

## New/Revised Program Description INNOVATION

- Completely New Program**  
 **Revised Previously Approved Program**

**Program Number/Name:** Coordinated Care Collaborative (CCC)

**Date:** September 1, 2014

Select **one** of the following purposes that most closely corresponds to the Innovation's learning goal.

- Increase access to underserved groups
- Increase the quality of services, including better outcomes
- Promote interagency collaboration
- Increase access to services

*1. Describe why your selected primary purpose for Innovation is most relevant to your learning goal and why this primary purpose is a priority for your county.*

The Inyo County Community Care Collaborative (CCC) was selected as a means to improve coordination of care with primary health care services for adults, ages 18 and older, with a serious mental illness. Persons with a serious mental illness are more likely to have chronic health conditions, and have shortened life spans by up to 25 years, compared to the general population. Inyo County is a small, rural county which meets the definition of a frontier county. The general population is 18,478. The county covers 10,180 square miles. In Inyo County, there are 1.8 persons per square mile, while statewide there are 239 persons per square mile.

We have a high proportion of persons who are older adults (19.5%), compared to California (11.7%). Our small, rural county is comprised of 65.7% white, non-Hispanic; 20.1% Mexican /Hispanic; and 12.4% Native American. The other race/ethnicity groups each represent fewer than 3% of the population.

Increasing access to and coordination with primary care services for our clients with a serious mental illness is a high priority for ICBH. By coordinating health, mental health and substance use disorder services, as well as adding a focus on wellness self-management including alternative healing, we will be able to improve outcomes for our clients and improve access to primary care and other wellness-focused services. The vision of Inyo County Behavioral Health (ICBH) is to build and support healthy futures in which people with a serious mental illness (SMI) are able to achieve health, wellness, and recovery through the development of integrated health care services and identification of person-centered health care and wellness. To achieve this vision, this Innovation project will develop strategies to promote wellness and integrate health care, mental health, and substance use services to improve health outcomes for our clients.

The CCC team will first identify clients receiving behavioral health services and help link them to health services in the community. The Innovation Project funding will initially partially help to support an additional full-time Nurse position (1.0 FTE) as a care coordinator. This Nurse position will act as a single point of contact to coordinate care including the integration of health and wellness activities for behavioral health clients. We will focus first on persons who are eligible to be enrolled or are enrolled and receiving services at the Northern Inyo Hospital Rural Health Clinic (NIHRHC) as the pilot project. After the initial period, we will expand to those at Southern Inyo Rural Health clinic and/or the Toiyabe Indian Health Project (TIHP) or other providers in the community.

The Project will also help to fund an Administrative Analyst to help to design and support data collection, monitoring and tracking around outcomes. As part of the Innovation Plan, we will be using a number of small change studies in order to test the most efficient and effective workflows and processes, ways to maximize self-management, management of cost, and consumer and provider satisfaction. In this way, we will be developing a coordinated service that best meets the needs, strengths and challenges of a frontier county.

The goal of the CCC is to build and support healthy outcomes in which adults ages 18 and older with a serious mental illness (SMI) are able to achieve health, wellness, and recovery through the development of a person-centered health care and a client-driven plan. Each individual with an SMI who is served by CCC will have access to a range of effective health services, supports, and resources to promote wellness, manage illnesses, and improve overall health outcomes.

CCC will help link individuals and their families to needed services, including substance use services in the community. A number of key health outcomes will be collected and routinely reported to clients, staff, and providers to demonstrate improved health indicators.

The CCC Team will coordinate health and behavioral health services for our identified adult clients. This will include the development of strategies for reconciling medications between health and mental health services. Further, the CCC Team will offer wellness activities at each of the sites, offering smoking cessation classes, yoga, meditation, nutrition, and other wellness activities to promote healthy outcomes. These services will be developed to coordinate with existing services at the health centers and ensure that services are culturally appropriate to meet the needs of the persons with a mental health disorder who are receiving services at these health centers. In addition, we will develop an Individual Wellness Report for CCC clients in order to give consumers, as well as providers, a clear and concise picture of health status and progress in reaching health goals.

The Coordinated Care Collaborative will address the following:

- Identify individuals who do not have an identified primary care physician, or routinely use primary care services, and link them to the appropriate provider/health clinic/healer/alternative health care in the community.
- Collect basic health information, including lab work, on individuals to help understand each person's current health indicators. Staff will work with the individual to understand their health indicators (e.g., height, weight, body mass index, A1c and risk for diabetes, hypertension/blood pressure, cholesterol, and lung functioning). These health indicators will be used to inform both the individual and staff on high risk health factors, and allow them to work together with the health clinic to identify goals on improving their health and wellness.
- Support an environment where clients and staff work together to develop health and wellness activities to support clients to improve their health. These may include developing walking groups, nutrition and cooking groups, relaxation, meditation, and yoga. Wellness information will also be offered to CCC clients in order to support ways for individuals to make healthy choices. Both self-direction and self-management will be encouraged to lead to positive outcomes.
- Peer support will also be developed. This will be a means to ensure that coordination occurs in a recovery context where client empowerment is encouraged. We will develop

the role of peer support and test its usefulness to the consumer. We will study whether this is a culturally sensitive, effective and cost efficient way to achieve goals.

*2. Describe the INN Program, the issue and learning goal it addresses, and the expected learning outcomes.*

The CCC Innovation Project will provide the foundation for integrating health and behavioral health care services through improved collaboration which will include enhanced communication, shared tracking of client health indicators, and supportive services to improve wellness and manage chronic illness. Currently, the Behavioral Health clinic, the Rural Health Clinics and the Indian Health Clinics share a number of patients, but do not have a formal and consistent way to share information, develop treatment strategies and support consumers in their efforts for improved holistic health. We will develop ways to reconcile medications across providers, health indicators and services received, and jointly measure health indicators over time. We will work collaboratively to find ways to involve consumers in the development of personal wellness goals and ways to motivate and support their efforts. This project will provide the opportunity to support the health care entities and providers, as well as develop relationships with healer and/or alternative medicine providers in the community. We will identify the most effective ways to communicate, develop strategies for sharing information, and develop shared health indicators to track health outcomes with clients.

CCC team members will talk with behavioral health clients about their need for primary care, identify current providers, and/or link each individual to a primary provider/health clinic/healer/alternative medicine provider of their choice. The CCC Team will collect a core set of information on health, mental health, and substance use to establish a baseline. The Behavioral Health Nurse will collect some core health information, including height, weight, Body Mass Index (BMI), blood pressure, and Carbon Monoxide level, using a standardized CO 2 monitor. This information will be collected at baseline and every six (6) months to enable us to evaluate progress over time.

The CCC team will also collect social outcomes measures including education level, employment, arrest history, alcohol and drug use, social connectedness, and mental health indicators (depression, functioning, activities of daily living). A modified National Outcomes Measures Questionnaire will be used to collect this information. This information will be collected at baseline and every six (6) months to enable us to evaluate progress over time.

Once linked to a primary care provider, each client will receive a physical and have baseline lab work completed. The lab work will establish a baseline of health indicators for each client, which will be used by the CCC team to identify any health risk factors, and allowing the consumer to develop wellness goals. The Lab work will provide information on hypertension, cholesterol, diabetes, thyroid functioning, and other key health factors which lead to chronic health conditions. Lab work will be collected at baseline and every twelve (12) months to enable us to evaluate progress over time.

The key health indicators will be compiled into Individual Wellness Reports and given to each client, Behavioral Health staff, and the Primary Care provider every six months. For each health indicator, the report will show areas of “normal” range, “at risk” for developing a chronic health condition, and “meets criteria” for a chronic health condition (e.g., BMI > 25; Blood Pressure > 140, etc.). These reports will provide a road map for developing strategies and goals for supporting the client to reduce their weight, blood pressure, and other indicators of a chronic

health condition. Over time, clients and staff will learn how to improve health, make healthy choices in food and exercise, and be supported to manage their health.

The CCC Team will also continue to develop classes at the Wellness Center and at each health clinic to provide the skills to make healthy lifestyle changes. For example, classes on nutrition, healthy cooking to reduce calories, and walking groups will be offered. In addition, classes in medication, yoga, relaxation, and social connections will be offered by staff or other persons in the program. Together, the CCC Team and clients will celebrate successes and improved health.

State how the Innovation meets the definition of Innovation to create positive change.

This Plan is primarily designed to meet the following purposes: 1) increase access to services: as co-occurring physical health and behavioral health conditions are recognized, there will be a “pathway” to refer these persons to the needed service and to support the development of a shared plan. This will increase access to the needed service, whether in physical health care or mental health care. Further, there will be in certain level of “whole health” support no matter what door is entered. 2) This approach will increase the quality of services received in both settings through the increased awareness of providers to see the person “holistically” as well as by placing the consumer at the center of the services. We will be able to measure outcomes in terms of satisfaction, health outcomes and cost. 3) We will achieve the first two purposes by promoting interagency collaboration by increasing communication and coordination with physical health care partners. In this collaboration, we will find ways to also provide peer support to the consumer. This will not only empower the consumer to have a voice, it will also allow the providers to experience persons with lived experience making a contribution to the health and wellness of other consumers.

MHSA definition of Innovation: This program lands primarily under the category of “making a change to an existing mental health practice or approach”. Projects to increase communication, coordination and integration of physical and behavioral health care have now been recognized and encouraged as part of the Affordable Care Act. This plan is innovative in Inyo County in the following ways: 1) We will use the collaborative opportunities afforded by a small rural community to test a more timely response to an “urgent” health care or mental health care need. We can develop agreed-upon response times and courses of action. For example, it is innovative for us to make an agreement with the Rural Health clinic that we will ensure a mental health appointment within 72 hours for a shared client that they have concerns about and that they are willing to schedule an appointment for a shared client that behavioral health has concern about. It is a change in our collaborative commitment to be responsive as partners to expressed needs and concerns. We will test the impact of this approach in terms of satisfaction with collaboration with partners. We will further test whether developing a coordinated care conference to include providers and the consumer will be successful in improving coordination and satisfaction with care and will improve health outcomes. While this type of coordinated collaborative effort is common in behavioral health and social services arenas, it is innovative in our community to include physical health. Will this be an efficient way to communicate and ensure a successful collaborative approach between two very different work cultures? How will consumers with SMI respond to the “coming together” and will they feel that they are treated holistically? Will consumers have a more positive experience of care? 2). We will implement a number of inclusive wellness activities within the community to test the impact on health indicators for the target population. We will work with healthcare providers to “prescribe” mental wellness activities as identified by consumers through motivational learning strategies. It is innovative to take a wider view on wellness and involve consumers in community activities that will impact overall health and wellness. We will test whether this approach has a positive impact on health

indicators and on satisfaction of consumers. 3) Consumers will generate Wellness Recovery Action Plans that will include a health goal. As a part of this, peer supporters and other providers will use brief strategic planning to result in small, incremental steps in meeting health goals. Consumers will be invited to share the Well Recovery Action Plans with providers. We will also share the Individual Wellness Reports with clients, behavioral health staff, and primary care staff, to help identify at risk and/or chronic health conditions, identify goals to addressing these conditions, track and share progress over time. This innovative method of sharing health indicators with the team will promote healthy outcomes for clients, help them to improve their health, and receive support and skills to make healthy choices. 4) We will look at whether having a peer supporter assists the consumer to better communicate with the health provider and meet health goals. We will look at the impact of peer support versus case manager support versus 5) Finally, we will examine the cost-effectiveness of this project in helping keep clients improve their health indicators. The CCC Project will help provide a model for other small counties on how to share health information, reconcile medications, develop shared goals, use natural and peer supporters and offer healthy activities to increase wellness for high risk clients.

3. *Include a description of how the project supports and is consistent with the applicable General Standards as set forth in CCR, Title 9, Section 3320.*

The CCC Project supports and is consistent with the General Standards of the MHSA as follows:

Community Collaboration

*Initiates, supports, and expands collaboration and linkages, especially connections with systems, organizations, healers and practitioners not traditionally defined as a part of mental health care cultural competence. Demonstrates cultural competency and capacity to reduce disparities in access to mental health services and to improve outcomes.*

The CCC Team will develop strategies and outcomes for enhancing communication between behavioral health and physical health care in the county. This will help improve services for clients, as well as improve service coordination by reconciling medications and developing shared treatment goals. These treatment goals will be client and family-driven. For example, the providers, including peer support persons, will assist the consumer to develop a Wellness Recovery Action Plan that will contain a health goal. Using motivational interviewing techniques, the providers will encourage the consumer to develop their own goals and strategies. The shared Individual Wellness Reports will be provided in order to give the providers and consumer information about their health status. These reports will improve communication between providers, has the opportunity to integrate alternative health practitioners and healers in the community, and will fully support clients to plan strategies to improve their health outcomes. The means to achieve the wellness goal will include strategies that reflect the consumer’s culture and beliefs about wellness. For example, a person could include attendance of “Sweat” as a part of meeting their health goal or might participate in yoga or a form of meditation. The Individual Wellness Reports will also clearly show progress toward improved health outcomes, and create the opportunity to celebrate success and identify opportunities for needed supportive services. This innovative approach will help promote healthy outcomes and improve chronic health conditions.

4. *Describe the population to be served, number of clients to be served annually, and demographic information including age, gender, race, ethnicity, and language spoken.*

The Coordinated Care Collaborative will focus on adults who are 18 years of age, and older who are living independently. We expect to serve 60 unduplicated clients each year. We estimate the following demographics for these clients:

- 12% Native American; 65% Caucasian; 20% Hispanic; 3% Other
- 35% male and 65% female
- 85% adults (18-59); 15% older adult (60+)

5. *Describe the total timeframe of the program. In your description include key actions and milestones related to assessing your Innovation and communicating results and lessons learned. Provide a brief explanation of why this timeline will allow sufficient time for the desired learning to occur and to demonstrate the feasibility of replicating the Innovation.*

Using our existing available resources, we took the initial steps towards readiness for implementation in September 2013. We had meetings with representatives from the local Rural Health Clinic and Indian Health Clinic to discuss options for coordinating services between Primary Care and Mental Health. Our partner at Toiyabe Indian Health Services is implementing a project specific to their own American Indian population so we have decided to pilot our project with the Bishop Rural Health clinic. Within the first six months we then identified approximated 85 consumers with co-occurring health and behavioral health conditions as our target pilot population for the pilot. We have taken part in the CIMH Coordinated Care Learning Collaborative as a structured way to more fully develop our plan and strategies using a change model.

This approach has allowed us to begin to evaluate both our program and data tracking and evaluation needs. We have recognized the need to expand our personnel dedicated to collection, input and analysis of data, including outcomes data. We will hire this position commencing our implementation of the Innovations Plan in September 2014. During our continued participation in the CIMH Coordinated Care Learning Collaborative, we will test and track a number of changes to develop our collaborative and related work flows and components. In mid FY 14/15 we will also begin to test this model as it relates to persons who are incarcerated who have both medical and behavioral health conditions. We will look at the role of the care coordinator as persons re-enter and make a transition into the community. We will test the impact of coordinated care to improve health outcomes for this subset of the shared clients. In 15/16 and 16/17 we will take the experiences and learning from the first year and expand our efforts to include further integration with the Toiyabe project and with health care providers in the south part of the County. While we will be tracking data and evaluating our processes on an ongoing basis, we will utilize the final three months of the project to conduct the concluding components of the evaluation activities, analyze the data, and develop a final report. The timeframe for this project will provide the opportunity to collect data, analyze it, and demonstrate the feasibility of replicating these CCC outcomes and integrated services in other communities. We will compare our strategies and outcomes with other small rural counties who are involved in similar projects, including other small counties that are participating in the CIMH Coordinated Care Learning Collaborative. We will share both successes and lessons learned.

6. *Describe how you plan to measure the results, impacts, and lessons learned from your Innovation, with a focus on what is new or changed. Include in your description the expected outcomes of the Innovation program, how you will measure these outcomes, and how you will determine which elements of the Innovation Program contributed to successful outcomes. Include in your description how the perspectives of stakeholders will be included in assessing and communicating results.*

In order to look at impact on health outcomes, the CCC Team will collect health and behavioral health indicators on each client admitted to the project. This will include an intake packet for the Primary Care indicators and an assessment packet for the mental health, drug and alcohol, and social connectedness indicators.

Once linked to a primary care provider, each client will receive a physical and have baseline lab work completed. The lab work will establish a baseline of health indicators for each client, which will be used by the CCC Team to identify any health risk factors, and develop wellness goals for each individual. The lab work will provide information on blood pressure (hypertension), heart disease and cholesterol, Fasting Plasma Glucose and diabetes, weight and Body Mass Index (BMI), and other key health factors which are known to lead to chronic health conditions. Lab work will be collected at baseline and every twelve (12) months to enable us to evaluate progress over time. We will also collect information on lung health by using a Carbon Monoxide Monitor. This instrument is valuable in providing information on the impact of smoking on the body, and provides positive feedback once the individual stops smoking.

The key health indicators will be compiled into Individual Wellness Reports and given to each client, Behavioral Health staff, and the Primary Care provider every six months. For each health indicator, the report will show areas of “normal” range, “at risk” for developing a chronic health condition, and “meets criteria” for a chronic health condition (e.g., BMI > 25; Blood Pressure > 140, etc.). These reports will provide a road map for developing strategies and goals for reducing weight, blood pressure, and other indicators of a chronic health condition. Over time, clients and staff will learn how to improve health, make more healthy choices in selecting meals and exercise, and the team will support them to manage their health.

We will also develop an effective process to reconcile medications between physical health and behavioral health on an ongoing basis for the CCC target population. After establishing the baseline number of discrepancies between the two records, we will enter updated information into a shared document that will also contain health indicators.

In addition, the Behavioral Health Case Managers will gather outcome data to measure progress on mental health and drug and alcohol indicators. These will include the client’s self-report on areas of dealing with everyday life (e.g., I deal effectively with daily problems; I am getting along with my family); violence and trauma; housing; education; employment; criminal justice; and social connectedness.

The evaluation team will produce Individual Wellness Reports for each client to provide information on these key health indicators and track progress. Behavioral Health staff will meet with the client to review their health indicators, identify wellness and mental health goals to work on, and share the information with the primary care provider. This approach will provide the opportunity to have all team members work together to identify chronic health conditions and risk factors, identify measurable goals, and improve communication, collaboration, and services to improve outcomes for each client.

In addition to measures on health indicators to measure client outcomes, we will also measure satisfaction and comfort with care. We will collect satisfaction with the coordinated approach and the use of peer supporters. We will also measure satisfaction of providers with this approach.

The data reports and other written information on the activities associated with the project will also be shared with stakeholders. Their input will be requested and documented throughout the

project. The data will provide valuable information on how to support individuals to improve health outcomes. It will help to document lessons learned and how best to engage clients and the support systems to help them make healthy choices, remain living in the community, and effectively manage their symptoms. Obtaining satisfaction surveys annually from clients will provide important information on individual perceptions of the value and outcomes of the services and activities.

Key outcome goals will include:

1. Increase the screening of individuals for mental health/substance abuse and chronic medical conditions within each care setting (Mental Health, Substance Use Disorder Agency, and Rural Health Clinic).
2. Increase the percentage of individuals with shared care objectives that address mental health, physical health and/or substance use disorder conditions including a measure of progress toward accomplishing wellness goals.
3. Improve medication reconciliation between Behavioral Health and Primary Health Providers to result in a consistent up-to-date list of medications that can be accessed from either setting.
4. Improve satisfaction with the experience of care.
5. Increased satisfaction of providers.
6. Increase self-management skills and use of peer support.
7. Reduce emergency room utilization
8. Improve health outcomes for identified population

We will have an opportunity to share results between different small rural counties who are also testing coordinated care models to identify the best practices. We will compare approaches with Tuolumne, Modoc, Lake, and Madera Counties who are part of the Learning Collaborative to look at variations in approaches and uses within our different counties. We are especially interested in the role of peer supporters as part of care collaboration. Further, we will compare lessons learned with our partners at the Toiyabe Indian Health clinic to identify any culturally specific approaches that might be most helpful. Finally, as we move forward, we will test the model with the population of persons who are incarcerated and re-entering our community. We will be looking for ways to address health issues for this population back into the community so that health care is addressed outside of the jail setting and successful engagement is facilitated through our efforts.

7. *If applicable, provide a list of resources to be leveraged.*

Leveraging of resources is not applicable to the Care Coordination Collaborative Project. We have been able to participate in the Coordinated Care Learning Collaborative in order to test changes using existing staff members to launch this project. We do plan to utilize Medi-Cal funding to support the services, whenever possible and work to build a business case for the continued use of the model.

8. *Please provide projected expenditures by each fiscal year during the program time frame, including both the current and future funding years. Please also describe briefly the logic for this budget: how your proposed expenditures will allow you to test your model and meet your learning and communication goals.*

Care Coordination Collaborative Project budget for three years is \$322,800. During our “Start up” Phase, we have taken part in the Learning Collaborative as a way to structure and pilot our

project, identifying our unique needs and challenges. We have identified the appropriate personnel needs and role expectations for coordinated care. We have identified the position of Behavioral Health Nurse as most appropriate to function in the care coordinator role. The Nurse position is most adept at bridging the two cultures of Behavioral Health and Physical Health care as well as being perceived by the consumers as a respected “helper”. We will fund a portion of this position for the project as we evaluate the cost-effectiveness of this approach. While we are able to access MediCal for some of the services offered, we will test the Nurse role to see what functions lead to the best outcomes. This will include prevention and self-management strategies as well as more traditional “treatment”. We have also identified our data collection, tracking and analysis needs. We propose to use some Innovation funds to support our increased need to use data to make “course corrections” as well as to evaluate progress and outcomes. We are challenged by the limitations of our electronic record to function as a way to track other outcomes in addition to functioning as a “billing” or cost tracking mechanism. We will investigate and develop methods to accomplish this tracking most efficiently through the addition of an analyst.

9. Provide an estimated annual program budget.

**INNOVATION PROJECT  
NEW ANNUAL PROGRAM BUDGET**

**A. EXPENDITURES FY1415**

	Type of Expenditure	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers/CBO's	Total
1.	Personnel	\$133,500			\$133,500
2.	Operating Expenditures	\$2,100			\$2,100
3.	Non-recurring Expenditures	\$8000			\$8000
4.	Contracts (Training Consultant Contracts)				
5.	Work Plan Management	\$10,000			\$10,000
6.	Other Expenditures(Admin)				
	<b>Operating Reserve</b>				
	<b>Total Proposed Expenditures</b>	<b>\$153,600</b>			<b>\$153,600</b>
<b>B. REVENUES</b>					
1.	New Revenues				
	a. Medi-Cal (FFP only)	\$46,000			\$46,000
	b. State General Funds				
	c. Other Revenues				
	<b>Total Revenues</b>				
<b>C. TOTAL FUNDING REQUESTED</b>		<b>\$107,600</b>			<b>\$107,600</b>

**INNOVATION PROJECT  
NEW ANNUAL PROGRAM BUDGET**

<b>A. EXPENDITURES FY1516</b>					
	<b>Type of Expenditure</b>	<b>County Mental Health Department</b>	<b>Other Governmental Agencies</b>	<b>Community Mental Health Contract Providers/CBO's</b>	<b>Total</b>
1.	Personnel	\$141,500			\$141,500
2.	Operating Expenditures	\$2,100			\$2,100
3.	Non-recurring Expenditures				
4.	Contracts (Training Consultant Contracts)				
5.	Work Plan Management	\$10,000			\$10,000
6.	Other Expenditures(Admin)				
	<b>Operating Reserve</b>				
	<b>Total Proposed Expenditures</b>	<b>\$153,600</b>			<b>\$153,600</b>
<b>B. REVENUES</b>					
1.	New Revenues				
	a. Medi-Cal (FFP only)	\$46,000			\$46,000
	b. State General Funds				
	c. Other Revenues				
	<b>Total Revenues</b>				
<b>C. TOTAL FUNDING REQUESTED</b>		<b>\$107,600</b>			<b>\$107,600</b>

**INNOVATION PROJECT  
NEW ANNUAL PROGRAM BUDGET**

**A. EXPENDITURES FY1617**

	Type of Expenditure	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers/CBO's	Total
1.	Personnel	\$141,500			\$141,500
2.	Operating Expenditures	\$2,100			\$2,100
3.	Non-recurring Expenditures				
4.	Contracts (Training Consultant Contracts)				
5.	Work Plan Management	\$10,000			\$10,000
6.	Other Expenditures(Admin)				
	<b>Operating Reserve</b>				
	<b>Total Proposed Expenditures</b>	<b>\$153,600</b>			<b>\$153,600</b>
<b>B. REVENUES</b>					
1.	New Revenues				
	a. Medi-Cal (FFP only)	\$46,000			\$46,000
	b. State General Funds				
	c. Other Revenues				
	<b>Total Revenues</b>				
<b>C. TOTAL FUNDING REQUESTED</b>		<b>\$107,600</b>			<b>\$107,600</b>

**D. BUDGET NARRATIVE**

It is anticipated that the Care Coordination Collaborative Project will be funded for \$322,800 over 3 years. Funds will be used to partially offset the cost of the Nurse position in the role of Care Coordinator at 33% of cost. The Nurse position will bill MediCal when appropriate. Funds will also be used to support wellness activities for consumers. In addition, funds will be used to offset the cost of an Administrative Analyst position who will be involved in data collection, tracking and outcomes monitoring.

## MHSA FY 2013/2014 Annual Update COUNTY CERTIFICATION

County: **INYO COUNTY MENTAL HEALTH**

<p style="text-align: center;"><b>County Mental Health Director</b></p> <p>Name: Gail Zwier, Ph.D.          Telephone Number: (760) 873-6533          E-mail: <a href="mailto:gzwier@inyocounty.us">gzwier@inyocounty.us</a></p>	<p style="text-align: center;"><b>Project Lead</b></p> <p>Name: Gail Zwier, Ph.D.          Telephone Number: (760) 873-6533          E-mail: <a href="mailto:gzwier@inyocounty.us">gzwier@inyocounty.us</a></p>
<p>Mailing Address:  <div style="text-align: center;">162 J Grove Street, Bishop, CA 93515</div></p>	

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 annual update, including stakeholder participation and non-supplantation requirements.

This 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 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 annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on February 4, 2014.

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 FY 2013/14 annual update are true and correct.

Gail Zwier, PhD  
 Mental Health Director/Designee (PRINT)

  
 Signature

4.17.14  
 Date

## MHSA FY 2013/2014 Annual Update FISCAL ACCOUNTABILITY CERTIFICATION<sup>1</sup>

County: Inyo

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

<b>County Mental Health Director</b>	<b>County Auditor-Controller</b>
Name: Gail Zwier, Ph.D.	Name: Amy Shepherd
Telephone: (760) 873-6533	Telephone: (760) 878-0343
E-mail: <a href="mailto:gzwier@inyocounty.us">gzwier@inyocounty.us</a>	E-mail: <a href="mailto:ashepherd@inyocounty.us">ashepherd@inyocounty.us</a>
Mental Health Department Mailing Address: 162 J Grove Street, Bishop, CA 93515	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update, OR Annual Review and Expenditure Report 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 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.

Gail Zwier, PhD  
Mental Health Director/Designee (PRINT)

G. Zwier PhD 4.17.14  
Signature Date

I hereby certify that for the fiscal year ended June 30, 2013, the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated March 28, 2014 for the fiscal year ended June 30, 2013. I further certify that for the fiscal year ended June 30, 2013, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County 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 update/report is true and correct to the best of my knowledge.

Christie Martindale  
County Auditor-Controller (PRINT)

[Signature] 4/21/2014  
Signature Date

<sup>1</sup>Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)  
MHSOAC Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (02/14/2013)