

- *Public Health*  
Phone (530) 233-6311  
Fax (530) 233-5754
- *Environmental Health*  
Phone (530) 233-6310  
Fax (530) 233-6342
- *Behavioral Health*  
Phone (530) 233-6312  
or (530) 233-6319  
Fax (530) 233-5754

**Modoc County**  
**( ) Department of Health Services**

*Director of Health Services*  
Karen Stockton PhD, MSW, BSN

*Public Health Officer*  
Edward P. Richert, MD

*Deputy Directors*  
*Behavioral Health:* Tara Shepherd, MA, CAS  
*Public Health:* Kelly Crosby, RN, PHN, BSN  
*Environmental Health:* Warren Farnam, REHS

February 8, 2011

Local Program Support  
Department of Mental Health  
1600 9<sup>th</sup> Street, Room 100  
Sacramento, CA 95814

MHSOAC  
1300 17<sup>th</sup> Street, Suite 1000  
Sacramento, CA 95811  
Attn: Wanda Kato

To Whom It May Concern:

Please see the following **UPDATED** Mental Health Services Act Innovation Work Plan for Fiscal Years 2010 -13 on behalf of Modoc County Behavioral Health Services. Electronic copies were sent via email to [ccta@dmh.ca.gov](mailto:ccta@dmh.ca.gov) and [MHSOAC@dmh.ca.gov](mailto:MHSOAC@dmh.ca.gov). This update is in response to the letter sent by the Mental Health Services Oversight and Accountability Commission (MHSOAC) and several email exchanges with Wanda Kato requesting clarification regarding the attached plan.

Modoc County is requesting that the MHSOAC and California Department of Mental Health review, approve, and fund the project within the enclosed Innovation Work Plan. This plan is based on a multiyear planning process and addresses the Mental Health Services Act and Innovation essential elements.

The enclosed Innovation Work Plan was publicly posted for a 30-day review and comment period prior to submission. A public hearing was held at the end of that period on January 4, 2011. Questions or comments regarding the enclosed plan may be directed to Tara Shepherd at 530-233-6312 or via email at [tarashepherd@co.modoc.ca.us](mailto:tarashepherd@co.modoc.ca.us). Thank you for your time and consideration.

Sincerely,



Karen E. Stockton, Ph.D., M.S.W., B.S.N.

**EXHIBIT A**

**INNOVATION WORK PLAN  
COUNTY CERTIFICATION**

**County Name:** Modoc

<b>County Mental Health Director</b>	<b>Project Lead</b>
Name: Karen Stockton	Name: Tara Shepherd
Telephone Number: 530-233-6312	Telephone Number: 530233-6312
E-mail: karenstockton@co.modoc.ca.us	E-mail: tarashepherd@co.modoc.ca.us
Mailing Address: 441 N. Main Street Alturas, CA 96101	Mailing Address: 441 N. Main Street Alturas, CA 96101

I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this Innovation Work Plan. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code Section 5891 and Title 9, California Code of Regulations (CCR), Section 3410, Non-Supplant.

This Work Plan has been developed with the participation of stakeholders, in accordance with Title 9, CCR Sections 3300, 3310(d) and 3315(a). The draft Work Plan was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board or commission. All input has been considered with adjustments made, as appropriate. Any Work Plan requiring participation from individuals has been designed for voluntary participation therefore all participation by individuals in the proposed Work Plan is voluntary, pursuant to Title 9, CCR, Section 3400 (b)(2).

All documents in the attached Work Plan are true and correct.

  
\_\_\_\_\_  
Signature (Local Mental Health Director/Designee)

1-6-2011  
Date

Director  
Title

## EXHIBIT B

### INNOVATION WORK PLAN

#### Description of Community Program Planning and Local Review Processes

County Name: Modoc County  
Work Plan Name: Innovation

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this Annual Update.

1. Briefly describe the Community Program Planning Process for development of the Innovation Work Plan. It shall include the methods for obtaining stakeholder input. (suggested length – one-half page)

Modoc County is a rural, sparsely populated, isolated county of over 7,800 square miles with a population of 9,197. The County has been designated by legislation as a "Frontier County," which means service delivery is hampered by the extremely low density of residents. The population density is 1.2 persons per square mile, compared with 217.2 persons per square mile in the rest of California. Sixty-nine percent of the population in Modoc County live in unincorporated areas throughout the county. The only incorporated city is Alturas, the County seat, with a population of under 3,000. As such, the entire population of the county is considered "underserved." The percentage of Mental Health services provided to members of the two primary ethnic minority groups is comparable to the percentages of the population (10% for Latino; 4% for Native Americans). Modoc County operates its entire mental health program, especially the MHSA programs, using a strong and functioning stakeholder group, the Community Partnership Group, which includes consumers with SMI and family members. This group provides assessment, information and implementation support for all elements of our programs. The Community Partnership Group identified full integration of alcohol and other drug services, mental health services and public health services as an area of great need, and one that would benefit from learning and innovation. As a result, the Group identified integration strategies as a possible Innovation Program at its meeting in January, 2009. In March, 2010, the Community Partnership Group affirmed this selection and appointed a subcommittee to fully develop an Innovation proposal. The confirmation of this Innovation Learning Objective and plans to implement that Objective took place in the context of a review of performance of the Community Supports and Services, Prevention and Early Intervention and Workforce, Education and Training components of the MHSA.

The subcommittee included representatives from mental health, public health, alcohol and drug services, the Modoc County Prevention Collaborative, education, and the court system. Mental Health representatives included a consumer (President of the local non-profit consumer's group, Sunrays of Hope), who is also a representative of the Latino community, and a Mental Health Specialist, who is also a leader of a local Native American organization. After the start of the subcommittee's work, the consumer

representative was hired as a full-time Mental Health Specialist to, among other duties, provide support and liaison services for other consumers, recruit consumers and family members to participate in the Project, and work closely with other staff to ensure ongoing cultural competence efforts. The subcommittee identified the barriers to achieving integration at the level of assessment and treatment planning. The subcommittee reviewed the experience of each partner. The intention of the subcommittee was to identify the tools and protocols necessary for integration of treatment teams, and to identify preliminarily whether there are tools in each system that might be adapted to a project that researched adapting cross-discipline tools to accomplish integrated teams.

Upon development of the subcommittee proposal, the resulting document was reviewed and edited by the entire Community Partnership Group. Focused briefings were done with key informants from the Latino and Native American communities, and with Sunrays of Hope, the consumer-run non-profit that operates a consumer wellness center. In addition, the plan was presented for input and feedback to consumers at the Sunrays of Hope center on October 25, 2010, with unanimous positive support from consumers present at the meeting.

The proposed Innovation Plan was posted for a 30-day public review process. A review of the document and public hearing was conducted by the Modoc County Mental Health/Alcohol and Drug Services Advisory Board.

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

\*Consumers and family members, including representatives of Sunrays of Hope, a consumer-run organization implementing consumer support services under MHSA

\*Education representatives

\*Tribal health representatives

\*Migrant education representatives

\*Representatives of partner agencies, including Law Enforcement, collaborative treatment courts (Adult Drug Court, Dependency Drug Court, and Juvenile Delinquency Prevention and Treatment Court), Health, Probation and Alcohol and Drug Programs

\*Representatives from Head Start, First Five and Modoc County's single non-profit human services provider, TEACH

\*Senior Center representatives

3. List the dates of the 30-day stakeholder review and public hearing. Attach substantive comments received during the stakeholder review and public hearing and responses to those comments. Indicate if none received.

The 30-day stakeholder review was conducted December 3, 2010 through January 2, 2011. The public hearing was noticed and held during the January 4, 2011 Behavioral Health Advisory Board meeting. No substantive comments were received during the review period and during the public hearing. The Advisory Board voted to submit the plan for approval.

**Innovation Work Plan Narrative**

**Date: 02-1-2011**

**County: Modoc**

**Work Plan #: 1**

**Work Plan Name: TAKING INTEGRATION PERSONALLY**

**Purpose of Proposed Innovation Project (check all that apply)**

- INCREASE ACCESS TO UNDERSERVED GROUPS
- INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- PROMOTE INTERAGENCY COLLABORATION
- INCREASE ACCESS TO SERVICES

*Briefly explain the reason for selecting the above purpose(s).*

The primary purpose of the "Taking Integration Personally" Innovation Project is to promote interagency collaboration through the development, evaluation, and implementation of integrated treatment processes. The underlying purpose is to improve clients' health outcomes.

Modoc County has operated using an integrated partnership system for planning and, to a large extent, implementing MHSA components. Partner agencies, including the consumers and family members associated with Sun Rays of Hope, have participated in the identification of unmet needs and the development of the Children, Youth and Transition Age Youth Interagency Team, the Older Adult Interagency Team, and the Adult and Family Interagency Team. Prevention and Early Intervention activities have been planned by a Prevention Collaborative that includes partner agencies from throughout the county.

However, stakeholders have indicated they want us to find a solution to the problems and barriers that limit our ability to fully integrate services to many of the county's most vulnerable residents - those with co-occurring disorders, which includes individuals with one or more mental health diagnoses, as well as a substance use disorder and/or serious medical needs (e.g., heart disease, diabetes). According to the NIMH Epidemiological Catchment Area Study (Regier, 1990) surveying over 20,000 individuals, the following percentages of mentally ill individuals were also diagnosed with substance use disorders: 47% of those with schizophrenia, 56% of those diagnosed with bipolar disorder, 32% with affective disorders, and 36% of those with

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panic disorder. A recent review of our client records indicated that only 25% were assessed as dually diagnosed. Further, recent studies have demonstrated that people living with serious and persistent mental illness (SPMI) die twenty-five years earlier than the general population, due in large measure to unmanaged and untreated physical health conditions. People living with SPMI have an average life expectancy of 51 years compared with 76 years for the general population and are 3.4 times more likely to die of heart disease, 6.6 times more likely to die of pneumonia and influenza, and 5 times more likely to die of other respiratory ailments (C. Colton, based on 1997-2000 data). There is currently no consistently applied process for integrated assessment and treatment of the dually diagnosed. Therefore, addressing dual-diagnosis or co-morbidity issues is of utmost importance in addressing health disparities and holistic wellness and recovery.

Our experience over the past four years has been that collaborative planning and outreach have been successful, and that we have met our goals in expanding outreach to underserved groups, especially underserved ethnic and geographic groups. However some barriers have prevented our system from reaping the benefits of this collaborative at the level of integrated team treatment. The Community Partnership Group that participated in the planning for this Innovation Project has agreed on pursuing a project aimed at integrating health system delivery (including mental health, alcohol and other drug services and public health).

Resource constraints have sometimes limited the ability of our partners to participate in team meetings, and cross-assessments by each discipline are not recorded formally in a shared treatment plan. In some cases, the lack of specific protocols have hindered the development of collaborative treatment plans. The lack of a formalized commitment to specific monitoring by a Steering Committee of community partners has delayed our ability to assure that integration is occurring at the individual client level.

Our Community Partnership Group therefore selected an Innovation Project committed to integrated public health system delivery (including initially mental health, alcohol and other drug programs and public health) to promote personal and community health and wellness, with linkages to primary care, social services, and the collaborative treatment courts.

We anticipate some of the barriers to integration of treatment processes to include:

- 1) attitudinal barriers. Even though we have demonstrated tremendous growth in collaborative planning and cooperative services, there are still some attitudes related to role definition or "turf" issues. These attitudes may well manifest within mental health, where clinicians will be transitioning from a "my client" point of view to "our client" in a treatment team process. Role definition issues may arise between formerly separate

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systems (e.g., mental health, alcohol and drug services, and/or public health) that will need to be addressed and overcome in order to implement fully integrated services. Undoubtedly stigma will need to be addressed as well.

2) a scarcity of resources in an rapidly changing national healthcare delivery environment. Some of our partners may lack information and understanding regarding the changing healthcare delivery system and the value of integrating treatment processes. In this environment of scarce resources, integration will make it possible to conserve resources, reduce redundancies, and increase efficiency. More importantly, we will be able to improve the quality of services, resulting in better individual outcomes.

3) a lack of established fiscal and procedural processes for integration of services and documentation. There is a serious dearth of specific protocols, policies and procedures for fully integrating services and for the exchange of health information. Electronic health record implementation processes that include integrated assessment, treatment planning, case management, and quality improvement are in early stages and often non-existent in frontier counties. Too often, consumers have experienced care and services that are side-by-side, not integrated into a single plan. The result has been inefficient, sometimes conflicting, processes and treatment goals.

Our Community Partnership Group therefore selected an Innovation Project committed to exploring and identifying processes to develop an integrated public health care system delivery, including integration of assessment tools and processes, protocols, and treatment team strategies occurring at the individual client level. In a frontier, rural setting where each partner, including mental health, alcohol and drug services, and public health, is small and challenged, this Project affords the opportunity for improving health system delivery and, ultimately, the health outcomes of individuals and the entire community.

**Innovation Work Plan Narrative**

**Project Description**

*Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length – one page)*

Our program will fulfill its title: Taking Integration Personally. Even though the concept of integration, *per se*, is not new, concrete integrative models and processes that meet the needs of a rural, frontier setting, in a very ambiguous health care delivery system environment, are scarce to nonexistent. We intend to take our success in building collaborative partnerships to the next level.

We will identify, adapt, and test assessment tools, treatment team models, and information exchange models to develop processes and protocols to collaboratively integrate mental health services, alcohol and other drug services, and public health services as needed to deliver consumer-centered, holistic wellness and recovery treatment. The development and testing of an integrated assessment tool as a process to facilitate integrated treatment delivery is the primary focus of the first phase of the project. Further, we plan to extend the collaborative treatment planning and delivery to demonstrate linkages with other partners to include primary care providers, social services, collaborative treatment courts and other services promoting holistic health and well-being. We are committed to developing and testing client-centered treatment processes so that each person who uses our health services will have a single, integrated treatment plan and potentially a treatment team that is unique to each client, depending on their identified needs.

Process Elements/Protocols to be developed over the life of the Project to insure that the limited services in this rural area are leveraged in an integrated plan for each client in our multiple systems:

- \* Develop an integrated assessment tool to assure that mental health, substance abuse, and public health issues presented by the consumer, and desired to be addressed by the consumer, will be included in a single treatment plan. The assessment tool/process will also include a physical health history and basic medical screening (blood pressure, weight, etc.).
- \* Identify models for developing a single, integrated treatment team for each client, depending upon needs identified during the assessment process.

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- \* Take our current Community Partnership Group training plan, developed by leadership from each of our partners, to the next level by identifying training needs to address barriers to consumer-level integrated treatment plans. We anticipate that these might include attitudinal barriers, and barriers to operating as a team, including time management and role definition issues.
- \* Identify models for blending medical records so that, with appropriate consumer consent, information about services in each treatment setting can be shared. One possible format is Nightengale Nurse Notes from the Public Health system, which has pathways for including primary care, mental health, alcohol and other drug, and income/basic living issues.
- \* Identify methods by which funding can be braided to provide an integrated resource for meeting individual treatment needs. This effort may explore using our non-profits, including TEACH, Inc. or the Strong Family Health Center to coordinate funds and assure that coordinated care is delivered. This element will help us identify how to sustain integrated treatment if our developed protocols are successful.

It is our hope that the investment of resources in this project will result in outcomes that support continued allocation of necessary resources to sustain the collaborative processes developed as our business model.

The Project will result in the development of processes and protocols that supports and are consistent with the General Standard of MHSA and Title 9, CCR, section 3320, including:

**Community Collaboration:** The key value underlying this project is partner collaboration. The project will focus on the key process elements to make collaboration more effective, to promote better collaborative team service delivery outcomes that result in improved client outcomes. A strength of our frontier county is the richness of our collaborative environment.

Our collaborative Steering Committee will provide planning and oversight services for the Project. We have commitments from the following groups for representatives to serve on the Steering Committee: Consumers (mental health and/or substance use treatment services) active in Sunrays of Hope, Alcohol and Drug Services, Public Health, the Collaborative Treatment Courts (Drug Court, Dependency Drug Court, and the Juvenile Delinquency Prevention and Treatment Court), and Strong Family Health Center (Indian Health Project). In addition, a nurse practitioner from the local medical clinic has agreed to be an active participant. We will do outreach to recruit other partners for the Steering Committee, to include, but not be limited to: family members of consumers, medical clinics in outlying areas of the county, the general public, businesses, youth, law enforcement, schools, the Senior Center, TEACH, Inc. (a local non-profit service provider), CalWORKs Employment Program, Social Services,

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Probation, Tribal representatives, Migrant Education, the faith community, and other leaders among our Native American and Latino populations.

Our collaborative Integration Team will have a more direct, “hands on” role in the Project, which includes identifying and/or designing measurement tools and surveys, as well as integrated assessment and treatment planning forms and processes. The Integration Team will also be responsible for designing, implementing, and evaluating the change process through rapid-cycle testing. For example, The Integration Team, including consumers and family members as full Team members, will design or adapt an integrated assessment tool. The Team might then develop mechanisms (forms or interview format) to solicit consumer and clinician feedback about the assessment tool to be used after implementation of the new tool. The feedback might result in small changes to the assessment tool, resulting in another rapid-cycle test with consumer and clinician feedback. The Integration Team will consist of those most directly involved with the processes, including consumers and family members, clinicians, nurses, case managers, supervisors and administrative staff from Mental Health, Public Health, and Alcohol and Drug Services, as well as a nurse practitioner from the local health clinic.

**Cultural Competence:** We conduct ongoing training with team members and core partners to ensure services are culturally and linguistically appropriate. Since there may be team members with little or no cultural competence training, the training will include basic training on cultural awareness and cultural responsiveness. In addition, more specialized training will be provided on Latino and Native American cultures, with trainers to include, but not be limited to, local Native and Latino leaders. Other topics relevant to cultural competence will be addressed through training on such topics as gender responsiveness, the culture of poverty, and other cultural groups identified in the collaborative process. The collaborative, integrated approach needs to reflect the different values and traditions of the diverse partners. The various collaborative groups (e.g., Steering Committee, Treatment Teams, Integration Team) will include a standard agenda item for each meeting to ensure cultural competence is addressed regularly in the Project processes. In addition, the collaborative groups may borrow ideas from traditions of various cultures to improve the partnerships. For instance, we might include, and provide training on, the Native American tradition of deep and longer listening as an element of collaborative group processes. The best way to engage people in collaborative processes is to honor their unique perspectives and to insure that the approach to collaboration supports cultural competence. To further this aim, when needed or desired, project materials (e.g., agendas, minutes, forms) will be translated into Spanish, and Spanish translators will be available at collaborative meetings. This project is designed to develop processes that focus on the unique individual, including respecting and valuing individual needs. This would not be effective unless cultural and linguistic needs were incorporated.

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**Client and Family-Driven Mental Health System:** The focus is on processes that encourage all collaborative partners to commit to a client and family member driven service delivery system that honors a client's preferences, values and traditions. All collaborative partners will be encouraged to embrace the value of consumers and family members as partners. This is likely to require mutual collaborative learning for all partners. Although family members have been involved in the process, we recognize the need for additional outreach to encourage more family involvement. Consumers and family members will continue to play a key role in the Project, including participation on the Steering Committee, the body charged with planning and oversight, and the collaborative Integration Team, the partnership providing "hands on" implementation through the development and testing of integrated assessment and treatment planning forms and processes.

**Wellness, Recovery, and Resilience Focused:** A core principle of this Innovation Project is to build skills for both staff and consumer clients that support wellness, recovery and resilience. By focusing on integration of services, the project lends itself toward assessing wellness of the whole person and providing recovery support.

**Integrated Service Experience:** The driving value underlying this Project is integration of services for holistic healthcare through a collaborative, integrated approach to assessment and treatment of services, as well as access to resources that promote a full spectrum of physical and behavioral health services and supports as consumers and their families navigate the health service system.

**Innovation Work Plan Narrative**

**Contribution to Learning**

*Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length – one page)*

Taking Integration Personally is anticipated to adapt existing models of collaboration in order to create a new model of integration of services. This proposed project is set in the context of a rural, frontier setting where resources are limited and the rural culture supports independence. We have experienced more than three years of successful collaboration with our partners in planning MHSA services, which gives us the partnership base to move forward.

A fundamental goal of the project is the development of an innovative approach to collaboration. The focus of the project will be the development of a new and effective process of client-centered collaboration, resulting in a new model of integration of services. Specifically, the development of frontier, rural protocols that facilitate collaborative integration of holistic health care, from assessments through fully integrated team service delivery.

The Project will address two types of learning goals -- process and outcome, as expressed in the learning questions and outcomes provided in Table 1 below:

**Table 1: Learning Questions**

<b>Learning Questions</b>	<b>Collaboration Learning Goal:</b> Development of a sustainable model of collaboration that supports Behavioral Health and holistic health care integration.	<b>System Learning Goal:</b> Development of system changes integral to integrated health care service delivery.
<b>Process/Elements</b>	What elements of process change will result in the desired outcomes?  1. What is a model that will work in a rural frontier county? 2. What partners should be included? 3. How do we engage collaborative members? 4. How do we retain collaborative members?	What elements of system change will result in the desired outcomes?  1. Time /staffing commitment from partners 2. Financial resource allocation 3. Changes in forms (assessment, treatment, consent, referral – especially in reference to primary care providers) 4. Changes in charting, billing, and software applications 5. Training in cultural competence, recovery

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		and resilience, client-& family member centered, stigma, discrimination, cross-training in organizational culture & language, along with other MHSA principles.
<b>Outcomes</b>	<p>Is there evidence of the following?</p> <ol style="list-style-type: none"> <li>1 Increased collaboration among partners in the assessment processes</li> <li>2 Increased collaboration providing client &amp; family focused unique treatment teams</li> <li>3 Increased collaboration in providing recovery services</li> <li>4 Increased cohesion and satisfaction among partners</li> </ol>	<p>Is there evidence of the following?</p> <ol style="list-style-type: none"> <li>1. Better identification of co-occurring needs of clients.</li> <li>2. Stronger linkages to primary care and other services.</li> <li>3. Use of integrated assessment tools including basic health screening (PH).</li> <li>4. Use of integrated treatment plan tools.</li> </ol>

These questions will be addressed through a change process, which will include using rapid-cycle testing, and PDSA (Plan, Do, Study, Act) change cycles. More specifically, we will plan the change, do the plan, study the results, and act on the new knowledge for questions addressed by these cycles. This will likely involve a number of short PDSA cycles.

Initially, we will address Behavioral Health collaboration and integration for Mental Health and Substance Abuse processes and services. Simultaneously we propose to engage other multidisciplinary collaborative partners. For effective collaboration to occur, the group needs something meaningful to work towards. We have chosen to focus on integrated assessment, treatment planning, and service delivery tools and processes, hence our system change goals/questions.

With future Innovation updates, we are likely to address: a) processes for braiding the myriad of potential funding sources to better leverage resources that support integration, and b) the development of protocols to utilize a shared electronic health record.

**Innovation Work Plan Narrative**

**Timeline: February, 2011 – June, 2014**

*Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length – one page)*

The following timeline is organized into “Collaboration Goals” and “System Integration Goals” for clarity. However, the timelines occur simultaneously.

***Collaboration Goals Timeline:***

February – March 2011	Identify partners for inclusion in collaborative processes
April 2011	Establish Steering Committee for planning and oversight
April – June 2011	Establish workgroups/committees from collaborative Integration Team for identification and development of integrated assessment and planning tools
May 2011	Establish a schedule and format for agendas/minutes for Steering Committee meetings, to include standard agenda items addressing cultural competence
May – June 2011	Identify/design a tool/survey (for use as pre/post test) to measure collaborative process (i.e., satisfaction, perceived level of collaboration)
July 2011	Administer pre test to collaborative partners
May – June 2011	Identify barriers, including resource allocation, to partner participation in Treatment Team meetings
July – December 2011	Develop a plan to address identified barriers
January – June 2012	Develop a protocol for the formation and implementation of collaborative treatment teams unique to each client with multiple needs.
January – June 2012	Establish a schedule and format for agenda/minutes for regular collaborative treatment team meetings

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January – June 2012	Identify training needs (i.e., common assessment tool, outcome reporting protocols, client/family centered services)
July – December 2012	Implement training
January 2013	First administration of post test to collaborative partners
March 2013	Interim report to Behavioral Health Advisory Board, Steering Committee, and Sunrays of Hope

### ***System Integration Goals Timeline:***

March – April 2011	Gather pre-clinical data from chart review and SCERP PIP
April - June 2011	Identify assessment tool or tools that can be tested
May – August 2011	Test assessment tool through PDSA process
September – October 2011	Train on use of assessment tool
November – December 2011	Implement assessment tool
January - March 2011	Identify treatment plan format that can be tested
April – June 2011	Test treatment plan format through PDSA process
July – August 2012	Implement treatment plan format
August 2012 – January 2014	Periodic review by the Integration Team (minimum once a quarter) of processes and activities to check for “gaps,” to evaluate need for revision of forms or procedures, and to monitor outcomes
January-February 2014	Gather post-clinical data from chart review and SCERP PIP
February - May 2014	Prepare draft report
June 2014	Submit report to OAC, including lessons learned and recommendations for the feasibility of replication. It is anticipated that the Project will be applicable to other small communities interested in pursuing an integrated health care system.
June 2014	Present the final report to Behavioral Health Advisory Board, Steering Committee, and Sunrays of Hope (consumer and family organization).

**Innovation Work Plan Narrative**

**Project Measurement**

*Describe how the project will be reviewed and assessed and how the county will include the perspectives of stakeholders in the review and assessment.*

The assessment of progress for Taking Integration Personally will include measures of both collaboration and system change processes/elements. Initial plans for measurement are indicated in Tables 2 and 3 below:

For the collaborative process learning goal, stakeholders (including consumers, family members, and other partners, active on the Steering Committee and the Integration Team) will participate in Project measurement. For instance, stakeholders will develop the tools (and revise, if needed) to measure perceived level of collaboration and perceived levels of cohesion/satisfaction, administer the tools, collate the data, and report back to the collaborative teams.

For the system integration learning goal, stakeholders involved on the Integration Team, including consumers, family members, substance abuse professionals, mental health clinicians, and representative(s) from primary care, will participate in designing and refining the tools (e.g., assessment, treatment plan) through PDSA cycles, as well as collating and analyzing the data for reporting.

Our agency’s hiring practices include placing a high value on lived experience when making decisions on who to hire, so that the consumer and family voice is embedded in all aspects of our services. More than 60% of Mental Health staff consist of consumers, former consumers, and/or family members of Mental Health services. In addition, consumers and family members who participate in Sunrays of Hope lend their knowledge and expertise to this process.

**Table 2: Collaborative Process Learning Goal Measurement**

<b>Learning Questions</b>	<b>Collaboration Goal:</b> Development of a sustainable model of collaboration that supports Behavioral Health and holistic health care integration.
<b>Learning Goal Questions</b>	What elements of process change will result in the desired outcomes? <ol style="list-style-type: none"> <li>1. What is a model that will work in a rural frontier county?</li> <li>2. What partners should be included?</li> <li>3. How do we engage collaborative members?</li> <li>4. How do we retain collaborative members?</li> </ol>
<b>Project Measurement by Outcome Learning Goals</b>	<b>Evidence of the following:</b>

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Outcome Learning Goal #1	1. Increased collaboration among partners in the assessment processes
Measure Learning Goal #1	a. Pre and post measurement of the number of participant/partners b. Ongoing attendance records c. Pre and post measurement of perceived level of collaboration
Outcome Learning Goal #2	2. Increased collaboration providing client & family focused unique treatment teams
Measure Learning Goal #2	a. Measurement and documentation of collaborative treatment team activity in client charts. Measurement and method of documentation to be determined through PDSA learning cycles.
Outcome Learning Goal #3	3. Increased collaboration in providing treatment/recovery services
Measure Learning Goal #3	a. Measurement and documentation of provision of collaborative treatment/recovery services documented in client charts. Measurement and method of documentation to be determined through PDSA learning cycles.
Outcome Learning Goal #4	4. Increased cohesion and satisfaction among partners
Measure Learning Goal #4	a. Pre and Post survey (to be developed) to measure partners' perceptions of cohesion and satisfaction with collaborative processes.

**Table 3: System Integration Learning Goal Measurement**

<b>Learning Questions</b>	<b>System Integration Learning Goal:</b> Development of system changes integral to integrated health care service delivery.
<b>Learning Goal Questions</b>	What elements of system change will result in the desired outcomes?  <ol style="list-style-type: none"> <li>1. Time/staffing commitment from partners</li> <li>2. Financial resource allocation to assist with engagement and retention of collaborative participants</li> <li>3. Changes in forms (assessment, treatment, consent, referral – especially in reference to primary care providers)</li> <li>4. Changes in charting, billing, and software applications</li> <li>5. Training in cultural competence, recovery and resilience, client-&amp; family member centered, stigma, discrimination, cross-training in organizational culture &amp; language, along with other MHSA principles.</li> </ol>
<b>Project Measurement by Outcome Learning Goals</b>	<b>Evidence of the following:</b>
Outcome Learning Goal #1	1. Better identification of co-occurring needs of clients.
Measure Learning Goal #1	a. Pre and post measurement of number/percentage of clients identified with co-occurring disorders (mental health and substance use disorder and/or major health condition)
Outcome Learning Goal #2	2. Stronger linkages to primary care
Measure Learning Goal #2	Pre and post measurement of number/percentage of client charts with: <ol style="list-style-type: none"> <li>a. documentation of client's primary care physician</li> <li>b. signed release for communicating with primary care physician</li> </ol>

## EXHIBIT C

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Outcome Learning Goal #3	3. Use of integrated assessment tools including basic health screening (PH).
Measure Learning Goal #3	a. Pre and post measurement of the number/percentage of client charts with completed integrated assessment
Outcome Learning Goal #4	4. Use of integrated treatment plan
Measure Learning Goal #4	a. Measurement of the number/percentage of client charts with completed integrated treatment plan

It is anticipated that after implementation of various system changes, data will be collected at 6 month intervals and compared to baseline data.

The initial monitoring of the results will be reviewed by the collaborative Integration Team and the results provided to the Steering Committee and the Community Partnership Group. This Group includes all stakeholders in the MHSA process. Six month reports will permit stakeholders to consider revisions or comments for the three year period of the Innovation Project.

**Innovation Work Plan Narrative**

**Leveraging Resources (if applicable)**

*Provide a list of resources expected to be leveraged, if applicable.*

The primary leveraging of resources in this project will be the clinical time of partner agencies to participate in joint treatment teams. In addition, treatment resources will be brokered for individual clients, dependent on the needs identified in the treatment plan. These will include:

Public Health Nurse participation on Steering Committee and collaborative treatment team meetings.

Alcohol and Drug clinician participation on Steering Committee treatment team meetings.

Collaborative resources for participation on Steering Committee, and treatment team when appropriate, from social services, education, TEACH Inc., Strong Family Health Center, and other partner agencies.

## EXHIBIT D

### Innovation Work Plan Description (For Posting on DMH Website)

County Name

Modoc

Annual Number of Clients to Be Served (If Applicable)

150 Total

Work Plan Name

Taking Integration Personally

Population to Be Served (if applicable):

Individuals with co-occurring mental health diagnoses and substance use disorders and/or serious medical conditions

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

The Modoc County "Taking Integration Personally" Innovation Project will promote interagency collaboration through the development, evaluation, and implementation of integrated treatment processes for consumers with co-occurring mental health and substance use disorders and/or serious medical conditions. Initially, the Project will address integration of mental health, alcohol and other drug services, and public health, with strong linkages to primary care, social services, collaborative treatment courts, and other partners. The Project will include integration of assessment tools and processes, as well as fully integrated team treatment provision, with a unique treatment team for each consumer client depending upon the assessed needs. In a frontier, rural setting where each partner, including mental health, is small and challenged, the Taking Integration Personally Project affords the opportunity to improve collaborative processes, improve system integration, and, ultimately, improve the health outcomes of individuals and the entire community.



## EXHIBIT F

### Innovation Projected Revenues and Expenditures

County: Modoc

Fiscal Year: 2010/11

Work Plan #: 1

Work Plan Name: Taking Integration

New Work Plan

Expansion

Months of Operation: 2/2011 - 6/2013  
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
<b>A. Expenditures</b>				
1. Personnel Expenditures	23,600			\$23,600
2. Operating Expenditures	47,400			\$47,400
3. Non-recurring expenditures				\$0
4. Training Consultant Contracts			3,000	\$3,000
5. Work Plan Management				\$0
<b>6. Total Proposed Work Plan Expenditures</b>	<b>\$71,000</b>	<b>\$0</b>	<b>\$3,000</b>	<b>\$74,000</b>
<b>B. Revenues</b>				
1. Existing Revenues				\$0
2. Additional Revenues				
a. (insert source of revenue)				\$0
b. (insert source of revenue)				\$0
c. (insert source of revenue)				\$0
3. Total New Revenue	\$0	\$0	\$0	\$0
4. Total Revenues	\$0	\$0	\$0	\$0
<b>C. Total Funding Requirements</b>	<b>\$71,000</b>	<b>\$0</b>	<b>\$3,000</b>	<b>\$74,000</b>

Prepared by: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

Date: \_\_\_\_\_

County of Modoc  
Work Plan Name: Taking Integration Personally

**Note: The total budgeted cost of the Project is \$353,200, to be expended over 3.5 years. This budget is for fiscal year 2010/11, followed on the next pages with the budget for fiscal year 2011/12. Including County administrative costs, the budget for the two years totals \$253,900. The remainder \$99,300 will be addressed in future Innovation updates.**

#### **FY 2010/11 – Budget Narrative**

##### ***Personnel Expenditures – \$23,600***

Personnel time (salaries & benefits) for planning and implementation of the Project, to include time spent: in collaborative planning and treatment/recovery team meetings; in collaborative creation of work product (e.g., integrated assessment and treatment plan forms; surveys); in data gathering and analysis; in writing reports; in Project related presentations; and in Project reporting requirements. It is likely that all personnel will be involved in the Project, including the director, deputy director, sychologist, nurses, clinicians, case managers, and administrative/clerical staff.

##### ***Operating Expenditures – \$47,400***

Incentives for participation of collaborative partners, to include reimbursement for staff time, as well as door prizes, snacks and other incentives to encourage on-going meeting attendance;  
Materials and supplies to support the Project;  
Travel and transportation costs associated with the Project (e.g., transportation for consumers and family members to local meetings; staff, consumer, and family member travel to outlying areas of the county or out-of-county meetings relevant to the Project;  
Miscellaneous operating expenditures, tbd.

##### ***Training Consultant Contracts – \$3,000***

Contracts for training services to support the Project. See Project narrative for examples of the type of training to be provided.

**Total Program Costs – \$74,000**

**County Administration – \$11,000**

**Total Projected Expenditures: \$85,000**

## EXHIBIT F

### Innovation Projected Revenues and Expenditures

County: Modoc

Fiscal Year: 2011/12

Work Plan #: 1

Work Plan Name: Taking Integration

New Work Plan

Expansion

Months of Operation: 2/2011 - 6/2013  
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
<b>A. Expenditures</b>				
1. Personnel Expenditures	47,300			\$47,300
2. Operating Expenditures	69,593			\$69,593
3. Non-recurring expenditures				\$0
4. Training Consultant Contracts			20,000	\$20,000
5. Work Plan Management			10,000	\$10,000
<b>6. Total Proposed Work Plan Expenditures</b>	<b>\$116,893</b>	<b>\$0</b>	<b>\$30,000</b>	<b>\$146,893</b>
<b>B. Revenues</b>				
1. Existing Revenues				\$0
2. Additional Revenues				
a. (insert source of revenue)				\$0
b. (insert source of revenue)				\$0
c. (insert source of revenue)				\$0
3. Total New Revenue	\$0	\$0	\$0	\$0
4. Total Revenues	\$0	\$0	\$0	\$0
<b>C. Total Funding Requirements</b>	<b>\$116,893</b>	<b>\$0</b>	<b>\$30,000</b>	<b>\$146,893</b>

Prepared by: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

Date: \_\_\_\_\_

County of Modoc  
Work Plan Name: Taking Integration Personally

## **FY 2011/12 – Budget Narrative**

### ***Personnel Expenditures – \$47,300***

Personnel time (salaries & benefits) for planning and implementation of the Project, to include, but not be limited to, time spent in: collaborative planning and treatment/recovery team meetings; collaborative creation of work product (e.g., integrated assessment and treatment plan forms; surveys); oversight; data gathering and analysis; writing reports; Project related presentations; Project reporting requirements. It is likely that all personnel will be involved in the Project, including the director, deputy director, psychologist, nurses, clinicians, case managers, and administrative/clerical staff.

### ***Operating Expenditures – \$69,593***

Incentives for participation of collaborative partners, to include reimbursement for time, as well as door prizes, snacks and other incentives to encourage on-going meeting attendance;  
Materials and supplies to support the Project;  
Travel and transportation costs associated with the Project (e.g., transportation for consumers and family members to local meetings; staff, consumer, and family member travel to outlying areas of the county or out-of-county meetings relevant to the Project;  
Miscellaneous operating expenditures, tbd.

### ***Training Consultant Contracts – \$20,000***

Contracts for training services to support the Project. See Project narrative for examples of the type of training to be provided.

### ***Work Plan Management – \$10,000***

Consultant costs for providing work plan assistance and oversight.

**Total Program Costs – \$146,893**

**County Administration – \$22,007**

**Total Projected Expenditures: \$168,900**

## Appendix A

## **Innovation Component Plan Posting Narrative**

The Modoc County Mental Health Services Act – Innovation Component Plan (3 year plan for \$353,200) is the focus of this posting for public review and comment. The funding requested in this plan is to be used to increase quality of services and better outcomes primarily through promotion of interagency collaboration. The 30 day posting is December 3, 2010 through January 2, 2011. A public hearing will be conducted at Modoc County Health Services in early January. A hard-copy is available upon request at 441 N. Main Street, Alturas, CA 96101, by calling 520-233-6312, or emailing Karen Stockton: [karenstockton@co.modoc.ca.us](mailto:karenstockton@co.modoc.ca.us). Comments can be submitted online at this site, by email, phone, or writing as indicated above.

The Mental Health Services Act (MHSA, the Act) provides for the Innovation Component of the County's Three-Year Program and Expenditure Plan (Three-Year Plan). Pursuant to the Act, Part 3.2, funding under this component is to be used to: increase access to underserved groups; increase the quality of services, including better outcomes; promote interagency collaboration and increase access to services.

Innovations are defined as novel, creative and/or ingenious mental health practices/approaches that are expected to contribute to learning, which are developed within communities through a process that is inclusive and representative, especially of unserved and underserved individuals and which are aligned with the General Standards identified in the MHSA and set forth in Title 9 of the California Code of Regulations, Section 3320. The Innovation Component allows Counties the opportunity to "tryout" new approaches that can inform current and future mental health practices/approaches.

[click here to download 3 year plan](#)