El Dorado County
FY 2016-17
MHSA Plan Update
Additional Attachments

Health and Human Services Agency, Mental Health Division

WELLNESS I RECOVERY I RESILIENCY

Attachment A
Performance Outcomes

Performance Outcomes

As used within the MHSA Plan Update, the following regional definitions apply:

West County	Cameron Park, El Dorado Hills, Rescue, Shingle Springs
Placerville Area	Diamond Springs, El Dorado, Placerville, Pleasant Valley
North County	Coloma, Cool, Garden Valley, Georgetown, Greenwood, Kelsey, Lotus, Pilot Hill
Mid County	Camino, Cedar Grove, Echo Lake, Kyburz, Pacific House, Pollock Pines, Twin Bridges
South County	Fair Play, Grizzly Flats, Mt. Aukum, Somerset
Tahoe Basin	Meyers, South Lake Tahoe, Tahoma

The full description for each project discussed below can be found in the FY 2016-17 MHSA Programs and Projects document.

PREVENTION AND EARLY INTERVENTION (PEI) PROJECTS

Project 1a: Children 0-5 and Their Families:

The Infant Parent Center provides prevention, early intervention, and access and linkage to treatment services to children age 0-5 and their families. A plan of care will be developed by service provider in concert with family and other community collaborators as appropriate to address the family's specific needs and goals. Some activities include infant-parent psychotherapy, counseling, home visitation, parenting support, education and a variety of evidence based therapies.

The Infant Parent Center provided services to approximately 189 unduplicated individuals and families in FY 2014-15. The total expenditures were approximately $229,475 with an approximate cost per participant of $1,214.

In FY 2014-15 the Children 0-5 and Their Families project served:

Age Group	Number
0-15 (children/youth)	93
16-25 (transitional age youth)	12
26-59 (adult)	29
Ages 60+ (older adults)	0
Unknown or declined to state	55

Gender	Number
Female	122
Male	67

Region of Residence	Number
West County	49
Placerville area	92
North County	7
Mid County	23
South County	4
Tahoe Basin	0
Unknown or declined to state	14

Race / Ethnicity	Number
American Indian or Alaska Native	2
Asian	0
Black or African American	2
Caucasian or White	125
Hispanic or Latino	27
Native Hawaiian or Other Pacific Islander	0
Multiracial	16
Other Race or Ethnicity	2
Unknown or declined to state	15

Language	Number
English	162
Spanish	18
Other Language	0
Bilingual	9
Unknown or declined to state	0

Outcome Measures:

MHSA funding has been instrumental to IPC's ability to assist families with young children in El Dorado County. This is due, in part, to an overall strengthening of a collaborative network of providers working to ensure that families with children in this age range receive specialized services to meet their needs. With few exceptions, the implementation of this project has proceeded as expected over the past year and we are grateful for this funding.

Major accomplishments

• Referrals - IPC saw an increase in referrals and a high rate of follow-through/on-going treatment.

• Perinatal Mood and Anxiety Disorder (PMAD) - There is a building awareness and decreased stigma related to PMAD with a documented decrease in sociality, abuse, shaken baby syndrome and isolation. (There were no reports of shaken baby during the term of this grant.)

• Mariposa Booklet - IPC developed and published this accessible resource guide as a complement to services or to be used as a stand-alone piece for expectant and new families. Mariposa covers a range of issues and needs (pregnancy, infant development and PMAD).

• Foster/Adoptive parents - IPC developed new programs to respond to our county's struggle to retain foster/adoptive parents and to keep children from placement outside the county. IPC

provides supportive services for parents, including Reflective Practice and interventions for relational/trauma needs.

• Pea Pod Booklet - IPC is finalizing development of this guide for foster/adopt parents and parents in the midst of reunification. Pea Pod is designed to help parents traverse the often difficult emotional landscape of children who are dealing with a host of issues, including grief, loss, abuse, etc.

• Inter-agency collaboration - IPC's work with clients has empowered them to have direct communication with a person at a linked referred agency and thus we have seen positive outcomes in those referrals to Early Head Start, Public Health, CPS, Mental Health, Victim Witness and Marshall Medical. IPC staff personally followed up on all of the clients linked to community partners to ensure good follow through.

Challenges

• Assessments **-** We found that some of the assessment tools for this plan were limited in their ability to assess for relational and transitional needs. For example, the Post-Partum Depression Scale (PPDS) did not address "goodness of fit" or compatibility issues between mother and child. In some cases, mothers referred for PMAD may have had pre-existing or undiagnosed depression and/or anxiety that was not relevant to baby and mother's relationship. Clinical supervisors are working with staff to improve documentation, completion of pre and post assessment tools and use of all assessment tools at their disposal, as appropriate. We are taking steps to improve compliance through staff training and also working with partner agencies to augment data we collect.

• Client Surveys - Not all clients are completing and returning our Satisfaction Surveys. We are working to improve this rate.

• There were 30 clients who we were unable to assist. Issues included a) no real buy-in from the client/client did not feel they needed the services; b) phone disconnected after initial contact; c) that during the outreach phase, we assessed that other services would be more beneficial for the client and referred them to another community resource.

• We have found it difficult to obtain good statistics related to how our work has impacted child abuse in our county or how our clients in the CPS system have fared once they leave our service. We would like to follow up with MHSA and CPS to develop a system of data collection and/or follow up on closed cases.

2. Working closely and in collaboration with our partner agencies, IPC noted improvement in the mental health of families with small children (0-5) in our county. Of our total caseload, 63.9% left with goals met. Another 11.6% left treatment with goals partially met and only 5.2% left treatment with goals not met. Highlights related to important MHSA focal areas are as follows:

<u>Prolonged Suffering</u>

• Of the 155 clients seen during this period, 99 left with goals met and another 18 partially met their therapeutic goals.

• Support for Foster/Adoptive parents improved their ability to cope with children placed in their care (ameliorating suffering for all) and stabilization for children in foster care.

Removal of Children from the Home

• IPC received 62 referrals from CPS during this period. IPC's strong focus on strengthening families has improved family dynamics to prevent a need to remove children from the home. Many of the referrals by CPS were for stabilization of placement, reunification and family therapy.

School Drop Out / Failure

• IPC was asked by teachers to intervene on-site for young children experiencing aggression, anxiety and trauma that was impeding their ability to learn and succeed in a classroom setting. IPC worked with parents, teachers and also created linkage as appropriate to Occupational, Speech Therapy and Alta Regional to support behaviors and provide a holistic approach to intervention.

Homelessness / Unemployment

• IPC provided direct services to women and their children sheltering at Hope House, Mother Teresa Homeless Shelter and United Outreach. When appropriate we provided linkage to Cal Works, Job I, etc.

• Several clients became motivated to pursue college as an avenue for greater economic success.

Incarceration

• IPC staff supported a decrease of incarceration for many families who needed to address alcohol or drug issues by supporting recovery work and linking them to recovery services.

• IPC worked with a number of families facing incarceration or recently released, helping to stabilize or refer them for other resources.

The majority of IPC's clients could be classified as Unserved/Underserved due to access, language, financial or other barriers to service. IPC's model of providing services in location(s) convenient for the client (in both Cameron Park, Placerville, in the client's home, in school settings or shelters) helps strip away this barrier. Services were provided in both English and Spanish.

IPC service plans are always developed in collaboration with the client's specific needs, including their cultural, financial, language needs and educational level. We provide services in English and Spanish, which has been sufficient to meet the communication needs of our clients. We work to see beyond pre-conceived ideas of what our clients "need", avoiding generalizations based solely on ethnicity. Client participation is essential to our service delivery model and ensures that all services are provided services in a culturally competent way.

IPC saw an increase in referrals from our community partners. IPC staff also referred clients back to area agencies, as appropriate. For example, mothers experiencing PMAD were referred to treating OB/GYNs or primary care physicians for medical follow up. Our work in the community (including our Mariposa Booklet) has increased awareness, thereby reducing stigma related to Post Partum issues. This outreach and education has been aimed at improving rates for self-referral, improving health and safety for both mothers and their young children. (We had 29 referrals from family/friends/self during this grant period.) IPC therapists and interns provided the following services to families in El Dorado County: Individual/Family therapy; Assessment; Case Management; Parent Support; Home Visits; Community Outreach (to increase awareness of issues/available services).

Collaborative community partners under this funding included: Public Health, Child Protective Services, Early Head Start, Hope House, Mother Teresa's Homeless Shelter, Progress House, First 5 programs (Together We Grow and Best Beginnings), New Morning, Marshall Hospital and CASA. IPC staff linked clients to community enhancement programs, such as mother's groups, library groups and community service districts programming. IPC receives donations throughout the year including office supplies, food, toys, clothing and certificates for services such as yoga and massage. IPC utilizes these donations for the benefit of all of its clientele including MHSA families. We leveraged funds for the additional administrative costs, booklet production, Mariposa distribution, mileage, and client enhancements (yoga classes, donation of goods from outside sources, etc). These were additional costs used directly to serve MHSA families. These families would not receive these supports had the leveraged funds and resources not been used from outside sources.

Measurement 1: Success will be measured on pre/post testing based on assessment tools, Parent Stress Index, Beck's Depression Beck's Depression and Anxiety Scale, Post-Partum Depression Scale, Ages and Stages, and Marshak Interaction Method:

> *Parent Stress Index (PSI) (Used for children 2 years and older) IPC staff used the PSI pre-test with 7 clients. Post testing was done with 2 clients. In both cases stress was alleviated and decreased. Of the remaining 5 clients, 3 clients tested within normal range and were not tested again; one test was invalid because of client's defensive attitude during testing (however with time and trust this family was successful in treatment); remaining client was not post-tested.*
> *Post-Partum Depression Screening (PPDS) - Nine clients were screened using the PPDS. IPC staff recorded a measurable decrease in Perinatal Mood and Anxiety Disorders (PMAD) in five clients. Five clients were screened using Pre-test, but were not tested again; one client moved and we were unable to perform post-testing. Overall, treatment outcomes were still successful in the majority of IPC cases.*
> *Marshak Interactive Measurement (MIM) is a tool using video to assess the interaction between caregiver and child. This was used with some clients as a part of the assessment process.*
> *Ages and Stages was not used as it is in use by Early Head Start.*

Measurement 2: Client satisfaction questionnaires, other provider questionnaires

CLIENT QUESTIONNAIRES:

On question 1, "*How would you rate the quality of our service?*" 100% of the clients rated it as "Excellent". Of 8 questions on the Client Questionnaire, on 7 questions 90% or more of respondents gave the most positive response. On question 3, although all respondents all gave positive responses, it was about evenly divided between "All needs met" and "Most of my needs met". One of the clients added a note

to this section, saying they were "Looking forward to the parenting portion," showing that future training activities might meet more of their needs.

Q1: **How Would You Rate Quality of Service?**
- 100% of respondents rated the quality as "Excellent"

Q2: **Did you get the kind of service you wanted?**
- 27, or 93% of respondents said "Definitely"
- 2, or 7%, said "Generally"

Q3: **To what extent has our program met your needs?**
- 16, or 55% of respondents said "All of my needs"
- 13, or 45%, said "Most of my needs"

Q4: **Would you recommend a friend?**
- 28, or 97% of respondents said "Yes, definitely"
- 1, or 3%, said "Yes, I think so"

Q5: **How satisfied are you with the amount of help you received?**
- 28, or 97% of respondents said "Very Satisfied"
- 1, or 3%, said "Mostly Satisfied"

Q6: **Have the services you received helped you deal with your problems?**
- 26, or 90% of respondents said "Yes, a great deal"
- 3, or 10%, said "Yes, somewhat"

Q7: **In a general sense, how satisfied are you with the service received?**
- 27, or 93% of respondents said "Very Satisfied"
- 2, or 7%, said "Mostly Satisfied"

Q8: **If you need help again would you come back to our program?**
- 26, or 90% of respondents said "Yes, definitely"
- 3, or 10%, said "Yes, I think so"

PROVIDER QUESTIONNAIRES:

How likely are you to recommend our agency to families or individuals in the future?	Did the Infant Parent Center respond in a timely manner to your referral?	Have you heard positive feedback from families with regard to services they received from IPC?	Did our services meet your client's needs?	How can we improve our services to better meet our clients' needs?
5 - Very Likely	5 - Absolutely	5 - Absolutely	5 - Absolutely	Services are excellent!
5 - Very Likely	5 - Absolutely	5 - Absolutely	5 - Absolutely	
5 - Very Likely	5 - Absolutely	5 - Absolutely	5 - Absolutely	
5 - Very Likely	N/A	5 - Absolutely	N/A	We did not do direct referrals but offer IPC as a resource to our clients. We do not receive follow up feedback on supports from IPC. We appreciate the inter-agency collaboration with both Jenn and Alison! Keep up the great work!

How likely are you to recommend our agency to families or individuals in the future?	Did the Infant Parent Center respond in a timely manner to your referral?	Have you heard positive feedback from families with regard to services they received from IPC?	Did our services meet your client's needs?	How can we improve our services to better meet our clients' needs?
5 - Very Likely	5 - Absolutely	5 - Absolutely	5 - Absolutely	
5 - Very Likely	3 - Sort Of	4 - Yes	4 - Yes	As reference to #3 there was a problem with receiving phone messages but that has been resolved.
5 - Very Likely	5 - Absolutely	4 - Yes	5 - Absolutely	
5 - Very Likely	5 - Absolutely	5 - Absolutely	5 - Absolutely	

Measurement 3: Tracking of self-referred clients - *There were 29 clients who were referred by friends/family/self.*

Measurement 4: Decreased incidents of shaken baby syndrome - *While IPC had 3 referrals for Shaken Baby in FY 2013-14, there were no referrals in FY 2014-15.*

Measurement 5: Reduction of hospital emergency department visits - *Four of five clients referred for risk for suicide were assisted by the IPC team without hospitalization. Only one client required an emergency department visit.*

Project 1b: Mentoring for 3-5 Year Olds by Adults and Older Adults:
Big Brothers Big Sisters recruits, screens and trains adults and older adults to mentor at-risk, unserved and underserved children at multiple county child development sites. This project will help reduce parental stress and increase parent-child interaction, as well as parent-teacher interaction. The mentor will teach child coping mechanisms to deal with day-to-day stressors and any mental health symptoms.

The majority of the fiscal year was spent recruiting and successfully matching both "Bigs" and "Littles". At the fiscal year end, 4 successful matches were made and more matches are anticipated in the current fiscal year, both on the West Slope and in South Lake Tahoe. The total expenditures for FY 2014-15 were approximately $100,233.

In FY 2014-15 the Mentoring for 3-5 Year Olds by Adults and Older Adults project served:

Age Group	Number
0-15 (children/youth)	4
16-25 (transitional age youth)	0
26-59 (adult)	0
Ages 60+ (older adults)	0
Unknown or declined to state	0

Gender	Number
Female	1
Male	3

Region of Residence	Number
West County	0
Placerville area	4
North County	0
Mid County	0
South County	0
Tahoe Basin	0
Unknown or declined to state	0

Race / Ethnicity	Number
American Indian or Alaska Native	0
Asian	0
Black or African American	0
Caucasian or White	2
Hispanic or Latino	2
Native Hawaiian or Other Pacific Islander	0
Multiracial	0
Other Race or Ethnicity	0
Unknown or declined to state	0

Language	Number
English	4
Spanish	0
Other Language	0
Bilingual	0
Unknown or declined to state	0

Outcome Measures:

Measurement 1: Pre/post surveys

6 Littles were referred by Head Start and State Preschool for enrollment in the Start Early Program, with 2 referred at the end of the school year which were carried over to the following year. They were all assessed at intake for program effectiveness and 4 Littles were matched with a Big Brother or Big Sister.

Measurement 2: Evaluations

5 Volunteer Bigs applied to be a Big Brother or Big Sister. All 5 were interviewed, screened, trained and accepted based on their evaluation for program participation. 4 of the Volunteers were matched with a Little Brother or Little Sister.

Measurement 3: Behavioral evaluation

Based on the behavioral evaluations completed at the beginning of the match, in conjunction with the referring teachers, 100% of the kids matched with a Big Brother or Big Sister struggled with in class behaviors (specifically with relating with other peers and listening to the teachers). By the end of the school year 50% of the Littles increased their relationships with peers and 75% of Littles increased their classroom behaviors.

Measurement 4: Documented skill building

Based on match support conducted with Bigs (monthly support conversations) throughout their match individual Littles have:

- *Increased their communication with their Bigs*
- *Been calmer in class while the Big was present*
- *Had more positive relationships with peers while the Big was present*

Measurement 5: Rating sheet

100% of the parents were sent rating sheets to rate their perceptions of BBBS and the matching of their child. Of the 4 sent 75% returned. 100% of the rating sheets were returned stating they were very satisfied with the program and strongly agreed their child has had a positive experience.

100% of the Volunteer Bigs were sent rating sheets to rate their perceptions of BBBS and their overall experience of being a Big. Of the 4 sent 100% returned. 100% felt the agency was easy to work with and friendly and have had a positive experience being a Big.

Measurement 6: West Slope: Big Brothers Big Sisters Youth Outcomes Survey and Strength of Relationship survey; similar outcome measurement for the Tahoe Basin

Survey (YOS) and Strength of Relationship survey (SOR)

From the YOS survey completed pre-match:

50% stated they did not have friends at school
50% stated they did not like to go to school
25% said it was OK to be mean to other kids
25% had a favorite adult in their life

From the YOS survey completed at the end of the school year:

100% stated they did have friends at school
75% stated they liked going to school
25% said it was OK to be mean to other kids
100% said they had a favorite adult in their life

From the SOR survey completed 3 months post match

100% said they liked their Big
100% said they liked when their Big visits them
0% stated their Big made them feel bad
50% felt they were close to their Big and 50% were not sure yet

From the SOR survey completed at the end of the school year:

100% said they liked their Big
100% said they liked when their Big visits them

0% stated their Big made them feel bad
100% felt they were close to their Big

Measurement 7: Recommended adult surveys and evaluations tools
From the SOR survey completed 3 months post match
75% of Bigs were not overwhelmed by their Little's difficulties
100% felt well matched with their Little
25% felt frustrated that not much had improved with their Little
0% felt it was hard to find time to be with their Little

From the SOR survey completed at the end of the school year:
25% were less overwhelmed by their Little's difficulties
100% felt they were well matched
0% felt frustrated that not much had improved with their Little
25% felt it was hard to find time to be with their Little

Measurement 8: Testimonials
"I like when my Big reads to me, no one else reads to me"
-Little Brother
"My favorite part of when my Big Sister comes is our walks. We get to walk around my school and we talk about our favorite things"
-Little Brother
"My Little has really opened up to me and become calmer and more communicative compared to when we were first matched"
-Big Sister
"My Little has reduced his aggressive behavior in class. When we were first matched his teachers informed me he would often hit his peers. Since we have been matched they report he no longer is acting out in this way"
-Big Brother

Project 1c: Parenting Skills:
New Morning Youth and Family Services offers parenting skills classes to promote emotional and social capability, and to reduce and treat behavioral and emotional problems in children ages two to twelve.

New Morning Youth and Family Services provided services to 42 unduplicated individuals in FY 2014-15. The total expenditures were approximately $35,094 with an approximate cost per participant of $836.

In FY 2014-15 the Parenting Skills project served:

Age Group	Number
0-15 (children/youth)	0
16-25 (transitional age youth)	2
26-59 (adult)	38
Ages 60+ (older adults)	2
Unknown or declined to state	0

Gender	Number
Female	35
Male	7

Region of Residence	Number
West County	4
Placerville area	5
North County	9
Mid County	15
South County	3
Tahoe Basin	6
Unknown or declined to state	0

Race / Ethnicity	Number
American Indian or Alaska Native	0
Asian	0
Black or African American	0
Caucasian or White	16
Hispanic or Latino	23
Native Hawaiian or Other Pacific Islander	0
Multiracial	2
Other Race or Ethnicity	1
Unknown or declined to state	0

Language	Number
English	25
Spanish	17
Other Language	0
Bilingual	0
Unknown or declined to state	0

Outcome Measures:
Measurement 1: Pre- and post-class survey – *The outcomes reported by parent participants whom successfully completed the course, was far above satisfactory. Parents indicated that the skills and support they received from both the program curriculum and the group facilitators aided them in learning skills and useful tools to strengthen their parent child relationships. The parenting tools and skills identified include: how to better use a time out and problem solve, the effect of interaction through play with their child, understanding the effect of positive reinforcement and how to make their child feel valued and loved. These skills and lessons learned helped improve and strengthen the parenting issues that originally prompted this class.*

Project 1d: Primary Intervention Project (PIP):
Black Oak Mine Unified School District (BOMUSD), El Dorado Community Vision Coalition (EDCVC), and Tahoe Youth and Family Services (TYFS) provide screening to identify children experiencing classroom difficulties. The Primary Intervention Project (PIP) is an evidence-based practice that offers short-term individual, non-directive play services with a trained school aide to students in kindergarten through third grade who are at risk of developing emotional problems.

The PIP provided services to approximately 214 unduplicated individuals in FY 2014-15. The total expenditures were approximately $184,755 with an approximate cost per participant of $863.

Outcome Measures:

Measurement 1: Administer Walker-McConnell Scale (WMS) assessment tool to students at the time student is selected to enter the program and again when the student exits the program (contracted vendor will be responsible for procuring use of the WMS tool) – *All three contracted vendors for PIP services met this goal.*

Measurement 2: Completion of service delivery report to the County on a PIP semester basis showing number of students served – *See a summary of data below.*

In FY 2014-15 the PIP served:

Age Group	Number
0-15 (children/youth)	214
16-25 (transitional age youth)	0
26-59 (adult)	0
Ages 60+ (older adults)	0
Unknown or declined to state	0

Gender	Number
Female	85
Male	117
Unknown	12

Race / Ethnicity	Number
American Indian or Alaska Native	7
Asian	9
Black or African American	4
Caucasian or White	127
Hispanic or Latino	56
Native Hawaiian or Other Pacific Islander	1
Multiracial	6
Other Race or Ethnicity	2
Unknown or declined to state	2

Region of Residence	Number
West County	45
Placerville area	0
North County	63
Mid County	0
South County	0
Tahoe Basin	106
Unknown or declined to state	0

Language	Number
English	172
Spanish	32
Other Language	5
Bilingual	4
Unknown or declined to state	1

Measurement 3: Completion of year-end progress report to the County showing annual number of students served and pre- and post- WMS scores, identifying program successes, challenges faced and post-PIP participation outcomes for the children.

Some of the program reported successes include:

- *BOMUSD - PIP continues to fill the need for many children and families who are either not eligible or unable to obtain more intensive interventions. PIP also introduces parents to mental health interventions that are less stigmatized and easier to accept than therapeutic models. For a family, PIP is often their first encounter with mental health services, and because it is such a positive experience for the child, it can make it easier to accept higher level interventions that may be necessary in the future.*

- *EDCVC – reported a very successful year, including the implementation of the PIP program at five schools in El Dorado Hills. The PIP Aides also implemented a "walking group" and a "lunch group". Each lunch group was five weeks long and included character development topics such as: Respect, Responsibility, Fairness, Cooperation, Caring, Citizenship, Patience, and Trust. These activities were supported by other funding, and augmented the PIP program.*
- *TYFS - The Primary Intervention Program has improved the overall mental health of the children because of the one-to-one, non-directive play experience. The nurturing and safe environment helps the children to gain tools to cope with issues at home and/or school by creating an avenue for the children to express themselves through play. The intervention is designed to minimize the need for more intensive and costly services.*

Some of the challenges faced include:

- *BOMUSD reported a few staffing challenges including the loss of their Director who retired after many years of managing the PIP. Early in the school year, BOMUSD faced some turnover of PIP Aides which was confusing for the children. The strength of the program is based on a trusting relationship formed with a caring adult, who they can count on being there for them.*
- *TYFS - The PIP was introduced late in the 2014-15 school year at all four elementary schools in the Lake Tahoe Unified School District. We experienced some challenges with getting started and coordinating between appropriate parties, but in a short time the children have made great accomplishments with peer relationships in classroom settings, and overall behavior issues. The allotted time and space for service delivery has posed challenges at some of the smaller facilities in Sierra House and Magnet School, causing some difficulty with scheduling enough time for set up and tear downs. We are hopeful with further planning and collaboration with the schools we can create additional space to work with more students during the semester.*

The results of the WMS evaluation reports for all three providers showed a marked increase on a pre- to post-participation basis and an overall higher improved percentage than the state average.

The evaluation data for this project for all the schools revealed that teachers felt that between 82 and 87 percent of participants showed some level of improvement in overall school adjustment, increased participation from their students, less aggressive behavior and much higher levels of social activity and involvement.

PIP participation outcomes for the children are as follows:

BOMUSD	*YES*	*NO*	*N/A*
Has your child looked forward to the play sessions and seemed to enjoy them?	24	0	1
Have you noticed improved behaviors since your child participated in PIP?	21	1	2
Increased motivation to attend school?	16	7	2
Increased ability to make friends?	20	1	4
Increased confidence and leadership skills?	20	3	2
Improved social behavior?	22	1	2

EDCVC – Summary of responses rating 1-5 (based on 21 responses)	*Total Points Scored*	*Total Points Available*	*Percentage*
How would you rate your experience with the program?	99	105	94.29%
Did you feel it was helpful to your students to participate in the program?	99	105	94.29%
Do you feel like the students' problems were addressed?	96	105	91.43%
Would you recommend this program to others who might benefit from it?	97	105	92.38%
Does your student appear to be integrating new behavior/choices into their play or interactions with others?	94	105	89.52%

Project 1f: Prevention and Early Intervention for Youth in Schools:

Minds Moving Forward

This pilot project will provide professional and para-professional staff on school campuses to improve youth mental health and address social and familial variations and stressors. This project will provide services to middle and high school students incorporating activities such as outreach, referrals, groups, classes, individual and family therapeutic services and on-going case management.

Outcome Measures:

Measurement 1: Continued engagement of students and parents in this project, including rate of attendance/missed appointments.

Measurement 2: Self-assessments measuring pre-, interim- and post-participation self-perceptions, and pre-, interim- and post-participation assessments completing by the referring party, as allowed by law, to measure the referring parties' perceptions of the students enrolled in this project and may also include parental assessments.

Measurement 3: Truancy rates/absences of the students enrolled in this project.

Measurement 4: The number of referrals for behavior problems or other disciplinary actions for the students enrolled in this project.

Measurement 5: The number of school dropouts within the students enrolled in this project.

Measurement 6: The number of incarcerations within the students enrolled in this project.

Measurement 7: The number of attempted or completed suicides by students enrolled in this project.

Measurement 8: School-wide surveys to determine the level of knowledge about mental illness, available resources and willingness to discuss mental health concerns.

Measurement 9: The California Healthy Kids Surveys will measure the long-range outcomes at the schools where this project is implemented as it relates to feelings of hopelessness and suicidal thoughts. The outcomes of this measurement may not be available annually or during the pilot period of the project.

As a result of a Request for Proposals (RFP), Minds Moving Forwarded was awarded the contract and a contract is currently in development. Outcomes for this project will be reported in the FY 2017-18 MHSA Plan.

Project 1g: Nurtured Heart Approach:
Summitview Child and Family Services will provide training to parents and caregivers of children and youth with behavioral difficulties at school and/or at home.

Outcome Measures:

Measurement 1: Pre- and post Conners Comprehensive Behavior Rating Scales (CBRS) assessment

Measurement 2: Participant surveys

The contract was executed in January 2016. Outcomes for this project will be reported in the FY 2017-18 MHSA Plan.

Project 2a: Mental Health First Aid:
This evidence-based project introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and provides an overview of common treatments, using the curriculum developed by Mental Health First Aid USA. There are three programs available: Mental Health First Aid, which focuses on risk-factors and mental illness in adults and Youth Mental Health First Aid, which focuses on risk-factors and mental illness in youth ages 12 to 25. There is also a military-focused module for the adult program which focuses on the needs of active duty military personnel, veterans and their families.

The Mental Health First Aid project provided classes to approximately 249 unduplicated individuals in FY 2014-15 including high school students, law enforcement chaplains, foster parents, Marshall Medical staff, South Lake Tahoe community college members, faith and general community members). There were 4 youth classes, 12 adult classes and 1 veterans' class. The total expenditures were approximately $42,691 with an approximate cost per participant of $171.

Outcome Measures:

Measurement 1: Class evaluation provided to attendees at the end of each session - *The formal class evaluations are submitted via an online survey to an outside organization. Informal surveys indicate positive feedback for the class content and the instructors.*

Measurement 2: Evaluation survey provided to attendees six months after taking the class, including information regarding application of material learned – *This evaluation survey was provided to attendees six months after taking the class.*

Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education:
This project supports differences, builds understanding through community involvement, and provides education to reduce shame and support to end discrimination. No new materials were purchased in FY 2014-15 for the PFLAG project.

Outcome Measures:

Measurement 1: Number of informing material distributed - *It is difficult to measure the outcomes of general public outreach activities due to their non-specific target population and methodology.*

Measurement 2: Number of people reached through presentations - *No presentations were offered in FY 2014-15.*

Project 2d: Community Information Access:
The Community Access Site (CAS) through Relias Learning provides a free, web-based community education and information resource center for consumers of mental health services, family members and community stakeholders. Stakeholder refers to a person, group or organization that affects or can be affected by an organization's actions. Included on this site is a comprehensive library of interactive online courses for use by both mental health professionals and the public. Services are available Countywide via the internet. It is difficult to measure the outcomes of general public outreach activities due to their non-specific target population and methodology.

Outcome Measures:

Measurement 1: Number of people accessing web-based information - *Relias Learning is unable to provide the total number of web page "hits", and therefore other sources for this information are being explored.*

Measurement 2: Number of bookmarks distributed - *The actual number of bookmarks is unknown, however they are made available to the public at all special events.*

Project 2e: Suicide Prevention and Stigma Reduction:
As a result of a Request for Proposals, Tahoe Youth and Family Services was awarded the contract to provide outreach to all ages Countywide to reduce suicide, increase awareness and access to services, identify how and when to access mental health services, and reduce stigma.

The contract is in development and outcomes for this project will be reported in the FY 2017-18 MHSA Plan. Approximately $927 was spent on training materials in support of this project in FY 2014-15.

Outcome Measures:

Measurement 1: Program quality will be measured by interviews and surveys about the program.

Measurement 2: Long term success will be measured by the school-wide California Healthy Kids Survey, conducted every other year.

Project 2f: Foster Care Continuum Training:
This project will improve the ability of foster parents, parents/guardians, foster family agency staff and County staff to identify mental health risk factors and to address negative behaviors early to improve placement stability of foster children and youth.

Outcome Measures:

Measurement 1: A reduction in seven-day notices.

Measurement 2: An improvement in foster care placement stability.

Measurement 3: Behavior tracking shows a decrease in maladaptive behavior.

Measurement 4: Behavior tracking shows increase in strengths.

Measurement 5: Increase in discharges to permanency.

The Request for Proposals has not yet been published. Outcomes for this project will be reported in the FY 2017-18 MHSA Plan.

Project 2g: Community Outreach and Resources:
This project provides printed information related to mental health, services available, support available, reference materials and resources.

The total expenditures for the Community Outreach and Resources project were approximately $1,237 in FY 2014-15.

Outcome Measures:

Measurement 1: Number of people accessing web-based information - *It is difficult to measure the outcomes of general public outreach activities due to their non-specific target population and methodology.*

Measurement 2: Number of brochures and other reference materials distributed - *Brochures and other printed materials have been distributed to Barton Hospital, Marshall Hospital, schools, The Center for Violence-Free Relationships, and other community-based organizations.*

Measurement 3: Number of individuals involved in future MHSA planning activities – *27 unduplicated individuals participated in the FY 2016-17 MHSA Community Planning Process meetings and 388 online surveys were completed.*

Project 2h: Statewide PEI Projects:
This project provides a mechanism at the Statewide level for counties to collectively address issues of suicide prevention, student mental health, and stigma and discrimination reduction.

Outcomes for this project will be reported in the FY 2017-18 MHSA Plan.

Project 2a: Wennem Wadati: A Native Path to Healing:
Foothill Indian Education Alliance provides culturally specific Native American services through use of Cultural Specialists, who are Native American community members, working in a professional capacity that access unique cultural contexts and characteristics through the use of traditional Native American healing approaches. The project employs various prevention strategies to address all age groups in the target population with the intent to maintain mental health well-being, improve wellness, and decrease health disparities experienced by the Native American community.

The Wennem Wadati: A Native Path to Healing project provided services to approximately 270 unduplicated individuals in FY 2014-15. The total expenditures were $111,589 with an approximate cost per participant of $413.

Outcome Measures:
Measurement 1: Casey Life Skills Native American Assessment, to be given when an individual joins the Talking Circles and when they end their participation – *Keeping Native students close to their culture is an important facet to keeping them healthy, happy, and building their self-identity. We found that Native students who completed the Casey Life Skills Assessment - American Indian Supplement pre and post showed significant growth when asked to respond to this statement – "I am connected to my Tribal/Native Heritage".*

As students become more connected to their culture through our talking circles and cultural activities, marked improvement is being seen in many areas. We see a large increase in those saying they are respectful to other, respectful to elders, I do what I can for my family, I do what I can for my Native community, and I try to live in balance with others.

Measurement 2: Quarterly client registration which includes client demographic data as well as specific client issues to be addressed – *A summary of the demographic data is included below.*

In FY 2014-15 the Wennem Wadati: A Native Path to Healing project served:

Age Group	Number
0-15 (children/youth)	121
16-25 (transitional age youth)	29
26-59 (adult)	87
Ages 60+ (older adults)	30
Unknown or declined to state	3

Gender	Number
Female	185
Male	79
Unknown	6

Race / Ethnicity	Number
American Indian or Alaska Native	225
Asian	0
Black or African American	1
Caucasian or White	29
Hispanic or Latino	14
Native Hawaiian or Other Pacific Islander	1
Multiracial	0
Other Race or Ethnicity	0
Unknown or declined to state	0

Region of Residence	Number
West County	35
Placerville area	165
North County	5
Mid County	29
South County	3
Tahoe Basin	1
Unknown or declined to state	32

Language	Number
English	262
Spanish	8
Other Language	0
Bilingual	0
Unknown or declined to state	0

Measurement 3: Year-end annual report which will includes a summary analysis of the Casey Life Skills Assessment, program accomplishments, community collaboration activities, program activities offered, and program outcome measures – *The Wennen Wadati program provides a variety of services in the community using traditional healing approaches. One of the main components of the program is talking circles. Talking circles offer youth the opportunity to interact and related with others with similar issues in a safe and constructive environment. Teenage talking circles have become a natural forum to process alcohol and other drug issues, relationship and family conflicts, academic struggles or successes, and future goals setting. There is also a crisis response or "helpline" where Cultural Specialists will assess the client's situation and create stability, offer solutions and/or refer to a treating agency such as Shingle Springs Health and Wellness Center, Friendship House residential treatment center, and other local service agencies. Research shows that Native people that are connected to their culture have a much better chance at staying mentally, physically, emotionally and spiritually healthy. To this end, the Wennem Wadati program provides ongoing cultural opportunities, including monthly cultural arts and Native craft activities, and an annual summer field trip for junior high and high school Native students to participate in leadership activities.*

Project 3b: Latino Outreach:
New Morning Youth and Family Services and the South Lake Tahoe Family Resource Center provide Promotoras to address isolation in the Spanish-speaking or limited English-speaking Latino adult population and peer and family problems in the youth population as community issues resulting from unmet mental health needs by contributing to system of care designed to

engage Latino families and provide greater access to culturally competent mental health services.

The Latino Outreach project provided services to approximately 838 unduplicated individuals and families in FY 2014-15. The total expenditures were approximately $213,301 with an approximate cost per participant of $255.

In FY 2014-15 the Latino Outreach project served:

Age Group	Number
0-15 (children/youth)	287
16-25 (transitional age youth)	127
26-59 (adult)	422
Ages 60+ (older adults)	2
Unknown or declined to state	0

Gender	Number
Female	540
Male	298

Region of Residence	Number
West County	58
Placerville area	215
North County	28
Mid County	77
South County	10
Tahoe Basin	449
Unknown or declined to state	1

Race / Ethnicity	Number
American Indian or Alaska Native	0
Asian	0
Black or African American	0
Caucasian or White	16
Hispanic or Latino	820
Native Hawaiian or Other Pacific Islander	0
Multiracial	2
Other Race or Ethnicity	0
Unknown or declined to state	0

Language	Number
English	163
Spanish	674
Other Language	1
Bilingual	0
Unknown or declined to state	0

Outcome Measures:

Measurement 1: Customer satisfaction surveys – *The Family Resource Center received 66 client satisfaction surveys. 100% of the respondents reported satisfaction with the services they received with 84% reporting the highest level of satisfaction. No negative or slightly negative comments were made, all were very positive.*

New Morning Youth Family Services: Latino Outreach - Client Satisfaction Questionnaire Report

How would you rate the quality of service you have received? (4 = Excellent, 3 = Good, 2 = Fair, 1 = Poor)	3.75
Did you get the kind of services you wanted? (4 = Yes, definitely, 3 =Yes, generally, 2 = No, not really, 1 = No, definitely not)	3.66

To what extent has our program met your needs? (4 = Almost all needs met, 3 =Most needs met, 2 = Only a few needs met, 1 = None of needs met)	3.62
If a friend were in need of similar help, would you recommend our program to him or her? (4 = Yes, definitely, 3 =Yes, I think so, 2 = No, I don't think so, 1 = No, definitely not)	3.83
How satisfied are you with the amount of help you have received? (4 = Very satisfied, 3 =Mostly satisfied, 2 = Indifferent or mildly satisfied, 1 = Quite dissatisfied)	3.72
Have the services helped you to deal more effectively with your problems? (4 = Yes, helped a great deal, 3 =Yes, helped somewhat, 2 = No, really didn't help, 1 = No, seemed to make things worse)	3.71
In an overall, general sense, how satisfied are you with the services you have received? (4 = Very satisfied, 3 =Mostly satisfied, 2 = Indifferent or mildly satisfied, 1 = Quite dissatisfied)	3.75
If you were to seek help again, would you come back to our program? 4 = Yes, definitely, 3 =Yes, I think so, 2 = No, I don't think so, 1 = No, definitely not)	3.80

Measurement 2: Client outcome improvement measurements – *The Family Resource Center reported that of the 66 clients who took the satisfaction survey, 34 believe that they are able to manage their symptoms, with 16 reporting almost always. 49 respondents reported feeling respected and welcomed at the FRC with another 7 saying almost always. New Morning's results are noted in the table above.*

Measurement 3: Increased engagement in traditional mental health services – *Both contracted vendors have seen an increase in the number of clients served in their Latino Outreach program indicating a reduction in stigma and an increase in referrals for mental health services. The MHD experienced a continual decrease in Hispanic and Latino clients seeking Specialty Mental Health Services since 2008, but the number of Hispanic and Latino clients have been increasing since 2013.*

Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness:

The partnership with the Wellness Center enables individuals who would traditionally not be eligible for mental health services to attend the Wellness Center and receive basic services and referrals. This project also allows family and friends who provide a support system to Wellness Center participants to attend activities at the Wellness Center to learn how to enhance their support roles.

There were approximately 649 visits by non-clients to the Wellness Centers in FY 2014-15; however, no MHSA funding was utilized for the Wellness Outreach Ambassadors and Linkage to Wellness project. This indicates that the visitors participated in Wellness Center activities, but may not have needed one-on-one services with mental health staff.

Outcome Measures:

Measurement 1: Number of participants and family/friends in their support network – *The Wellness Centers received approximately 649 non-client visits in FY 2014-15.*

Measurement 2: Continued or increased attendance at the Wellness Center - *This will be a focus area of data collection for FY 2015-16.*

Measurement 3: Area of County in which participant resides - *This new outcome measure will be implemented during FY 2015-16.*

Project 4b: Senior Peer Counseling:
Senior Peer Counseling provides free confidential individual counseling to adults age 55 and older. Senior Peer Counseling volunteers evaluate the needs of potential clients, frequently referring them or assisting them in making contact with other community services, including Mental Health evaluation and treatment.

The Senior Peer Counseling project provided services to approximately 31 unduplicated individuals in FY 2014-15. The total expenditures were approximately $25,351 with an approximate cost per participant of $818.

In FY 2014-15 the Senior Peer Counseling project served:

Age Group	Number
0-15 (children/youth)	0
16-25 (transitional age youth)	0
26-59 (adult)	4
Ages 60+ (older adults)	27
Unknown or declined to state	0

Gender	Number
Female	26
Male	5

Region of Residence	Number
West County	7
Placerville area	14
North County	1
Mid County	7
South County	2
Tahoe Basin	0
Unknown or declined to state	0

Race / Ethnicity	Number
American Indian or Alaska Native	0
Asian	0
Black or African American	0
Caucasian or White	31
Hispanic or Latino	0
Native Hawaiian or Other Pacific Islander	0
Multiracial	0
Other Race or Ethnicity	0
Unknown or declined to state	0

Language	Number
English	31
Spanish	0
Other Language	0
Bilingual	0
Unknown or declined to state	0

Outcome Measures:
Measurement 1: Counselors will complete a pre- and post-rating form which measures TLCs, primarily pro-health and pro-mental health activities and habits which have been shown to lead to positive physical, emotional and cognitive improvements in people of all ages. The categories to be measured are:

Exercise, Nutrition / Diet, Nature, Relationships, Recreation / Enjoyable Activities, Relaxation / Stress Management, Religious / Spiritual Involvement, Contribution / Service

Senior Peer Counseling has designed and implemented measurement tools that were designed to assist clients in learning about themselves and how their lifestyle habits can affect their sense of wellbeing and happiness. Overall the measures have been well received and clients are showing overall improvement in most categories.

Measurement 2: Volunteers will record the clients' self-reported improvement in the presenting problem as selected by the client at the start of counseling – *Most clients reported improvement in their overall wellbeing since participating with Senior Peer Counseling.*

Measurement 3: ORS which measures the following four psychological categories:

1) Individually (personal well-being)
2) Interpersonally (family, close relationships)
3) Socially (work, school, friendships)
4) Overall (general sense of well-being)

Senior Peer Counseling Outcome Survey

Please check one: My experience with a Senior Peer Counselor has been: From 0 to 10 (0 – least helpful, 10 – very helpful)	Average score: 9.5
I would recommend Senior Peer Counseling to others: Yes or No	All Yes
How do you feel emotionally? From 0 to 10 (0 – worse, 5 – about the same, 10 – better)	Average score: 8.3
How would you rate your close relationships (family, partner)? (0 – poor, 10 – excellent)	Average score: 7.6
How satisfied are you with your social activities (friends, hobbies, and clubs)? (0 – not satisfied, 10 – very satisfied)	Average score: 8.1
Since you began Senior Peer Counseling, overall have you: Improved, stayed the same, gotten worse?	15 improved 1 stayed the same

Project 4c: Older Adult Program:

This project focuses on depression among older adults, the community issues of isolation, and the inability to manage independence that result from unmet mental health needs. The goal is to reduce institutionalization or out of home placement.

Outcome Measures:

Measurement 1: Clients will complete a pre- and post-rating form.

Measurement 2: Number of clients that are referred to out-of-home placement for care.

The Request for Proposals has not yet been published. Outcomes for this project will be reported in the FY 2017-18 MHSA Plan.

Project 5a: Community-Based Mental Health Services:

This project provides mental health prevention and early intervention services in local communities. Mental Health clinical staff will visit various locations in the County and participate in and coordinate with multi-disciplinary teams and community-based organizations to receive referrals.

The total expenditures for the Community-Based Mental Health Services project were approximately $2,516 in FY 2014-15.

Outcome Measures:

Measurement 1: Number of individuals/families served, and outcomes for each – *General outreach was performed by MHD staff, but the number of individual/families served in FY 2014-15 is unknown.*

Measurement 2: Client satisfaction surveys – *The number of individual/families served in FY 2014-15 is unknown.*

Project 5b: Community Health Outreach Worker:

This project will provide a point of contact for general mental health information coordination and community resources. The Community Mental Health Coordinator would work closely with primary care providers, hospitals, Public Health Nurses, community-based organizations, caring friends and family, and individuals in need of services to determine the appropriate referrals for individuals and families, and to work closely with those individuals and families in establishing services.

Outcome Measures:

Measurement 1: Number of service providers contributing information to the resource tool.

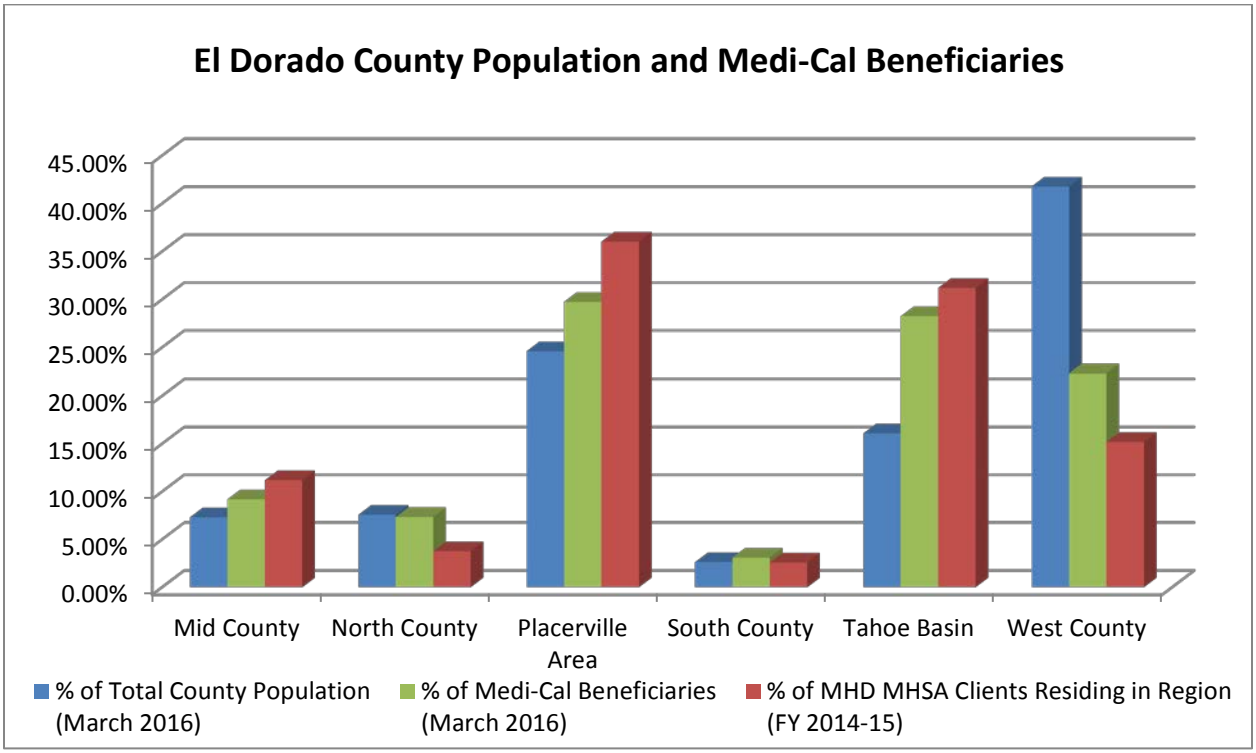
Measurement 2: Number of calls annually.

Measurement 3: Number of calls to 911 for non-emergency information.

Measurement 4: Number of emergency room visits for non-emergency issues.

The Request for Proposals has not yet been published. Outcomes for this project will be reported in the FY 2017-18 MHSA Plan.

COMMUNITY SERVICES AND SUPPORTS (CSS) PROJECTS



Project 1a: Youth and Family Full Service Partnership:

Services in this project are aimed at helping El Dorado County youth avoid more restrictive and expensive placements, including group home placement, hospitalization and incarceration. A FSP project provides an individualized approach to meeting needs for mental health and support services to children / youth, and their families, who are at risk of foster care placement, or who are already in foster care, to prevent placement in a higher level of care facility. The intent of this project is to support children / youth, their caretakers, and the community by keeping children / youth healthy and safe at home, in school and out of trouble.

The Youth and Family Full Service Partnership project provided services to approximately 50 unduplicated individuals in FY 2014-15. The total expenditures were approximately $378,895 with an approximate cost per participant of $7,578.

In FY 2014-15 the Youth and Family Full Service Partnership project served:

Age Group	Number
0-15 (children/youth)	40
16-25 (transitional age youth)	10
26-59 (adult)	0
Ages 60+ (older adults)	0
Unknown or declined to state	0

Gender	Number
Female	22
Male	28

Region of Residence	Number
West County	9
Placerville area	20
North County	4
Mid County	7
South County	2
Tahoe Basin	8
Out of County	0
Unknown or declined to state	9

Race / Ethnicity	Number
American Indian or Alaska Native	3
Asian	0
Black or African American	1
Caucasian or White	38
Native Hawaiian or Other Pacific Islander	0
Other Race or Ethnicity	8
Unknown or declined to state	0
Ethnicity:	
Mexican/Mexican American	4
Puerto Rican	0
Other Hispanic/Latino	1
Not Hispanic	43
Unknown or declined to state	2

Language	Number
English	50
Spanish	0
Other Language	0
Bilingual	Unknown
Unknown or declined to state	0

Outcome Measures:

Measurement 1: Days of psychiatric hospitalization
Measurement 2: Days in shelters
Measurement 3: Days of arrests
Measurement 4: Type of school placement
Measurement 5: School attendance
Measurement 6: Academic performance
Measurement 7: Days in out of home placement
Measurement 8: Child care stability

This reporting requirement was not in the previous children's services agreements for service with contracted providers. As part of the new agreements for service that became effective November 1, 2015, the providers of the children's FSP services are required to submit regular reports with the above information and the data is entered into the State's ITWS system. The FY 2015-16 data will be reported in the next MHSA Plan.

However, the MHD is able to obtain limited data through the electronic medical record and other service logs regarding hospitalizations. Of the 50 children served in this project in FY 2014-15, there were four children who were hospitalized (for five total hospitalization) during

their FSP episode (approximately 5%) of the total children's psychiatric hospitalizations in FY 2014-15 (includes both children assessed in El Dorado County or at hospitals outside the County).

Project 1c: Foster Care Enhanced Services:

This project provides assessment and Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) for qualifying members of the target population through the development of a treatment plan that provides for the full spectrum of community services that may be needed so that the client can achieve the identified goals. This project is designed to provide mandated mental health and supportive services resulting from the *Katie A. vs. Bonta* class action settlement agreement.

The Foster Care Enhanced Services project provided services to approximately 73 unduplicated individuals in FY 2014-15. The total expenditures were approximately $607,694 with an approximate cost per participant of $8,325.

In FY 2014-15 the Foster Care Enhanced Services project served:

Age Group	Number
0-15 (children/youth)	60
16-25 (transitional age youth)	13
26-59 (adult)	0
Ages 60+ (older adults)	0
Unknown or declined to state	0

Gender	Number
Female	31
Male	42

Region of Residence	Number
West County	11
Placerville area	23
North County	2
Mid County	10
South County	1
Tahoe Basin	21
Out of County	5
Unknown or declined to state	0

Race / Ethnicity	Number
American Indian or Alaska Native	3
Asian	0
Black or African American	1
Caucasian or White	58
Native Hawaiian or Other Pacific Islander	1
Other Race or Ethnicity	8
Unknown or declined to state	2
Ethnicity:	
Mexican/Mexican American	2
Puerto Rican	0
Other Hispanic/Latino	4
Not Hispanic	58
Unknown or declined to state	9

Language	Number
English	69
Spanish	1
Other Language	0
Bilingual	Unknown
Unknown or declined to state	3

Outcome Measures:

Measurement 1: Days of psychiatric hospitalization

Measurement 2: Days in shelters

Measurement 3: Days of arrests

Measurement 4: Type of school placement
Measurement 5: School attendance
Measurement 6: Academic performance
Measurement 7: Days in out of home placement
Measurement 8: Child care stability

This reporting requirement was not in the previous children's services agreements for service with contracted providers. As part of the new agreements for service that became effective November 1, 2015, the providers of the children's Foster Care Enhanced Services are required to submit regular reports with the above information and the data is entered into the State's ITWS system. The FY 2015-16 data will be reported in the next MHSA Plan.

However, the MHD is able to obtain limited data through the electronic medical record and other service logs regarding hospitalizations. Of the 73 children served in this project in FY 2014-15, there were four children who were hospitalized during their Foster Care Enhanced Services episode. One child had three hospitalizations, while the remaining three children each had one hospitalization, representing approximately 6% of the total children's psychiatric hospitalizations in FY 2014-15 (includes both children assessed in El Dorado County or at hospitals outside the County).

Project 2a: Wellness Centers:

This project provides a welcoming location for individuals with severe mental illness to receive mental health services, gain life skills for independence, and minimize negative effects of isolation frequently associated with mental illness.

The Wellness Centers project received approximately 10,050 visits in FY 2014-15 in Diamond Springs and South Lake Tahoe. This number includes both clients and non-clients. The total expenditures were approximately $2,331,867 with an approximate cost per participant visit of $232. There were approximately 518 unduplicated clients who had an open Wellness Center episode in Avatar in FY 2014-15.

In FY 2014-15 the Wellness Centers project served:

Age Group	Number
0-15 (children/youth)	2[1]
16-25 (transitional age youth)	44
26-59 (adult)	421
Ages 60+ (older adults)	51
Unknown or declined to state	0

Gender	Number
Female	279
Male	239

Region of Residence	Number
West County	70
Placerville area	176
North County	21
Mid County	54
South County	16
Tahoe Basin	160
Out of County	20
Unknown or declined to state	1

Race / Ethnicity	Number
American Indian or Alaska Native	5
Asian	4
Black or African American	5
Caucasian or White	460
Native Hawaiian or Other Pacific Islander	4
Other Race or Ethnicity	37
Unknown or declined to state	3
Ethnicity:	
Mexican/Mexican American	15
Puerto Rican	3
Other Hispanic/Latino	36
Not Hispanic	431
Unknown or declined to state	33

Language	Number
English	500
Spanish	10
Other Language	4
Bilingual	Unknown
Unknown or declined to state	4

Outcome Measures:

Program Status – FY 2014-15 Participants	Number
Unique Clients	518
Total Episodes	524
Wellness Episode Closed in FY 2014-15	241
Wellness Episode Closed in FY 2015-16	88
Open as of 4-6-16	195
Of the Episodes Closed:	
Increased Services During FY 2014-15	8
Changed Program During FY 2014-15 (same level of service)	1
Decreased Services During FY 2014-15	3

Measurement 1: Number of participants and frequency of attendance – *There were 518 unduplicated clients who had an open Wellness Center episode in the electronic medical record at any point in time in FY 2014-15. Additionally, the Wellness Centers received approximately 10,050 visits in*

[1] Error in episode assignment which has been resolved.

FY 2014-15 in Diamond Springs and South Lake Tahoe including both clients and non-clients, with many individuals attending multiple times per week.

Measurement 2: Continued engagement in mental health services – *Of the 518 clients who had at least one Wellness episode open at any time during FY 2014-15, the average length of stay in a Wellness episode was 749 days, ranging from one day to 2,492 days with a median of 582 days. As the MHD moves towards a greater focus on short term services, it is anticipated that the length of participation in Wellness episodes will decrease in FY 2016-17.*

Measurement 3: Attainment of individualized goals – *In FY 2014-15, 241 Wellness episodes were closed. The level of service for an additional eight clients was increased to FSP, and one individual transferred from Adult Wellness into the TAY Wellness program. The MHD is developing a new report from its electronic medical record to identify the reason why each episode was closed to determine which clients "graduated" from Wellness and which clients may have withdrawn from services for other reasons. Of the Wellness episodes that were opened during FY 2014-15, 21 were a result of a client stepping down in their service level needs from a FSP to a Wellness episode, three of whom stepped back up to a FSP in FY 2014-15.*

Project 2b: Adult Full Service Partnership:

The Adult Full Service Partnership (FSP) project assists clients in becoming more engaged in their recovery through intensive client-centered mental health and non-mental health services and supports focusing on recovery, wellness and resilience.

The Adult FSP project provided services to approximately 133 unduplicated individuals in FY 2014-15. The total expenditures were approximately $3,210,260 with an approximate cost per participant of $24,137. It is important to note that the costs for this project include the Adult Residential Facility (ARF) and the Intensive Case Management (ICM) team, which bring individuals who have been placed in a locked facility out of county back to El Dorado County for continued treatment. These clients require a high level of staff support and the client to clinician ratio is low.

In FY 2014-15 the Adult Full Service Partnership project served:

Age Group	Number
0-15 (children/youth)	1[2]
16-25 (transitional age youth)	20
26-59 (adult)	101
Ages 60+ (older adults)	11
Unknown or declined to state	0

Gender	Number
Female	57
Male	76

Region of Residence	Number
West County	10
Placerville area	60
North County	1
Mid County	9
South County	0
Tahoe Basin	45
Unknown or declined to state	8

Race / Ethnicity	Number
American Indian or Alaska Native	1
Asian	3
Black or African American	2
Caucasian or White	114
Native Hawaiian or Other Pacific Islander	1
Other Race or Ethnicity	11
Unknown or declined to state	1
Ethnicity:	
Mexican/Mexican American	3
Puerto Rican	0
Other Hispanic/Latino	7
Not Hispanic	119
Unknown or declined to state	4

Language	Number
English	130
Spanish	0
Other Language	0
Bilingual	Unknown
Unknown or declined to state	3

Outcome Measures:

Program Status – FY 2014-15 Participants	Number
Unique Clients	133
Total Episodes	139
FSP Episode Closed in FY 2014-15	65
FSP Episode Closed in FY 2015-16	46
Still Open as of 4-1-16	35
Of the Episodes Closed:	
Increased Services During FY 2014-15	12
Changed Program During FY 2014-15 (same level of service)	1
Decreased Services During FY 2014-15	23

Measurement 1: Key Event Tracking (KET) (As changes occur in a client's status related to housing, employment, education, entry or exit from a psychiatric hospital, emergency department or jail) – *This information will need to be obtained from the State's Information*

[2] Error in episode assignment which has been resolved.

Technology Web Services (ITWS) database. Challenges exist with obtaining that data, but the MHD continues to work on the ability to obtain this data in a usable format.

Measurement 2: Achieving goals identified on the ISSP – *In FY 2014-15, 65 FSP episodes were closed. The level of service for an additional 20 clients were decreased to Wellness, and 15 clients were transferred from FSP into Adult Traditional programs. The MHD is developing a new report from its electronic medical record to identify the reason why each episode was closed to determine which clients "graduated" from FSP, which clients may have withdrawn from services for other reasons, and which clients may have been moved to a higher level of care (locked inpatient facility).*

Of the FSP episodes that were opened during FY 2014-15, 16 were a result of a client stepping down in their service level needs from an out-of-County placement to a FSP episode, eight stepping up from a Wellness episode to a FSP episode, and 1 stepped up from a TAY episode to an Adult FSP episode.

Measurement 3: Continued engagement in services – *Of the 133 clients who had at least one FSP episode open at any time during FY 2014-15, the average length of stay in a FSP episode was 639 days, ranging from 2 day to 2,439 days with a median of 370 days.*

Project 2d: Assisted Outpatient Treatment:

The Assisted Outpatient Treatment project provides for limited term, court-ordered outpatient mental health treatment for those individuals meeting the criteria set forth by the law.

Outcome Measures:

Measurement 1: Key Event Tracking (KET) - As changes occur in a client's status related to housing, employment, education, entry or exit from a psychiatric hospital, emergency department or jail.

Measurement 2: Reduction in institutionalization and incarceration.

Measurement 3: Continued engagement in services, as needed, after discharge from AOT.

A Request for Proposals (RFP) was issued in January 2016, but no responses were received. The MHD is exploring other options to implement this program. Outcomes for this project will be reported in the FY 2017-18 MHSA Plan.

Project 3a: TAY Engagement, Wellness and Recovery Services:

This project provides services to meet the unique needs of transitional age youth (TAY) and encourage continued participation in mental health services.

The TAY Engagement, Wellness and Recovery Services project provided services to approximately 84 unduplicated individuals in FY 2014-15. The total expenditures were approximately $101,242 with an approximate cost per participant of $1,205.

In FY 2014-15 the TAY Engagement, Wellness and Recovery Services project served:

Age Group	Number
0-15 (children/youth)	7
16-25 (transitional age youth)	77
26-59 (adult)	0
Ages 60+ (older adults)	0
Unknown or declined to state	0

Gender	Number
Female	47
Male	37

Region of Residence	Number
West County	13
Placerville area	15
North County	1
Mid County	6
South County	1
Tahoe Basin	48
Unknown or declined to state	0

Race / Ethnicity	Number
American Indian or Alaska Native	2
Asian	1
Black or African American	1
Caucasian or White	60
Native Hawaiian or Other Pacific Islander	1 17
Other Race or Ethnicity	2
Unknown or declined to state	
Ethnicity:	15
Mexican/Mexican American	1
Puerto Rican	9
Other Hispanic/Latino	53
Not Hispanic	6
Unknown or declined to state	2

Language	Number
English	81
Spanish	2
Other Language	0
Bilingual	Unknown
Unknown or declined to state	1

Outcome Measures:

Program Status – FY 2014-15 Participants	Number
Unique Clients	84
Total Episodes	84
TAY Episode Closed in FY 2014-15	55
TAY Episode Closed in FY 2015-16	17
Still Open as of 4-1-16	12
Of the Episodes Closed:	
Increased Services During FY 2014-15	0
Changed Program During FY 2014-15 (same level of service)	0
Decreased Services During FY 2014-15	2

The MHD is currently able to obtain limited data for TAY participants who are considered a FSP through the electronic medical record and other service logs regarding hospitalizations. The remainder of the information will need to be obtained from the State's Information Technology Web Services (ITWS) database. Challenges exist with obtaining that data, but the MHD continues to work on the ability to obtain this data in a usable format.

Measurement 1: Number of days of institutional care placements – *Of the 84 youth served in this project in FY 2014-15, there was one youth who was hospitalized.*

Measurement 2: Number of days of homelessness / housing stability – *The MHD is developing a method to capture this information for the TAY clients.*

Measurement 3: Education attendance and performance – *The MHD is developing a method to capture this information.*

Measurement 4: Employment status – *The MHD is developing a method to capture this information.*

Measurement 5: Continued engagement in mental health services – *Of the 84 clients who had at least one TAY episode open at any time during FY 2014-15, the average length of stay in a TAY episode was 299 days, ranging from 16 day to 1,804 days with a median of 290 days. Of the TAY episodes that were opened during FY 2014-15, 6 were a result of a client moving into the TAY program from a Children's Traditional program and one moved into the TAY program from the Adult Wellness program.*

Measurement 6: Linkage with primary health care – *This data is not yet available.*

Project 4a: Outreach and Engagement Services:

This project engages individuals with a serious mental illness in mental health services and to continue to keep clients engaged in services by addressing barriers to service.

The Outreach and Engagement Services project provided services to approximately 1,852 unduplicated individuals in FY 2014-15. The total expenditures were approximately $769,498 with an approximate cost per participant of $415.

Additional services are provided to individuals through this project with services including general inquiry calls that did not result in a request for services, outreach and engagement in the community and at the hospitals, and worker of the day functions. These additional services are not captured within the Request for Services data. There were an additional 390 general inquiry calls in FY 2014-15, and the MHD is working on a method to adequately capture worker of the day interactions and other activities.

In FY 2014-15 the Outreach and Engagement Services project served:

Age Group	Number
0-15 (children/youth)	578
16-25 (transitional age youth)	322
26-59 (adult)	856
Ages 60+ (older adults)	96
Unknown or declined to state	0

Gender	Number
Female	1,010
Male	842

Region of Residence	Number
West County	311
Placerville area	568
North County	107
Mid County	185
South County	51
Tahoe Basin	545
Unknown or declined to state	67

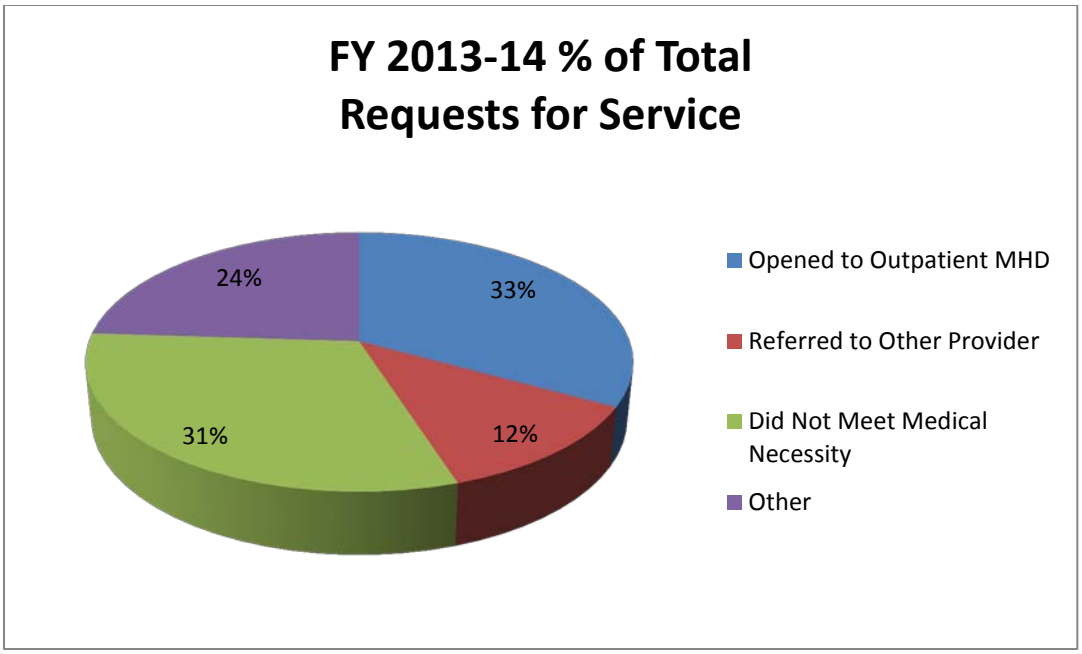
Race / Ethnicity	Number
American Indian or Alaska Native	37
Asian	16
Black or African American	38
Caucasian or White	1,533
Native Hawaiian or Other Pacific Islander	13
Other Race or Ethnicity	158
Unknown or declined to state	57
Ethnicity:	
Mexican/Mexican American	151
Puerto Rican	7
Other Hispanic/Latino	106
Not Hispanic	1,423
Unknown or declined to state	165

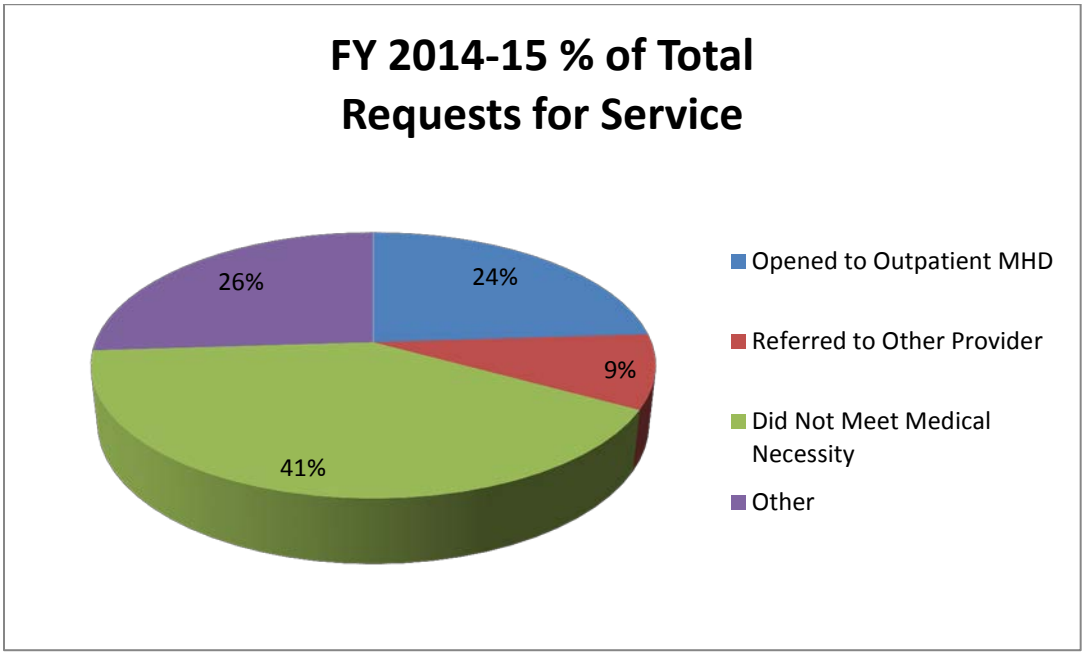
Language	Number
English	1,728
Spanish	63
Other Language	12
Bilingual	Unknown
Unknown or declined to state	49

Outcome Measures:

Measurement 1: Service engagement – *The number of requests for services in FY 2014-15 increased by approximately 29%. There are several factors which may contribute to this increase, such as the increased number of Medi-Cal beneficiaries, an increased awareness and stigma reduction related to mental health needs, insufficient information about services that are available through Managed Care Plans, and insufficient information regarding appropriate referrals to the MHD. These numbers do not include requests for re-authorization of services. Total requests for services were:*

FY 2013-14	FY 2014-15	% Increase
1,432	1,852	29%


FY 2013-14 % of Total Requests for Service
24%
33%
31%
12%
Opened to Outpatient MHD
Referred to Other Provider
Did Not Meet Medical Necessity
Other


FY 2014-15 % of Total Requests for Service
26%
24%
9%
41%
Opened to Outpatient MHD
Referred to Other Provider
Did Not Meet Medical Necessity
Other

The breakdown of service requests for FY 2014-15 is:

CHILDREN	**FY 2013-14**			**FY 2014-15**		
Results (Discharge from "Pre-Admit" Status)	**South Lake Tahoe**	**West Slope**	**Total**	**South Lake Tahoe**	**West Slope[3]**	**Total**
Opened to Outpatient MHD	98	93	191	64	158	222
Referred to Other Provider	2	116	118	21	110	131
Did Not Meet Medical Necessity[4]	16	74	90	51	184	235
Other[5]	16	56	72	17	106	123
Total	132	339	471	153	558	711

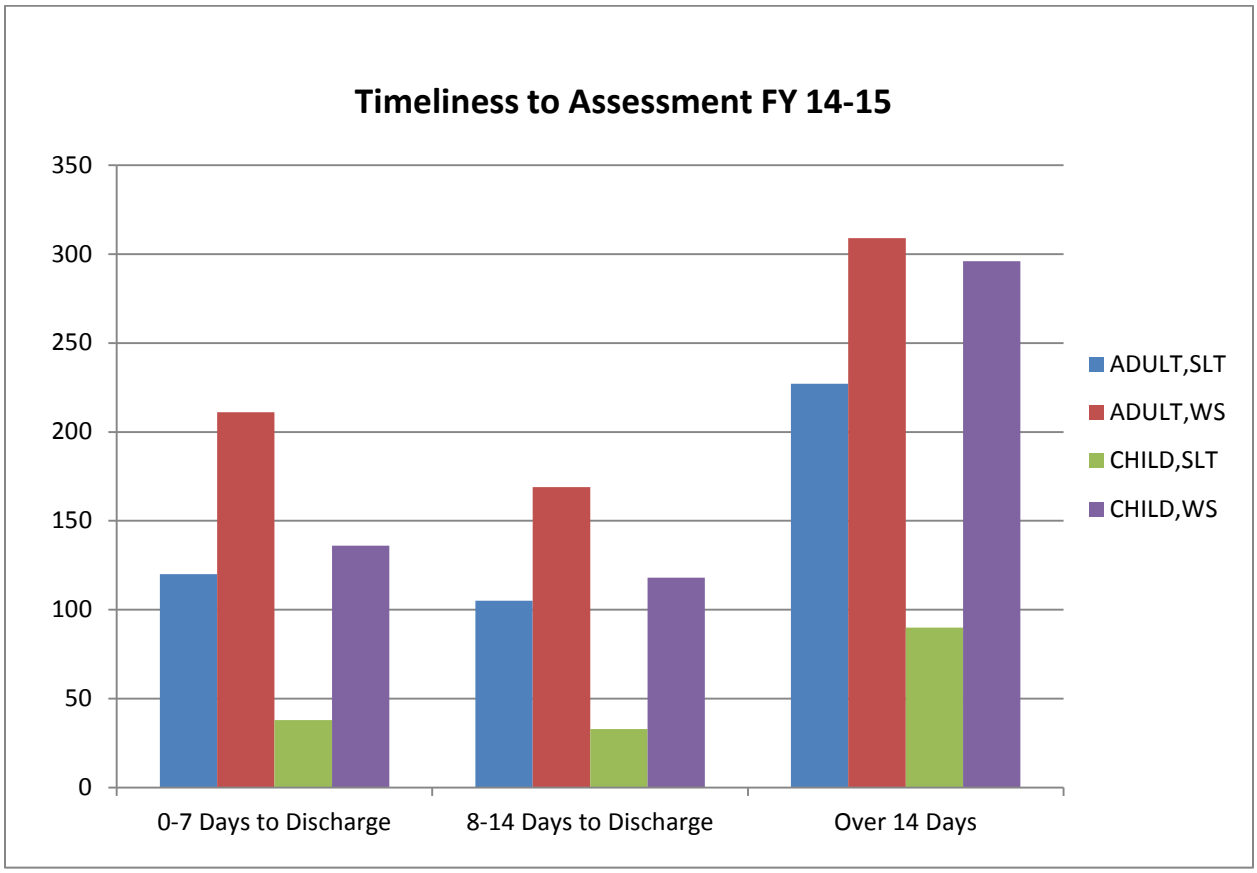
ADULTS	**FY 2013-14**			**FY 2014-15**		
Results (Discharge from "Pre-Admit" Status)	**South Lake Tahoe**	**West Slope**	**Total**	**South Lake Tahoe**	**West Slope**	**Total**
Opened to Outpatient MHD	129	158	287	97	134	231
Referred to Other Provider	8	44	52	12	24	36
Does not meet Medical Necessity	94	263	357	159	359	518
Other	94	171	265	124	232	356
Total	325	636	961	392	749	1,141

Category	**FY 2013-14**			**FY 2014-15**		
	South Lake Tahoe	**West Slope**	**Total**	**South Lake Tahoe**	**West Slope**	**Total**
Children	132	339	471	161	550	711
Adults	325	636	961	452	689	1,141
Total Requests	457	975	1,432	613	1,239	1,852

[3] For purposes of these two charts, "West Slope" also includes requests from individual reflecting an out-of-County mailing address.
[4] Referred to Primary Care, Managed Care Plan or referred to other community-based services.
[5] Assessment was not completed due to reasons such as individual incarcerated, moved out of county, cancelled, did not show up for appointment, could not be contacted or transferred to Psychiatric Emergency Services staff.

Measurement 2: Wellness Center Attendance – *It has been determined that it is not possible to obtain the data on all referrals to the Wellness Centers as individuals may not sign in and attendance at the Wellness Center is not captured in the electronic medical record unless an individual attends a group.*

NEW in FY 2014-15 -- Measurement 2: Timeliness to Assessment – *The timeliness to assessment identifies how quickly individuals requesting services are assessed for eligibility for Specialty Mental Health Services. The MHD strives for a 14 day turnaround of requests for services.*



The MHD continues to explore processes to streamline requests for services to facilitate appropriate service engagement in the shortest amount of time, whether those services are from a Specialty Mental Health Services provider or through the Managed Care Plans.

Once it has been determined whether or not an individual meets medical necessity, the MHD's Access Team will either open an individual to Outpatient Mental Health services or provide "resourcing", which includes referrals to Primary Care, Managed Care Plans and/or community-based organizations as needed to address an individual's needs.

Project 4b: Community-Based Mental Health Services:

This project provides assessments and specialty mental health services in local communities. Clinical staff will visit local communities to provide mental health services to clients.

The Community-Based Mental Health Services project provided services to approximately 67 unduplicated individuals in FY 2014-15. The total expenditures were approximately $165,528 with an approximate cost per participant of $2,471.

In FY 2014-15 the Community-Based Mental Health Services project served:

Age Group	Number
0-15 (children/youth)	0
16-25 (transitional age youth)	11
26-59 (adult)	54
Ages 60+ (older adults)	2
Unknown or declined to state	0

Gender	Number
Female	14
Male	53

Region of Residence	Number
West County	17
Placerville area	30
North County	4
Mid County	11
South County	2
Tahoe Basin	1
Unknown or declined to state	2

Race / Ethnicity	Number
American Indian or Alaska Native	1
Asian	0
Black or African American	3
Caucasian or White	56
Native Hawaiian or Other Pacific Islander	0
Other Race or Ethnicity	3
Unknown or declined to state	4
Ethnicity:	
Mexican/Mexican American	2
Puerto Rican	0
Other Hispanic/Latino	1
Not Hispanic	57
Unknown or declined to state	7

Language	Number
English	61
Spanish	0
Other Language	1
Bilingual	Unknown
Unknown or declined to state	5

Outcome Measures:

Program Status – FY 2014-15 Participants	Number
Unique Clients	67
Total Episodes	69
AB109 Episode Closed in FY 2014-15	52
AB109 Episode Closed in FY 2015-16	13
Still Open as of 4-1-16	4
Of the Episodes Closed:	
Increased Services During FY 2014-15	1
Decreased Services During FY 2014-15	1

Measurement 1: Continued engagement in mental health services – *There were 67 unique individuals engaged in AB109 services at any point of time in FY 2014-15, with two individuals having*

been engaged in AB109 at two separate times during the year. Of those 67 adults, the average length of stay in the episode was 188 days, ranging from 9 days to 629 days with a median of 173 days. Of the AB109 episodes that were opened during FY 2014-15, 1 was a result of a client moving to a lower level of service into the AB109 program.

Measurement 2: Days of homelessness, institutionalization, hospitalization, and incarceration – *This data is not yet available for clients served through this project.*

Measurement 3: Linkage with primary health care – *This data is not yet available.*

Measurement 4: Levels of Care Utilization System (LOCUS)/CALOCUS – *This data is not yet available for participants in this project.*

Measurement 5: Outcome measurement tools (e.g., CANS) – No children/youth were served through this project which would necessitate use of the CANS. The ANSA, the assessment for adults, has not been implemented in the electronic medical record. It is anticipated that this data will be available in future MHSA Plans / Plan Updates.

Project 4c: Resource Management Services:

This project develops key community relationships, provides program evaluation and quality improvement oversight for the MHSA programs, and improves access and service delivery.

Outcome Measures:

Measurement 1: Update and expansion of resource list; dissemination of information to clients – *MHD managers meet with health care providers and Managed Care Plans on a regular basis to disseminate information, including the Community Health Center, Marshall Medical Center, Barton Health, California Health and Wellness, Shingle Springs Health and Wellness Center, California Health and Wellness, and other task forces and cooperatives. Additionally, the MHD hired a "Resource Specialist" in FY 2014-15 whose primary focus is identifying community resources for the benefit of clients, and includes assisting clients directly with identifying housing opportunities and other resource needs. The MHD has also developed a Resource List that clients and community members can keep in their wallet. The Resource List contains phone numbers to various community services, such as mental health, police, health centers, crisis/emergency lines, food closets, clothing closets, alcohol and drug programs, and advocacy services.*

Measurement 2: Client wait times – *The MHD recognizes the importance of clients being able to see a psychiatrist for an evaluation in a timely manner. The MHD implemented a program improvement project to help improve wait times. A new No-Show Policy became effective in May 2015, which provides clients and staff with a procedure for what occurs when a client misses an appointment with the psychiatrist. Steps include the client speaking with their Clinician, meeting with their Clinician and seeing the doctor on a "wait list" basis.*

For purposes of reporting, a "psychiatric evaluation" appointment is any appointment with a psychiatrist that is scheduled for 60 minutes or more. Follow-up psychiatric appointments are generally scheduled for 30 to 45 minutes in duration.

Clients may request a single appointment at a future date (such as the psychiatrist wanting to see the client in eight weeks), or schedule multiple appointments over several months from a single request. This long-term planning on behalf of clients tends to skew the timeliness data, however the practice is encouraged so that clients become familiar with how to manage their doctor appointments.

Of the 564 appointments in FY 2014-15 that were considered a psychiatric evaluation, 11 of those dates appear to have data anomalies resulting from appointments being selected for a date in the past. Those 11 dates have been removed from the sample below.

Days to Appointment	Number of Appointments	Percent of Total
0	113	20%
1-7	114	21%
8-14	97	18%
15-21	77	14%
22-30	45	8%
31+	107	19%
Total	553	100%

The MHD continues to explores ways in which it can separate new requests versus re-occurring requests for psychiatric appointments.

Measurement 3: Client satisfaction surveys – *In May 2015, client satisfaction surveys were administered and received from 87 clients and families. Out of 87 participants, over 88% indicated that they agreed or strongly agreed that they were happy with of liked the level of mental health services received.*

Measurement 4: Establishment of standard evaluation process for MHSA programs and dissemination of information – *The MHD continues to work on a standard evaluation process.*

Measurement 5: Results of EQRO annual review – *The 2015 EQRO identified the following four recommendations:*

1. *Investigate the feasibility to expand Wellness Center hours. Both Centers currently are open from 1:00 – 4:00 p.m. work days. (Access, Wellness & Recovery)*

   MHD Activities: The MHD has continued to review the viability of this recommendation, with considerations such as other community-based service availability, Wellness Center access for client populations with different needs (e.g., TAY, Conservatees, adult Wellness clients), available staffing, available funding, and MHD service array.

   The Wellness Center Program is one of the identified items in the MHD's 2016 Areas of Focus under the Treatment/Program Design category, which will allow the MHD to engage in a focused planning effort to identify diverse client needs and feasibility of this recommendation.

2. *Develop Avatar training program for new employees as well as refresher classes for current employees to review recent Avatar software enhancements. Schedule trainings on a regular basis. Also, explore feasibility of internal online training courses for employees. (Information Systems, Staff Training)*

   MHD Activities: The MHD is evaluating web-based services to allow online training courses, however the MHD conducted 17 in-person trainings during the period of April 2015 - February 2016. Additionally, the MHD has identified "Staff Training and Development" as one of its Areas of Focus in 2016. Through this initiative, the MHD will establish a schedule of Avatar trainings for new and existing staff.

3. *Implement processes that measures both access and timeliness to psychiatry services. Track and trend average wait times and no show appointments and compare those results to period July-December 2014 with the goal to improve upon 17 days wait time and 37% no show appointments. Periodically publish results to inform stakeholders, providers, and the community. (Access, Timeliness, Use of Data)*

   MHD Activities: The MHD has been tracking psychiatry wait times. The average wait time for psychiatric appointments was 16 in FY 2014-15, which includes appointments that were purposefully scheduled at a future date (e.g., six or eight weeks in the future). The MHD continues to explores ways in which it can separate new requests versus re-occurring requests for psychiatric appointments.

4. *Prioritize the development, recruitment, and filling of at least two paid peer positions to lead the two Wellness Centers. Emphasize and recognize the lived experience existing staff bring to the table. Create and publicize more volunteer opportunities for CFMs system wide. (Quality of Care, Consumer Employment)*

   MHD Activities: The MHD recognizes the value of peer positions in providing services to its clients. In the past year, there have been no candidates for employment that have self-identified as having lived experience with mental illness. However, the peer program in the Wellness Centers is expanding and will be a subject of the MHD's 2016 Areas of Focus under the Treatment/Program Design category.

HOUSING PROJECTS

Consumers, family members and service providers in El Dorado County have consistently identified housing needs of the seriously mentally ill as a priority. The MHSA Housing Program provides funding for the development, acquisition, construction and/or rehabilitation of permanent supportive housing for persons with serious mental illness and their families who are homeless or at risk of homelessness. The housing program offers consumers housing and supportive services that will enable them to live more independently in our communities.

Program 1: West Slope – Trailside Terrace, Shingle Springs:
MHSA Housing funds were utilized to provide for five units in Shingle Springs targeting households that are eligible for services under the Full Service Partnership project. All units are occupied and the MHD maintains a waiting list.

Program 2: East Slope – The Aspens at South Lake, South Lake Tahoe:
MHSA Housing funds were utilized to provide for six units in South Lake Tahoe targeting households that are eligible for services under the Full Service Partnership project. All units are occupied and the MHD maintains a waiting list.

Program 3: Local Housing Assistance:
These CSS-Housing funds must be utilized to provide housing assistance to those with a serious mental illness who are homeless or soon-to-be-homeless, and include costs such as rental assistance, security deposits, utility deposits, other move-in costs, and/or moving costs.

Workforce Education and Training (WET) Programs and Projects

Program 1: Workforce Education and Training (WET) Coordinator:
This program, required by the MHSA, coordinates WET programs and activities and serves as the liaison to the State. Total expenditures for the WET Coordinator in FY 2014-15 were approximately $8,767.

Outcome Measures:
Measurement 1: Increase the number of training opportunities for the mental health workforce - *The WET Coordinator has signed up for a variety of distribution lists to be notified of upcoming trainings. Information about upcoming trainings applicable to mental health is distributed to managers and supervisors, and when possible, to the MHSA email distribution list.*

Program 2: Workforce Development:
This program includes education and training programs and activities for prospective and current public mental health system employees, contractors and volunteers. Total expenditures for the Workforce Development program in FY 2014-15 were approximately $39,068.

Outcome Measures:
Measurement 1: Increase the number of training opportunities for the public mental health system workforce, including staff, contractors, volunteers and consumers - *Training opportunities are distributed via email to appropriate supervisors and managers within HHSA, and to the public via directed emails or the MHSA email distribution list.*

Measurement 2: Increased number of bilingual / bicultural public mental health workforce system staff in the County - *There has been no new bilingual/bicultural staff hired in FY 2014-15*.

Program 6: Consumer Leadership Academy:
This program provides educational opportunities to inform and empower consumers to become involved in meaningful participation in the broader community. The academy includes peer-training, peer supportive skills training, job skill training, and training related to consumer leadership in the community. Total expenditures for the Consumer Leadership Academy program in FY 2014-15 were approximately $320, which is for program supports only. Staff time is charged to CSS.

Outcome Measures:
Measurement 1: Number of graduates of the consumer leadership academy - *During FY 2014-15, there was one Academy held with six graduates.*

Measurement 2: Number of organizations identified for employment and/or volunteer opportunities - *The Academy works with the local Connections One-Stop and the Workforce Innovation and Opportunity Act (WIOA) programs.*

Measurement 3: Number of consumers who receive employment and/or volunteer opportunities after completion of the Consumer Leadership Academy and duration of their employment and/or volunteer

position - *This data is not yet known. There have been at least five consumers working with Connections One-Stop.*

Program 7: Crisis Intervention Team Training:

This program provides crisis intervention training workshops for law enforcement and other first responders to provide increased knowledge of available community resources, tools and skills to manage and de-escalate crisis situations.

Outcome Measures:

Measurement 1: Reduction in negative outcomes between law enforcement and individuals with a mental illness

Measurement 2: Increase in respectful treatment of individuals with a mental illness

Measurement 3: From course surveys, gauge the knowledge gained by the participants

No MHSA funding was utilized for Crisis Intervention Team Training in FY 2014-15. Outcomes for this project will be reported in the FY 2017-18 MHSA Plan.

Capital Facilities and Technological Needs (CFTN) Programs and Projects

Program 1: Electronic Health Record System Implementation, Project 1a: Avatar Clinical Workstation

The implementation of the County's Electronic Health Record system, Avatar Clinical Workstation, enables Mental Health staff to safely and securely access a client's medical record. The use of electronic mental health records enhances communication between treating health care professionals, thus promoting coordination of mental and physical health care needs. Total expenditures for the Avatar Clinical Workstation Project in FY 2014-15 were approximately $55,684.

Outcome Measures:

Measurement 1: Implementation of EHR throughout the MHD. – *Completed May 2013.*

Measurement 2: Ability to provide centralized, electronic appointment scheduling. – *Completed May 2013.*

Measurement 3: Updated and standardized business procedures and assessments, resulting in practices that are more efficient. – *Ongoing.*

Measurement 4: Improved reporting capabilities (to audit charts and provide information relevant to program development). – *Ongoing.*

Measurement 5: Successful maintenance of the EHR and continued training. – *Ongoing.*

Program 2: Telehealth

This project provides for the expansion of psychiatric services to clients who are either unable to travel or who live in remote areas of the County and utilize video conferencing to further

the public mental health system within El Dorado County. Total expenditures for the Telehealth program in FY 2014-15 were approximately $25,702.

Outcome Measures:

Measurement 1: Increase the number of clients served in remote areas of the County through use of telemedicine.

Measurement 2: Utilization of the video conference equipment for general system development and health practice training.

Video-conferencing equipment has been fully installed at both the South Lake Tahoe Outpatient Clinic and the West Slope Outpatient Clinic in Diamond Springs.

Attachment B
FY 2016-17
MHSA Funding Summary and Expenditure Plan

FY 2016-17 Budget and Expenditure Plan

MHSA Funding

The revenue and expenditure data contained in this Plan is based upon the FY 2016-17 HHSA budget. In the event the actual revenues are higher than anticipated, the additional funding may be utilized to support the projects identified in this Plan Update or rolled into the FY 2016-17 fund balance to be utilized on projects identified in the FY 2017-18 Plan. In the event the actual revenues are lower than anticipated, the County will access fund balances remaining from previous years at a higher than anticipated rate and/or reduce funding levels.

Based on current projections, there are sufficient revenues and fund balance for all planned expenditures for the next three fiscal years. Further adjustments to the budget may be necessary due to changing revenues or projected County expenditures.

Annual Revenues

MHSA funds are based on a one percent (1%) tax on personal income in excess of $1,000,000, and the amount received by the County varies each month and each year based upon the tax revenues received by the State.

Fiscal Year	Projected MHSA Revenue	Actual Revenues[6]
FY 2012-13	$5,389,559	$6,465,198
FY 2013-14	$6,025,786	$5,025,862
FY 2014-15	$6,869,250	$7,035,053
FY 2015-16	$6,069,917	$TBD
FY 2016-17	$8,271,319	$TBD
FY 2017-18	$8,804,926	$TBD
FY 2018-19	$8,600,036	$TBD

Fund Balances

In addition to the FY 2016-17 revenues, the El Dorado County MHSA programs maintain fund balances accrued from previous fiscal years that may be accessed during the term of this Plan. There is a planned usage of fund balances for each component.

[6] Based on data from the California State Controller's Office "Monthly Mental Health Service Fund" reports for each fiscal year.

FY 2016-17 Budgeted Revenues and Expenditures by Component

	CSS	PEI	WET	INN	CFTN	CSS Housing	TOTAL
Prop 63	$6,286,202	$1,571,551		$413,566			**$8,271,319**
Federal: PATH and MHBG	$372,590						**$372,590**
Medi-Cal	$2,643,310						**$2,643,310**
Private Insurance	$3,400						**$3,400**
Private Payors	$5,000						**$5,000**
Misc. Revenue (rental reimbursements)	$134,400						**$134,400**
AB 109 / AOT (Community Corrections Partnership)	$153,844						**$153,844**
Fund Balance	$4,195,049	$1,928,936	$52,163	$1,364,701	$250,022	$11,858	**$7,802,729**
Total Revenues Budgeted	**$13,793,795**	**$3,500,487**	**$52,163**	**$1,778,267**	**$250,022**	**$11,858**	**$19,386,592**
FY 2016-17 MHSA Plan Expenditures	$10,742,986	$1,688,900	$52,163	$1,021,000	$235,186	$11,858	**$13,752,093**
Estimated Fund Balance 7/1/17	*$3,050,809*	*$1,811,587*	*$0*	*$757,267*	*$14,836*	*$0*	***$5,634,499***

Prudent Reserve

The County is required to maintain a Prudent Reserve of MHSA funding to provide MHSA services during years in which MHSA revenues fall below recent averages and in which the MHSA allocations are insufficient to continue to serve the same number of individuals as the County had been serving in the previous fiscal year. Previously, legislation required counties to maintain a prudent reserve totaling 50% of the total CSS allocation; however, this requirement was recently eliminated and the amount of the prudent reserve is determined by each county. The balance of the County's Prudent Reserve is $1,898,284. No funds will be transferred into the Prudent Reserve in FY 2015-16, and therefore the balance will remain at $1,898,284. All references in this Plan to "fund balance" exclude the Prudent Reserve.

Transfer of Funds Between Components

Welfare and Institutions Code (WIC) §5892(b) allows counties to use a portion of their CSS funds for WET, CFTN, and the Prudent Reserve. The total amount of CSS funding used for this purpose may not exceed 20% of the total average amount of funds allocated to that County for the previous five years. No CSS funds were shifted into WET or CFTN in FY 2015-16.

Reversion

Unspent MHSA funding may be carried forward as a fund balance to the next fiscal year for a limited duration of time. Funds that are not used within the reversion period must be returned to the State. CSS, PEI and INN funds will revert to the State if they are not utilized within three years. WET and CFTN funds that are not fully expended within 10 years from the year of allocation will revert to the State.

Rolling of Project Budgets

Recognizing that new projects may take time to become fully established and may have higher costs within the first year of operation, funds allocated but unspent in first year of operations for any new projects will roll from the first full or partial year of operations into second year of operations. Starting in the third year of operations, projects will maintain an annual budget amount without any rollover.

MHSA Component Funding

PEI Budget

Of the total MHSA funding received by the County, a net 19% must be allocated to PEI per the MHSA. PEI funds must be expended within three years or the funds are subject to reversion to the State. It is not anticipated that any PEI funding will revert to the State in FY 2016-17.

SIGNIFICANT PEI BUDGET CHANGES:

Based upon the feedback received from the FY 2016-17 Community Planning Process and the demand for services for children, this MHSA Plan Update increases the budgets for both Project 1a and Project 1d. These projects have consistently utilized their funding, have had excellent outcomes, and have demonstrated need and capacity to provide more services. Other projects have been adjusted based on MHD staffing costs.

Prevention and Early Intervention (PEI) Budget

Program/Project	*FY 15-16 MHSA Plan Budget*	FY 16-17 MHSA Plan Budget	FY 17-18 MHSA Plan Budget	FY 18-19 MHSA Plan Budget
Program 1: Youth and Children's Services				
Project 1a: Children 0-5 and Their Families				
Provider: Infant-Parent Center	*$125,000*	$175,000	$175,000	$175,000
Project 1b: Mentoring for 3-5 Year Olds				
Provider: Big Brothers Big Sisters - West Slope	*$50,000*	$50,000	$50,000	$50,000
Provider: Big Brothers Big Sisters - South Lake Tahoe	*$25,000*	$25,000	$25,000	$25,000
Project 1c: Parenting Skills				
Provider: New Morning Youth and Family Services	*$50,000*	$50,000	$50,000	$50,000

Program/Project		FY 15-16 MHSA Plan Budget	FY 16-17 MHSA Plan Budget	FY 17-18 MHSA Plan Budget	FY 18-19 MHSA Plan Budget
	Project 1d: Primary Intervention Project (PIP)				
Provider: Black Oak Unified School District		*$212,700 (for all three providers)*	$88,000	$88,000	$88,000
Provider: El Dorado Community Vision Coalition			$90,000	$90,000	$90,000
Provider: Tahoe Youth & Family Services			$97,000	$97,000	$97,000
	Project 1f: Prevention and Early Intervention for Youth in Schools				
Provider: Minds Moving Forward		*$150,000*	$150,000	$150,000	$150,000
	Project 1g: Nurtured Heart Approach				
Provider: Summitview Child & Family Services		*$19,500*	$19,500	TBD	TBD
Program 2: Community Education Project					
	Project 2a: Mental Health First Aid				
Provider: Mental Health Division		*$100,000*	$117,000	$117,000	$117,000
	Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education				
Provider: Mental Health Division		*$5,000*	$5,000	$5,000	$5,000
	Project 2d: Community Information Access				
Provider: Relias Learning		*$16,000*	$16,000	$16,000	$16,000
	Project 2e: Suicide Prevention and Stigma Reduction				
Provider: Tahoe Youth & Family Services		*$30,000*	$30,000	$30,000	$30,000
	Project 2f: Foster Care Continuum Training				
Provider: To Be Determined via a Request for Proposal		*$50,000*	$50,000	$50,000	$50,000
	Project 2g: Community Outreach and Resources				
Provider: Mental Health Division		*$31,125*	$15,000	$15,000	$15,000
	Project 2h: Statewide PEI Projects				
Provider: CalMHSA		*$9,471*	$9,500	$9,500	$9,500

Program/Project		FY 15-16 MHSA Plan Budget	FY 16-17 MHSA Plan Budget	FY 17-18 MHSA Plan Budget	FY 18-19 MHSA Plan Budget
Program 3: Health Disparities Program					
	Project 3a: Wennem Wadati - A Native Path to Healing				
Provider:	*Foothill Indian Education Alliance*	*$125,725*	$125,750	$125,750	$125,750
	Project 3b: Latino Outreach				
Provider:	*New Morning Youth and Family Services*	*$231,128 (for both providers)*	$96,000	$96,000	$96,000
Provider:	*South Lake Tahoe Family Resource Center*		$135,150	$135,150	$135,150
Program 4: Wellness Outreach Program for Vulnerable Adults					
	Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness				
Provider:	*Mental Health Division*	*$50,000*	$40,000	$40,000	$40,000
	Project 4b: Senior Peer Counseling				
Provider:	*Senior Peer Counseling /Fiscal Agent EDCA Lifeskills*	*$65,000 (includes rollover from prior year)*	$55,000	$55,000	$55,000
	Project 4c: Older Adult Program				
Provider:	*To Be Determined via a Request for Proposal*	*$85,000*	$90,000	$90,000	$90,000
Program 5: Community-Based Services					
	Project 5a: Community-Based Mental Health Services				
Provider:	*Mental Health Division*	*$10,000*	$10,000	$10,000	$10,000
	Project 5b: Community Health Outreach Worker				
Provider:	*To Be Determined via a Request for Proposal*	*$50,000*	$50,000	$50,000	$50,000
Administrative Costs					
	MHSA Team	*$250,000*	$100,000	$100,000	$100,000
Total Budget PEI Programs		***$1,865,649***	**$1,688,900**	**$1,669,400**	**$1,669,400**

CSS Budget

Of the total MHSA funding received by the County, a net 76% must be allocated to CSS per the MHSA. CSS funds must be expended within three years or the funds are subject to reversion to the State. It is not anticipated that any CSS funding will revert to the State in FY 2016-17.

SIGNIFICANT CSS BUDGET CHANGES:

Based upon the feedback received from the FY 2016-17 Community Planning Process and the demand for services for children and TAY, this MHSA Plan Update increases the budgets for Project 1a: Youth and Family Full Service Partnership, Project 1c: Foster Care Enhanced Services, and Project 3a: TAY Engagement, Wellness and Recovery Services. There is also an increase in the budget for Project 2b: Adult Full Service Partnership based on prior year demand for services. Other projects have been adjusted based on prior year-end expenditures and MHD staffing costs.

Community Services and Supports (CSS) Budget

Program/Project		*FY 15-16 MHSA Plan Budget*	FY 16-17 MHSA Plan Budget	FY 17-18 MHSA Plan Budget	FY 18-19 MHSA Plan Budget
Program 1: Youth and Family Strengthening Program					
Project 1a: Youth and Family Full Service Partnership					
Provider: New Morning Youth & Family Services		*$375,000 (split between Sierra Child & Family and Summitview Child & Family)*	$23,958	$23,958	$23,958
Provider: Remi Vista			$23,958	$23,958	$23,958
Provider: Sierra Child & Family Services			$335,417	$335,417	$335,417
Provider: Stanford Youth Solutions			$75,000	$75,000	$75,000
Provider: Summitview Child & Family Services			$167,708	$167,708	$167,708
Provider: Tahoe Youth & Family Services			$23,959	$23,959	$23,959
Project 1c: Foster Care Enhanced Services					

Program/Project		FY 15-16 MHSA Plan Budget	FY 16-17 MHSA Plan Budget	FY 17-18 MHSA Plan Budget	FY 18-19 MHSA Plan Budget
	Provider: New Morning Youth & Family Services	*$755,700 (split between Sierra Child & Family and Summitview Child & Family)*	$24,793	$24,793	$24,793
	Provider: Remi Vista		$24,793	$24,793	$24,793
	Provider: Sierra Child & Family Services		$595,040	$595,040	$595,040
	Provider: Stanford Youth Solutions		$75,000	$75,000	$75,000
	Provider: Summitview Child & Family Services		$446,280	$446,280	$446,280
	Provider: Tahoe Youth & Family Services		$24,793	$24,793	$24,793
	Provider: CASA El Dorado		$20,000	$20,000	$20,000
	Program 2: Wellness and Recovery Services				
Project 2a: Wellness Centers		*$2,500,000*	$2,045,874	$2,045,874	$2,045,874
	Project 2b: Adult Full Service Partnership				
	Provider: Mental Health Division	*$4,050,000 (includes MHD and ARF)*	$3,854,536	$3,854,536	$3,854,536
	Provider - Adult Residential Facility: Summitview Child & Family Services		$711,724	$711,724	$711,724
Project 2d: Assisted Outpatient Treatment		*$100,000*	$200,000	$200,000	$200,000
	Program 3: Transitional Age Youth (TAY) Services				
Project 3a: TAY Engagement, Wellness and Recovery Services		*$464,498*	$714,707	$714,707	$714,707
	Program 4: Community System of Care				
Project 4a: Outreach and Engagement Services		*$803,543*	$802,578	$802,578	$802,578
Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services)		*$206,840*	$230,761	$230,761	$230,761
Project 4c: Resource Management Services		*$75,000*	$107,000	$107,000	$107,000
	Administrative Costs				
	MHSA Team	*$245,000*	$215,107	$215,107	$215,107
Total Budget CSS Programs		***$9,575,581***	**$10,742,986**	**$10,742,986**	**$10,742,986**

WET Budget

MHSA no longer provides funding for WET activities. The County has been operating this program through funds previously received and remaining as a fund balance. WET funds that are not expended are subject to reversion after FY 2017-18. The remaining WET fund balance has been budget for FY 2016-17. Any unspent funds from FY 2016-17, if any, will be budgeted in FY 2017-18. It is not anticipated that El Dorado County will transfer CSS funds to the WET component in the future.

Workforce Education and Training (WET) Budget

Program/Project	*FY 15-16 MHSA Plan Budget*	FY 16-17 MHSA Plan Budget	FY 17-18 MHSA Plan Budget	FY 18-19 MHSA Plan Budget
Program 1: Workforce Education and Training (WET) Coordinator *Provider: Mental Health Division*	*$11,000*	$21,300	TBD	TBD
Program 2: Workforce Development *Providers: Various*	*$40,000*	$12,000	TBD	TBD
Program 6: Consumer Leadership Academy *Provider: Mental Health Division*	*$1,000*	$1,000	TBD	TBD
Program 7: Crisis Intervention Team Training *Provider: To Be Determined by Law Enforcement Agency*	*$10,000*	$10,000	TBD	TBD
Administrative Costs - MHSA Team	*$16,000*	$7,863	TBD	TBD
Total Budget WET Programs	***$78,000***	**$52,163**	**$TBD**	**$TBD**

CFTN Budget

MHSA no longer provides funding for CFTN activities. The County has been operating this program through funds previously received and remaining as a fund balance. CFTN funds that are not expended are subject to reversion after FY 2017-18. The remaining CFTN fund balance has been budgeted for FY 2016-17. Any unspent funds from FY 2016-17, if any, will be budgeted in FY 2017-18. It is not anticipated that El Dorado County will transfer CSS funds to the CFTN component in the future.

Capital Facilities and Technological Needs (CFTN) Budget

Program/Project	*FY 15-16 MHSA Plan Budget*	FY 16-17 MHSA Plan Budget	FY 17-18 MHSA Plan Budget	FY 18-19 MHSA Plan Budget
Program 1: Electronic Health Record System Implementation				
Project 1a: Avatar Clinical Workstation *Provider: Netsmart (for Avatar)* *TBD for Other Software*	*$150,686*	$213,186	$14,836	TBD
Program 2: Telehealth (*Provider: TBD As Needed)*	*$10,000*	$20,000	TBD	TBD
Administrative Costs - MHSA Team	*$5,000*	$2,000	TBD	TBD
Total Budget CFTN Programs	***$165,686***	**$235,186**	**$14,836**	**$TBD**

INN Budget
Of the total MHSA funding received by the County for CSS and PEI, five percent (5%) of the funding is allocated to Innovation.

Innovation (INN) Budget

Program/Project	*FY 15-16 MHSA Plan Budget*	FY 16-17 MHSA Plan Budget	FY 17-18 MHSA Plan Budget	FY 18-19 MHSA Plan Budget
Project 1: Restoration of Competency in an Outpatient Setting	*n/a*	$355,000	$373,000	n/a
Project 2: Community-Based Engagement and Support System	*n/a*	$641,000	$673,000	$706,000
Administrative Costs - MHSA Team	*n/a*	$25,000	$25,000	$25,000
Total Budget INN Programs	***n/a***	**$1,021,000**	**$1,071,000**	**$731,000**

State Form

Fiscal Year 2016/17 Mental Health Services Act Annual Update Instructions

General: Round all amounts to the nearest whole dollar.

Heading: Enter the County name and the date the worksheet is completed.

Component Worksheets:

General: Each individual component worksheet has a section for fiscal year (FY) 2016/17.
Column A represents the total estimated program expenditures for each program and represents the sum of the funding sources for the program. Counties should do their best to estimate the funding from the sources identified so as to reflect the estimated expenditures of the entire program.

Definitions:

Medi-Cal Federal Financial Participation (FFP) represents the estimated Medi-Cal FFP to be received by the program based on Medi-Cal Certified Public Expenditures (CPE) incurred by the County.

1991 Realignment represents the estimated 1991 Realignment to be used to fund the program.

Behavioral Health Subaccount represents the estimated funding from the Behavioral Health Subaccount used to fund the program. This would generally represent some of the matching funds for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) programs.

Estimated Other Funding represents the any other funds used to fund the program, which could include, but is not limited to, County General Fund, grants, patient fees, insurance, Medicare.

Community Services and Supports Worksheet:

The County should identify Community Services and Support (CSS) programs as either those with Full Service Partnership (FSP) expenditures and those without FSP expenditures (i.e., any program with a FSP expenditure would be reported under the FSP program section). Enter the program names on a line in the appropriate section. The line number does not need to correlate with the program number.

Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.

Enter the estimated funding for CSS Administration in columns B through F. Total estimated CSS Administration is automatically calculated as the sum of columns B through F.

Enter the estimated funding for CSS MHSA Assigned Housing Funding in columns B through F. Total estimated CSS MHSA Assigned Housing Funding is automatically calculated as the sum of columns B through F.

Total CSS estimated expenditures and funding is automatically calculated.

FSP Programs as a percent of total is automatically calculated as the sum of total estimated FSP program expenditures divided by the sum of CSS funding. Counties are required to direct a majority of CSS funding to FSP pursuant to California Code of Regulations Section 3620.

Prevention and Early Intervention Worksheet:

The County should identify Prevention and Early Intervention (PEI) programs as either those focused on prevention or those focused on early intervention. Enter the PEI program names on a line in the appropriate section. The line number does not need to correlate with the program number.

Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.

Enter the estimated funding for PEI Administration in columns B through F. Total estimated PEI Administration is automatically calculated as the sum of columns B through F.

Enter the estimated funding for PEI Assigned Funds in columns B through F. PEI Assigned Funds represent funds voluntarily assigned by the County to California Mental Health Serivces Authority (CalMHSA) or any other organization in which counties are acting jointly. Total estimated PEI Assigned Funds is automatically calculated as the sum of columns B through F.

Total PEI estimated expenditures and funding is automatically calculated.

Innovations Worksheet:

The County should enter the Innovation (INN) program names on a line in the appropriate section. The line number does not need to correlate with the program number.

Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.

Enter the estimated funding for INN Administration in columns B through F. Total estimated INN Administration is automatically calculated as the sum of columns B through F.

Total INN estimated expenditures and funding is automatically calculated.

Workforce, Education and Training Worksheet:

The County should enter the Workforce, Education, and Training (WET) program names on a line in the appropriate section. The line number does not need to correlate with the program number.

Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.

Enter the estimated funding for WET Administration in columns B through F. Total estimated WET Administration is automatically calculated as the sum of columns B through F.

Total WET estimated expenditures and funding is automatically calculated.

Capital Facilities/Technological Needs Worksheet:

The County should identify Capital Facilities/Technological Needs (CFTN) projects as either capital facilities projects or technological needs projects. Enter the CFTN program names on a line in the appropriate section. The line number does not need to correlate with the program number.

Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.

Enter the estimated funding for CFTN Administration in columns B through F. Total estimated CFTN Administration is automatically calculated as the sum of columns B through F.

Total CFTN estimated expenditures and funding is automatically calculated.

Funding Summary Worksheet:

General: The County should report estimated available funding and expenditures for FY 2015/16 by each component. The estimated unspent funds are automatically calculated. The County should use available forecasts of estimated Mental Health Services Act (MHSA) funding to try and determine new available MHSA funding for FY 2015/16.

Sections A, C and E

Line 1 Enter the estimated available funding from the prior fiscal years for FY 2016/17 in Section A.

Line 2 Enter the estimated new funding for FY 2016/17 for each component. The County should reduce the amount of estimated distributions by any estimated prior year reverted funding assuming the reverted funds will be offset against new distributions.

Line 3 Enter the amount of funds requested to be transferred from CSS to CFTN, WET and/or the Local Prudent Reserve. Funds requested to be transferred to CFTN, WET and/or the Local Prudent Reserve will be subtracted from the Estimated Available CSS Funding and the amount is automatically calculated in Column A (CSS). Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

Line 4 Enter the requested amount to be accessed from the Prudent Reserve for either CSS or PEI. The total is automatically summed in Column F (Prudent Reserve).

Line 5 This amount is automatically calculated and represents the estimated available funding for each component.

Sections B, D and F

This amount is automatically transferred from the CSS, PEI, INN, WET, and CFTN worksheet.

Section G

This amount is automatically calculated and represents the difference between the estimated available funding and the estimated expenditures at the end of FY 2017/18.

Section H

Enter the estimated Local Prudent Reserve balance on June 30, 2016. The rest of the cells are automatically calculated.

FY 2016/17 Mental Health Services Act Annual Update
Funding Summary

County: El Dorado Date: 4/14/16

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	4,195,049	1,928,936	1,364,701	52,163	250,022	
2. Estimated New FY 2016/17 Funding	9,598,746	1,571,551	413,566			
3. Transfer in FY 2016/17[a/]	0			0	0	0
4. Access Local Prudent Reserve in FY 2016/17	0	0				0
5. Estimated Available Funding for FY 2016/17	13,793,795	3,500,487	1,778,267	52,163	250,022	
B. Estimated FY 2016/17 MHSA Expenditures	10,742,986	1,688,900	1,021,000	52,163	235,186	
G. Estimated FY 2016/17 Unspent Fund Balance	3,050,809	1,811,587	757,267	0	14,836	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2016	
2. Contributions to the Local Prudent Reserve in FY 2016/17	1,898,284
3. Distributions from the Local Prudent Reserve in FY 2016/17	0
4. Estimated Local Prudent Reserve Balance on June 30, 2017	1,898,284

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

FY 2016/17 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: El Dorado | Date: 4/14/16

		Fiscal Year 2016/17					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs							
1.	Program 1: Youth and Family Strengthe	1,860,699	1,304,013	552,486			4,200
2.	Program 2: Wellness and Recovery Serv	4,766,260	3,235,879	1,370,981			159,400
3.		0					
4.		0					
5.		0					
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.		0					
19.		0					
Non-FSP Programs							
1.	Program 2: Wellness and Recovery Serv	2,045,874	1,434,081	607,593			4,200
2.	Program 3: Transitional Age Youth (TAY	714,707	264,939	112,250			337,518
3.	Program 4: Community System of Care	1,140,339	976,423				163,916
4.		0					
5.		0					
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.		0					
19.		0					
CSS Administration		215,107	245,000				
CSS MHSA Housing Program Assigned Funds		11,858	11,858				
Total CSS Program Estimated Expenditures		10,754,844	7,472,193	2,643,310	0	0	669,234
FSP Programs as Percent of Total		88.7%					

FY 2016/17 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: El Dorado Date: 4/14/16

		Fiscal Year 2016/17					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention							
1.	Program 1: Youth and Children's Services	419,500	419,500				
2.	Program 2: Community Education Project	242,500	242,500				
3.	Program 3: Health Disparities Program	356,900	356,900				
4.	Program 4: Wellness Outreach Program for Vulnerable Adults	185,000	185,000				
5.	Program 5: Community-Based Services	60,000	60,000				
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
PEI Programs - Early Intervention							
11.	Program 1: Youth and Children's Services	325,000	325,000				
12.	Program 2: Community Education Project	0	0				
13.	Program 3: Health Disparities Program	0	0				
14.	Program 4: Wellness Outreach Program for Vulnerable Adults	0	0				
15.	Program 5: Community-Based Services	0	0				
16.		0					
17.		0					
18.		0					
19.		0					
20.		0					
PEI Administration		100,000	100,000				
PEI Assigned Funds		0	0				
Total PEI Program Estimated Expenditures		1,688,900	1,688,900	0	0	0	0

FY 2016/17 Mental Health Services Act Annual Update

Innovations (INN) Funding

County: El Dorado Date: 4/14/16

		Fiscal Year 2016/17					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs							
1.	Project 1: Restoration of Competency in an Outpatient Setting	355,000	355,000				
2.	Project 2: Community-Based Engagement and Support System	641,000	641,000				
3.		0					
4.		0					
5.		0					
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.		0					
19.		0					
20.		0					
INN Administration		25,000	25,000				
Total INN Program Estimated Expenditures		1,021,000	1,021,000	0	0	0	0

FY 2016/17 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: El Dorado Date: 4/14/16

		Fiscal Year 2016/17					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs							
1.	Program 1: Workforce Education and Training (WET) Coordinator	21,300	21,300				
2.	Program 2: Workforce Development	12,000	12,000				
3.	Program 6: Consumer Leadership Academy	1,000	1,000				
4.	Program 7: Crisis Intervention Team Training	10,000	10,000				
5.		0					
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.		0					
19.		0					
20.		0					
WET Administration		7,863	7,863				
Total WET Program Estimated Expenditures		52,163	52,163	0	0	0	0

FY 2016/17 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: El Dorado Date: 4/14/16

		Fiscal Year 2016/17					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects							
1.	None	0					
2.		0					
3.		0					
4.		0					
5.		0					
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
CFTN Programs - Technological Needs Projects							
11.	Program 1: Electronic Health Record System Implementation: Avatar Clinical Workstation	213,186	213,186				
12.	Program 2: Telehealth	20,000	20,000				
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.		0					
19.		0					
20.		0					
CFTN Administration		2,000	2,000				
Total CFTN Program Estimated Expenditures		235,186	235,186	0	0	0	0

Attachment C
Community Planning Process

Community Planning Process

The general public and stakeholders were invited to participate in or host MHSA planning opportunities and provide initial comment to contribute to the development of the County's FY 2016-17 MHSA Plan Update. Local organizations were invited to host a MHSA planning meeting for their staff, clients and/or members. One organization, NAMI El Dorado, hosted a community planning meeting. Four additional community planning meetings were held at the Diamond Springs and South Lake Tahoe Wellness Centers.

The community planning process for the FY 2016-17 started in the fall of 2015 so that input could be received in adequate time to be incorporated into the County's budget process for the FY 2016-17 budget. A press release was issued on September 18, 2015 regarding the MHSA public meetings, and distributed to local media contacts, including the Mountain Democrat, Tahoe Daily Tribune, El Dorado Hills Telegraph, Life Newspapers, Georgetown Gazette and Sacramento Bee, posted on the County's web page, and sent out via email to the MHSA distribution list. New this year, the public was invited to provide input via SurveyMonkey®. The survey link was posted to the County's website and sent out via email to the MHSA distribution list. Hard copy surveys were also distributed and collected from a variety of agencies and contract providers. Additionally, flyers listing the meetings were made available at various locations, such as the Mental Health Division offices, libraries, and locations where information notices are commonly shared.

Plan progress, anticipated changes, budget allocations, program planning and objectives, mental health policy, plan implementation, and outcome measures/monitoring/program evaluation and quality improvement were discussed at various points during the community planning process. MHSA updates and program planning have also taken place as part of the Mental Health Commission meetings.

In addition to the above-referenced topics, participants in the Community Planning Process were asked to submit Innovation ideas and proposals.

Informational documents and forms are available in English and in Spanish on the community planning process web page, along with information about the FY 2016-17 community planning process.

There were 28 attendees (27 unique participants) at the community planning meetings and the MHSA project team received 388 surveys (360 English and 28 Spanish). All input received was considered in the development of this Plan, whether through a formal public meeting, informal discussions, surveys, emails or other meetings.

Stakeholder Representation

The MHSA project team maintains an email distribution list for individuals who have expressed an interest in MHSA activities. Members of this distribution list include:

- adults and seniors with severe mental illness;
- families of children, adults and seniors with severe mental illness;
- providers of services;

- law enforcement agencies;
- education;
- social services agencies;
- veterans;
- representatives from veterans organizations;
- providers of alcohol and drug services;
- health care organizations; and
- other interested individuals.

During this community planning process, there were approximately 680 individuals on the email distribution list who received notifications regarding the community planning process and MHSA updates.[7] Emails regarding the community planning process were also sent to outside contract providers and all staff within HHSA. These emails were subsequently distributed through other networks to individuals and organizations on their email distribution lists.

MHSA Public Meetings

During the FY 2016-17 community planning process, both morning and evening times were offered to accommodate as many interested participants as possible. Turnout at the FY 2016-17 public meetings was lower than the last two years. The total number of unique participants at the FY 2016-17 public MHSA community planning meetings was 27, and the total attendance was 28. The MHSA project team will continue to work towards increasing participation at the public community planning meetings.

Date	Host	Location	Time	Attendees
Tuesday, 10/6/15	NAMI El Dorado	Placerville	5:30 pm	13
Thursday, 10/15/15	MHD Wellness Center	Diamond Springs	5:30 pm	3
Monday, 10/19/15	MHD Wellness Center	South Lake Tahoe	11:30 am	4
Monday, 10/19/15	MHD Wellness Center	South Lake Tahoe	5:30 pm	2
Thursday, 10/22/15	MHD Wellness Center	Diamond Springs	11:30 pm	6
			Total Attendees (Duplicated):	28
			Total Attendees (Unduplicated):	27

One-on-one meetings, small group meetings and presentations, by either the MHD or other organizations, were also held to discuss the mental health programs and needs in the community.

[7] If you wish to join the MHSA email distribution list, please send an email to MHSA@edcgov.us with the subject of "Subscribe".

Date	Host / Location	Topic
2/24/16	Mental Health Division staff 3057 Briw Road Placerville	Mental Health 101 (approximately 50 attendees from a variety of organizations)
3/8/16	Live Violence Free South Lake Tahoe High School	SafeTALK (Suicide Prevention Training)

Topics discussed at these meetings generally focused on the interests of those in attendance.

Additional Opportunities for Raising Awareness about the MHSA Community Planning Process and MHSA Plan

Throughout the year, Mental Health staff attends many other meetings not specifically related to MHSA and/or the mental health needs within our County, but which provide an opportunity to raise awareness about mental health and MHSA, discuss how to become involved in the planning process, and/or learn about the general needs of the community. Some of these meetings include:

- Chronic Disease Coalition
- Community Strengthening/Ready by 5
- Continuum of Care
- Diamond Springs/El Dorado Community Advisory Committee
- Drug Free Divide
- El Dorado County Commission on Aging
- El Dorado County Veteran Commission
- El Dorado Community Vision Coalition
- Lake Tahoe Collaborative
- Multidisciplinary Adult Services Team (MAST)

When in line with the structure of these meetings, attendees were provided with comment forms and flyers about how to become involved in the MHSA planning process.

Other Methods of Input

The public was invited to provide input through SurveyMonkey®, either online or via hard copy survey, via email or via regular mail.

SurveyMonkey® asked for basic demographic information, and included the following topics:

- Familiarity with existing MHSA-funded programs
- Innovation definition and input for ideas
- Rate groups with the highest need for mental health services
- Rate El Dorado County Mental Health
- Rate MHSA-funded programs
- Other programs or services El Dorado County Mental Health should consider funding?
- Additional comments regarding programs and services now being funded by MHSA?

Substantive Comments Received – Community Planning Process

The following issues were of primary concern to the planning participants:

- More funding for children's mental health services and school-based services
- Publish program outcomes data
- Improve the quality of mental health services
- Too many MHSA programs, need to reduce and consolidate services
- Increase mental health services for adults
- Increase outreach, engagement and early intervention
- More community collaboration
- More services for Transitional Age Youth (TAY)
- Increase General Fund contribution for mental health services

Due to an administrative error in the administration of the survey, the question regarding the rating of groups with the highest need for mental health services was not considered. Therefore, the priority populations identified in the prior year community planning process are being used. However, the comments received support the continued need for services for the following:

- School-aged children
- Older adults
- LGBTQ individuals
- TAY individuals
- Jail releases and clients on probation
- Homeless

Project-Specific Proposals Received

Other than Innovation ideas, which are detailed in MHSA Plan Update, there were no specific new proposals identified through the FY 2016-17 community planning process.

Notification of the Draft FY 2016-17 MHSA Plan

HHSA provided notification of the Draft FY 2016-17 Plan publication as follows:

- **FY 2016-17 Plan 30-Day Comment Period:** The Draft FY 2016-17 MHSA Plan Update was posted on the County's website on April 21, 2016 for a 30-day review period. Emails were sent on April 21, 2016 to the MHSA distribution list, the Mental Health Commission members, the Chief Administrative Office (CAO), the Board of Supervisors' offices, and HHSA staff advising recipients that the Draft FY 2016-17 MHSA Plan Update was posted and available for public comment for 30 days. A press release was distributed on April 21, 2016, to the Tahoe Daily Tribune, Mountain Democrat, Georgetown Gazette, Sacramento Bee, Life Newspaper (Village Life) and El Dorado Hills Telegraph. The public comment period closed on May 23, 2016 at 12:00 Noon.
- **FY 2016-17 MHSA Plan Update Public Hearing:** The Mental Health Commission held a public hearing on the Draft FY 2016-17 MHSA Plan Update on May 25, 2016. The date and

time of the meeting was noticed on the Mental Health Commission's calendar (available on the County's calendar at https://eldorado.legistar.com/Calendar.aspx), the MHSA web page (www.edcgov.us/mentalhealth/mhsa.aspx), and was sent out to the individuals on the MHSA email distribution list.

- **El Dorado County Board of Supervisors:** After the Public hearing, it is anticipated that this Plan Update will be presented to the El Dorado County Board of Supervisors for adoption on June 13, 2016. Notification of the date was posted on the MHSA web page (www.edcgov.us/mentalhealth/mhsa.aspx) and was included on the Board of Supervisors agenda. Once the El Dorado County Board of Supervisors adopts the FY 2016-17 MHSA Plan Update, all components of this plan will become effective with the exception of the Innovation Plans that must be approved by the State prior to becoming effective.
- **California Mental Health Services Oversight and Accountability Commission (MHSOAC):** Within 30 days of the Board of Supervisors' approval of the FY 2016-17 MHSA Plan, a copy of the Plan will be provided to the MHSOAC as required by the MHSA, and the Innovation Plans will be considered for approval by the MHSOAC.

Substantive Comments Summary

The following issues were of primary concern during the 30 day comment period / public hearing:

- Improved measurement of, communication about and dissemination of outcome measures to the stakeholders and the public.
- Use of PEI funding for services to children and their families.
- Use of CSS funding for services to children and adults.
- Support for the Community-Based Engagement and Support Services Innovation proposal and providing mental health outreach using a community hubs approach.

Substantive Comments / Recommendations

Substantive comments received during the comment period and public hearing process, responses to those comments, and a description of any substantive changes made to the MHSA Plan are summarized below.

The MHSA project team encourages greater discussion regarding these items and other topics impacting mental health services in El Dorado County during the upcoming MHSA Three-Year Plan Community Planning Process.

General	
1.	*Note:* Throughout the document, references to the Plan Update being a "draft" or projects being "proposed" have been changed to reflect their status after adoption of the Plan Update. Other grammatical and non-substantive wording issues have been corrected.
Outcome Measures	
2.	*Comment:* Many comments were received regarding outcome measures, and

	dissemination of information, including: • Increased link between the project goals and the outcome data; • Goals should have some measures built in; • Identify repercussions if there is low enrollment or inadequate communication and dissemination data; • Create a cross-functional steering committee to oversee program outcomes, goals, and metrics; • Use evidence-based pre- and post-data and outcome measures for services provided with a more data driven approach; • More frequent reporting of the outcome measure; • Client satisfaction survey results are not helpful for evaluating a program; • There is a need for more data regarding treatment and outcomes to show if a program is helping a client to stepdown to less intensive treatment; • Need to utilize well-established scales; • Outcome measures should be reported on WellDorado.org; • Capture best practices across PEI service channels to enable lessons learned informing services; • Need to look at quantifiable data, but it is also useful to recognize faith and capacity for doing good; • Data for prevention programs is often difficult to measure and provide due to the nature of the services; • Increased marketing and outreach efforts to maximize participation in services; • Collaborate actively in developing strategies and services – particularly as we move to the next three year planning cycle; • Collaboration and leveraging of funds with the schools is important; and • Equitable funding of services to both east and west slope communities.
	Response: The MHP agrees these are important steps in developing and monitoring an effective system of care and is committed to collaborate to find better ways to measure program outcomes. Greater emphasis will be placed on these items during FY 2016-17.
FY 2017-18 MHSA Plan Community Planning Process	
3.	*Note:* Several comments were received that were not specifically related to the Draft FY 2016-17 MHSA Plan Update, however they are important topics to be considered during the FY 2017-18 MHSA Plan Community Planning Process. These comments include: • Proposals for new projects should summarize how their project will utilize outcome data and will report such data. • Encourage the application of principles of neuroscience into all programs. • Emphasize fostering a seamless early assessment resiliency model that includes effective assessment tools and indicators (such as ACEs), as well as adoption of graphing of diagnosis being treated. • Adopt a commitment to "First Episode" style psychosis intervention throughout the provider network. • Concern for use of MHSA fund utilization for mental health mandated services as a result of AB403.

	• Concern for how the MHD may be a conduit to transfer funds from the MHD to the schools (AB114) for mental health services.
	Response: The MHSA project team encourages feedback and discussion regarding these topics during the upcoming MHSA Three-Year Plan Community Planning Process. Regarding First Episode Psychosis (FEP), the majority of FEPs emerge during the TAY years (16-25), and the CSS Project 3a: Transitional Age Youth Engagement, Wellness and Recovery Services project addresses FEP services.
PEI – General	
4.	*Note:* Changes have been made to program types and outcome measures for PEI projects based on the new PEI regulations. These items are required elements of a MHSA Plan/Plan Update.
5.	*Comment:* Two comments recommended keeping funding for children's PEI projects at FY 2015-16 levels or reducing them below FY 2015-16 levels. *Comment:* Many comments were received regarding the importance of reaching children at an early age, and also reaching their families, to help address early signs and/or symptoms of mental health concerns.
	Response: The MHSA Plan Update identifies 52% of the PEI funding is directed towards programs that serve the needs of children. The new PEI regulations require that at least 51% of the PEI funding be directed towards programs serving the needs of children absent a declaration from the Board of Supervisors that the County cannot meet the requirements because of specified local conditions.
6.	*Comment:* The need for mental health dollars for TAY and adults will continue to rise unless prevention and early intervention programs are used. *Comment:* We need to look at increasing resiliency in families
	Response: The purpose of PEI funding is to keep a mental illness from becoming severe and disabling. 52% of the funds must be directed to programs that address the needs of children. The current PEI programs address the needs from infants to older adults, however greater discussion regarding how to better achieve the desired goal of PEI will be done during the FY 2017-18 MHSA Plan Community Planning Process.
PEI Project 1a: Children 0-5 and Their Families	
7.	*Comment:* Eighteen comments and/or letters of support were received for the Children 0-5 and Their Families project. Supporters noted the critical need for prevention and early intervention services for this age group and the importance of increasing resiliency in families.
	Response: The Children 0-5 and Their Families project has demonstrated successful services and outcomes to the target population and has received substantial community support. The MHD will continue to evaluate service levels and provide program outcomes.
PEI Project 1b: Mentoring for 3-5 Year Olds by Adults and Older Adults	

8.	*Comment:* Concern was shared that the Mentoring for 3-5 Year Olds by Adults and Older Adults project has not been an effective use of funds with only 4 matches and this programs should be discontinued.
	Response: The MHD will continue to evaluate service levels for this project and review outcomes. The MHSA project team encourages feedback and discussion regarding this and other funded projects during the upcoming MHSA Three-Year Plan Community Planning Process.
PEI Project 1f: Prevention and Early Intervention for Youth in Schools	
9.	*Comment:* A recommendation to keep funding for this program at FY 2015-16 levels since the program has not yet been implemented.
	Response: The MHD agrees with the recommendation and has adjusted the budget in this Draft Plan Update.
PEI Project 2g: Community Outreach and Resources	
10.	*Comment:* The Mental Health Cooperative in South Lake Tahoe has been very successful in getting mental health information out to the community, reducing stigma and increasing prevention/early intervention. Comments were received that the funding for Project 2g could be better utilized by forming a similar Cooperative on the West Slope, which would be modeled after the South Lake Tahoe program.
	Response: As the project is currently written, this could be an allowable use of the funding. The MHSA project team will explore options for the feasibility of this activity on the West Slope.
PEI Project 3a: Wennem Wadati – A Native Path to Healing	
11.	*Comment:* Support was received for the Native Path to Healing project. Please consider increased funding for this project.
	Response: The Wennem Wadati – A Native Path to Healing project has demonstrated successful services and outcomes to the native population. The MHD will continue to evaluate service levels for this project to determine if there is a need for funding changes.
CSS Project 1a: Youth and Family Full Service Partnership	
12.	*Comment:* A comment was received to keep funding for this program at FY 2015-16 levels due to limited data to support the increase.
	Response: The budget for the Youth and Family Full Service Partnership Program was increased as a true-up to the FY 2016-17 budget and to meet the increased demand for specialty mental health services for this population. The MHD will continue to expand outcome data and evaluate service levels for this project to determine if there is a need for future funding changes.
CSS Project 1c: Foster Care Enhanced Services	
13.	*Comment:* A comment was received to keep funding for this program at FY 2015-16 levels due to limited data to support the increase and because actual FY 2014-15 expenses were close to the amount budgeted in FY 2014-15.

	Response: The budget for the Youth and Family Full Service Partnership Program was increased as a true-up to the FY 2016-17 HHSA budget and to meet the increased demand for the children and youth in this population. The MHD will continue to expand outcome data and evaluate service levels for this project to determine if there is a need for future funding changes.
CSS Project 2a: Wellness Centers	
14.	*Comment:* Comment was received in support of the proposed funding decrease to this project. *Comment:* Comment was received that the Wellness Centers are an integral part of adult treatment programs and concern was expressed for possible future decreases to this program (since it is not a mandated program) due to new mandates that may require additional MHSA funding and given that Wellness Centers are not mandated programs.
	Response: The funding decrease for the Wellness Centers was a true-up to the FY 2016-17 HHSA budget, however the MHP recognizes that the Wellness Centers are a critical component of in the adult system of care and their important role and operational model will continue to be evaluated for appropriate funding levels.
CSS Project 2b: Adult Full Service Partnership	
15.	*Comment:* A comment was received agreeing with the proposed funding increase to this project. *Comment:* The expenditures for the FSP program should be separated to show the cost breakdown for the ICM team and the ARF.
	Response: The funding decrease for the Adult Full Service Partnership project was a true-up to the FY 2016-17 HHSA budget. The amount budgeted for operation of the ARF has been reflected in the full project description budget section ($711,724).
CSS Project 3a: Transitional Age Youth (TAY) Services	
16.	*Comment:* A comment was received in agreement with the proposed funding increase to this project. *Comment:* There are not enough services for the clients in the Juvenile Justice System.
	Response: The funding increase for this project was a true-up to the FY 2016-17 HHSA budget, which included additional funding for services through Substance Abuse and Mental Health Services Administration (SAMHSA). Children in Juvenile Hall receive services from a provider contracted with the Probation Department. Children out of Juvenile Hall who are on probation and who meet the criteria for Specialty Mental Health Services are provided with mental health services through the appropriate children's program (either through a Traditionally-funded program or through an MHSA-funded program).
CSS Project 4b: Community-Based Mental Health Services	
17.	*Comment:* A comment agreed with the proposed funding increase to this project.
	Response: The funding change for this project was a true-up to the FY 2016-17 HHSA budget. The MHD will continue to evaluate service levels for this project to determine

	future funding changes.
Innovation – Community-Based Engagement and Support Services Project	
18.	*Note:* Clarification has been incorporated into the two Innovation Proposals based on the Innovation regulations and recommendations from the Mental Health Oversight Services and Accountability Commission (MHSOAC).
19.	*Comment:* Sixteen comments and/or letters of support were received for the Community-Based Engagement Support Services Innovation project through the 30-day public comment and public hearing process. Supporters noted the need for a decentralized service access points, such as the county libraries, as a more effective way to provide community-based mental health services. This idea encourages collaboration between many community partners and will provide education and resources that can be individualized and tailored to specific communities. The proposed library sites are already known and frequented by the community and are already an existing resource for the target population.
	Response: The MHD is excited to bring this project forward to the Board of Supervisors and the Mental Health Services Oversight and Accountability Commission (MHSOAC) for approval and implementation.

Attachment D
Mental Health Services Act

Mental Health Services Act

California voters passed Proposition 63, the Mental Health Services Act (MHSA), in November of 2004, and the MHSA was enacted into law January 1, 2005. The MHSA imposes a one percent (1%) tax on personal income in excess of $1,000,000. These funds are distributed to counties through the State and are intended to transform the mental health system.

The MHSA established five components that address specific goals for priority populations and key community mental health needs:

- Prevention and Early Intervention (PEI)
- Community Services and Supports (CSS)
- Innovation (INN)
- Workforce Education and Training (WET)
- Capital Facilities and Technology Needs (CFTN)

To develop and implement each of these MHSA components, the County of El Dorado (County) holds community planning meetings to gather information from consumers, their families, providers, and community members throughout the County.

MHSA Purpose and Intent

The MHSA, Section 3, states the purpose and intent of the MHSA is:

(a) To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.

(b) To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.

(c) To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.

(d) To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs.

(e) To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices

subject to local and state oversight to ensure accountability to taxpayers and to the public.[8]

MHSA General Standards

Services provided under MHSA must integrate the following General Standards:[9]

(1) Community Collaboration: "a process by which clients and/or families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources in order to fulfill a shared vision and goals."[10]

(2) Cultural Competence: "incorporating and working to achieve each of the goals listed below into all aspects of policy-making, program design, administration and service delivery. Each system and program is assessed for the strengths and weaknesses of its proficiency to achieve these goals. The infrastructure of a service, program or system is transformed, and new protocol and procedure are developed, as necessary to achieve these goals.

(1) Equal access to services of equal quality is provided, without disparities among racial/ethnic, cultural, and linguistic populations or communities.

(2) Treatment interventions and outreach services effectively engage and retain individuals of diverse racial/ethnic, cultural, and linguistic populations.

(3) Disparities in services are identified and measured, strategies and programs are developed and implemented, and adjustments are made to existing programs to eliminate these disparities.

(4) An understanding of the diverse belief systems concerning mental illness, health, healing and wellness that exist among different racial/ethnic, cultural, and linguistic groups is incorporated into policy, program planning, and service delivery.

(5) An understanding of the impact historical bias, racism, and other forms of discrimination have upon each racial/ethnic, cultural, and linguistic population or community is incorporated into policy, program planning, and service delivery.

(6) An understanding of the impact bias, racism, and other forms of discrimination have on the mental health of each individual served is incorporated into service delivery.

(7) Services and supports utilize the strengths and forms of healing that are unique to an individual's racial/ethnic, cultural, and linguistic population or community.

(8) Staff, contractors, and other individuals who deliver services are trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural, and/or linguistic population or community that they serve.

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[8] The Mental Health Services Act, Section 3, Purpose and Intent.
[9] California Code of Regulations (CCR), Title 9, Division 1, Chapter 14, Section 3320, General Standards.
[10] CCR, Title 9, Division 1, Chapter 14, Section 3200.060, Community Collaboration.

(9) Strategies are developed and implemented to promote equal opportunities for administrators, service providers, and others involved in service delivery who share the diverse racial/ethnic, cultural, and linguistic characteristics of individuals with serious mental illness/emotional disturbance in the community."[11]

(3) Client Driven: "the client has the primary decision-making role in identifying his/her needs, preferences and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for him/her. Client driven programs/services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes."[12]

(4) Family Driven: "families of children and youth with serious emotional disturbance have a primary decision-making role in the care of their own children, including the identification of needs, preferences and strengths, and a shared decision-making role in determining the services and supports that would be most effective and helpful for their children. Family driven programs/services use the input of families as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes."[13]

(5) Wellness, Recovery, and Resilience Focused: "promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination."[14]

(6) Integrated Service Experiences for clients and their families: "the client, and when appropriate the client's family, accesses a full range of services provided by multiple agencies, programs and funding sources in a comprehensive and coordinated manner."[15]

Public Mental Health System

The public mental health system consists of governmental and contracted providers who provide mental health services through local government, state and/or federal funding. The specific nature of the mental health needs and impairments are assessed for each individual to determine their eligibility to receive services through the County's mental health programs. The primary focus of these services is for individuals who are on Medi-Cal or uninsured and meet the specialty mental health/medical necessity criteria.

MHSA provides public education and support for the public mental health system through the development and funding of specific projects, but it is not "the mental health system" nor "the public mental health system". MHSA cannot fund all mental health needs within a county, nor is MHSA designed to fill that role. "The MHSA addresses a broad continuum of prevention, early intervention and service needs and provides funding for the necessary infrastructure,

[11] CCR, Title 9, Division 1, Chapter 14, Section 3200.100, Cultural Competence.
[12] CCR, Title 9, Division 1, Chapter 14, Section 3200.050, Client Driven.
[13] CCR, Title 9, Division 1, Chapter 14, Section 3200.120, Family Driven.
[14] Welfare and Institutions Code (WIC) Section 5813.5(d)(1).
[15] CCR, Title 9, Division 1, Chapter 14, Section 3200.190, Integrated Service Experience.

technology and training elements that will effectively support the local mental health system."[16] The role of primary care physicians and mental health services available through health insurance networks is of utmost importance in also supporting the local mental health needs.

All communities have service priorities, but there is limited funding available. Unfortunately, this means that not all wants and needs can be funded through MHSA. Therefore, even though a service need is identified, it does not mean the project will be able to be funded through MHSA. Rather, the totality of identified needs are considered, weighed against current programs, their outcomes and available funding, and a determination is made based on those factors as to whether a new program should be introduced to the MHSA service array. Similar considerations are made as to whether an existing program should be eliminated, be reduced in funding or be increased in funding.

MHSA Plan Requirements

On April 30, 2015, the Mental Health Services Oversight and Accountability Commission (MHSOAC) issued instructions for the Fiscal Year (FY) 2015-16 MHSA Plan Update.[17] The instructions summarize MHSA Plan requirements found within the MHSA, the Welfare and Institutions Code (WIC) and the California Code of Regulations (CCR), including the stakeholder process (community planning process), public review, the information to include regarding programs and outcome measures, expenditure plan, compliance and fiscal accountability certifications, and Board of Supervisors adoption. A copy of the instructions can be found as Attachment C.

MHSA Plans are written for a three-year duration, however plans are to be updated annually. This allows for necessary changes to be implemented, such as projects to be added, discontinued or amended, changes in revenues and/or expenditures to be addressed, or other important information to be incorporated.

MHSA Plans may also be amended mid-year, however amendments require the same community planning process as a Plan or Plan Update require, and are generally only undertaken due to extraordinary circumstances or significant revenues/expenditures adjustments.

Instructions for this year's Plan Update included a slightly different designation for PEI projects than previously required. The new PEI regulations state that programs be reported as:

> …"Prevention" (i.e., direct service programs that serve individuals who are at risk for mental illness/emotional disturbance), "Early Intervention" (i.e., direct service programs that provide service to individuals showing early onset of mental illness/emotional disturbance), and "Other" PEI programs that are neither "Prevention" nor "Early Intervention" (i.e., that do not have a direct service component). "Other" programs could include stand-alone programs focused on

[16] California Department of Mental Health. Mental Health Services Act Expenditure Report Fiscal Year 2007-2008. http://www.dhcs.ca.gov/services/MH/Documents/MayLegReportFormat4_14_08_V8.pdf.
[17] Mental Health Services Oversight and Accountability Commission, *FY 2015-2016 MHSA Annual Update Instructions*. April 30, 2015. http://www.mhsoac.ca.gov/docs/FY14-17_3YrProgExpendPlan_Instructions.pdf.

Outreach for Increasing Recognition of Early Signs of Mental Illness, Access to Treatment, Improving Timely Access to Services for Underserved Populations, Stigma and Discrimination Reduction, and Suicide Prevention.

Therefore, the PEI section of the FY 2016-17 Plan Update includes some re-designation of PEI Programs to match these new categories.

MHSA Changes Anticipated in FY 2016-17

Innovation Regulation Changes

The MHSOAC approved new regulations for INN effective October 1, 2015. More information about the regulations and other MHSOAC activities may be found on their website (http://mhsoac.ca.gov/).

PEI Regulation Changes

The MHSOAC approved new regulation for PEI effective October 6, 2015. The new changes, including program types, demographic reporting requirement changes, and outcome requirements have been incorporated into this MHSA Plan Update.

MHSA Terminology

As used within this document, and generally within MHSA:

- "**Component**" refers to the MHSA funding streams of:
  - Prevention and Early Intervention (PEI)
  - Community Services and Supports (CSS)
  - Innovation (INN)
  - Workforce Education and Training (WET)
  - Capital Facilities and Technology Needs (CFTN)
- "**Program**" refers to a grouping of projects under a component designed to achieve a common goal, serve a common demographic, or address a common community need. In the past, "Programs" were referred to as "Workplans".
- "**Project**" refers to a set of targeted activities focusing a specific aspect of a program. One or more projects will be found within each program.
- "**Activities**" are what will occur within each project.

A glossary has been included at the beginning of this document, Attachment A, to assist with the terminology utilized within this Plan.

MHSA Funding Methodology

On October 21, 2015, Department of Health Care Services (DHCS) released MHSD Information Notice 15-049, which identifies the "Methodology for Distributions to Local Mental

Health Services Fund".[18] Through application of the methodology described in MHSD Information Notice 15-049, El Dorado County received 0.406698% of the total MHSA funding available through September 2015, and starting in October 2015, El Dorado County receives 0.413649%.

The State no longer provides counties with specific annual MHSA allocations. Rather, the MHSA funding distributed to each county is based on a percentage of the actual deposits into the State's Mental Health Services fund. Therefore, the amount distributed fluctuates monthly.[19] The estimated MHSA revenues is based upon revenues received in prior fiscal years, estimated MHSA revenues identified in the State's budget, and estimates from statewide MHSA organizations and their consultants.

Additional funding, attributed to the MHSA programs as offsets to expenditures, is available from Medi-Cal or other reimbursements for services. Interest on funds already received but not yet expended and Public Safety Realignment 2011 (Assembly Bill [AB] 109) are examples of other revenue sources.

El Dorado County reports the total MHSA revenues and expenditures annually to the State. This report is referred to as the "Revenue and Expenditure Report". The report for FY 2013-14 is included as Attachment D. Please note this does not represent the total cost of the MHSA programs, but rather the MHSA funds that are utilized to fund the programs (other funding may be provided through Medi-Cal reimbursements, grant funding, etc.).

Component Funding

The MHSA specifies the percentage of total funding applied to each of its components:

Component	Net % of Annual Allocation
CSS	76%
PEI	19%
INN	5%
WET	0% - Utilizing Fund Balance or Reallocation from CSS
CFTN	0% - Utilizing Fund Balance or Reallocation from CSS

80% of the MHSA funds are allocated to CSS
20% of the MHSA funds are allocated to PEI and from that total, 5% is allocated to INN

The ability to shift funds between components is dictated by the terms of the MHSA. CSS funds may be shifted to WET and CFTN, but may not exceed 20% of the total average amount of funds allocated to that County for the previous five years. Funds may not be transferred into PEI. There is also some flexibility to move funding between projects within the same component, however if services are provided through a contracted vendor, there may be contractual issues, in addition to any required community planning process requirements, to be addressed before funds could be shifted.

[18] California Department of Health Care Services, MHSD Information Notice 15-049. October 21, 2015. http://www.dhcs.ca.gov/formsandpubs/Pages/Information-Notices-2015.aspx.
[19] *Ibid.*

Attachment E
County Profile, Demographics and Needs Assessments

County Profile

El Dorado County encompasses a large geographic area (1,805 square miles, of which approximately 51% is U.S. Forest Service land[20]), with two incorporated cities (South Lake Tahoe and Placerville) and twelve unincorporated Census-Designated Places (CDPs)[21].

Demographics

As of 2016, the population within the County is 185,441[22] Approximately 33% of the County's population resides toward the western border of the County in the El Dorado Hills and Cameron Park communities, with the Tahoe basin on the eastern border being the second highest region in population.

Approximately eighty percent of the County's population resides in unincorporated areas of the County. The communities within the County have developed out of the distinct characteristics of each of these regions and have historically operated quite independently. The rural nature of many unincorporated areas of the County results in challenges to obtaining mental health services (e.g., transportation to services, outreach to residents, and public awareness relative to available services).

Location	2016 Population	Percent of County
Cameron Park	29,616	15.96%
Camino	4,849	2.61%
Cool	3,715	2.00%
Diamond Springs	4,142	2.23%
Echo Lake	41	0.02%
El Dorado	4,485	2.42%
El Dorado Hills	42,910	23.12%
Fair Play	3,687	1.99%
Garden Valley	3,312	1.78%
Georgetown	3,482	1.88%
Greenwood	1,287	0.69%
Grizzly Flats	1,176	0.63%

[20] Retrieved from http://www.fs.usda.gov/main/eldorado/about-forest

[21] Retrieved from http://www.dof.ca.gov/research/demographic/state_census_data_center/census_2010/documents/2010Census_DemoProfile1.xls

[22] Unless otherwise noted, all demographic data is retrieved from http://www.welldorado.org

Kyburz	205	0.11%
Lotus	819	0.44%
Pilot Hill	1,456	0.78%
Placerville	37,058	19.96%
Pollock Pines	8,495	4.58%
Rescue	5,024	2.71%
South Lake Tahoe	28,651	15.44%
Tahoma	1,175	0.63%
Twin Bridges	37	0.02%
El Dorado County Total *	185,622	100.0%

** There is a variance of 181 between the total 185,622 listed in the table above and the total of 185,441 reported on www.welldorado.org which is due to one zip code being split into two counties.*

The County seat, Placerville, is surrounded by unincorporated, rural areas. South Lake Tahoe (the city and unincorporated areas of the Tahoe Basin) features a resort community, a sizable transient community, and is much more ethnically diverse than the remainder of the County.

The Tahoe Basin is separated from the remainder of the County by the Sierra Nevada Mountains, with Highway 50 providing a mountainous, 60-mile connector route between the two regions. There is no locally operated public transportation between the Tahoe basin and the West Slope of the County, however Amtrak California operates once daily bus service between the two cities. In terms of service provision, the Tahoe basin and the West Slope of the County are essentially two distinct areas.

Gender distribution in the County is nearly equal between men (92,723) and women (92,718). There are approximately 15,793[23] Veterans in El Dorado County, which represents approximately 8.5% of the population.

The race / ethnicity distribution within the County is as follows:

Race / Ethnicity	Total	Percent of County
Caucasian or White	144,754	78.06%
Hispanic or Latino	23,834	12.85%
Asian	7,385	3.98%
American Indian or Alaska Native	1,457	0.79%
Black or African American	1,519	0.82%
Native Hawaiian and Other Pacific Islander	296	0.16%
Multiracial	5,873	3.17%
Other Race	323	0.17%

The median age in the County is 45.5, distributed as follows:

[23] Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

Age	Total	Percent of County
Under 5	8,537	4.60%
5 to 9	9,772	5.27%
10 to 14	11,651	6.28%
15 to 17	7,628	4.11%
18 to 20	6,868	3.70%
21 to 24	8,982	4.84%
25 to 34	18,403	9.92%

Age	Total	Percent of County
35 to 44	19,622	10.58%
45 to 54	27,103	14.62%
55 to 64	32,534	17.54%
65 to 74	21,317	11.50%
75 to 84	9,211	4.97%
85 and Over	3,813	2.06%

Children 0 to 20 comprise 23.96% of the population and adults age 65 and over comprise 18.53% of the population.

Income Levels

The median household income in El Dorado County is $64,687. However, economic disparities are evident across the County:

Place of Residence within the County	Median Household Income
Cameron Park	$73,311
Camino	$56,692
Cool	$86,695
Diamond Springs	$48,801
Echo Lake	$33,750
El Dorado	$49,547
El Dorado Hills	$116,669
Fair Play	$48,893
Garden Valley	$61,494
Georgetown	$45,728
Greenwood	$58,194
Grizzly Flats	$47,132
Kyburz	$35,682
Lotus	$73,305
Pilot Hill	$88,542
Placerville	$52,170
Pollock Pines	$56,034
Rescue	$88,127
South Lake Tahoe	$43,284
Tahoma	$37,298

Twin Bridges	$50,000
El Dorado County Average Median Income	$64,687

Languages

The primary language spoken within El Dorado County is English. As of August 2013, California DHCS identified Spanish as the only "threshold language" within El Dorado County.[24] A "threshold language" is the primary language identified by 3,000 or five percent of the Medi-Cal beneficiaries, whichever is lower, in an identified geographic area. MHSA considers threshold languages when determining other languages to be considered in program design and implementation.

Health Insurance

With the implementation of the Affordable Care Act, the collaboration between insurance providers, health care providers, mental health providers, and specialty mental health care providers in serving the needs of El Dorado County residents is more important than ever.

Enroll America identified that approximately 13% (approximately 19,674) of the residents under the age of 65 in El Dorado County were uninsured prior to the implementation of the Affordable Care Act.[25] With the implementation of the Affordable Care Act, it is anticipated that this number will drop, however more recent estimates of the number of uninsured specifically for El Dorado County are not yet available.

According to DHCS, 21,749 individuals in El Dorado County were receiving Medi-Cal as a "mandatory" participant as of March 2014.[26] Mandatory participants are those enrolled in programs such as CalWORKs, seniors, persons with disabilities, and those who have no share of cost for their Medi-Cal.

The role of health care providers in the provision of mental health services cannot be underestimated. Individuals frequently feel more comfortable addressing mental health concerns with their primary care physician. For those with private insurance, referrals for mental health services would be handled through their insurance networks. For individuals with Medi-Cal, mild to moderate mental health needs are served through their primary care physicians, and individuals with severe mental illness are served through the Mental Health Division (MHD) of Health and Human Services Agency (HHSA). Therefore, CSS services are

[24] California Department of Health Care Services. MHSD Information Notice No.: 13-09, Enclosure 1. http://www.dhcs.ca.gov/formsandpubs/Documents/13-09Encl1.pdf. April 2013.
[25] Enroll America. State Maps & Info, California. http://www.enrollamerica.org/state-maps-and-info/state-profiles/california/. Retrieved April 25, 2014.
[26] California Department of Health Care Services, All Plan Letter 14-008 (Revised), Standards For Determining Threshold Languages, August 27, 2014. http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-008.pdf.

primarily for those with Medi-Cal or those who are uninsured. MHSA programs cannot provide services that are available through private insurance.[27]

Demand for Mental Health Services

A February 2012 report[28] to the California DHCS identified that approximately 4.6% of the population in El Dorado County has a need for mental health services based upon the serious mental illness definition. Within households with income below the 200% poverty level, this rate increases to approximately 8.9%. When a broader definition of mental health needs is utilized, a level which is beyond the scope of the MHSA CSS funding, the percent of population that has a need for mental health services increases to approximately 12.2% of the population, and within households with income levels below the 200% poverty level, the need increases to approximately 19.5%. However, it is important to remember that under most circumstances, participation in mental health services is voluntary in nature.[29]

Mental illness can affect anyone, regardless of their ethnicity, income, housing status, age, or any number of other criteria. The MHSA projects are designed to address the needs of those residents who meet the eligibility criteria of each project. However, research has shown that there is a higher prevalence of mental illness in households that are considered low-income.[30] Per the United States Department of Health and Human Services, "In 2010, adults living below the poverty level were three times more likely to have serious psychological distress as compared to adults [with income] over twice the poverty level."[31]

A key element in encouraging individuals to seek mental health treatment is addressing the stigma and discrimination long associated with mental illness. The PEI projects within this MHSA Plan and the Statewide PEI Stigma and Discrimination Reduction program work to reduce the stigma and discrimination associated with mental illness. Once mental illness becomes more understood by the general public as a medical issue and the historical stigma is reduced, those in need of services will hopefully become more willing to seek services.

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[27] The Mental Health Services Act, Section 3(d), Purpose and Intent. "State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs."

[28] Technical Assistance Collaborative, *California Mental Health and Substance Use System Needs Assessment* (February, 2012) at http://www.dhcs.ca.gov/provgovpart/Pages/BehavioralHealthServicesAssessmentPlan.aspx.

[29] The exception being services in which an individual is legally required to participate.

[30] References include:

- Mental Health: A report of the Surgeon General. 1999, as referenced by NAMI. http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Annual_Minority_Mental_Healthcare_Symposia/Latino_MH06.pdf.
- "The Vicious Cycle of Poverty and Mental Health | World of Psychology." PsychCentral.com. http://psychcentral.com/blog/archives/2011/11/02/the-vicious-cycle-of-poverty-and-mental-health/.
- Hudson, C.G. (2005). Socioeconomic Status and Mental Illness: Tests of the Social Causation and Selection Hypotheses. American Journal of Orthopsychiatry, 75, 3-18.
- Lancet. (2011). Mental health care—the economic imperative. The Lancet, 378, 1440. doi:10.1016/S0140-6736(11)61633-4.

[31] United States Department of Health and Human Services, Office of Minority Health, http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=539, referencing the Centers for Disease Control and Prevention, *Health, United States, 2011*, page 38. http://www.cdc.gov/nchs/data/hus/hus11.pdf.

Information about the levels of requests for services and the outcomes of those requests is available in the Current MHSA Projects and Performance Outcomes section of this Plan Update.

Suicide Rate

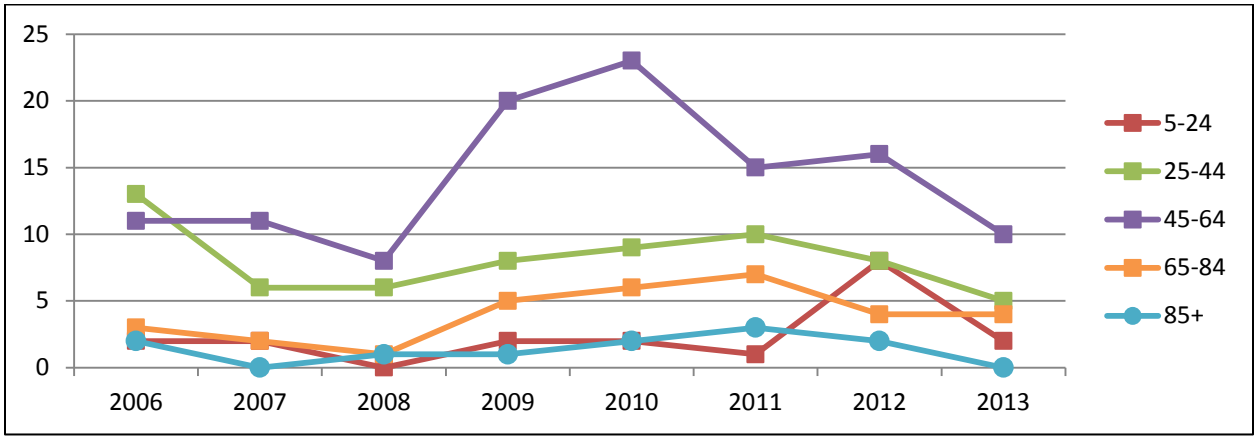
Data from the California Department of Public Health reflects that from 2006 through 2013, El Dorado County experienced 241 deaths due to suicide.[32]

Age	Total	% of Total
5-14	2	1%
15-24	17	7%
25-34	22	9%
35-44	43	18%
45-54	67	28%

Age	Total	% of Total
55-64	47	20%
65-74	20	8%
75-84	12	5%
85+	11	5%
TOTAL	241	100%

The annual data is reflected for age range blocks in Chart 1.

Chart1. Number of Deaths by Suicide 2006-2013.



A key element in encouraging individuals to seek mental health treatment, including treatment for those who may have suicidal thoughts, is addressing the stigma long associated with mental illness. This MHSA Plan includes a suicide prevention program that has been awarded through a competitive procurement process to Tahoe Youth and Family Services. It is anticipated that the contract will be developed and executed early in FY 2016-17. This MHSA Plan also includes a contribution to the Statewide PEI Projects, which includes a suicide prevention project.

[32] California Department of Public Health, Health Information and Strategic Planning, Vital Statistics Query System. http://www.apps.cdph.ca.gov/vsq/default.asp. As of March 2016, the 2014 data is not yet available.

Needs Assessments

Workforce Needs

Within WET, the 2008 Workforce Needs Assessment identified the hard-to-fill positions of psychiatrists, nurses and Marriage and Family Therapist Interns. It also identified a need for bilingual (Spanish) staff in the public mental health system workforce. The MHD is in the process of updating its Workforce Needs Assessment, but the needs previously identified continue to be a need in 2016. Current staffing trends identify challenges in staffing psychiatrists, nurses, psychiatric technicians, mental health clinicians (licensed and pre-licensed), licensed clinical social workers (licensed and pre-licensed); bilingual/bicultural staff; and all positions that work evenings, weekends, and part-time and/or on-call.

Previous MHSA Plans detailing the early community planning processes, needs assessments and origins of the MHSA programs may be found on the County's MHSA web page.[33]

Barton Health Community Health Needs Assessment

Barton Health published its CHNA in March 2015. The full report can be downloaded at http://southlaketahoe.healthforecast.net or accessed on the Well Dorado webpage at http://www.welldorado.org. Issues related to mental health for the Barton Health hospital service area included:

- Suicide deaths;
- Seeking help for mental health;
- Mental Health ranked #2 as a "major problem" in the Online Key Informant Survey

Barton Health continues to work on addressing these needs and implementing system improvements. Barton Health has been instrument in progressing Mental Health awareness in the Tahoe Basin through the formation of and continued progress by the Mental Health Forum and the Mental Health Collaborative.

Marshall Medical Center Community Health Needs Assessment

Marshall Medical Center published its CHNA in October 2013.[34] Priority health needs for the Marshall Medical Center hospital service area included:

- Limited mental health services/lack of access to mental health services;
- Lack of access to inpatient and outpatient substance abuse treatment;
- Limited transportation options; and
- Perceptions of limited cultural competence in health care and related systems.

[33] El Dorado County, MHSA Plans Archive. http://www.edcgov.us/MentalHealth/MHSA_Plans.aspx.
[34] Valley Vision, Inc. for Marshall Medical Center. A Community Health Needs Assessment of the Marshall Medical Center Hospital Service Area. 2013, p 5.

Marshall Medical Center continues to work on addressing these needs and implementing system improvements.

California Healthy Kids Survey

The data provided in the FY 2015-16 MHSA Plan about the California Healthy Kids Survey is the most recent information available to the MHD.

Attachment F
Initials Used in the MHSA Plan

Initials

AB	Assembly Bill
AB 109	Public Safety Realignment 2011
ANSA	Adult Needs and Strengths Assessment
AOD	Alcohol and Other Drugs
AOT	Assisted Outpatient Treatment
APS	Adult Protective Services
ARF	Adult Residential Facility
ART	Aggression Replacement Therapy
BOMUSD	Black Oak Mine Union School District
CalMHSA	California Mental Health Services Authority
CALOCUS	Child/Adolescent Levels of Care Utilization System
CANS	Child and Adolescent Needs and Strengths
CAO	Chief Administrative Office
CAS	Community Access Site
CBO	Community-Based Organization
CBRS	Conners Comprehensive Behavior Rating Scales
CBT	Cognitive Behavioral Therapy
CCR	California Code of Regulations
CDBG	Community Development Block Grant
CDP	Census-Designated Place
CFR	Code of Federal Regulations
CFTN	Capital Facilities and Technology
CHA	Community Health Advocate
CHNA	Community Health Needs Assessment
CIMH	California Institute for Mental Health
CIOM	Clinically Informed Outcomes Management
CIT	Crisis Intervention Techniques
County	El Dorado County
CPRT	Child Parent Resource Team
CSS	Community Services and Supports

CSS-Housing	Community Services and Supports – Housing
CWS	Clinical Workstation
DBT	Dialectical Behavior Therapy
DHCS	California Department of Health Care Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
EDCOE	El Dorado County Office of Education
EDCVC	El Dorado Community Vision Coalition
EFC	Extended Foster Care
EHR	Electronic Health Record
EMDR	Eye Movement Desensitization Reprocessing
ESL	English as a Second Language
FSP	Full Service Partnership
FY	Fiscal Year
GSD	General System Development
HHSA	Health and Human Services Agency
HOME	Home Investment Partnership Program
ICC	Intensive Care Coordination
ICM	Intensive Case Management
IEP	Individualized Education Program
IHBS	Intensive Home-Based Services
INN	Innovation
ISSP	Individual Services and Supports Plan
IT	Information Technologies
KET	Key Event Tracking
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Questioning
LOCUS	Levels of Care Utilization System
MAST	Multidisciplinary Adult Services Team
MBSR	Mindfulness Based Stress Reduction
MHBG	Mental Health Block Grant
MHD	Mental Health Division of HHSA
MHSA	Mental Health Services Act
MHSOAC	Mental Health Services Oversight and Accountability Commission

MIM	Marshak Interactive Measurement
MST	Mobile Support Team
NAMI	National Alliance on Mental Illness
NMD	Non-Minor Dependents
OE	Outreach and Engagement
ORS	Outcome Rating Scale
PCIT	Parent-Child Interactive Therapy
PEI	Prevention and Early Intervention
PEI-TTACB	Prevention and Early Intervention - Training, Technical Assistance and Capacity Building
PFLAG	Parents, Families, Friends of Lesbians and Gays
PHF	Psychiatric Health Facility
PHN	Public Health Nurse
PI	Priority Indicators
PIP	Primary Intervention Project
PMAD	Perinatal Mood and Anxiety Disorders
PMHP	Primary Mental Health Project
PPDS	Post-Partum Depression Screening
PSA	Public Service Announcement
PSC	Personal Service Coordinator
PSI	Parent Stress Index
PTSD	Post-Traumatic Stress Disorder
QI	Quality Improvement
RCL	Rate Classification Level
RER	Revenue and Expenditure Report
RFP	Request for Proposals
SAMHSA	Substance Abuse and Mental Health Services Administration
SARB	School Attendance Review Board
SB	Senate Bill
SDR	Stigma and Discrimination Reduction
SED	Seriously Emotionally Disturbed
TAY	Transitional Age Youth
TBD	To be determined

TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TLC	Therapeutic Lifestyle Changes
TTACB	Training, Technical Assistance and Capacity Building (TTACB)
TYFS	Tahoe Youth and Family Services
UMDAP	Uniform Method of Determining Ability to Pay
WET	Workforce Education and Training
WIC	Welfare and Institutions Code
WMS	Walker-McConnell Scale

Attachment G
County Compliance and Fiscal Accountability Certification Forms

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: _____

☐ Three-Year Program and Expenditure Plan
☐ Annual Update

Local Mental Health Director	Program Lead
Name:	Name:
Telephone Number:	Telephone Number:
E-mail:	E-mail:
Local Mental Health Mailing Address:	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and nonsupplantation requirements.

This Three-Year Program and Expenditure Plan or 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 Three-Year Program and Expenditure Plan or 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 _____.

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.

_____ _____
Local Mental Health Director (PRINT) Signature Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: _____

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name:	Name:
Telephone Number:	Telephone Number:
E-mail:	E-mail:
Local Mental Health Mailing Address:	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue 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 period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

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

_____ _____
Local Mental Health Director (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, _____, 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,_____. I further certify that for the fiscal year ended June 30,_____, the State MHSA distributions were recorded as 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 if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

_____ _____
County Auditor Controller / City Financial Officer (PRINT) 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 (07/22/2013)

Attachment H
FY 2015-16
MHSA Annual
Update Instructions

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Title

FY 2015-2016
MHSA Annual Update Instructions

Background

Welfare and Institutions Code Section (WIC §) 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan (Plan) and Annual Updates for Mental Health Service Act (MHSA) programs and expenditures.

Plans and Annual Updates must be adopted by the county Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days after Board of Supervisor adoption.

WIC § 5848 states the mental health board shall conduct a public hearing on the draft Annual Update at the close of a 30-day comment period.

For those counties that have already posted their plans for the 30-day public comment period, the counties have the option of using these instructions or the 2014/15 through 2016/17 Three-Year Program and Expenditure Plan Instructions.

These are instructions for the MHSA Fiscal Year (FY) 2015-2016 Annual Update, which provides updates to the FY 2014-2015 through FY 2016-2017 Plan. These instructions are based on WIC and the California Code of Regulations Title 9 (CCR) in effect at the time these instructions were released.

WIC § 5891 states that MHSA funds may only be used to pay for MHSA programs.

Purpose

The purposes of these instructions are to:

- Assist counties and their stakeholders in developing the FY 2015-2016 Annual Update to include all the necessary elements as required by statute and regulation.
- Provide the essential elements legally necessary in preparing the Annual Update for approval by the county Board of Supervisors. Counties retain the option to include more in their stakeholder process, Plan, and/or Annual Update than the statutory minimum. Any additional information provided in the Annual Update should be consistent with federal and state privacy laws to protect privileged and confidential information.
- Provide the MHSOAC with some of the information it needs to carry out its oversight responsibilities.
- Provide the MHSOAC the information it needs to approve new or amended Innovation (INN) project plans.

These instructions often refer to WIC or CCR, which remain the authority on requirements. These instructions do not negate the MHSOAC's authority, pursuant to WIC Section 5845(d)(6), to obtain additional data and information from state or local entities that receive MHSA funds for the MHSOAC to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity

regarding projects and programs supported with MHSA funds.

Who Should be Involved in the Stakeholder Process

WIC § 5848 states that each Annual Update shall be developed with local stakeholders, including:

- Adults and seniors with severe mental illness
- Families of children, adults, and seniors with severe mental illness
- Providers of services
- Law enforcement agencies
- Education
- Social services agencies
- Veterans
- Representatives from veterans organizations
- Providers of alcohol and drug services
- Health care organizations
- Other important interests (e.g., individuals served or targeted by Prevention and Early Intervention (PEI) services and individuals expected to benefit from INN projects).

CCR § 3300 further includes:

- Representatives of unserved and/or underserved populations and family members of unserved/underserved populations, as defined in CCR § 3200.300 and CCR § 3200.310
- Stakeholders that reflect the diversity of the demographics of the county, including but not limited to, geographic location, age, gender, and race/ethnicity
- Clients with serious mental illness and/or serious emotional disturbance, and their family members.

What Should be Included in the Stakeholder Process

WIC § 5848 states that counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on:

- Mental health policy
- Program planning
- Implementation
- Monitoring
- Quality improvement
- Evaluation
- Budget allocations.

CCR § 3300 states that involvement of clients and their family members be in all aspects of the community planning process and that training shall be offered, as needed, to stakeholders, clients, and client's family who are participating in the process.

What Standards Should be Used for the Stakeholder Process

CCR § 3320 states that counties shall adopt the following standards in planning, implementing, and evaluating programs:

- Community collaboration, as defined in CCR § 3200.060
- Cultural Competence, as defined in CCR § 3200.100
- Client-Driven, as defined in CCR § 3200.50
- Family-Driven, as defined in CCR § 3200.120
- Wellness, recovery, and resilience-focused, as described in WIC § 5813.5
- Integrated service experiences for clients and their families, as defined in CCR § 3200.190.

Public Review

WIC § 5848 states that a draft Annual Update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy.

Additionally, the mental health board shall conduct a public hearing on the draft Annual Update at the close of the 30-day comment period. It also should review the adopted Annual Update and make recommendations for revisions.

What to Include in the Annual Update about the stakeholder Process

Per **WIC § 5848** and **CCR § 3315 and § 3300**, this section of the Annual Update shall include:

- A description of the local stakeholder process including date(s) of the meeting(s) and any other planning activities conducted.
- A description of the stakeholders who participated in the planning process in enough detail to establish that the required stakeholders were included, and reflected the diversity of the County.
- A description of how stakeholder involvement demonstrates a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations consistent with WIC § 5848.
- A description of training provided to participants in community planning; if the Annual Update includes a new INN project, a description of how training informed planning participants about the specific purposes and MHSA requirements for the INN component is required.
- The dates of the 30-day review process.
- Methods used by the county to circulate for the purpose of eliciting public comment the draft of the Annual Update to representatives of the stakeholders' interests and any other interested party who requested a copy.
- The date of the public hearing held by the local mental health board or commission.
- Summary and analysis of any substantive recommendations received during the 30-day public comment period and the county's resulting actions, including any substantive changes made to the Annual Update in response to public comments.

What to Include in the Annual Update About Programs

WIC § 5847 states the Annual Update shall include updates from the Plan. Please include a detailed description of new programs, programs that have changed from what was described in and/or discontinued from the FY 2014-2015 through FY 2016-2017 Plan, and the rationale for any and all added, changed, or discontinued programs. Descriptions should include, but not be limited to, any and all stakeholder input and/or evaluation data that contributed to the decision to add, change or discontinue a program, and any and all impact on individuals served in changed or discontinued programs. Include this information for the following programs:

- Services to children, including a wrap-around program (exceptions apply). These programs shall include services to address the needs of transition age youth ages 16 to 25 and foster youth. The number of children served by program and the cost per person must be included. These programs shall be in accordance with WIC § 5878.1.
- Services to adults and seniors, including services to address the needs of transition-age youth ages 16 to 25. The number of adults and seniors served by program and the cost per person must be included. These programs shall be in accordance with WIC § 5813.5. WIC § 5813.5 states that Annual Updates shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons. When included in county plans pursuant to WIC § 5847, funds may be used for the provision of mental health services under WIC § 5347 and § 5348 in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with WIC § 5345) of Chapter 2 of Part 1).
- Prevention and Early Intervention (PEI) programs designed to prevent mental illnesses from becoming severe and disabling. These programs shall be in accordance with WIC § 5840. Please describe programs and program components/activities separately by "Prevention" (i.e., direct service programs that serve individuals who are at risk for mental illness/emotional disturbance), "Early Intervention" (i.e., direct service programs that provide service to individuals showing early onset of mental illness/emotional disturbance), and "Other" PEI programs that are neither "Prevention" nor "Early Intervention" (i.e., that do not have a direct service component). "Other" programs could include stand-alone programs focused on Outreach for Increasing Recognition of Early Signs of Mental Illness, Access to Treatment, Improving Timely Access to Services for
- Underserved Populations, Stigma and Discrimination Reduction, and Suicide Prevention.
- Innovation (INN) in accordance with WIC § 5830.
- Technological needs and capital facilities in accordance with WIC § 5847(b)(5).
- Identification of shortages in personnel and the additional assistance needs from education and training programs in accordance with WIC § 5847(b)(6).
- Prudent Reserve in accordance with WIC § 5892(b) and § 5847(b)(7).

What to Include in the Annual Update About Programs (cont.)

In addition to the required program updates listed above, counties should include the following information as part of the Annual Update:

- A description of county demographics, including but not limited to size of the county, threshold languages, unique characteristics, age, gender, and race/ethnicity.
- The number of children, adults, and seniors served in each PEI program and INN project that provide direct services to individuals/groups.
- The cost per person for PEI programs and INN projects that provide direct services to individuals/groups. Please provide the cost per person for PEI programs and program components/activities separately by "Prevention" (i.e., direct service programs that serve individuals who are at risk for mental illness/emotional disturbance), "Early Intervention" (i.e., direct service programs that service individuals showing early onset of mental illness/emotional disturbance), and "Other" PEI programs that are neither "Prevention" nor "Early Intervention" (i.e., that do not have a direct service component). "Other" programs could include stand-alone programs focused on Outreach for Increasing Recognition of Early Signs of Mental Illness, Access to Treatment, Improving Timely Access to Services for Underserved Populations, Stigma and Discrimination Reduction, and Suicide Prevention.
- Examples of notable community impact for any program, if applicable.
- Any challenges or barriers with each of the programs and strategies to mitigate those challenges or barriers.

What to Include in the Annual Update About INN

WIC § 5830 states that counties shall expend funds for their INN projects upon approval by the MHSOAC and details INN requirements. Annual Updates should include sufficient information about proposed new and changed INN projects so that the MHSOAC may determine if the project meets statutory requirements and can be approved.

Please describe minor changes within the Annual Update for changed INN projects that do not require MHSOAC approval (i.e., changes not made to the total funding for the project, the primary purpose, or the basic practice or approach that the county is piloting and evaluating).

If an INN project has proven successful and the county chooses to continue it, the INN project shall transition to another category of funding as appropriate.

Please refer to the MHSOAC Innovation Review Tool for details on what information to include for new and changed INN projects: http://www.mhsoac.ca.gov/Counties/Innovation/docs/InnovationPlans/Inn_Rev_Tool_6-1-09.pdf.

What to Include in the Annual Update About Performance Outcomes	**WIC § 5848** states that Annual Updates shall include reports on the achievement of performance outcomes for MHSA services. Please include available results of any evaluations or performance outcomes for any and all programs. When including results of any evaluations or performance outcomes for PEI programs and program components/activities please separate by "Prevention" (i.e., direct service programs that serve individuals who are at risk for mental illness/emotional disturbance), "Early Intervention" (i.e., direct service programs that service individuals showing early onset of mental illness/emotional disturbance), and "Other" PEI programs that are neither "Prevention" nor "Early Intervention" (i.e., that do not have a direct service component). "Other" programs could include stand-alone programs focused on Outreach for Increasing Recognition of Early Signs of Mental Illness, Access to Treatment, Improving Timely Access to Services for Underserved Populations, Stigma and Discrimination Reduction, and Suicide Prevention. Please specify the time period these performance outcomes cover.
What to Include in the Annual Update About County Compliance Certification	**WIC § 5847** states that certification by the county mental health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements, must be included in the Annual Update. Please use the MHSA County Compliance Certification form included with these Instructions.
What to Include in the Annual Update About County Fiscal Accountability Certification	**WIC § 5847** states that certification by the county mental health director and the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the MHSA, shall be included in the Annual Update. Please use the MHSA County Fiscal Accountability Certification form included with these Instructions.
What to Include in the Annual Update About Board of Supervisor Adoption	**WIC § 5847** states that the Board of Supervisors shall adopt the Annual Update. Please include documentation that the Board of Supervisors adopted the Annual Update and the date of that adoption.

What to Include in the Annual Update About An Expenditure Plan

WIC § 5847 states that each county shall prepare an expenditure plan for the Annual Update based on available unspent funds, estimated revenue, and reserve amounts.

Please read the Expenditure Plan Funding instructions and complete the form included with these Instructions.

In addition, please include the budgeted amount to be spent for FY 2015-2016 on:

- Full Service Partnerships, as defined in CCR § 3620, which should be at least 50% of CSS funds
- General System Development, as defined in CCR § 3630
- Outreach Engagement, as defined in CCR § 3640
- Each PEI program or component listed separately by "Prevention" (i.e., direct service programs that serve individuals who are at risk for mental illness/emotional disturbance), "Early Intervention" (i.e., direct service programs that service individuals showing early onset of mental illness/emotional disturbance), and "Other" PEI programs that are neither "Prevention" nor "Early Intervention" (i.e., that do not have a direct service component). "Other" programs could include stand-alone programs focused on Outreach for Increasing Recognition of Early Signs of Mental Illness, Access to Treatment, Improving Timely Access to Services for Underserved Populations, Stigma and Discrimination Reduction, and Suicide Prevention (20% of MHSA funds distributed to a county)
- INN by project (5% of CSS funds and 5% of PEI funds distributed to a county)
- Workforce Education and Training Program
- Capital Facilities and Technological Needs
- Prudent Reserve: Mental Health Services Act (MHSA) provided for a local Prudent Reserve for the purpose of continuing services when revenues fall beneath recent averages.

When the Annual Update Should be Submitted to the MHSOAC

Per **WIC § 5847** please submit your FY 2015-2016 MHSA Annual Update to the MHSOAC within 30 days of adoption by the Board of Supervisors. All FY 2015-2016 Annual Updates must be received by the MHSOAC no later than **December 30, 2015**.

Attachment I
FY 2013-14
Revenue and Expense Report

Annual Mental Health Services Act Revenue and Expenditure Report
FY 2013-14 Summary

TABLE A

Enclosure 3

COUNTY: El Dorado

DATE: 09/28/2015

PEI Statewide Funds assigned to CalMHSA? (Y/N)	Yes

	Fiscal Year 2013-14	(A) Community Services and Supports	(B) Prevention and Early Intervention	(C) Innovation	(D) Workforce Education and Training	(E) Capital Facilities and Technological Needs	(F) TTACB	(G) WET Regional Partnerships	(H) PEI Statewide Projects Funds	(I) Prudent Reserve	(J) Total-All Components
1	**Unspent Funds Available From Prior Fiscal Years[1]**										
	a Local Prudent Reserve									$1,898,284	$1,898,284
	b FY 2006-07 Funds				$0						$0
	c FY 2007-08 Funds				$0	$0					$0
	d FY 2008-09 Funds	$0	$0	$0	$2,084	$0	$0	$0	$0		$2,084
	e FY 2009-10 Funds	$0	$0	$0	$0	$0	$0	$0	$0		$0
	f FY 2010-11 Funds	$0	$0	$567,681	$389,700	$770,953	$24,366	$0	$0		$1,752,700
	g FY 2011-12 Funds	$1,356,304	$565,045	$198,100	$0	$0	$21,700	$0	$360,859		$2,502,008
	h FY 2012-13 Funds	$4,913,551	$1,228,388	$323,260	$0	$0					$6,465,199
	i Cumulative Interest	$16,398	$7,287	$6,447	$2,794	$10,647	$317	$0	$3,337		$47,227
	j TOTAL	$6,286,253	$1,800,720	$1,095,488	$394,578	$781,600	$46,383	$0	$364,196	$1,898,284	$12,667,502
2	**MHSA Funds Revenue in FY 2013-14[2]**										
	a Transfer of funds from the Local Prudent Reserve	$0	$0							$0	$0
	b FY 2013-14 MHSA Revenue Received	$3,819,655	$954,914	$251,293							$5,025,862
	c FY 2013-14 Interest Earned on MHSA Funds	$13,680	$3,919	$2,384	$859	$1,700	$0	$0	$0	$0	$22,542
	d TOTAL	$3,833,335	$958,833	$253,677	$859	$1,700	$0	$0	$0	$0	$5,048,404
3	**Expenditure and Funding Sources for FY 2013-14[3]**										
	A MHSA Funds										
	a FY 2006-07 MHSA Funds				$0						$0
	b FY 2007-08 MHSA Funds				$0	$0					$0
	c FY 2008-09 MHSA Funds				$2,084	$0		$0			$2,084
	d FY 2009-10 MHSA Funds				$0	$0		$0			$0
	e FY 2010-11 MHSA Funds				$198,329	$177,956		$0			$374,285
	f FY 2011-12 MHSA Funds	$1,356,304	$565,045	$1,056	$0	$0	$10,656	$0	$240,581		$2,173,642
	g FY 2012-13 MHSA Funds	$1,089,573	$48,446	$0	$0	$0					$1,138,019
	h FY 2013-14 MHSA Funds	$0	$0	$0	$0	$0					$0
	MHSA Net Expenditures Subtotal for FY 2013-14	$2,445,877	$613,491	$1,056	$198,413	$177,956	$10,656	$0	$240,581		$3,688,030
	i Interest	$0	$0	$0	$0	$0	$0	$0	$0		$0
	B Other Funds										
	a 1991 Realignment	$0	$0	$0	$0	$0	$0	$0	$0		$0
	b Behavioral Health Subaccount	$0	$0	$0	$0	$0	$0	$0	$0		$0
	c Other	$0	$0	$0	$0	$0	$0	$0	$0		$0
	d TOTAL MHSA and Other Funds	$2,445,877	$613,491	$1,056	$198,413	$177,956	$10,656	$0	$240,581		$3,688,030
	e Total Program Expenditures	$2,445,877	$613,491	$1,056	$198,413	$177,956	$10,656	$0	$240,581		$3,688,030

NOTE TO COUNTY: Total Program Expenditures, 3(d), MUST match Total Expenditure Funding Sources, 3(e). If ERROR, recheck and correct.

Updated: 07/24/2015

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2013-14
Community Services and Supports (CSS) Summary

County: El Dorado Date: 09/28/2015

Community Services and Supports Component	Total (Gross) Mental Health Expenditures
FSP Programs	
1 CSS WP1 Youth and Family Strengthening	$209,961
2 CSS WP2 Adult Wellness & Recovery	$499,369
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	
24	
25	
Subtotal FSP Programs	$709,330
Non-FSP Programs	
1 CSS Non-FSP	$1,054,520
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
Subtotal Non-FSP Programs	$1,054,520
Total FSP and Non-FSP Programs	$1,763,850
CSS Evaluation	
CSS Administration	$682,027
CSS MHSA Housing Program Assigned Funds	
Total CSS Expenditures	$2,445,877

Updated: 05/08/2015

Enclosure 3

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2013-14
Prevention and Early Intervention (PEI) Summary

County: El Dorado **Date:** 09/28/2015

Prevention and Early Intervention Component	(A) Total (Gross) Mental Health Expenditures
PEI Programs-Prevention	
1 WP2 Community Education Project	$51,128
2 WP4 Wellness Outreach/Vulnerable Adults	$88
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
Subtotal PEI Programs-Prevention	$51,216
PEI Programs-Early Intervention	
1 WP1 Youth and Children's Services	$182,352
2 WP3 Health Disparities Program	$207,369
3 WP5 Community-Base Services	$115,430
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
Subtotal PEI Programs-Prevention	$505,151
PEI Programs-Other	
1	
2	
3	
Subtotal PEI Programs-Other	$0
Subtotal PEI Programs-Prevention & Early Intervention and Other	$556,367
PEI Evaluation	
PEI Administration	$57,124
Total PEI Expenditures	$613,491

Updated: 05/08/2015

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2013-14
Innovation (INN) Summary

County: El Dorado **Date:** 09/28/2015

Innovation Component	(A) Total (Gross) Mental Health Expenditures
Innovation Programs	
1 Planning	$0
2 Closing the Gap	$0
3	
4	
5	
6	
7	
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19	
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21	
22	
23	
24	
25	
Subtotal	$0
Innovation Evaluation	$0
Innovation Administration	$1,056
Total Innovation Expenditures	$1,056

Updated: 05/08/2015

Enclosure 3

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2013-14
Workforce Education and Training (WET) Summary

County: El Dorado **Date:** 09/28/2015

Workforce Education and Training Component	(A) Total (Gross) Mental Health Expenditures
WET Funding Category	
Workforce Staffing Support	$5,313
Training and Technical Assistance	$144,743
Mental Health Career Pathways Programs	$1,252
Residency and Internship Programs	
Financial Incentive Programs	
Total WET Programs	$151,308
WET Administration	$47,105
Total WET Expenditures	$198,413

Updated: 05/08/2015

Annual Mental Health Services Act Revenue and Expenditure Report
Fiscal Year 2013-14
Capital Facilities/Technological Needs (CF/TN) Summary

County: El Dorado **Date:** 09/28/2015

Capital Facility/Technological Needs Projects	(A) Total (Gross) Mental Health Expenditures
Capital Facility Projects	
1 WP1 Electronic Health Record (CWS)	$138,903
2 WP 2 Telehealth	$34,918
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
Total CF Projects	$173,821
Capital Facility Administration	$4,135
Total Capital Facility Expenditures	$177,956
Technological Needs Projects	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
Total TN Projects	$0
Technological Needs Administration	
Total Technological Needs Expenditures	$0
Total CFTN Expenditures	$177,956

Updated: 05/08/2015

Annual Mental Health Services Act Revenue and Expenditure Report
Fiscal Year 2013-14
Other MHSA Funds Summary

County: El Dorado **Date:** 09/28/2015

	(A) Total (Gross) Expenditures
Training, Technical Assistance and Capacity Building	$10,656
WET Regional Partnerships	$0
PEI Statewide Projects	$240,581

Updated: 07/24/2015

Enclosure 3

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2013-14
Adjustments Summary

County:

Date: 09/28/2015

FY	Amount	Reason For Adjustment
2013-2014	$10,656	To use FY10-11 fund balance 1st for expenses
2012-13	-$2,815,425	To record County Auditor Adj of MHSA Fund Balance due to unposted MHSA Charges in FY 2010-11. Due to the length of time between FY 10-11 and this adjustment being recoginized on the RER, the funds had to be adjusted from the FY 12-13 RER.
2011-12	-$18,469	To record County Auditor Adj of MHSA Fund Balance due to unposted MHSA Charges in FY 2010-11. Due to the length of time between FY 10-11 and this adjustment being recoginized on the RER, the funds had to be adjusted from the FY 11-12 RER.
2010-11	-$53,504	To record County Auditor Adj of MHSA Fund Balance due to unposted MHSA Charges in FY 2010-11
TOTAL	**-$2,876,742**	
	-$2,876,742	

NOTE TO COUNTY: Total Adjustments recorded in the Adjustments Summary worksheet MUST match Total Adjustments recorded on the RER Summary Worksheet. If ERROR, recheck and correct.

Updated: 05/08/2015

Annual Mental Health Services Act Revenue and Expenditure Report
FY 2013-14

END NOTES:

[1] Total unspent funds from prior fiscal years MUST match the Total Unspent Funds in the Local MHS Fund from prior year RER.

[2] DHCS will utilize the allocation report provided by the SCO and counties should utilize the same report when determining the total State MHSA Fund revenue to be reported on the FY 2013-14 RER. The report is available at: http://www.sco.ca.gov/ard_payments_mentalhealthservicefund.html

[3] Expenditure funding sources for each component must equal the total program expenditures as reported on the Component Summary Worksheets.

[4] WIC Section 5892(b) permits a County to use up to 20 percent of the average amount of funds allocated to the county for the previous five years to fund technological needs and capital facilities, human resource needs, and a prudent reserve. The amount of funds transferred from CSS will be reported in the CSS column as a negative amount. The funds transferred into WET, CFTN, or Prudent Reserve should be reflected as a positive amount. For each year reported, the amount transferred from CSS should equal zero when added to the funds transferred into WET, CFTN, or Prudent Reserve.

[5] Payments from the MHSA Fund should be reflected in the Adjustments section as a negative amount. Receipts into the MHSA Fund should be reflected in the Adjustments section as a positive amount.

[6] Total Unspent funds in the Local MHS Fund will auto populate for each Fiscal Year.

[7] The FFP amount represents the estimated FFP revenue generated in FY 2013-14 and attributable to MHSA funds.