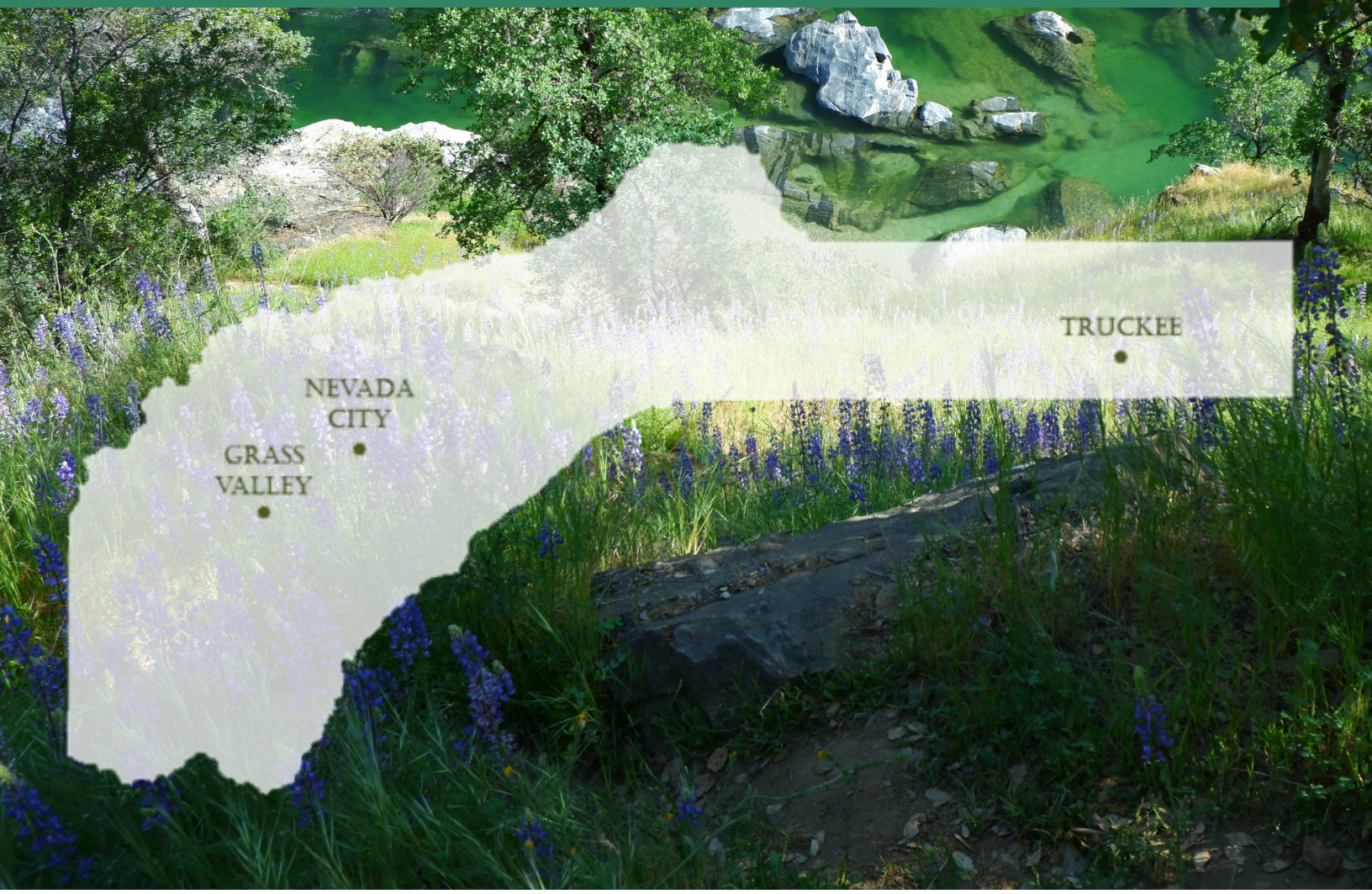
NEVADA COUNTY
MHSA ANNUAL PLAN UPDATE
FISCAL YEAR 22/23



NEVADA COUNTY
CALIFORNIA

MENTAL HEALTH SERVICES ACT (MHSA)
ANNUAL PLAN UPDATE FOR FISCAL YEAR (FY) 22/23

Table of Contents

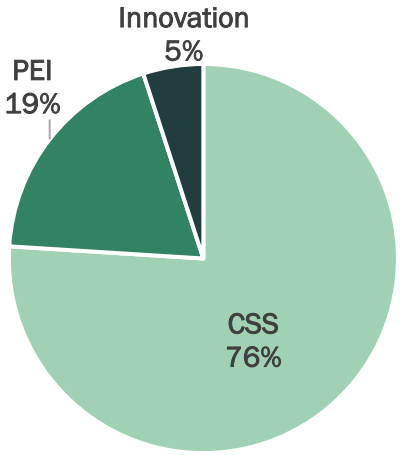
Executive Summary

The Mental Health Services Act (MHSA), also known as Proposition 63, was passed by California voters in November 2004 and went into effect in January 2005. MHSA is funded by a 1% tax on personal income over $1 million per year, and is designed to expand and transform California's county mental health systems. The Mental Health Services Act revenue is allocated to California counties to expand services for individuals with mental health disorders and those at-risk of developing a mental health disorder.

MHSA Program Components

The major components of the Mental Health Services Act are Community Services and Support (CSS), Prevention and Early Intervention (PEI), and Innovation (INN). Other MHSA program components include Workforce Education and Training (WET), Technological Needs, and Capital Facilities.

- **Community Services and Support (CSS)** programs provide treatment and recovery services to individuals living with serious mental illness or emotional disturbance. Counties must spend at least 51% of CSS funding on Full Service Partnerships (FSP). 76% of total MHSA funds are allocated towards CSS.
- **Prevention and Early Intervention (PEI)** programs aim to prevent the development of serious mental health issues, and implement early intervention to keep mental illnesses from becoming serious and disabling. Counties must spend at least 51% of PEI funding on individuals 25 years old or younger. 19% of total MHSA funds are allocated towards PEI.
- **Innovation** projects are novel, community-driven approaches that can last for a maximum of 5 years. 5% of total MHSA funds are allocated towards Innovation.



MHSA Guiding Principles

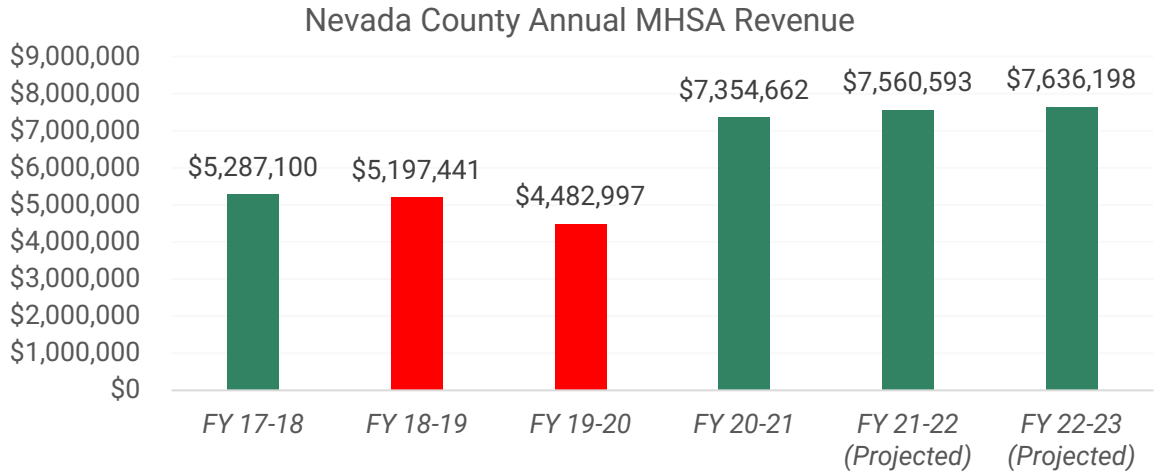
The following principles guide all MHSA programs and initiatives:

- **Cultural Competence**: Services should reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access.
- **Community Collaboration**: Services should strengthen partnerships with diverse sectors to help create opportunities for employment, housing, and education.
- **Client, Consumer, and Family Involvement**: Services should engage clients, consumers, and families in all aspects of the mental health system, including planning, policy development, service delivery and evaluation.
- **Integrated Service Delivery**: Services should reinforce coordinated agency efforts to create a seamless experience for clients, consumers and families.
- **Wellness and Recovery**: Services should promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives.

Three Year Plan Overview

Counties are required to develop Three-Year MHSA Program and Expenditure plans, in collaboration with stakeholders, to determine priorities and direction for MHSA funding allocations and programs. Every three years, counties must develop a Three-Year Plan which outlines priorities for MHSA funding over the following three fiscal years. Each year, counties must provide an update to the Three-Year Plan which highlights any significant changes from the Three-Year plan or from previous years' programming. The Fiscal Year 2020/2021 Annual Plan Update outlines updates to the FY 2020/2021 through 2022/2023 Three-Year MHSA Plan. Budgets and program plans are estimates based on current information, and amendments and annual plan updates will be issued throughout the plan period. The plan and its priorities are based on the needs identified by the department and the community through the mental health needs assessment and planning process, as outlined in the Community Planning Process section.

Fiscal Year 2022/2023



After a 14% decline in MHSA revenue in FY 19/20, revenues were historically high in FY 20/21, increasing about 64% from the previous fiscal year. While projections are unpredictable and volatile, MHSA revenues are currently projected to stay at these historically high levels if not slightly grow in the coming fiscal year. As a result, Nevada County Behavioral Health aims to support and enhance existing MHSA programming, as well as support new initiatives that align with the priorities of the Three Year Plan and department and client needs.

Notable Changes in the FY 22/23 Annual Plan Update:

- **Funding increases for existing contracts**
  - Increases for existing MHSA funded contracts, ranging between 10 and 30%
  - Strategic increases for Prevention and Early Intervention programs targeting youth, and for Full Service Partnership programs
  - Exploring addition of new youth FSP provider

    - Additional funding to support 24/7 FSP permanent supportive housing staffing for house that was purchased with MHSA CSS funds in FY 21/22
- **Support for Homeless Outreach and Medical Engagement (HOME) Team**
    - Exploring CalAIM Enhanced Care Management (ECM) funding and other sources to create long term sustainability plan for time-limited HOME Team Innovation project
    - More cohesive staffing model with some staff embedded within BH department and some staff remaining within Hospitality House
    - Better connectivity and referral flow to Behavioral Health services
    - Funding will support gap that ECM funding cannot cover, in addition to start up costs such as the purchase of two County vehicles for HOME Team staff to utilize
- **Electronic Health Record (EHR)**
    - Current Electronic Health Record (EHR) Anasazi sunsets in 2023
    - Funding needed for transition to a new EHR, including one-time startup and implementation costs
    - Allocating funding from CSS to Capital Facilities and Technological Needs (CFTN) to support transition to a new EHR

Key Behavioral Health Priorities and Updates for FY 2020-21, 2021-22, and 2022-23

- Continued focus on those experiencing homelessness, including enhanced data tracking of the number served experiencing homelessness within MHSA funded programs; roughly 40% of our total MHSA budget is projected to serve those experiencing homelessness.
- Sustained prioritization of those with criminal justice involvement, in line with the Stepping Up initiative to reduce the number of individuals with mental illness in jail
- Provide more behavioral health services to those in the child welfare system, particularly those in foster care settings, including children ages 0-5
- Expanded services in Tahoe/Truckee, including implementation of children's Full Service Partnership program, case management for adults with mental illness and/or substance use disorder, and supportive housing
- Increased and strategic utilization of peer specialists within behavioral health system of care
- Explore targeted mental health treatment program for Transition Age Youth (TAY, ages 16-25), which may include a targeted TAY Full Service Partnership program and identification of the early onset of serious mental illness
- Increased focus on evaluation and performance outcomes, especially within Prevention and Early Intervention (PEI) programs
- Community crises response, such as with the COVID-19 pandemic, with community level behavioral health support
- Partner more closely with Medi-Cal managed care plans for "whole health" approach for behavioral health clients with high medical needs
- Family-centered programming including family support groups and education
- Workforce Education and Training (WET) programming including peer support, intern supervision, training, and supporting statewide strategies to increase the behavioral health workforce

Community Service and Supports (CSS)	
Program	**Program Description**
Full Service Partnership (FSP)	
Children's Full Service Partnership	Comprehensive 24/7 wraparound treatment for children (age 0 - 17) with serious emotional disturbance or serious mental illness; utilize small caseloads and peer and family supports
Adult Full Service Partnership	Assertive Community Treatment (ACT) for adults (age 18 and up) that includes an individualized service plan and a "whatever it takes" flexible treatment approach that can include housing and employment support; services are available 24/7 with small caseloads
General System Development (GSD)	
Expand Network Providers	Provides funding to network therapists who accept referrals from Nevada County Behavioral Health for program participants with less acute needs
Expand Adult and Child Behavioral Health & Psychiatric Services	Expanded children's and adult psychiatry and mental health services, including vocational training, activity groups, and flexible funds to support and engage clients in treatment
Expand Crisis and Mobile Crisis Intervention Services	Crisis services at the Crisis Stabilization Unit (CSU), available 24/7; provides direct crisis intervention services to program participants by phone and via face-to-face evaluations
	Insight Respite Center is a peer centered program where guests seeking relief from symptom distress are treated as equals on their path to recovery
Emergency Department Outreach and Engagement	On-call peer support to individuals in crisis in the Emergency Department or Crisis Stabilization Unit, including follow-up calls for additional support and linkage to services
Intensive Services for Youth	Specialty mental health services for children and families with specific focus on children at risk of removal from their homes or in congregate care and pre and post adoptive families
Alternative Early Intervention for Youth and Young Adults	Flexible, alternative treatment for youth and transition age youth including nature-based therapy
Family Education and Support	Education & support program that includes community system navigation for families of those with mental illness
Tahoe/Truckee Case Management Services	Personal services coordination and case management to Tahoe/Truckee Medi-Cal eligible persons who have a mental illness.
Project Based Housing	Lease or purchase of housing units for individuals with serious mental illness, including purchase
Outreach and Engagement	
Expanded Mental Health Services in North San Juan	Provides outreach, engagement and care coordination services to individuals in the underserved area of North San Juan Ridge.

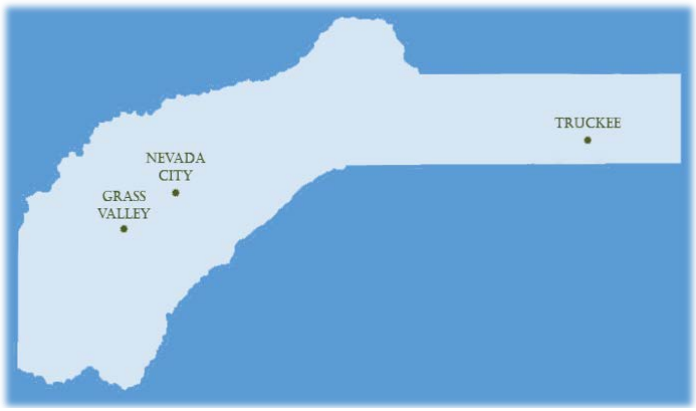
Case Management & Therapy for Homeless Individuals with Mental Illness	Embedded case manager and therapist at Hospitality to assist clients in meeting their expressed mental health-related goals, including assistance with medication management and housing
Forensic Liaison	Forensic Liaison aims to prevent & decrease law enforcement contact and incarceration for individuals experiencing mental health conditions
Veterans' Services & Therapy	Provides mental health services and therapy for veterans locally
Adult Wellness Center and Peer Support Training	Adult peer wellness center that offers individual peer support, weekly support groups, referrals to community services, and WRAP (Wellness Recovery Action Plan)
Housing & Supportive Services to Severely Mentally Ill Homeless	Provides housing and supportive services for homeless individuals with mental illness and assists them with rental applications, lease agreements, and general living skills to maintain their housing
Prevention and Early Intervention (PEI)	
Program	**Program Description**
Early Intervention	
Bilingual Therapy	Early, short term intervention and therapy for Spanish speaking individuals of all age groups
Perinatal Depression Program	Moving Beyond Depression: Evidence-based program providing in-home cognitive behavioral therapy to women in home visitation program experiencing prenatal or postpartum depression
Early Intervention for Youth in Crisis	Therapeutic early intervention, counseling and crisis response for youth in crisis in Eastern Nevada County
Access and Linkage	
Homeless Outreach	Homeless outreach program that provides outreach, access, and linkage services for homeless individuals
Senior, Disabled and Isolated Outreach Program	Reduces isolation via in-home visits to seniors and persons with disabilities via in-home visits
	Registered Nurse or Social Worker makes home visits to older adults and adults with disabilities
Mental Health Screening in High Schools	Universal mental health screening program for high school students
Outreach for Increasing Recognition of Early Signs of Mental Illness	
Community Mental Health and Crisis Training	Mental Health First Aid is a course that presents an overview of mental illness and substance use disorders, introduces participants to risk factors & warning signs of mental health problems
Prevention	
Youth Mentoring	Youth mentoring and after-school youth support program
Youth Wellness Center	Wellness Center provides a youth-friendly point of entry for students to connect to supportive adults and access wellness services at school sites

Family Support/Parenting Classes	Positive parenting classes aiming to decrease family isolation and stress, educate parents about mental health issues, and promote the development of peer supports.
Community Crisis Response	Provide disaster relief in the form of crisis response, including individual and group crisis intervention sessions for victims and survivors
LGBTQ+ Support	Provide facilitation support and create peer-led support structures for LGBTQ+ youth in local high schools
Stigma and Discrimination Reduction	
LatinX Outreach	Promotora Program utilizes "community health workers" to help Latino families connect to health resources and offers health education, including mental health services and stigma reduction
	LatinX youth and transition age youth peer support and mindfulness program
Youth Empowerment	Youth empowerment groups will help individuals identify personal strengths and supportive resources
Suicide Prevention	
Suicide Prevention and Intervention	Suicide Prevention and Postvention coordination that implements suicide prevention and intervention training programs, reduces stigma around suicide and mental illness, and provides crisis intervention and support
Workforce Education & Training (WET)	
Program	**Program Description**
Community and Workforce Training and Technical Assistance	Provide education, training and workforce development programs and activities that contribute to developing and maintaining a culturally competent workforce
Intern Supervision	Adds service capacity in Nevada County by funding clinical supervision of behavioral health interns
HCAI WET Contribution	Support regional WET initiative through California Department of Health Care Access and Information (HCAI)
Innovation (INN)	
Program	**Program Description**
Homeless Outreach and Medical Engagement (HOME) Team	Team including personal services coordinators, peer specialist, and nurse performing outreach and relationship building to those experiencing homelessness, paired with low-barrier housing
Capital Facilities and Technological Needs (CFTN)	
Program	**Program Description**
Electronic Health Record (EHR)	Startup, implementation, and maintenance costs for new Electronic Health Record (EHR) which will be implemented by July 2023; current EHR Anasazi sunsets in 2023

Nevada County Overview

Nevada County is a small, rural, mountain community, home to an estimated 99,107 (2016 US Census Bureau estimate https://www.census.gov/quickfacts/) individuals. According to the 2016 US Census estimate, over 93% of the Nevada County residents identified their race as White, while over 3% of residents combined identified their race as African American, Asian, American Indian, Alaska Native, Native Hawaiian and Pacific Islander. In regards to ethnicity, an estimated 85.4% of the population identified as Non-Hispanic or Latino and 9.5% of the population of Nevada County identified themselves as Hispanic or Latino. Therefore, Nevada County's one threshold language is Spanish. 23% of Nevada County's residents are over 65 years of age as compared to the statewide average of 13.9%. As of July 2018, 21% or 21,104 residents are Medi-Cal recipients.

The county lies in the heart of the Sierra Nevada Mountains and covers 958 square miles. Only 32% of Nevada County's population live in incorporated areas, with 16% in the Town of Truckee, 13% in the City of Grass Valley, and 3% in Nevada City, while 68% live in the outlying unincorporated areas.



Community Program Planning Process

30-Day Public Comment Period Dates: April 13, 2022 through May 13, 2022

Public Hearing Date: May 13, 2021 at Nevada County Mental Health and Substance Use Advisory Board Meeting

Nevada County Behavioral Health held MHSA Community Meetings to educate the community and gather input about priorities for our Annual Plan Update. These community meetings included representation from service providers, contract providers, program participant/family advocates, program participants, family members, County employees and interested community members. Any member of the public is welcome to attend and provide input at these meetings. In FY 21/22, NCBH held MHSA Community Meetings on: 11/30/21 and 4/6/22.

Other meetings attended include, but are not limited to: Stepping Up, Cultural Competency Committee, Mental Health and Substance Use Advisory Board, Quality Improvement Committee, Nevada County Behavioral Health (NCBH) Contractors Meeting, Nevada County Health Collaborative, Nevada County Coordinating Council for the Homeless, Tahoe Truckee Community Collaborative, and NCBH Staff Meetings.

The Plan was posted for 30-day public review to the County website. After the plan is posted, it is shared with e-mail lists of interested individuals. These lists contain approximately 180 individuals, who range from family members, program participants, contractors, community based organizations, interested community members, law enforcement, school personnel, substance use service providers, and staff from various departments within Nevada County. Included in this distribution list are our area's major media outlets.

If any member of our community requests a hard copy of the plan, NCBH will mail a copy of the plan.

The Local Mental Health and Substance Use Advisory Board conducts a public hearing after the 30 day public review period. The Local Board reviews the plan and public comments and makes the recommendation that the plan be presented to the Nevada County Board of Supervisors.

Changes made during public comment:

- Simplified Technological Needs project description based on feedback from Department of Health Care Services (DHCS)
- Realigned "Housing and Supportive Services to the Severely Mentally Ill Homeless" from the CSS Category "General System Development" to "Outreach and Engagement"

Community Services & Support (CSS)

A) *CSS Category*: Full Service Partnership (FSP)

1) Program: Children's Full Service Partnership (FSP)

Target Population:

Children (age 0 – 17) who are seriously emotionally disturbed who meet one or more of the following:

1) As result of mental health disorder, child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; AND either of the following occur:
    a) Child is at-risk of removal from home or has already been removed from home
    b) Mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
2) Child displays one of the following: psychotic features, risk of suicide or risk of violence due to mental disorder
3) Child qualifies for special education placement due to emotional disturbance

Program Description:

Children's Full Service Partnership (FSP) are intensive treatment programs that utilize a "whatever it takes" approach.

Children's System of Care Approach: The Children's FSP uses a Children's System of Care approach to serving high-risk children and youth age 0-25. Seventeen year-old transition age youth can access this system and transition automatically to the adult supports and services, or remain on the Wraparound (WRAP) Team if that level of care is more appropriate for their specific developmental stage.

Wraparound Treatment & Services:

Nevada County's comprehensive Wraparound Treatment Teams provide services 24/7, utilize small team-based caseloads, provide field-based services, and emphasize individual and family strengths. The Teams focus on reducing or preventing out-of-home placement through close interagency collaboration, individualized treatment plans, and a full range of services available within the Teams. Wraparound services include peer and family support and advocacy services through Parent Partners and flexible funding for support in services such as housing and childcare, and employment services. While the primary focus of the Wraparound team is residents of Nevada County, services may be targeted towards children who are placed outside of the County.

Latino Outreach: Wraparound providers may have bilingual and bicultural staff that work with families where available. Nevada County also has the Promotoras, who are bilingual and bicultural health educators who help with outreach and engagement to Latino families for Wraparound service providers.

2) Program: Adult Full Service Partnership (FSP)

Target Population:

Adults age 18 and over who are seriously mentally ill and whose service needs are unmet or minimally met and are at-risk of: homelessness, involvement in the criminal justice system, institutionalization, frequent usage of hospital and/or emergency room services as primary resource for mental health treatment, or involuntary care.

Program Description:

Assertive Community Treatment (ACT): The Assertive Community Treatment (ACT) Model features clinical/community-based team-coordinated care. Each program participant has an individualized and culturally competent service plan. Team members share responsibility for the individuals served by the team. Members may receive services from any staff person on the treatment team. The staff-to-consumer ratio is small, approximately one staff member per 10 clients. The range of treatment and services is comprehensive and flexible, and services are available 24 hours per day, 7 days per week. The team is proactive in engaging individuals needing care. Services include, but are not limited to, peer/family counseling, assisted outpatient treatment, psychiatric services, treatment for co-occurring disorders, outreach/engagement services for homeless individuals, housing and employment support, "whatever it takes" services.

Step Down ACT Team: The Step-Down ACT Team, operated by the Behavioral Health Department, is called New Directions and helps FSP participants integrate into the larger community.

Assisted Outpatient Treatment (AOT): ACT services are available to individuals participating in the Assisted Outpatient Treatment (AOT) program. A Licensed Mental Health Professional (LMHP) receives referrals from Nevada County Behavioral Health. These referrals may be initiated by a qualified party including a family member, peace officer, probation, licensed treatment provider or others as identified in W&I code 5346(b) 2. The LMHP reviews the available treatment history, conducts an assessment, and develops treatment plans. If appropriate, the referred individual will receive comprehensive services from the ACT Team. No MHSA funds will be used for law enforcement or court staff.

Nevada County values consumer choice and individual responsibility, and will not discriminate enrollment in this full service partnership based on legal status. Individuals who are conserved, on probation, on parole, or committed under AOT will be welcomed into the voluntary array of services provided by the ACT Team in an unlocked setting.

B) *CSS Category*: General System Development

1) **Expand Network Provider**
   Expands network provider service capacity, increases access and broadens services throughout the County.
2) **Expand Adult and Children's Behavioral Health & Psychiatric Services**
   Including vocational training, activity groups, flexible funds to support and engage clients in treatment, and a focus on increasing clinical capacity to treat ages 0 – 5.
3) **Expand Crisis and Mobile Crisis Intervention Services**, including:
   - Crisis services at the Crisis Stabilization Unit (CSU), available 24/7; provides direct crisis intervention services to program participants by phone and via face-to-face evaluations

- Peer-centered adult Respite Center where guests seeking relief from symptom distress are treated as equals on their path to recovery

4) **Emergency Department Outreach and Engagement**, including:
On-call crisis peer support to individuals in crisis in the Emergency Department or Crisis Stabilization Unit, including follow-up calls for additional support and linkage to services
5) **Intensive Services for Youth**
Specialty mental health services for children and families with specific focus on children at risk of removal from their homes or in congregate care and pre and post adoptive families
6) **Alternative Early Intervention for Youth and Young Adults**
Flexible, alternative treatment for youth and transition age youth including nature-based therapy
7) **Family Education and Support**
Education and support program that includes community system navigation for families of those with mental illness
8) **Tahoe/Truckee Case Management**
Personal services coordination and case management to Tahoe/Truckee Medi-Cal eligible persons who have a mental illness.
9) **Project Based Housing**
Allows for lease or purchase of housing units for individuals with serious mental illness, including purchase of house/units, development, renovation and/or construction (including feasibility studies, environmental reviews, etc)

C) *CSS Category*: Outreach and Engagement

1) **Expanded Mental Health Services in North San Juan**
Expand mental health treatment, case management, and outreach and engagement services in underserved area of North San Juan
2) **Case Management and Therapy for Homeless Individuals with Mental Illness**
Embedded case manager and therapist at Hospitality House to assist clients in meeting their expressed mental health-related goals, including assistance with medication management and housing
3) **Forensic Liaison**
Forensic Liaison aims to prevent & decrease law enforcement contact and incarceration for individuals experiencing mental health conditions
4) **Veterans' Services & Therapy**
Provides mental health services and therapy for veterans locally
5) **Adult Wellness Center and Peer Support Training**
Adult peer wellness center that offers individual peer support, weekly support groups, referrals to community services, peer support training and certification, and WRAP (Wellness Recovery Action Plan);
6) **Housing and Supportive Services to the Severely Mentally Ill Homeless**
Provides housing and supportive services for homeless individuals with mental illness and assists them with rental applications, lease agreements, and general living skills to maintain their housing

D) Program Expenditures

Expenditures for this work plan may include all expenditures identified in the Original Three-Year Plan (for FY 2005/2006 through 2007/2008), subsequent Annual Updates and Three-Year Plans, and items on the MHSA Needs Assessment FY 2020 - 2023 document, including but not limited to: staffing and professional services, operating expenses, office supplies, travel and transportation, client vouchers and stabilization funding to meet other client expenses needs based on the "whatever it takes" MHSA approach for FSP clients, translation and interpreter services, rent, utilities and equipment, medications and medical support, telepsychiatry equipment, office furniture, capital purchases, training and education, food, client incentives, and the cost of improving the functionality of information systems used to collect and report client information. Capital purchases may include the cost of vehicles, costs of equipping employees with all necessary technology (cellular telephones, computer hardware and software, etc), the cost of enhanced and/or increased space needs related to services, and other expenses associated with the services in this plan.

E) Future Programs

The expansion of services in the future may include any other activities approved in the original CSS Plan or subsequent Annual Updates or the MHSA Needs Assessment FY 2020 - 2023 document, including, but not limited to: Transition Age Youth (TAY) Full Service Partnership or targeted outpatient treatment; homeless outreach, support and engagement services; North San Juan Ridge and Truckee services; enhanced services to court involved families; enhanced jail services for inmates; foster care youth; support for at-risk youth in the school system and/or community; to serve unserved, underserved and inappropriately served populations; consultation with clinics and Primary Care Physicians and other health care providers; contract services; peer support; expansion of Children's System of Care and Adult System of Care, and psychiatric services and/or non-psychiatric Network Provider services.

F) CSS Program Costs and Cost per Person

The estimated cost for CSS programs based on the number of individuals served in FY 20/21 and FY 22/23 plan updates: 1) FSP programs is $2,925,173, 2) General System Development programs is $1,927,791, 3) Outreach and Engagement Programs and activities is $430,873, and 4) Administration cost is $197,817. The estimated total cost is $5,481,654. The average estimated cost per person involved in a CSS activity will be $1,804 ($5,481,654/3,039). We estimate serving during a given year 294 children, 406 TAY, 1,302 adults, 489 older adults and 548 individuals' ages may not be known.

Age	# Served in FSP	% of Total	Est. FSP cost/age	# Served in GSD	% of Total	Est. GSD cost/age	# Served in O&E	% of Total	Est. O&E cost/age
Unknown Age	0	0%	$0	28	2%	$31,585	520	48%	$204,990
Children	101	43%	$1,249,421	191	11%	$215,001	2	0.2%	$788
TAY	58	24%	$714,659	315	18%	$355,778	33	3%	$13,009
Adults	51	21%	$628,407	893	52%	$1,007,324	358	33%	$141,128
Older Adults	27	11%	$332,686	282	17%	$318,102	180	16%	$70,958
Total	237	100%	$2,925,173	1,709	100%	$1,927,791	1,093	100%	$430,873

G) CSS Administration

MHSA CSS Administration funding is used to sustain the costs associated with the intensive amount of administration support required to ensure ongoing community planning, implementation, monitoring and evaluation of the CSS programs and activities. The expenditures within the administration budget are recurring in nature. All administrative cost in the original CSS plan and subsequent Updates are applicable expenses.

Besides the MHSA Coordinator, the Administration costs includes other staff to support the CSS Programs. Supportive staff includes, but is not limited to: the Behavioral Health Director, Adult, Children's and Drug and Alcohol Program Managers, Behavioral Health Adult and Children Supervisors, Behavioral Health Workers, Behavioral Health Technicians, Analyst, Administrative Assistant, Administrative Services Officer, and the Accounting Technician. All of the above staff are involved in the community planning, implementation, and/or monitoring and evaluation of the MHSA programs and activities.

Operating expenditures tend to increase yearly and are based on prior year actual expenses. The increases are due to increase in staff, contractors and program activities. Expenses may include, but are not limited to: contract administration and management, office supplies, office furniture, other operating expenses, capital purchases, training and education, food, incentives, the cost of improving the functionality of information systems used to collect and report program participant and program information.

County Allocated Administration is also a covered expense and is increasing due to the increase in staff working on MHSA projects and programs. Countywide Administration (A-87) expenditures are based on a formula prepared annually by the County Auditor based on the activities for the prior year.

Lastly, it is anticipated that the MHSA CSS programs will generate new Medi-Cal revenues. These funds will be used to help cover the costs to administer the MHSA CSS Programs.

Prevention and Early Intervention (PEI)

SB 1004:
SB 1004 was passed in 2019 and established new priorities for Prevention and Early Intervention (PEI) funds. These priorities include:

1) Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.
2) Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan.
3) Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.
4) Culturally competent and linguistically appropriate prevention and intervention.
5) Strategies targeting the mental health needs of older adults.

Nevada County PEI programs address all of the priorities established by SB 1004, as identified in the PEI section below.

A) *PEI Category*: Early Intervention

Early Intervention programs aim to address and promote recovery and improved outcomes for a mental illness early in its emergence, including diminishing the negative effects that may result from untreated mental illness. Early Intervention services will be provided for those with any mental illness for which short-term therapy and case management is appropriate and that the program has the capacity to treat, including depression, anxiety, suicidality, and bipolar disorder.

1) Program Name: Bilingual Therapy

a. Target Population:

i. **Demographics:** Spanish speaking individuals; services will be provided to all age groups, gender and sexual orientation. Services are provided in Eastern and Western Nevada County.

ii. **How each participant's early onset of mental illness will be determined:** All referred individuals and families are assessed and a treatment plan is created. Part of the assessment will be to ask the individual or their family members when the mental illness began.

iii. **SB 1004:** Culturally competent and linguistically appropriate prevention and intervention

b. Program Description:

The LatinX population in Nevada County is growing, though there is a challenge in accessing Spanish-speaking mental health resources. This challenge stems from a variety of reasons including: not enough professionals who speak Spanish, lack of transportation, and stigma about reaching out for help with mental health issues.

Nevada County will serve the LatinX population by hiring and/or contracting bi-lingual therapists who take referrals from the Family Resource Centers (FRC), the local Promotoras Programs, schools, the Woman Infant Child (WIC) Program and other community based services providers that serve the LatinX population. The therapists provide early, short term intervention therapy with individuals whose mental illness has recently manifested or where treatment will decrease the negative effects of the illness. Additionally, therapist(s) will collaborate and work

with community based Promotoras to consult one-on-one about individuals, to create psycho-education material, and attend psycho-educational groups. This therapy occurs at the Behavioral Health Department, at the Family Resource Centers, schools, or at a location in the community that the individual chooses. Nevada County is a small county and has a very limited number of Spanish speaking therapists. Promotoras bring new program participants into the Nevada County Behavioral Health office and do a warm handoff to the therapist for the individual's first appointment. Having any access to a Spanish-speaking therapist enhances and improves the outcomes for this population.

Because the program sees all age groups and each person may have different needs, any one or several of the seven negative outcomes may be affected: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness and removal of children from the home. It is anticipated that for adults Basis-24 and CANS for children and youth will be utilized to evaluate the reduction of prolonged suffering. The mental health indicator that will be used will be determined by the program participant and their specific goals and treatment plan. Spanish speaking therapists administer the evaluation and evaluation forms are available in Spanish.

c. **How program helps to Improve Access to Services for Underserved Populations:** The individuals in this program may not be eligible and/or cannot access other programs because they do not have health insurance, are not legal immigrants, do not trust other organizations, their mental health issues are preventing them from accessing care, etc. The program is improving access to services by outreaching to the underserved and connecting to these individuals' natural community support systems.

d. **How program is Non-Stigmatizing and Non-Discriminatory:** The warm handoff process between the Promotoras and Nevada County Behavioral Health intends to reduce the stigma of mental health services. Evaluation forms are provided in English and Spanish.

e. **Estimate Number Served Per Year:** 74 individuals

f. **Estimated Cost Per Person:** $265.58 ($19,653.00/74 individuals) per program participant

g. **Program delivered by:** In FY 22/23, program services are anticipated to be provided by Nevada County Behavioral Health

2) Program Name: Perinatal Depression Program

a. **Target Population:**
   i. **Demographics:** Pregnant and postpartum women experiencing perinatal depression who are involved in a home visiting program
   ii. **How each participant's early onset of mental illness will be determined:** All referred individuals and families are assessed and a treatment plan is created. Part of the assessment will be to ask the individual or their family members when the mental illness began.
   iii. **SB 1004:** Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan

b. **Program Description:**

Perinatal depression cases go undetected in approximately 50% of cases, and women suffer in silence. In addition to the effects of depression on the mother, maternal depression can have serious negative impacts on the well-being, health, and development of their young children. These include: delayed development of the child, a predisposing factor for child abuse; poor health outcomes; potential for school entry problems; increased childhood anxiety; and conduct problems & hyperactive symptoms.

Moving Beyond Depression is an evidence-based program provides in-home Cognitive Behavioral therapy to program participants. Providing treatment to the women in their home environment eliminates most barriers to accessing treatment, enhances the positive benefits of a home visitation program, and, thereby, enhances the overall well-being of their children. The majority of referrals come through Healthy Babies, the main home visiting program in Nevada County.

This program will likely have long-term impacts on any one or several of the seven negative outcomes, but will specifically impact: suicide, prolonged suffering, and removal of children from the home.

The evaluations at a minimum will be done at the beginning of therapy and at program exit. Spanish and English speaking therapists administer the evaluation. Evaluation forms are offered in Spanish and English. Program participants are offered the option of filling out the evaluation themselves or with available assistance. Progress is measured through the evidence-based Edinburg Perinatal Depression Screen as well as the Interpersonal Support Evaluation List (ISEL) tool.

c. **How program helps to Improve Access to Services for Underserved Populations:** The program is improving access to services by out stationing services and outreaching to the underserved by connecting to these individual's natural community support systems and working with these support systems to build trust.

d. **How program is Non-Stigmatizing and Non-Discriminatory:** Healthy Baby home visitors are paired, when possible, with clients who are similar culturally, including bilingual and bicultural Spanish staff. Monolingual Spanish-speaking participants may also be referred to the County's Bilingual Therapy program. The Behavioral Health Department is training community partners to increase and improve their knowledge, skills and attitudes around mental illness, so that community members will refer individuals to treatment services. Evaluation forms are provided in Spanish and English.

e. **Estimate Number Served Per Year:** 36 individuals

f. **Estimated Cost Per Person:** $1,000.00 ($36,000/36 individuals) per program participant

g. **Program delivered by:** In FY 22/23, program services are anticipated to be provided by Nevada County Public Health.

3) Program Name: Early Intervention for Youth in Crisis (Eastern County Only)

a. **Target Population:**
   i. **Demographics:** Youth in crisis with early onset symptoms of mental illness, and their families, in Eastern Nevada County
   ii. **How each participant's early onset of mental illness will be determined:** All referred individuals and families are assessed and a treatment plan is created. Part of the assessment will be to ask the individual or their family members when the mental illness began.
   iii. **SB 1004:** Childhood trauma prevention and early intervention to deal with the early origins of mental health needs

b. **Program Description:**

Youth in crisis in Eastern Nevada County are in need of more intensive support, particularly those who may not qualify for County Behavioral Health services (i.e. private insurance holders). Crises may result in a 5150 psychiatric assessment and/or hospitalization. Historically, after such crises, families who are ineligible for County services often wait weeks for follow-up support services. The Early Intervention for Youth in Crisis program will provide short-term

(roughly 90 days) individual and family counseling support while helping families get connected to longer term mental health services.

This program will impact the following negative outcomes: suicide, incarceration, school failure or dropout, prolonged suffering, homelessness, and removal of children from the home. It is anticipated that the Youth Outcomes Questionnaire Self Report (YO-QSR) and Perception of Care survey will be utilized to evaluate the reduction of prolonged suffering, however, if appropriate other instruments or evaluation tools may be used. The mental health indicator that will be used will be determined by the program participant and their specific goals and treatment plan.

The evaluations at a minimum will be done at the beginning of the program and at program exit. Evaluation forms are offered in Spanish and English. Program participants are offered the option of filling out the evaluation themselves or with available assistance.

c. **How program helps to Improve Access to Services for Underserved Populations:** The program is improving access to services by supporting youth in a region with limited mental health providers.
d. **How program is Non-Stigmatizing and Non-Discriminatory:** This program focuses more on relationship-building than clinical approaches, which can help with some of the stigma especially with youth around mental illness. The Behavioral Health Department is training community partners to increase and improve their knowledge, skills and attitudes around mental illness, so that community members will refer individuals to treatment services. Evaluation forms are provided in Spanish and English.
e. **Estimate Number Served Per Year:** 19 individuals
f. **Estimated Cost Per Person:** $662.21 ($12,582/19 individuals) per program participant
g. **Program delivered by:** In FY 22/23, program services are anticipated to be provided by Gateway Mountain Center.

B) *PEI Category*: Access and Linkage to Treatment

Access and Linkage to Treatment Programs aim to reduce risk factors for developing a potentially serious mental illness and to build protective factors.

1) Program Name: Homeless Outreach

a. **Target Population:**
   i. **Demographics:** Individuals experiencing homelessness of any age, sex or ethnicity.
   ii. **How each participant's early onset of mental illness will be determined:** All referred individuals and families are assessed and a treatment plan is created. Part of the assessment will be to ask the individual or their family members when the mental illness began.
   iii. **SB 1004:** Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan
b. **Program Description:**

In the January 2019 Homeless Point-in-Time Count, 410 individuals experiencing homelessness were counted in Nevada County living in tents or different temporary shelters in the woods, in emergency shelters, or in locations not fit for human habitation. Of the 410 homeless individuals, 21% identified themselves as having a serious mental illness, and 34% were experiencing chronic or long-time homelessness. Additionally, many of the homeless are people who mistrust government and government services.

Through the Homeless Outreach program, outreach workers will conduct outreach and engagement services, assessments, and referrals to individuals experiencing homelessness. Services will be provided at emergency shelters, transitional housing facilities, community-based organizations, out in the woods where the homeless are located, and to support the homeless once they are housed. This program may impact all of the seven negative outcomes: suicide, incarceration, unemployment, school failure or dropout, prolonged suffering, homelessness, and removal of children from the home. The primary goal of the Homeless Outreach program will be to identify individuals in need of mental health services, make referrals to treatment and case management services, and support individuals in securing housing.

CSS and/or PEI funds may also be used to support the implementation of No Place Like Home Program (NPLH). Support may include: planning, outreach and engagement, implementation, evaluation, and reporting out on outcomes.

c. **How program helps to Improve Access to Services for Underserved Populations:** This program will meet individuals where they are at and will provide field-based services to serve individuals who are typically underserved and disconnected from traditional mental health services.
d. **How program is Non-Stigmatizing and Non-Discriminatory:** The Behavioral Health Department is training community partners to increase and improve their knowledge, skills and attitudes around mental illness, so that community members will refer homeless individuals to treatment services. Evaluation forms are available in both English and Spanish.
e. **Estimate Number Served Per Year:** 79 individuals
f. **Estimated Cost Per Person:** $1,043.63 ($82,447/79 individuals) per program participant
g. **Program delivered by:** In FY 22/23, program services are anticipated to be provided by AMI Housing and Bright Futures for Youth.

2) Program Name: Senior, Disabled and Isolated Outreach Program

a. **Target Population:** Individuals that are homebound due to age and/or disability
    i. **SB 1004:** Strategies targeting the mental health needs of older adults
b. **Program Description:** The Senior, Disabled and Isolated Outreach program contains two main programs:

The Friendly Visitor program trains senior or older adult volunteers to visit homebound or isolated older adults or disabled adults. The program aims to reduce the loneliness and isolation of program participants, and to reduce the likelihood of resulting mental health issues such as depression. Each volunteer is assigned a program participant and visits program participants in person and/or by phone on a regular basis. Evaluations will be performed at program entry and annually and/or at program exit. The Program Manager and program volunteers are trained in recognizing the signs and symptoms of mental health conditions, how to make a secured referral, and to support the program participant with referred services. All referred program participants will be screened for depression. The Program Manager or volunteer will refer individuals that screen high on the depression screening tool to the Social Outreach nurse/social worker, their primary care physician, or a mental health professional. Certain participants will also be eligible for the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS), an evidence-based intervention model through the University of Washington Health Promotion Center for individuals with late life depression.

The Social Outreach program utilizes Social Workers or Nurses who visit homebound individuals and utilizes a depression screening tool along with other physical health and fall

prevention screening tools. The Social Outreach Worker makes referrals to mental health treatment for those who screen above a certain level on the depression screening tool.

c. **How program helps to Improve Access to Services for Underserved Populations:** This program will provide in-home services to populations who are underserved due to their isolation in being largely home-bound due to their age or disability.
d. **How program is Non-Stigmatizing and Non-Discriminatory:** Volunteers will be matched with program participants based on common traits, activities, personality and culture.
e. **Estimate Number Served Per Year:** 201 individuals
f. **Estimated Cost per Person:** $587.57 ($118,102/201 individuals) per program participant
g. **Program Delivered By:** In FY 22/23, program services are anticipated to be provided by FREED and Sierra Nevada Memorial Foundation.

3) Program Name: Mental Health Screening in High Schools

a. **Target Population:** 9th and 10th graders in Nevada County
    i. **SB 1004:** Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs
b. **Program Description:** This program implements in-school mental health screenings and supports for high schoolers. The screening is offered to all Nevada County high school students enrolled at Nevada Joint Union High School District and Tahoe Truckee Unified School District, contingent on a signed permission slip. The evidence-based screening tool include Columbia Teen Screen protocols and the Diagnostic Predictive Scales, and screens for depression, suicide risk, anxiety, and other emerging mental health challenges.

    Students who screen as high-risk receive in-depth clinical interviews to assess the need for further evaluation or treatment, and will be offered case management services. The program will also offer prevention group meetings at participating high schools.
c. **How program helps to Improve Access to Services for Underserved Populations:** This program will help detect students who are not receiving adequate or necessary mental health care through its universal screening methodology.
d. **How program is Non-Stigmatizing and Non-Discriminatory:** Program staff will address the higher needs of underserved populations including LGBTQIA+, homeless, and Spanish-speaking youth and their families. Staff will participate in trainings on best practices for culturally appropriate interventions as well as consult with local specialized service providers on how to best serve these populations.
e. **Estimate Number Served Per Year:** 263 individuals
f. **Estimated Cost per Person:** $711.13 ($187,027/263 individuals) per program participant
g. **Program Delivered By:** In FY 22/23, program services are anticipated to be provided by What's Up? Wellness Checks.

C) *PEI Category*: Outreach for Increasing Recognition of Early Signs of Mental Illness

Outreach for Increasing Recognition of Early Signs of Mental Illness Programs engage and educate the community about ways to recognize and respond to early signs of mental illness.

1) Program Name: Community Mental Health and Crisis Training

a. **Program Description:** There is a strong need for increased community awareness about mental illness. This includes identifying the signs of mental illness, and how to help someone who is in crisis or is struggling with their mental illness. Virtually any member of the community would be appropriate to receive this type of training, including but not limited to family members, consumers, service providers, school personnel, safety officers, emergency personnel, property managers/landlords, community volunteers, and court personnel. Trainings are typically provided within the community depending on the target audience (e.g., in churches, schools, community centers, etc.)

Nevada County provides community mental health and crisis trainings to the community. Evidence based or community proven training will be provided to interested community members, including but not limited to Mental Health First Aid, Youth Mental Health First Aid, and Teen Mental Health First Aid. Training recipients may interact with or respond to an individual in crisis in their home, on the streets, at school, on the job, at church, etc.

Outreach and engagement of potential participants will be tailored to the specific audiences of the training. For example, outreach may be performed at local schools and churches for trainings such as Mental Health First Aid.

SB 1004: Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan

b. **How program helps to Improve Access to Services for Underserved Populations:** By expanding the pool of trained community members, this program improves access to a wider population of individuals with mental illnesses, including unserved and underserved populations.
c. **How program is Non-Stigmatizing and Non-Discriminatory:** Whenever possible, the program will provide trainers that come from the group being trained. The program will also involve consumers and family members whenever possible. The program has trained Promotoras who can work with the Latino population that they serve.
d. **Estimate Number Served per Year:** 89individuals per year
e. **Estimated Cost per Person:** $306.11 (27,244/89 individuals) per program participant
f. **Program Delivered By:** In FY 22/23, program services are anticipated to be provided by What's Up? Wellness Checks – Mental Health First Aid (MHFA) trainings.

D) *PEI Category*: Prevention

Prevention Programs aim to reduce risk factors for developing a potentially serious mental illness and to build protective factors.

1) Program Name: Youth Mentoring

a. **Target Population:** Youth of all races, ethnicities, genders, and sexual orientations
    i. **SB 1004:** Childhood trauma prevention and early intervention to deal with the early origins of mental health needs
b. **Program Description:** The community has expressed concerned about children who have a number of risk factors and do not have an adult in their life that can help to build protective factors. The school based mentoring programs specifically connect older teens to mentor younger children in their school. Youth who are at-risk of failing or falling behind in school will be referred to the mentoring program by a parent, teacher, school counselor or community member. Mentors are provided training on the signs and symptoms of mental health illness. When a mentee is not responding to the mentoring relationship, the youth is assessed and if needed, a referral is made to a community based or community service provider. Mentoring

services are provided in the school setting, where mentees feel safe and mentors can access school personnel if needed.

c. **How program is Non-Stigmatizing and Non-Discriminatory:** Teen mentors and the mentoring coordinators receive training in mental health issues, and services are provided in a school setting.
d. **Estimate Number Served Per Year:** 111 individuals
e. **Estimated Cost per Person:** $495.68 ($55,020/111 individuals) per program participant
f. **Program Delivered By:** In FY 22/23, program services are anticipated to be provided by Big Brothers Big Sisters and Boys & Girls Club of North Lake Tahoe.

2) Program Name: Youth Wellness Center (Eastern County Only)

a. **Target Population:** Individuals in high school in the Tahoe Truckee area with mental health conditions and/or emerging mental health issues. These Wellness Centers are open to all individuals regardless of race/ethnicity, gender, or sexual orientation.
    i. **SB 1004:** Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs
b. **Program Description:** Individuals with mental health conditions or emerging mental health conditions need a place they feel safe and can learn skills to cope with their unique challenges. Wellness Centers empower individuals by giving them a voice in decisions around creating their own well-being and developing sustainable wellness practices for life. Wellness Centers serve as a hub for individuals to talk to other caring people, connect to community resources, and learn new skills to develop sustainable wellness practices. The Wellness Centers see individuals of all ages and their families; each person may have different needs, so any one or several of the seven negative outcomes may be affected: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness and removal of children from the home. The Youth Wellness Center Liaison, adult volunteers and Youth Peer Mentors are trained in recognizing the signs and symptoms of mental health conditions, how to make a secured referral, and to support the program participant follow-up with referred services. The Youth Wellness Centers are located at schools, where students can easily access services and participate in program activities.
c. **How program is Non-Stigmatizing and Non-Discriminatory:** Services are provided on-site at school rather than at a mental health office. The Wellness Centers also utilizes Youth Peer Mentors throughout its programming.
d. **Estimate Number Served Per Year:** 192 individuals
e. **Estimated Cost per Person:** $628.67 ($120,704/192 individuals) per program participant
f. **Program Delivered By:** In FY 22/23, program services are anticipated to be provided by Tahoe Truckee Unified School District.

3) Program Name: Family Support/Parenting Classes (Eastern County Only)

a. **Target Population:** Families in need of additional knowledge and support around parenting their children in Eastern Nevada County
    i. **SB 1004**: Childhood trauma prevention and early intervention to deal with the early origins of mental health needs
b. **Program Description:** Families face significant stressors in the Tahoe/Truckee region, including isolation, tourism-dependent employment, high cost of living and limited resources. Free programs for families and parents are particularly scarce. In order to strengthen

protective factors in local families, this program will provide play groups, support groups and classes aimed at decreasing family isolation, fostering development of peer networks and building skills and confidence in parents. Offerings are responsive to community need and may include Parent Project®, Loving Solutions®, The Incredible Years, Parent Café, Family Room and other programs. For many families, these classes provide a first point of contact to the broader continuum of care as class facilitators provide referrals and information to assist families with accessing healthcare enrollment, mental health services, childcare resources, and other systems navigation services. Programs like Family Room and Mom's Café promote the development of peer networks and support. Additionally, these programs utilize strategies that foster knowledge of child development, which is a protective factor against child abuse.

In addition to supporting positive parenting and decreasing family isolation and stress, program facilitators will educate parents about mental health issues including the high incidence of Perinatal or Post-Partum Mood and Anxiety Disorders PMAD) and promote the development of peer supports. This approach serves to decrease the stigma around mental health issues by increasing awareness. Additionally, parents learn strategies for dealing with stress and where to access help when they need it. Staff will be ready to share with participants information about resources and refer them to available services when they express needs in relation to safety, mental and behavioral health.

c. **How program is Non-Stigmatizing and Non-Discriminatory:** Programs will be offered free of cost to families and will aim to destigmatize mental illness. Program participants' culture, language, and religious preferences will be considered and incorporated where appropriate.
d. **Estimate Number Served Per Year:** 90 individuals
e. **Estimated Cost per Person:** $687.66 ($61,889/90 individuals) per program participant
f. **Program Delivered By:** In FY 22/23, program services are anticipated to be provided by Sierra Community House.

4) Program Name: Community Crisis Response

a. **Target Population:** Anyone in Nevada County who has experienced a crisis or traumatic event
    i. **SB 1004**: Childhood trauma prevention and early intervention to deal with the early origins of mental health needs; Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan.
b. **Program Description:** This program follows the NOVA (National Organization for Victim Assistance) Crisis Response Team model, which provides disaster relief in the form of crisis response. The goal is to assist victims and survivors to understand and normalize their reactions and allow them to begin their physical and emotional recovery. Examples of incidents that the NOVA model can be applied to include suicide, wildfires and other natural disasters, accidents, overdose deaths, and mass casualties. Individuals trained in the NOVA model will coordinate with appropriate officials to offer direct services through individual and group crisis intervention sessions, as well as providing companionship and assistance for victims or survivors.
c. **How program is Non-Stigmatizing and Non-Discriminatory:** Programs will be offered free of cost to individuals in need. Individuals will be offered support voluntarily, and will never be required to participate in services. Program participants' culture, language, and religious preferences will be considered and incorporated.
d. **Estimate Number Served Per Year:** 100

e. **Estimated Cost per Person:** $250 ($25,000/100 individuals) per program participant
f. **Program Delivered By:** Program services are anticipated to be provided by Nevada County Behavioral Health.

5) Program Name: LGBTQ+ Support

a. **Target Population:** LGBTQ+ young adults
    i. **SB 1004**: Childhood trauma prevention and early intervention to deal with the early origins of mental health needs
b. **Program Description:** This program focuses on providing support to LGBTQ youth in high schools. There are various levels of support at the different high schools in Nevada County, and this program aims to provide more consistency across schools as well as a model for long term sustainability of programming. School staff are stretched thin and do not have capacity to facilitate extracurricular support groups such as Gay Straight Alliances or LGBTQ+ Peer Support groups. This program will provide facilitation support and create peer-led support structures for LGBTQ+ youth in local high schools. Services will be provided on site wherever possible, and will create space for young adults to meet, share experiences, offer and receive help, and learn about related issues, including mental health and suicide prevention resources.
c. **How program is Non-Stigmatizing and Non-Discriminatory:** Programs will be offered free of cost to individuals in need. Programs will emphasize peer leadership. Program participants' culture, language, and religious preferences will be considered and incorporated.
d. **Estimate Number Served Per Year:** 50
e. **Estimated Cost per Person:** $1,600 ($80,000/50 individuals) per program participant
Program Delivered By: A provider is still being finalized but will involve partnership with the schools.

E) *PEI Category*: Stigma Reduction and Discrimination Reduction

1) Program Name: LatinX Outreach

a. **Target Population:** LatinX population in Nevada County
    i. **SB 1004:** Culturally competent and linguistically appropriate prevention and intervention
b. **Program Description:** Nevada County will serve the Latinx population by expanding existing "Promotoras" programs in the Truckee and Grass Valley areas. Traditionally, Promotoras are "community health workers" who usually share ethnicity, language, socioeconomic status, and/or life experiences with the community members they serve. Promotoras in Nevada County are Spanish-speaking bi-cultural and/or bilingual paraprofessionals who help LatinX families connect to resources in the community. Promotoras offer interpretation and translation services, provide culturally appropriate physical health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, and advocate for individuals and community health needs. The BHD funds the Promotoras to expand the services they provide to include mental health education, support and advocacy. The Promotoras conduct outreach and conduct psycho-educational groups for LatinX families in Spanish about mental health care. Psycho-education groups will educate people about mental health issues to decrease stigma about reaching out for help for mental health issues. By decreasing stigma about mental health conditions the program will promote, maintain, and improve individual and community mental health. Childcare may be offered at mental health education classes. In the LatinX Outreach Project, the Promotoras link

individuals and families that they serve to needed services in the community which includes mental health services and when necessary accompany individuals to their first appointment for a warm handoff to the mental health professional. In Eastern Nevada County, this program will also include the Family Support Advocate who will support LatinX adults receiving behavioral health services.

In Eastern Nevada County, the LatinX Youth and Transitional Youth Leadership Development will recruit, train, and support youth to provide peer counseling, including certification in mindfulness-based substance abuse treatment.

c. **Estimate Number Served Per Year:** 310 individuals
d. **Estimated Cost per Person:** $510.27 ($158,184/310 individuals) per program participant
e. **Program Delivered By:** In FY 22/23, program services are anticipated to be provided by Sierra Community House, Nevada County Superintendent of Schools (PARTNERS Family Resource Center), and Gateway Mountain Center.

2) Program Name: Youth Empowerment (Eastern County Only)

a. **Target Population:** Youth in Eastern Nevada County ages 9 - 18
    i. **SB 1004:** Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.
b. **Program Description:** Empowerment Groups will be offered to students to enhance a variety of skills and opportunities. Topics for these groups include creating positive environments and communities, promoting healthy friendships, relationships and choices, increasing positive self-worth, engaging and empowering youth to speak out and model healthy lifestyles, and increasing the understanding of mental health stigma and how to support others and seek help. Empowerment groups will help individuals identify personal strengths and supportive resources, and develop new ways of thinking and addressing challenges-both internal and external. Facilitators will build rapport with youth, and provide the space and opportunity for students to open up through discussion, activities, writing and art. Multiple curricula are used, depending on the topic needs and focus of the specific group including Young Men's Work and Young Women's Lives.
c. **Estimate Number Served Per Year:** 27 individuals
d. **Estimated Cost per Person:** $438.93 ($11,851/27 individuals) per program participant
e. **Program Delivered By:** In FY 22/23, program services are anticipated to be provided by Sierra Community House.

F) *PEI Category*: Suicide Prevention

1) Program Name: Suicide Prevention and Intervention Program

a. **Program Description:** The Suicide Prevention Coordinator's goal is to help create a more "suicide aware" community by 1) Raising awareness that suicide is preventable; 2) Reducing stigma around suicide and mental illness; 3) Promoting help-seeking behaviors; and 4) Implementing suicide prevention & intervention training programs. The Suicide Prevention Coordinator will implement various evidence-based curriculum which may include Living Works, Know the Signs, and ASIST to build community capacity and provide linkage to services. The coordinator conducts outreach, capacity-building activities and trainings in the schools, in faith based organizations, business community, county offices, public health sites, city offices and others that request the assistance. The Behavioral Health Department will also

provide support as needed in the event of a crisis in the community. Lastly, this program will provide suicide prevention services as needed and appropriate in the Tahoe Truckee region. **SB 1004:** Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan

b. **Estimated Number Served Per Year:** 585 individuals
c. **Estimated Cost per Person:** $352.21 ($176,103/585 individuals) per program participant
d. **Program Delivered By:** In FY 21/22, program services are anticipated to be provided by Nevada County Public Health, Nevada County Behavioral Health, and Sierra Community House.

G) *PEI Assigned Funds –CALMHSA*

California Mental Health Services Authority (CalMHSA)

California Mental Health Services Authority (CalMHSA) is a Joint Powers of Authority who implements statewide Prevention and Early Intervention services under the Mental Health Services Act. Some of the statewide strategies CalMHSA implements include stigma reduction (including the Each Mind Matters and Know the Signs campaigns), creating and distributing outreach materials, building capacities of schools to address mental health, contribution to regional suicide prevention hotline, and technical assistance and research for counties. Nevada County's assignment of funds to CalMHSA also contributes to the North Valley Suicide Prevention Hotline, which is a regional call center operated out of Yolo County for calls to the National Suicide Prevention Hotline. In FY 21/22, Nevada County estimates to assign $27,250 to CalMHSA.

H) *PEI Funding Expenditures*

PEI funding for all programs listed above may be used to fund expenditures for all expenditures identified in the Original Three-Year Plan and the subsequent Annual Updates, or for activities listed in the MHSA Needs Assessment FY 2020 - 2023 document, including but not limited to: staffing, professional services, stipends, operating expenses (office supplies, travel and transportation, program participant vouchers, translation and interpreter services, rent, utilities and equipment, etc.), tele/video psychiatry equipment, office furniture, capital purchases, training and education, food and incentives for meetings, and the cost of improving the functionality of information systems used to collect and report program participant information. Capital purchases for staff and contractors may include the cost of vehicles, the cost of equipping new employees or contractors with all necessary technology (cellular telephones, computer hardware and software, projectors, etc.), the cost of enhanced and/or increased space needs related to services and other expenses associated with activities in this plan.

I) *PEI Program Costs and Cost per Person*

The estimated cost for 1) Early Intervention programs is $68,235, 2) Access and Linkage programs is $387,576, 3) Prevention programs is $342,613, 4) Outreach is $27,244, 5) Stigma and Discrimination Programs is $170,035, 6) Suicide Prevention Program is $188,676, 7) PEI Assigned Funds is $27,250, and 8) Administration $148,227. The estimated total PEI program costs are $ $1,359,856. Using an estimate number based partially on the number of individuals served in FY 20/21, it is estimated that PEI programs will serve 5,127 individuals, and that the average cost per person involved in a PEI activity will be $265 ($1,359,856/5,127).

Note: These are only estimates and the actual cost by program and number served may change.

J) *PEI Future Funded Activities*

The expansion of services in the future may include any other activities approved in the original PEI Plan or subsequent Annual Updates or the MHSA Recommendations of Needed Mental Health Services FY 2017-2020 document, including, but not limited to: additional Latino outreach; additional homeless outreach, homeless housing support services; early intervention and prevention services; additional services to seniors; additional or enhanced services to court involved families; juvenile wards at juvenile hall and Foster Care children; services on the San Juan Ridge and Truckee; additional or enhanced jail services for inmates within six months of their release; additional support for at-risk children and youth; additional peer support; additional contract services; consultation to primary care clinics; additional Children's System of Care (CSOC) and Adult System of Care (ASOC) services; and psychiatric services.

K) *MHSA PEI Administration*

MHSA PEI Administration funding is used to sustain the costs associated with the intensive amount of administration support required to ensure ongoing community planning, implementation, monitoring and evaluation of the PEI programs and activities. The expenditures within the administration budget are recurring in nature. The increases in expenditures are due to expansion of personnel and the associated operating costs assigned and assisting in the delivery of the programs. All administrative cost in the original PEI plan and subsequent Updates are applicable expenses.

The supportive staff dedicated to PEI activities includes, but is not limited to: the Behavioral Health Director, Adult and Children's Program Managers, Behavioral Health Adult and Children Supervisors, Behavioral Health Workers, Behavioral Health Technicians, Analyst, Administrative Assistant, Administrative Services Officer and Accounting Technician. All of the above staff are involved in the community planning, implementation, and/or monitoring and evaluation of the MHSA programs and activities. Yearly, the benefits of assigned staff will be charged to MHSA PEI based on time spent on MHSA activities as outlined above.

Operating expenditures tend to increase yearly and are based on prior year actual expenses. Expenses may include, but are not limited to: office supplies, office furniture, other operating expenses, capital purchases, training and education, food, incentives, the cost of improving the functionality of information systems used to collect and report program participant and program information. This includes funding for the annual Point In Time Count, and any associated planning or evaluation costs. Capital purchases may include the cost of vehicles, costs of equipping new employees with all necessary technology (telephones, computer hardware and software, etc.), the cost of enhanced and/or increased space needs related to services, and other administration expenses associate with the services in this plan.

Administration funds may also be used to pay for training and education expenses for county staff, contractors and community stakeholders including program participants and their family. Training and education cost may include, but is not limited to: travel, food, lodging, airfare, parking, registration fees, incentives, etc. County Allocated Administration is also a covered expense and is increasing due to the increase in staff working on MHSA projects and programs. Countywide Administration (A-87) expenditures are based on a formula prepared annually by the County Auditor based on the activities for the prior year.

Lastly, it is anticipated that the MHSA PEI programs may generate new Medi-Cal revenues. These funds may be used to cover the costs to administer the MHSA PEI Programs.

Innovation (INN)

Nevada County's Innovation Plans were approved in a separate process by the Mental Health Services Oversight and Accountability Commission (MHSOAC). There is one active Innovation plan:

1) *Homeless Outreach and Medical Engagement (HOME) Team*

Project Title: Homeless Outreach and Medical Engagement Team (HOME)
Project Period: Approved by MHSOAC on 2/28/19**;** Project Period: 2019 – 2024

Innovation Project Change – FY 20/21 (effective July 1, 2020):

There have been significant savings of roughly $104,000 annually as compared to the original budgeted line item for the rent/utilities of the master-leased house due to finding a house with lower rent than budgeted.

Additionally, a need has emerged for a formal supervisor for the HOME Team. In the original Innovation plan, and in practice currently, the Behavioral Health Program Manager oversees the program from a high level in terms of strategic planning, data quality, and marketing and communications. However, there is a strong need for frontline supervision of the HOME Team staff related to day-to-day activities, data collection, and supervision. The HOME Team is made up of staff from four different contracted providers, which can create silos and logistical challenges from a supervision standpoint. As a result, we will utilize savings from the master-leased house to fund the salary and benefits of a streamlined and centralized frontline supervisor for the HOME Team.

Currently, the historically PEI-funded homeless outreach worker has informally taken on a supervisory type role of the HOME Team, as this position has a long history of outreach work with this population. Formalizing the position as a supervisory role within the Innovation HOME Team will allow for salary and benefits more aligned with a supervisor position, sufficient training, and roles and responsibilities commiserate with the current demands of the HOME Team to ensure the program's success. Roles and responsibilities of the HOME Team Supervisor will include:

- Coordinate Homeless Outreach Team (HOT) meetings
- Track metrics for HOME Team core staff such as attendance, data entry, reporting deliverables, etc. to report back to contracted agency supervisors
- Assist with data quality and reporting for grant administration and Homeless Management Information System (HMIS)
- Provide regular feedback to contracted agency supervisors about core members' performance and participation
- Design outreach strategy and schedule
- Lead daily HOME morning huddles
- Provide day-to-day direction to staff on outreach areas, activities, etc.
- Collaborate with Behavioral Health leadership on case management transition planning

- Liaison between core members and HOME Leadership Team about what is happening on the ground that needs to be addressed
- Review housing/case plans with Personal Services Coordinators and Substance Use Disorder Counselors weekly

There is no change in the overall budget originally approved by the MHSOAC, nor the intent or scope of the project.

Stakeholders were involved in this project change, and the need to have a centralized HOME Team supervisor was addressed in various stakeholder meetings including the HOME Leadership meetings, Stepping Up Community and internal meetings, Homeless Resource Team meetings, and Homeless Outreach Team meetings. This change was also addressed at the MHSA Community meeting on 9/22/20.

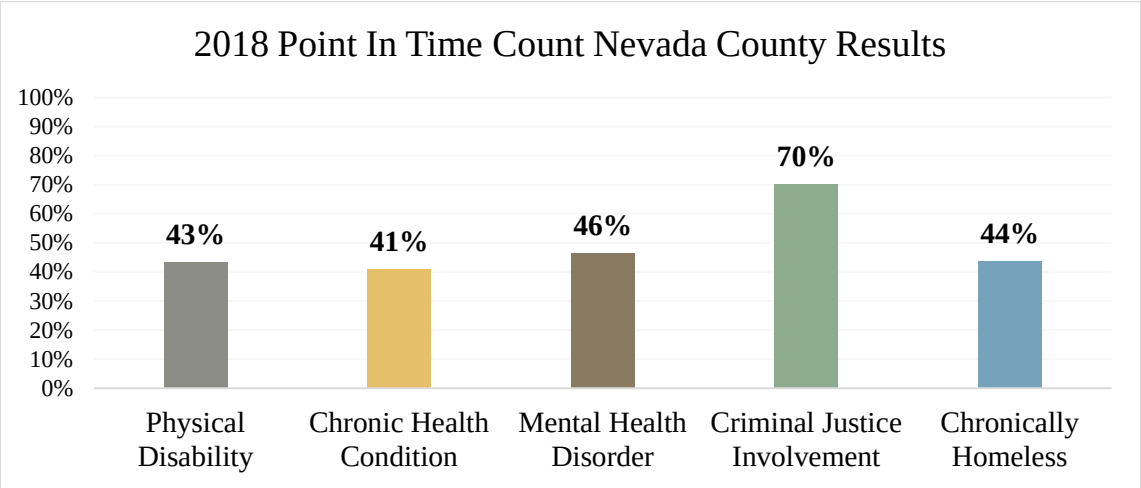
This project makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population. This project increases access to mental health services, including but not limited to, services provided through permanent supportive housing.

PRIMARY PROBLEM
Like many communities in California, homelessness is a significant problem in Nevada County. Perhaps somewhat unique to our community, though, is the proportion of our homeless population who has been unsheltered for more than a year and is considered chronically homeless. We are well above state averages for this group; 44% of people surveyed in our 2018 Point in Time count met the chronically homeless definition versus the state average of 28%. This exposes the urgent need in Nevada County to create programming that is more effective at engaging our most difficult and hard to reach homeless community members.

Throughout our stakeholder process, our community has strongly expressed the desire to focus our Innovation project on those experiencing homelessness in Nevada County. In a rural county which covers over 956 square miles and has minimal public transportation, many of our homeless community members are physically isolated. In addition, a culture of independence and distrust of government permeates our county and adds to the challenges of engaging people in supportive services. Reaching this population is a high priority for the Nevada County Board of Supervisors. The Board has identified the Health and Human Services Agency's plan to address homelessness as a top board priority in early 2018. This plan specifically includes an increased supply of low barrier "Housing First" units within our community and an increased focus on outreach and engagement for people who are difficult to reach.

While we have implemented programs that provide case management services in the community to help identify and link homeless mentally ill individuals to services, we continue to struggle to be effective in reaching our most vulnerable population of chronically homeless people. We have found that these individuals often distrust traditional service delivery models, and are therefore ineligible for certain services and opportunities such as housing that requires engagement with mental health services or sobriety. This distrust has been exacerbated by anti-camping enforcement and camp removals recently implemented in our local incorporated jurisdictions largely in response to wildfire concerns. These actions have increased the level of distrust felt by homeless individuals who are reluctant to engage with Behavioral Health system staff out of fear

of being removed from their camping location or losing their belongings. Meanwhile, the demand from community members and local businesses for assistance with engaging this population continues to increase.



According to our 2018 Point In Time (PIT) Count, 272 people in Nevada County are homeless, although our HMIS system currently identifies over 475 homeless people and anecdotal evidence from service providers puts the estimate even higher. In addition to our high percentage of people who have been homeless for a long time, 41% of those surveyed in our 2018 PIT Count identified as suffering from chronic health conditions, and 43% reported having a physical disability. This high percentage of people self-reporting as having unmet physical health needs illustrates the opportunity for a creative strategy to engage this population in care. Unmet physical health needs often create a barrier to accessing other necessary services such as behavioral health treatment, substance use treatment, and housing. In addition, unaddressed physical health issues and chronic conditions also result in high utilization of emergency and urgent medical care (Behr & Diaz, 2016). Offering to address these physical health and disability issues may be a critical entry point for engaging these individuals in other services.

A second and related defining characteristic of our homeless population in Nevada County is the high degree of criminal justice involvement faced by this population. In our 2018 PIT count, 70% of individuals self-reported having been involved in the criminal justice system. Our county has created a multidisciplinary team of county departments focused on the Stepping Up Initiative, which aims to reduce the number of incarcerated individuals with mental illness, and has also expressed concern about the warm handoff process for this target population as they exit jail. Interrupting this cycle of homelessness and incarceration is a high priority for the county.

Lastly, substance use is a significant challenge for most of our residents who struggle with long-term homelessness. Unfortunately, the vast majority of housing options in our county, including our only local emergency shelter and many of our permanent supportive housing programs, have sobriety requirements that limit access to these resources. A contributing factor to our high

percentage of chronically homeless individuals in Nevada County is our inability to shelter or house much of this population due to their substance use issues.

PROPOSED PROJECT
It is our goal to create an innovative Homeless Outreach and Medical Engagement Team (HOME) that includes a Nurse, Personal Services Coordinator, and Peer Specialist to identify physical health, mental health, and substance use disorder needs in a welcoming and destigmatizing manner. The HOME team will meet with individuals who are experiencing chronic homelessness at locations in the community where they are living. This team will employ strategies directed at the specific needs of Nevada County community members struggling with chronic homelessness. The team will engage people through:

- Providing physical health care services first, which is a less stigmatized form of care than substance use or mental health services
- Embedding a person with lived experience in the team who will be able to address issues of mistrust in this population
- Offering low barrier, housing first options that do not require sobriety or service engagement for entrance
- Creating a close connection with the County jail and law enforcement staff so that people who are arrested or incarcerated are quickly offered services and housing

The first challenge for the HOME team will be to build relationships with chronically homeless individuals who have developed a fear and distrust of service providers. The peer team member will be invaluable in educating the team in the best strategies for engagement and in providing the initial relationship connections with community members. Experience in other communities has demonstrated that embedding medical care within an outreach team is also an effective way to engage homeless individuals (Rosenblum, Nuttbrock, McQuiston, Magura, & Joseph, 2009). The Nurse will be able to both triage critical issues as well as conduct assessments to identify chronic and acute health conditions, including linking the individual to health services and primary care connections. The team will be based out of a van so in addition to being highly mobile, they will be able to transport people to more intensive medical care as needed.

In addition to field-based outreach, the HOME team will also work closely with key partners such as the hospital, homeless shelter, law enforcement, and jail. In order to divert people with mental illness and substance use challenges out of the criminal justice system as quickly as possible, the team will respond to requests from law enforcement and the jail. The team will attempt to engage individuals prior to arrest or incarceration and offer them support and housing instead. They will also collaborate with the existing Forensic Liaison to improve the warm handoff and supportive services available to those who would otherwise exit our jail into homelessness. This engagement is intended to result in a positive and measurable reduction in the cycle of homelessness and incarceration.

The HOME team will be able to make referrals to low barrier master-leased housing units, without preconditions of sobriety or engagement with traditional County Behavioral Health services. The County will most likely contract with AMI Housing (Advocates for the Mentally Ill) to master-lease private homes and/or apartment units. AMI Housing has already successfully master-leased

several homes in our community for permanent supportive housing for our Full Service Partnership clients, and has developed good rapport with many local landlords in our community who are willing to rent their homes. The units will likely be located in one of the two incorporated cities in the Western side of our county in order to be close to services and amenities. The units will either be private homes with six or less units or individual apartment units so as not to require any special permits or licensing. There will be minimum of 12 master-leased units funded through our Innovation project, with a ramp-up period built in to the first year to allow for the location and acquisition of the units. These units will be supported by a housing Personal Services Coordinator who will provide a continuum of services and support as these individuals enter housing, including strategies for maintaining housing stability and linkage to benefits and other services such as substance use and behavioral health treatment, as applicable. The housing Personal Services Coordinator will also be involved in the acquisition of the master-leased units and will be the first point of contact for any issues that may arise with the units and/or neighbors. Our county has already seen initial success in this model through our Bridges to Housing program, which houses vulnerable individuals with a focus on behavioral expectations as opposed to traditional house rules of sobriety and engagement in treatment. This project will expand that type of housing opportunity as well as add the element of direct placement from a camping or unsheltered setting into this housing. All tenants will sign admission agreements similar to a lease for a one-year initial period, with the opportunity to extend for an additional year as needed. Our goal is to use the housing as a bridge to permanent housing, and we will work with each client individual to ensure access to permanent and sustainable housing that fits their specific income and living needs. In addition, the HOME team will have access to flex funds which can be used for some of the costs associated with engaging a person and addressing some of their primary needs. A specific focus of this flex funding will be medications and triage supplies an individual may need to address their health issues.

The innovative composition of the HOME team, combined with the access to low barrier housing, will allow our County to lower the numbers of chronically homeless individuals in our community. The team will be trained in critical modalities such as Motivational Interviewing and Mental Health First Aid. The Personal Services Coordinator, and perhaps others on the team, will have a background in substance use services including a CADAC credential. Our Peer Specialist will complete our local peer training course. While our traditional outreach model has always included a Personal Services Coordinator, we have never utilized a Nurse or a Peer Specialist to directly engage individuals out in the community. The HOME team will develop creative and innovative strategies to quickly engage homeless and high-risk individuals in services, begin meeting their needs, and link them to services. HOME will assist the individual in developing a strong, positive support network to help promote ongoing recovery and wellness.

Services provided by the team will be culturally relevant, and individuals will be linked to resources that are sensitive to their age, race, ethnicity, sexual identity, consumer culture, religion, and health needs. Providing access to vocational training, education, and employment will also be a long-term goal. The implementation of this innovative, holistic team to address immediate needs, including offering immediate health care, will help Nevada County learn how to effectively engage high-need chronically homeless individuals and expedite services to meet their immediate and long-term needs.

This innovation project makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population. The HOME team project design draws on a number of strategies we have tested in other settings and combines them in a unique way to address the specific goal of lowering our persistently high percentage of chronically homeless individuals. This program will build on some separate pilot efforts in our county, including our low barrier Bridges to Housing program and our existing Personal Services Coordinator positions that are focused on homeless connections. In addition we will draw from experience we gained integrating physical health and mental health services for clients of the Behavioral Health Department. The program also builds on the learnings from other communities around the most effective models in engaging and successfully housing long term chronically homeless individuals.

Specifically we will utilize our learnings from a three-year Health Resources and Services Administration (HRSA) Rural Health Grant we received in 2012. During this project, we worked closely with a local Federally Qualified Health Center (FQHC) to integrate health and mental health services for clients of our Behavioral Health Department. The grant utilized a Nurse and Peer Counselors to support adults with a serious mental illness to access health care, understand their chronic health conditions, and coordinate health services between primary care and psychiatry to improve health outcomes. HOME will utilize strategies learned from this project to apply to persons who are homeless and have complex health, mental health, and substance use issues.

Through this grant, we found that the integration of primary care and behavioral health has a significant impact on the health and well-being of persons with a Serious Mental Illness. Many individuals do not access primary care and/or know how to manage their chronic health conditions. Similarly, Behavioral Health staff do not typically understand chronic health conditions or have the skills needed to help clients improve their health functioning. Through coordinated and integrated health, behavioral health, and substance use treatment services, clients can improve their health conditions and achieve positive outcomes. This model has been effective at improving continuity of care and we believe it will be effective when implemented with persons who are chronically homeless, helping to create positive health and wellness outcomes for these at-risk individuals who are not already connected to services.
A second source of learnings on which this program is based is our experience to date with outreach and engagement. Nevada County's strategy has historically consisted of Personal Services Coordinators engaging individuals in homeless shelters or occasionally in the field, with a strong focus on connection with traditional behavioral health and/or substance use disorder services. In researching other counties' homeless outreach strategies, we believe that communities have more success when the outreach team focuses first on physical health care as compared to mental health services. We have reviewed a variety of street medicine teams that include nurses providing physical health care in the field or in focused clinics. These teams are proving to be highly successful in building a connection with hard to serve individuals (Rosenblum, Nuttbrock, McQuiston, Magura, & Joseph, 2009). Our Home team program design builds upon these successes by having a nurse as a core partner, but supplements this with a Peer Specialist which we believe will add a stronger capacity for connection and building trust.

Additionally, outreach teams typically gauge housing readiness based on engagement with traditional services such as mental health care and progress towards sobriety. Nevada County's HOME Innovation project is unique in that housing will be offered upfront to individuals, regardless

of engagement in traditional behavioral health or substance use services. In line with the "Housing First" principles, this project assumes that housing should be the first step in breaking down barriers that individuals may be experiencing, including physical health needs, behavioral health needs, or substance use disorder needs. Without stable housing, individuals often have difficulty maintaining necessary appointments, and Personal Services Coordinators experience challenges with continued engagement and relationship development when they cannot easily and consistently locate their clients. We have begun offering this low barrier, housing first approach in Nevada County through our Bridges to Housing program. The HOME team project will build upon the successes we are seeing by linking that housing strategy to direct outreach and engagement.

A final area of learning that this project draws from is around the importance of closely linking supportive services to the criminal justice system. Unique to Nevada County is the coexistence of the Probation and Public Defenders departments alongside the Behavioral Health department within the Health and Human Services Agency structure of the county. This ensures a very close working relationship between these program areas. The HOME team program design capitalizes on this connection by utilizing referrals and warm hand offs from these key partners as well as from law enforcement and jail staff.

This project aims to engage a minimum of 30 unique individuals per year, and directly support at least 12-15 people per year in attaining and sustaining stable housing. Across the five (5) project years, it is estimated that HOME will engage 150 adults, ages 18 and older. This estimate is based on the average caseload of our outreach Personal Services Coordinators, adjusted slightly downwards to account for the HOME team's focus on chronically homeless individuals in our community.

The Innovation HOME team project will serve individuals ages 18 years and older who are experiencing chronic homelessness. This population will include all persons, regardless of gender, race, ethnicity, sexual orientation, and language. These individuals do not access traditional services, and may be fearful of the behavioral health service delivery system. Homeless individuals who are in jail and are ready to be released will also be eligible for services. HOME will coordinate services with jail staff and the Forensic Liaison to identify high-risk persons ready for release from the jail. Early identification of these individuals will allow HOME staff to meet with the individual to begin developing a relationship and assess needs for housing benefits and other services while still in jail.

RESEARCH ON INN COMPONENT

The HOME team is a unique program design created to address the specific need of reducing a disproportionately large population of chronically homeless individuals in our rural county. Elements of the program build upon successes experienced elsewhere, but by combining medical care with peer support, together with a housing first approach, we believe we will be able to successfully engage and support a population that has proven to be difficult to stabilize. In addition, by utilizing the close relationships inherent within our unique Health and Human Services Agency structure and by capitalizing on the opportunities of our recent expansion of substance use disorder services through opting into the Organized Delivery System, this project builds creatively upon our natural assets. Homelessness is experienced differently in small rural counties than in urban centers. The challenges of expansive geography, unique cultural and social

norms, and limited services all have influenced our program design. Nevada County is excited to tackle the challenge of creating an effective homeless outreach and engagement program for a rural setting.

The California Whole Person Care projects have created a variety of strategies to meet the needs of homeless persons in the state. This pilot project has identified successful strategies for engaging persons who are homeless, identifying ways to coordinate services with hospital Emergency Departments (ED) to identify when high-risk individuals receive ED services, and link individuals to needed services in the community. These projects help illustrate effective practices for this high-risk population. This project builds on some of the most successful elements of the Whole Person Care pilot while adding specific unique elements that reflect the needs of our rural county.

As described above, project design for the HOME team builds upon some of the best practices for outreach and engagement for chronically homeless populations while adapting and combining those strategies to best fit our rural community. For example, a study of a mobile crisis team conducted by Lyons, Cook, Ruth, Karver, & Slagg found that embedded Peer Specialists made the team significantly more effective, writing; "consumer staff are more willing and better to engage mentally ill people on the street." Additionally, a study by Rosenblum, Nuttbrock, McQuiston, Magura, & Joseph found that centering a homeless outreach program around health care resulted in reductions in drug use, homelessness and health complaints. The HOME program design combines the successful strategies from each of these efforts in hopes of even greater success with our particularly challenging chronic population. While Peer Specialists have been shown to have positive effects on health issues such as HIV treatment and condom use for those experiencing homelessness (Deering et. al 2009; Fogarty et al. 2001), there is inadequate research on the effects of Peer Specialists with regard to longer term and ongoing health, mental health, and substance use disorder treatment services. Furthermore, the majority of mobile health programs serve urban areas (Centrone, 2009), and there are significant learning opportunities for implementing this type of model in a rural setting. As a small, rural county, it is essential that we are creative at improving access to services. Additionally, the Department of Housing and Urban Development (HUD) has shifted in recent years to explicitly support the low-barrier, Housing First approach.

LEARNING GOALS/PROJECT AIMS

The primary learning goal of the HOME Project is to understand what strategies are effective in engaging the specific population of long-term unsheltered individuals within the context of rural communities. Specifically, we wish to assess the effectiveness of a unique multi-disciplinary team in engaging persons in the field who are chronically homeless and linking them to needed services including immediate housing, health and behavioral health care, benefits, and other adjunct services (e.g., caring for their pets; cell phones; tents).

The specific learning objectives and key evaluation outcomes that will be measured are outlined below:

1. Will creating a HOME Team that is comprised of the Nurse, Personal Services Coordinator, and Peer Specialist increase the number of homeless individuals who engage in services (Substance Use Disorder treatment, SSI/SSDI benefits, CalFresh, etc)?

2. Will the HOME Team nurse's ability to immediately address the individual's health care needs help develop a trusting relationship and help engage individuals in services?
3. Will offering a low barrier housing option increase the number of individuals who move into a safe and stable housing situation?
4. Will the HOME Team's coordination with law enforcement and probation decrease the number of persons re-arrested?
5. Will the HOME Team's coordination with law enforcement increase the number of inmates (with no identifiable address) leaving the jail who have a plan for securing safe and stable housing at the time of release from jail?
6. Will the HOME Team increase the number of homeless individuals who access health care services?
7. Will the HOME Team increase the number of homeless individuals who access mental health and/or substance use services, including residential treatment?
8. Will participants in the program develop positive social connections?
9. Will persons who receive HOME Team services report improved outcomes and positive perception of services?

The critical innovative element of our program design is the unique composition of our outreach team, as well as the capacity of the team to immediately link people to housing. The learning goal for this project is to determine if these two elements are effective in engaging and successfully housing the specific population of chronically homeless individuals. The specific learning objectives listed above demonstrate our efforts to understand which aspects of the program are the critical elements of success. If the HOME team is able to engage and house people who have been unsheltered for a year or more, we hope to discern which elements of the program design are allowing us to be successful in a rural community with a population that is challenging to build trust with.

EVALUATION OR LEARNING PLAN

This Innovative Project is examining the success of the HOME team model of using a Nurse, Personal Services Coordinator, and Peer Specialist in improving engagement of persons who are homeless, and offering welcoming and timely services to help individuals achieve positive outcomes of safe and stable housing; immediate health and behavioral health care; and access to benefits and other adjunct services.

The HOME Project evaluation will have several components and the data collected for each objective is outlined below:

1. *Will creating a HOME Team that is comprised of the Nurse, Personal Services Coordinator, and Peer Specialist increase the number of homeless individuals who engage in services (Substance Use Disorder treatment, SSI/SSDI benefits, CalFresh, etc)?*
   Service-level data will be collected to measure engagement activities; referrals and linkages to services; number of contacts and duration of services; the number of services; and location of services. This data will provide information on timely engagement and access to services. Many individuals who are homeless are very suspicious of governmental agencies, and do not trust people trying to offer help. As a result, engagement may take several attempts and weeks, or even months, of outreach to reduce

the barriers to service engagement. The number of attempts to engage, the role of each member of the HOME Team, and amount of time spent will be measured.

2. *Will the HOME Team nurse's ability to immediately address the individual's health care needs help develop a trusting relationship and help engage individuals in services?*
   The types of health care services delivered by the nurse to help engage each individual will be documented. This will help identify the key nursing behaviors that help engage individuals in services. This may include wound care, answering health care questions, helping secure needed medications, and other immediate health concerns. The time to link the individual to ongoing health care will also be measured.

3. *Will offering a low barrier housing option increase the number of individuals who move into a safe and stable housing situation?*
   The amount of time from HOME Team engagement to date of moving into the low barrier housing option, and length of time stably housed, will be measured.

4. *Will the HOME Team's coordination with law enforcement and probation decrease the number of persons re-arrested?*
   The number of arrests, parole violations, days in jail, and living situation at time of release from jail, and length of time to being housed, will be measured. As law enforcement becomes more engaged in the activities of the HOME Team, situations where individuals are diverted from the jail will be documented, when available.

5. *Will the HOME Team's coordination with law enforcement increase the number of inmates (with no identifiable address) leaving the jail have a plan for securing safe and stable housing at the time of release from jail?*
   See data from #5 above.

6. *Will the HOME Team increase the number of homeless individuals who access health care services?*
   The number of persons assisted by the HOME Team who become enrolled in FQHC or other health care services will be documented. The individual's perception of their health on a Perception of Care survey will be administered annually.

7. *Will the HOME Team increase the number of homeless individuals who access mental health and/or substance use services, including residential treatment?*
   The number of persons assisted by the HOME Team who receive mental health and/or substance use services and the individual's perception of improved mental health and/or substance use on a Perception of Care survey administered annually. The number and percentage of chronically homeless individuals that the HOME team engages with who are diagnosed with a serious mental illness will also be measured.

8. *Will HOME Team members in the program develop positive social connections?*
   The number of persons assisted by the HOME Team who report improved social connections on a Perception of Care survey administered annually.

9. *Will persons who receive HOME Team services report improved outcomes and positive perception of services?*
   The number of persons assisted by the HOME Team who report improved outcomes on a Perception of Care survey administered annually.

Services will be evaluated to assess the timeliness of services and outcomes over time. Individuals will be surveyed using a Perception of Services Survey periodically to obtain their experience in receiving services and the impact of services on their outcomes. This will provide important information on continually improving services and identify opportunities for celebrating success.

CONTRACTING

Nevada County has a long history of contracting for specialty mental health services, substance use services, and integrated health services. NCBH staff provide ongoing management and oversight of all behavioral health contracts, and services have been exemplary from these organizations. It is anticipated that one or more of the existing organizational providers that currently has a contract with NCBH will be selected to implement the HOME project. Evaluation activities will be utilized to provide ongoing feedback on access, quality, and cost-effectiveness of services, as well as outcomes achieved.

COMMUNITY PROGRAM PLANNING

Nevada County held 11 meetings throughout the county to get community input. We received consistent community feedback that future Innovation plans should be focused on those in our community experiencing homelessness. Once our plan was developed, it was posted on our County website for 30-day public review from November 6th through December 7th. When the plan was posted, an email was sent to our MHSA contact lists, which contains over 175 individuals including family members, mental health consumers, contractors, community based organizations, and staff from various departments within Nevada County. Additionally, an email press release was sent to all major media outlets that serve Nevada County, including legal advertisements advising the public of the public comment period and location of the Innovation plan. Lastly, public comment was received at our Public Hearing that was held at our Mental Health Board Meeting on December 7th, 2018.

As a result of federal grant funding via SAMHSA that was awarded during the public comment period, Nevada County removed MHSA funding of the Personal Services Coordinator and increased the FTE of the Nurse from 0.5 FTE to 1.0 FTE. Increasing the Nurse from 0.5 FTE to 1.0 FTE was also suggested during the public comment period by the Nevada County Public Health Nursing Director. Additionally, Nevada County increased the salary of the Peer Specialist to align with industry standards.

MHSA GENERAL STANDARDS

The HOME services will reflect and be consistent with all of the MHSA General Standards. Enhanced community collaboration and cross-organization coordination of services is one of the primary strategies of our Innovation Project. These activities closely align with the General Standards. All services will be culturally and linguistically competent. It is our goal to hire a bilingual and/or bicultural Peer Specialist, if possible, to help meet the needs of our Latino community. In addition, we will strive to provide culturally-sensitive services to the LGBTQ

community, adults and older adults, consumers, and family members, to support optimal outcomes. Services will be client and family driven, and follow the principles of recovery, wellness, and resilience. These concepts and principles of recovery incorporate hope, empowerment, self-responsibility, and an identified meaningful purpose in life. Services will be recovery-oriented and promote choice, self-determination, flexibility, and community integration to support wellness and recovery.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Stakeholders have been and will be actively involved in all components of the HOME project. This involvement includes ongoing input into planning, prioritizing services for the homeless, creative methods for engaging, assessing, and meeting the needs of high-risk individual, design of the implementation and evaluation activities, and ongoing funding. Meetings will be held at least quarterly with stakeholders and organizations to discuss implementation strategies, identify opportunities to strengthen services, and celebrate HOME successes. Data on access to services, service utilization, and client outcomes will also be reviewed with stakeholders to provide input on the success of the project and the sustainability and/or expansion of services throughout the five years and beyond. Furthermore, HOME program data, challenges, and learnings will be shared at the biweekly Homeless Outreach Team (HOT) meetings, which is a collaborative group for anyone in the community who is contributing to or impacted by homeless outreach efforts, including participating local service providers, law enforcement and advocates. Data will also be reviewed to ensure that services are delivered in a culturally responsive manner. Access to services by different cultures will be reviewed for various ethnic and cultural groups, including but not limited to Transition Age Youth; Older Adults; veterans; LGBTQ+, and those with chronic health conditions.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

The HOME project will create the opportunity to develop and strengthen services to individuals who have been unsheltered for a year or more. It is anticipated that the majority of persons served will have a serious mental illness. A core function of the HOME team will be to connect individuals to appropriate care such as mental health services, but this connection will be secondary to establishing trust through outreach, providing medical care and offering housing. Because this population has traditionally been untrusting of county services, the warm hand off to a mental health care provider will take time. However, by providing peer support as well as a long term relationship with a Personal Services Coordinator, we are hopeful that this team will be more successful connecting this population to traditional care. In addition, if the HOME team model is successful, the county will sustain the program through MHSA funds, county realignment and Medi-Cal funding, so that high-risk individuals will continue to receive services to meet their needs. Throughout the duration of the project, we will be exploring how to build the capacity of the team to bill Medi-Cal for services that may be reimbursable. If the project is successful, the County will also apply for HUD permanent supportive housing vouchers for units filled by chronically homeless individuals with serious mental illness. Throughout the program, the housing Personal Services Coordinator will attempt to secure income for program participants that would sustain long-term housing solutions, either in the HOME-supported units or in other permanent housing units. Furthermore, it is anticipated that by the end of the HOME project, additional housing will be available through the No Place Like Home program. Additionally, we will explore future

partnerships with our local hospitals and mental health providers for sustainable funding of the HOME program.

COMMUNICATION AND DISSEMINATION PLAN

HOME activities are planned for a five-year implementation cycle to ensure sufficient time to develop a comprehensive, coordinated HOME service delivery model, and to learn the most effective way to engage, develop a trusting relationship, identify health and other needs, provide services, and link to community-based services to ensure positive outcomes over time. This project will include identifying successful strategies for integrating and coordinating services to meet the needs of individuals.

Information learned from the innovation project will be disseminated to stakeholders throughout the county, and at regional and statewide meetings. This project is a high-priority for the Board of Supervisors, so HOME will provide periodic reports to the BOS to share information and report successes of the program. Similarly, the Behavioral Health Board will receive periodic reports on the outcomes of HOME, as well as obtain ongoing input into improving service, to ensure that a continuous quality improvement process is in place. In addition, the Behavioral Health Director will share lessons learned from this project with the Small Counties sub-group of the California Behavioral Health Directors Association. The learnings from this project should be highly relevant to other rural counties struggling with a persistent population of homeless people who are difficult to engage in services and housing. Ongoing data and evaluation activities will help us to learn how to refine services and identify the most effective strategies for different populations of people who are homeless. Similarly, evaluation of the role of each HOME member will help to identify the needs of the team and the homeless, to ensure that staffing levels meet the needs of the individuals being served.

TIMELINE

Timeline	Milestone/Activities
March-June 2019	Select partner provider(s) for implementation and enter into contract(s) Begin looking for available housing units
March 2019 – March 2024	Provide updates on HOME team successes, challenges, and learnings during quarterly MHSA Community meetings
July 2019 – March 2024	HOME Team begins participation with Homeless Outreach Team (HOT) meetings, which is a collaborative group for anyone in the community who is contributing to or impacted by homeless outreach efforts, including participating local service providers, law enforcement and advocates. meetings; continues biweekly throughout 5-year project period Ongoing relationship building with key institutional partners such as law enforcement, jail staff, hospital, homeless shelter staff

July/August 2019	Secure outreach vehicle for HOME team
July - September 2019	HOME team begins street engagement and relationship development with individuals experiencing homelessness Master-lease housing units and begin placement of target population into units
January - February 2020	Analyze evaluation outcomes for Year One of Program implementation Ongoing search for more HOME Program housing units
March 2020 - June 2019	Contract renewals for HOME partner providers Successful attainment of HUD vouchers to provide ongoing housing stability Increased Medi-Cal revenue from team activities
January – March 2024	Final Innovation Program Report Hold Evaluation Review Community and Stakeholder Meetings Finalize sustainability planning where applicable

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

BUDGET NARRATIVE
The total requested Innovation budget is $2,395,892.02 over 5 years.

Personnel Costs:

- 1.0 Nurse at $101,244.18 per year with anticipated Cost of Living Adjustments (COLA) for 5 years; Total = $527,942.64
- 1.0 Peer Specialist at $43,764.20 per year with anticipated Cost of Living Adjustments (COLA) for 5 years; Total = $227,745.45
- 1.0 Housing Coordinator at $53,387.29 per year with anticipated Cost of Living Adjustments (COLA) for 5 years; Total = $277,829.58
- The 1.0 Personal Services Coordinator will be funded through federal grant funding via SAMHSA.

Direct Operating costs will total $957,354.03 over the 5-year project period and will include mileage, vehicle maintenance, supplies, flexible funds for client program expenses including medications, and expenses for the master-leased units including rent, utilities, furniture, and repairs. Specifically, $127,200 per year will be allocated for rent, utilities, and repairs for a minimum of 12 master-leased units, with a smaller amount of $63,600 allocated for the first year to allow for a ramp-up period while locating and acquiring the units. Indirect operating costs will

total 10% of direct operating costs for administrative functions likely performed by contractors, in addition to $149,315.38 of anticipated administration support by Nevada County Behavioral Health staff including a Program Manager, the MHSA Coordinator (Administrative Analyst II), and the MHSA Evaluator (Administrative Analyst II).

It is anticipated that in Year One of the program, the HOME team will utilize up to $30,000 to purchase a vehicle to be used for outreach purposes.

Approximately $12,000 per year will be utilized to contract with an evaluator for program evaluation design, data collection, and ongoing analysis of the program, with an additional $4,000 towards evaluation start-up costs in the first program year.

;oFederal Financial Participation (FFP) – Non-MHSA Funding: It is anticipated that Nevada County will receive $186,697.60 in FFP funding, depending on the amount of Medi-Cal billable activities performed by the HOME team.

AB 114: This Innovation plan will use FY 08/09, 09/10, 10/11, 13/14, and 14/15 funds that were deemed reallocated to Nevada County via AB 114. The total amount of AB 114 funds that will be expended prior to June 30, 2020 is $493,460.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1	Salaries	**198,394.66**	**202,362.56**	**206,409.81**	**211,064.68**	**215,285.97**	**1,033,517.67**
2	Direct Costs	**-**	**-**	**-**	**-**	**-**	**-**
3	Indirect Costs (contractor 10% admin)	**49,598.67**	**50,590.64**	**51,602.45**	**52,766.17**	**53,821.49**	**258,379.42**
4	Total Personnel Costs	**247,993.33**	**252,953.19**	**258,012.26**	**263,830.84**	**269,107.46**	**1,291,897.09**
OPERATING COSTS		**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**TOTAL**
5	Direct Costs	**127,269.33**	**207,369.66**	**207,469.33**	**207,571.00**	**207,674.70**	**957,354.03**
6	Indirect Costs (contractor 10% admin)	**31,817.33**	**51,842.42**	**51,867.33**	**51,892.75**	**51,918.68**	**239,338.51**
7	Total Operating Costs	**159,086.67**	**259,212.08**	**259,336.67**	**259,463.75**	**259,593.38**	**1,196,692.53**
NON-RECURRING COSTS (equipment, technology)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
8	**Vehicle**	**30,000.00**	**-**	**-**	**-**	**-**	**30,000.00**
9		**-**	**-**	**-**	**-**	**-**	**-**
10	Total Non-recurring costs	**30,000.00**	**-**	**-**	**-**	**-**	**30,000.00**
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
11	Direct Costs	**-**	**-**	**-**	**-**	**-**	**-**
12	Indirect Costs	**16,000.00**	**12,000.00**	**12,000.00**	**12,000.00**	**12,000.00**	**64,000.00**
13	Total Consultant Costs	**16,000.00**	**12,000.00**	**12,000.00**	**12,000.00**	**12,000.00**	**64,000.00**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
14		**-**	**-**	**-**	**-**	**-**	**-**
15		**-**	**-**	**-**	**-**	**-**	**-**
16	Total Other Expenditures	**-**	**-**	**-**	**-**	**-**	**-**
BUDGET TOTALS							
Personnel (line 1)		**198,394.66**	**202,362.56**	**206,409.81**	**211,064.68**	**215,285.97**	**1,033,517.67**
Direct Costs (add lines 2, 5 and 11 from above)		**127,269.33**	**207,369.66**	**207,469.33**	**207,571.00**	**207,674.70**	**957,354.03**
Indirect Costs (add lines 3, 6 and 12 from above)		**97,416.00**	**114,433.05**	**115,469.79**	**116,658.92**	**117,740.17**	**561,717.92**
Non-recurring costs (line 10)		**30,000.00**	**-**	**-**	**-**	**-**	**30,000.00**
Other Expenditures (line 16)		**-**	**-**	**-**	**-**	**-**	**-**
TOTAL INNOVATION BUDGET		**453,079.99**	**524,165.27**	**529,348.93**	**535,294.59**	**540,700.84**	**2,582,589.62**

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1	Innovative MHSA Funds	24,424.80	30,729.92	31,040.94	31,397.68	31,722.05	149,315.38
2	Federal Financial Participation	24,424.80	30,729.92	31,040.94	31,397.68	31,722.05	149,315.38
3	1991 Realignment	-	-	-	-	-	-
4	Behavioral Health Subaccount	-	-	-	-	-	-
5	Other funding*	-	-	-	-	-	-
6	**Total Proposed Administration**	**48,849.60**	**61,459.83**	**62,081.87**	**62,795.35**	**63,444.10**	**298,630.75**
EVALUATION							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1	Innovative MHSA Funds	**16,000.00**	**12,000.00**	**12,000.00**	**12,000.00**	**12,000.00**	**64,000.00**
2	Federal Financial Participation	**-**	**-**	**-**	**-**	**-**	**-**
3	1991 Realignment	**-**	**-**	**-**	**-**	**-**	**-**
4	Behavioral Health Subaccount	**-**	**-**	**-**	**-**	**-**	**-**
5	Other funding*	**-**	**-**	**-**	**-**	**-**	**-**
6	**Total Proposed Evaluation**	**16,000.00**	**12,000.00**	**12,000.00**	**12,000.00**	**12,000.00**	**64,000.00**
TOTAL							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1	Innovative MHSA Funds	**421,716.54**	**485,455.90**	**490,557.87**	**496,420.22**	**501,741.48**	**2,395,892.02**
2	Federal Financial Participation	**31,363.46**	**38,709.37**	**38,791.05**	**38,874.37**	**38,959.35**	**186,697.60**
3	1991 Realignment	**-**	**-**	**-**	**-**	**-**	**-**
4	Behavioral Health Subaccount	**-**	**-**	**-**	**-**	**-**	**-**
5	Other funding*	**-**	**-**	**-**	**-**	**-**	**-**
6	**Total Proposed Expenditures**	**453,079.99**	**524,165.27**	**529,348.93**	**535,294.59**	**540,700.84**	**2,582,589.62**
*If "Other funding" is included, please explain.							

Workforce Education and Training (WET)

1) **Community and Workforce Training and Technical Assistance**: Provide education, training and workforce development programs and activities that contribute to developing and maintaining a culturally competent workforce
2) **Intern Supervision**: Adds service capacity in Nevada County by funding clinical supervision of behavioral health interns
3) **HCAI WET Contribution**: Support statewide and regional WET initiative through the California Department of Health Care Access and Information (HCAI). The 2020-2025 Workforce Education and Training (WET) program aims to address the shortage of mental health practitioners in the public mental health system (PMHS) through a framework that engages Regional Partnerships and supports individuals through five potential categories including: Pipeline Development, Undergraduate College and University Scholarships, Clinical Master and Doctoral Graduate Education Stipends, and Retention Activities. California is separated into five different regions with each region designating its local priorities within the five categories.

   The Superior Region - consisting of Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, and Trinity County - selected these four categories as their local priorities.
   - Loan Repayment – Up to 200 awardees will receive $11,000 each, after completing a 12-month service obligation in the PMHS.
   - Educational Stipend - Up to 150 awardees will receive $8,000 per academic year, in installments throughout the year.
   - Peer scholarship - The SRP will dedicate $1,000 scholarships to individuals who identify as Peers, to use for career development activities.
   - Retention Activities – regional training opportunities including continuing education credits

Capital Facilities

Nevada County has utilized all of the original allotment of Capital Facilities funds.

Technological Needs

1. Electronic Health Record

Nevada County Behavioral Health's current Electronic Health Record (EHR) is Anasazi, operated by Cerner. Cerner is stopping support and future enhancements to Anasazi starting in 2023, and NCBH must therefore identify a replacement EHR vendor and administrative agency to oversee the EHR. NCBH also utilizes systems like SharePoint and Excel to accommodate for processes and data that are currently not accommodated within Anasazi. Technological Needs project funds may include individual licenses, modules, maintenance, support costs, and one-time implementation and startup costs.

This project is critical to the accomplishment of County and MHSA goals of excellent client care, integration and interoperability of systems, quality assurance, compliance with growing state regulations, implementation of CalAIM, evaluation of programming, financial sustainability, and clinician satisfaction. The Electronic Health Record will house all NCBH client records and service entries, including service entries for contracted providers that will be utilized for billing purposes. The new EHR will be up to date with all current security and interoperability standards.

The EHR will be utilized by contractors who are currently using our existing EHR Anasazi. Contractors will be trained in the new EHR alongside NCBH staff. It is our hope that the new EHR will have improved interface with other EHRs, in the case where contracted providers are using EHRs outside of our EHR.

<u>Anticipated Timeline:</u>

July 2022: NCBH will enter into contract with selected administrative vendor (with pre-selected EHR).

July – December 2022: Administrative vendor will gather requirements from existing system and what is needed from the new system, and will begin work on software design, development, and configuration. Internal oversight of this process at NCBH will be held by the EHR Implementation Team consisting of Department Head, Program Managers, Department Analysts, Supervising Health Technician, and Administrative Services Officer (Fiscal).

January – July 2023: Administrative vendor will conduct backend testing on systems such as billing, reporting, and documentation. Vendor will coordinate training with both NCBH staff and contracted staff who utilize our EHR.

July 2023: Go-Live for full EHR Implementation

Prudent Reserve

Nevada County Behavioral Health will access the Prudent Reserve when there are not enough CSS or PEI funds to maintain the current CSS and PEI programs. Additionally, any CSS funds that may revert in any year will be transferred to the Prudent Reserve to avoid reversion of those funds.

NCBHD started to fund the Prudent Reserve with Unapproved FY 2005/2006 Estimate Funds in the amount of $158,857. In FY 2008/2009 Nevada County directed a total of $870,293 into the Prudent Reserve. Lastly, NCBHD shifted $100,000 of FY 2007/2008 PEI Unspent Funds to the Prudent Reserve. In FY 19/20, NCBHD shifted $81,804 out of the Prudent Reserve into CSS in accordance with the new Prudent Reserve limits set by SB 192. The current Prudent Reserve amount is $1,111,502.

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: Nevada County

☐ Three-Year Program and Expenditure Plan
☑ Annual Update

Local Mental Health Director Name:	**Program Lead**
Phebe Bell, MSW Telephone Number: (530) 470-2784 E-mail: Phebe.Bell@co.nevada.ca.us	Name: Priya Kannall Telephone Number: (530) 265-1790 E-mail: Priya.Kannall@co.nevada.ca.us
Local Mental Health Mailing Address: 500 Crown Point Circle, STE 120 Grass Valley, CA 95919	

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.

Phebe Bell, MSW_____ _____
Local Mental Health Director (PRINT) Signature Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Nevada County

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

Local Mental Health Director Name:	**County Auditor-Controller / City Financial Officer**
Phebe Bell, MSW Telephone Number: (530) 470-2784 E-Mail: Phebe.Bell@co.nevada.ca.us	Name: Marcia L. Salter Telephone Number: (530) 265-1251 E-mail: Marcia.Salter@co.nevada.ca.us
Local Mental Health Mailing Address: 500 Crown Point Circle, STE 120 Grass Valley, CA 95945	

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.

Phebe Bell, MSW

_____ _____

Local Mental Health Director (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, 2021 , 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.

Marcia L. Salter

_____ _____

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

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

FY 2022/23 Mental Health Services Act Annual Update
Funding Summary

County: Nevada

Date: 4/13/22

	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 2022/23 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	4,120,292	1,390,024	1,393,457			
2. Estimated New FY 2022/23 Funding	5,277,456	1,497,432	394,061			
3. Transfer in FY 2022/23a/	(712,272)			112,272	600,000	
4. Access Local Prudent Reserve in FY 2022/23	0					0
5. Estimated Available Funding for FY 2022/23	8,685,476	2,887,456	1,787,518	112,272	600,000	
B. Estimated FY 2022/23 MHSA Expenditures	5,481,654	1,359,856	547,198	112,272	600,000	
G. Estimated FY 2022/23 Unspent Fund Balance	3,203,822	1,527,600	1,240,320	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2022	1,111,502
2. Contributions to the Local Prudent Reserve in FY 2022/23	0
3. Distributions from the Local Prudent Reserve in FY 2022/23	0
4. Estimated Local Prudent Reserve Balance on June 30, 2023	1,111,502

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 2022/23 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: Nevada Date: 4/13/22

	Fiscal Year 2022/23					
	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. Children's FSP	2,857,795	1,329,697	1,513,098		0	15,000
2. Adult FSP	4,041,083	1,595,476	2,274,255		0	171,352
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: General System Development						
1. Expand Network Provider	156,000	60,414	95,586		0	
2. Expand Adult and Children's Behavioral Health & Psychiatric Services	1,231,330	442,609	701,523	0	0	87,198
3. Expand Crisis and Mobile Crisis Intervention Services	775,849	428,169	272,908	0	0	74,772
4. Emergency Department Outreach and Engagement	99,769	99,769				
5. Intensive Services for Youth	993,419	412,619	560,800		0	20,000
6. Alternative Early Intervention for Youth and Young Adults	126,987	35,251	91,736		0	
7. Family Education and Support	30,695	30,695				
8. Tahoe Truckee Case Management	102,623	71,710	30,913			
9. Project Based Housing	250,000	250,000				
Non-FSP Programs: Outreach & Engagement						
1. Expanded Mental Health Services in North San Juan	8,085	8,085				
2. Case Management & Therapy for Homeless Individuals with Mental Illness	132,040	97,445	34,595			
3. Forensic Liaison	69,300	69,300				
4. Veterans' Services & Therapy	52,445	52,445				
5. Adult Wellness Center & Peer Support Training	203,598	203,598				
6. Housing and Supportive Services to the Severely Mentally Ill Homeless	96,555	96,555				0
CSS Administration	230,340	197,817	32,523			
CSS MHSA Housing Program Assigned Funds	0	0	0	0	0	0
Total CSS Program Estimated Expenditures	11,457,913	5,481,654	5,607,937	0	0	368,322
FSP Programs as Percent of Total	61.4%					

FY 2022/23 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Nevada

Date: 4/13/22

	Fiscal Year 2022/23					
	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 - Early Intervention						
1. Bilingual Therapy	100,000	19,653	80,347			
2. Perinatal Depression	36,000	36,000				
3. Early Intervention for Youth in Crisis	12,582	12,582				
PEI Programs - Access and Linkage						
1. Homeless Outreach	82,447	82,447				
2. Senior, Disabled and Isolated Outreach Program	118,102	118,102				
3. Mental Health Screening in High Schools	187,027	187,027				
PEI Programs - Prevention						
1. Youth Mentoring	55,020	55,020				
2. Youth Wellness Center	120,704	120,704				
3. Family Support/Parenting Classes	61,889	61,889				
4. Community Crisis Response	25,000	25,000				
5. LGBTQ+ Support	80,000	80,000				
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
1. Community Mental Health and Crisis Training	27,244	27,244				
PEI Programs - Stigma Reduction						
1. LatinX Outreach	158,184	158,184				
2. Youth Empowerment	11,851	11,851				
PEI Programs - Suicide Prevention and Intervention						
1. Suicide Prevention and Intervention	188,676	188,676				
PEI Administration	172,603	148,227	24,376			
PEI Assigned Funds - CalMHSA JPA	27,250	27,250				
Total PEI Program Estimated Expenditures	1,464,579	1,359,856	104,723	0	0	0

FY 2022/23 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: Nevada Date: 4/13/22

	Fiscal Year 2022/23					
	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. Peer Support Program	0	0	0			
2. Intern Supervision	94,772	94,772				
3. Training and Technical Assisstance	10,000	10,000				
4. HCAI Contribution	0	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					
WET Administration	7,500	7,500				
Total WET Program Estimated Expenditures	112,272	112,272	0	0	0	0

FY 2022/23 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: Nevada

Date: 4/13/22

	Fiscal Year 2022/23					
	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. HOME Team	514,003	493,907	20,096			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	53,291	53,291	0			
Total INN Program Estimated Expenditures	567,294	547,198	20,096	0	0	0

FY 2022/23 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: Nevada

Date: 4/13/22

	Fiscal Year 2022/23					
	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.	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. Electronic Health Record	600,000	600,000				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	600,000	600,000	0	0	0	0