to read at the reference desk of all public libraries in Tuolumne County and in the public waiting areas of the following locations during regular business hours:

- Tuolumne County Behavioral Health, 101 Hospital Rd, Sonora.
- Tuolumne County Administrator Office, 2 South Green St, Sonora
- The David Lambert Center, 347 W. Jackson St, Sonora
- Tuolumne County Enrichment Center, 102 Hospital Rd, Sonora
- Tuolumne County Health & Human Services, 20075 Cedar Rd North, Sonora

To obtain a copy by mail, or to request additional information, call the MHSA Coordinator at (209) 533-6262 before 5:00pm on Friday, March 14, 2014.

Tuolumne County Behavioral Health
Mental Health Services Act (MHSA)
Update to FY 2013/14 – MHSA Annual Update
New INNOVATION Project Proposal
30 Day Public Comment Form
Dates of Posting: _____ to _____

PERSONAL INFORMATION	
Name:_____	
Agency/Organization:_____	
Phone Number:_____	E-mail Address:_____
Mailing Address:_____	
YOUR ROLE IN THE MENTAL HEALTH SYSTEM	
_____ Client/Consumer _____ Family Member _____ Education _____ Social Services	_____ Service Provider _____ Law Enforcement/Criminal Justice _____ Probation _____ Other (specify)_____
COMMENTS: *All Comments Must Be Received by: DATE*	

All Electronic Comments and Inquiries Regarding the Proposed New Innovation Project and Update to the FY 2013/14 Annual Update should be sent to:
Email address: KConforti@co.tuolumne.ca.us

Written Comments may be submitted by mail to:
Kristi Conforti, MHSA Coordinator – Tuolumne County Behavioral Health: 2 South Green St – Sonora, CA 95370
*All Comments Must Be Received by:*5:00 P.M., Friday, March 14, 2014
A Public Hearing on the Update to the FY 2013/14 MHSA Annual Update will be held on Monday March 17, 2014 at 5:00pm. The meeting will convene at: Tuolumne County Behavioral Health Department, 105 Hospital Road, Sonora, California

Tuolumne County Behavioral Health
Mental Health Services Act Update to the Annual Update New Innovation Plan for 2013/2014

30 Day Review Period: February 13, 2014 – March 14, 2014

Public Comments Received and Actions Taken:

1. No substantive public comments were received

2. Updated the Innovation Projected Revenues and Expenditures Budget sheets for each fiscal year to show Medi-Cal (FFP only) and MHSA FSP/CSS revenue breakdown. Overall funding requirements and revenues remain the same.

3. Updated Table of Contents to reflect correct page numbers which did not affect or change the content of the report.

4. Additional grammatical and formatting edits were completed and some verbiage reworded to ensure accuracy and clarify information. These edits did not change the content of the report.

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Tuolumne County

Local Mental Health Director	**Program Lead**
Name: Rita Austin, LCSW	Name: Kristi Conforti
Telephone Number: (209) 433-6265	Telephone Number: (209) 533-6262
E-mail: laustin@co.tuolumne.ca.us	E-mail: KConforti@co.tuolumne.ca.us

County Mental Health Mailing Address:

2 South Green Street, Sonora, CA 95370

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this update to the annual update, including stakeholder participation and non-supplantation requirements.

This update to the annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft update to the annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The update to the annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on 4/1/14.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

Rita Austin LCSW Rita Austin, LCSW

Local Mental Health Director/Designee (PRINT) Signature

County: Tuolumne

Date: 4/2/14

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City : Tuolumne County

[ ] Three-Year Program and Expenditure Plan
[X] Annual Update
[ ] Annual Revenue and Expenditure Report

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

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report, or Update to the Annual Plan, is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for other counties in future years.

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

Rita Austin, LCSW
Local Mental Health Director (PRINT)

Rita Austin LCSW 4/2/14
Signature **Date**

I hereby certify that for the fiscal year ended June 30, 14, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated for the fiscal year ended June 30, 14. I further certify that for the fiscal year ended June 30, 14, the State MHSA distributions were recorded as

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

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

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

Deborah Bautista

County Auditor Controller/City Financial Officer (PRINT)

Debbie Bautista 4-8-14

Signature **Date**

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