County of El Dorado
Mental Health Services Act (MHSA)
Fiscal Year 2015-16
Three-Year Plan Update

Health and Human Services Agency

Mental Health Division

August 25, 2015

Excerpt from the "Proclamation of the Board of Supervisors of the County of El Dorado Proclaiming May as Mental Health Month in the County of El Dorado:"

> *NOW, THEREFORE BE IT RESOLVED, that the Board of Supervisors of the County of El Dorado does hereby proclaim May 2015 as Mental Health Month in the County and calls upon all citizens, governmental agencies, public and private institutions, businesses, hospitals and schools in the County of El Dorado to increase public awareness of the importance of mental health, reduce stigma and discrimination, promote greater understanding and hope for those who live with mental illness, and pay tribute to all who devote their skill and expertise to the cause of better mental health for our citizens.*
>
> *PASSED AND ADOPTED by the Board of Supervisors of the County of El Dorado at a regular meeting of said Board, held the 12th day of May 2015.*

Table of Contents

Attachments

Program and Project Descriptions

Purpose of Plan Update

This FY 2015-16 Mental Health Services Act (MHSA) Plan Update is prepared to provide the public with information about the current status of MHSA in El Dorado County.

FY 2015-16 MHSA Plan Update:

- **Part 1. Program Outcomes and Changes**
  Contains program outcomes for FY 2013-14 and a portion of FY 2014-15, as available. This section also identifies any new projects included in this Plan Update and any changes to existing projects.
- **Part 2. MHSA Funding, Procurement and Staffing**
  Contains information relating to the MHSA revenues, expenditures and fund balances, along with how services are procured, and staffing information.
- **Part 3. MHSA New Project Descriptions**
  Contains the full description for any new MHSA projects proposed in this Plan Update.

Attachments: There are several attachments that provide reference materials and other required elements of the MHSA Plan Update.

- **Attachment A - Initials Used in the MHSA Plan**
  Contains a list of initials used within the MHSA Plan.
- **Attachment B - County Certification Form**
  Contains the Certification Forms required by the Mental Health Services Oversight and Accountability Commission (MHSOAC).
- **Attachment C - FY 2015-16 MHSA Annual Update Instructions**
  Contains the instructions provided by the MHSOAC.
- **Attachment D - FY 2012-13 Revenue and Expense Report (RER)**
  The FY 2012-13 RER is the most recent RER required by the State. It is important to note that this report reflects only the net program expenditures paid by MHSA. Medi-Cal or other reimbursements for services are not reflected on this report.
- **Attachment E - FY 2015-16 MHSA Funding Summary and Expenditure Plan**
  Contains detailed information about the budgets for the components, programs and projects.
- **Attachment F - Community Planning Process**
  This section contains updates to the community needs assessments that have been performed within El Dorado County and provides the required information regarding the community planning process.
- **Attachment G - Summary of Public Meetings and Comment Form Input**
  Contains the information gathered during the Community Planning Process.

- **Attachment H - Mental Health Services Act, County Profile and Need Assessments** Contains much of the same text as Part I of the FY 2014-15 MHSA Plan. This section provides background about MHSA and the County profile as required by the MHSOAC. This section includes new information about "MHSA Changes in FY 2015-16".

FY 2015-16 MHSA Programs and Projects:

- The separate document "FY 2015-16 MHSA Programs and Projects" provides the full description for all MHSA programs and projects in the FY 2015-16 MHSA Plan Update.

Part 1. Program Outcomes and Changes

Program Outcomes and Changes

This Plan Update includes outcomes for FY 2013-14 and, when possible, interim outcomes for FY 2014-15. Due to the timing of the MHSA Plans, reporting of the full outcomes for FY 2014-15 will occur in the FY 2016-17 MHSA Plan.

Funding level changes and other program changes are identified in this Plan Update. Once the FY 2015-16 MHSA Plan is adopted by the Board of Supervisors, the MHSA Project Descriptions document, which provides the full description for all approved MHSA programs in El Dorado County, will be updated to reflect changes made by the FY 2015-16 MHSA Plan Update. The MHSA Project Descriptions document may be accessed through the MHSA web site at www.edcgov.us./mentalhealth/mhsa.aspx.

Universal Change - Procurement

Procurement for all services will be performed as noted in the project description. Where appropriate, the "Procurement Method" has been updated to reflect that procurement will be done in compliance with the Board of Supervisors Policy C-17, Procurement Policy.

Project Funding Levels

Funding for all components is located in Attachment E.

Prevention and Early Intervention (PEI)

During FY 2013-14, PEI programs provided services to approximately 1,347 people in the following projects, and Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness had 747 visits to the Wellness Centers from individuals who are not clients of the MHD.

FY 2013-14 Projects	PEI Project Type			Number Served	Cost per Participant
	Prevention	Early Intervention	Other		
1a: Children 0-5 and Their Families	✓	✓		23 Children 9 Adults 2 Age Unknown	$603
1b: Mentoring for 3-5 Year Olds	✓			Not yet implemented	--
1c: Parenting Skills	✓			43 Adults	$654
1d: Primary Intervention Project (PIP)	✓	✓		138 Children	$920
1e: SAMHSA Model Programs	✓	✓		Not yet implemented	--

FY 2013-14 Projects	PEI Project Type			Number Served	Cost per Participant
	Preven-tion	Early Inter-vention	Other		
2a: Mental Health First Aid			✓	318 Participants	$177
2b: National Alliance on Mental Illness Training			✓	Discontinued	--
2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education			✓	Not required	--
2d: Community Information Access			✓	Not required	--
2e: Suicide Prevention and Stigma Reduction			✓	Not yet implemented	--
2f: Foster Care Continuum Training			✓	Not yet implemented	--
2g: Community Outreach and Resources			✓	Not required	--
3a: Wennem Wadati - A Native Path to Healing	✓	✓		50 Children 61 Adults 22 Seniors 43 Age Unknown	$630
3b: Latino Outreach	✓	✓		428 Adults 208 Children 2 Seniors	$339
4a: Wellness Outreach Ambassadors and Linkage to Wellness		✓		Total Visits: Tahoe: 232 West Slope: 515 (through March 31, 2015)	$4 per visit
4b: Senior Peer Counseling	✓	✓		Not yet implemented	--
4c: Older Adult Program	✓	✓		Not yet implemented	--
5a: Community-Based Mental Health Services	✓	✓		No direct services	--
5b: Community Health Outreach Worker	✓	✓		Not yet implemented	--

During the first and second quarters of FY 2014, PEI programs provided services to approximately 2,332 people in the following projects, and Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness had 884 visits to the Wellness Centers from individuals who are not clients of the MHD from July 1, 2014 through March 31, 2015:

FY 2014-15 Projects	PEI Project Type			Number Served through 12/31/14
	Preven-tion	Early Inter-vention	Other	
1a: Children 0-5 and Their Families	✓	✓		19 Adults 72 Children 14 Age Unknown
1b: Mentoring for 3-5 Year Olds	✓			3 Adults 17 Seniors
1c: Parenting Skills	✓			43 Adults 3 Seniors
1d: Primary Intervention Project (PIP)	✓	✓		121 Children
1e: SAMHSA Model Programs	✓	✓		1,291 Participants (students, staff and community members)
1f: Prevention and Early Intervention for Youth in Schools	✓	✓		Not yet implemented
2a: Mental Health First Aid			✓	202 Participants
2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education			✓	Not required
2d: Community Information Access			✓	Not required
2e: Suicide Prevention and Stigma Reduction			✓	Not yet implemented
2f: Foster Care Continuum Training			✓	Not yet implemented
2g: Community Outreach and Resources			✓	Not required
3a: Wennem Wadati - A Native Path to Healing	✓	✓		40 Adults 73 Children 11 Seniors 3 Age Unknown

FY 2014-15 Projects	PEI Project Type			Number Served through 12/31/14
	Prevention	Early Intervention	Other	
3b: Latino Outreach	✓	✓		572 Adults 246 Children 2 Seniors
4a: Wellness Outreach Ambassadors and Linkage to Wellness		✓		Total Visits: Tahoe: 395 (through March 31, 2015) West Slope 489 (through March 31, 2015)
4b: Senior Peer Counseling	✓	✓		20 Seniors
4c: Older Adult Program	✓	✓		Not yet implemented
5a: Community-Based Mental Health Services	✓	✓		No direct services provided
5b: Community Health Outreach Worker	✓	✓		Not yet implemented

Of the total individuals served through PEI in the first two quarters of FY 2014-15, the following information represent the number of individuals who self-identified with the associated demographic:

Age	
Child and Youth (0-17)	516
Adult (18-59)	474
Older Adult (60+)	33

Gender	
Female	664
Male	365

City of Residence	
Cameron Park / Shingle Springs	72
Camino	67
Cool	2
Diamond Springs	28
El Dorado	3
El Dorado Hills	44

City of Residence	
Georgetown Divide	50
Grizzly Flat / Mt. Aukum	3
Homeless	2
Lotus / Coloma	1
Other Area	13
Placerville	279
Pollock Pines	30
Somerset / Fair Play	11
South Lake Tahoe	400

Primary Language	
Cantonese	1
English	487
Russian	1
Spanish	549
Tagalog	2
Other	1

Race / Ethnicity	
American Indian or Alaska Native	113
Asian	6
Black or African American	2
Hispanic or Latino	680
Multiracial	12
Native Hawaiian or Other Pacific Islander	1
White or Caucasian	218
Other	3

Economic Status	
Extremely Low Income	45
Very Low Income	40
Low Income	63
Moderate Income	68
High Income	15

Other Status	
Disabled	9

Other Status	
LGBTQ	1
Veteran	1

Health Insurance Status	
Medi-Cal	197
Medicare	24
Uninsured	15
Private Insurance	59
Other	42

Program 1: Youth and Children's Services

Project 1a: Children 0-5 and Their Families

Vendor:	Infant-Parent Center
Expenditures:	FY 2013-14: $20,492 (contract executed March 25, 2014) FY 2014-15: TBD
Service Locations:	Cameron Park, but residents from any part of the County meeting eligibility criteria may participate
Outcomes:	Since the execution of the contract, through the second quarter of FY 2014-15, Infant-Parent Center has served 105 new clients and families. Services provided during this time include referrals to collaborating partners, ongoing case management and short-term psychotherapeutic service. Additionally, Infant-Parent Center staff has focused efforts on outreach and education to strengthen relationships with community partners and reduce stigma and discrimination. Outcomes show that families receiving services are being stabilized. This is evidenced by presenting concerns, collaboration reports, parent surveys, surveys, therapist observation, and preliminary standardized assessment results. Because the contract was executed so late in FY 2013-14, there was an insufficient period of time and measureable data to report upon for that fiscal year. The following specific measurements will be provided in the year-end progress report for FY 2014-15 and will be reported in the FY 2016-17 MHSA Plan Update: **Measurement 1:** Success will be measured on pre/post testing based on assessment tools, Parent Stress Index, Beck's Depression Beck's Depression and Anxiety Scale, Post-Partum Depression Scale, Ages and Stages, and Marshak Interaction Method **Measurement 2:** Client satisfaction questionnaires, other provider questionnaires **Measurement 3:** Statistics provided by Child Welfare Services

	related to incidence of child abuse/neglect/placement in target population **Measurement 4:** Informal feedback from area educators in improvement of school readiness and achievement **Measurement 5:** Tracking of self-referred clients **Measurement 6:** Decreased incidents of shaken baby syndrome **Measurement 7:** Reduction of hospital emergency department visits **Measurement 8:** Decreased incidents of domestic violence
FY 15-16 Changes:	Project extension through June 30, 2017 will be for an additional $125,000
Project 1b: Mentoring for 3-5 Year Olds	
West Slope:	
Vendor:	Big Brothers Big Sisters
Expenditures:	FY 2013-14: None (contract not in place until June 2014) FY 2014-15: TBD
Service Locations:	Various locations on the West Slope based on available facilities and location of volunteers
Outcomes:	The contract was executed effective June 10, 2014. Big Brothers Big Sisters staff has been doing extensive outreach in the community to recruit "Bigs" and has started making their first matches with "Littles." Because the contract was executed so late in FY 2013-14, there was an insufficient period of time and measureable data to report upon for that fiscal year. The following specific measurements will be provided in the year-end progress report for FY 2014-15 and will be reported in the FY 2016-17 MHSA Plan Update: **Measurement 1:** Pre/post surveys **Measurement 2:** Evaluations **Measurement 3:** Behavioral evaluation **Measurement 4:** Documented skill building **Measurement 5:** Rating sheet **Measurement 6:** West Slope: Big Brothers Big Sisters Youth Outcomes Survey and Strength of Relationship Survey; similar outcome measurement for the Tahoe Basin **Measurement 7:** Recommended adult surveys and evaluations tools **Measurement 8:** Testimonials
FY 15-16 Changes:	Project extension through June 30, 2017 will be for an additional $50,000

Tahoe Basin:	
Vendor:	Big Brothers Big Sisters
Expenditures:	FY 2013-14: None (contract not in place) FY 2014-15 through March 31, 2015: None (contract not yet in place)
Service Locations:	Various locations in the Tahoe Basin based on available facilities and location of volunteers
Outcomes:	The Request for Proposals awarded to Big Brothers Big Sisters on February 19, 2015 by the Board of Supervisors and the contract is in development. Outcomes will be reported in the FY 2016-17 MHSA Plan.
FY 15-16 Changes:	Project extension through June 30, 2017 will be for an additional $25,000
Project 1c: Parenting Skills (was previously called "Incredible Years")	
Vendor:	New Morning Youth and Family Services
Expenditures:	FY 2013-14: $28,114 FY 2014-15: TBD
Service Locations:	Based on demand in the following locations: North County (e.g., Georgetown Divide, Cool, and surrounding areas); South County (e.g., Grizzly Flats, Somerset, Fairplay, and surrounding areas); West County (e.g., El Dorado Hills, Cameron Park, Rescue, Shingle Springs, and surrounding areas); Mid-County (e.g., Pollock Pines, Camino, and surrounding areas); South Lake Tahoe area (e.g., Meyers, South Lake Tahoe, and surrounding areas); and Placerville area (e.g., Placerville, Diamond Springs, and surrounding areas).
Outcomes:	The contract was executed February 13, 2014. Since the execution of the contract, through the second quarter of FY 2014-15, New Morning has provided classes in Placerville, Camino, South County (Pioneer School), Cool and Cameron Park to 45 participants. **Measurement 1:** Pre- and post-class survey. • Results of satisfaction surveys completed by the participants indicated that the skills and support the parents received from both the program curriculum and the group facilitators helped them improve the parenting issues that originally prompted their class participation. Participants reported that their parent child relationship had been strengthened which resulted in an increased confidence in their parenting style/ability.
FY 15-16 Changes:	Project extension through June 30, 2017 will be for an additional $50,000

Project Id: Primary Intervention Project (PIP)	
Vendor:	Black Oak Mine Unified School District
Expenditures:	FY 2013-14: $40,284 FY 2014-15: TBD
Service Locations:	Black Oak Mine Unified School District
Outcomes:	Contract was executed on February 13, 2014. Since the execution of the contract, through the second quarter of FY 2014-15, Black Oak Mine Unified School District provided PIP services to 50 students. PIP continues to fill the need for many children and families who are either not eligible or unable to obtain more intensive interventions. PIP also introduces parents to mental health interventions that are less stigmatized and easier to accept than therapeutic models. For a family, PIP is often their first encounter with mental health services, and because it is such a positive experience for the child, it can make it easier to accept higher level interventions that may be necessary in the future.
Vendor:	El Dorado Hills Community Vision
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Expenditures:	FY 2013-14: $41,266 FY 2014-15: TBD
Service Locations:	Buckeye Unified School District
Outcomes:	Contract was executed on February 13, 2014. Since the execution of the contract, through the second quarter of FY 2014-15, El Dorado Hills Community Vision provided PIP services to 22 students. The PIP program provides one-on-one time each week with a trained, caring adult with each student. The students very much look forward to this time, when they can direct the activity and conversation and feel free to be themselves and receive support and affirmation. PIP aides assist the child in implementing proactive social and interaction skills, culminating in a much more positive outlook and interaction with their peers.

Vendor:	Tahoe Youth and Family Services
Expenditures:	FY 2013-14: $35,509 FY 2014-15: TBD
Service Locations:	Lake Tahoe Unified School District
Outcomes:	Contract was executed on February 20, 2014. Since the execution of the contract, through the second quarter of FY 2014-15, Tahoe Youth and Family Services provided PIP services to 54 students. The PIP aides were able to build trust with the children, which resulted in them sharing their thoughts and feelings. The PIP aides provided an emotionally safe space for the children to be relaxed and feel comfortable engaging in non-directive play therapy. This enhanced the healthy development of their social and emotional skills. PIP improved the overall mental health of the children, families, and community by providing individualized school support to its participants resulting in increased connectedness at school, a sense of control over ones' life, and an increased sense of self-competency.
Vendor:	HHSA
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Expenditures:	FY 2013-14: $700 FY 2014-15: $0
Service Locations:	Not applicable.
Outcomes:	Purchase of Walker-McConnell Scale (WMS) evaluation services. Starting in FY 2014-15, each provider is responsible for obtaining WMS evaluation services directly.
Outcomes:	**Measurement 1:** Administer Walker-McConnell Scale (WMS) assessment tool to students at the time student is selected to enter the program and again when the student exits the program (contracted vendor will be responsible for procuring use of the WMS tool). • The outcomes of the WMS assessments for FY 2014-15 will be reported in the FY 2016-17 MHSA Plan Update. **Measurement 2:** Completion of service delivery report to the County on a monthly basis showing number of students served. • Please see the descriptions above for the number of students served. **Measurement 3:** Completion of year-end progress report to the County showing annual number of students served and pre- and post- WMS scores, identifying program successes, challenges faced and post-PIP participation outcomes for the children. • The year-end progress report for FY 2014-15 will be reported in the FY 2016-17 MHSA Plan Update.
FY 15-16 Changes:	Extend program through June 30, 2017 at the same level of funding, and adjust contract amounts based on current percent of

	total budget (amounts noted above, equal to 28.9% to Black Oak Mine Unified School District, 29.7% to El Dorado Hills Community Vision, and 41.4% to Tahoe Youth and Family Services). Expand program into Rescue Union School District, and the Buckeye Unified School District and Rescue Union School District will rotate the PIP program between elementary schools based on funding and staffing availability.
Project 1e: SAMHSA Model Programs	
Vendor:	El Dorado County Office of Education
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Expenditures:	FY 2013-14: None (contract not in place) FY 2014-15: TBD
Service Locations:	Countywide in schools; at least one program in each school
Outcomes:	The contract was executed on June 24, 2014. Since the execution of the contract, through the second quarter of FY 2014-15, SAMHSA Model programs, training and materials have been provided to six schools or school districts countywide serving approximately 1,291 staff, students, parents, and other community members. El Dorado Union High School District – Independence High School provided the Relapse Prevention and Moral Reconation Therapy program to 4 staff, 17 students and 3 other community members Groups are being offered twice a week and there has been a drop in the overall number of out of school suspension and expulsions related to drugs and alcohol. The students are showing more positive social functioning and are working well with each other and incidents of bullying are very rare as students learn tolerance and patience with each other. Gold Oak Union School District – Gold Oak Elementary School and Pleasant Valley Middle School provided the Safe School Ambassador Training to 52 staff, 260 students, 175 parents and 32 other community members. Based on preliminary survey results, school climate has improved, anonymous bullying reports are down, incident reports are down by 8%, there have been no reports of physical bullying and there are approximately 65% fewer suspensions that this time last year. Indian Diggings School District – Indian Diggings School provided the FRIENDS and Open Circle programs to 5 staff, 12 students, 20 parents and 4 other community members. Topics covered include feelings, cooperation, self-regulation and self-esteem. Comparing pre and post survey on covered topics, 80% felt an increase in cooperation, 75% showed improved feelings and self-regulation and there was a 45% decrease in bullying behaviors. Lake Tahoe Unified School District – Tahoe Valley Elementary School provided the Safe and Civil Schools Positive Behavioral

	Interventions and Supports Model program to 45 staff, 478 students, 184 parents and 10 other community members. The school reported increased student awareness of school-wide expectations by way of a behavioral matrix and expectations are shared at monthly award assemblies. There has been an increase in positive academic and social behaviors, a reduction in bullying on campus and a reduction in suspensions. Pioneer Union School District – Pioneer Elementary School, Walt Tyler Elementary School and Mountain Creek Middle School recently provided the Behavior Intervention / Positive Approach program to 2 staff members and implementation is currently in progress. Placerville Union School District – Edwin Markham Middle School provided the Safe Schools Ambassadors Training to 35 staff, 340 students, 60 parents and 15 other community members. The school is currently collecting data regarding academic achievement, and changes in the incidents of bullying. The students have reported they are more confident and comfortable speaking with other kids that they don't know. Because the contract was executed so late in FY 2013-14, there was an insufficient period of time and measureable data to report upon for that fiscal year. The following specific measurements will be provided in the year-end progress report for FY 2014-15 and will be reported in the FY 2016-17 MHSA Plan Update: **Measurement 1:** Increase youth engagement in school and community activities that are safe and healthy. **Measurement 2:** Students and school personnel are able to identify warning signs of vulnerable students at risk of suicide. **Measurement 3:** Satisfaction surveys completed by families and youth. **Measurement 4:** Program outcome measures for the individual SAMHSA Model Programs implemented.
FY 15-16 Changes:	None.
Project 1f: Prevention and Early Intervention for Youth in Schools	
Vendor:	TBD
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Expenditures:	FY 2014-15: None (RFP in development)
Service Locations:	Countywide based on requests and facility and staffing availability.
Outcomes:	The RFP for these services is in the development process. Outcomes will be reported in the FY 2016-17 MHSA Plan.
FY 15-16 Changes:	Increase in funding.

NEW Project 1g: Nurtured Heart Approach	
Vendor:	Summitview Child and Family Services
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Project Amount:	Approximately $19,500 in FY 2015-16 and FY 2016-17; project will be evaluated for continuation into FY 2017-18.
Expenditures:	None (contract will be developed once Plan Update is adopted)
Service Locations:	Countywide based on requests, facility and staffing availability.
Outcomes:	Outcomes will be reported in the FY 2016-17 MHSA Plan.
FY 15-16 Changes:	This is a new project in FY 2015-16.
Program 2: Community Education Project	
Project 2a: Mental Health First Aid	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Expenditures:	FY 2013-14: $56,353 FY 2014-15: TBD
Service Locations:	Countywide based on requests and facility and staffing availability.
Outcomes:	For the first two quarters of FY 2014-15, 15 Mental Health First Aid classes have been offered, with 202 attendees. Additional classes are scheduled in January through August 2015. Participants have included pastors, pastoral staff, health ministry members, registered nurses, teachers, school administrators, high school peer advocates, health academy students, foster parents and other interested community members. Classes have been expanded to include a module for Veterans and their families. **Measurement 1:** Class evaluation provided to attendees at the end of each session. • The formal class evaluations are submitted via an online survey to an outside organization. Informal surveys indicate positive feedback for the class content and the instructors. **Measurement 2:** Evaluation survey provided to attendees six months after taking the class, including information regarding application of material learned. • The formal class evaluations are submitted via an online survey to an outside organization. Historically, responses to the request for six-month evaluations is very low. **Measurement 3:** Identify attendees who re-register for the class after three years in order to maintain their certification. • The tracking mechanism for this measurement is not yet in place.
FY 15-16 Changes:	Funding continued into FY 2017-18 a slightly lower amount ($100,000 rather than $105,000).
Project 2b: National Alliance on Mental Illness (NAMI) Training	
Project was discontinued effective with the FY 2014-15 MHSA Plan.	

Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education	
Vendor:	Purchases through PFLAG by HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Expenditures:	FY 2013-14: $445.85 FY 2014-15: TBD
Service Locations:	Countywide based on requests for materials.
Outcomes:	No materials have been purchased to date in FY 2014-15. **Measurement 1:** Number of informing material distributed. • It is difficult to measure the outcomes of general public outreach activities due to their non-specific target population and methodology. **Measurement 2:** Number of people reached through presentations. • No presentations have been offered in FY 2014-15.
FY 15-16 Changes:	Funding continued into FY 2017-18 at the same level.
Project 2d: Community Information Access	
Vendor:	Relias Learning
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Expenditures:	FY 2013-14: $9,870 FY 2014-15: TBD
Service Locations:	Countywide via the internet
Outcomes:	It is difficult to measure the outcomes of general public outreach activities due to their non-specific target population and methodology. **Measurement 1:** Number of people accessing web-based information. • Relias Learning is unable to provide the total number of web page "hits", and therefore other sources for this information are being explored. **Measurement 2:** Number of bookmarks distributed. • The actual number of bookmarks is unknown, however they are made available to the public at all special events.
FY 15-16 Changes:	The MHD is exploring other similar products that may result in lower costs and higher service levels, and if it is determined that a different product would be more beneficial, the MHD may change contracted providers without a separate MHSA Community Planning Process to accomplish the change. Funding increased in FY 2015-16 and FY 2016-17, and extended into FY 2017-18 at $16,000 annually.

Project 2e: Suicide Prevention and Stigma Reduction	
Vendor:	To Be Determined
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Expenditures:	FY 2013-14: None (contract not in place) FY 2014-15: TBD
Service Locations:	Countywide
Outcomes:	The Request for Proposals has been published. Outcomes will be reported in the FY 2016-17 MHSA Plan. In FY 2014-15, SafeTalk manuals for classes offered through in-County SafeTalk trainers have been purchased and SafeTalk classes have been provided.
FY 15-16 Changes:	Funding continued into FY 2017-18 at the same level.
Project 2f: Foster Care Continuum Training	
Vendor:	To Be Determined
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Expenditures:	FY 2013-14: None (contract not in place) FY 2014-15 through March 31, 2015: None (contract not in place)
Service Locations:	County-wide based on demand and results of competitive procurement process
Outcomes:	The Request for Proposals has not yet been published. Outcomes will be reported in the FY 2016-17 MHSA Plan.
FY 15-16 Changes:	Funding continued into FY 2017-18 at the same level.
Project 2g: Community Outreach and Resources	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Expenditures:	FY 2013-14: None (no items necessary) FY 2014-15: TBD
Service Locations:	Countywide based on demand.
Outcomes:	It is difficult to measure the outcomes of general public outreach activities due to their non-specific target population and methodology. **Measurement 1:** Number of people accessing web-based information. **Measurement 2:** Number of brochures and other reference materials distributed • Brochures and other printed materials have been distributed to Barton Hospital, Marshall Hospital, schools, The Center for Violence-Free Relationships, and other community-based organizations. **Measurement 3:** Number of individuals involved in future MHSA planning activities • 36 unduplicated individuals participated in the FY 2015-16 MHSA Community Planning Process.

FY 15-16 Changes:	Funding continued into FY 2017-18 at $31,125 (rather than $10,000).
NEW Project 2h: Statewide PEI Projects	
Vendor:	CalMHSA
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Project Amount:	$9,471 in FY 2015-16 through FY 2017-18.
Outcomes:	Outcomes will be reported in the FY 2016-17 MHSA Plan.
FY 15-16 Changes:	This is a new project in FY 2015-16.
Program 3: Health Disparities Program	
Project 3a: Wennem Wadati - A Native Path to Healing	
Vendor:	Foothill Indian Education Alliance
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Expenditures:	FY 2013-14: $110,805 FY 2014-15: TBD
Service Locations:	Schools, Foothill Indian Education Alliance's office in Placerville, and other community-based sites that are accessible to the Native American population on the West Slope, including the provision of Talking Circles in schools or other locations.
Outcomes:	The Wennem Wadati program provided services to 127 unique individuals during the first two quarters of FY 2014-15. The program has served local American Indian individuals and families by means of monthly traditional programs to spread cultural knowledge and family preservation. Outreach and early intervention strategies include traditional Talking Circles, monthly cultural activities, individual and educational crisis intervention, and youth and student leadership activities. One of the planned student leadership activities for the current year includes a field trip to Point Reyes where many talented tribal youth will have the opportunity to examine their strengths and help build their self-esteem and identity in a location full of tribal tradition, culture, and history. In addition to continuing many of the same activities, the program is hoping to add a Talking Circle at Blue Oaks school in Cameron Park starting in FY 2015-16. The following specific measurements will be provided in the year-end progress report for FY 2014-15 and will be reported in the FY 2016-17 MHSA Plan Update: **Measurement 1:** Casey Life Skills Native American Assessment, to be given when an individual joins the Talking Circles and when they end their participation. **Measurement 2:** Quarterly client registration which includes client demographic data as well as specific client issues to be addressed. **Measurement 3:** Year-end annual report which will includes a summary analysis of the Casey Life Skills Assessment, program

	accomplishments, community collaboration activities, program activities offered, and program outcome measures.
FY 15-16 Changes:	Funding continued into FY 2017-18 at the same level.
Project 3b: Latino Outreach	
Vendor:	South Lake Tahoe Family Resource Center
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Expenditures:	FY 2013-14: $134,456 FY 2014-15: TBD
Service Locations:	South Lake Tahoe
Outcomes:	The South Lake Tahoe Family Resource Center provided services to 345 unique individuals during the first two quarters of FY 2014-15. The Latino Outreach program helps reduce disparities through addressing various topics, including mental health care and stigmas, public health topics, health insurance and access to quality care, environmental awareness issues, compulsory education, adult continuing education, transportation, nutrition, access to a variety of services and information that increases resilience and knowledge of cutting edge modalities and options. The short term goals for this project are to increase mental health services utilized by the Latino community, thereby decreasing isolation and problems that arise from unmet mental health needs. The long term goals of this project include reducing stigma and discrimination associated with mental illness, the achievement of integration of prevention programs, and reduction of suicide, incarcerations, and school failure or dropouts. Data collected indicates that folks are self-medicating less, and seeking other forms of activities for enjoyment and diversion. The data demonstrates the effectiveness of the Latino Outreach program, with the vast majority of clients showing improvement and increased indicators of healthy actions, attitudes and perceptions.
FY 15-16 Changes:	Funding continued into FY 2017-18 at the same level.
Vendor:	New Morning Youth and Family Services
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Expenditures:	FY 2013-14: $43,745 FY 2014-15: TBD
Service Locations:	West Slope
Outcomes:	New Morning Youth and Family Services provided service to 273 unique individuals during the first two quarters of FY 2014-15. The Latino Outreach program provided a wide range of services, and the Promotoras worked diligently with each client and family to identify their specific needs to work towards solutions. The Promotoras provided advocacy, outreach, translation and linkage to crucial programs and resources for new and existing clients.
FY 15-16 Changes:	Funding continued into FY 2017-18 at the same level.

Vendor:	HHSA
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Expenditures:	FY 2013-14: $37,986 FY 2014-15: TBD
Service Locations:	West Slope
Outcomes:	Interim services were provided by HHSA in FY 2013-14 while the RFP was issued and prior to execution of the new agreement for services with New Morning Youth and Family Services.
Outcome:	The following specific measurements will be submitted by the contract providers on the year-end progress report for FY 2014-15 and will be reported in the FY 2016-17 MHSA Plan Update: **Measurement 1:** Customer satisfaction surveys. **Measurement 2:** Client outcome improvement measurements. **Measurement 3:** Increased engagement in traditional mental health services. Quarterly reporting will also include, but is not limited to, client demographic data.
Program 4: Wellness Outreach Program for Vulnerable Adults	
Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Expenditures:	FY 2013-14: $3,526 FY 2014-15: TBD
Service Locations:	South Lake Tahoe and Diamond Springs
Outcomes:	The Wellness Centers provide a wide range of services from drop in classes, resource referrals, and food education. During the past year, the Wellness Centers have been focusing on increasing the number and type of classes offered. **Measurement 1:** Number of participants and family/friends in their support network. • The South Lake Tahoe Wellness Center had a duplicated count of 232 individuals in FY 2013-14. In 2014-15 (through March 31, 2015), there have been 395 duplicated individuals participating in Wellness Center activities. • The West Slope Wellness Center had a duplicated count of 515 individuals in FY 2013-14. In 2014-15 (through March 31, 2015), there have been 489 duplicated individuals participating in Wellness Center activities. **Measurement 2:** Linkage with medically necessary care. • This measurement is extremely difficult to measure as non-clients do not receive case management services and may not return to the Wellness Center after their first visit. Therefore this measurement will be deleted in the FY 2015-16 MHSA Plan Update.

	Measurement 3: Continued or increased attendance at the Wellness Center. • This will be a focus area of data collection for FY 2015-16. **Measurement 4:** Area of County in which participant resides. • This new outcome measure will be implemented during FY 2015-16.
FY 15-16 Changes:	Change in Outcome Measurements. Funding continued into FY 2017-18 at the same level.
Project 4b: Senior Peer Counseling	
Vendor:	EDCA Lifeskills as the fiscal and administrative contractor on behalf of Senior Peer Counseling
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Expenditures:	FY 2013-14: None (contract not in place) FY 2014-15: TBD
Service Locations:	Placerville office, clients' homes and other community meeting places on the West Slope; future plans include exploring how services may be expanded to or developed in the Tahoe Basin
Outcomes:	Contract was executed on August 12, 2014. Since the execution of the contract, through the second quarter of FY 2014-15, Senior Peer Counseling has provided services to 20 seniors. Quarterly satisfaction survey results indicated an improvement in general well-being, emotional improvement, improved relationships and satisfaction with social activities since starting with Senior Peer Counseling. Clients reported feeling thankful for the service and appreciated having someone in their age group to talk to. The following specific measurements will be provided in the year-end progress report for FY 2014-15 and will be reported in the FY 2016-17 MHSA Plan Update: **Measurement 1:** Counselors will complete a pre- and post-rating form which measures TLCs, primarily pro-health and pro-mental health activities and habits which have been shown to lead to positive physical, emotional and cognitive improvements in people of all ages. The categories to be measured are: 1) Exercise 2) Nutrition / Diet 3) Nature 4) Relationships 5) Recreation / Enjoyable Activities 6) Relaxation / Stress Management 7) Religious / Spiritual Involvement 8) Contribution / Service **Measurement 2:** Volunteers will record the clients' self-reported improvement in the presenting problem as selected by the client at the start of counseling.

	Measurement 3: ORS which measures the following 4 psychological categories: 1) Individually (personal well-being) 2) Interpersonally (family, close relationships) 3) Socially (work, school, friendships) 4) Overall (general sense of well-being)
FY 15-16 Changes:	Funding continued into FY 2017-18 at $55,000.
Project 4c: Older Adult Program	
Vendor:	To Be Determined
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Expenditures:	FY 2013-14: None (contract not in place) FY 2014-15: None (contract not in place)
Service Locations:	Countywide
Outcomes:	The Request for Proposals has not yet been published. Outcomes will be reported in the FY 2016-17 MHSA Plan.
FY 15-16 Changes:	Funding continued into FY 2017-18 at the same level as FY 2016-17.
Program 5: Community-Based Services	
Project 5a: Community-Based Mental Health Services	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Expenditures:	FY 2013-14: $6,273 FY 2014-15: TBD
Service Locations:	County-wide based on demand
Outcomes:	Due to low staffing levels, the MHD has not been able to fully implement this program. However, MHD staff participate in community events to provide support for attendees when necessary. **Measurement 1:** Number of individuals/families served, and outcomes for each. • There were no individual/family directed services in FY 2014-15. **Measurement 2:** Client satisfaction surveys. • There were no individual/family directed services in FY 2014-15.
FY 15-16 Changes:	Decrease in annual budget to $10,000 annually as a true-up towards actual expenditures in FY 2013-14, and extended into FY 2017-18.

Project 5b: Community Health Outreach Worker	
Vendor:	To Be Determined
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Expenditures:	FY 2013-14: None (contract not in place) FY 2014-15: None (contract not in place)
Service Locations:	County-wide based on demand and results of competitive procurement process
Outcomes:	The Request for Proposals has not yet been published. Outcomes will be reported in the FY 2016-17 MHSA Plan.
FY 15-16 Changes:	Increase is annual budget to $50,000 annually and extended into FY 2017-18.
Administrative Costs	
Vendor:	HHSA, MHD
Expenditures:	FY 2013-14: $197,341 FY 2014-15: TBD.
FY 15-16 Changes:	Funding continued into FY 2017-18 at the same level as FY 2016-17.
PEI-TTACB	
Project was discontinued effective with the FY 2014-15 MHSA Plan.	

Community Services and Supports (CSS)

Under CSS (and other non-MHSA funding), the MHD provides medically necessary specialty mental health services for those who are indigent and individuals who are on Medi-Cal. Individuals with private insurance and Medi-Care are treated through their insurance network providers for all levels of mental health needs. Services for individuals with mild to moderate mental health needs who are indigent or on Medi-Cal are treated through their primary care providers, managed care plans, or fee-for-service providers. However "many children with impairments that may be considered moderate meet, and will continue to meet, medical necessity criteria (Title 9, California Code of Regulations (CCR), Section 1830.210) to access Medi-Cal specialty mental health services."[1]

MHD Priority Indicators

In addition to project-specific outcomes, the MHD has developed a list of 12 priority indicators (PI) that will be tracked for all specialty mental health services. The MHD is in the process of identifying data sources for these items and it is anticipated that the FY 2016-17 MHSA Plan Update will include these indicators for the MSHA projects, as applicable.

[1] MHSUDS Information Notice No.: 14-020, "New Outpatient Medi-Cal Mental Health Services Covered By Medi-Cal Managed Care Plans and Fee-For-Service Medi-Cal." May 29, 2014. http://www.dhcs.ca.gov/formsandpubs/Documents/14-020.pdf.

Outcomes	
O1	Reduction in days incarcerated since partnership
O2	Reduction in days psychiatrically hospitalized since partnership
O3	Reduction of clients homeless since partnership
O4	Number of individuals stepping into a lower level of care by program
Utilization	
U1	Number served by program
U2	Case load by provider
U3	Billing percent
U4	Client base
U5	Mental Health services appointments offered within X days of initial request for appointment
U6	Average length of participation/stay by program
Applicability	
A1	Locus score, ANSA/CANS, number of visits by client
Satisfaction	
S1	Consumer Perception Survey Results (State survey, two times per year)

Total Episodes

An "episode" is the type of project (services) in which an individual may be enrolled. In certain circumstances an individual may have more than one episode open at any given time or an individual may move between programs in the course of their treatment as their mental health needs increase or decrease. When an individual does have multiple episodes open at any one time, it means they are receiving different types of mental health services under each episode. This most frequently occurs when an individual has a crisis event or a short-term inpatient hospitalization. Upon closure of the Crisis episode and/or discharge from an inpatient facility, the client would return to having just one open episode. The breakdown of total episodes is:

Episode Types (duplicated client count)	**FY 2013-14**			**FY 2014-15 through 3/31/15 (9 months)**		
	Adults	**Children**	**Total**	**Adults**	**Children**	**Total**
Traditional Funded Mental Health Outpatient Services	431	960	1,391	317	601	918
MHSA Funded Mental Health Outpatient Services	647	113	760	695	120	815
Psychiatric Emergency Services (Crisis)[2]	748	121	869	560	124	684
PHF	364	0	364	243	0	243

[2] Includes only those individuals seen at hospitals; does not include the many phone calls that PES staff receive.

Non-PHF Inpatient Placements	61	13	74	68	6	74
Total Episodes	2,251	1,207	3,458	1,883	851	2,734

The breakdown of total MHSA episodes (duplicated count of clients) open during all or part of the time period specified below is. This information addresses outcome measure U1, Number served by program.

Episode Types by Associated MHSA Project (duplicated client count)	FY 2013-14			FY 2014-15 through 3/31/15 (9 months)		
	Adults	Children	Total	Adults	Children	Total
Program 1: Youth and Family Strengthening Program						
Project 1a: Youth and Family Full Service Partnership[3]	2 (under 21)	34	36	6 (under 21)	32	38
Project 1b: Family Strengthening Academy	0	5	5	0	0	0
Project 1c: Foster Care Enhanced Services[4]	0	47	47	6 (under 21)	64	70
Program 2: Wellness and Recovery Services						
Project 2a: Wellness Centers	513	3[5]	516	473	2[6]	475
Project 2b: Adult Full Service Partnership	90	2[7]	92	115	0	115
Project 2c: Older Adults Program[8]	0	0	0	0	0	0
Program 3: Transitional Age Youth (TAY) Services						
Project 3a: TAY Engagement, Wellness and Recovery Services	23 (18 and over but under 25)	22 (under 18)	45	44 (18 and over but under 25)	22 (under 18)	66
Program 4: Community System of Care						
Project 4b: Community-Based Mental Health Services (AB 109 Only)	19	0	19	51	0	51

[3] Includes individuals who continued with their Children's Services Provider after turning 18 due to continued eligibility for the project.
[4] Includes individuals who continued with their Children's Services Provider after turning 18 due to continued eligibility for the project.
[5] Data anomaly that has been resolved.
[6] Data anomaly that has been resolved.
[7] Data anomaly that has been resolved.
[8] Older Adults are currently enrolled in other episode types.

Episode Types by Associated MHSA Project (duplicated client count)	FY 2013-14			FY 2014-15 through 3/31/15 (9 months)		
	Adults	Children	Total	Adults	Children	Total
Total Episodes (Duplicated Clients)	647	113	760	695	120	815
Total Unduplicated Clients	623	102	725	670	106	776

MHSA Episodes - Client Demographics

The following demographics are unduplicated counts of the number of clients with at least one open MHSA episode during the time period identified.

Gender	FY 2013-14			FY 2014-15 through 3/31/15 (9 months)		
	Adult	Children	Total	Adult	Children	Total
Male	300	59	359	329	61	390
Female	323	43	366	341	45	386
Total	623	102	725	670	106	776

Service Location	FY 2013-14			FY 2014-15 through 3/31/15 (9 months)		
	Adult	Children	Total	Adult	Children	Total
South Lake Tahoe	161	32	193	172	46	218
West Slope	462	70	462	498	60	558
Total	623	102	725	670	106	776

Age at Discharge (or Current Age If Episode Still Open)	FY 2013-14 Total	FY 2014-15 through 3/31/15 (9 months) Total
12 and Under	49	52
13-17	36	54
18-24	79	84
25-59	498	529
Over 60	64	57
Total	726[9]	776

MHSA Episodes - Unduplicated Client Counts

As of March 31, 2015, 462 individuals were enrolled in an MHSA program (403 adults and 59 children) (unduplicated count). This information addresses outcome measure U1, Number served by program.

Episode Types by Associated MHSA Project (unduplicated client count)	As of 3/31/15 Adults	Children	Total
Program 1: Youth and Family Strengthening Program			
Project 1a: Youth and Family Full Service Partnership	3 (under 21)	23	26
Project 1b: Family Strengthening Academy	0	0	0
Project 1c: Foster Care Enhanced Services	2 (under 21)	28	30
Program 2: Wellness and Recovery Services			
Project 2a: Wellness Centers	292	0	292
Project 2b: Adult Full Service Partnership	69	0	69
Project 2c: Older Adults Program[10]	0	0	0
Program 3: Transitional Age Youth (TAY) Services			
Project 3a: TAY Engagement, Wellness and Recovery Services	24 (18 and over but under 25)	8 (under 18)	32

[9] One individual moved between age groups at change of episode type during this time period and that individual is therefore counted twice.

[10] Older Adults are currently enrolled in other episode types.

Episode Types by Associated MHSA Project (unduplicated client count)	As of 3/31/15		
	Adults	Children	Total
Program 4: Community System of Care			
Project 4b: Community-Based Mental Health Services (AB 109 Only)	13	0	13
Total Unduplicated Clients	**403**	**59**	**462**

This information addresses outcome measure U4, Client base:

Location	As of 3/31/15		
	Adults	Children	Total
West County	68	5	73
Placerville Area	177	18	195
North County	22	2	24
South County	16	1	17
Mid County (Pollock Pines Area)	42	6	48
Tahoe Basin	70	23	93
Out of County	7	4	11
Unknown / Homeless	1	0	1
Total	403	59	462

MHSA Projects – Program Costs and Cost per Person

Based on the total number of individuals who have received a MHSA service, the average cost per person is identified below for FY 2013-14. Due to cost allocation methodologies and the County's accounting system, the expenditures for each project for FY 2014-15 are not yet available. FY 2014-15 expenditures will be reported in the FY 2016-17 MHSA Plan Update.

In the table below, individuals who were enrolled multiple times in the same program during the specified time period are counted only once. For example, an individual who moves from Project 1a to Project 1c and then back to Project 1a is counted only once in Project 1a and once in Project 1c (although the total number of episodes would be three).

Episode Types by Associated MHSA Project	FY 2013-14			FY 2014-15 through 3/31/15 (9 months)	
	Total Individuals (unique by Project)	**Total Cost**	**Cost per Person**	**Total Individuals** (unique by Project)	**Total Individuals** (unique by Program)
Program 1: Youth and Family Strengthening Program[11]					
Project 1a: Youth and Family Full Service Partnership	33	$375,836	$10,440	34	91
Project 1b: Family Strengthening Academy	5	$13,664	$2,733	0	
Project 1c: Foster Care Enhanced Services	47	$171,653[12]	$3,652	63	
Program 2: Wellness and Recovery Services*					
Project 2a: Wellness Centers	516	$1,005,141	$1,948	475	570
Project 2b: Adult Full Service Partnership	91	$1,131,216	$12,431	115	
Project 2c: Older Adults Program[13]	0	$0	$0	0	
Program 3: Transitional Age Youth (TAY) Services					
Project 3a: TAY Engagement, Wellness and Recovery Services	45	$24,349	$541	66	66
Program 4: Community System of Care					
Project 4a: Outreach and Engagement Services	1,432	$338,316	$236	*See below*	
Project 4b: Community-Based Mental Health Services (AB 109 Only)	19	$54,158	$2,850	51	51
Project 4c: Resource Management Services	Not applicable	$7,553	Not applicable	--	
Total	**756**	**$3,121,886**		**804**	**778**

Project 2a: Wellness Centers

Operation of the Wellness Centers in South Lake Tahoe and Diamond Springs are part of Project 2a: Wellness Centers (in addition to the direct treatment services provided through this project). In October 2013, the West Slope Outpatient Clinic and Wellness Center

[11] May include individuals who may also be considered in the TAY age range (16-24), but are being served through a non-TAY-specific project.
[12] Represents only a partial year of services. This project was not fully operational until the fourth quarter of the fiscal year.
[13] Older Adults are currently enrolled in other episode types.

relocated to Diamond Springs, and in September 2014, the South Lake Tahoe Outpatient Clinic and Wellness Center relocated to a new building within South Lake Tahoe.

Type	FY 2013-14		FY 2014-15 through 3/31/15	
	South Lake Tahoe Entire Year	West Slope 8/9/13 through 6/30/14	South Lake Tahoe 9 months	West Slope 9 months
Total Client Visits (duplicated clients)	1,998	5,696	1,268	5,880
Total Clients (unduplicated clients)	not available	234	not available	247

Project 4a: Outreach and Engagement Services

Project 4a: Outreach and Engagement Services works to engage eligible individuals in specialty mental health services and provide referrals for those individuals who do not meet the criteria for specialty mental health services. The primary means of doing this is through direct telephone contact with individuals requesting mental health services. Effective January 2015, all telephone requests for services are processed through the West Slope office of the MHD, however the data below represents the area from which the request originated rather than the office processing the request.

The number of requests for services received by the MHD are reflected below. These numbers do not include requests for re-authorization of services.

Category	FY 2013-14			FY 2014-15 through 3/31/15 (9 months)		
	South Lake Tahoe	West Slope	Total	South Lake Tahoe	West Slope	Total
Children	132	339	471	122	384	506
Adults	325	636	961	314	505	819
Total Requests	457	975	1,432	436	889	1,325

Service requests through March 31, 2015 (75% of the year) are at 92.5% of the total number of requests for services processed in FY 2013-15. The estimated number of requests for services in FY 2014-15 is projected to exceed 1,700 at the current rate of requests.

Once services are requested, an individual's needs are assessed and a determination is made regarding the outcome of the request for services. The reasons for these "discharges" from requests for services/pre-admit status are:

CHILDREN Results (Discharge from "Pre-Admit" Status)	FY 2013-14			FY 2014-15 through 3/31/15 (9 months)		
	South Lake Tahoe	West Slope	Total	South Lake Tahoe	West Slope	Total
Discharged to Outpatient MHD	98	93	191	57	95	152
Discharged to Other MH Provider	2	116	118	18	104	122
Does not meet Medical Necessity	16	74	90	32	108	140
Moved Out of County	1	0	1	1	2	3
Cancel or No Show	10	4	14	1	17	18
Incarceration (3 mos. or more)	0	0	0	1	0	1
Could Not Be Contacted	5	49	54	11	58	69
Discharge to Crisis	0	3	3	1	0	1
Total	132	339	471	122	384	506

ADULTS Results (Discharge from "Pre-Admit" Status)	FY 2013-14			FY 2014-15 through 3/31/15 (9 months)		
	South Lake Tahoe	West Slope	Total	South Lake Tahoe	West Slope	Total
Discharged to Outpatient MHD	129	158	287	76	94	170
Discharged to Other MH Provider	8	44	52	12	17	29
Does not meet Medical Necessity	94	263	357	125	246	371
Moved Out of County	0	4	4	9	2	11
Cancel or No Show	38	30	68	22	48	70
Incarceration (3 mos. or more)	0	1	1	2	0	2
Could Not Be Contacted	47	124	171	67	94	161
Discharge to Crisis	9	12	21	1	4	5
Total	325	636	961	314	505	819

Project-Specific Outcomes and Changes

Program 1: Youth and Family Strengthening Program	
Project 1a: Youth and Family Full Service Partnership	
Vendor:	Sierra Child and Family Services
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Expenditures:	FY 2013-14: $311,949 FY 2014-15: TBD
Service Locations:	Countywide based on clients' location and needs
Vendor:	Summitview Child and Family Services
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Expenditures:	FY 2013-14: $53,175 FY 2014-15: TBD
Service Locations:	Countywide based on clients' location and needs
Vendor:	HHSA
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Expenditures:	FY 2013-14: $10,713 FY 2014-15: TBD
Service Locations:	Countywide based on clients' location and needs
Outcomes:	The outcome measures for FSP projects require specialized reporting, and the MHD continues to work with the providers and the State to obtain the necessary data (FSP data is entered into a State database with limited reporting capabilities). An RFP was released in early 2015 and any resulting agreements for services resulting from the RFP will require reporting on these specific measures: Measurement 1: Days of psychiatric hospitalization Measurement 2: Days in shelters Measurement 3: Days of arrests Measurement 4: Type of school placement Measurement 5: School attendance Measurement 6: Academic performance Measurement 7: Days in out of home placement Measurement 8: Child care stability
FY 15-16 Changes:	The funding for Project 1a: Youth and Family Full Service Partnership and Project 1c: Foster Care Enhanced Services will be combined to provide the greatest service level flexibility for children and youth meeting the criteria for these project. It would be expected that children and youth meeting the criteria of Project 1c would step-down to Project 1a, and it is possible that children and youth in Project 1a would step up to Project 1c. The projects must be maintained separately as their program description and eligibility for criteria is different (the State requires counties to track and report separately on the children

	and youth meeting the criteria for Project 1c), but both projects provide FSP services and therefore the MHSA funds designated as FSP are being utilized appropriately, whether under Project 1a or Project 1c. Funding continued into FY 2017-18. Funding levels decreased by $55,000 as a true-up to FY 2013-14 and projected FY 2014-15 actual costs. An RFP was released in early 2015 for Children's Specialty Mental Health Services. The outcome of the RFP may result in the same or different service providers.
Project 1b: Family Strengthening Academy	
Vendor:	Not Applicable
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Expenditures:	FY 2013-14: $13,664 FY 2014-15: TBD
Outcomes:	This project has not been utilized by the MHD.
FY 15-16 Changes:	This program is proposed to be discontinued in FY 2015-16. Based on input received during the FY 2014-15 MHSA community planning process, this project was to create a continuum of services for school-aged youth participating in the PEI Project 1f: Prevention and Early Intervention for Youth in Schools who were in need of specialty mental health services. Specialty mental health services will continue to be available to students referred from PEI Project 1f who meet medical necessity criteria through other MHD programs.
Project 1c: Foster Care Enhanced Services	
Vendor:	Sierra Child and Family Services
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Expenditures:	FY 2013-14: $171,653 FY 2014-15: TBD
Service Locations:	Based on clients' location and needs
Vendor:	Summitview Child and Family Services
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Expenditures:	FY 2013-14: None (contract not in place) FY 2014-15: TBD
Service Locations:	Based on clients' location and needs
Vendor:	CASA
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Expenditures:	FY 2013-14: None (contract not in place) FY 2014-15: TBD
Service Locations:	Based on clients' location and needs
Outcomes:	Outcomes will be reported in the FY 2015-16 MHSA Plan.

Outcomes:	The outcome measures for FSP projects require specialized reporting, and the MHD continues to work with the providers and the State to obtain the necessary data (FSP data is entered into a State database with limited reporting capabilities). An RFP was released in early 2015 and any resulting agreements for services resulting from the RFP will require reporting on these specific measures: Measurement 1: Days of psychiatric hospitalization Measurement 2: Days in shelters Measurement 3: Days of arrests Measurement 4: Type of school placement Measurement 5: School attendance Measurement 6: Academic performance Measurement 7: Days in out of home placement Measurement 8: Child care stability
FY 15-16 Changes:	The funding for Project 1a: Youth and Family Full Service Partnership and Project 1c: Foster Care Enhanced Services will be combined to provide the greatest service level flexibility for children and youth meeting the criteria for either project. The projects must be maintained separately as their services and eligibility for criteria is different (the State requires counties to track and report separately on the children and youth meeting the criteria for Project 1c), but both projects provide FSP services whether under Project 1a or Project 1c. Funding continued into FY 2017-18. Funding levels decreased by $72,269 due to limited CSS funding. An RFP was released in early 2015 for Children's Specialty Mental Health Services. The outcome of the RFP may result in the same or different service providers.

Program 2: Wellness and Recovery Services	
Project 2a: Wellness Centers	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Expenditures:	FY 2013-14: $1,131,216 FY 2014-15: TBD
Service Locations:	South Lake Tahoe and Diamond Springs
Outcomes:	Since relocating to the Diamond Springs location, the West Slope Outpatient Wellness Center has seen an increase in daily attendance. This trend is anticipated to continue. The South Lake Tahoe Wellness Center is anticipated to relocate in mid- to late-2014 and it is anticipated a similar trend will occur once it is settled into its new location. **Measurement 1:** Number of participants and frequency of attendance. • Please see program data above. **Measurement 2:** Continued engagement in mental health services. • Please see program data above. **Measurement 3:** Attainment of individualized goals. • Attainment of individualized goals indicates an individual is ready to graduate from the Wellness program. In such instances, an individual would return to the care of their primary care provider or become a "medication only" client, meaning they only receive medication services from the MHD. While reviewing data for this MHSA Plan Update it was determined that the discharge report does not identify from which project an individual graduated, and therefore this measurement will be reported in the next MHSA Plan Update after the discharge report is modified.
FY 15-16 Changes:	Funding continued into FY 2017-18. Increase in funding due to higher staffing costs.

Project 2b: Adult Full Service Partnership	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Expenditures:	FY 2013-14: $1,005,141 FY 2014-15: TBD
Service Locations:	Countywide based on clients' location and needs
Outcomes:	In FY 2013-14, FSP services were expanded to the Tahoe Basin. The MHD has received approval to proceed with securing master leases on housing for FSP clients. Rather than entering into a lease agreement with individual clients, the landlords will lease to the County, which in turn will lease directly to the clients. Clients will continue to pay their share of housing costs, however clients who are in the FSP program will be eligible for housing assistance, and other supportive services, if needed. Additional housing opportunities are being explored on both the West Slope and in the South Lake Tahoe area.
Vendor:	Summitview Child and Family Services
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Expenditures:	FY 2013-14: None (contract not in place) FY 2014-15: TBD
Service Locations:	West Slope
Outcomes:	The Adult Residential Facility (ARF) opened in December 2014. Between December 2014 and March 31, 2015, there have been seven residents at the ARF. One resident returned to a higher level of care, and a new resident moved in at that time. Outcomes will be reported in the FY 2015-16 MHSA Plan.
Outcomes:	**Measurement 1:** Key Event Tracking (KET) - As changes occur in a client's status related to housing, employment, education, entry or exit from a psychiatric hospital, emergency department or jail. • The outcome measures for FSP projects require specialized reporting, and the MHD continues to work with the State to obtain the necessary data (FSP data is entered into a State database with limited reporting capabilities). **Measurement 2:** Achieving goals identified on the ISSP. **Measurement 3:** Continued engagement in services. • Attainment of individualized goals indicates an individual is ready to graduate from the FSP program. In such instances, an individual would likely step-down to a lower level of services for maintenance, and then graduation from services. Continued engagement of services would indicate that a client was keeping appointments, working on treatment goals and continuing to stay engaged with case workers. While reviewing data for this MHSA Plan Update it was determined

	that the necessary reports do not identify from which project an individual graduated, or stepped down from, and therefore these two measurements will be reported in the next MHSA Plan Update after the reports are modified.
FY 15-16 Changes:	Funding continued into FY 2017-18. Increase in funding due to higher staffing costs and additional transitional houses operated through master lease agreements.
Project 2c: Older Adults Program (Partner program to PEI Older Adults Program)	
This project is discontinued in the FY 2015-16 MHSA Plan Update and there were no expenditures in FY 2013-14 or FY 2014-15. Services to older adults will continue to be provided through other outpatient programs.	
Future Potential Project 2d: Assisted Outpatient Treatment	
Vendor:	None selected – potential future project
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Expenditures:	FY 2013-14: None (project not yet approved for implementation) FY 2014-15: None (project not yet approved for implementation)
Service Locations:	To be determined
Outcomes:	The Mental Health Commission and HHSA continue exploration of this project. On February 25, 2015, the Community Corrections Partnership received a presentation about Assisted Outpatient Treatment (AOT) and a motion was made and passed in support of AOT implementation in El Dorado County pending a determination of how the project would be funded. The project is still under review and cannot yet be implemented, so it is identified as a potential future project.
FY 15-16 Changes:	Funding continued into FY 2017-18. Decrease in funding due to limited CSS funding due to the requirement of Welfare and Institutions Code section 5349, which states in part that "no voluntary mental health program serving adults, and no children's mental health program, may be reduced as a result of the implementation of this article."

Program 3: Transitional Age Youth (TAY) Services	
Project 3a: TAY Engagement, Wellness and Recovery Services	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Expenditures:	FY 2013-14: $24,349 FY 2014-15: TBD
Service Locations:	Countywide based on clients' location and needs
Outcomes:	Staff from both outpatient clinics have been engaging transitional age youth in services. These services include therapy, psychiatry, groups, and development of independent living skills. The MHD is arranging training on first episode of psychosis as it is within this age group that the Similar to other projects, the reports for this data need to be modified to provide the required information. Therefore, outcomes will be reported in the FY 2016-17 MHSA Plan. **Measurement 1:** Number of days of institutional care placements **Measurement 2:** Number of days of homelessness / housing stability **Measurement 3:** Education attendance and performance **Measurement 4:** Employment status **Measurement 5:** Continued engagement in mental health services **Measurement 6:** Linkage with primary health care
FY 15-16 Changes:	Utilizing new funding available through the Mental Health Block Grant (MHBG) and funding through MHSA continue to develop and expand a First Episode Psychosis (FEP) program specifically for Transitional Age Youth age 16-25. Extend the age range for participation in this program through age 25 (currently is 24). This will allow better alignment of the project with programs for FEP. Funding continued into FY 2017-18. Decrease in funding as a true-up to staffing levels and budget.
Program 4: Community System of Care	
Project 4a: Outreach and Engagement Services	
Vendor:	HHSA, MHD
Expenditures:	FY 2013-14: $338,316 FY 2014-15 projected through June 30, 2015: Approximately $795,000
Service Locations:	Countywide
Outcomes:	When a request for services is received, the Clinicians in the Quality Assurance-Utilization Review unit will contact the requesting party to discuss their mental health needs. In the event

	the individual does not meet the medical necessity requirement for specialty mental health services, the Clinicians will provide referrals to other resources in the community that may be able to provide the necessary services. **Measurement 1:** Service engagement. • The demand for mental health services in El Dorado County remains high. Please see data above. **Measurement 2:** Wellness Center attendance. • Please see data above.
FY 15-16 Changes:	There were no respondents to the RFP for the PATH funds and discussions with a potential sole source provider did not result in an agreement for services. HHSA will continue to explore options with the PATH funding. Future PATH funds may be utilized by HHSA directly, contracted with a provider, or returned to the State. Funding continued into FY 2017-18. Slight decrease in funding due to a true-up to staffing and budget.
Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services)	
Vendor:	HHSA, MHD
Expenditures:	FY 2013-14: $54,158 FY 2014-15: TBD
Service Locations:	Shingle Springs; countywide based on clients' location and needs
Outcomes:	Due to low staffing levels, the MHD has not been able to fully implement this program beyond the staffing at the Community Corrections Center in Shingle Springs. **Measurement 1:** Continued engagement in mental health services **Measurement 2:** Days of homelessness, institutionalization, hospitalization, and incarceration **Measurement 3:** Linkage with primary health care **Measurement 4:** Levels of Care Utilization System (LOCUS)/CALOCUS **Measurement 5:** Outcome measurement tools (e.g., CANS)
FY 15-16 Changes:	Funding continued into FY 2017-18. Increase in funding due to true-up to budget. Although the project allows for an array of community-based services, the only service currently funded through this project are those provided by the Clinician stationed at the Community Corrections Center in Shingle Springs.
Project 4c: Resource Management Services	
Vendor:	HHSA, MHD
Expenditures:	FY 2013-14: $7,553

FY 2014-15: TBD

Service Locations: Countywide

Outcomes: MHD staff have been working with community providers to improve collaboration and service provision. Internally, the MHD has been working to improve access and service delivery, as well as access for primary care physicians to psychiatric consultations.

Measurement 1: Update and expansion of resource list; dissemination of information to clients.

The Resource Associate position was filled mid-FY 2014-15. A resource list has been developed, which is distributed to clients and to the public at various event.

Measurement 2: Client wait times.

- Average length of time from first request for service to first clinical assessment during the first two quarters of FY 2014-15.

  Adult Services 13 days
  Children's Services 16 days

Measurement 3: Client satisfaction surveys.

- The Consumer Perception Survey was completed in May 2014, December 2014 and May 2015. Data for May 2014 is the only survey data currently available. There were 15 completed surveys in May 2014. Responses indicated that 72% of the respondents "Agreed" or "Strongly Agreed" overall to a satisfaction with services, through questions such as
  - I like the services that I received here
  - Services were available at times that were good for me
  - Staff encouraged me to take responsibility for how I live my life

  Because the survey response sample was so small for the May 2014 survey, the MHD is awaiting the results of the December 2014 and May 2015 surveys to better evaluate client satisfaction.

Measurement 4: Establishment of standard evaluation process for MHSA programs and dissemination of information.

- On January 29, 2015, the MHD launched the priority indicators project, which will be tracking the 12 indicators identified above. The Performance Management Team will continue to meet to develop necessary reports, review outcomes and make recommendations.

Measurement 5: Results of EQRO annual audit.

- The 2015 EQRO review was held on April 8, 2015. The result of that review are not yet available.
- The 2014 EQRO report is available at http://www.caleqro.com/archived-data/el-dorado-final-report-fy13-14_ee861ac.zip

	Measurement 6: Results of Program Improvement Plan for Primary Care Providers. • This Program Improvement Plan ended after training was provided. The MHD continues to work towards graduating clients to their primary care providers. This measurement will therefore be deleted. **Measurement 7:** Primary care provider satisfaction surveys. • This data is not available. Since the Program Improvement Plan for Primary Care Providers ended prior to completion, this measurement will be deleted.
FY 15-16 Changes:	Funding continued into FY 2017-18. Decrease in funding due to lack of funds and true-up towards FY 2013-14 expenditures.
CSS-Housing	
Project 1: Trailside Terrace	
Location:	Shingle Springs
Number of Units:	40
MHSA Units:	5
Status:	Four MHSA units are occupied and one application is being processed for the fifth apartment. The MHD maintains a waiting list of eligible individuals/families.
FY 15-16 Changes:	None.
Project 2: The Aspens at South Lake	
Location:	South Lake Tahoe
Number of Units:	48
MHSA Units:	6
Status:	All six MHSA units are currently leased. The MHD maintains a waiting list of eligible individuals/families.
FY 15-16 Changes:	None.
Project 3: Local Housing Assistance	
Vendor:	HHSA, MHD
Project Amount:	Approximately $11,858.
Service Locations:	Countywide
FY 15-16 Changes:	This is a new project in FY 2015-16. These CSS-Housing funds will be utilized to provide housing assistance to clients enrolled in a Full Service Partnerships project who are homeless or soon-to-be-homeless, which includes clients moving from transitional housing to independent living. Any fund balance remaining at the end of FY 2015-16 will be available for use in FY 2016-17. Any fund balance remaining at the end of and FY 2016-17 will be available for use in FY 2017-18. Any unspent funds after three years will revert back to the State.

Program 1: Workforce Education and Training (WET) Coordinator	
Vendor:	HHSA, MHD
Expenditures:	FY 2013-14: $5,691 FY 2014-15: TBD
Outcomes:	**Measurement 1:** Increase the number of training opportunities for the mental health workforce. • The WET Coordinator has signed up for a variety of distribution lists to be notified of upcoming trainings. Information about upcoming trainings applicable to mental health is distributed to managers and supervisors, and when possible, to the MHSA email distribution list. Notices received regarding trainings applicable to other disciplines (e.g., Child Welfare Services, Public Health) is also distributed when possible. **Measurement 2:** Increased number of bilingual / bicultural mental health workforce employed within the public mental health system. • There have been no new bilingual/bicultural staff hired in FY 2014-15. However, the ability to impact the hiring of bilingual/bicultural mental health staff is beyond the control of the WET Coordinator, this measurement will be removed in FY 2015-16.
FY 15-16 Changes:	Funding continued into FY 2017-18. Decrease in funding as a true-up to budget.
Program 2: Workforce Development	
Expenditures:	FY 2013-14: $152,324 FY 2014-15: TBD
Outcomes:	**Measurement 1:** Increase the number of training opportunities for the public mental health system workforce, including staff, contractors, volunteers and consumers. • Training opportunities are distributed via email to appropriate supervisors and managers within HHSA, and to the public via directed emails or the MHSA email distribution list. **Measurement 2:** Increased number of bilingual / bicultural public mental health workforce system staff in the County. • There have been no new bilingual/bicultural staff hired in FY 2014-15.
FY 15-16 Changes:	Funding continued into FY 2017-18. Decrease in funding as a true-up to budget and lack of funding.
Program 3: Psychiatric Rehabilitation Training	
This program was moved under Program 2: Workforce Development with the adoption of the FY 2014-15 MHSA Plan.	

Program 4: Early Indicators of Mental Health Issues	
Provider:	EDCOE
Expenditures:	FY 2013-14: None (contract not in place) FY 2014-15: None (contract not in place)
Outcomes:	The contract nearing execution. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 15-16 Changes:	Funding will end as of 6/30/16.
Program 5: Suicide Education and Training	
Provider:	EDCOE
Expenditures:	FY 2013-14: None (contract not in place) FY 2014-15: None (contract not in place)
Outcomes:	The contract is nearing execution. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 15-16 Changes:	Funding will end as of 6/30/16. Remove the requirement for having at least one suicide prevention trainer/specialist at each high school due to the determination that there are few age-appropriate suicide prevention trainings that have a train-the-trainer component to them. Modify the requirement to have at least one suicide prevention trainer/specialist at each school site to read: "Have at least one suicide prevention specialist at each school site, with a "specialist" being an individual who has received suicide prevention training, with priority given to high schools and middle schools"
Program 6: Consumer Leadership Academy	
Expenditures:	FY 2013-14: $1,223 FY 2014-15: TBD
Outcomes:	**Measurement 1:** Number of graduates of the consumer leadership academy. • During FY 2014-15, there was one Academy held with six graduates. **Measurement 2:** Number of organizations identified for employment and/or volunteer opportunities. • The Academy works with the local Connections One-Stop and the Workforce Investment Act (WIA) programs. **Measurement 3:** Number of consumers who receive employment and/or volunteer opportunities after completion of the Consumer Leadership Academy and duration of their employment and/or volunteer position. • This data is not yet known. There have been at least five consumers working with Connections One-Stop.
FY 15-16 Changes:	Funding increased starting FY 2015-16, and continues into FY 2017-18 at the same level.

Program 7: Crisis Intervention Team Training	
Expenditures:	FY 2013-14: None (CIT training has been funded directly by law enforcement agencies) FY 2014-15: None (CIT training has been funded directly by law enforcement agencies)
Outcomes:	No MHSA funding has been utilized for Crisis Intervention Team Training through March 31, 2015.
FY 15-16 Changes:	Decrease in funding due to limited funding. A maximum of $10,000 will continue to be available into FY 2017-18 at the same level. Any funding available at the end of each fiscal year will be available in the next fiscal year for a maximum of $10,000 in total.

Program 1: Electronic Health Record System Implementation	
Project 1a: Avatar Clinical Workstation	
Expenditures:	FY 2013-14: $ 139,892 FY 2014-15: TBD
Outcomes:	**Measurement 1:** Implementation of EHR [electronic health record] throughout the MHD. – *Completed May 2013.* **Measurement 2:** Ability to provide centralized, electronic appointment scheduling. – *Completed May 2013.* **Measurement 3:** Updated and standardized business procedures and assessments, resulting in practices that are more efficient. – *Ongoing.* **Measurement 4:** Improved reporting capabilities (to audit charts and provide information relevant to program development). – *Ongoing.* **Measurement 5:** Successful maintenance of the EHR and continued training. – *Ongoing.* In FY 2014-2015, HHSA hired a Senior Department Analyst to work closely with Netsmart, County IT, MHD staff and other entities for continuation of the activities required in support of Measurements 3, 4 and 5. Costs for this position have been alloca ted across the MHD and is not solely funded through this project.
FY 15-16 Changes:	Funding from this project may be utilized to explore and purchase software to allow for greater integration with other mental health service providers and primary health care providers. Such software allows for increased communications between entities to facilitate referrals, authorizations, invoicing and client progress notes, amongst other benefits such as providing a better continuum of care for shared clients. Decreased costs for Netsmart (Avatar) software due to the MHD's allocation methodology. Increased costs in this project for the additional software described above. Funding continued into FY 2017-18. Net decrease in funding levels.

Project 1b: Electronic Outcome Measurement Tools	
Expenditures:	FY 2013-14: None. Tool selected is free of charge. FY 2014-15: TBD However, there may be some costs associated with developing the necessary forms and reports in the EHR for utilizing these tools.
Outcomes:	The EHR system has been updated with the forms and reports for the Child and Adolescent Needs and Strengths (CANS) and the forms and reports for the Adult Needs and Strengths Assessment (ANSA) are in the process of being finalized for distribution.
FY 15-16 Changes:	Funding ends June 30, 2016. Decrease in funding due to selected tool being available free of charge, leaving only potential forms and reports development in the EHR.
Program 2: Telehealth (formerly Telemedicine)	
Expenditures:	FY 2013-14: $34,918 FY 2014-15: TBD
Outcomes:	Video-conferencing equipment has been fully installed at both the South Lake Tahoe Outpatient Clinic and the West Slope Outpatient Clinic in Diamond Springs.
FY 15-16 Changes:	Funding continued into FY 2017-18 at a decreased level as a true-up to budget and anticipated future expenditures.
Program 3: Electronic Care Pathways	
Expenditures:	FY 2013-14: None. FY 2014-15: TBD. iReach has been discontinued.
Outcomes:	With the implementation of EHRs by health care providers and the Mental Health Division, the use of iReach was discontinued and replaced with a referral process utilizing forms printed directly from the EHR (rather than double entering of data into iReach and the EHR). Referrals are faxed to providers. Please see Project 1a: Avatar Clinical Workstation regarding potential expansion to include software to automate the referral process from within the EHRs.
FY 15-16 Changes:	Project officially discontinued effective upon the adoption of this Plan Update.

Part 2. MHSA Funding, Procurement and Staffing

MHSA Funding

The revenue and expenditure data contained in this Plan is based upon projections for FY 2014-15 and FY 2015-16, and are inclusive of a one-time-only adjustment for FY 2012-13 received in FY 2014-15. In the event the actual revenues are higher than anticipated, the additional funding may be utilized to support the projects identified in this Plan Update or rolled into the FY 2015-16 fund balance to be utilized on projects identified in the FY 2015-16 Plan. In the event the actual revenues are lower than anticipated, the County will access fund balances remaining from previous years at a higher than anticipated rate and/or reduce funding levels.

There are sufficient revenues and fund balance for all planned expenditures for the next three fiscal years; however, unless revenues are higher than anticipated, the budget is not sustainable in future years. Further adjustments to the budget may be necessary due to changing revenues or projected County expenditures.

Available Funding

Annual Revenues

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

Fiscal Year	Projected Revenue	Actual Revenues[14]
FY 2012-13	$5,389,559	$6,465,198
FY 2013-14	$6,025,786	$5,025,862
FY 2014-15	$6,869,250	$7,035,053
FY 2015-16	$6,069,917	TBD
FY 2016-17	$6,828,459	TBD
FY 2017-18	$6,828,459	TBD

Fund Balances

In addition to the FY 2015-16 revenues, the El Dorado County MHSA programs maintain fund balances accrued from previous fiscal years that may be accessed during the term of this Plan. There is a planned usage of fund balances for each component.

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

Budgeted Revenues and Expenditures by Component[15]

FY 2015-16 Revenues	CSS	PEI	INN	WET	CFTN	CSS-Housing	Total
Fund Balances	$4,911,557	$1,798,001	$1,656,206	$121,481	$308,519	$0	$8,674,283
MHSA	$4,637,577	$1,124,548	$295,934	--	--	$11,858	$6,069,917
Public Safety Realignment 2011 (AB 109)	$138,866	--	--	--	--	--	$138,866
Grants	$85,235	--	--	--	--	--	$85,235
Private Payor/ Other Insurance	$8,400	--	--	--	--	--	$8,400
Offsetting Expenditures •Medi-Cal Reimbursement •Housing	$2,696,652 $134,400	--	--	--	--	--	$2,831,052
Reallocation from CSS	($46,519)	--	--	$46,519	--	--	$0
Potential Reversion	--	--	($567,000)	--	--	--	($567,000)
Available Revenues	$12,566,168	$2,922,549	$1,385,140	$168,000	$308,519	$11,858	$17,362,234

[15] MHSA revenues also include interest on funds previously received but not yet spent and Medi-Cal administration revenues in an amount of approximately $25,000. These funds are budgeted under MHSA administration and allocated across MHSA components when the fiscal year is reconciled. Due to the minimal amount, these funds are not included in the above components.

FY 2015-16 Expenditures	CSS	PEI	INN[16]	WET	CFTN	CSS-Housing	Total
MHSA Programs	$9,311,083	$1,865,649	$597,850	$168,000	$168,186	$11,858	$12,122,626
Potential Future Project	$75,000	--	--	--	--	$0	$75,000
Contribution to Prudent Reserve	--	--	--	--	--	$0	$0
Total Expenditures	$9,386,083	$1,865,649	$597,850	$168,000	$168,186	$11,858	$12,197,626

FY 2015-16	CSS	PEI	INN[17]	WET	CFTN	CSS-Housing	Total
Estimated Fund Balances 7/1/16	$3,180,085	$1,056,900	$1,363,380	$0	$140,333	$0	$5,740,698

For more details regarding MHSA allocations and expenditures by component and project, please see Attachment E.

[16] A separate planning process will occur for Innovation. The current anticipated expenditures are for the costs associated with those planning sessions and writing the Innovation plan.
[17] A separate planning process will occur for Innovation. The current anticipated expenditures are for the costs associated with those planning sessions and writing the Innovation plan.

MHSA Funding Allocations

Within El Dorado County, MHSA funds are allocated by target populations through individual projects, and is not based solely on overall population rates of a geographic area. The target population for each project is identified based through the community planning process and each project description identifies the target population.

Costs Included

In addition to direct service expenditures, component costs include administrative costs, such as general MHSA program planning and implementation costs and other departmental expenses including County and Department costs that are spread across programs based on a methodology utilized by HHSA and approved by the State. The total administrative costs are included in the expenditures identified above.

Additionally, in FY 2013-14, the Board of Supervisors approved salary increases of 5% to staff, management and unrepresented management. Therefore, there will be an additional 5% increase in salaries in FY 2015-16.

Prudent Reserve

The County is required to maintain a Prudent Reserve of MHSA funding to provide MHSA services during years in which MHSA revenues fall below recent averages and in which the MHSA allocations are insufficient to continue to serve the same number of individuals as the County had been serving in the previous fiscal year. Previously, legislation required counties to maintain a prudent reserve totaling 50% of the total CSS allocation; however, this requirement was recently eliminated and the amount of the prudent reserve is determined by each county.

The balance of the County's Prudent Reserve is $1,898,284. No funds will be transferred into the Prudent Reserve in FY 2015-16, and therefore the balance will remain at $1,898,284. All references in this Plan to "fund balance" exclude the Prudent Reserve.

Transfer of Funds Between Components

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

No CSS funds were shifted into WET or CFTN in FY 2014-15. This MHSA Plan Update includes shifting funds from CSS to WET starting in FY 2015-16. There is no anticipated shift of CSS funds from CSS to CFTN due to a change in allocation of software licensing costs.

Reversion

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

three years. WET and CFTN funds that are not fully expended within 10 years from the year of allocation will revert to the State.

Rolling of Project Budgets

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

MHSA Component Funding

PEI Budget

Of the total MHSA funding received by the County, a net 19% must be allocated to PEI per the MHSA. PEI funds must be expended within three years or the funds are subject to reversion to the State. It is not anticipated that any PEI funding will revert to the State in FY 2015-16. PEI receives only MHSA funds (i.e., there are no Medi-Cal reimbursements for PEI).

The PEI fund balance will be utilized for limited-term programs or for planned one-time-only start-up costs or other expenses.

Based on current revenue and expenditure projections, and current approved projects, the PEI budget is not sustainable beyond FY 2018-19. As a result, unless funding increases, a reduction in PEI services should be anticipated in FY 2017-18.

For additional information regarding MHSA allocations and expenditures, please see Attachment E.

PEI Funding by Age

Children's programs receive the highest level of PEI funding, which is an age group identified as a priority through the community planning process. However, other age groups were identified as in need of services, including older adults and transitional aged youth. There was also a need expressed for more education relative to mental illness, suicide prevention, stigma reduction and available resources through PEI funding.

Of the total PEI funding for projects (excluding administrative costs), approximately:

- 50% is allocated to projects addressing the needs of children (from birth through age 18) or children and their families:
  - Project 1a: Children 0-5 and Their Families
  - Project 1b: Mentoring for 3-5 Year Olds
  - Project 1c: Parenting Skills (formerly Incredible Years)
  - Project 1d: Primary Intervention Project (PIP)
  - Project 1e: SAMHSA Model Programs

- Project 1f: Prevention and Early Intervention for Youth in Schools
- Project 1g: Nurtured Heart Approach
- Project 2f: Foster Care Continuum Training

- 9% is allocated to projects specifically designed to address the needs of older adults (age 60+):
  - Project 4b: Senior Peer Counseling
  - Project 4c: Older Adult Program
- 3% is allocated to projects to address the needs of adults of any age):
  - Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness
- 22% is allocated to programs to address health disparities, which include services for children, adults and families:
  - Project 3a: Wennem Wadati - A Native Path to Healing
  - Project 3b: Latino Outreach
- 12% is allocated to projects to education programs:
  - Project 2a: Mental Health First Aid
  - Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education
  - Project 2d: Community Information Access
  - Project 2e: Suicide Prevention and Stigma Reduction
  - Project 2g: Community Outreach and Resources
- 4% is allocated to community-based projects:
  - Project 5a: Community-Based Mental Health Services
  - Project 5b: Community Health Outreach Worker

Funding by Geographic Location

Of the total PEI funding for projects (excluding administrative costs), approximately:

- 33% is allocated to projects that are performed in various locations throughout the County, including schools:
  - Project 1b: Mentoring for 3-5 Year Olds
  - Project 1e: SAMHSA Model Programs
  - Project 2a: Mental Health First Aid
  - Project 2e: Suicide Prevention and Stigma Reduction
  - Project 4b: Senior Peer Counseling
  - Project 4c: Older Adult Program
  - Project 5a: Community-Based Mental Health Services
  - Project 5b: Community Health Outreach Worker
- 41% is allocated to projects offered in a specific location(s) as a result of a competitive procurement process:
  - Project 1c: Parenting Skills (formerly Incredible Years)
  - Project 1d: Primary Intervention Project (PIP)
  - Project 2f: Foster Care Continuum Training
  - Project 3a: Wennem Wadati - A Native Path to Healing
  - Project 3b: Latino Outreach
- 9% is allocated to pilot projects offered at specific locations:

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

- 12% is allocated to projects that serve eligible populations in the County, but the services must be provided at a specific location due to necessary facilities/equipment; and
  - Project 1a: Children 0-5 and Their Families
  - Project 1g: Nurtured Heart Approach
  - Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness
- 4% is allocated to projects that provide information/activities in all schools, educational classes, and/or information Countywide based on internet access, newspaper distribution or other posted materials:
  - Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education
  - Project 2d: Community Information Access
  - Project 2g: Community Outreach and Resources
  - Project 2h: Statewide PEI Projects

CSS Budget

Of the total MHSA funding received by the County, a net 76% must be allocated to CSS per the MHSA. CSS funds must be expended within three years or the funds are subject to reversion to the State. It is not anticipated that any CSS funding will revert to the State in FY 2015-16.

Public input on CSS service and funding priorities would be very valuable since demand for CSS services has increased in the past two years, while funding remains limited. Based on current projections the CSS fund balance will be nearly depleted at the end of Fiscal Year 2017-18. The Mental Health Division will continue to discuss this topic with the public and the Mental Health Division, and will continue to monitor project progress.

Full Service Partnership Funding

MHSA requires counties to direct the majority of the CSS funds to the FSP service category (excluding CSS-Housing funds).[18] Planned FSP expenditures (not including FSP services within the TAY Engagement, Wellness and Recovery Services program or the future potential project of Assisted Outpatient Treatment) are:

Fiscal Year	FSP Projects as Percent of Total Budget
FY 2015-16	56%
FY 2016-17	56%
FY 2017-18	57%

Total FSP expenditures (as opposed to GSD or OE expenditures) in the TAY Engagement, Wellness and Recovery Services program will be determined based upon client need. However, it is estimated that approximately 10% of the expenditures in the TAY Engagement, Wellness and Recovery Services program may be FSP expenditures, but FSP expenditures within the TAY Engagement, Wellness and Recovery Services program will not be limited to only 10%.

[18] CCR, Title 9, Division 1, Chapter 14, Section 3620, Full Service Partnership Service Category, subsection (c)

For additional information regarding MHSA allocations and expenditures, please see Attachment E.

Funding by Age

Of the total CSS funding for projects (excluding administrative costs and reallocation to WET), approximately:

- 12% is allocated to projects addressing the needs of children (from birth through age 18) or children and their families:
  - Project 1a: Youth and Family Full Service Partnership
  - Project 1c: Foster Care Enhanced Services
- 3% is allocated to projects addressing the needs of transitional age youth (ages 16 through 24):
  - Project 3a: TAY Engagement, Wellness and Recovery Services
- 75% is allocated to projects specifically designed to address the needs of adults (age 18+, and includes TAY and older adults):
  - Project 2a: Wellness Centers
  - Project 2b: Adult Full Service Partnership
  - Project 3a: TAY Engagement, Wellness and Recovery Services
  - Project 4b: Community-Based Mental Health Services
  - Future Potential Project 2d: Assisted Outpatient Treatment
- 10% is allocated to projects addressing the needs of the general population (children and adults):
  - Project 4a: Outreach and Engagement Services
  - Project 4c: Resource Management Services
- 43% is allocated to projects designed for outreach and engagement and general system improvement:
  - Project 4a: Outreach and Engagement Services
  - Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services)
  - Project 4c: Resource Management Services
- 57% is allocated to projects designed for Full Service Partnership (FSP):
  - Project 1a: Youth and Family Full Service Partnership
  - Project 1c: Foster Care Enhanced Services
  - Project 2b: Adult Full Service Partnership
  - Project 3a: TAY Engagement, Wellness and Recovery Services

Funding by Geographic Location

Of the total CSS funding for projects (excluding administrative costs and reallocation to WET), approximately:

- 44% is allocated to projects that are performed in various locations throughout the County based on client preference and/or location:
  - Project 1a: Youth and Family Full Service Partnership
  - Project 1c: Foster Care Enhanced Services

- Project 2b: Adult Full Service Partnership
- Project 3a: TAY Engagement, Wellness and Recovery Services
- Future Potential Project 2d: Assisted Outpatient Treatment

- 44% is allocated to projects that serve eligible populations in the County, but the services must be provided at a specific location due to necessary facilities/equipment:
  - Project 2a: Wellness Centers
- 2% is allocated to projects offered in locations in the community:
  - Project 4b: Community-Based Mental Health Services
- 10% is allocated to outreach and engagement and resource management, which may be performed through the outpatient clinics or in various locations in the community:
  - Project 4a: Outreach and Engagement Services
  - Project 4c: Resource Management Services

All CSS programs are offered on both the West Slope and in the Tahoe Basin, however the specific types of services available through each office may differ slightly depending upon availability (e.g., transitional housing availability is difficult to procure in the Tahoe Basin).

WET Budget

MHSA no longer provides funding for WET activities. The County has been operating this program through funds previously received and remaining as a fund balance. There is no risk of WET fund reversion in FY 2015-16.

During FY 2015-16, it is anticipated that the remaining fund balance will be fully utilized. Per WIC §5892(b), counties may use a portion of their CSS funds for WET, CFTN, and the Prudent Reserve. The total amount of CSS funding used for this purpose may not exceed 20% of the total average amount of funds allocated to that County for the previous five years. El Dorado County will transfer CSS funds to the WET component starting in FY 2015-16 as follows:

Fiscal Year	Amount
FY 2015-16	$46,519
FY 2016-17	$52,000
FY 2017-18	$37,000

For additional information regarding MHSA allocations and expenditures, please see Attachment E.

CFTN Budget

MHSA no longer provides CFTN funding. The County has been operating this program through funds previously received and remaining as a fund balance. There is no risk of CFTN fund reversion in FY 2015-16.

It is anticipated there will be an adequate CFTN fund balance to continue to operate the CFTN programs through FY 2017-18, so there is no transfer of funding from CSS to CFTN.

For additional information regarding MHSA allocations and expenditures, please see Attachment E.

Innovation Budget

Of the total MHSA funding received by the County for CSS and PEI, five percent (5%) of the funding is allocated to Innovation. A portion of the Innovation funds received in prior years may be subject to reversion in FY 2015-16. The Innovation budget will be discussed in greater detail in the Innovation Plan that will be developed and published separately from this document.

For additional information regarding MHSA allocations and expenditures, please see Attachment E.

Procurement of Services

All procurement processes identified in this Plan will be done in compliance with the Board of Supervisors Policy C-17, Procurement Policy.[19]

Although this Plan identifies service providers as of the date of publication, there may be a change in service providers that occurs during the term of this Plan due to unforeseen circumstances. In such situations, services will be obtained through the procurement method identified under each project. When there are no providers contracted for the services, the MHD may utilize its staff to provide the services or acquire the necessary materials via its purchasing process on an interim basis.

In addition to the method of procurement identified for each program/project, additional services may be procured through sole-source contracts based on the needs of the clients. These services would not be for program/project operations, but rather specific supportive services for the clients. Contracted vendors for client needs are not specifically identified as utilization of specific vendors may change on a regular basis based upon the needs of the clients.

Staffing

Staffing Levels

Adequate staffing levels within the public mental health system is key to a strong mental health system. Key to success of this Plan is adequate staffing levels, both within the HHSA MHD and through our contracted service providers. Projects and activities will be implemented to the extent that adequate staffing is available.

The importance of staff retention is recognized by HHSA, and HHSA continues to recruit critical staff to provide services. The primary challenge in staffing continues to be psychiatrists.

[19] El Dorado County Board of Supervisors Policy Manual. http://www.edcgov.us/Government/BOS/Policies/Policy_Manual.aspx

Education and Training Program Assistance

The importance of education and training was commented upon during the FY 2015-16 Community Planning Process, but were primarily directed toward the need for community education and training related mental health, including the provision of Mental Health First Aid in high schools, parental involvement, mental health resources, student and teacher education, and changing the perception of mental health/illness.

Staff training continues to be important for the provision of services. Ongoing training related to Dialectical Behavior Therapy (DBT) is provided within the MHD as a basis of the service delivery model of the MHD. Other primary areas of training needs relate to the development of the First Episode of Psychosis under the CSS Project 3a: TAY Engagement, Wellness and Recovery Services and services provided through the Community Corrections Partnership (CCC) funded through AB 109 revenues, but incorporated into CSS Project 4b: Community-Based Mental Health Services. Cultural competency is another important training area to assist staff in providing all services in a culturally competent manner.

Part 3. MHSA New Project Descriptions

Project Name: The Nurtured Heart Approach 1g

New Project in FY 2015-16

Program Type:	☐ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☐ Suicide ☐ Incarcerations ☒ School Failure or Dropout ☐ Unemployment	☐ Prolonged Suffering ☐ Homelessness ☒ Removal of Children from Their Homes
Objective	Provide training to parents and caregivers of children and youth who are having difficulties with behaviors at school and/or at home.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☐ Middle School ☐ High School	☒ Adults (parenting) ☒ Older Adults (parenting) *Provided participants are adults with caregiver responsibilities for children and youth* ☐ All Ages
Service Location(s)	Placerville, but all eligible participants Countywide may apply for this project.	
Project Duration	The project will be funded for two fiscal years (FY 2015-16 and FY 2016-17) and will be evaluated during the community planning process for the FY 2017-18 MHSA Plan to determine whether the project will be continued.	
Activities Performed	**Outreach:** Outreach will be accomplished through direct consumer contact, publications, flyers, web-based content and/or other media outlets. **Access and Linkage to Medically Necessary Care:** Participants would receive linkage to medically necessary care through individual referrals and increased awareness about risk factors leading to self-referrals. **Stigma and Discrimination Reduction:** Client participation in this program will serve to break down barriers, reduce stigma and reduce discrimination through a more thorough understanding of mental illness. **Activities:** Provide training in The Nurtured Heart Approach® is a relationship-focused methodology originally developed for working with the most difficult children. It has a proven impact on children, including those who are challenged behaviorally, socially and academically. One of the strengths of the Nurtured Heart Approach is reducing stigma regarding mental illness diagnosis. This program will offer parent education and support which improves the caregiver-child relationship and the child/teens' behavior. If a child's condition requires additional	

Project Name: The Nurtured Heart Approach 1g

	types of intervention, caregiver(s) will be referred to appropriate providers. Activities under this program will include publicity of upcoming trainings, preparation for classes, classes, phone follow-up coaching, and child care during the trainings.
	☒ Contracted Vendor ☐ Volunteers ☒ County Staff Support
Procurement Method	Sole source to Summitview Child and Family Services
Short-Term Goals	• Improvement in the caregiver-child relationship • Reduction in problematic behaviors at home, in school, and in the community
Long-Term Goals	• Reduction in dollars spent on mental health services, special education, and criminal justice involvement
Outcome Measures	Measurement 1: Pre- and post Conners Comprehensive Behavior Rating Scales (CBRS) assessment Measurement 2: Participant surveys
Number of Services / Quantity of Service	At least four quarterly one-day training classes per year with six thirty-minute follow up coaching sessions during the six weeks following the training, which will be offered to help participants use the approach successfully.
Budget	
FY 2015-16	$19,500 on a reimbursement basis
FY 2016-17	$19,500 on a reimbursement basis
FY 2017-18	Project will be evaluated during the community planning process for the FY 2017-18 MHSA Plan to determine whether the project will be continued.

Project Name: Statewide PEI Projects 2g

New Project in FY 2015-16

Project Type:	☒ Prevention	☐ Early Intervention
Negative Outcome(s) Addressed:	☒ Suicide ☒ Incarcerations ☒ School Failure or Dropout ☒ Unemployment	☒ Prolonged Suffering ☒ Homelessness ☒ Removal of Children from Their Homes
Objective	Provides a mechanism at the Statewide level for counties to collectively address issues of suicide prevention, student mental health, and stigma and discrimination reduction.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☐ Middle School ☐ High School	☐ Adults ☐ Older Adults ☒ All Ages
Service Location(s)	Statewide	
Project Duration	Ongoing.	
Activities Performed	The provider of the Statewide PEI Projects (currently CalMHSA) may continue to provide projects such as, but not limited to: • Educational Materials • Statewide Suicide Prevention Campaign • Each Mind Matters Activities • Walk In Our Shoes • LivingWorks Education • Friendship Line for Older Adults • WellSpace Health (General Population) Hotline • Student Mental Health Activities	
Services Provided By	☒ Contracted Vendor ☐ Volunteers ☐ County Staff Support[20] CalMHSA, or other provider selected to provide services for the Statewide PEI Projects.	

[20] County staff will be utilized to perform tasks such as: administrative activities (e.g., contracting, accounting), program analysis, and quality assurance activities related to this project. Costs will be applied to these projects either directly (such as through direct recording of time from time card) or indirectly (such as through County cost applied charges).

Project Name: Statewide PEI Projects 2g

Procurement Method	State selection process.
Goals	Reduce the stigma and discrimination associated with mental illness, prevent suicide, and improve student mental health.
Budget	This Plan Update includes a 1% contribution of $9,471, as calculated by CalMHSA and based upon the projections for annual MHSA funding that were available in March 2014, for the Statewide PEI Projects. These funds will be provided from the County to CalMHSA annually for the ongoing support of the Statewide PEI Projects as a lump sum payment after Plan Update approval by the Board of Supervisors.
FY 2015-16	$9,471
FY 2016-17	$9,471
FY 2017-18	$9,471

Attachment A
Initials Used in the MHSA Plan

Initials

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

DHCS	California Department of Health Care Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
EDCOE	El Dorado County Office of Education
EFC	Extended Foster Care
EHR	Electronic Health Record
EMDR	Eye Movement Desensitization Reprocessing
ESL	English as a Second Language
FSP	Full Service Partnership
FY	Fiscal Year
GSD	General System Development
HHSA	Health and Human Services Agency
HOME	Home Investment Partnership Program
ICC	Intensive Care Coordination
ICM	Intensive Case Management
IEP	Individualized Education Program
IHBS	Intensive Home-Based Services
INN	Innovation
ISSP	Individual Services and Supports Plan
IT	Information Technologies
KET	Key Event Tracking
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Questioning
LOCUS	Levels of Care Utilization System
MAST	Multidisciplinary Adult Services Team
MBSR	Mindfulness Based Stress Reduction
MHBG	Mental Health Block Grant
MHD	Mental Health Division of HHSA
MHSA	Mental Health Services Act
MHSOAC	Mental Health Services Oversight and Accountability Commission
MST	Mobile Support Team
NAMI	National Alliance on Mental Illness
NMD	Non-Minor Dependents
OE	Outreach and Engagement

ORS	Outcome Rating Scale
PCIT	Parent-Child Interactive Therapy
PEI	Prevention and Early Intervention
PEI-TTACB	Prevention and Early Intervention - Training, Technical Assistance and Capacity Building
PFLAG	Parents, Families, Friends of Lesbians and Gays
PHF	Psychiatric Health Facility
PI	Priority Indicators
PIP	Primary Intervention Project
PMHP	Primary Mental Health Project
PSA	Public Service Announcement
PSC	Personal Service Coordinator
PTSD	Post-Traumatic Stress Disorder
QI	Quality Improvement
RCL	Rate Classification Level
RER	Revenue and Expense Report
RFP	Request for Proposals
SAMHSA	Substance Abuse and Mental Health Services Administration
SARB	School Attendance Review Board
SB	Senate Bill
SDR	Stigma and Discrimination Reduction
SED	Seriously Emotionally Disturbed
TAY	Transitional Age Youth
TBD	To be determined
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TLC	Therapeutic Lifestyle Changes
TTACB	Training, Technical Assistance and Capacity Building (TTACB)
UMDAP	Uniform Method of Determining Ability to Pay
WET	Workforce Education and Training
WIC	Welfare and Institutions Code
WMS	Walker-McConnell Scale

Attachment B
County Certification Forms

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: _____

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

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

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

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

_____ _____
Local Mental Health Director (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, _____, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated _____ for the fiscal year ended June 30,_____. I further certify that for the fiscal year ended June 30,_____, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

_____ _____
County Auditor Controller / City Financial Officer (PRINT) Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: _____

☐ Three-Year Program and Expenditure Plan
☐ Annual Update

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

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

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

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

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

_____ _____

Local Mental Health Director (PRINT) Signature Date

Attachment C
FY 2015-16 MHSA Annual Update Instructions

Mental Health Services
Oversight & Accountability Commission

Title

FY 2015-2016
MHSA Annual Update Instructions

Background

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

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

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

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

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

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

Purpose

The purposes of these instructions are to:

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

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

regarding projects and programs supported with MHSA funds.

Who Should be Involved in the Stakeholder Process

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

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

CCR § 3300 further includes:

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

What Should be Included in the Stakeholder Process

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

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

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

What Standards Should be Used for the Stakeholder Process

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

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

Public Review

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

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

What to Include in the Annual Update about the stakeholder Process

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

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

What to Include in the Annual Update About Programs

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

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

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

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

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

What to Include in the Annual Update About INN

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

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

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

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

What to Include in the Annual Update About Performance Outcomes

WIC § 5848 states that Annual Updates shall include reports on the achievement of performance outcomes for MHSA services. Please include available results of any evaluations or performance outcomes for any and all programs. When including results of any evaluations or performance outcomes for PEI programs and program components/activities please separate by "Prevention" (i.e., direct service programs that serve individuals who are at risk for mental illness/emotional disturbance), "Early Intervention" (i.e., direct service programs that service individuals showing early onset of mental illness/emotional disturbance), and "Other" PEI programs that are neither "Prevention" nor "Early Intervention" (i.e., that do not have a direct service component). "Other" programs could include stand-alone programs focused on Outreach for Increasing Recognition of Early Signs of Mental Illness, Access to Treatment, Improving Timely Access to Services for Underserved Populations, Stigma and Discrimination Reduction, and Suicide Prevention. Please specify the time period these performance outcomes cover.

What to Include in the Annual Update About County Compliance Certification

WIC § 5847 states that certification by the county mental health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements, must be included in the Annual Update.

Please use the MHSA County Compliance Certification form included with these Instructions.

What to Include in the Annual Update About County Fiscal Accountability Certification

WIC § 5847 states that certification by the county mental health director and the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the MHSA, shall be included in the Annual Update.

Please use the MHSA County Fiscal Accountability Certification form included with these Instructions.

What to Include in the Annual Update About Board of Supervisor Adoption

WIC § 5847 states that the Board of Supervisors shall adopt the Annual Update. Please include documentation that the Board of Supervisors adopted the Annual Update and the date of that adoption.

What to Include in the Annual Update About An Expenditure Plan

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

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

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

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

When the Annual Update Should be Submitted to the MHSOAC

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

Attachment D
FY 2012-13 Revenue and Expense Report

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2012-13

County: **El Dorado** **Date:** 03/23/2015

Community Services and Supports Component	Total (Gross) Mental Health Expenditures
FSP Programs	
1 CSS WP 1 Youth and Family Strengthening	$262,367
2 CSS WP 2 Adult Wellness & Recovery	$340,203
3	
4	
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22	
23	
24	
25	
Subtotal FSP Programs	$602,570
Non-FSP Programs	
1 CSS Non-FSP	$1,574,788
2	
3	
4	
5	
6	
7	
8	
Subtotal Non-FSP Programs	$1,574,788
Total FSP and Non-FSP Programs	$2,177,358
CSS Evaluation	
CSS Administration	$274,032
CSS MHSA Housing Program Assigned Funds	
Total CSS Expenditures	$2,451,390

Updated: 09/05/2013

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2012-13

County: El Dorado **Date:** 03/23/2015

	Prevention and Early Intervention Component	(A) Total (Gross) Mental Health Expenditures
PEI Programs-Prevention		
1	Community Education Project	$25,795
2	Wellness Outreach Program for Vulnerable Adults	$32,318
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
	Subtotal PEI Programs-Prevention	$58,113
PEI Programs-Early Intervention		
15	Early Intervention Program for Youth	$14,972
16	Primary Intervention Project (PIP)	$189,343
17	Incredible Years	$1,119.00
18	Wennem Wadati	$125,199
19	Health Disparities Initative	$204,038
20		
21		
22		
23		
	Subtotal PEI Programs-Early Intervention	$534,671
Total PEI Programs		$592,784
PEI Evaluation		
PEI Administration		$64,237
Total PEI Expenditures		$657,021

Updated: 09/05/2013

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2012-13

County: El Dorado **Date:** 03/23/2015

Innovation Component	(A) Total (Gross) Mental Health Expenditures
Innovation Programs	
1 Planning	$38
2 Closing the Gap	$346
3	
4	
5	
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7	
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12	
13	
14	
15	
16	
17	
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19	
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21	
22	
23	
24	
25	
Total INN Programs	$384
Innovation Evaluation	
Innovation Administration	$8,627
Total Innovation Expenditures	$9,011

Updated: 09/05/2013

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2012-13

County: El Dorado **Date:** 03/23/2015

Workforce Education and Training Component	(A) Total (Gross) Mental Health Expenditures
WET Funding Category	
Workforce Staffing Support	$3,207
Training and Technical Assistance	$19,402
Mental Health Career Pathways Programs	
Residency and Internship Programs	$432
Financial Incentive Programs	
Total WET Programs	$23,041
WET Administration	$7,144
Total WET Expenditures	$30,185

Annual Mental Health Services Act Revenue and Expenditure Report
Fiscal Year 2012-13

County: El Dorado **Date:** 03/23/2015

Capital Facility/Technological Needs Projects	(A) Total (Gross) Mental Health Expenditures
Capital Facility Projects	
1 Electronic Health Records (Clinical Work Station	$639,938
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
Total CF Projects	$639,938
Capital Facility Administration	$39,505
Total Capital Facility Expenditures	$679,443
Technological Needs Projects	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
Total TN Projects	$0
Technological Needs Administration	
Total Technological Needs Expenditures	$0
Total CFTN Expenditures	$679,443

Annual Mental Health Services Act Revenue and Expenditure Report
Fiscal Year 2012-13

County: El Dorado **Date:** 03/23/2015

	(A) Total (Gross) Expenditures
Training, Technical Assistance and Capacity	$7,567
WET Regional Partnerships	$0
PEI Statewide Projects	$147,309

Annual Mental Health Services Act Revenue and Expenditure Report
FY 2012-13 Summary

TABLE A

COUNTY: El Dorado **DATE: 03/23/2015**

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

Fiscal Year 2012-13	(A) Community Services and Supports	(B) Prevention and Early Intervention	(C) Innovation	(D) Workforce Education and Training	(E) Capital Facilities and Technological Needs	(F) TTACB	(G) WET Regional Partnerships	(H) PEI Statewide Projects Funds	(I) Prudent Reserve	(K) Total-All Components
1 Unspent Funds Available From Prior Fiscal Years[1]										
a Local Prudent Reserve									$1,898,284	$1,898,284
b FY 2006-07 Funds				$0						$0
c FY 2007-08 Funds				$0	$0					$0
d FY 2008-09 Funds	$0	$0	$0	$0	$0	$0	$0	$0		$0
e FY 2009-10 Funds	$0	$0	$0	$0	$0	$0	$0	$0		$0
f FY 2010-11 Funds	$0	$0	$552,132	$377,007	$1,406,664	$22,366	$0	$428,249		$2,786,418
g FY 2011-12 Funds	$1,303,619	$583,464	$198,100	$0	$0	$21,700	$0	$79,919		$2,186,802
h Interest	$8,560	$4,767	$4,846	$1,923	$7,652	$206	$0	$0		$27,954
i TOTAL	$1,312,179	$588,231	$755,078	$378,930	$1,414,316	$44,272	$0	$508,168	$1,898,284	$6,899,458
2 MHSA Funds Revenue in FY 2012-13										
a Transfer of funds from the Local Prudent Reserve	$0	$0							$0	$0
b Revenue received from the State MHSA Fund[2]										
1 FY 2012-13 MHSA Funds	$4,913,551	$1,228,388	$323,260							$6,465,199
c Interest Earned on MHSA Funds	$7,838	$2,520	$1,601	$871	$2,995	$111	$0	$0	$0	$15,936
d TOTAL	$4,921,389	$1,230,908	$324,861	$871	$2,995	$111	$0	$0	$0	$6,481,135
3 Expenditure and Funding Sources for FY 2012-13[3]										
a FY 2006-07 MHSA Funds				$0						$0
b FY 2007-08 MHSA Funds				$0	$0					$0
c FY 2008-09 MHSA Funds				$30,185	$0					$30,185
d FY 2009-10 MHSA Funds				$0	$0					$0
e FY 2010-11 MHSA Funds	$690,314	$572,646	$9,011	$0	$679,443	$7,567	$0	$147,309		$2,106,290
f FY 2011-12 MHSA Funds	$1,761,076	$84,375	$0	$0	$0	$0	$0	$0		$1,845,451
g FY 2012-13 MHSA Funds	$0	$0	$0							$0
h Interest	$0	$0	$0	$0	$0	$0	$0	$0		$0
i 1991 Realignment	$0	$0	$0	$0	$0	$0	$0	$0		$0
j Behavioral Health Subaccount	$0	$0	$0	$0	$0	$0	$0	$0		$0
k Other	$0	$0	$0	$0	$0	$0	$0	$0		$0
l TOTAL	$2,451,390	$657,021	$9,011	$30,185	$679,443	$7,567	$0	$147,309		$3,981,926
m Total Program Expenditures	$2,451,390	$657,021	$9,011	$30,185	$679,443	$7,567	$0	$147,309		$3,981,926

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

COUNTY: El Dorado **DATE: 03/23/2015** **Enclosure 3**

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

Fiscal Year 2012-13	(A) Community Services and Supports	(B) Prevention and Early Intervention	(C) Innovation	(D) Workforce Education and Training	(E) Capital Facilities and Technological Needs	(F) TTACB	(G) WET Regional Partnerships	(H) PEI Statewide Projects Funds	(I) Prudent Reserve	(K) Total-All Components
4 Transfers to Prudent Reserve, WET, CFTN[4]										
a FY 2010-11	$0			$0	$0				$0	$0
b FY 2011-12	$0			$0	$0				$0	$0
c FY 2012-13	$0			$0	$0				$0	$0
5 Adjustments[5]										
a Local Prudent Reserve									$0	$0
b FY 2006-07 Funds				$0						$0
c FY 2007-08 Funds				$0	$0					$0
d FY 2008-09 Funds				$32,269	$0					$32,269
e FY 2009-10 Funds				$0	$0					$0
f FY 2010-11 Funds	$690,314	$572,646	$24,560	$12,693	$43,732	$9,567	$0	-$65,976		$1,287,536
g FY 2011-12 Funds	$1,813,761	$65,956	$0	$0	$0	$0	$0	$65,976		$1,945,693
h FY 2012-13 Funds	$0	$0	$0	$0	$0	$0	$0	$0		$0
i Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
j TOTAL	$2,504,075	$638,602	$24,560	$44,962	$43,732	$9,567	$0	$0	$0	$3,265,498
6 Unspent Funds in the Local MHS Fund[6]										
a Local Prudent Reserve Balance									$1,898,284	$1,898,284
b FY 2006-07 Funds				$0						$0
c FY 2007-08 Funds				$0	$0					$0
d FY 2008-09 Funds	$0	$0	$0	$2,084	$0	$0	$0	$0		$2,084
e FY 2009-10 Funds	$0	$0	$0	$0	$0	$0	$0	$0		$0
f FY 2010-11 Funds	$0	$0	$567,681	$389,700	$770,953	$24,366	$0	$214,964		$1,967,664
g FY 2011-12 Funds	$1,356,304	$565,045	$198,100	$0	$0	$21,700	$0	$145,895		$2,287,044
h FY 2012-13 Funds	$4,913,551	$1,228,388	$323,260	$0	$0					$6,465,199
i Interest	$16,398	$7,287	$6,447	$2,794	$10,647	$317	$0	$0		$43,890
j TOTAL	$6,286,253	$1,800,720	$1,095,488	$394,578	$781,600	$46,383	$0	$360,859	$1,898,284	$12,664,165

TABLE B[7]

Estimated FFP Revenue Generated In FY 2012-13	Amount
Federal Financial Participation (FFP)	$435,169

RER Contact Person	
Name	Michele McAfee
Title	Accountant I
Phone	530-295-6910
Email	michele.mcafee@edcgov.us

Updated: 12/02/2014

Enclosure 3

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2012-13
Adjustments Summary

County: **El Dorado**

Date: 03/23/2015

FY	Amount	Reason For Adjustment
2008-2009	$32,269	Revision of the Mental Health FY 08-09 Cost Report
2010-2011	$1,287,536	Revision of the Mental Health FY 10-11 Cost Report
2011-2012	$1,945,693	Revision of the Mental Health FY 11-12 Cost Report
TOTAL	**$3,265,498**	
	$3,265,498	

NOTE TO COUNTY: Total Adjustments in cell B22 MUST match Total Adjustments in cell P55 on the RER Summary Worksheet. If ERROR, recheck and correct.

Annual Mental Health Services Act Revenue and Expenditure Report
FY 2012-13

END NOTES:

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

[2] DHCS will utilize the allocation report provided by the SCO and counties should utilize the same report when reporting MHSA revenue. The report is available at: http://www.sco.ca.gov/ard_payments_mentalhealthservicefund.html

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

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

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

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

[7] The FFP amount represents the estimated FFP revenue generated in FY 2012-13 and attributable to MHSA funds.

Attachment E
FY 2015-16
MHSA Funding Summary and Expenditure Plan

Prevention and Early Intervention (PEI) Budgeted Revenues and Expenditures

Program/Project	FY 15-16 MHSA Plan Budget	FY 16-17 MHSA Plan Budget	FY 17-18 MHSA Plan Budget	FY 15-16 % of Expenditures	0-5	Elementary School	Middle School	High School	Adults	Older Adults	Families	All Ages
Revenues:												
Fund Balance	$1,798,001	$1,056,900	$618,658									
Revenues	$1,124,548	$1,297,407	$1,297,407									
Available Revenues	$2,922,549	$2,354,307	$1,916,066									
Expenditures:												
Program 1: Youth and Children's Services												
Project 1a: Children 0-5 and Their Families *Provider: Infant-Parent Center*	$125,000	$125,000	$125,000	7%	✓						✓	
Project 1b: Mentoring for 3-5 Year Olds *Provider: Big Brothers Big Sisters*	$75,000	$75,000	$75,000	4%	✓ 3-5						✓	
Rollover for SLT from FY 14-15	$25,000	$0	$0	1%								
Project 1c: Parenting Skills (formerly Incredible Years) *Provider: New Morning Youth and Family Services*	$50,000	$50,000	$50,000	3%	✓ 2-5	✓ <12					✓	
Project 1d: Primary Intervention Project (PIP) *Providers: Black Oak Unified School District* *El Dorado Hills Vision Coaliation* *Tahoe Youth & Family Servicese*	$212,700	$212,700	TBD	11%		✓ K-3						
Project 1e: SAMHSA Model Programs *Provider: El Dorado County Office of Education (EDCOE)*	$100,000	$0	$0	5%		✓	✓	✓				
Project 1f: Prevention and Early Intervention for Youth in Schools *Provider: To Be Determined via a Request for Proposal*	$150,000	$150,000	$150,000	8%			✓	✓	✓	✓	✓	
NEW Project 1g: Nurtured Heart Approach *Provider: Summitview Child & Family Services*	$19,500	$19,500	TBD	1%							✓	
Program 2: Community Education Project												

Prevention and Early Intervention (PEI) Budgeted Revenues and Expenditures

Program/Project	FY 15-16 MHSA Plan Budget	FY 16-17 MHSA Plan Budget	FY 17-18 MHSA Plan Budget	FY 15-16 % of Expenditures	0-5	Elementary School	Middle School	High School	Adults	Older Adults	Families	All Ages
Project 2a: Mental Health First Aid *Provider: Mental Health Division*	$100,000	$100,000	$100,000	5%				✓ 16+	✓	✓		
Project 2b: National Alliance on Mental Illness Training	Discontinued	Discontinued	Discontinued	--								
Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education *Provider: Mental Health Division*	$5,000	$5,000	$5,000	<1%			✓	✓	✓	✓		
Project 2d: Community Information Access *Provider: Relias Learning*	$16,000	$16,000	$16,000	1%				✓	✓	✓		
Project 2e: Suicide Prevention and Stigma Reduction *Provider: To Be Determined via a Request for Proposal*	$30,000	$30,000	$30,000	2%								✓
Project 2f: Foster Care Continuum Training *Provider: To Be Determined via a Request for Proposal*	$50,000	$50,000	$50,000	3%			✓	✓	✓	✓	✓	
Project 2g: Community Outreach and Resources *Provider: Mental Health Division*	$31,125	$31,125	$31,125	2%								✓
NEW Project 2h: Statewide PEI Projects *Provider: CalMHSA*	$9,471	$9,471	$9,471	1%								✓
Program 3: Health Disparities Program												
Project 3a: Wennem Wadati - A Native Path to Healing *Provider: Foothill Indian Education Alliance*	$125,725	$125,725	$125,725	7%								✓
Project 3b: Latino Outreach *Providers: South Lake Tahoe Family Resource Center* *New Morning Youth and Family Services*	$231,128	$231,128	$231,128	12%								✓

Prevention and Early Intervention (PEI) Budgeted Revenues and Expenditures

Program/Project	FY 15-16 MHSA Plan Budget	FY 16-17 MHSA Plan Budget	FY 17-18 MHSA Plan Budget	FY 15-16 % of Expenditures	0-5	Elementary School	Middle School	High School	Adults	Older Adults	Families	All Ages
Program 4: Wellness Outreach Program for Vulnerable												
Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness *Provider: Mental Health Division*	$50,000	$50,000	$50,000	3%					✓	✓		
Project 4b: Senior Peer Counseling *Provider: Senior Peer Counseling /Fiscal Agent EDCA Likeskills*	$45,000	$55,000	$55,000	2%						✓		
Rollover from FY 14-15	$20,000	$0	$0	1%								
Project 4c: Older Adult Program *Provider: To Be Determined via a Request for Proposal*	$85,000	$90,000	$90,000	5%						✓		
Program 5: Community-Based Services												
Project 5a: Community-Based Mental Health Services *Provider: Mental Health Division*	$10,000	$10,000	$10,000	1%								✓
Project 5b: Community Health Outreach Worker *Provider: To Be Determined via a Request for Proposal*	$50,000	$50,000	$50,000	3%								✓
Administrative Costs												
MHSA Team	$250,000	$250,000	$250,000	13%								✓
Total PEI Program Expenditures	$1,865,649	$1,735,649	$1,503,449									
Anticipated Year-End Fund Balance	$1,056,900	$618,658	$412,617									

Community Services and Supports (CSS) Budgeted Revenues and Expenditures

Program/Project *All services provided by the Mental Health Division unless other noted*	FSP	GSD	OE	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 15-16 % of Expenditures** (includes future potential project)
Revenues:							
Fund Balance				$4,911,557	$3,180,085	$1,623,075	
Revenues (MHSA)				$4,637,577	$5,189,629	$5,189,629	
Other Revenues (e.g., AB 109, interest, Medi-Cal Admin, Housing Payments)				$556,399	$581,399	$581,399	
Offsetting Expenditures (e.g., Medi-Cal reimbursement)				$2,696,652	$2,250,000	$2,000,000	
Available Revenues				$12,802,185	$11,201,113	$9,394,103	
Expenditures:							
Program 1: Youth and Family Strengthening Program							
Project 1a: Youth and Family Full Service Partnership *Provider - Current: Sierra Child & Family Services and Summitview Child & Family Services* *Provider - Future: Per outcome of Request for Proposal*	✓			$375,000	$375,000	$375,000	4%
Project 1b: Family Strengthening Academy		✓		Discontinued	Discontinued	Discontinued	--
Project 1c: Foster Care Enhanced Services *Provider - Current: Sierra Child & Family Services and Summitview Child & Family Services* *Provider - Future: Per outcome of Request for Proposal*	✓			$755,700	$755,700	$755,700	8%
Program 2: Wellness and Recovery Services							
Project 2a: Wellness Centers		✓	✓	$2,500,000	$2,400,000	$2,300,000	26%
Project 2b: Adult Full Service Partnership *Provider: Mental Health Division* *Provider - ARF: Summitview Child & Family Services*	✓			$4,050,000	$4,000,000	$3,900,000	42%
Project 2c: Older Adults Program (Partner program to PEI Older Adults Program)		✓	✓	Discontinued	Discontinued	Discontinued	--
Project 2d: Assisted Outpatient Treatment	✓			$100,000	$200,000	$200,000	1%

Community Services and Supports (CSS) Budgeted Revenues and Expenditures

Program/Project *All services provided by the Mental Health Division unless other noted*	**FSP**	**GSD**	**OE**	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 15-16 % of Expenditures** (includes future potential project)
Program 3: Transitional Age Youth (TAY) Services							
Project 3a: TAY Engagement, Wellness and Recovery Services	✓	✓	✓	$464,498	$464,498	$464,498	5%
Program 4: Community System of Care							
Project 4a: Outreach and Engagement Services			✓	$803,543	$804,000	$804,000	8%
Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services)		✓	✓	$206,840	$206,840	$206,840	2%
Project 4c: Resource Management Services		✓	✓	$75,000	$75,000	$75,000	1%
Administrative Costs							
MHSA Team			✓	$245,000	$245,000	$245,000	3%
Total CSS Program Expenditures				$9,575,581	$9,526,038	$9,326,038	
Reallocation to WET				$46,519	$52,000	$37,000	0.5%
Reallocation to CFTN				$0	$0	$0	0%
Contribution to the Prudent Reserve				$0	$0	$0	0%
Total Reallocation of CSS				$46,519	$52,000	$37,000	
Total CSS Expenditures				$9,622,100	$9,578,038	$9,363,038	
Anticipated Year-End Fund Balance				$3,180,085	$1,623,075	$31,065	

Workforce Education and Training (WET) Budgeted Revenues and Expenditures

Program/Project	Training and Technical Assistance	Residency and Internship Programs	Workforce Staffing Support	Mental Health Career Pathways Programs	Financial Incentive Programs	FY 15-16 Expenditures	FY 16-17 Expenditures	FY 17-18 Expenditures
Revenues:								
Fund Balance						$121,481	$0	$0
Transfer from CSS						$46,519	$52,000	$37,000
Available Revenues						**$168,000**	**$52,000**	**$37,000**
Expenditures:								
Program 1: Workforce Education and Training (WET) Coordinator *Provider: Mental Health Division*	✓		✓			$11,000	$11,000	$11,000
Program 2: Workforce Development *Providers: Various*	✓		✓			$40,000	$30,000	$20,000
Program 3: Psychiatric Rehabilitation Training						Realigned under Program 2	Realigned under Program 2	Realigned under Program 2
Program 4: Early Indicators of Mental Health Issues *Provider: El Dorado County Office of Education (EDCOE)*			✓			$45,000	$0	$0
Program 5: Suicide Education and Training *Provider: El Dorado County Office of Education (EDCOE)*			✓			$45,000	$0	$0
Program 6: Consumer Leadership Academy *Provider: Mental Health Division*			✓	✓		$1,000	$1,000	$1,000
Program 7: Crisis Intervention Team Training *Provider: To Be Determined by Law Enforcement Agency*			✓			$10,000	$0	$0
Administrative Costs - MHSA Team						$16,000	$10,000	$5,000
Total WET Expenditures						**$168,000**	**$52,000**	**$37,000**
Anticipated Year-End Fund Balance						**$0**	**$0**	**$0**

Capital Facilities and Technology (CFTN) Budgeted Revenues and Expenditures

Program/Project	FY 15-16 Expenditures	FY 16-17 Expenditures	FY 17-18 Expenditures
Revenues:			
Fund Balance	$308,519	$140,333	$62,833
Transfer from CSS	$0	$0	$0
Available Revenues	$308,519	$140,333	$62,833
Expenditures:			
Program 1: Electronic Health Record System Implementation			
Project 1a: Avatar Clinical Workstation *Provider: Netsmart (for Avatar)* *TBD for Other Software*	$150,686	$60,000	$51,000
Project 1b: Electronic Outcome Measurement Tools *Provider: Praed Foundation*	$2,500	$2,500	$0
Program 2: Telehealth (formerly Telemedicine) *Provider: TBD As Needed*	$10,000	$10,000	$9,333
Program 3: Electronic Care Pathways	Discontinued	Discontinued	Discontinued
Administrative Costs - MHSA Team	$5,000	$5,000	$2,500
Total CFTN Program Expenditures	$168,186	$77,500	$62,833
Anticipated Year-End Fund Balance	$140,333	$62,833	$0

State Form

Fiscal Year 2015/16 Mental Health Services Act Annual Update
Instructions

General: Round all amounts to the nearest whole dollar.
Heading: Enter the County name and the date the worksheet is completed.

Component Worksheets:

General: Each individual component worksheet has a section for fiscal year (FY) 2015/16.
Column A represents the total estimated program expenditures for each program and represents the sum of the funding sources for the program. Counties should do their best to estimate the funding from the sources identified so as to reflect the estimated expenditures of the entire program.

Definitions:

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

1991 Realignment represents the estimated 1991 Realignment to be used to fund the program.
Behavioral Health Subaccount represents the estimated funding from the Behavioral Health Subaccount used to fund the program. This would generally represent some of the matching funds for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) programs.
Estimated Other Funding represents the any other funds used to fund the program, which could include, but is not limited to, County General Fund, grants, patient fees, insurance, Medicare.

Community Services and Supports Worksheet:

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

Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.
Enter the estimated funding for CSS Administration in columns B through F. Total estimated CSS Administration is automatically calculated as the sum of columns B through F.
Enter the estimated funding for CSS MHSA Assigned Housing Funding in columns B through F. Total estimated CSS MHSA Assigned Housing Funding is automatically calculated as the sum of columns B through F.
Total CSS estimated expenditures and funding is automatically calculated.
FSP Programs as a percent of total is automatically calculated as the sum of total estimated FSP program expenditures divided by the sum of CSS funding. Counties are required to direct a majority of CSS funding to FSP pursuant to California Code of Regulations Section 3620.

Fiscal Year 2015/16 Mental Health Services Act Annual Update
Instructions

Prevention and Early Intervention Worksheet:

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

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

Innovations Worksheet:

The County should enter the Innovation (INN) program names on a line in the appropriate section. The line number does not need to correlate with the program number.
Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.
Enter the estimated funding for INN Administration in columns B through F. Total estimated INN Administration is automatically calculated as the sum of columns B through F.
Total INN estimated expenditures and funding is automatically calculated.

Workforce, Education and Training Worksheet:

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

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

Capital Facilities/Technological Needs Worksheet:

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

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

Fiscal Year 2015/16 Mental Health Services Act Annual Update
Instructions

Funding Summary Worksheet:

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

Sections A, C and E

Line 1 Enter the estimated available funding from the prior fiscal years for FY 2015/16 in Section A.

Line 2 Enter the estimated new funding for FY 2015/16 for each component. The County should reduce the amount of estimated distributions by any estimated prior year reverted funding assuming the reverted funds will be offset against new distributions.

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

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

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

Sections B, D and F

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

Section G

This amount is automatically calculated and represents the difference between the estimated available funding and the estimated expenditures at the end of FY 2016/17.

Section H

Enter the estimated Local Prudent Reserve balance on June 30, 2015. The rest of the cells are automatically calculated.

FY 2015/16 Mental Health Services Act Annual Update
Funding Summary

County: El Dorado

Date: 6/15/15

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports*	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	4,923,415	1,798,001	1,656,206	121,481	308,519	
2. Estimated New FY 2015/16 Funding	7,701,130	1,124,548	305,024			
3. Transfer in FY 2015/16[a/]	(46,519)			46,519	0	0
4. Access Local Prudent Reserve in FY 2015/16	0	0				0
5. Estimated Available Funding for FY 2015/16	12,578,026	2,922,549	1,961,230	168,000	308,519	
B. Estimated FY 2015/16 MHSA Expenditures	9,397,941	1,865,649	597,850	168,000	168,186	
G. Estimated FY 2015/16 Unspent Fund Balance	3,180,085	1,056,900	1,363,380	0	140,333	

*Includes CSS-Housing Project 3

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2015	1,898,284
2. Contributions to the Local Prudent Reserve in FY 2015/16	0
3. Distributions from the Local Prudent Reserve in FY 2015/16	0
4. Estimated Local Prudent Reserve Balance on June 30, 2016	1,898,284

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

FY 2015/16 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding*
*Includes CSS-Housing Project 3

County: El Dorado Date: 8/7/15

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Program 1: Youth and Family Strengthening Program	1,130,700	752,156	374,344			4,200
2. Program 2: Wellness and Recovery Services	4,150,000	2,649,756	1,340,844			159,400
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Program 2: Wellness and Recovery Services	2,500,000	1,668,118	827,682			4,200
2. Program 3: Transitional Age Youth (TAY) Services	464,498	96,054	153,783			214,661
3. Program 4: Community System of Care	1,085,383	911,445	0			173,938
4. Reallocation to WET	46,519	46,519	0			
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	245,000					
CSS MHSA Housing Program Assigned Funds	11,858					11,858
Total CSS Program Estimated Expenditures	9,633,958	6,124,049	2,696,652	0	0	568,257
FSP Programs as Percent of Total	86.2%					

FY 2015/16 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: El Dorado Date: 8/7/15

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Program 1: Youth and Children's Services	439,675	439,675				
2. Program 2: Community Education Project	226,596	226,596				
3. Program 3: Health Disparities Program	267,640	267,640				
4. Program 4: Wellness Outreach Program for Vulnerable Adults	75,000	75,000				
5. Program 5: Community-Based Services	55,000	55,000				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Program 1: Youth and Children's Services	317,525	317,525				
12. Program 2: Community Education Project	15,000	15,000				
13. Program 3: Health Disparities Program	89,213	89,213				
14. Program 4: Wellness Outreach Program for Vulnerable Adults	125,000	125,000				
15. Program 5: Community-Based Services	5,000	5,000				
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	250,000	250,000				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	1,865,649	1,865,649	0	0	0	0

FY 2015/16 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: El Dorado Date: 8/7/15

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. None	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration (includes reversion)	597,850	597,850				
Total INN Program Estimated Expenditures	597,850	597,850	0	0	0	0

FY 2015/16 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: El Dorado Date: 8/7/15

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Program 1: Workforce Education and Training (WET) Coordinator	11,000					
2. Program 2: Workforce Development	40,000					
3. Program 4: Early Indicators of Mental Health Issues	45,000					
4. Program 5: Suicide Education and Training	45,000					
5. Program 6: Consumer Leadership Academy	1,000					
6. Program 7: Crisis Intervention Team Training	10,000					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	16,000					
Total WET Program Estimated Expenditures	168,000	0	0	0	0	0

FY 2015/16 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: El Dorado Date: 8/7/15

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. None	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Project 1a: Avatar Clinical Workstation Project 1b: Electronic Outcome	150,686	150,686				
12. Measurement Tools Program 2: Telehealth (formerly	2,500	2,500				
13. Telemedicine)	10,000	10,000				
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	5,000	5,000				
Total CFTN Program Estimated Expenditures	168,186	168,186	0	0	0	0

Attachment F
Community Planning Process

Community Planning Process

The general public and stakeholders were invited to participate in or host MHSA planning opportunities and provide initial comment to contribute to the development of the County's FY 2015-16 MHSA Plan Update. As was done in FY 2014-15, local organizations were invited to host a MHSA planning meeting for their staff, clients and/or members. Three organizations hosted community planning meetings (Folsom Lake College Foster and Kinship Parent Program, NAMI El Dorado and Pioneer Union School District).

The community planning process for the FY 2015-16 started in the fall of 2014 (rather than the winter/spring of 2015) so that input could be received in adequate time to be incorporated into the County's budget process for the FY 2015-16 budget. A press release was issued on October 30, 2014 regarding the MHSA public meetings, and distributed to local media contacts, including the Mountain Democrat, Tahoe Daily Tribune, El Dorado Hills Telegraph, Life Newspapers, Georgetown Gazette and Sacramento Bee. The press release was also posted on the County's News and Hot Topics web page and distributed via email to all individuals who have requested to receive News and Hot Topics email notifications. Additionally, flyers listing the meetings were made available at various locations, such as the Mental Health Division offices, libraries, and locations where information notices are commonly shared (such as the bulletin board at Pioneer Park and Gray's Corner).

Plan progress, anticipated changes, budget allocations, program planning and objectives, mental health policy, plan implementation, and outcome measures/monitoring/program evaluation and quality improvement were discussed at various points during the community planning process. MHSA updates and program planning have also taken place as part of the Mental Health Commission meetings, including the formation of an ad hoc committee by the Mental Health Commission for the purpose of reviewing the CSS budget and identify potential program changes to meet budget requirements. The report out from the Ad Hoc Committee can be found in Attachment G.

In addition to the above-referenced topics, participants in the Community Planning Process were asked to consider three specific areas:

- CSS Budget Shortfalls
- Outcome Measures
- New Innovation and PEI Regulations

Informational documents and forms are available in English and in Spanish on the community planning process web page, along with information about the FY 2015-16 community planning process (http://www.edcgov.us/MentalHealth/MHSA_Meetings/2015/FY1516CPP.aspx).

All input received was considered in the development of this Plan, whether through a formal public meeting, informal discussions, emails or other meetings. The input received is summarized in Attachment G.

Stakeholder Representation

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

- adults and seniors with severe mental illness;
- families of children, adults and seniors with severe mental illness;
- providers of services;
- law enforcement agencies;
- education;
- social services agencies;
- veterans;
- representatives from veterans organizations;
- providers of alcohol and drug services;
- health care organizations; and
- other interested individuals.

During this community planning process, there were approximately 575 individuals on the email distribution list who received notifications regarding the community planning process and MHSA updates.[21] Information about the Community Planning Process was provided in the September, October and November MHSA El Dorado email updates, which are distributed to over 575 individuals on the MHSA email distribution list and all staff within HHSA. These emails were subsequently distributed through other networks, such as the NAMI El Dorado newsletter, Community Strengthening Coalition/Ready by Five, and the Chronic Disease Coalition to individuals and organizations on their email distribution lists.

MHSA Public Meetings, One-on-One Meetings and Small Group Meetings

During the FY 2013-14 community planning process, input was received that the times of the public meetings were not convenient. Therefore, the MHSA project team released a survey prior to the FY 2014-15 community planning process to determine the days of the weeks and the time of days that are most convenient for public meetings. The most popular days of the week were Tuesday, Wednesday and Thursday and the most popular times of the day were 10:00 am and 6:00 pm. During the FY 2015-16 community planning process, meeting dates and times were offered at those times, offered when a host organization scheduled them or offered as otherwise noted below, with the time of the meeting frequently based on availability of facilities.

Turnout at the FY 2015-16 public meetings was much lower than the last two years. The total number of unique participants at the FY 2015-16 public MHSA community planning meetings was 36, and the total attendance was 38. The MHSA project team will continue to work towards increasing participation at the public community planning meetings.

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

Date	Host	Location	Time	Attendees
Tuesday, 10/21/14	Folsom Lake College Foster and Kinship Parent Program*	Placerville	11:00 am	6
Thursday, 11/20/14	MHD	South Lake Tahoe	10:00 am	6
Tuesday, 12/2/14	MHD	Placerville	10:00 am	0
Tuesday, 12/2/14	NAMI	Placerville	5:30 pm	7
Wednesday, 12/3/14	MHD	Georgetown	1:30 pm	6
Thursday, 12/4/14	Pioneer Union School District*	Somerset	6:00 pm	4 (plus 1 at Gray's Mart)
Thursday, 12/11/14	MHD	Placerville	6:00 pm	0
Tuesday, 12/16/14	MHD	South Lake Tahoe	6:00 pm	1
Wednesday, 12/17/14	MHD	El Dorado Hills	6:00 pm	3
Thursday, 12/18/14	MHD	Cameron Park	10:00 am	4
			Total Attendees (Duplicated):	38
			Total Attendees (Unduplicated):	36

*Date, time and location selected by host/site organizer.

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

Date	Host / Location	Topic
1/26/15	Summitview Child and Family Services at the MHD in Diamond Springs	Adult Residential Facility
1/29/15	Mental Health Division Staff Diamond Springs and South Lake Tahoe	CSS Programs and Budget Shortfalls
2/18/15	El Dorado County Office of Education Principals' Meeting at the SELPA Offices	Referrals to El Dorado County Mental Health Division
2/25/15	Community Corrections Partnership (CCP) at the Probation Department in Shingle Springs	Assisted Outpatient Treatment

Topics discussed at these meetings generally focused on the interests of those in attendance (e.g., foster care parents and education providers focused on children's needs, the CCP was focused on Assisted Outpatient Treatment).

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

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

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

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

Areas of focus for increasing participation include working with service organizations, professional organizations, Chambers of Commerce, and/or organizations established for specific interests (e.g., hobbies).

Other Methods of Input

The public was also invited to provide input through a comment form, via email or via regular mail.

The comment form asked for basic demographic information, and included the following six comment areas:

- Mental Health Service Gaps / Needs
- Recommendation(s) / What is Needed
- What's Working
- What's Not Working
- Any Other Comments about MHSA or mental health needs and services?

- Did this meeting meet your expectations; if no, why not, and any other comments about the meeting (when the comment form was completed after attending one of the MHSA meetings)

Input Received

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

- Lack of services in remote areas
- More school-based services are needed
- More services for older adults are needed
- Transitional housing in South Lake Tahoe
- More peer-to-peer services
- Service collaboration

Priority populations were identified as:

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

Please see Attachment G for the input received and more specific discussion topics.

CSS Budget Shortfalls

Options for increasing revenues to help offset the CSS budget shortfall included:

- Applying for grants
- Seeking contributions from the casinos
- Increasing community donations, including donations for specific programs
- Reducing the HHSA and County indirect costs
- Increasing the use of interns

Outcome Measures

Potential outcome measures are identified in Attachment G. Many of the suggested outcome measures are covered under the priority indicators the MHD is in process of collecting and the remainder will be explored by the MHD's Performance Management Team as possible additional measures.

New Innovation and PEI Regulations

Although the new Innovation and PEI regulations are not yet finalized, the potential changes as a result of these new regulations were discussed at various points during the community planning process. As the impact from these new regulations is not yet known, there were no comments specifically relating to them.

Project-Specific Proposals Received

Since adoption of the FY 2014-15 MHSA Plan, specific proposals have been identified through activities such as the community planning process, one-on-one or small group meetings, public meetings and the Mental Health Commission meetings.

Required Plan Change

- **CSS:** Adjust expenditures in CSS programs to provide a balanced three-year budget. During the community planning process, the public was encouraged to provide input on how this should be accomplished (i.e., should programs be reduced in service levels, eliminated, or re-configured, and how the reductions should be implemented).
    - This change has been incorporated into the FY 2015-16 MHSA Plan Update. Please see the Attachment E, FY 2015-16 MHSA Funding Summary and Expenditure Plan and the Part 1, Program Outcomes and Changes, for more information.

Specific Proposals / Plan Changes

- **CSS:** Allow funding in CSS Project 1a (Youth and Family Full Service Partnership) and CSS Project 1c (Foster Care Enhanced Services) to be shared between the programs. This will allow maximum funding to be utilized to support the needs of children with higher level service needs.
    - This proposal has been incorporated into the FY 2015-16 MHSA Plan Update. The two projects will remain as separate projects due to differences in eligibility criteria and services provided, however the total funding for the two projects will float between the two projects as a single funding source. This change was made to allow more flexibility with the provision of services since children may move between these two programs.
- **CSS:** Utilizing new funding available through the Mental Health Block Grant (MHBG) and funding through MHSA, develop in FY 14/15 under the current Transitional Age Youth program (CSS Project 3a) and expand in the future a First Episode Psychosis (FEP) program as part of CSS Project 3a specifically for Transitional Age Youth age 16-25.
    - This proposal has been incorporated into the FY 2015-16 MHSA Plan Update.
- **CSS:** Extend the age range for participation in CSS Project 3a (Transitional Age Youth) through age 25 (currently is 24). This will allow better alignment of the project with programs for First Episode Psychosis (FEP).
    - This proposal has been incorporated into the FY 2015-16 MHSA Plan Update.
- **CSS:** Creation of a Mobile Support Team (MST) made up of licensed mental health clinicians and certified substance abuse specialists, to provide field-based support to law enforcement. When law enforcement encounters a mental health crisis, or even a situation that might have evolved from mental health challenges, they would call the

MST to the scene for help in making the right assessments and coming to the best outcome for everyone involved.

  - This proposal has not been incorporated into the FY 2015-16 MHSA Plan Update. Although the value of this service is recognized, there is currently insufficient funding to implement this project at this time.

- **CSS:** Provide Psychiatric Emergency Services for adults via an in-person response at Marshall Hospital and Barton Hospital, with only those portions of the day in which no in-person response for adults at the hospitals is available through the MHD would be paid through MHSA. The hours of coverage would primarily be overnight shifts (from 12:00 a.m. to 8:00 a.m.), seven days per week, including holidays, however additional hours may be included.

  - This proposal has not been incorporated into the FY 2015-16 MHSA Plan Update. Although the value of this service is recognized, there is currently insufficient funding to implement this project at this time.

- **CSS:** Eliminate Project 1b: Family Strengthening Academy since children are eligible to receive services through other Traditional and MHSA projects.

  - This proposal has been incorporated into the FY 2015-16 MHSA Plan Update due to lack of funding.

- **CSS:** Eliminate Project 2c: Older Adults Program (Partner program to PEI Older Adults Program) since older adults are eligible to receive services through other Traditional and MHSA projects.

  - This proposal has been incorporated into the FY 2015-16 MHSA Plan Update

- **CSS-Housing:** El Dorado County is eligible to request nonencumbered CSS-Housing funds from CalHFA (the estimated amount is $11,858). These funds must be utilized to provide housing assistance to those with a serious mental illness who are homeless or soon-to-be-homeless, and include costs such as rental assistance, security deposits,, utility deposits, other move-in costs, moving costs. It would be anticipated that the County would request these funds to be returned and utilized for clients meeting the criteria for Full Service Partnerships, who are homeless or soon-to-be-homeless. These funds must be utilized within three years.

  - This proposal has been incorporated into the FY 2015-16 MHSA Plan Update as CSS-Housing Project 3: Local Housing Assistance.

- **PEI/CSS:** Bring programs such as Roots of Empathy and Collaborative Problem Solving to our local schools (PEI) and treatment facilities (CSS).

  - This proposal has not been incorporated into the FY 2015-16 MHSA Plan Update due to lack of funding.

- **PEI:** Extend current funding levels for Project 1d: Primary Intervention Project (PIP) into FY 16/17.

- This proposal has been incorporated into the FY 2015-16 MHSA Plan Update.

- **PEI:** Increase funding levels for Project 1d: Primary Intervention Project (PIP) into FY 16/17.
  - This proposal has not been incorporated into the FY 2015-16 MHSA Plan Update due to lack of funding.

- **PEI:** Expand the service areas for Project 1d: Primary Intervention Project (PIP).
  - This proposal has been incorporated into the FY 2015-16 MHSA Plan Update due as this is a pilot project and the outcomes of the project must be evaluated before expanding the project.

- **PEI:** Increase the funding level for Project 1f: Prevention and Early Intervention for Youth in Schools.
  - This proposal has been incorporated into the FY 2015-16 MHSA Plan Update.

- **PEI:** Expand the service areas for Project 1f: Prevention and Early Intervention for Youth in Schools.
  - This proposal has not been incorporated into the FY 2015-16 MHSA Plan Update due to lack of funding. Additionally, this is a pilot program and it will not be considered for expansion until the outcomes of this program have been determined.

- **PEI:** Contribution to CalMHSA to support the Statewide Prevention and Early Intervention (PEI) programs in an amount equal to 1% ($9,471) to 7% ($66,291) of the annual PEI revenues.
  - This proposal has been incorporated into the FY 2015-16 MHSA Plan Update as PEI Project 2h: Statewide PEI Projects at the 1% funding level. Funding directly from the State for these activities is no longer available, and this contribution will help CalMHSA continue to provide Statewide PEI programs.

- **PEI:** Provide peer-to-peer classes designed for adolescent youth (ages 12-18) who are involved with other adolescents experiencing a mental health or addiction challenge or crisis. Youth often go to other youths for support before or instead of going to an adult. This type of class would give the youth tools to support their peers.
  - This proposal has not been incorporated into the FY 2015-16 MHSA Plan Update due to lack of funding. However, these types of programs could be implemented as part of Project 1f: Prevention and Early Intervention for Youth in Schools . Additionally, Mental Health First Aid is offered in some high schools to youth in their junior or senior year.

- **PEI:** "Nurtured Heart Approach" - Summitview Child and Family Services proposes a Nurtured Heart Approach training on a quarterly basis with six follow up coaching sessions for participants. The Nurtured Heart Approach is a set of strategies that "inspires appropriate behaviors by energizing children when things are "going right", and

it sets clear limits." More information can be found at http://www.childrenssuccessfoundation.com/. Estimated cost annually not to exceed $19,500.

  - This proposal has been incorporated into the FY 2015-16 MHSA Plan Update as PEI Project 1g: The Nurtured Heart Approach as a sole source contract to Summitview Child and Family Services. The project will be funded for two fiscal years and will be evaluated during the community planning process for the FY 2017-18 MHSA Plan to determine whether the project will be continued.

- **WET:** In the Program 5, "Suicide Education and Training", eliminate the requirement for at least one suicide prevention trainer / specialist at each high school and remove the requirement that each school site have at least one suicide prevention trainer (however keep the requirement for a specialist, with a "specialist" being an individual who has received suicide prevention training. Priority will be given to high schools and middle schools. This is due to the limited number of suicide prevention programs suitable for school-aged students that also have the availability of "train-the-trainer" components.
  - This proposal has been incorporated into the FY 2015-16 MHSA Plan Update.
- **CFTN:** Eliminate funding for iReach support ($900) and program evaluation ($5,000). With the implementation of electronic health records by health care providers and the Mental Health Division, the use of iReach was discontinued and replaced with a referral process utilizing referrals printed directly from electronic health records (rather than double entering of data into iReach and the electronic health records). Referrals are faxed to providers.
  - This proposal has been incorporated into the FY 2015-16 MHSA Plan Update.

Notification of the Draft FY 2015-16 MHSA Plan

HHSA provided notification of the Draft FY 2015-16 Plan publication as follows:

- **FY 2015-16 Plan 30-Day Comment Period:** The Draft FY 2015-16 MHSA Plan Update was posted on the County's website on June 15, 2015 for a 30-day review period. Emails were sent on June 15, 2015 to the MHSA distribution list, the Mental Health Commission members, the Chief Administrative Office (CAO), the Board of Supervisors' offices, and HHSA staff advising recipients that the Draft FY 2015-16 MHSA Plan Update was posted and available for public comment for 30 days. A press release was distributed on June 15, 2015, to the Tahoe Daily Tribune, Mountain Democrat, Georgetown Gazette, Sacramento Bee, Life Newspaper (Village Life) and El Dorado Hills Telegraph.
- **FY 2015-16 MHSA Plan Update Public Hearing:** The Mental Health Commission held a public hearing on the Draft FY 2015-16 MHSA Plan Update on July 22, 2015. The date and time of the meeting was noticed on the Mental Health Commission's calendar (available on the County's calendar at https://eldorado.legistar.com/Calendar.aspx), the MHSA web page (www.edcgov.us/mentalhealth/mhsa.aspx), and sent out to the individuals on the MHSA email distribution list.

- **El Dorado County Board of Supervisors:** After the Public hearing, this Plan Update was presented to the El Dorado County Board of Supervisors for adoption on August 25, 2015. Notification of the date was posted on the MHSA web page (www.edcgov.us/mentalhealth/mhsa.aspx) and included on the Board of Supervisors agenda.
- **California Mental Health Services Oversight and Accountability Commission (MHSOAC):** Within 30 days of the Board of Supervisors' approval of the FY 2015-16 MHSA Plan, a copy of the Plan will be provided to the MHSOAC as required by the MHSA.

Substantive Comments/Recommendations

Substantive comments received during the comment period and public hearing process, responses to those comments, and a description of any substantive changes made to the MHSA Plan are summarized below. A summary of comments and input received during the comment period and public hearing process can be found in Attachment G, pages 16-17.

General	
1.	*Note:* Throughout the document, references to the Plan Update being a "draft" or projects being "proposed" have been changed to reflect their status after adoption of the Plan Update. Other grammatical or non-substantive wording issues or correction of information have been corrected.
2.	*Comment:* Minimize proposals from community providers and increase direction from the Mental Health Division.
	Response: WIC §5848(a) requires that "Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations." Proposals are accepted as part of the community planning process, but may not necessarily be incorporated into the final MHSA Plan/Plan Update. When proposals are received from community providers or other stakeholders, the MHD reviews each proposal to determine if it addresses an identified community need, if it meets the requirements of MSHA, and how the proposal may be incorporated into the current or future program structure of MHSA.

3.	*Comment:* Increase collaboration with multiple agencies and community providers to build and support an evidence-based system of care.
	Response: Please see response to Comment 2, above. Over the past two and half years, the MHD has been working to restructure the MHSA program to create a more cohesive system of care. These efforts will continue with each MHSA Plan/Plan Update.
4.	*Comment:* Too much money is being spent on piecemeal programs from community interests rather than on developing and building a system of care.
	Response: Please see response to Comments 2 and 3, above.
PEI	
5.	*Comment:* There should be more focus on Early Detection and Intervention with the age 12-25 group.
	Response: PEI Project 1f: Prevention and Early Intervention for Youth in Schools is designed to provide increased services for middle school and high school children and youth (generally 12-18). Please see response to Comment 8, below related to ages 16-19. Project 3a: Transitional Age Youth Engagement, Wellness and Recovery Services is able to provide outreach and engagement services to youth up to age 25 in addition to providing therapeutic interventions.
6.	*Comment:* Family education is important and parents need to be engaged.
	Response: An additional parenting project has been added as PEI Project 1g: The Nurtured Heart Approach, which is a relationship-focused methodology originally developed for working with the most difficult children. This program offers parent education and support, which improves the caregiver-child relationship and the child/teens' behavior, including after the classroom training is complete.
CSS	
7.	*Comment:* Mental Health crisis workers at the Emergency Departments at Marshall and Barton are not included in the MHSA projects.
	Response: MHSA funding can only be utilized to fund new or expanded services; MHSA funding cannot be used to supplant other funding for the same services. MHSA currently funds the placement of a crisis worker at the Marshall Hospital Emergency Department between the hours of 8:00 p.m. and 12:00 a.m. Having a staff actually placed at the hospital was an expanded service. Provision of crisis services at the Emergency Departments on an on-call basis has been provided and funded historically through Traditional Mental Health Funding, and is therefore not eligible for MHSA funding since the service is not new or expanded.

8.	*Comment:* Increase services in CSS Project 3a: Transitional Age Youth Engagement, Wellness and Recovery Services through the use of the Mental Health Block Grant funding.
	Response: The Mental Health Block Grant, identifying TAY as the target population to be served, is being incorporated into Project 3a. The target population for this funding source will be 16-19 year old high school students who are presenting with symptoms consistent with diagnoses of Bi-Polar Disorder, Major Depression/Anxiety or Schizophrenia and/or engaging in high risk behaviors (suicide, self-harm, substance abuse), many of whom will be dually diagnosed individuals. Other services currently available through Project 3a will continue to be provided.
9.	*Comment:* Increase funding for CSS Future Potential Project 2d: Assisted Outpatient Treatment.
	Response: Welfare and Institutions Code section 5349 states in part that "no voluntary mental health program serving adults, and no children's mental health program, may be reduced as a result of the implementation of this article." At this time, it is not possible to increase MHSA funding to this project without decreasing other programs. However, the CCP has budgeted $125,000 in AB 109 funding to augment the MHSA funding for CSS Project 2d: Assisted Outpatient Treatment and this increase is reflected in the project's budget.
10.	*Comment:* There needs to be a Mental Health Probation staff dedicated to providing services to individuals involved in the justice system.
	Response: Staffing levels within the Probation Department are beyond the control of HHSA, however, HHSA is a member of the CCC and provides both Mental Health Clinical Staff and Alcohol and Drug Program Staff at the CCC to assist individuals with the mental health and substance use issues. Primary funding for the Mental Health Clinical Staff comes from AB 109 and is complemented with MHSA funding for those services. However, it is important to remember that under most circumstances, participation in mental health services is voluntary in nature.
11.	*Comment:* Reduce family strengthening programs to allow for enhanced services for adults.
	Response: CSS Project 1b: Family Strengthening Academy is discontinued in the FY 2015-16 MHSA Plan Update, as reflected in the Draft Plan Update.

Attachment G Summary of Public Meetings and Comment Form Input

Mental Health Services Act (MHSA)
FY 2015-16 Community Planning Process

Information about the FY 2015-16 MHSA Community Planning Process can be found at:
http://www.edcgov.us/MentalHealth/MHSA_Meetings/2015/FY1516CPP.aspx

Getting the Word Out

- Ten public meetings were held between October 21 and December 18, 2014.
- There were 36 unique attendees at the public meetings.
- Information about the MHSA Planning Process was shared at various community meetings (e.g., Community Strengthening Coalition/Ready by Five, Veteran Affairs Commission, Chronic Disease Prevention Coalition, Continuum of Care) to over 75 individuals.
- Information about the Community Planning Process was provided in the September, October and November MHSA El Dorado email updates, which are distributed to over 575 individuals and all staff within HHSA.
- Information about the Community Planning Process was shared through other networks as well, such as the NAMI El Dorado newsletter, Community Strengthening Coalition/Ready by Five, and the Chronic Disease Coalition email distribution lists.
- A press release regarding the Community Planning Process was distributed to media contacts on October 30, 2014. The press release was also published on the County's website under "News & Hot Topics" on October 31, 2014, which triggers an email update to over 1,100 individuals.
- Flyers listing the various meetings were made available at various locations, such as the Mental Health Division offices, libraries, and posted in locations where information notices are commonly shared (such as the bulletin board at Pioneer Park and Gray's Corner).
- Meetings occurred with the Mental Health Division Staff to talk about program design and needs.
- Efforts to obtain input from all stakeholders will continue (e.g., law enforcement).
- The Mental Health Division will be hosting a combined Quality Improvement Committee (QIC) and MHSA Advisory Board meeting quarterly, and input from those meetings will be considered in the development of MHSA Plans/Plan Updates.

FY 2015-16 Input Timelines

- Initial input relating to fiscal matters was requested to be submitted by January 9 for inclusion in the FY 2015-16 MHSA budget requests. Given the low level of input received, that date has been extended to January 30.
- Input for the FY 2015-16 MHSA Plan Update can be submitted at any time prior to publication of the Draft FY 2015-16 MHSA Plan Update, during the 30-day comment period on the Draft Plan Update, or at the Public Hearing for the Draft Plan Update.
- Input on the mental health needs in our community can be provided to the MHSA Project Team at any time throughout the year, but the receipt date of that input determines whether the information will be incorporated into the MHSA Plan/Plan Update currently under development, or whether the input will need to be held for the next MHSA Plan/Plan Update. For example, input received in September 2015 will not be able to be considered for the FY 2015-16 MHSA

Plan Update (which will already have been approved by the Board of Supervisors by then), but the input can be considered for the FY 2016-17 MHSA Plan Update.

- Input from Mental Health Commission meetings through the year is also considered in the development of the MHSA Plans/Plan Updates.

Specific Areas Discussed at Public Meetings

- CSS Funding – How to maximize funding and minimize expenditures. Can any programs be eliminated? Can any programs be reconfigured? Should funding be reduced or expanded in any programs?
- Outcome Measures – If asked to make a decision about program funding, what outcomes do you want to know about?
- New PEI/INN Regulations – What do they mean for our County?

Summary of FY 2015-16 MHSA Community Planning Process Meeting Notes

General Category	Topic	PVL 10/21	SLT 11/20	PVL 12/2	GT 12/3	SMR 12/4	SLT 12/16	EDH 12/17	CP 12/18
CIT	CIT in Tahoe		x						
CIT	Collaboration with Mental Health and Police		x						
Current Projects	PEI - Concern for Children 0-5 Program – not in line with intent of MHSA			x					
Current Projects	CSS - Consolidation of services						x		
Current Projects	CSS - Contracted services in CSS				x				
Current Projects	CSS - Cross training staff						x		
Current Projects	CSS - Extended Wellness Center hours			x					
Current Projects	PEI - Mental Health First Aid in SLT High School						x		
Current Projects	PEI - Parental input into project if pilot	x							
Current Projects	PEI - Primary Intervention Program								x
Current Projects	CSS - What does a treatment plan look like? – making sure clients know their treatment plan			x					
Funding	Apply for grants								x
Funding	Casino contributions		x						
Funding	Community donations				x				
Funding	Donations for specific programs							x	
Funding	Grants / donations						x		
Funding	Reduce HHSA indirect			x					
Funding	Use of interns								x
Health Care	Stronger connection with Community Health			x					
Issues	Bullying		x					x	
Issues	Drug and alcohol use and acceptance					x			
Issues	Effects of social media								x
Issues	Gender								x
Issues	High expectation for students – internal and external, starts in elementary school								x
Issues	Issues at home (school is a safe place)	x							
Issues	Lack of food					x			
Issues	Lack of parental involvement					x			
Issues	Meds when released from jail		x						

CP	Cameron Park	GT	Georgetown	SLT	South Lake Tahoe
EDH	El Dorado Hills	PVL	Placerville	SMR	Somerset

General Category	Topic	PVL 10/21	SLT 11/20	PVL 12/2	GT 12/3	SMR 12/4	SLT 12/16	EDH 12/17	CP 12/18
Issues	Poverty - Stress - Separation anxiety - Depression - Homelessness - Impacting children / concerns for parents - Anger - Domestic violence					x			
Issues	Prop 47 impact		x						
Issues	Sexual orientation								x
Issues	Slow approval process								x
Issues	Social skills		x						
Issues	Suicide								x
Linkage	Connecting children to services				x				
Linkage	Connecting clients at Progress House to local services				x				
Linkage	Linkage for services after in-patient			x					
Needs	23 hour crisis stabilization						x		
Needs	College students – peer groups				x				
Needs	Community education							x	
Needs	Community-based services								x
Needs	Developmental disability and mental health care coordination							x	
Needs	Family involvement								x
Needs	Getting the word out – psychologists, school counselors, administration, EDCOE principal meetings	x				x			
Needs	High school health classes – is there a mental health component?	x							
Needs	Housing			x	x				
Needs	Increased collaboration with specialized community partners		x						
Needs	List of services available and where to access them – including collateral services			x					
Needs	Local services					x			
Needs	Local services and coordinated care				x				
Needs	Medication management			x					
Needs	Mental Health outreach					x			
Needs	Older adults programs?			x					

CP Cameron Park
EDH El Dorado Hills
GT Georgetown
PVL Placerville
SLT South Lake Tahoe
SMR Somerset

General Category	Topic	PVL 10/21	SLT 11/20	PVL 12/2	GT 12/3	SMR 12/4	SLT 12/16	EDH 12/17	CP 12/18
Needs	Parental involvement							x	
Needs	Partnering with community-based organizations							x	
Needs	Prevention – tools, resources, coping skills, management tools, education								x
Needs	Reaching home schooled children / youth		x						
Needs	Respite care linkage for foster parents / grandparents	x							
Needs	Services for homeless			x					
Needs	Small groups for 4-5th grade and into middle school too							x	
Needs	Student education – peer support, especially starting younger	x							
Needs	Support for individuals and families who aren't able to get needed support through their private insurance – "we can't serve you now, but consider…"			x					
Needs	Transportation				x	x			
Needs	Volunteers						x		
Needs	Warm room		x						
Needs	Wellness Center – local				x				
Participation	Changing the terminology							x	
Participation	Community capacity building – what happened with the John Ott process?	x							
Participation	Reframing the message		x						
Participation	What is the public's perception of MHSA?							x	
Participation	How many parents opt their child out of Healthy Kids Survey?	x							
Schools	Counselors on school campuses					x			
Schools	Educationally related Mental Health services					x			
Schools	Mental health services in schools								x
Schools	More focus to younger age groups							x	
Schools	PEI in schools at an earlier age							x	
Schools	Reduce recidivism by starting services at younger ages							x	
Schools	Stress management in schools		x						
Schools	Teacher support		x						
Schools	The younger the better	x							
Staffing	Staff needed to implement programs					x			

CP Cameron Park
EDH El Dorado Hills
GT Georgetown
PVL Placerville
SLT South Lake Tahoe
SMR Somerset

General Category	Topic	PVL 10/21	SLT 11/20	PVL 12/2	GT 12/3	SMR 12/4	SLT 12/16	EDH 12/17	CP 12/18
Stigma	Children being pulled from school or low attendance	x							
TAY	TAY first episode psychosis – availability to under 16?			x					
Treatment	Client driven treatment plans			x					

Comments Specifically Related to Outcome Measures

General Category	Topic	PVL 10/21	SLT 11/20	PVL 12/2	GT 12/3	SMR 12/4	SLT 12/16	EDH 12/17	CP 12/18
Outcomes	Accountability in service delivery - From caregivers, what should be happening?	x							
Outcomes	Administrative cost of programs					x			
Outcomes	Attendance	x					x		
Outcomes	Behavior at schools	x							
Outcomes	Being involved in treatment / engaged						x		
Outcomes	Client feedback based on program objectives - Child, parent, caregiver - Pre-post - Level of impact, if not, where did it fall down?	x							
Outcomes	Client satisfaction surveys / outcomes	x							
Outcomes	Client self-assessment and family involvement			x					
Outcomes	Contracted providers								x
Outcomes	Cost					x			
Outcomes	Data treatment outcomes			x					
Outcomes	Duplication of services between programs								x
Outcomes	Effectiveness and efficiency of programs					x			
Outcomes	Effectiveness of services – step down / lower level of services			x					
Outcomes	Feedback to referring doctor				x				
Outcomes	Grades (academics)	x							
Outcomes	LOCUS			x					
Outcomes	Medications – changes / stability?			x					
Outcomes	Number enrolled		x						

CP	Cameron Park	GT	Georgetown	SLT	South Lake Tahoe
EDH	El Dorado Hills	PVL	Placerville	SMR	Somerset

General Category	Topic	PVL 10/21	SLT 11/20	PVL 12/2	GT 12/3	SMR 12/4	SLT 12/16	EDH 12/17	CP 12/18
Outcomes	Number of people served and cost per person (average)								x
Outcomes	Participation rates					x			
Outcomes	Recidivism and reasons why		x						
Outcomes	Revenue decrease based on reduced services								x
Outcomes	Service needs			x					
Outcomes	Staff experiences							x	
Outcomes	Success rates					x			
Outcomes	Treatment goals						x		
Outcomes	What's not working?						x		
Outcomes	Why program may be under-utilized - Is there sufficient funding? - How do the families find out about it? - How does the word get out?	x							

CP	Cameron Park	GT	Georgetown	SLT	South Lake Tahoe
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Meeting Dates and Locations

Location/Date	Location Details
PVL 10/21	Tuesday, October 21, 2014 11:00 am Hosted by: Folsom Lake College Foster and Kinship Parent Program 312 Main Street, Suite 3 Placerville
SLT 11/20	Thursday, November 20, 2014 10:00 am South Lake Tahoe Library 1000 Rufus Allen Blvd. South Lake Tahoe
PVL 12/2	Tuesday, December 2, 2014 5:30 pm Hosted by: National Alliance on Mental Illness (NAMI) 330 Fair Lane, Conference Room A Placerville
GT 12/3	Wednesday, December 3 2014 1:30 pm The Hut 6540 Wentworth Springs Road Georgetown
SMR 12/4	Thursday, December 4, 2014 6:00 pm Hosted by: Pioneer Union School District Pioneer Elementary School Library 6860 Mt. Aukum Road Somerset
SLT 12/16	Tuesday, December 16, 2014 6:00 pm South Lake Tahoe Library 1000 Rufus Allen Blvd. South Lake Tahoe
EDH 12/17	Wednesday, December 17, 2014 6:00 pm El Dorado Hills Library 7455 Silva Valley Parkway El Dorado Hills
CP 12/18	Thursday, December 18, 2014 10:00 am Cameron Park Library 2500 Country Club Drive Cameron Park

CP	Cameron Park	GT	Georgetown	SLT	South Lake Tahoe
EDH	El Dorado Hills	PVL	Placerville	SMR	Somerset

Summary of Input from Comment Forms, Letters, and Individual and Small Group Meetings

- In favor of school based mental health services
- In favor of mental health counselors in schools
- More groups and individual counseling needed in schools
- Coordination of service between agencies
- Housing
- Mental Health services on the Divide
- Wellness Center / activities on the Divide
- Turning Point or similar program
- Medication management
- Case management and psychiatrists
- Access to care
- Community outreach and education
- More funding to County Mental Health to enhance services
- Community Wellness forums
- More mental health professionals in South Lake Tahoe
- Nurtured Health Approach
- Increased funding for PIP
- Expand PIP to more locations
- Expand PEI Pilot Program 1f (locations and funding)
- Small groups for 4-5th grades and middle schools
- Increased Wellness Center funding for food, special events and hours
- Barriers to services:
  - Transportation to services
  - Prolonged wait times
  - Connecting homeless individuals in rural areas to services
  - Lack of providers accepting Medi-Cal and Medicare
- Mentor Houses or Crisis Transitional Home
  - To help individuals move from an inpatient hospitalization or locked psychiatric facility to a lower level of care
  - Houses would be staffed 24/7
- Assisted Outpatient Treatment – The minutes from the Community Corrections Partnership February 25, 2015 are not yet available, however a motion was made to support moving forward with Assisted Outpatient Treatment pending determination of available funding
- Reduce 20% of funding from Children's programs and 15% of funding from programs provided by the schools
- Eliminate the Older Adults program partnering with PEI
- Eliminate the Family Strengthening Academy
- Reduce MHD staff for eliminated programs
- Provide more services, including vocational training, for individual on probation
- PEI – Too much money for the Children 0-5 and Their Families
- PEI – Too much money to local schools
- PEI – More money is needed for older adults as they are isolated

- If funding is reduced, it should be reduced in programs for under 18 years of age as first break occurs around age 20
- Provide more Mental Health First Aid for Veterans
- Add groups to the Wellness Centers to address specific needs of individuals on an LPS conservatorship, such as activities of daily living groups
- Offer medication management groups as part adult MHSA services
- T-houses needed in Tahoe
- Increase the number of groups specific to the TAY population
- Add more ADP groups for the Wellness Centers
- Offer the Wellness Center to TAYs on a specific day per week and close to other adult clients
- More services needed in outlying areas of the County
- More outreach for seniors needed
- More services needed that are specifically designed for those who identify as LGBTQ
- Assist with transportation to services in Sacramento County for those who identify as LGBTQ
- Provide more psychiatric consulting with primary care providers
- Increase peer involvement in the Wellness Centers, including offering more peer led groups
- Encourage Peer Leadership Academy graduates to become peer advocates
- Increase Peer Leadership Academy curriculum
- Increase partnerships with community-based organizations and other governmental agencies/programs
- Authorize adult services for a specific length of time similar to how children's authorizations are completed
- Provide a warm handoff for graduating clients to their primary care providers.
- Off groups on the shuttle
- PEI Project 1e: SAMHSA Model Programs does not allow schools to charge their staff time to the project
- Need for integrated Behavioral Health Collaborative Health Program
- Lack of services for individuals with mild to moderate mental health needs
- More services for individuals with a dual diagnosis of mental health needs and substance use disorders
- Behavioral health facility
- Full time psychiatrists needed
- Spend MHSA funds on housing and services rather than HHSA infrastructure
- Restructure the MHD to make them more accountable for services
- Wellness Center and PIP program are working
- Provide crisis workers in the hospitals during overnight shifts

Report Out by the "MHSA CSS Ad Hoc Budget Shortfall Committee" of the Mental Health Commission

On January 7, 2015, the Mental Health Commission appointed an ad hoc committee to review the projected budget shortfall in the Mental Health Services Act (MHSA) Community Services and Supports (CSS) component and make recommendations to the Mental Health Commission on service reductions and/or changes to achieve a balanced budget in future years.

On May 27, 2015, the Ad Hoc Committee provided the information identified below to the Mental Health Commission as a report out. The Mental Health Commission took no action on the report out.

CSS Program		Report Out	Resulting Amount in FY 2015-16	Resulting Amount in FY 2016-17	Resulting Amount in FY 2017-18
Program 1: Youth and Family Strengthening Program					
	Project 1a: Youth and Family Full Service Partnership	Reduce FY 2015-16 by $30,000	$400,000	$400,000	$400,000
	Project 1b: Family Strengthening Academy	Eliminate Project (not yet implemented)	$0	$0	$0
	Project 1c: Foster Care Enhanced Services	Reduce FY 2015-16 by $27,969	$800,000	$800,000	$800,000
Program 2: Wellness and Recovery Services					
	Project 2a: Wellness Centers	Hold at FY 2014-15 level	$2,120,769	$2,120,769	$2,120,769
	Project 2b: Adult Full Service Partnership	Hold at FY 2015-16 level	$3,202,500	$3,202,500	$3,202,500
	Project 2c: Older Adults Program (Partner program to PEI Older Adults Program)	Eliminate Project (not yet implemented)	$0	$0	$0
Program 3: Transitional Age Youth (TAY) Services					
	Project 3a: TAY Engagement, Wellness and Recovery Services	Hold at FY 2014-15 level	$342,387	$342,387	$342,387
Program 4: Community System of Care					
	Project 4a: Outreach and Engagement Services	Reduce FY 2015-16 by $100,000	$740,000	$740,000	$740,000
	Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services)	Hold at FY 2015-16 level	$157,500	$157,500	$157,500
	Project 4c: Resource Management Services	Reduce FY 2015-16 by $83,750	$100,000	$100,000	$100,000

CSS Program		Report Out	Resulting Amount in FY 2015-16	Resulting Amount in FY 2016-17	Resulting Amount in FY 2017-18
Administrative Costs					
	MHSA Team (MHSA Coordinator, Analysts)	Hold at FY 2015-16 level	$215,010	$215,010	$215,010
CSS Program Expenditures			$8,078,166	$8,078,166	$8,078,166
Reallocation to WET		Reduce FY 2015-16 by $91,000; Reduce FY 2016-17 by $81,000	$75,000	$75,000	$75,000
Reallocation to CFTN		Hold at FY 2015-16 level	$136,176	$136,176	$136,176
Contribution to the Prudent Reserve		No change	$0	$0	$0
Reallocation of CSS			$211,176	$211,176	$211,176
Total CSS Expenditures (without Future Potential Project)			$8,289,342	$8,289,342	$8,289,342
Future Pending Project:					
	Project 2d: Assisted Outpatient Treatment	Push out current budget to the next three fiscal years.	$125,000	$225,000	$175,000
Total CSS Expenditures (If Future Pending Project is Implemented)			$8,414,342	$8,514,342	$8,464,342
Potential CSS Savings			$644,563	$580,860	--

Required Plan Change

Required Plan Change

- **CSS:** Reduce expenditures in CSS programs to provide a balanced three-year budget. The public is encouraged to provide input on how this should be accomplished (i.e., should programs be reduced in service levels, eliminated, or re-configured; and how the reductions should be implemented).

Specific Proposals / Plan Changes Received

These items were listed on the MHSA Community Planning Process web page as specific proposals/changes that may or may not be included in the FY 2015-16 MHSA Plan Update. The inclusion of such proposals/changes is dependent upon a number of factors, including but not limited to the requirements of the Mental Health Services Act, needs in our County, and availability of funding. Additional proposals or changes to the current MHSA Plan may have also been identified as a result of the Community Planning Process.

Specific Proposals

- **CSS:** Allow funding in CSS Project 1a (Youth and Family Full Service Partnership) and CSS Project 1c (Foster Care Enhanced Services) to be shared between the programs. This will allow maximum funding to be utilized to support the needs of children with higher level service needs.

- **CSS:** Utilizing new funding available through the Mental Health Block Grant (MHBG) and funding through MHSA, develop in FY 2014-15 under the current Transitional Age Youth program (CSS Project 3a) and expand in the future a First Episode Psychosis (FEP) program as part of CSS Project 3a specifically for Transitional Age Youth age 16-25. [Updated 12/8/14]

- **CSS:** Extend the age range for participation in CSS Project 3a (Transitional Age Youth) through age 25 (currently is 24). This will allow better alignment of the project with programs for First Episode Psychosis (FEP).

- **CSS:** Creation of a Mobile Support Team (MST) made up of licensed mental health clinicians and certified substance abuse specialists, to provide field-based support to law enforcement. When law enforcement encounters a mental health crisis, or even a situation that might have evolved from mental health challenges, they would call the MST to the scene for help in making the right assessments and coming to the best outcome for everyone involved.

- **CSS:** Provide Psychiatric Emergency Services for adults via an in-person response at Marshall Hospital and Barton Hospital, with only those portions of the day in which no in-person response for adults at the hospitals is available through the MHD would be paid through MHSA. The hours of coverage would primarily be overnight shifts (from 12:00 a.m. to 8:00 a.m.), seven

days per week, including holidays, however additional hours may be included.

- **CSS-Housing:** El Dorado County is eligible to request nonencumbered CSS-Housing funds from CalHFA (the estimated amount is $11,858). These funds must be utilized to provide housing assistance to those with a serious mental illness who are homeless or soon-to-be-homeless, and include costs such as rental assistance, security deposits,, utility deposits, other move-in costs, moving costs. It would be anticipated that the County would request these funds to be returned and utilized for clients meeting the criteria for Full Service Partnerships, who are homeless or soon-to-be-homeless. These funds must be utilized within three years.

- **PEI:** Contribution to CalMHSA to support the Statewide Prevention and Early Intervention (PEI) programs in an amount equal to 1% ($9,471) to 7% ($66,291) of the annual PEI revenues. Statewide PEI funding is no longer available and this will help CalMHSA continue to provide Statewide PEI programs. CalMHSA has prepared an impact statement for the Statewide PEI programs for El Dorado County in support of this proposal. Click here to read the impact statement.

- **PEI:** Extend current funding levels for Project 1d: Primary Intervention Project (PIP) into FY 2016-17.

- **PEI:** Increase funding levels for Project 1d: Primary Intervention Project (PIP) into FY 2016-17.

- **PEI:** Expand the service areas for Project 1d: Primary Intervention Project (PIP).

- **PEI:** Increase the funding level for Project 1f: Prevention and Early Intervention for Youth in Schools.

- **PEI:** Expand the service areas for Project 1f: Prevention and Early Intervention for Youth in Schools.

- **PEI:** Provide peer-to-peer classes designed for adolescent youth (ages 12-18) who are involved with other adolescents experiencing a mental health or addiction challenge or crisis. Youth often go to other youths for support before or instead of going to an adult. This type of class would give the youth tools to support their peers. [Note from the MHSA Project Team: Mental Health First Aid is offered in some high schools to youth in their junior or senior year.]

- **PEI/CSS:** Bring programs such as Roots of Empathy and Collaborative Problem Solving to our local schools (PEI) and treatment facilities (CSS).

- **PEI:** "Nurtured Heart Approach" - Summitview Child and Family Services proposes a Nurtured Heart Approach training on a quarterly basis with six follow up coaching sessions for participants. The Nurtured Heart Approach is a set of strategies that "inspires appropriate behaviors by energizing children when things are "going right", and it sets clear limits." More information can be found at http://www.childrenssuccessfoundation.com/. Estimated cost annually not to exceed $19,500.

- **WET:** In the Program 5, “Suicide Education and Training”, eliminate the requirement for at least one suicide prevention trainer / specialist at each high school and remove the requirement that

each school site have at least one suicide prevention trainer (however keep the requirement for a specialist, with a "specialist" being an individual who has received suicide prevention training. Priority will be given to high schools and middle schools. This is due to the limited number of suicide prevention programs suitable for school-aged students with the availability of "train-the-trainer" components.

- **CFTN:** Eliminate funding for iReach support ($900) and program evaluation ($5,000). With the implementation of electronic health records by health care providers and the Mental Health Division, the use of iReach was discontinued and replaced with a referral process utilizing referrals printed directly from electronic health records (rather than double entering of data into iReach and the electronic health records). Referrals are faxed to providers.

Note: There are new PEI regulations that will go into effect at a yet to be determined date. The impact of those new regulations on our current and future PEI Projects is not yet know.

Draft FY 2015-16 MHSA Plan Update
Comment Period June 15 – July 15, 2015
Public Hearing July 22, 2015

Comments Received During 30-Day Comment Period

Substantive Comments

- Minimize proposals from community providers and increase direction from the Mental Health Division.
- Increase collaboration with multiple agencies and community providers to build and support an evidence-based system of care.
- Too much money is being spent on piecemeal programs from community interests rather than on developing and building a system of care.
- There should be more focus on Early Detection and Intervention with the age 12-25 group.
- Mental Health crisis workers at the Emergency Departments at Marshall and Barton are not included in the MHSA projects.
- Increase services in CSS Project 3a: Transitional Age Youth Engagement, Wellness and Recovery Services through the use of the Mental Health Block Grant funding.
- Increase funding for CSS Future Potential Project 2d: Assisted Outpatient Treatment.
- There needs to be a Mental Health Probation staff dedicated to providing services to individuals involved in the justice system.
- Reduce family strengthening programs to allow for enhanced services for adults.

Questions Received

- Are Veterans and their families considered as part of this funding stream?

Other General Input (not comments on the Draft Plan Update)

- Mandatory therapy/participation in therapy to obtain/maintain benefits
- Follow up with individuals receiving psychiatric medications to make sure they are taking their medications

Comments Received During the Public Hearing

PEI

- Funding is better served by putting it towards FSPs.
- Need to learn to provide services better.
- MHSA funding may be reduced as millionaires move out of California.
- Direct more funds to adults.
- Deficiencies in the home at an early age follows children through their lifetime.
- The more emphasis we put on training families to e primary therapeutic agents of children, the better. Need to train parents to produce better results.
- Emphasis is needed on early intervention, first episode psychosis and wellness for youth.

- Family education is important. There is a significant reduction in ongoing concerns when mental health issues are caught early.
- First Episode Psychosis services needed for ages 18-24.
- Look at partnering to create programs.
- Concern for overlap in services for children at school age. Need to look at how to identify children showing signs of serious mental illness. Treatment is often received far too late to make a difference.
- Many other counties are focusing on early psychosis.
- First breaks are being seen at an earlier age, even in middle school.
- Family education and more involvement is needed.
- Family education needs to include foster parents and substance use disorder services.
- The Primary Intervention Project works with children on classroom adjustments and social behaviors, and help identify mental health needs early.
- Issues with the Primary Intervention Project often stem from the parents and challenges in engaging the parents.
- Why was funding for PEI Project 1f: Prevention and Early Intervention for Youth in Schools increased?
- There is value in the programs, but schools should be providing PEI programs from their own budgets.
- Need to look ahead to find other funding for PEI projects.

CSS

- When will there be updated outcome data available?
- AOT should have the same level of MHSA funding identified in the FY 2014-15 MHSA Plan.
- Other counties have hired outside agencies to establish measures.
- Intensive Case Management is good, but difficult to measure success.
- People have no insight into their mental illness and don't see a need for services. There is a hole with LPS laws that AOT could help fill.
- Every time someone has a crisis event, their baseline decreases.
- There isn't just a cost in dollars, but also a cost in victimization for untreated mental illness.
- AOT would save money in other programs, not just Mental Health.
- Can the fund balance be utilized to fund programs?
- How much will the Medi-Cal adjustment be in FY 2015-16?
- How secure is the CCP funding for AOT?
- Some clients eligible for AOT would be new and some are already in treatment. It's unlikely to cost $25,000 per person per year.
- Can a survey or preliminary Request for Proposal be done to obtain ideas on how to implement AOT?
- Other counties have AOT models.
- Why aren't children served under PEI rather than CSS?

INN

- It's a challenge to find a new program.
- Project idea: Occupational training for clients.
- Project idea: Change focus to lifestyle options (nutrition, exercise) to help improve mental health.

Attachment H Mental Health Services Act, County Profile and Needs Assessments

Mental Health Services Act

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

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

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

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

MHSA Purpose and Intent

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

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

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

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

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

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

subject to local and state oversight to ensure accountability to taxpayers and to the public.[22]

MHSA General Standards

Services provided under MHSA must integrate the following General Standards:[23]

(1) Community Collaboration: "a process by which clients and/or families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources in order to fulfill a shared vision and goals."[24]

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

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

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

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

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

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

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

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

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

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

(9) Strategies are developed and implemented to promote equal opportunities for administrators, service providers, and others involved in service delivery who share the diverse racial/ethnic, cultural, and linguistic characteristics of individuals with serious mental illness/emotional disturbance in the community."[25]

(3) Client Driven: "the client has the primary decision-making role in identifying his/her needs, preferences and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for him/her. Client driven programs/services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes."[26]

(4) Family Driven: "families of children and youth with serious emotional disturbance have a primary decision-making role in the care of their own children, including the identification of needs, preferences and strengths, and a shared decision-making role in determining the services and supports that would be most effective and helpful for their children. Family driven programs/services use the input of families as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes."[27]

(5) Wellness, Recovery, and Resilience Focused: "promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination."[28]

(6) Integrated Service Experiences for clients and their families: "the client, and when appropriate the client's family, accesses a full range of services provided by multiple agencies, programs and funding sources in a comprehensive and coordinated manner."[29]

Public Mental Health System

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

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

[25] CCR, Title 9, Division 1, Chapter 14, Section 3200.100, Cultural Competence.
[26] CCR, Title 9, Division 1, Chapter 14, Section 3200.050, Client Driven.
[27] CCR, Title 9, Division 1, Chapter 14, Section 3200.120, Family Driven.
[28] Welfare and Institutions Code (WIC) Section 5813.5(d)(1).
[29] CCR, Title 9, Division 1, Chapter 14, Section 3200.190, Integrated Service Experience.

technology and training elements that will effectively support the local mental health system."[30] The role of primary care physicians and mental health services available through health insurance networks is of utmost importance in also supporting the local mental health needs.

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

MHSA Plan Requirements

On April 30, 2015, the Mental Health Services Oversight and Accountability Commission (MHSOAC) issued instructions for the Fiscal Year (FY) 2015-16 MHSA Plan Update.[31] The instructions summarize MHSA Plan requirements found within the MHSA, the Welfare and Institutions Code (WIC) and the California Code of Regulations (CCR), including the stakeholder process (community planning process), public review, the information to include regarding programs and outcome measures, expenditure plan, compliance and fiscal accountability certifications, and Board of Supervisors adoption. A copy of the instructions can be found as Attachment A.

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

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

Instructions for this year's Plan Update included a slightly different designation for PEI projects than previously required. New this year is the requirement that PEI programs be reported as:

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

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

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

Therefore, the PEI section of the FY 2015-16 Plan Update will include some re-designation of PEI Programs to "Other".

MHSA Changes Anticipated in FY 2015-16

Proposed Innovation Regulation Changes

The MHSOAC is in the process of updating the regulations related to the Innovation Component of the MHSA. MHD anticipates starting Innovation meetings under these new regulations in late spring or early summer of 2015.

Proposed PEI Regulation Changes

The MHSOAC is in the process of updating the regulations related to the PEI Component of the MHSA. Once implemented, these new regulations will result in significant changes to the PEI Component, mostly in the area of reporting, outcome measures and the structure and designations of our programs. These changes will likely be implemented in the FY 2016-17 MHSA Plan.

MHSA Terminology

As used within this document, and generally within MHSA:

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

A glossary has been included at the end of this document (before the Plan attachments) to assist with the terminology utilized within this Plan.

MHSA Funding Methodology

On September 25, 2014, Department of Health Care Services (DHCS) released MHSD Information Notice 14-029, which identifies the "Methodology for Distributions to Local Mental

Health Services Fund".[32] Through application of the methodology described in MHSD Information Notice 14-029, El Dorado County will continue to receive 0.406698% of the total MHSA funding available. Please see Part 4, MHSA Funding and Pro

The State no longer provides counties with specific annual MHSA allocations. Rather, the MHSA funding distributed to each county is based on a percentage of the actual deposits into the State's Mental Health Services fund. Therefore, the amount distributed fluctuates monthly.[33] The estimated MHSA revenues is based upon revenues received in prior fiscal years, estimated MHSA revenues identified in the State's budget, and estimates from statewide MHSA organizations and their consultants.

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

El Dorado County reports the total MHSA revenues and expenditures annually to the State. This report is referred to as the "Revenue and Expenditure Report". The report for FY 2012-13 is included as Attachment B. Please note this does not represent the total cost of the MHSA programs, but rather the MHSA funds that are utilized to fund the programs (other funding may be provided through Medi-Cal reimbursements, grant funding, etc.).

Component Funding

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

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

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

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

[32] California Department of Health Care Services, MHSD Information Notice 14-029 and Enclosure 1. September 25, 2014. http://www.dhcs.ca.gov/formsandpubs/Pages/MH-InfoNotices-2014.aspx.
[33] *Ibid.*

County Profile

El Dorado County encompasses a large geographic area (1,708 square miles, of which approximately 51% is U.S. Forest Service land[34]), with two incorporated cities (South Lake Tahoe and Placerville) and twelve unincorporated Census-Designated Places (CDPs)[35].

Demographics

According to the 2010 census, the population within the County is 181,058, which represents a 15.8% increase since the 2000 census.[36] Approximately 33% of the County's population resides toward the western border of the County in the El Dorado Hills and Cameron Park communities, with the Tahoe basin on the eastern border being the second highest region in population.

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

Location	2010 Census Population[37]	Percent of County	Persons per Square Mile[38]
City of Placerville (incorporated)	10,389	5.7%	1,787.5
City of South Lake Tahoe (incorporated)	21,403	11.8%	2,106.3
Auburn Lake Trails CDP	3,426	1.9%	269.2
Cameron Park CDP	18,228	10.1%	1,641.2
Camino CDP	1,750	1.0%	777.7
Cold Springs CDP	446	0.2%	590.4
Coloma CDP	529	0.3%	157.7
Diamond Springs CDP	11,037	6.1%	663.2
El Dorado Hills CDP	42,108	23.3%	869.0
Georgetown CDP	2,367	1.3%	156.5
Grizzly Flats CDP	1,066	0.6%	160.8
Pollock Pines CDP	6,871	3.8%	866.7

[34] Retrieved from http://www.fs.usda.gov/main/eldorado/about-forest, March 7, 2013.
[35] Retrieved from http://www.dof.ca.gov/research/demographic/state_census_data_center/census_2010/documents/2010Census_DemoProfile1.xls, June 25, 2013.
[36] Unless otherwise noted, all demographic data is retrieved from the 2010 census (http://quickfacts.census.gov/qfd/states/06000.html), March 7 and May 7, 2013.
[37] Retrieved from http://www.dof.ca.gov/research/demographic/state_census_data_center/census_2010/documents/2010Census_DemoProfile1.xls, June 25, 2013.
[38] *Ibid.*

Location	2010 Census Population[37]	Percent of County	Persons per Square Mile[38]
Shingle Springs CDP	4,432	2.4%	539.9
Tahoma CDP	1,191	0.7%	459.2
Remainder of Unincorporated Area	55,815	30.8%	35.9
El Dorado County Total	181,058	100.0%	106.0

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

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

Gender distribution in the County is nearly equal between men (90,571) and women (90,487).[39] Veterans represent approximately 9.8% of the population.

The race distribution within the County is as follows:

Race	Percent of County
White (not Hispanic)	79.6%
Hispanic or Latino Origin	12.3%
Asian	3.7%
American Indian and Alaska Native	1.4%
Black	0.9%
Native Hawaiian and Other Pacific Islander	0.2%
Persons Reporting Two or More Races	3.3%

The median age in the County is 43.6, distributed as follows:[40]

[39] Gender distributions from U.S. Census Bureau data and compiled by Sacramento Area Council of Governments (SACOG).

[40] Age distributions from U.S. Census Bureau data and compiled by Sacramento Area Council of Governments (SACOG).

Age	Total	Percent of County
Under 5	9,513	5.3%
5 to 9	11,126	6.1%
10 to 14	12,506	6.9%
15 to 19	12,522	6.9%
20 to 24	8,958	4.9%
25 to 34	17,244	9.5%
35 to 44	22,203	12.3%

Age	Total	Percent of County
45 to 54	32,346	17.9%
55 to 59	15,146	8.4%
60 to 64	12,970	7.2%
65 to 74	15,437	8.5%
75 to 84	7,969	4.4%
85 and Over	3,118	1.7%

Children 0 to 19 comprise 25.2% of the population and adults age 60 and over comprise 21.8% of the population. The population of adults age 55 and over has increased significantly from 2000. In 2000, this group consisted of 34,691 individuals (22.2% of the total population), whereas in 2010, the same age range consisted of 54,640 individuals (30.2% of the total population).

Income Levels

The median household income in El Dorado County is $68,815.[41] However, economic disparities are evident across the County:

Place of Residence within the County	Median Household Income[42]	Percent of Individuals Below the Poverty line[43]
Cameron Park	$72,562	4.3%
El Dorado Hills	$115,121	2.7%
Placerville (city)	$53,385	14.0%
South Lake Tahoe (city)	$41,685	18.4%
Remaining County Unincorporated Areas	Not Available	Not Available
El Dorado County Total	$68,815	8.4%

According to the American Fact Finder, approximately 8.4% of the County's population has been below the poverty level within a 12 month period during the time period of 2007-2011.[44] There are specific areas of the County that experience higher poverty levels. Of the 43 census

[41] Median household income, U.S. Census Bureau 2007-2011 American Community Survey 5-Year Estimates. http://factfinder2.census.gov/.
[42] Median household income, U.S. Census Bureau 2007-2011 American Community Survey 5-Year Estimates. http://factfinder2.census.gov/.
[43] People of all ages in poverty - percent, U.S. Census Bureau 2007-2011 American Community Survey 5-Year Estimates. http://factfinder2.census.gov/
[44] American Fact Finder. *Poverty Status in the Past 12 Months.* Retrieved from http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_5YR_S1701&prodType=table. September 29, 2013.

tracts within El Dorado County, 18 are above the County's average poverty level, representing approximately 44% of the County's population.[45]

Poverty Status in the Past 12 Months
2007-2011 American Community Survey 5-Year Estimates[46]

Includes All or Portion of Area	Includes All or Portion of Zip Code[47]	2007-2011 Population	% Population Below Poverty Level	Population Below Poverty Level
Countywide	--	178,630	8.4%	15,005
South Lake Tahoe	96150	28,887	16.06%	4,639
Camino, Placerville	95667, 95709	11,319	9.83%	1,113
Diamond Springs, El Dorado/Nashville, Placerville	95619, 95623, 95667	11,451	8.80%	1,008
El Dorado/Nashville, Placerville	95623, 95667	6,820	14.10%	962
Placerville	95667	6,100	14.30%	872
Camino, Pollock Pines	95709, 95726	4,781	15.20%	727
El Dorado Hills	95762	27,110	2.68%	726
Coloma, Placerville	95613, 95667	4,590	13.00%	597
Cool, Garden Valley, Georgetown, Greenwood, Lotus, Pilot Hill, Placerville	95614, 95633, 95634, 95635, 95651, 95664, 95667	6,381	8.80%	562
Placerville, Pollock Pines	95667, 95726	5,980	8.90%	532
Cameron Park/Shingle Springs, El Dorado Hills	95682, 95762	9,996	5.12%	512
Cool, Greenwood, Pilot Hill	95614, 95635, 95664	4,946	7.30%	361
Cameron Park/Shingle Springs, Rescue	95672, 95682	6,937	5.10%	354
Cameron Park/Shingle Springs	95682	5,427	6.47%	351
Cameron Park/Shingle Springs, Placerville	95667, 95682	4,848	5.90%	286

[45] Maps showing the locations of census tracts within El Dorado County are available through the U.S. Census Bureau website at http://www2.census.gov/geo/maps/dc10map/tract/st06_ca/c06017_el_dorado/.
[46] American Fact Finder. *Poverty Status in the Past 12 Months.* Retrieved from http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_5YR_S1701&prodType=table. September 29, 2013.
[47] Based on Census Tract Boundaries. Maps showing census tract zip code locations within El Dorado County are available through the El Dorado County Surveyor's Office website at http://edcapps.edcgov.us/maplibrary/html/ImageFiles/gi005667a.pdf.

Includes All or Portion of Area	Includes All or Portion of Zip Code[47]	2007-2011 Population	% Population Below Poverty Level	Population Below Poverty Level
Garden Valley, Georgetown, Placerville, Pollock Pines, Twin Bridges	95633, 95634, 95667, 95726, 95735	3,208	8.50%	273
Cameron Park/Shingle Springs, El Dorado Hills, Rescue	95672, 95682, 95762	7,356	3.10%	228
Camino, Placerville, Pollock Pines	95667, 95709, 95726	2,192	9.50%	208
El Dorado/Nashville, Grizzly Flats, Mt. Aukum, Placerville, Somerset	95623, 95636, 95656, 95667, 95684	5,015	4.10%	206
Cameron Park/Shingle Springs, Lotus, Placerville	95651, 95667, 95682	2,844	5.40%	154
Cameron Park/Shingle Springs, El Dorado/Nashville, Placerville	95623, 95667, 95682	2,747	5.40%	148
Cameron Park/Shingle Springs, El Dorado Hills, Pilot Hill, Rescue	95664, 95672, 95682, 95762	3,939	3.10%	122
Echo Lake, South Lake Tahoe, Tahoma	95721, 96142, 96150	662	5.10%	34
El Dorado Hills, Rescue	95672, 95762	5,048	0.60%	30
Kyburz, Pollock Pines, Twin Bridges	95720, 95726, 95735	46	0%	0

Languages

The primary language spoken within El Dorado County is English. As of August 2013, California DHCS identified Spanish as the only "threshold language" within El Dorado County.[48] A "threshold language" is the primary language identified by 3,000 or five percent of the Medi-Cal beneficiaries, whichever is lower, in an identified geographic area. MHSA considers threshold languages when determining other languages to be considered in program design and implementation.

According to the U.S. Census, approximately 4% of the population age five and over speaks only Spanish at home.[49] Approximately 65% of this population resides in South Lake Tahoe,

[48] California Department of Health Care Services. MHSD Information Notice No.: 13-09, Enclosure 1. http://www.dhcs.ca.gov/formsandpubs/Documents/13-09Encl1.pdf. April 2013.
[49] 2010 U.S. Census. *Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over (Hispanic Or Latino)*.

16% resides in Placerville and 7% resides in Cameron Park/Shingle Springs. The remaining 12% is distributed throughout the remainder of the County.[50]

Health Insurance

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

Enroll America identified that approximately 13% (approximately 19,674) of the residents under the age of 65 in El Dorado County were uninsured prior to the implementation of the Affordable Care Act.[51] With the implementation of the Affordable Care Act, it is anticipated that this number will drop, however more recent estimates of the number of uninsured specifically for El Dorado County are not yet available.

According to DHCS, 21,749 individuals in El Dorado County were receiving Medi-Cal as a "mandatory" participant as of March 2014.[52] Mandatory participants are those enrolled in programs such as CalWORKs, seniors, persons with disabilities, and those who have no share of cost for their Medi-Cal.

The role of health care providers in the provision of mental health services cannot be underestimated. Individuals frequently feel more comfortable addressing mental health concerns with their primary care physician. For those with private insurance, referrals for mental health services would be handled through their insurance networks. For individuals with Medi-Cal, mild to moderate mental health needs are served through their primary care physicians, and individuals with severe mental illness are served through the Mental Health Division (MHD) of Health and Human Services Agency (HHSA). Therefore, CSS services are primarily for those with Medi-Cal or those who are uninsured. MHSA programs cannot provide services that are available through private insurance.[53]

Demand for Mental Health Services

A February 2012 report[54] to the California DHCS identified that approximately 4.6% of the population in El Dorado County has a need for mental health services based upon the serious

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[50] U.S. Census, PCT011: Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over (Hispanic or Latino).

[51] Enroll America. State Maps & Info, California. http://www.enrollamerica.org/state-maps-and-info/state-profiles/california/. Retrieved April 25, 2014.

[52] California Department of Health Care Services, All Plan Letter 14-008 (Revised), Standards For Determining Threshold Languages, August 27, 2014. http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-008.pdf.

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

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

mental illness definition. Within households with income below the 200% poverty level, this rate increases to approximately 8.9%. When a broader definition of mental health needs is utilized, a level which is beyond the scope of the MHSA CSS funding, the percent of population that has a need for mental health services increases to approximately 12.2% of the population, and within households with income levels below the 200% poverty level, the need increases to approximately 19.5%. However, it is important to remember that under most circumstances, participation in mental health services is voluntary in nature.[55]

Mental illness can affect anyone, regardless of their ethnicity, income, housing status, age, or any number of other criteria. The MHSA projects are designed to address the needs of those residents who meet the eligibility criteria of each project. However, research has shown that there is a higher prevalence of mental illness in households that are considered low-income.[56] Per the United States Department of Health and Human Services, "In 2010, adults living below the poverty level were three times more likely to have serious psychological distress as compared to adults [with income] over twice the poverty level."[57]

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

Information about the levels of requests for services and the outcomes of those requests is available in the *Program Outcomes and Changes* section of this Plan Update.

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

[56] References include:

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

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

Suicide Rate

Data from the California Department of Public Health reflects that from 2006 through 2013, El Dorado County experienced 241 deaths due to suicide.[58]

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

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

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

Chart 1. Number of Deaths by Suicide 2006-2013.

A key element in encouraging individuals to seek mental health treatment, including treatment for those who may have suicidal thoughts, is addressing the stigma long associated with mental illness. This MHSA Plan includes a suicide prevention program that will be awarded through a competitive procurement process, as well as a contribution to the Statewide PEI Projects, which includes a suicide prevention project, and a suicide prevention program through WET to provide training to school personnel.

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

Needs Assessments

Workforce Needs

Within WET, the 2008 Workforce Needs Assessment identified the hard-to-fill positions of psychiatrists, nurses and Marriage and Family Therapist Interns. It also identified a need for bilingual (Spanish) staff in the public mental health system workforce. Although it had been anticipated that the Workforce Needs Assessment would be performed in FY 2014-15, staffing levels within the MHD precluded that from occurring. However, current staffing trends identify challenges in staffing psychiatrists, nurses, psychiatric technicians, mental health clinicians (licensed and pre-licensed), licensed clinical social workers (licensed and pre-licensed); bilingual/bicultural staff; and all positions that work evenings, weekends, and part-time and/or on-call.

Previous MHSA Plans detailing the early community planning processes, needs assessments and origins of the MHSA programs may be found on the County's MHSA web page.[59]

Barton Health Community Health Needs Assessment

In FY 2014-15, Barton Health continued to focus on address the needs identified in its Community Health Needs Assessment (CHNA) Report for the South Lake Tahoe and surrounding communities. one of which is "Mental Health & Mental Disorders"[60] The main issues discussed included shortage of psychiatrists and treatment facility options, stress management, stigma associated with mental illness, and individuals living with disabilities.[61] More information about the Barton Health CHNA, along with the complete report, can be accessed from http://www.bartonhealth.org/main/community-health.aspx.

On March 5, 2015, Barton Health convened a second Mental Health Forum, where the needs of specific age groups were identified, along with potential solutions, timelines for implementation and pledges of support/services from specific organizations. Barton Health continues to work with the Mental Health Forum attendees with follow-up meetings to implement the identified solutions.

Additionally, Barton Health strongly promoted May 2015 as Mental Health Awareness Month in the Tahoe Basin. Various activities were organized by Barton Health and partnering agencies and organizations, and the activities were well received by the Tahoe community.

[59] El Dorado County, MHSA Plans Archive. http://www.edcgov.us/MentalHealth/MHSA_Plans.aspx.
[60] Professional Research Consultants, Inc. for Barton Health. *2012 PRC Community Health Needs Assessment Report.* 2012, pp. 12-13.
[61] *Ibid.* p. 41.

Marshall Medical Center Community Health Needs Assessment

Marshall Medical Center published its CHNA in October 2013.[62] Priority health needs for the Marshall Medical Center hospital service area included:

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

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

California Healthy Kids Survey

The data provided in the FY 2014-15 MHSA Plan about the California Healthy Kids Survey is the most recent information available to the MHD.

[62] Valley Vision, Inc. for Marshall Medical Center. A Community Health Needs Assessment of the Marshall Medical Center Hospital Service Area. 2013, p 5.