2010/11 ANNUAL UPDATE **EXHIBIT A**

COUNTY SUMMARY SHEET

This document is intended to be used by the County to provide a summary of the components included within this annual update or update. Additionally, it serves to provide the County with a listing of the exhibits pertaining to each component.

County:	***El Dorado***																				
			Exhibits																		
			A	**B**	**C**	**C1**	**D**	**D1***	**E**	**E1**	**E2**	**E3**	**E4**	**E5**	**F****	**F1****	**F2****	**F3****	**F4****	**F5****	**G*****	**H******
For each annual update/update:			☑	☑	☑	☑			☑													
Component	**Previously Approved**	**New**																				
☑ CSS	$5,265,407	$4,588,048				☑	☑	☑		☑					☐	☐					☐	☐
☑ WET	$310,500	$363,682				☑	☑	☑			☑				☑	☑						
☐ CF	$	$						☐				☐			☐		☐					
☐ TN	$	$						☐				☐			☐			☐				
☑ PEI	$ 635,998 (6 months)	$2,018,644				☐	☑	☐					☑		☑				☑			
☐ INN							☐	☐						☐	☐					☐		
Total	$ 6,211,905	$ 6,970,374																				

Dates of 30-day public review comment period:	August 6, 2010 - September 6, 2010
Date of Public Hearing***:**	Tuesday, September 07, 2010
Date of submission of the Annual MHSA Revenue and Expenditure Report to DMH:	**6/30/2010**

*Exhibit D1 is only required for program/project elimination.

**Exhibit F - F5 is only required for new programs/projects.

***Exhibit G is only required for assigning funds to the Local Prudent Reserve.

****Exhibit H is only required for assigning funds to the MHSA Housing Program.

*****Public Hearings are required for annual updates, but not for updates.

COUNTY CERTIFICATION

County: El Dorado

County Mental Health Director	**Project Lead**
Name: Neda West	Name: Chris Kondo-Lister
Telephone Number: 530-621- 6156	Telephone Number: 530-621-6290
E-mail: Neda.West@edcgov.us	E-mail: Christine.Kondo-Lister@edcgov.us
Mailing Address: El Dorado County Health Services Administration 931 Spring Street Placerville CA 95667	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations, laws and statutes for this annual update/update, including all requirements for the Workforce Education and Training component. 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.

This annual update has been developed with the participation of stakeholders, in accordance with sections 3300, 3310, subdivision (d), and 3315, subdivision (a). The draft FY 2010/11 annual update was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health commission. All input has been considered with adjustments made, as appropriate.

The County agrees to participate in a local outcome evaluation for the PEI program(s) identified in the PEI component.[1]

The County Mental Health Director approves all Capital Facilities and Technological Needs (CFTN) projects.

The County has complied with all requirements for the Workforce Education and Training component and the Capital Facilities segment of the CFTN component.

The costs of any Capital Facilities renovation projects in this annual update are reasonable and consistent with what a prudent buyer would incur.

The information provided for each work plan is true and correct.

All documents in the attached FY 2010/11 annual update/update are true and correct.

Neda West _____ _____

Mental Health Director/Designee (PRINT) Signature Date

[1] Counties with fewer than 100,000 residents, per Department of Finance demographic data, are exempt from this requirement and may strike this line from the certification.

HEALTH SERVICES DEPARTMENT

MENTAL HEALTH DIVISION

Treatment Works, People Recover
El tratamiento es efectivo, las personas se recuperan

Neda West, Director / Christine Kondo-Lister, LCSW, Deputy Director
670 Placerville Drive, Suite 1B, Placerville, CA 95667 (530) 621-6200 / Fax (530)295-2639

Mental Health Services Act (MHSA)
FY 2010/11
Administrative Costs

The County of El Dorado is submitting FY 2010/11 MHSA Plan Update documents representing a total funding request of $6,970,374, described below. As specified in DMH Information Notice 10-09, page 9, this document serves as a signed statement which accompanies the County's request for administrative costs above 15 percent (15%) of the total direct program costs.

1) The Community Services and Supports (CSS) Annual Update includes a request for funding in the amount of $3,260,500 combined with FY 2010/11 carryover funds of $1,327,548 for a total plan amount of $4,588,048. The total combined funds are requested to be allocated as follows:
    - Program Plan: $3,342,110
    - County Administration: $828,843
    - Operating Reserve: $417,095

2) The Workforce Education and Training (WET) Annual Update includes a request for funding in the amount of $363,682. The total combined funds are requested to be allocated as follows:
    - Program Plan: $261,981
    - County Administration: $68,639
    - Operating Reserve: $33,062

3) The Prevention and Early Intervention (PEI) Annual Update includes a request for funding in the amount of $2,018,644. The total combined funds are requested to be allocated as follows:
    - Program Plan: $1,595,766
    - County Administration: $239,365
    - Operating Reserve: $183,513

County administrative costs exceed the recommended funding limit of 15% in both the CSS and WET plan, as follows:

- CSS county administrative costs of $828,843 represent 24.8% of program costs
- WET county administrative costs 0f $68,639 represent 26.2% of program costs

Administrative costs for the county's PEI plan are maintained within the 15% recommended funding limit because that plan contains a high proportion (approximately 38%) of subcontracted serves. In contrast, subcontracted services account for less than 5% of the CSS and WET program budgets. Additionally, administrative costs in the County of El Dorado may be high relative to some other California counties because of our smaller size. Representatives from small counties have in the past discussed the recommended funding limit of 15% for administration costs and several counties have

experienced that this percentage is inadequate to fund their true administrative costs. In the past, representatives from the State have acknowledged that there may be merit to the argument that small counties require a larger percentage for administrative costs.

The administrative costs allocated to El Dorado County's MHSA program for FY 2010/11 were derived using methodologies consistent with both DMH Letter No. 05-10 and with former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225). Also, Welfare and Institutions Code Section 5891 states, "The state shall not make any change to the structure of financing mental health services, which increases a county's share of cost or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk." In consideration of these guidelines and regulations, the County respectfully requests approval for an allocation in excess of the 15% recommended for FY 2010/11.

In summary, this document serves to verify that:

- The additional county administrative costs are based on an acceptable allocation method, consistently applied by the county in similar circumstances, which allocates an increased share of costs to the MHSA funding stream in proportion to the benefit to the program/project; and,
- That these costs do not violate the requirements of Welfare and Institutions Code section 5891, subdivision (a), and California Code of Regulations section 3410.

Neda West _____ _____

Mental Health Director Signature Date

COMMUNITY PROGRAM PLANNING AND LOCAL REVIEW PROCESS

County: El Dorado

Date: September 28, 2010

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this annual update/update per title 9 of the California Code of Regulations, sections 3300 and 3315.

Counties may elect to attach the Mental Health Board meeting minutes in which the annual update was discussed if it provides additional information that augments the responses to these questions.

Community Program Planning
1. Briefly describe the Community Program Planning (CPP) Process for development of the FY 2010/11 annual update/update. Include the methods used to obtain stakeholder input.
MHSA Community Meetings and Advisory Meetings were held twice since the last MHSA Annual update was approved. Updates regarding plan progress, anticipated changes, budget issues and future planning were discussed. In addition, Community Program Planning (CPP) targeted focus groups were conducted and included updates and inquiries regarding previously approved plans, as well as components pending an approved plan. MHSA updates and discussions have also taken place in the Mental Health Division (MHD) Leadership Teams and the three Clinical Treatment Teams. Finally, MHSA updates and discussions have taken place as part of the Mental Health Commission meetings both in Placerville and South Lake Tahoe.
2. Identify the stakeholder entities involved in the Community Program Planning (CPP) Process.
The general public are invited to the MHSA Community Meetings; the MHSA Advisory Committee is represented by the County Office of Education, Shingle Springs Rancheria, consumer and family members, Calworks program, NAMI, Public Health Division, Marshall Medical Center, Community Health Center, Alcohol and Drug Treatment Programs, Center for Violence-free Relationships, Probation Department, Sheriff's Department, Foster Parent Association, Family Resource Center, 1st Five, and Department of Human Services. The representatives who participated in the most recent CPP planning process included Mental Health Division staff, NAMI, the Mental Health Commission, local Community Strengthening Groups, El Dorado Hills community representatives, Georgetown Divide community representatives, PFLAG, SPEAR, Center for Violence-free Relationships, Senior Peer Counseling, Peer Counselors, and Human Services Ombudsman.
3. If eliminating a program/project, please include how the stakeholders were involved and had the opportunity to participate in the decision to eliminate the program/project.
The proposal and rationale to eliminate the MHSA Loan Assumption, BHC Client Outcomes, and unfunded programs under WET were discussed at the MHSA Community Meetings, MHSA Advisory Meetings, and Mental Health Commission meetings and the MHD Leadership Meetings.
Local Review Process
4. Describe methods used to circulate, for the purpose of public comment, the annual update or update.
The Annual Update was posted on the Mental Health Division website on August 6, 2010 for a 30-day review period. E-mail notifications were sent to a 400-member MHSA e-mail group, the Mental Health Commission members, the Chief Administrative Office (CAO), the Board of Supervisors' offices, the MHSA Advisory Committee members, and the Mental Health Division staff. The notification on the e-mail and on the web-site indicated that feedback and/or questions could be submitted via e-mail, regular mail, or to a specific phone line. Further, details regarding the Public Hearing were also provided as a venue for providing feedback. The Public Hearing was scheduled to be hosted by the Mental Health Commission on Tuesday, September 7, 2010 at 12 pm at the Public Health Division facilities both in Placerville and South Lake Tahoe via teleconference.

COMMUNITY PROGRAM PLANNING
AND LOCAL REVIEW PROCESS

5. Include substantive comments received during the stakeholder review and public hearing, responses to those comments, and a description of any substantive changes made to the proposed annual update/update that was circulated. The County should indicate if no substantive comments were received.

Public Hearing regarding the El Dorado County MHSA Plan Update for FY 2010-11
Summary of Community Discussion – September 7, 2010.

The El Dorado County Mental Health Commission hosted a public hearing on Tuesday, September 7, 2010 regarding the County's MHSA Plan Update. The hearing was held from 12:00 – 1:00 p.m. in the Public Health/EMS teleconference rooms at 415 Placerville Drive, Suite K in Placerville and 1360 Johnson Blvd #103 in South Lake Tahoe. Notice of the meeting was posted on the County website (http://www.edcgov.us/mentalhealth/mhsa.html), and press releases were sent to the following local newspapers:

- Mountain Democrat
- Sacramento Bee
- Tahoe Tribune
- Life Newspapers
- El Dorado Hills Telegraph
- Georgetown Gazette

In addition, e-mail notifications of the Public Hearing date, time and place were sent to:

- MHSA e-mail group
- Mental Health Commission
- MHSA Advisory Committee
- Board of Supervisors
- Chief Administrators Office
- Mental Health Division staff

Twelve (12) people attended the meeting and Lisa Shafer, chair of the South Lake Tahoe MH Commission, presided. The following is a summary of the public discussion.

Question /Comment

The Mental Health Commission has reviewed the MHSA Plan Update and issued two specific recommendations:

- The Commission is recommending changes in the Life Skills modules that are available to clients, specifically transitioning away from the modules currently in use and suggesting that other teaching materials – including those developed at Boston University - be explored and adopted; and,
- The Commission is recommending that the Plan Update include a renewed focus on enrichment activities for clients who reside in Board-and-Care facilities.

Ensuing Discussion

On behalf of the Mental Health Commission, Lisa Shafer noted that an assessment of groups, including those focused on Life Skills, had been done in South Lake Tahoe as part of the Commission's 2010 Annual Report[1]. The assessment found that clients were dissatisfied with the Life Skills modules, and at that time the Commission recommended that the MHD investigate other formats for the group process.

[1] El Dorado County Mental Health Commission 2010 Annual Report is available in the BOS agenda item 10-0350, 5/04/2010

Chris Kondo-Lister described alternate models currently being considered or implemented, including an Anger Management group and "Seeking Safety," an evidence-based group model for addressing substance abuse and trauma-related issues.

Please see WET Action #3 which now reflects changes to include a focus on the Psychiatric Rehabilitation Training approach out of Boston University.

Question/Comment
One individual commented on the importance of the PEI component. She noted that prevention and early intervention is extremely critical especially with regard to co-occurring disorders, adding that the use of drugs and alcohol can trigger a psychotic break.
Ensuing Discussion
There was general agreement that the services provided under the PEI plan, with their focus on youth and preventative programs, were needed, important and appreciated.

Question/Comment
Another individual commented on the difficulty experienced in trying to navigate the MHSA documents and expressed the hope that the Mental Health Commission would be kept informed and included early in the development process for future MHSA plans and updates.
Ensuing Discussion
Chris Kondo-Lister provided a timeline for the MHSA Plan Update for FY 2011-2012 (expected to begin after the first of the year and target a posting date of March 2011). She also outlined the planned development of an additional MHSA plan for Housing (with community meetings to start in September), as well as future planning for MHSA Innovation and Capital Facilities/Technology funds.

Question/Comment
A question was asked about the availability of MHD contracts with other providers of mental health services. The individual wanted to know if, when and where the terms of those contracts are available to the Mental Health Commission.
Ensuing Discussion
Chris Kondo-Lister explained that contracts which exceed a set dollar amount must be approved by the Board of Supervisors and are posted prior to approval on the BOS website. Brenda Bailey, a staff member in the office of the Board of Supervisors, added that the public can subscribe to receive regular updates to the Board agenda and minutes. She suggested that training in how to access and navigate the BOS website might be helpful, and Chris Kondo-Lister offered that such training could be provided at a future meeting of the MH Commission.

Question/Comment
A question was asked about the likelihood of a Board-and-Care facility being established in El Dorado County.
Ensuing Discussion
Chris Kondo-Lister described trying to work with a very well established provider of Board-and-Care facilities in Sacramento County. In this case, bringing a Board-and-Care facility to El Dorado County was not feasible due to both practical and financial issues. The MHD has been working with Transitional Homes in the County, and although these are different from Board-and-Care facilities, they do provide needed housing options for some of our clients. In addition, the MHD is

beginning discussions necessary to bring permanent, supported housing to El Dorado County through the use of MHSA Housing funds.

In addition, the following feedback was received during the 30-day Public Review and Comment Period:

August 23, 2010 – a list of questions was submitted by a subcommittee of the Mental Health Commission. The following is a list of the questions and the MHD responses:

Comments:
The WS and SLT Councils have delegated five members of the EDC Mental Health Commission to begin the process of carrying out our duties under Article IX of our Bylaws. We met at Lake Tahoe Community College on August 19, 2010. At that meeting and subsequently, each member of the committee has reviewed those documents available to us now.

Each member of the committee has communicated to me via e-mail some findings and questions.

We find that the documents do [not] contain enough information to enable us, or any reader, to know what outcomes are associated with any proposed contract. We acknowledge that there may be many other documents that spell out these outcomes, but we have not seen them.

We cannot determine from the documents available how *anyone* could determine, in terms of operational definition, what a contractor is contracted to accomplish for the money. Levels of effort, or the maximum hours that can be billed, is inadequate information, and not satisfactory to us. Most of the text wording is general, vague, and nonspecific. The Department may have operationally defined criteria for measuring performance, but none of the documents reviewed specify them. Invoices billing for hours is not the kind of outcome we are writing about.

The committee has named me as their chair, and asked me to collate their questions and present them to you, with the expectation that significant clarification will be forthcoming in time for the August 25 teleconference, or as soon thereafter as feasible.

It has been suggested to me that the wording in the documents that we have had a chance to see are *supposed* to be general, vague, and nonspecific, as they are to fulfill some State format, and are not intended to communicate what a contractor is actually to achieve in performance of their contract. If that be the case, then there must be other documents that would enable measuring contractor performance in terms of operationally defined outcomes. The term "evidence-based" has been employed in talking about mental health projects and practices. I stand by my request that we apply this concept to contractor performance. I affirm that some members have explicitly told me that they cannot tell what the contractor is actually supposed to be doing and achieving in exchange for the contract dollars.

Response:
The information and language used in the MHSA Plan Update draft is intended to address the questions posed in the required State Department of Mental Health (DMH) application for the FY 10-11 MHSA allocation of funds. Specific contract requirements and performance measures will be articulated in Service Agreements or Contracts proposed by the Mental Health Division (MHD), and upon approval of the County's MHSA Plan Update, approved and executed by the County of El

Dorado Purchasing Agent or Board of Supervisors.

In regard to evidence-based practices, while the MHSA strongly encourages application of these strategies, they are not required for all intervention strategies funded with these dollars.

For example:

1) Use of MHSA funds to pay for outreach and engagement services often will not involve evidence-based practices, but outreach and engagement is highly encouraged to increase access and decrease disparities;
2) The Wraparound program for youth that was highly encouraged under the CSS program was a Promising Practice at the time and some consider a Best Practice at this time – it has not yet been measured as an Evidence-based Practice; and,
3) Support for the use of culturally-specific strategies within various communities is encouraged yet many of these strategies are not considered “evidence-based”.

Therefore, the general expectation that contract providers, as well as the MHD, apply use of evidence-based practices in MHSA-funded programs is an appropriate and shared goal – but not an absolute requirement.

Comments:
CSS - "Other disciplines and community-based agencies" needs to be fully spelled out in detail. Specifically, how is the money requested for CSS to be used? What are the outcomes?

Response:
The reference speaks to the desire to continue to develop the Wellness Center to serve as a community-building force that is inclusive, normalizing, and holistic in supporting behavioral health recovery. While this effort may include contracting out services (to date, CSS funds contracts for vocational rehabilitation with Crossroads), many desired partnerships may entail in-kind support, pro-bono work, and volunteerism. The intended outcomes are community-capacity building, increased access to services, user-friendly one-stop model of service delivery, and the application of a whole person and community-integration approach.

For example:

- Human Services providing Benefits Screening.
- Social Security providing outreach and education regarding SSI.
- Public Health providing health education and screening.
- Drug and Alcohol Program providing prevention and education.
- 12 Step Groups

Comments:
P.E.I. Program 1. What does "expansion of the mechanisms for referral and access" mean in terms that we can fully understand? "Referrals from additional sources . . . ." Precisely, what are these additional sources? How many individuals are expected to be beneficiaries of the services budgeted for $319,768?
Response:
“Referrals from additional sources will be entertained.” on page 1 of the PEI plan was added to include sources of referral into the program beyond school personnel. Other potential sources of referral might include clinicians and other community organizations and agencies that serve families

in need. For the fiscal year, an estimate of 55 individuals will be served.

Comments:
PEI Program 2. Budgeted for $237,830. Which are the schools to be involved, and how many expected recipients in each named school?

Response:

School & Location	Number of Children Expected to Participate
Oak Meadow Elementary School, El Dorado Hills	42
Northside School, Cool	42
Georgetown School, Georgetown	42
Bijou Community School, South Lake Tahoe	60
Lake Tahoe Environmental Science Magnet School, South Lake Tahoe	30
Sierra House Elementary School, South Lake Tahoe	30
Tahoe Valley Elementary, South Lake Tahoe	60

Comments:
PEI Program 3. What are the specific sites, and how many intended beneficiaries?

Response:

Incredible Year (IY) Sites & Location	Number of Expected Participants (Families)
Independence High School, Diamond Springs	35
Mount Tallac Continuation School, South Lake Tahoe	10
Tahoe Tot Spot, South Lake Tahoe	10
White Rock Village Apartments, El Dorado Hills (2 sessions)	24
Union Mine High School, El Dorado	15

Comments:
PEI Program 4. In operationally defined terms, what outcomes are intended for this project? Describe the various users of the project in terms of computer skills and aptitudes needed.

COMMUNITY PROGRAM PLANNING
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Response:
There are several components that make up Program 4:

a) Parenting Wisely Program (Selective and Indicated Prevention Approaches) This parent training program targets parents with children ages 5-18. The Parenting Wisely Program uses a self-administered, interactive and multimedia CD-ROM as the training vehicle and thereby overcomes illiteracy and transportation barriers. Usage involves very limited computer skills; participants insert the DVD and follow guidelines provided on-screen.

b) NAMI training capacity building (Selective and Indicated Prevention Approaches)
The National Alliance on Mental Illness (NAMI) serves to provide awareness, education and advocacy as a means to offer hope, reform and health to the community. This group began in 1979 and represents families, friends and individuals affected by mental illness. The local NAMI chapters have been successfully providing the Family to Family Program (a 12-week course provided to families, friends, and caregivers and community members) by NAMI volunteers free of cost. This program does not require any computer skills.

c) PFLAG Community Education (Universal, Selective and Indicated Prevention Approaches)
As an approved PEI program under Community Education, the MHD is partnering with Parents, Families, Friends of Lesbians and Gays (PFLAG) to provide outreach, education and training to mental health providers and interested community members. PFLAG provides an opportunity for dialogue about sexual orientation and gender identity and acts to create a society that is healthy and respectful of human diversity. Their mission is to support diversity, community involvement to build understanding, education to reduce stigma, and advocacy to end discrimination. This program does not require computer skills.

d) Community Information Access
Under this program, a Community Access Site (CAS) or web-based community education and information resource center for consumers of mental health services, family members and community stakeholders will be initiated, as well. This community referral site provides free access to a comprehensive library of interactive online courses targeting the general public.

Topics include:
- General mental health
- Addiction, treatment and recovery
- Issues facing families
- Needs of children and adolescents
- Living with mental illness and working toward recovery
- Workforce skills – including basic computer training
- Issues related to older adults
- Needs of returning veterans
- WRAP information Center.

This program requires limited computer skills to navigate the website.

e) Consumer Leadership Academy
This program will include a Leadership Academy providing educational opportunities designed to inform and empower consumers in relationship to meaningful participation in the broader community.

COMMUNITY PROGRAM PLANNING
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This program has begun locally as a grassroots effort with very favorable response on both slopes. Consumers have identified a need for support related to transportation assistance, funding for food during activities, and training resources and fees. In addition, funding and the establishment of a stipend program to address costs incurred for participants will be pursued. One desired outcome is increased participation on the Mental Health Commission. Training will also be pursued through the California Institute on Mental Health (CIMH) for Mental Health Board Trainings and through the MHSA WET Regional Collaborative for the Recovery-Oriented Leadership series. Peer counselor training may also be included in future Leadership Academy training events.

For the Consumer Leadership Academy activities, transportation assistance for county-wide events will be made available on a quarterly basis. Healthy snacks will be funded for locally held monthly consumer meetings at both SLT and WS. Staff support for a range of these events will be provided, as well. The WET Coordinator, Patients Rights Advocate, and Volunteer Coordinators, and Mental Health Aides on both slopes will collaborate with consumers on this project. A meaningful role in the community may serve to be one of the most effective preventive measures to avoid relapse to illness.

This section of the plan will not require the use of a computer.

f) Mental Health First Aid
The MHD proposes to engage the local community and participate in a training program sponsored by the Central Region Collaborative to establish community Mental Health First Aid Trainers. These individuals will attend a weeklong training fully funded by the Central Region MHSA WET funds and return to the County to provide the training described below.

The Mental Health First Aid program is an interactive session which runs 12 hours and provides certification which must be renewed every three years. This training introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and provides an overview of common treatment modalities. Mental Health First Aid is designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The evidence behind the program demonstrates that it does build mental health literacy and helps the public to identify, understand and respond to signs of mental illness.

Intended Outcomes:
Mental Health First Aid in the US can become as common as CPR and First Aid. It has the potential to reduce stigma, improve mental health literacy, and empower individuals. As such, it has great potential as a community capacity building educational strategy. Staff and community members will be invited to become trainers and develop a county training plan.

Computer literacy is not required for this program.

Comments:
Program 5. Budgeted for $116,865. Define operationally the outcomes expected.

Response:
This project, Wennem Wadati – A Native Path to Healing, targets the PEI target population of *children and youth in stressed families* and, as such, is intended to address the community mental health

needs surrounding *at-risk children, youth and young adults*. This program was designed by and for the local Native American community thereby addressing the community mental health need of disparity in access. As a comprehensive program serving youth and families and individuals of all ages, this program also addresses populations of trauma-exposed individuals and children and youth who are at risk for school failure and at risk of juvenile justice involvement. Finally, given the disproportionately high rates of suicide among this population, this culturally-specific program is designed to address a high-risk population.

Mental Health Prevention Goal – Mental health promotion through a combination of mental health services and traditional cultural teachings unique to the local Native American community.

Approach -Universal, Selective, and Targeted Prevention.

Intervention Strategy/Model:
Native Americans suffer from a disproportionate level of health-related problems and shorter life spans. Traumatic stress issues, depression, anxiety and low self-esteem are focal issues in the management of self-care among Native American families. As such, a community and culturally-based PEI program serves as a critically needed strategy.

The Native American Resource Collaborative (NARC) has been working together toward the development of an innovative community-based approach to address alcohol, substance abuse, and mental health issues that is integrated and shaped by the values and traditions of Native Americans and their cultures. Another identified need was for a centralized location for Native American youth and families to get information about resources and how to access them.

Wennem Wadati – A Native Path to Healing applies a combination of mental health early intervention strategies, traditional cultural teachings, and crisis intervention support for youth within the public school system. Specifically, this program will provide outreach to Native American youth by inviting their participation in traditional talking circles (selective) and involving them in prevention activities. In addition, outreach to Native American families to participate in monthly traditional gatherings designed to spread cultural knowledge and family preservation (universal) will be conducted. Finally, during school hours, a phone line will provide access to an Native American mental health specialist who will be available via answering service to respond to school sites in situations where Native American students are experiencing a mental health crisis (indicated).

Intended Outcomes
This program is designed to –

- Improve the overall mental health care of Native American individuals, families, and communities;
- Reduce the prevalence and incidence of alcoholism and other drug dependencies;
- Maximize positive behavioral health and resiliency in Native American individuals and families thereby reducing the suicide risk, prolonged suffering, unemployment, and incarceration.
- Reduce school drop out rates.

This program will incorporate cultural, traditional and spiritual prevention interventions that have been proven effective in many Native American communities throughout tribal Nations in the United States. Continuous needs assessment and client surveys will be used to evaluate effectiveness. Evaluation will be ongoing throughout the program. NARC will conduct reviews of service documentation,

participant data, and survey results. The results and efficacy of the program will be shared with all participating agencies, including the MHD.

Comments:
PEI Program 6. How many meals expected to be delivered?

Response:
The current Area Plan (2009-2012) for the El Dorado County Area Agency on Aging reports that 385 people are served daily with 800 unduplicated participants annually in the Meals on Wheels program. Human Services also provides meals to seniors at seven dining facilities in the County. No meals are being paid for with MHSA funds. This MHSA program will provide outreach to seniors who are identified as experiencing mental distress as a result of identification by the meal delivery volunteers. In addition, an expansion of this program to include the target population of vulnerable adults will allow similar outreach, engagement and partnership with volunteers to adults who are isolated but may not be over the age of 60. The proposed program expansion is in response to community feedback regarding vulnerable adults who may not qualify for specialty mental health services and/or who may not be accessing mental health services but who are experiencing the risk factors associated with suicide, depression and isolation, limited social supports, and exposure to trauma.

Comments:
PEI Program 7. We request a detailed breakdown for "personnel expenditures" and "additional operating expenditures." Define operationally the outcomes Sandra Dunn and Associates contract to deliver for $31,744. Level of effort does not tell us what we should know. What exactly would Community Health Clinic do for the contracted funds? Is there to be a new FQHC? What is the group of private physicians? What was the initial cost of iREACH and what is the ongoing cost? Is this system not already in full implementation? Who are the anticipated "health care partners?"

Response:
To provide a better context for the responses to these questions, the following is a more detailed description of the Care Pathways model that is being applied in this PEI program. (After this description, each of the above questions is repeated and then answered.)

Care Pathways are a jointly developed series of shared, coordinated, and standardized steps/processes which are used by community health partners to bring about solutions to identified health challenges. The Care Pathways developed to-date among health partners in El Dorado County are based upon the successful outcome-based model initially developed in Ohio. Care Pathways currently in use within our County focus on helping individuals to: secure health insurance coverage; secure a medical home; use a medical home appropriately; access pediatric mental health services; and gain access to specialty care services. None of these existing Pathways were developed using MHSA funds. These cross-agency Pathways include step-by-step actions for obtaining the identified objective, resolving problems/barriers, and tracking outcomes.

Through this PEI plan, we are proposing to work collaboratively with the El Dorado County Community Health Center (a local FQHC), and other experienced resources, to develop and implement new Care Pathways specifically designed to improve health access and outcomes for adult clients with mental health needs. The proposed Pathways do not currently exist; however, once developed and implemented, will be available for use with multiple community health partners throughout our County. Specifically, we intend to develop a Pathway to ensure an effective two-way

referral process relative to mental health services (for primary care clients that may need referral to County Mental Health's high level of specialty mental health services, or for stabilized County Mental Health clients that become appropriate for referral to primary care for their psychiatric medication management, along with a lower level of behavioral health services available at a primary care setting such as a community health center/clinic). We also intend to develop a Pathway to ensure that clients who are appropriately receiving specialty mental health services from County Mental Health, are also referred to and properly using a primary care medical home to address other health issues. Ultimately, we'd like to develop additional Care Pathways/processes for improved integration of Mental Health, primary care, and alcohol/drug services.

PEI funding is proposed to be used to leverage existing resources and expertise. To support the development of new Pathways described above, we intend to procure support from individuals with prior experience in developing, implementing, and using Care Pathways in El Dorado County. We also propose obtaining evaluation support services from the Sphere Institute, or a similar firm specializing in outcome evaluation. The following summarizes the proposed experienced technical support and associated supplies:

Care Pathways/QA Manager (0.4 FTE)	$19,244	(Part-time staff in County Public Health)
Physician Champion (60 hours)	$6,000	(Such as, Jon Lehrman, M.D.)
Supplies	$1,500	
Evaluation Services	$5,000	(Such as, the SPHERE Institute)
Total	$31,744	

To support new Care Pathway design and implementation, we also propose funding staff within County Mental, as well as six months of dedicated staff (we anticipate a Clinical Social Worker, at approx. $48K) within the El Dorado County Community Health Center. We are referring to these cross-agency staff as Community Navigators since, during Pathway implementation/use, they will help individuals navigate the Care Pathways medical systems/processes and will ensure that any problems/barriers to accessing appropriate services are resolved. They will also actively work with clients to promote related self-care behaviors and assist in identifying and obtaining other natural supports that may be available within our communities to promote client wellness and recovery.

Program 7. We request a detailed breakdown for "personnel expenditures" and "additional operating expenditures."
Personnel and operating expenditures are itemized in some detail within the Budget Narrative section of Exhibit F, Program 7. Those details are included here, with additional comment included for clarification:

1. To continue services originally included as part of the Latino Engagement Initiative:
   - Personnel costs (salary and benefits) for a 0.1 FTE for a County Liaison /Utilization Review Coordinator: $12,772 [This is an EDC MHD employee who spends time providing oversight of the Latino Engagement Program.]
   - Subcontracted, professional services to provide preventative mental health services to the Latino population on the West Slope (WS) of El Dorado County and in South Lake Tahoe:
     - Family Connections (WS), $114,000 [This contract pays for community-based outreach, peer education, resource guidance and support, transportation, interpretation, prevention, early intervention, and engagement services at multiple community sites, neighborhoods and in homes to Latino adults, children and families on the Western Slope of El Dorado County.

Promotoras assist in identifying mental health needs and service options, and provide outreach to community groups; in addition, a group educator conducts on-going weekly support groups and facilitates community meetings to promote participants health, life and parenting skills, and to address the prevention of mental health issues.]

- Family Resource Center (Tahoe), $149,409 [This contract pays for Promotora services to include bilingual/bicultural Spanish-speaking outreach, engagement, screening, administration of outcome and satisfaction survey measures, service linkage, interpretation services and peer/family support to increase access and decrease health disparities. Peer and family support (individual and group) is provided for the duration of the mental health need. In addition, bilingual/bicultural Spanish-speaking early intervention counseling services may be provided for at-risk Latino individuals and their families.]

- Educational materials and supplies, $2,227
- Facility costs, indirect and overhead expenditures of $6,856. Operating expenditures include costs allocated based on the former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225), including facility expenses such as rent, utilities, and janitorial services, as well as other operating expenditures such as clinical management, computing equipment and software licensing.

2. New components of this program:
   - Primary Health Systems Linkage component, totaling $89,319. [These are EDC MHD employees who will be involved in the development and implementation of the Care Pathways to increase access and linkage for adults with behavioral healthcare and primary healthcare needs. Their roles will include working with clients to ascertain primary health care needs; interfacing with physicians to aid clients in finding a medical home; assessing and evaluating clients referred from health care partners for mental health needs; and providing administrative support and follow-up services.] By job category, anticipated personnel costs are comprised of the following:
     - Psych Tech, 20 hours/week for 25 weeks (approximately 500 hours or 0.25 FTE)
     - Pathways/QA Manager, 16 hours/week for 25 weeks (approximately 400 hour or 0.2 FTE)
     - Community-based Mental Health Clinician, 40 hours a week for 25 weeks (approximately 1,000 hours or 0.5 FTE)
     - 4 hours/week for 25 weeks (approximately 100 hours or 0.05 FTE) County Liaison/Utilization Review Coordinator
     - Medical Office Assistant 8 hours/week for 25 weeks (approximately 200 hours or 0.1 FTE)
     - Mental Health Program Coordinator at 4 hours/week for 25 weeks (approximately 100 hours or 0.05 FTE)
   - Additional operating expenditures in the amount of $62,675. Once again, operating expenditures include supplies, facility expenses such as rent, utilities, and janitorial services, as well as other operating expenditures such as clinical management, computing equipment and software licensing. These costs are allocated based on the former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225).
   - Professional services to develop and implement cross-agency outcomes-based Care Pathways and to mobilize movement toward linkage, collaboration and integration of physical and mental health services as described above:
     - Care Pathways Physician Champion (MD in role of Liaison/Advocate), $6,000
     - Program Evaluation Services for Care Pathways program, $5,000
     - Community Health Center, $48,000 [This will be used to fund salary and benefits for a full-time Licensed Clinical Social Worker (for a period of six months, equivalent to 0.5 FTE) who will help to coordinate services with the El Dorado County Community Health Center to

establish and utilize care pathways. This is time-limited funding to support the active participation of the Community Health Center; during the initial six months, it is anticipated that program start-up will require a higher level of systems development and implementation work. Thereafter, the ongoing navigation will be related to supporting clients needing services.]

Define operationally the outcomes Sandra Dunn and Associates contract to deliver for $31,744. Level of effort does not tell us what we should know.

We do not anticipate contracting with Sandra Dunn and Associates – information regarding the resources anticipated to be needed to develop and implement new Care Pathways specifically addressing behavioral health and primary care integration was acquired from Sandra Dunn as her agency had previously participated in development/implementation of other Care Pathways already being effectively utilized within the County.

As noted above, the PEI plan funds the development and implementation of care pathways for adults with mental health needs, including two-way referral pathways between County Mental Health and other community primary care partners. We anticipate that the broad outcomes will include the development of electronic care pathways support within iREACH to most efficiently facilitate the primary care and mental health care needs of adults. More specific contract negotiations are dependent on approval of the PEI funding request.

What exactly would Community Health Clinic do for the contracted funds?

As noted above, funding for the Community Health Center would support the hiring of a full-time Licensed Clinical Social Worker for a period of six months to participate with the MHD in development and implementation of care pathways in order to better coordinate primary care and mental health care services. This individual will help clients navigate the care pathways medical systems/processes and will ensure that any problems/barriers to accessing services are resolved. She/he will also work with clients to promote related self-care behaviors and will assist in identifying and obtaining other natural supports that may be available within communities to promote client wellness and recovery.

Is there to be a new FQHC?

This program does not fund the development of a new FQHC nor are we aware of any other project currently proposed or under discussion that would fund the development of a new FQHC. This program proposes working with an existing FQHC, the El Dorado County Community Health Center, in the development of Care Pathways to improve care for clients with mental illness.

What is the group of private physicians?

The private physicians involved in the Access El Dorado (ACCEL) Initiative are primarily associated with the agencies involved as community health care partners the ACCEL-Initiative's Care Pathways program. These are Barton Healthcare System, Marshall Medical Center, El Dorado County Community Health Center, and Shingle Springs Tribal Community Health Clinic. Existing Care Pathways involve participants from many disciplines: physicians, nurses, community health workers, mental health clinicians, and administrators.

COMMUNITY PROGRAM PLANNING
AND LOCAL REVIEW PROCESS

What was the initial cost of iREACH and what is the ongoing cost? Is this system not already in full implementation?

Initial funding for the ACCEL Initiative came when the El Dorado County Board of Supervisors allocated Tobacco Master Settlement Funds to address health care needs in the County. A variety of grants also supported ACCEL activities, including the Care Pathways developed to date. iREACH is the web-based health information management system that is used by the ACCEL community health partners; this technological tool is in place and will not be funded by MHSA. We do not have information on the initial and on-going cost of iREACH; most recently, funding and technical support for iREACH has been provided by two local, private hospitals.

However, in order for iREACH to be used to address the specific service needs of mental health clients, new pathways must be analyzed, mapped and programmed. To date, ACCEL has developed six care pathways to improve access to medical care and these are fully operational. This PEI plan funds the development and implementation of new care pathways specifically for adults with mental health needs. Currently these pathways do not exist. The funding requested for a Pathways/QA Manager (16 hours/week for 25 weeks) will be used to support this function. The plan is to use an existing tool (iREACH) and leverage existing collaborative resources and expertise to better coordinate health care services for adult mental health clients.

Who are the anticipated "health care partners?"
Community health care partners participating in the Access El Dorado (ACCEL) Initiative's Care Pathways program along with the County Health Services Department are: Barton Healthcare System (with affiliated medical providers and rural clinic), Marshall Medical Center (with affiliated medical providers and rural clinic), El Dorado County Community Health Center, and Shingle Springs Tribal Community Health Clinic.

Comment:
Across all Programs, what is the anticipated total funding for Community Health Center in the EDC MHD budget?

Response:
PEI Plan 7 Health Disparities (proposed) $48,000.

Comment:
What are the MHSA proposed or existing contracts, amounts, and provider locations proposed under this plan? Please provide a table with this information – including a brief description of each contract.

COMMUNITY PROGRAM PLANNING
AND LOCAL REVIEW PROCESS

Response:

Vendor	**Program: PEI**	**Amount**
Black Oak Mine School District 6540 Wentworth Springs Road PO Box 4510 Georgetown, CA 95634 Serving the communities of Pilot Hill, Cool, Greenwood, Georgetown, Garden Valley, Kelsey, and Volcanoville	#2 Primary Intervention Project (PIP) At two locations within the Georgetown Divide Region, teachers and a screening team will identify children "at risk" for developing emotional problems, as indicated by school adjustment difficulties. For children identified as appropriate for PIP intervention, trained PIP aids will provide program services in the form of one-on-one, non-directive play for approximately 30-45 minutes per week for 12-15 weeks.	$84,000
Vision Coalition: El Dorado Hills Community Vision 895 Embarcadero Drive #208 El Dorado Hills, CA 95762	#2 Primary Intervention Project (PIP). Vision Coalition will provide PIP services equivalent to those described in the Black Oak Mine School District contract at one location in El Dorado Hills. (Oak Meadow Elementary School).	$42,000
	#3 Incredible Years (IY) Vision Coalition will furnish personnel, materials and facilities necessary for County Mental Health staff to conduct IY Workshops in El Dorado Hills. Specifically, Vision Coalition will coordinate program advertisement and referrals, provide adequate facilities and custodial services, and provide the necessary materials and staffing for childcare activities while parents attend IY classes.	$10,000
Total VC Contracts Amount		$52,000
South Lake Tahoe Tot Spot Tahoe Tot Spot 1012 Al Tahoe Blvd South Lake Tahoe, CA 96150	#3 Incredible Years (IY) Use of the Tot Spot facility necessary for County Mental Health staff to conduct IY Workshops in South Lake Tahoe. This will include site supervision and the cost to provide an additional Child Care Worker.	$1,500

COMMUNITY PROGRAM PLANNING AND LOCAL REVIEW PROCESS

Vendor	**Program: PEI**	**Amount**
MHD partners with NAMI to have staff trained as trainers in NAMI modalities – no contract	#4 Community Education Project support Family to Family Training	$2,000
CiMH California Institute for Mental Health (CiMH) 2125 19th Street, 2nd Floor Sacramento, CA 95818	#4 Community Education Project-Provide Training to Mental Health Commission	$1,200
MHD purchases materials for distribution by PFLAG volunteers – no contract	#4 Conduct Education Project-materials, support Outreach, Education and Training Activities	$2,000
Foothill Indian Education Alliance 100 Forni Road Placerville, CA 95667 Mail to: P.O. Box 1418 El Dorado, CA 95623	#5 Wennam Wadati: This program will center on traditional talking circles, monthly family gatherings and crisis intervention for youth and families in El Dorado County. Specific services will include the implementation of school-based Talking Circles, Native American cultural activities, oversight of a dedicated telephone crisis line, and the provision of monthly student leadership youth activities, including suicide prevention strategies, mental and spiritual health issues, issues related to family dynamics, peer pressure, dating, mental health and wellness.	$116,865
Family Connections 344 Placerville Drive Suite 10 Placerville, CA 95667	#7 Health Disparities Provide Preventative Mental Health Services West Slope targeting the Latino population	$114,000
Family Resource Center 3501 Spruce Avenue, Suite B South Lake Tahoe, CA 96150	#7 Health Disparities Provide Preventative Mental Health Services South Lake Tahoe targeting the Latino population.	$149,409

COMMUNITY PROGRAM PLANNING AND LOCAL REVIEW PROCESS

Vendor	Program: PEI	Amount
Community Health Center El Dorado County Community Health Center 4327 Golden Center Dr Placerville, CA 95667	#7 Health Disparities: specifically to ensure smooth transitions for clients who are referred for mental health services by primary care or need to be seen by a primary care provider – develop and implement cross agency outcomes-based Care Pathways and to mobilize movement towards linkage, collaboration and integration of physical and mental health care.	$48,000
Public Health Division costs – Care Pathways Manager and Supplies El Dorado County Health Services Public Health Division 931 Spring Street Placerville, CA 95667	#7 Health Disparities: specifically to ensure smooth transitions for clients who are referred for mental health services by primary care or need to be seen by a primary care provider – develop and implement cross agency outcomes-based Care Pathways and to mobilize movement towards linkage, collaboration and integration of physical and mental health care.	$20,744
Dr Jon Lehrman – Physician Champion Family Practice Marshall Center Provider 1095 Marshall Way Placerville, CA 95667	#7 Health Disparities: specifically to ensure smooth transitions for clients who are referred for mental health services by primary care or need to be seen by a primary care provider –develop and implement cross agency outcomes-based Care Pathways and to mobilize movement towards linkage, collaboration and integration of physical and mental health care.	$6,000
SPHERE – evaluation component The SPHERE Institute 500 Airport Blvd. Suite 340 Burlingame, CA 94010	#7 Health Disparities: specifically to ensure smooth transitions for clients who are referred for mental health services by primary care or need to be seen by a primary care provider – develop and implement cross agency outcomes-based Care Pathways and to mobilize movement towards linkage,	$5,000

	collaboration and integration of physical and mental health care.	
Vendor	**Program: CSS**	**Amount**
Crossroads Diversified 9300 Tech Center Drive #100 Sacramento, CA 95826	#2: Adult Wellness and Recovery Services. Crossroads will provide vocational rehabilitation and related skills training to severely mentally ill adults. Specific services consist of vocational assessment, pre-employment classes, individual support services to aid clients in finding employment, employment preparation classes, job development and placement services, post-employment support, small business development, and additional support services as needed.	$99,800
Trails Trails at the Lake 2572 Lake Tahoe Blvd. #2 South Lake Tahoe, CA 96150	#2: Adult Wellness and Recovery Services. Trails will provide services necessary to enable clients referred by the County to engage in work readiness activities including competitive employment. Specific services include vocational assessment, pre-employment classes, job development and placement services and other employment-related services similar to those described in the Crossroads Diversified contract.	$30,000
Turning Point Turning Point Community Programs (TPCP) 3440 Viking Drive, Suite 114 Sacramento, CA 95827	#2: Adult Wellness and Recovery Services. Turning Point serves as a consultant and expert in the provision of Full Service Partnership (FSP) training, assessment and planning to ensure quality of services and MHSA program compliance. Services will consist of Recovery-Oriented Immersion training for staff and community partners; coordination of informant interviews, focus groups and partnership meetings to address	$58,000

	community mental health and FSP issues; focused client assessment to ensure that the appropriate clients are served by this model; and specialized FSP treatment planning.	

August 25, 2010 – additional questions were posed verbally in a joint Mental Health Commission meeting. The following is a list of the questions and the MHD responses:

Feedback:
It is difficult to determine from the MHSA Plan draft what the contractors are expected to deliver in regard to measurable outcomes.

Response:
The DMH-required MHSA plan application form and structure dictates what information is requested and therefore provided by counties. The information requested ensures compliance with the MHSA requirements. The County later develops contracts when community providers are used to deliver MHSA services; these contracts articulate the scope of work, reporting requirements, and deliverables, and other performance measures. The contracts also specify the compensation terms and include many other contract provisions.

Question:
How much leeway is built into the MHSA plan application? In other words, the Mental Health Commission needs to know how much detail realistically should be expected in the Plan?

Response:
The State DMH actually publishes a document that shows how they review the Plan Updates and this document is available on their website and can be shared with the Mental Health Commission at the next meeting.

Question:
What are the services and programs proposed under the CSS program? Why is there so little information about this program?

Response:
The CSS program update pages are more limited in number than those under WET and PEI largely because in following the DMH application structure, limited information was requested since these programs are not being changed.

Under CSS there are now two programs:

- The Family and Youth Strengthening Program includes Wraparound Full Service Partnerships, use of evidence-based practices, and a Transitions Program for youth in detention
- The Adult Wellness and Recovery Services Program includes Assertive Community Treatment (ACT) Full Service Partnerships, a Wellness Center program offering groups and a clubhouse, as well as case management and counseling services

Contracted services include vocational rehabilitation and a proposed new contract with Turning Point

to provide a Full Service Partnership program assessment.

Feedback:
The Commission would like to know what agencies are receiving MHSA funding, the amounts, and what the contracts are for.

Response:
A table of the contract providers and contract amounts was provided to one of the subcommittee members – however, this did not include the CSS contracts mentioned above. We will amend the list to include the CSS information.

Question:
Why are MHSA funds being used to pay for a new FQHC?

Response:
The statement about developing a new FQHC on the PEI Program #7, Health Disparities, Exhibit F4 was provided as background information in relationship to an existing program – ACCEL in which a FQHC was established in El Dorado County with Tobacco Settlement funding through the efforts of the Public Health Department in 2002. There is no plan to use MHSA funds to create another FQHC in El Dorado County.

MHSA funds are being proposed to build on this project by use of the successful Care Pathways model to better coordinate referrals and linkage to services for adults with serious mental illness. Some adults may first approach the MHD for mental health services but are more appropriate for services provided at the FQHC. Conversely, some adults may approach the FQHC but require specialty mental health services, such as those provided by the MHD. Finally, some clients appropriately served at the MHD may need a primary healthcare home and doctor, and the FQHC may be the appropriate provider for those services. Each of these instances can benefit from having a clearly defined and agreed upon pathway or referral system by which clients can be effectively linked to the appropriate level and type of services to best meet their needs.

Question:
Why are the Latino and Native American programs being eliminated?

Response:
The Exhibit D1 was completed, as required, for the CSS program. This form was used to indicate that, as approved in the last plan update, the Health Disparities programs were moved from the CSS program to the PEI program in January 2010. As a result, the contracted services formerly funded by MHSA CSS funds were transferred to be funded by MHSA PEI funds, and the Health Disparities program was “eliminated” from the CSS program. Contracted services to the Latino population in SLT and the WS are continuing uninterrupted and services to the Native American population will be funded under PEI Program #5.

Question:
Doesn’t the Vision Coalition and the Community Health Center have other grant funds and/or funding sources?

Response:
We believe these agencies may have other grant funding but this would need to be confirmed with them. In regard to the proposed MHSA funding for these agencies, it is important to keep in mind that grant funds are typically earmarked for specific projects. For example, the MHSA funds proposed for the specific MHSA projects in this Plan Update cannot be used for other operational needs at the Vision Coalition or Community Health Center. It is our understanding that MHSA funds are needed for these agency projects because they do not have alternative funding sources that can pay for these MHSA-proposed projects.

September 2, 2010 – Recommendations were formally approved for submission by the Mental Health Commission to the MHD in relationship to the FY 10/11 MHSA Plan Update. The following is a list of the recommendations and the MHD responses:

Feedback:
The majority of the Commission members felt that they did not have enough information about the MHSA plan.

Response:
The MHD recognizes that this document contains a large amount of information and can be difficult to read. It was clarified that the document is comprised of the State-required forms necessary to acquire the MHSA funding. In addition, the MHD has recently experienced significant and fast-paced change at the programmatic, fiscal and administrative levels in order to address recent serious fiscal challenges. As a result, time will be required to work together to share information and provide the necessary training so that the Commission feels better informed. The MHD is committed to working in partnership with the Commission to this end.

Feedback:
Based on the findings in the Commission's report to the Board of Supervisors in March 2010, we [the Commission] recommend that the Mental Health Division develop an alternate means of providing psychiatric rehabilitation services, other than using the Life Skills Modules published by Robert Liberman, et al, from work done at the Veterans Hospital-Brentwood. We advise that the Division redirect the $31,000 identified for training staff on evaluations of the Liberman materials. The Commission has already evaluated the way those materials have been used, via consumer interviews, and has found sufficient dissatisfaction to warrant a new approach. The funding should instead go towards purchasing a set of materials developed by the Center for Psychiatric Rehabilitation, affiliated with Boston University, and evaluating their approach. In the first year, this funding may go also towards staff training in the use of these materials. We request that the staff develop a plan to phase out the Life Skills Modules, while implementing the Boston University approach. We realize that this will take several months to accomplish. Consumers who seem to be receiving some benefit from the Modules considered appropriate for them would complete them through the end of the respective workbooks as the new program is phased in. The Consumer Leadership Committee would be a good choice to look over possible new programs.

Response:
The MHD has taken note of the feedback from 14 South Lake Tahoe consumers regarding the skills training classes. Since March, alternative group models have been investigated. As a result, both WS and SLT staff have been trained in an anger management group module and materials for

another group model addressing trauma and addictions has been purchased – training will be pursued, as well. The MHD is very interested in learning about the Boston University approach and has requested information from a graduate of this program. In addition, other models will be explored. At this time, there is not a specific plan to phase out the skills training classes – a key strategy is to ensure that there are treatment options and consumer choice. However, the MHD is committed to investigating and considering other approaches, such as that of Boston University.

Feedback:
The Commission would like to have provisions made for ways to enrich the lives of consumers who live in Board and Care facilities and for those who have living arraignments that are not ideal. The above mentioned consumers should have more enriching experiences outside in the real world. The Commission would like to see where in the MHSA plan are there provisions for the enrichment of consumer residents in Board and Care and what the exact allocation is.

Response:
On the second page of Exhibit D, under the Wellness Center and Clubhouse, the following statement is included:

"Community reintegration activities and life skills training will be provided for Crisis Residential Treatment Facility clients and others deemed appropriate. The target population includes clients who reside in Board and Care Homes."

It is under this CSS Plan #2, funded at $2,753,432/year that MHSA funds may be applied for enrichment activities for clients who reside in Board and Cares.

September 2, 2010 - Recommendations were presented verbally by the Consumer Leadership subcommittee of the Mental Health Commission to the MHD in relationship to the FY 10/11 MHSA Plan Update. The following is a list of the recommendations and the MHD responses:

Feedback:
The Consumer Leadership Subcommittee of the MH Commission recommended combining the budget line items for stipends ($5,000) and training ($10,000) for the Leadership Academy for increased flexibility in the use of these dollars. They further requested clarification regarding the distinction between strategies to address consumers and strategies to address family members under the MHSA PEI Community Education Program #4. In addition, they recommended that staff resources to support the Leadership Academy are extra help mental health aide positions filled with consumers.

Response:
The budget has been adjusted as suggested for increased flexibility. The language in the plan has been amended to clarify that there was an intended distinction between activities for the Consumer Leadership Academy (transportation assistance, funding for stipends and training) versus activities in support of the Mental Health Commission training ($1,200). The language in the plan has been amended to clarify that the role of the Patient Rights Advocate and the WET Coordinator is targeting the WET - funded Volunteer Program - we do anticipate that both consumers and family members will continue to serve as volunteers and thereby will benefit from this program. Extra help mental health aides will be available to assist and participate in the quarterly county-wide gatherings of the Leadership Academy.

2010/11 ANNUAL UPDATE **EXHIBIT C**

COMMUNITY PROGRAM PLANNING
AND LOCAL REVIEW PROCESS

September 1, 2010 - Letter in support of the plan from James Ellsworth, Executive Director, Community Health Center.

El Dorado County
Community Health Center

4327 Golden Center Drive
Placerville, CA 95667
(530) 621-7700 Fax (530) 621-7707

4641 Missouri Flat Road
Placerville, CA 95667
(530) 621-7700 Fax (530) 622-8436

Improving the Health of Our Community Through Quality Healing and Preventative Services

September 1, 2010

MHSA Project Management
El Dorado County Health Services Department, Mental Health Division
670 Placerville Drive, Suite 1B
Placerville CA 95667
Attention: Stephanie Carlson

Gentlepersons:

This letter will serve to communicate our support for the proposed programs and budgets set forth in the Mental Health Services Act FY2010-11 Plan for El Dorado County. We look forward to collaborating with the Mental Health Division of El Dorado County in delivering behavioral health services.

Sincerely,

James Wm. Ellsworth
Executive Director

IMPLEMENTATION PROGRESS REPORT ON FY 08/09 ACTIVITIES

County: El Dorado

Date: September 28, 2010

Instructions: Welfare and Institutions Code section 5848 specifies that DMH shall establish requirements for the content of the annual update and updates including reports on the achievement of performance outcomes for services. Provide an update on the overall progress of the County's implementation of the MHSA including CSS, PEI and WET components during FY 2008/09.

CSS, WET and PEI

1. Briefly report on how the implementation of the MHSA is progressing: whether implementation activities are generally proceeding as described in the County's approved Plan, any key differences, and any major challenges.
[X] Please check box if PEI component not implemented in FY 08/09.

MHSA CSS Workplan #1 – Youth and Family Strengthening Program Progress

Use of Assessment Tools
During this fiscal year, staff training in the use of the CALOCUS (Child and Adolescent Levels of Care Utilization System) rather than the Child and Adolescent Service Intensity Instrument (CASII) took place. As expected, a baseline measure of all youth served by both the Mental Health Division (MHD) staff and the local outpatient services contract providers (New Morning, Summitview, and Sierra Family Services) took place. The findings were applied to match the level of service delivery to the assessment findings. Discussions regarding continuous use of the tool have taken place since that time. The Adult Services Team and the South Lake Tahoe Team are moving forward to implementation of routine use of the CALOCUS and LOCUS, and the WS Children's Services Team is evaluating ongoing application of the CALOCUS in the EPSDT Planning Group. This application is considered a major challenge by the Team.

Wraparound FSP
As planned, the desire to most effectively use MHSA funds – including in the application of FSP programs – resulted in a broadening of the target population for this strategy (inclusion of Medi-Cal eligible youth) in order to leverage funds. In keeping with the goal of preventing out-of-home placement, this shift also included an emphasis on youth grades K-6 who were not eligible for the SB163-funded Wraparound program. The program was able to continue to serve a few uninsured youth, as anticipated. The current challenge in FY 10-11 is a result of the inability of the County General Fund to provide the necessary match to draw down SB163 funds. As a result, the ability to leverage Wraparound personnel resources (Parent Partner, Wrap Workers) will be limited. The MHD and the County Human Services Department continues to partner to serve high-risk youth to minimize out-of-home placements by use of this model. MHSA funding to this end is increasingly valuable.

Family Strengthening Academy
Consistent with the Workplan, a variety of evidence-based practice strategies were employed to serve the County's youth (e.g., Incredible Years, Teaching Pro-social Skills or TPS, and Trauma-focused Cognitive Behavioral Therapy). As a result, use of group intervention strategies began to increase. However, the data indicates that we did not serve the anticipated number of youth and families in this program. Further, we did not gather data to annotate the number of non-Medi-Cal youth or uninsured youth served. In a recent External Quality Review Organization (EQRO) site visit, it was determined that the opportunities for outcome and fidelity measures had not been consistently applied. Therefore, a future challenge will be to establish and maintain improved data collection methodologies.

Transitions Project
As planned, the MHD has provided MHSA-funded staff and services to youth and families involved with the juvenile justice system. TPS groups, family re-unification services, and discharge planning service linkage have been provided on both slopes. These services are extremely well-received and viewed as invaluable to this high-risk population. Future challenges include the limited capacity available based the MHD staffing levels and limits of the MHSA CSS funding.

IMPLEMENTATION PROGRESS REPORT ON FY 08/09 ACTIVITIES

MHSA CSS Workplan #2 – Wellness and Recovery Services Program
Consistent with the plan, the MHSA adult programs were integrated and streamlined along levels of care dimensions. Use of the LOCUS was applied to all adult clients to establish a baseline measure by which to align service plans with level of need. In addition, the populations served through this wellness and recovery-oriented approach were more broadly defined to include those at risk of homelessness, institutionalization, and those living in the community at all levels (board and care, transitional housing, independent living, etc.). The goals of reducing recidivism to institutions, such as the jails, Institutes of Mental Disease (IMDs), and hospitals were incorporated, as well.

Staff training in the Social and Independent Living Skills (SILS) evidence-based practice was conducted and multiple groups were started in various settings. Case management was added for clients who preferred to receive medication services only, and Assertive Community Treatment (ACT) was used as a service intervention strategy for various clients who posed high-risk and/or who were at imminent risk of institutionalization, as with many of our Transitional Age Youth (TAY) and Transitional Housing clients.

Areas of key differences included a decrease in our capacity to serve clients in an ongoing outreach and engagement modality, the discontinuation of the CMSP grant participation and our on-site presence at a local primary care setting, and inability to staff a data management and program evaluation unit. Hence, future challenges include establishing the mechanism and resources to provide outreach and engagement, to partner with primary healthcare, and to conduct the program evaluation necessary for compliance and quality assurance purposes.

MHSA CSS Workplan #3 – Crisis Residential Facility
The Crisis Residential Facility was renamed as the Crisis Residential Treatment (CRT) Facility and opened in early February. It has quickly become a successful and valued program, assisting clients who are transitioning out of the Psychiatric Health Facility (PHF) and clients served in the community who require brief, crisis stabilization in a 24-hour supervised setting. Staff, community members, and clients have provided unsolicited positive feedback regarding both the value of this additional level of care and the welcoming setting in which the care is provided.

A challenge is the limit of space and capacity – today, the 6 beds are often full.

MHSA CSS Workplan #4 – Health Disparities and Culturally-specific services
This initiative has continued through the provision of services by community contract providers. Addressing levels of care planning did not take place, as originally intended. However, the Latino providers reported active use of outreach, engagement and group services.

One of the ongoing challenges remains the integration of service delivery between the providers and the MHD. Improved collaboration allows the system to better serve the clients and community as a whole in an increasingly culturally competent way. Strategies by which to improve the various partnerships include training and cross-training opportunities, clarification of expectations through the contracts planning process, regularly scheduled contracts review and service provider meetings, and improved data collection and reporting tools. Resources for these processes must, therefore, be identified.

MHSA WET Program – as expected, key differences, and major challenges
This plan was approved mid fiscal year. During this fiscal year, a Reduction in Force (RIF) resulted in a 29% decrease in permanent staff allocations and many extra help positions, as well. However, the findings of the workforce assessment needs remain relevant. Challenges continue in the area of psychiatrist recruitment and sufficient on-site Spanish language capacity. In addition, while MHSA funding and programming has resulted in some progress, the meaningful participation of consumer and family members remains an important growth area. One area where progress has been made – the use of registered and licensed clinicians for the assessment of clients is now universal.

During this year of significant transition, upon plan approval a full-time Workforce Education and Training (WET) Coordinator was assigned. Research regarding the e-learning technology options, the establishment of the Social and Independent Living Skills (SILS) training modules and the related partnership with the High School Health and Human Services Academy, negotiations regarding participation in the Rural Mental Health MSW Weekend Program, and the transition of the Friendly Visitor Program to the WET Consumer and Family Volunteer Program were among the activities staffed by the WET Coordinator and the MHSA Project Management Team.
A highlight of the year included the series of SILS training classes that were attended by MHD staff, consumers, family members and high school students and teachers. At this time, we do have SILS classes being co-facilitated by staff and consumers, as well.

IMPLEMENTATION PROGRESS REPORT ON FY 08/09 ACTIVITIES

Challenges included the inability to sustain a full time assignment to the WET Coordinator position due to Division capacity limits and to sustain a Clinical Outcomes Measures program specific to the Behavioral Health Court. In addition, the interface of the MHD's SILS training initiative with the High School Academy was challenging in part due to the different goals that the two agencies are tasked with addressing. Finally, one of the unfunded activities – the coordination of interagency internships and clinical supervision – was beyond the capacity scope of this new program with extremely limited funding and capacity.

We also discovered new information along the way that informed the implementation of the WET Plan. This proposal includes a recommendation for a decrease in the funding for the administrative costs of the MHSA Rural Mental Health Weekend Program due to the decreased local county participation. Further, that we eliminate the funding for a local Loan Assumption program as we learned that there are several programs for which the El Dorado County public mental health workforce may be eligible given the County designation as a Health Professional Shortage Area (HPSA) in January 2008. These key differences will be addressed in the proposed WET plan update.

2. Provide a brief narrative description of progress in providing services to unserved and underserved populations, with emphasis on reducing racial/ethnic service disparities.

Racial and Ethnic Group Service Disparities Highlights

- Of the youth served in the Wraparound program, 43% were Latino.
- 42% of the MHSA clients served were non-Caucasian (compared to 9% of the overall County population).
- 22% of the MHSA clients served were primary language, Spanish-speaking (compared to 10% of the County population for whom the language spoken at home is other than English)
- The Health Disparities Programs served 28% of the total numbers of clients served.

The MHSA emphasis on reducing racial/ethnic services disparities was supported by the County MHSA programs during FY 08-09.

Please note that El Dorado County has one threshold language – which is Spanish.

3. Provide the following information on the number of individuals served:

	CSS	PEI	WET	
Age Group	**# of individuals**	**# of individuals (for universal prevention, use estimated #)**	**Funding Category**	**# of individuals**
Child and Youth (0-17)	**52**		Workforce Staff Support	
Transition Age Youth (16-25)	**72**		Training/Technical Assist.	**108**
Adult (18-59)	**548**		MH Career Pathway	**77**
Older Adult (60+)	**80**		Residency & Internship	**0**
Race/Ethnicity		**CSS Rates**	Financial Incentive	**3**
White	**399**	**57%**		
African American	**7**	**1%**	[ ] WET not implemented in FY 08/09	
Asian	**6**	**0.9%**		
Pacific Islander	**6**	**0.9%**		
Native American	**88**	**13%**		
Hispanic	**188**	**27%**		
Multi				
Other				
Unknown	**2**	**0.3%**		
Other Cultural Groups				
LGBTQ	**unknown**			
Other				
Primary Language		**CSS Rates**		
English	**539**	**77%**		
Spanish	**155**	**22%**		
Vietnamese				
Cantonese				
Mandarin				
Tagalog	**1**	**0.1%**		

IMPLEMENTATION PROGRESS REPORT
ON FY 08/09 ACTIVITIES

	Cambodian			
	Hmong			
	Russian	**1**	**0.1%**	
	Farsi			
	Arabic			
	Other			

PEI

4. Please provide the following information for each PEI Project in short narrative fashion:
- **a) The problems and needs addressed by the Project.**
- **b) The type of services provided.**
- **c) Any outcomes data, if available. (Optional)**
- **d) The type and dollar amount of leveraged resources and/ or in-kind contributions (if applicable).**

NA – no PEI program implementation in FY 08-09.

2010/11 ANNUAL UPDATE

EXHIBIT E

MHSA SUMMARY FUNDING REQUEST

County: El Dorado

Date: 9/28/2010

	MHSA Funding					
	CSS	**WET**	**CFTN**	**PEI**	**INN**	**Local Prudent Reserve**
A. FY 2010/11 Planning Estimates						
1. Published Planning Estimate	$3,260,500			$798,000	$485,500	
2. Transfers	$0	$0	$0			
3. Adjusted Planning Estimates	$3,260,500					
B. FY 2010/11 Funding Request						
1. Requested Funding in FY 2010/11	$4,588,048	$363,682	$0	$2,018,644	$0	
2. Requested Funding for CPP	$0			$0	$0	
3. Net Available Unexpended Funds						
a. Unexpended FY 06/07 Funds		$277,134				
b. Unexpended FY 2007/08 Funds[a/]	$0	$0	$0			
c. Unexpended FY 2008/09 Funds	$1,327,548		$0	$75,929		
d. Adjustment for FY 2009/2010		$277,134		$75,929		
e. Total Net Available Unexpended Funds	$1,327,548	$0	$0	$0	$0	
4. Total FY 2010/11 Funding Request	**$3,260,500**	**$363,682**	**$0**	**$2,018,644**	**$0**	

2010/11 ANNUAL UPDATE

EXHIBIT E

MHSA SUMMARY FUNDING REQUEST

C. Funds Requested for FY 2010/11						
1. Previously Approved Programs/Projects						
a. Unapproved FY 06/07 Planning Estimates		**$0**				
b. Unapproved FY 07/08 Planning Estimates[a/]	$0	$0				
c. Unapproved FY 08/09 Planning Estimates	**$0**		Pending resolution of inquiry submitted to DMH	**$257,204**		
d. Unapproved FY 09/10 Planning Estimates	**$0**			**$295,137**		
e. Unapproved FY10/11 Planning Estimates	**$3,260,500**					
Sub-total	**$3,260,500**	**$0**		**$552,341**	**$0**	
f. Local Prudent Reserve	**$0**			$0		
2. New Programs/Projects						
a. Unapproved FY 06/07 Planning Estimates						
b. Unapproved FY 07/08 Planning Estimates[a/]	0	$363,682				
c. Unapproved FY 08/09 Planning Estimates	0					
d. Unapproved FY 09/10 Planning Estimates	0			$922,963		
e. Unapproved FY10/11 Planning Estimates	0			$543,340		
Sub-total	$0	$363,682	$0	$1,466,303	$0	
f. Local Prudent Reserve	0			$0		
3. FY 2010/11 Total Allocation[b/]	**$3,260,500**	**$363,682**	**$0**	**$2,018,644**	**$0**	

a/Only applies to CSS augmentation planning estimates released pursuant to DMH Info. Notice 07-21, as the FY 07/08 Planning Estimate for CSS is scheduled for reversion on June 30, 2010.

b/ Must equal line B.4. for each component.

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: #1 Youth and Family Strengthening Program

Date: 9/28/2010

Select one:
- ☑ CSS
- ☐ WET
- ☐ PEI
- ☐ INN

CSS and WET

Previously Approved

No.	Question	Yes	No	
1.	Is this an existing program with no changes?	☒	☐	If yes, answer question #5 and complete Exh.E1 or E2 accordingly; If no, answer question #2
2.	Is there a change in the service population to be served?	☐	☑	If yes, complete Exh. F1; If no, answer question #3
3.	Is there a change in services?	☐	☑	If yes, complete Exh. F1; If no, answer question #4
4.	Is there a change in funding amount for the existing program?	☑	☐	If yes, answer question #4(a); If no, complete Exh. E1or E2 accordingly
a)	Is the change within ±15% of previously approved amount?	☑	☐	If yes, answer question #5 and complete Exh. E1or E2; If no, complete Exh. F1 and complete table below.
5.	**For CSS programs:** Describe the services/strategies and target population to be served. This should include information about targeted age, gender, race/ethnicity and language spoken of the population to be served. **For WET programs:** Describe objectives to be achieved such as days of training, number of scholarships awarded, strategies that expand outreach, recruitment and retention efforts to increase diversity in mental health workforce and other major milestones to be reached.			

FY 09/10 funding	FY 10/11 funding	Percent Change

The Youth and Family Strengthening Program provides at-risk and under-served youth of all ages with a range of outreach programs, treatment options and general services. Targeted at-risk youth include those who are not succeeding at school as well as those at risk of out-of-home placement and those currently or previously involved with the juvenile justice system. The identified population of under-served youth includes Latino and Native American children and adolescents, youth in grades K-6 who are at risk of out-of-home placement, and transition age youth (16-17). Families with mentally ill parents,TAY at risk of homelessness, and Native American male youth are also identified as high risk and under-served.

Services provided under the CSS Youth and Family Strengthening Program include the following:

MHSA Wraparound (Outreach and Engagement and FSP program)
Wraparound services are available for at least five full service partnerships distributed county-wide as need arises and capacity allows. These services are available to both Medi-Cal and non-Medi-Cal ("scholarship") youth and families, and the program generally but not exclusively serves youth in grades K through 6 who are at risk of out-of-home foster-care placement. Outreach and engagement services as well as other supportive activities, including but not limited to food, youth activities, and transportation, may be funded by MHSA for stabilization purposes.

Family Strengthening Academy (General Systems Development program)
The county-wide Family Strengthening Academy offers a range of promising, best, and evidence-based practices (including but not limited to the Incredible Years, Teaching Pro-Social Skills (TPS) and Trauma-Focused Cognitive Behavioral Therapy) in a variety of settings. These programs are designed to promote family unification in a cost-effective manner (Outreach and Engagement and General Systems Development funded). MHSA funds may used to provide a limited number of "scholarships" for uninsured or under-insured youth and families to participate. Food, household items, childcare and transportation to and from groups may be offered.

*PEI Projects previously approved are now called Previously Approved Programs

PREVIOUSLY APPROVED PROGRAM

Transitions Project (General Systems Development program) At-risk youth and transition age youth receive discharge planning and family-reunification services prior to and immediately following release from the juvenile hall in both the SLT and WS regions of the County. This strategy is designed to engage youth and transition age youth and their families in mental health, addiction and other specialized treatment services in order to reduce recidivism and out-of-home placements. The Transitions Project provides support and strengthens the families of youth who are under-served and may be at-risk for further detention and/or homelessness.

*PEI Projects previously approved are now called Previously Approved Programs

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: #2 Adult Wellness and Recovery Services

Date: 9/28/2010

Select one:

- ☑ CSS
- ☐ WET
- ☐ PEI
- ☐ INN

CSS and WET

Previously Approved

No.	Question	Yes	No	
1.	Is this an existing program with no changes?	☒	☐	If yes, answer question #5 and complete Exh.E1 or E2 accordingly; If no, answer question #2
2.	Is there a change in the service population to be served?	☐	☑	If yes, complete Exh. F1; If no, answer question #3
3.	Is there a change in services?	☐	☑	If yes, complete Exh. F1; If no, answer question #4
4.	Is there a change in funding amount for the existing program?	☑	☐	If yes, answer question #4(a); If no, complete Exh. E1or E2 accordingly
a)	Is the change within ±15% of previously approved amount?	☑	☐	If yes, answer question #5 and complete Exh. E1or E2; If no, complete Exh. F1 and complete table below.
5.	**For CSS programs:** Describe the services/strategies and target population to be served. This should include information about targeted age, gender, race/ethnicity and language spoken of the population to be served. **For WET programs:** Describe objectives to be achieved such as days of training, number of scholarships awarded, strategies that expand outreach, recruitment and retention efforts to increase diversity in mental health workforce and other major milestones to be reached.			

FY 09/10 funding	FY 10/11 funding	Percent Change

The target population for this program is vulnerable adults, including older adults, and transition age youth (18-25) who are homeless or at risk of homelessness or institutionalization. Adults of all ages and transitional age youth who have been recognized as having untreated mental illness and those who are transitioning from institutional custody (jails, IMDs and psychiatric hospitals) to community-based placement are also served by CSS Adult Wellness and Recovery programs. In addition, the target population includes but is not limited to adults with co-occurring disorders, the Latino and Native American populations, and those who have been significantly under-served in out-of-county Board and Care homes.

The Adult Wellness and Recovery Services program will serve as the umbrella for several programs. Full Service Partnerships (FSPs), as well as outreach and engagement strategies, will be utilized as appropriate to meet client needs.

Resource Management Services (General Systems Development) Program
Managers, supervisors or designees, as assigned, will develop key relationships and build access to resources for the consumers and families served (e.g., housing, vocational, educational, benefits eligibility and substance abuse treatment). MHSA-funded psychiatry time to serve un-insured MHSA clients and engage in general systems development planning to improve access and service delivery is included, as well. In part, the psychiatry time will be used to evaluate and re-design psychiatry services to be effective within our Wellness and Recovery Programs. This component also provides program evaluation and quality improvement oversight for the CSS programs. Funding needs include training and travel (e.g., in data management, quality improvement, and program evaluation) and the personnel, supplies and equipment necessary to administer and score program evaluation, assessment and outcome measures. Food, equipment and supplies may be purchased, as well.

*PEI Projects previously approved are now called Previously Approved Programs

PREVIOUSLY APPROVED PROGRAM

Outreach and Engagement Services (Outreach and Engagement funding)
Mental health professionals, in concert with peer counselors, provide outreach and engagement services for individuals with serious mental illness who are homeless, in the jails, receiving services in primary care, have co-occurring disorders, and who require outreach to their homes – in order to reach the at-risk adult population. Supports such as food, transportation assistance, and emergency shelter may be purchased.

Assertive Community Treatment (ACT) - Full Service Partnership (FSP) funding
A highly individualized and community-based level of intensive case management will be provided via Assertive Community Treatment (ACT) for seriously mentally ill individuals who have co-occurring disorders, and/or are at risk of criminal justice involvement, homelessness and/or institutionalization. Some of these individuals will be eligible for the limited transitional housing beds and/or housing subsidies available for Full Service Partners (FSPs).

The ACT model will be used with severely mentally ill El Dorado County adults who are underserved (in out-of- county Board and Care homes) and/or institutionalized in Institutes of Mental Disease (IMDs) upon readiness for community placement. This component seeks to consolidate dedicated partnerships between clients, family members, the public guardian, courts and housing providers to facilitate recovery and progress toward the least restrictive level of care. Food, household supplies and subsidies, activities and transportation may be funded.

Wellness Center and Clubhouse (General Systems Development funding)
The integrated service delivery system will provide a range of services including but not limited to evidence-based practice interventions[1] both onsite and in community-based settings. Costs for training, materials, associated supports (food, travel, and transportation) and program evaluation are included. As indicated in previous CSS Plans, the Wellness Center provides the setting in which we are building our local capacity to meet the diverse needs of the seriously mentally ill and their families. Collaboration with other disciplines, community-based agencies, NAMI, consumers, and volunteers allows us to provide enhanced services, including family and peer support. Community reintegration activities and life skills training will be provided for Crisis Residential Treatment Facility clients and others deemed appropriate. The target population includes clients who reside in Board and Care Homes. Food and general household supplies may be funded, along with transportation support and petty cash for laundry, toiletries, etc. Individuals who prefer to receive medications alone will be provided case management services to support their ongoing stability.

Crisis Residential Treatment (CRT) Program (General Systems Development)
The CRT is located adjacent to the Psychiatric Health Facility (PHF) and is staffed in part by individuals who provide crisis counseling as part of a 24/7 Psychiatric Emergency Services (PES) response. This team provides proactive measures by which to outreach and engage individuals into various levels of treatment thereby avoiding involuntary care when appropriate. We project that 48 clients will be placed at the CRT each year. The target population for this program includes adults with serious mental illness who meet medical necessity for specialty mental health services and who require 24/7 supervision for a brief period of crisis stabilization or resolution on a voluntary basis, typically as a transition from institutional care (such as a PHF, IMD, psychiatric hospital or residential care) or for those who require a temporary increase in services for stabilization purposes in order to regain a level of functioning needed to maintain their community placement. The services provided include psychiatric assessment, medication stabilization services, individual, family and group counseling, life skills training, community integration activities and 24/7 clinical supervision and residential care. Meals, household supplies, activities and transportation may be funded.

[1] Anger Management, Seeking Safety, and Social and Independent Living Skills, to name just a few options.

*PEI Projects previously approved are now called Previously Approved Programs

2010/11 ANNUAL UPDATE **EXHIBIT D1**

ELIMINATION OF PROGRAM/PROJECT

Select one:

County: El Dorado

Program/Project Number/ Name: #3 Health Disparities Initiative

Date: 9/28/2010

- ☑ **CSS**
- ☐ **WET**
- ☐ **CF**
- ☐ **TN**
- ☐ **PEI**[1]
- ☐ **INN**

1. Clearly identify the program/project proposed for elimination.

Work plan # 3 Health Disparities Initiative: This work plan provides for culturally competent services in appropriate settings to ensure treatment engagement and positive outcomes while strengthening the family unit and serving all age groups. These services are being delivered by local contract providers who were assessed to have the appropriate qualifications to provide bilingual and bicultural mental health services and engagement within Native American and Latino communities.

2. Describe the rationale for eliminating the program/project.

Services funded through this work plan are focused on outreach, engagement, and early intervention. In our FY 09-10 MHSA Annual Update, the County indicated that upon approval of our PEI plan, we would request to transfer this work plan to the PEI program. That PEI plan was approved effective 12/17/2009 and it includes the Health Disparities Initiative component. Consequently, we are removing this work plan from our CSS plan as those activities are now more appropriately funded through PEI.

3. Describe how the funding for the eliminated program/project will be used.

Funding that would have been used for the Health Disparities Initiative will be divided proportionally to the County's ongoing CSS programs: (1) Family Youth and Strengthening and (2) Wellness and Recovery Services.

[1] For PEI only – Counties eliminating a project with funds targeted toward Children, Youth, and Transitional-Aged Youth, the PEI Funding Request (Exhibit E4) should reflect that at least 51% of PEI funds are directed towards individuals under age 25. Small counties are exempt from this requirement. The PEI Program selected for local evaluation may not be eliminated.

FY 2010/11

EXHIBIT E1

CSS BUDGET SUMMARY

County: El Dorado

Date: 28-Sep-10

	CSS Programs		FY 10/11 Requested MHSA Funding	Estimated MHSA Funds by Service Category				Estimated MHSA Funds by Age Group				
	No.	Name		Full Service Partnerships (FSP)	General System Development	Outreach and Engagement	MHSA Housing Program	Children and Youth	Transition Age Youth	Adult	Older Adult	
Previously Approved Programs												
1.	1	Youth and Family Strengthening Program	$588,678	$294,339	$206,037	$88,302		$559,244	$29,434			
2.	2	Adult Wellness and Recovery Services	$2,753,432	$1,530,908	$886,605	$335,919			$275,343	$2,202,746	$275,343	
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.	Subtotal: Programs [a/]		$3,342,110	$1,825,247	$1,092,642	$424,221	$0	$559,244	$304,777	$2,202,746	$275,343	Percentage
17.	Plus up to 15% County Administration		$828,843									24.8%
18.	Plus up to 10% Operating Reserve		$417,095									10.0%
19.	Subtotal: Previously Approved Programs/County Admin./Operating Reserve		$4,588,048									
New Programs												
1.			$0									
2.			$0									
3.			$0									
4.			$0									
5.			$0									
6.	Subtotal: Programs [a/]		$0	$0	$0	$0	$0	$0	$0	$0	$0	Percentage
7.	Plus up to 15% County Administration											#VALUE!
8.	Plus up to 10% Operating Reserve											#VALUE!
9.	Subtotal: New Programs/County Admin./Operating Reserve		$0									
10.	**Total MHSA Funds Requested for CSS**		$4,588,048									

a/ Majority of funds must be directed towards FSPs (Cal. Code Regs., tit. 9, § 3620, subd. (c)). Percent of Funds directed towards FSPs= 54.60%

Additional funding sources for FSP requirement:

County must provide the majority of MHSA funding toward Full Service Partnerships (FSPs). If not, the county must list what additional funding sources and amount to be used for FSPs. In addition, the funding amounts must match the Annual Cost Report. Refer to DMH FAQs at http://www.dmh.ca.gov/Prop_63/ MHSA/Community_Services_and_Supports/docs/FSP_FAQs_04-17-09.pdf

CSS Majority of Funding to FSPs

		Other Funding Sources									
	CSS	State General Fund	Other State Funds	Medi-Cal FFP	Medicare	Other Federal Funds	Re-alignment	County Funds	Other Funds	Total	Total %
Total Mental Health Expenditures:	$1,825,247	$0	$0	$0	$0	$0	$0	$0	$0	$1,825,247	55%