Lake County Behavioral Health

6302 13th Avenue - PO Box 1024
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Mental Health Services Act

2016-2017 Annual Update

FINAL

30-Day Comment Period

3/20/2017-4/19/2017

Public Hearing

4/20/2017

ACKNOWLEDGEMENTS

Lake County Behavioral Health Department wishes to thank the many participating stakeholders who gave their time and energy to this process.

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Stakeholders and Key Contributors:

Bridge Peers
Circle of Native Minds Tribal Elders
Continuum of Care Lake County
First 5 Lake County/Mother-Wise
Health Policy Cabinet
Konocti Senior Support/Senior Peer Counseling
Konocti Senior Support/Friendly Visitor Program
Lake County Behavioral Health Staff Members
Lake County Office of Education/Safe Schools
Lake County Probation
Lake County Sheriff's Office
Lake County Social Services
Lake County Tribal Health Consortium
Lake County Veteran's Services
Lake Family Resource Center
Lakeport Police Department
Latinos United Lake County

Mendocino Community Health Clinics, Lakeview Health Center
Partnership Health Plan of California
Redwood Community Services/Harbor on Main
St. Helena Clearlake Hospital and Medical Clinics
Vet Connect Lake County
Veterans Administration, San Francisco

Definitions:

The following are terms that are frequently used within this document.

California Department of Health Care Services (DHCS): DHCS administers and provides oversight for many programs that are mandated by state law and the federal government. Their mission is to provide Californians with access to affordable, high-quality health care, including medical, dental, mental health, substance use disorder services, and long-term services and supports. Their vision is to preserve and improve the physical and mental health of all Californians.

California Housing Finance Agency (CalHFA): CalHFA, along with the DHCS, jointly administers the MHSA Permanent Supportive Housing programs on behalf of counties.

California Mental Health Services Authority (CalMHSA): A Joint Powers Agreement between participating California counties which was formed in July 2009 to implement mental health initiative statewide.

Consumer: An individual who receives services for a mental illness.

Full Service Partnership (FSP): Program for adults with serious mental illness or a child/youth with a serious emotional disturbance. The program is defined by the California Code of Regulations, Title 9, Section 3200.130 as "the collaborative relationship between the County and the client, and when appropriate the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals."

Lake County Behavioral Health (LCBH): The LCBH is a governmental department within Lake County. It includes an Office of the Director which oversees two branches: Mental Health and Alcohol and Other Drug Services.

Mental Health Services Oversight and Accountability Commission (MHSOAC): Established by Proposition 63, the role of the MHSOAC is to oversee the implementation of the MHSA by providing training and technical assistance for county mental health planning as needed. Additionally, the Commission evaluates MHSA-funded programs throughout the State as well as approves county Innovation plans. The MHSOAC receives all county 3-year plans, annual updates, and annual Revenue and Expenditure Reports.

MHSA Community Stakeholder: An MHSA community stakeholder is any individual, group, or organization that has an interest in the MHSA and wants to participate in the process. It includes consumers of mental health services and their families, service providers, educators, veterans, law enforcement, social service agencies, veterans, providers of alcohol and drug services, health care providers and anyone with an interest in mental health services.

Proposition 63, Mental Health Services Act (MHSA): The MHSA was approved by the California voters in November 2004 and became law in January 2005. It is funded by imposing an additional 1-percent tax on individual taxable income in excess of one million dollars and represents a comprehensive approach to the development of a system of community-based mental health services and supports.

Serious Emotional Disturbance (SED): Defined as a child who possesses a diagnosable, serious disorder such as pervasive developmental disorder, childhood schizophrenia, schizophrenia of adult-type manifesting in adolescence, conduct disorder, affective disorder, other disruptive behaviors, or other disorders with serious medical implications.

Serious Mental Illness (SMI): Persons 18 years and older who, at any time during a given year, had a diagnosable mental, behavioral, or emotional disorder that met the criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

Lake County Mental Health Board (LCMHB): California code has provisions for community mental health services to have an advisory board. It is the mission of LCMHB to inform and educate the public on mental health issues and to advise LCBH on program development, availability of services, and planning efforts. The LCMHB members are from the community, as well as a representative from the Lake County Board of Supervisors.

History:

Proposition 63, now known as the MHSA, was passed by the California voters in November 2004 and became law in January 2005. The MHSA is funded by imposing a 1% income tax on personal taxable income in excess of $1 million. It represents a comprehensive approach to the development of a system of community-based mental health services and supports. The MHSA addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology, and training elements that support this system.

The purpose and intent of the MHSA is as follows:

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

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

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

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

- To ensure that all funds are expended in the most cost-effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.

Introduction:

This second update to the 3-Year Program and Expenditure Plan for FY 2014/15 through FY 2016/17 represents continued implementation, and minor changes and adjustments to existing approved programming in fiscal year 2016-17. The following changes (highlighted in yellow throughout the document) are found in the program and budget descriptions contained herein. Included in this update is the final approved Innovation Project of Full Cycle Referral and Care Coordination programming and the proposed scope of work for the evaluation of the project intended for the next five years.

1. The Innovation program, Full Cycle Referral and Care Coordination has been approved by the Mental Health Services Oversight and Accountability Commission.
2. The MHSA Housing program plan has ended and the permanent housing funds were moved to a new program called the Local Government Special Needs Housing Program (SNHP).
3. CalMHSA is in Phase 2 of their current implementation of Statewide Projects. Phase 3 will begin in FY 17/18 and they are proposing to focus most of their efforts in social marketing as they feel it would have the most statewide impact, and that it is the best avenue for collaboration and integration at the local level. At the direction of the CalMHSA Board (which includes our director), CalMHSA will continue to implement Each Mind Matters and Know the Signs, contingent upon receiving funding for these programs. The County Impact Report is attached as Appendix C.

Permanent Housing:

The Mental Health Service Act Housing Program was developed in 2008 as a result of voter approved Proposition 63 and offers permanent financing and capitalized operating subsidies for the development of permanent supportive housing to serve persons with serious mental illness and their families who are homeless or at risk of homelessness.

MHSA Housing Program funds are allocated for the development, acquisition, construction, and/or rehabilitation of permanent supportive housing. Using a one-time MHSA appropriation of $400 million shared by 51 participating mental health agencies, the participants assigned their MHSA funds to California Department of Mental Health (DMH), who assigned them to the California Housing Finance Agency (CalHFA) who, in turn, administered the funds on behalf of the mental health agencies (MHAs).

MHAs generally solicited housing proposals through a local over-the-counter process or through a competitive request for housing proposals. The goal of each MHA was to award funds to those projects that best leveraged the limited MHSA resources, while still meeting the need to create permanent supportive housing opportunities across the state, while providing greater accessibility and integration of housing in communities.

Since the implementation of the MHSA Housing Program by DMH and CalHFA in May of 2008, over $391 million of MHSA funds have been allocated to housing proposals financed by MHSA capital development loans and long-term capitalized operating subsidy reserves. MHSA units are typically located within larger affordable rental housing developments and restrict occupancy to MHSA clients that include individuals, families, seniors, and Transitional Aged Youth leaving the foster care system. Some MHSA units also allow for occupancy preferences for veterans. Local MHAs commit to provide MHSA residents with an individualized array of supportive services to assist with their recovery and increase the likelihood of them becoming fully functioning community members. The California Department of Health Care Services (DHCS) took over DMH responsibilities in 2012. The MHSA Housing Program sunset on May 30, 2016 with the expiration of the 8-year Interagency Agreement between CalHFA and DHCS.

CalHFA operates the Local Government Special Needs Housing Program (SNHP) on behalf of jurisdictions throughout California. The SNHP allows local governments to use Mental Health Services Act (MHSA) and other local funds to provide financing for the development of permanent supportive rental housing that includes units dedicated for individuals with serious mental illness, and their families, who are homeless or at risk of homelessness.

The SNHP has been created to replace the MHSA Housing Program as an option for local governments to begin or continue to development supportive housing for MHSA-eligible persons, and to more fully utilize MHSA funds for housing purposes. An advantage of the SNHP allows local governments to roll over their unused MHSA Housing funds when the MHSA Housing Loan Program ended on May 30, 2016. Participation in the SNHP also ensures County MHSA funds are not redirected locally for other purposes, and allow a County over time to roll over any residual receipt loan payments and deposit supplemental MHSA funds into the SNHP for the development of new housing opportunities and supplement expiring capitalized operating subsidy reserve (COSR) accounts to ensure a longer term of affordability for their MHSA residents.

CalHFA, the state's affordable housing bank, is uniquely qualified to provide housing development expertise and real estate lending services for the benefit of other governmental entities in the State of California for the construction, rehabilitation, and development of housing for persons qualifying for mental health services under the Act.

www.calhfa.ca.gov/multifamily/mhsa/index.htm

(LCBH SNHP agreement attached as Appendix B.)

Community Program Planning and Stakeholder Process

The Community Program Planning process in Lake County is an ongoing process of key informant contact, monthly departmental MHSA meetings, monthly meetings with consumers, and planning meetings that include county-wide stakeholders. The information gathered through this process is considered and incorporated in the resulting 2016-2017 Annual Update to the Three-Year Program and Expenditure Plan for FY 2014/15 through FY 2016/17. Further planning, stakeholder input, and resulting changes for the 2016-2017 Annual Update are contained in this plan and build on previous planning efforts, specifically to the current Three-Year Plan.

Community stakeholder meetings were held semi-annually in fiscal year 2015-2016 on the following dates:

May 18, 2016
November 2, 2016

Community Planning Meetings

Behavioral Health Advisory Board	1
The Bridge	1
CalMHSA	1
Circle of Native Minds	2
Client	1
Family Member	2
HLN	1
Konocti Senior Support	2
Lake County Area Agency on Aging	1
Lake County Behavioral Health	15
Lake County Office of Education	2
Lakeview Health Center	2
Mother-Wise	4
Public	1
Redwood Children's Services/The Harbor on Main	8
La Voz	1
Total	45

(Information presented at these meetings is attached as Appendix D.)

Key Informant/Single Topic/Population Meetings

Throughout the year the MHSA Team reaches out to existing collaborations, consortiums, and individuals in the community to take input on needs and gaps in services available in Lake County and their relation to the existing plan. In fiscal year 2015-2016 this effort included attendance at standing meetings for the Tribal Elders Talking Circle, the Health Leadership Network, the Forensic Multi-Disciplinary Team, and the Continuum of Care, Children's Council, Healthy Start Collaborative. Individual key informants for the year include representatives from Latinos United Lake County, Lake County Tribal Health, Indian Child Welfare Advocates, First 5 Lake County, Konocti Senior Support, the senior center directors, Lake County Office of Education, and the Lake County Suicide Prevention Taskforce.

Local Review Process

The MHSA Annual Update to the Three-Year Program and Expenditure Plan (the Plan) for 2016-2017 will be reviewed by stakeholders at the agency level and in a public forum. The Plan will be posted for 30 days on the County website with copies distributed to all active stakeholders via e-mail, and hard copies made available at Department clinics, the peer recovery support centers, and by mail upon request. At the end of the 30-day posting period, the Plan will be presented to the Mental Health Board (MHB) at their monthly meeting. The MHB will hold a public hearing to address substantive comments or input. The comments and input are documented in the Plan with corresponding responses or actions. The Plan will then be heard by the Lake County Board of Supervisors for adoption. A copy of the Plan will then be forwarded to the Mental Health Services Oversight and Accountability Commission for informational purposes

Comment Period and Substantive Feedback

The plan update was made available for public comment for 30 days prior to the Mental Health Board meeting and public hearing on 4/20/2017 at 4:00 pm. Substantive feedback below.

Substantive Feedback:	LCBH Response:
During the Stakeholder interview process no TAY youth or TAY providers were interviewed. Was input requested from TAY Stakeholders regarding the planning process? If so, what was the collection process and how was this information used to inform the updated plan? If not, how does LCBH plan to gather and incorporate input from these Stakeholders	We have received input from TAY at the Stakeholder meetings, however, we have not had an interview process. Specific population interviews will be incorporated as part of the Three Year planning process.
On page 7 it is reported the MHSA housing program funds were moved to a new program called SNHP. Will LCBH apply for the No Place Like Home funding through the California Department of Housing and Community Development to expand available permanent supportive housing within Lake County?	That is in discussion and we are looking at all possibilities to expand permanent supportive housing. This will be one of the main topics at the next Stakeholder meetings. We are coordinating schedules with Fiscal and housing experts and will announce the date in the very near future.
On page 12 in the description of the Crisis Access Continuum, the following services are outlined as being utilized within Lake County: Crisis Hotline, Warm Line, Outreach and Engagement services for individuals who have recently been hospitalized. Does the County track demographic records of clients accessing these services? Can LCBH provide engagement and referral outcomes for these consumers?	Yes, this will be a benefit of our new Innovation Closed Loop Referral System and we are moving forward with that evaluation plan.
On page 16 the plan outlines that 43 consumers were provided with Transitional Housing and 35 consumers were provided with Permanent Supportive Housing. Can LCBH provide the community with a breakdown by age or target populations of consumers accessing these housing resources?	Target populations are those considered Severely Mentally Ill/Severely Emotionally Disturbed, Homeless and/or at risk of Homelessness. We will provide more detail as part of the Three Year Planning Process.
On page 16 the plan provides information regarding current number of FSP recipients by age, including that 17 TAY received FSP services. Can LCBH provide information on how many consumers by age range were evaluated for FSP services in Lake County during the three year period?	Not specifically as FSP. Eligibility is considered for anyone seeking services.

Why were the quarterly Stakeholder meeting's reduced to semi-annual?	A variety of reasons changed the scheduling of community Stakeholder meetings. Staffing challenges, no program changes or program change requests. We encourage input from Stakeholders at any time and plan to hold many meetings as part of the Three Year Planning Process.
Can LCBH provide evidence of current evaluation measures and outcomes achieved? How does LCBH plan to improve evaluation of current MHSA funding issues? Will outcomes and measures be updated to capture missing information during the next three years?	Yes, we can provide evidence and we are looking at a way to condense that data into a meaningful report for Stakeholders. We will incorporate the tools used in the Innovation Evaluation Planning and provide that information as we begin the Three Year Plan.
Is there a total number of slots per demographic for FSP or is it one budget line item that is filled based on need at any given fiscal year?	No, there are not slots per demographic as we want to make sure any eligible consumer can be served in an FSP.

MHSA Programming in Lake County -

Component	Program Name	Program Description
Community Services and Supports – Full Service Partnership	Full Service Partnership	Consumers of all ages (children 0-15, transition age youth 16-25, adults 26-59, and older adults 60+) who meet eligibility requirements are provided "whatever it takes" services. A full array of recovery-oriented mental healthcare, including psychiatric services, is provided to consumers enrolled in an FSP. Services and supports include funding for housing, food, clothing, primary healthcare, transportation, education, and vocational opportunities.
Community Services and Supports – General Systems Development	Crisis Access Continuum	Provides increased access and an introduction to mental health recovery concepts at the earliest opportunity for consumers experiencing challenges. Provides a local crisis hotline, a warm line, and outreach and engagement services for consumers who have recently been hospitalized or released from a crisis evaluation, and respite in a supported transitional housing setting.
Community Services and Supports – General Systems Development	Forensic Mental Health Partnership	Provides support for consumers who encounter legal problems or are incarcerated in jail or juvenile hall due to mental illness. Assists consumers in addressing their mental health needs, navigating the legal process, transition planning, and provides support in the community after release from incarceration through service coordination, clinical services, and the FSP program when indicated.
Community Services and Supports – General Systems Development	Housing Access	Provides resources and linkage to MHSA-subsidized housing for FSP consumers, one-time funding for those consumers at risk of losing their housing or needing assistance getting established in housing, and transitional housing for homeless consumers.
Community Services and Supports – General Systems Development	Older Adult Access	Provides outreach and engagement services, linkage to resources, mental health interventions, and FSP programming to seniors who may be experiencing mental health challenges. The Senior Peer Counseling program provides peer-aged volunteer support to older adults who may be isolating or experiencing mild mental health concerns.

Component	Program Name	Program Description
Community Services and Supports – General Systems Development	Coordinated Care for Co-occurring Behavioral and Physical Health Conditions	This expanding element in the recovery planning process is a critical component of comprehensive services and supports that has been identified as an obstacle to wellness for consumers experiencing behavioral health difficulties. The program is intended to provide coordinated resources and treatment options for consumers with complex co-occurring behavioral and physical health disorders.
Community Services and Supports – General Systems Development	Peer Support	Supports staffing to serve both transition age youth and adult consumers in the TAY and Adult Peer Support Centers. Programs provide access to services (including non-mental health related), peer support, socialization, and companionship to these two age groups. The concepts of wellness, recovery, and resiliency are imbedded in the programming in both locations.
Community Services and Supports – General Systems Development	Parent Partner Support	Supports families involved with community mental health. A Parent Partner with "lived experience" as a family member assists families with navigating the system, service coordination, group support, and, as an FSP team member, assists the family through the FSP process.
Community Services and Supports – Outreach and Engagement	Community Outreach and Engagement	Serving specifically the Tribal and Latino communities in the corresponding Peer Support Centers serving each population. Each culturally influenced program provides access to services (including non-mental health related), peer support, socialization, and companionship to these two communities. The concepts of wellness, recovery, and resiliency are imbedded in the programming in both locations.
Prevention and Early Intervention	Early Intervention Services	Lake County Behavioral Health provides the equivalent of one full-time mental health specialist to provide direct early intervention services and supports to those consumers and families who experience the first onset of a serious emotional disturbance or serious mental illness.
Prevention and Early Intervention	Early Student Support	Enhances the social and emotional development of young students (grades K-5) who are experiencing school adjustment difficulties such that they are served in an intensive services setting. Alternative personnel provide direct services to students under ongoing supervision and training by credentialed school psychologists in collaboration with Lake County Behavioral Health Department professional staff.
Prevention and Early Intervention	Peer Support Recovery Centers	The Bridge Peer Support Center, Harbor on Main Transition Age Youth Peer Support Center, Circle of Native Minds Center and La Voz de la Esperanza, serve niche populations, promote cultural competency through program design, and allow access to resources and linkage to needed services. They are intended to reduce disparities in access to mental health services to the identified priority population. Provide project coordination and peer training.

Component	Program Name	Program Description
Prevention and Early Intervention	Older Adult Outreach and Prevention	The Friendly Visitor Program provides companionship to the vulnerable population of homebound older adults. The volunteers offer individualized companionship, support, and friendship on a regular basis to seniors who have limited access to outside activities. Reassuring phone calls and access to the MHSA-funded Senior Peer Counseling Program are also benefits of the program.
Prevention and Early Intervention	Postpartum Depression Screening and Support	Mother-Wise provides volunteers, in their role as Saathi, who offer mothers the companionship of a listening ear and a helping hand. They offer real support and solutions to mothers at a time when they need it the most through home visitation. Mother-Wise services are available for all pregnant women or new moms with babies under twelve months, regardless of income.
Prevention and Early Intervention	Trauma Focused Co- Occurring Disorder Screening and Treatment	Serving clients in community collaboration for screening and treatment of trauma and co-occurring disorders.
Prevention and Early Intervention	Prevention Mini-Grants	Invites community-based providers and organized consumer and family groups to design prevention activities and submit a funding request to Lake County Behavioral Health. This mini-grant program issues funding of $1,500 to $2,500 for one-time events and projects.
Prevention and Early Intervention – Training, Technical Assistance, and Capacity Building	Regional Data Workgroup	Lake County committed this resource to the California Mental Health Services Authority and the Superior Region Data Workgroup to identify outcome measures to be used across programs. This pilot project was facilitated by RAND corporation providing training to the County on results based accountability using the Getting to Outcomes © approach to program design, evaluation, and continuous quality improvement.
Prevention and Early Intervention	Statewide and Regional Projects	Lake County is contributing 7% of its PEI funds to support the continuation of the Statewide Projects: Suicide Prevention, Stigma and Discrimination Reduction, and the Student Mental Health Initiative. The County is also continuing to support the regional suicide prevention hotline by providing sustainability funding beginning in fiscal year 2015/16.

Component	Program Name	Program Description
Prevention and Early Intervention	Regional Suicide Prevention	Funding to support the regional suicide prevention hotline and local suicide prevention task force.
WET	Workforce Education and Training	Provides funding for workforce staffing support, training and staff development, mental health career pathways strategies, and financial incentives to address shortages in the public mental health workforce.
WET	Superior Region WET Collaborative	Lake County has been a contributing member of this 16-county partnership since 2008. The collaborative is focused on the development of career pathways in community mental health in conjunction with institutions of higher education in the region.
INN	Full Cycle Referral and Consumer Driven Care Coordination	This proposed two phase project will include the use of a web based call center and community resources clearinghouse to link consumers to needed resources. Phase one involves notification of when referrals are sent, received, and completed. The system will also allow consumers to grant access to personal health information to anybody in their circle of support by way of a secure electronic personal health record in Phase two.
CFTN	Capital Facilities	The Clearlake Clinic will be renovated to provide a more integrated experience that promotes wellness, recovery, and resiliency and increased access and engagement to underserved populations.
CFTN	Lake County Electronic Health Record Project	Addresses technological needs for secure, reliable, real-time access to client health record information where and when it is needed to support care. Includes the following components: implementation of Anasazi software, conversion to Microsoft SQL servers, conversion of paper charts, purchasing additional hardware, and ongoing service/maintenance, as well as meeting Meaningful Use and Interoperability requirements.
CSS – Housing	Local Government Special Needs Housing Program (Formerly Housing Program)	The MHSA Housing Program provides funding for development, acquisition, construction and/or rehabilitation of permanent supportive housing for individuals and their families who have a mental illness and are homeless, or at risk of homelessness.

Local Program Data and Evaluation Efforts

While Lake County is considered a small county according to its population of 64,591 (1), Lake County is not small in geography, covering over 1,300 square miles (2). With a population increase of over 10% in the past decade, almost 20% of the population below poverty level, and significant percentages of Latino and Tribal community members (3), Lake County has the unique challenge of providing services to diverse groups and communities that are also geographically varied, and must contend with the need for flexible service delivery, cultural competency across groups, and transportation and access to services across a vast territory.

MHSA programming in Lake County served 4711 consumers in fiscal year 2015-2016. The total number of consumers served in CSS programs was 1311. Community Services and Supports programs provided services to 86 consumers enrolled in Full Service Partnerships (FSPs). The number of child, TAY, adult and older adult FSPs served during the year was 4, 17, 50, and 15 respectively. The actual expenditure per consumer will be available upon completion of the cost reporting and revenue expense report processes in the coming months. PEI Programming provided services to 3312 consumers, some of whom participated in programs modeled after the Substance Abuse and Mental Health Services Administrations Eight Dimensions of Wellness Program. Data collection has begun and evaluations will be provided at a future stakeholder meeting. MHSA provided Transitional Housing for 43 consumers, and Permanent Housing for 35 consumers, for a total of 78. Of those consumers, 23 transitioned from Transitional to Permanent Housing.

1 US Census Bureau, 2010, http://www.census.gov/quickfacts/table/PST045215/06033,00
2 Lake County, "Lake County at a Glance," 2011, http://lakecounty.com/explore/lake-county-california-at-a-glance/
3 US Census Bureau, 2010, http://quickfacts.census.gov/qfd/states/18/18089.html

Component	Program Name	Percentage	2016 Budgeted	2016 Target Number of Individuals	2016 Status of Budget Narrative	2016 Projected Cost per Client	Percentage	FY 16/17 Roughout	FY 16/17 Budgeted	FY 17/18 Roughout	FY 17/18 Budgeted
CSS - FSP	Full Service Partnership	54.35%	$ 1,250,000	140		$ 8,929	55.00%	$ 1,233,143	$ 1,235,000	$ 1,334,110	
CSS - GSD	Crisis Access Continuum	11.96%	$ 275,000	600		$ 458	11.96%	$ 271,291	$ 270,000	$ 293,504	
CSS - GSD	Forensic Mental Health Partnership	4.35%	$ 100,000	50		$ 2,000	4.35%	$ 98,651	$ 100,000	$ 106,729	
CSS - GSD	Housing Access	3.48%	$ 80,000	100		$ 800	3.48%	$ 78,921	$ 80,000	$ 85,383	
CSS - GSD	Older Adult Access	6.96%	$ 160,000	1500		$ 107	6.96%	$ 157,842	$ 160,000	$ 170,766	
CSS - GSD	Coordinated Care for COD	2.61%	$ 60,000			$ -	2.61%	$ 59,191	$ 60,000	$ 64,037	
CSS - GSD	Peer Support	6.09%	$ 140,000	800		$ 175	6.09%	$ 138,112	$ 140,000	$ 149,420	
CSS - GSD	Parent Partner Support	2.61%	$ 60,000	140		$ 429	2.61%	$ 59,191	$ 60,000	$ 64,037	
CSS-OE	Community Outreach and Engagement	7.61%	$ 175,000	500		$ 350	7.61%	$ 172,640	$ 160,000	$ 186,775	
PEI	Early Intervention Services	18.61%	$ 115,000	24		$ 4,792	18.61%	$ 133,468	$ 115,000	$ 135,133	
PEI	Early Student Support	9.71%	$ 60,000	160		$ 375	9.71%	$ 69,635	$ 60,000	$ 70,504	
PEI	Peer Support Recovery Centers	31.55%	$ 195,000	1500		$ 130	31.55%	$ 226,315	$ 200,000	$ 229,138	
PEI	Older Adult Outreach and Prevention	4.85%	$ 30,000	350		$ 86	4.85%	$ 34,818	$ 30,000	$ 35,252	
PEI	Postpartum Depression Screening and Support	11.49%	$ 71,000	160		$ 444	11.49%	$ 82,402	$ 71,000	$ 83,430	
PEI	Trauma Informed Screening for Co-Occuring SUD	12.94%	$ 80,000	20		$ 4,000	12.94%	$ 92,847	$ 80,000	$ 94,005	
PEI	Prevention Mini-Grants	4.05%	$ 25,000	1500		$ 17	4.05%	$ 29,015	$ 25,000	$ 29,377	
PEI	Statewide Projects	4.37%	$ 27,000	-		$ -	4.37%	$ 31,336	$ 27,000	$ 31,727	
PEI	Regional Suicide Prevention	2.43%	$ 15,000	-		$ -	2.43%	$ 17,409	$ 15,000	$ 17,626	
INN	Full Cycle Referral and Care Coordination	100.00%	$ 150,000	-		$ -	100.00%	$ 188,749	$ 150,000	$ 150,000	
WET	Workforce Education and Training	100.00%	$ 168,000	-		$ -	100.00%		$ 168,000	$ 168,000	
WET	Superior Region WET Collaborative	0.00%	$ -	-		$ -	0.00%		$ -	$ -	
CFTN	Capitial Facilities		$ 1,000,000	-		$ -			$ 1,200,000	$ 1,400,000	
CFTN	Lake County Electronic Health Record Project		$ 125,000	-		$ -			$ 125,000	$ 125,000	
Admin	MHSA - Administration		$ 229,000	-		$ -			$ 229,000	$ 229,000	
Totals			$ 4,590,000						$ 4,760,000	$ 5,252,953	

Lake County Behavioral Health
MHSA Estimations for FY 16/17

MHSA Revenue Estimated By Mike Geiss		Actual				Estimated		
		FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19
	Cash Transfers	$ 1,204.0	$ 1,189.0	$ 1,355.0	$ 1,422.3	$ 1,480.0	$ 1,538.0	$ 1,592.0
	Annual Adjustments	$ 157.0	$ 153.5	$ 479.8	$ 94.3	$ 464.1	$ 417.7	$ 378.0
	Interest	$ 0.7	$ 1.2	$ 0.6	$ 0.6	$ 0.6	$ 0.6	$ 0.6
	Total Estimated	$ 1,361,700,000	$ 1,343,700,000	$ 1,835,400,000	$ 1,517,200,000	$ 1,944,700,000	$ 1,956,300,000	$ 1,970,600,000
MHSA Revenue Disbursed Statewide		1,589,680,373	1,235,772,421	1,729,797,749	1,418,777,892	$ 1,813,284,666	$ 1,832,411,824	
MHSA Revenue Received		3,290,574.78	2,557,999.48	3,580,612.15	2,987,398.04	$ 3,774,977	$ 3,822,056	
						Estimated		
	Variance	116.74%	91.97%	94.25%	93.51%	93.24%		93.67%
	Distribution Percentage	0.20700%	0.20700%	0.20700%	0.21056%	0.20818%	0.20858%	

Total Lake County MHSA Estimated FY 16/17			$ 3,774,977	
	Total CSS	$ 2,868,982	$ (600,000)	$ 2,268,982
	Total PEI	$ 717,246		$ 717,246
	Total INN	$ 188,749		$ 188,749
	Total WET			$ -
	Total CFTN		$ 400,000	$ 400,000
	Total Prudent Res		$ 200,000	$ 200,000
Total MHSA Components				**$ 3,774,977**

Total Lake County MHSA Estimated FY 16/17			$ 3,822,056	
	Total CSS	$ 2,904,762	$ (450,000)	$ 2,454,762
	Total PEI	$ 726,191		$ 726,191
	Total INN	$ 191,103		$ 191,103
	Total WET			$ -
	Total CFTN		$ 250,000	$ 250,000
	Total Prudent Res		$ 200,000	$ 200,000
Total MHSA Components				**$ 3,822,056**

Mental Health Services
Oversight & Accountability Commission

Title

FY 2015-2016
MHSA Annual Update Instructions

Background

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

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

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

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

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

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

Purpose

The purposes of these instructions are to:

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

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

review, training and technical assistance, accountability, and evaluation capacity regarding projects and programs supported with MHSA funds.

Who Should be Involved in the Stakeholder Process

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

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

CCR § 3300 further includes:

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

What Should be Included in the Stakeholder Process

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

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

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

What Standards Should be Used for the Stakeholder Process

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

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

Public Review

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

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

What to Include in the Annual Update about the stakeholder Process

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

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

What to Include in the Annual Update About Programs

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

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

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

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

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

What to Include in the Annual Update About INN

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

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

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

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

What to Include in the Annual Update About Performance Outcomes

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

What to Include in the Annual Update About County Compliance Certification

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

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

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

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

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

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

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

What to Include in the Annual Update About An Expenditure Plan

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

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

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

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

When the Annual Update Should be Submitted to the MHSOAC

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

Mental Health Services
Oversight & Accountability Commission

2016/17 Annual Update Instructions

2016/17 Annual Update Instructions

Doc date: Thursday, May 5, 2016

Doc file:

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

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

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

Definitions:

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

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

Community Services and Supports Worksheet:

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

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

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

Prevention and Early Intervention Worksheet:

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

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

Innovations Worksheet:

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

Workforce, Education and Training Worksheet:

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

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

Capital Facilities/Technological Needs Worksheet:

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

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

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

Funding Summary Worksheet:

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

Sections A, C and E

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

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

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

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

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

Sections B, D and F

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

Section G

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

Section H

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

Appendices

Appendix A – Innovation Plan Final Approved: Full Cycle Referral and Care Coordination and Resource Development Associates Evaluation and Scope of Work
Appendix B – Lake County Behavioral Health Special Needs Housing Program Agreement
Appendix C – California Mental Health Services Authority Statewide PEI Project County Impact Report
Appendix D – Community Program Planning Process Presentations

Appendix - A

MHSA Innovation Program Plan: Full Cycle Referral and Virtual Care Coordination

Project Purpose

Purpose of the proposed innovation project

☐ Increase access to underserved groups
☐ Increase the quality of services, including better outcomes
☐ Promote interagency and community collaboration
☒ Increase access to services

While Lake is considered a small county with a population of less than 65,000, the County spans a large geographic area of over 1,300 square miles.[1],[2] High levels of poverty, unemployment, and rural and cultural isolation affect many residents of the County, where over 25% of the population lives below the poverty line. This rate is notably higher among the County's significant percentages of Latino and Tribal community members.[3] The demographics of behavioral health consumers, and those in need of behavioral health services, mirror those of the county's population. In addition to high rates of poverty, the County includes a significantly high proportion of formerly incarcerated individuals and residents face some of the worst health outcomes in the entire state.[4]

The County, with its distinct geographic, cultural, and socio-economic characteristics, has the unique challenge of providing services to diverse groups and communities that are also geographically varied. These factors indicate the need for flexible service delivery, cultural competency across groups, transportation, and access to services across a vast territory. During the community planning process, stakeholders connected the challenge of meeting the behavioral health needs of the County's diverse and scattered population to multiple factors, including the need for increased coordination across providers who may be located in various regions, the limited capacity for information sharing across the network of individuals important to the consumer's recovery, and the need for expanded consumer access to health and wellness information.

To more adequately address the mental health needs of the community effective programs must include strategies that provide the County's diverse behavioral health consumers with the appropriate tools to empower them to manage their health, create continuous and consistent consumer-provider communication, increase the capacity for communication among providers, and provide culturally-relevant and tailored information on available appropriate behavioral health services.

[1] US Census Bureau, 2010, http://quickfacts.census.gov/qfd/states/18/18089.html,
[2] Lake County, "Lake County at a Glance," 2011, http://www.lakecounty.com/AboutLC/Glance.htm
[3] US Census Bureau, 2010, http://quickfacts.census.gov/qfd/states/18/18089.html
[4] http://www.countyhealthrankings.org/app/california/2015/rankings/lake/county/outcomes/overall/snapshot

This Innovation program will address the County's identified needs by creating an online web portal that supports successful referrals and increased interagency collaboration by providing a platform for secure communication and care coordination between all agencies involved in a consumer's care plan. The project aims to increase access to quality services and improve outcomes for consumers by directly engaging consumers in the management of their service needs and wellness progress, a strategy that has been shown to be effective behavioral health settings. Studies suggest that health technology, or eHealth, can be an effective tool to provide outreach and access to care regardless of an individual's socioeconomic status, race, ethnicity, or geographic location.[5]

Project Description

The Lake County Behavioral Health Full Cycle Referral and Virtual Care Coordination portal directly addresses the identified need for a consumer-driven information system that will increase communication and coordination between providers and directly engage consumers in the management of their own care by building on an existing and effective eHealth tool, the Network of Care. The Network of Care is an interactive web portal that can be used by consumers and those who support them to quickly access a variety of information relating to services and resources. The system is expected to engage the consumer in the management of their care through the use of Personal Health Records (PHRs).

The aim of this project is to expand on and innovate the Network of Care model by establishing a robust online health portal and information management system that blends consumer education and resource awareness, service coordination and referral tracking, and treatment management and wellness tracking over time into a single system that is entirely consumer-driven. The web portal will become a central point of access for any behavioral health related referrals, providers, and clinicians in Lake County and/or surrounding areas that may serve LCBH clients. In addition to acting as a critical information resource for consumers, the portal will increase information sharing to the network of individuals important to the consumer's recovery, as identified by the consumer, and can include preventative and primary health care services, or other services as identified by the consumer, in addition to behavioral health.

The program will be implemented in two phases. Implementation will begin with the initial adoption of the Network of Care web portal, which will engage consumers in the management of their care and wellness through a comprehensive directory of health resources within the service area of LCBH and the creation of consumer PHRs. Consumers will be able to grant access to any relevant members of their care team. The PHR functionality will include initial and ongoing consumer health and wellness self-assessments to aid the tracking of progress and wellness over time.

During the initial phase, Trilogy Integrated Resources, the developers of Network for Care will implement a Network of Care referral "call center" that is specifically tailored to support the Behavioral Health community's needs by opening up communication between the agency making the referral and

[5] eHealth Initiative (2012). *A Study and Report on the Use of eHealth Tools for Chronic Disease Care among Socially Disadvantaged Populations*.

the provider accepting the referral. When a referral is made, the system will automatically notify the provider that there will be incoming referrals. Providers will be able to manage their referrals, updating information about whether the client was a no-show or not, if they were able to assist the client, etc. This information will be logged and made available via reports, allowing the county to measure outcomes and effectiveness.

Phase two will include the implementation of the virtual care coordination platform, which will allow a consumer, and/or a consumer's care coordinator or care team, to not only communicate with providers via the PHR, but also allow providers to communicate directly with each other about a specific consumer's specified unmet needs, care plan, and progress.

While the LCBH Network of Care Portal and PHR system will be available for use by all county residents, implementation of the full-cycle referral module and virtual care coordination platform will initially be tested by a small group of consumers. After an initial testing phase, both modules will be piloted county wide. Each phase of implementation will be evaluated based on process and outcome measures identified by the peer-led evaluation committee.

EHealth tools have been used to increase the capacity of both providers and consumers in a variety of health settings, though primarily in the arena of physical health in the management of chronic conditions. EHealth tools are less widely implemented in behavioral health settings, especially community behavioral health settings. Patient web portals such as the Network of Care, are gaining in popularity and implementation, with a number of major health organizations creating and implementing portals for their use by providers and consumers. Studies suggest that these portals show potential for facilitating communication between patients and providers, as well as a means of accessing educational materials to assist all populations in the management and care of their recovery and wellness.[6] Patient web portals have the potential to help patients manage their care across the continuum, and can be a key facilitator of linking behavioral health and primary/preventative health care services and service providers, allowing consumers to track progress on a variety of health and wellness goals.

Incorporating full cycle referral and virtual care coordination functionality into the Network of Care web portal is expected to improve the ability of County behavioral health consumers to access relevant and appropriate services by providing timely access to health information, including access via mobile platforms (such as smart phones) to individuals who may not have access to internet of computers in the home. As it is completely client-driven and tailored to a client's specific identified needs and wellness goals, this program is expected to result in more effective engagement of County behavioral health consumers and increased access to services by ensuring that providers have the ability to track referrals to services and follow-up with consumers via the portal if necessary, both of which may have a significant positive impact on mental health outcomes. Collaboration across service providers, consumers, and other members involved in a care plan will reduce redundancies in efforts to share information about treatment plans, crisis events, emergency department visits, and other services. The end result may see a reduction in the trauma associated with mental health crisis events when members

[6] eHealth Initiative (2012). *A Study and Report on the Use of eHealth Tools for Chronic Disease Care among Socially Disadvantaged Populations*.

of a care team have the information necessary to act quickly. This project is consistent with the following MHSA general standards:

- Community Collaboration: This project contributes to increased engagement of County behavioral health consumers across socio-demographic groups by engaging individuals in the management of their own care, providing up-to-date and relevant resource information, and enabling communication across providers involved in an individual's care plan.
- Cultural Competence: The varied demographic characteristics of County behavioral health consumers contribute to the need for culturally appropriate services and supports for these populations. This Innovation program will increase consumer's ability to access relevant services through providing accurate information about available services.
- Client-driven: The consumer-driven PHR and care coordination platform ensures that consumers have the ability to direct every aspect of their wellness and recovery plan, including which providers can collaborate through the PHR and what information is shared.
- Family-driven: Consumer's will be able to engage family members through the platform as key members of their care team. Family members who act as the primary caregiver for a consumer will be encouraged to utilize the platform to aid in the management of the consumer's wellness and recovery.
- Wellness, Recovery, and Resiliency-focused: The proposed INN program focuses on wellness and recovery as it encourages consumers to take an active role in setting and tracking wellness and recovery goals, and provides access to the resources and services that are necessary to reach those goals.
- Integrated Service Experience: The project supports the capacity of providers to engage with each other collaboratively to provide the services necessary to address an individual's specified needs. The platform increases information sharing to the network of individuals important to the consumer's recovery, as identified by the consumer, which may include primary health or other services.

Contribution to Learning

Implementation of consumer-driven, integrative care via virtual care coordination approaches has been shown to have positive impacts on health outcomes and behavior changes when used in the management of chronic health conditions. This program adapts approaches that have been shown to be successful in healthcare and social services for implementation in a community-based behavioral health setting.

Though the Network of Care web portal and PHR system are currently utilized by various healthcare systems, including community mental health systems, this project meets Innovation criteria by 1) testing eHealth technologies and practices used in other healthcare service delivery systems in mental health and 2) integrating closed loop referral and virtual care coordination capabilities into a client-directed PHR platform, an approach that is innovative in mental health practice.

The project will contribute to learning on integrating consumer-driven eHealth technology in a community mental health setting. Little research has been conducted on the mental health and behavioral impacts of consumer-driven technology interventions, however, the process of engaging consumers in the management of their own care though technology has been shown to have positive impacts on the health and behavior outcomes of consumers. It is possible that engaging county behavioral health consumers in a consumer-driven care management process will facilitate positive mental health and/or social outcomes beyond an increase in service access. Additionally, the closed-loop referral capability will inform understanding of factors contributing to the referral and successful receipt of services for socio-demographically diverse consumers, which may inform the creation of innovative strategies for serving a geographically diverse population and aid in the continuous quality improvement process.

The key learning questions this project answers include:

- Does closed-loop referral tracking support more successful referrals and lead to increased service access and receipt?
- How will implementation of a virtual care coordination platform increase the wellness and recovery of participating consumers?
- How does engaging consumers in the management of their own care via consumer-driven care coordination increase consumer perceptions of service quality and relevance?

The project may look at other learning including:

- How will system-wide tracking of closed-loop referrals increase capacity to engage in continuous quality improvement?

- How does Network of Care implementation contribute to improved collaboration 1) amongst providers and 2) between consumers and their providers?

Evaluation

Successful outcomes from the project would support broader implementation of consumer-directed PHR with closed-loop referral and virtual care coordination integration in community mental health settings. The County will measure program success by engaging County stakeholders in a peer-led evaluation, leveraging the evaluation capacity built during the County's first INN program implementation.

In 2012, LCBH recruited and trained a diverse committee of behavioral health consumers and family members, community members, and staff, to assist LCBH to improve its mental health and behavioral health service facilities. The County engaged the evaluation Steering Committee, which is reflective of Lake County demographics and inclusive of mental health consumers and family members, in an iterative process of gathering, interpreting, and analyzing data on Lake County's behavioral health clinics and Wellness Centers. The committee participated in key knowledge and skill-building trainings that bolstered the Committee's capacity for consensus decision-making, assertive communication, and in

addressing the stigma of mental illness within the committee, its members, and other underserved groups. LCBH will use a similar process to engage the committee to design and implement an evaluation of the Full Cycle Referral and Virtual Care Coordination portal.

The County will measure program success using both process and outcome indicators. The evaluation committee will work to identify data points and evaluation methods that will be used to measure program implementation and impact. Data points may include baseline and ongoing individuals level consumer data from PHR wellness surveys, utilization and other data from the Network of Care portal, and other sources as identified during the evaluation design.

During both phases of INN program implementation, the evaluation committee will conduct a concurrent evaluation process, beginning with an evaluation design utilizing information from the initial pilot to solidify process and outcome measures. Process indicators measure to what extent the program was implemented as intended, while outcome measures will provide information on the impact of the program on participants, community, and the mental health system overall.

(This proposal was developed in collaboration with Resource Development Associates, 2015)

Key Learning Question	Potential Process Measures	Potential Outcome Measures	Potential Data Source(s)
1. Does closed-loop referral tracking support more successful referrals and lead to increased service access and receipt?	❖ # of consumer and provider users ❖ # of referrals made	# of closed referrals ↑ service receipt by NOC users ↑ perceptions of service quality and relevance	NOC usage data NOC referral data LCBH utilization data
2. How will implementation of a virtual care coordination platform increase the wellness and recovery of participating consumers?	❖ # of consumer and provider users ❖ # and type of providers granted access by consumers ❖ # and type of communication points between participating users	↑ service receipt by NOC users ↑ awareness of culturally appropriate services ↑ perceptions of service quality and relevance ↑ consumer perceptions of wellness/recovery	NOC usage data NOC referral data LCBH utilization data Consumer wellness survey
3. How does engaging consumers in the management of their own care via consumer-driven care coordination increase consumer perceptions of service quality and relevance?	❖ # of users with PHR ❖ Level of user engagement with PHR	↑ Increased consumer perception of service quality/relevance	NOC usage data Consumer wellness survey
*4. How will system-wide tracking of closed-loop referrals increase capacity to engage in continuous quality improvement?	❖ Identification of CQI indicators ❖ # of CQI meetings ❖ # of CQI plans based on indicators	❖ Implementation of CQI plans based on indicators	NOC usage data NOC referral data LCBH utilization data
*5. How does NOC implementation contribute to improved collaboration 1) amongst providers and 2) between consumers and their providers?	❖ # of consumer and provider users ❖ # and type of providers granted access by consumers ❖ # and type of communication points between participating users	↑ Increased stakeholder perceptions of system-wide collaboration	NOC usage data Collaboration survey tools (e.g., Wilder Collaboration Factors Inventory)

* Additional learning questions that may be considered

Timeline

Years 1 - 2, 2016-2017

- Establish Network of Care portal and site launch
- Implement referral notification and tracking system
- Conduct trainings for providers and consumers
- User pilot of NOC portal and referral tracking system
- Peer-led evaluation design

Years 2 - 3, 2017-2918

- Continue use of referral notification and tracking system
- Pilot integration of care communication platform into PHR and referral system
- Enable communication between consumer/provider and between providers
- Conduct trainings for providers and consumers
- User pilot of virtual care coordination environment
- Evaluation outcome measures

Years 3 - 4, 2018-2019

- Continue use of referral notification and tracking system
- Continue integration of care communication platform into PHR and referral system
- Enable communication between consumer/provider and between providers
- Conduct trainings for providers and consumers
- Continued implementation of virtual care coordination environment
- Evaluation outcome measures
- Data analysis and findings development
- Recommendations
- Dissemination of findings

* Above Approved by BOS 2/26/2016 15/16 Annual Update

Years 4 - 5, 2018-2019

- Data analysis and findings development
- Recommendations
- Dissemination of findings

Approved MHSOAC 3/24/16

Years 5 - 6, 2018-2019

- Data analysis and findings development
- Recommendations
- Dissemination of findings

** Years 4-6 Proposed Innovation Continuation – Next Lake 3-year 2018-20 MHSA Expenditure Plan

Lake County
Innovation
2016-2020

Projected Revenues and Expenditures

County: Lake Fiscal Years: 2015/2016

Work Plan #: 2

Work Plan Name: Full Cycle Referral and Care Coordination

New Work Plan ☑

Expansion ☐

Months of Operation: 04/16-06/16
MM/YY - MM/YY

	Lake County Behavioral Health	Program Years x Estimated Annual	Total Cumulative
A. Expenditures			
1. Personnel Expenditures	$ 21,250	(3.5 years)	$ 21,250
2. Operating Expenditures	$ 10,588	(3.5 years)	$ 10,588
3. Non-recurring expenditures	$ 37,000	(Year 1-2)	$ 37,000
4. Training Expenses	$ 1,500	(3.5 years)	$ 1,500
5. Work Plan Management/Evaluation	$ 7,500	(3.5 years)	$ 7,500
6. Total Proposed Work Plan Expenditures	$ 77,838		$ 77,838
B. Revenues			$ -
1. Annual Innovation Distribution	$ 150,000	(3.5 years)	$ 150,000
2. Additional Revenues			
a. Unspent Innovation Funds	$ 350,000	(-2.5 years)	350,000
3. Total Revenue	$ 500,000		$ 500,000
Projected Innovation Reserve	$ 422,163		$ 922,163
C. Total Funding Requirements*			

*** Projected Innovation Reserve**

Above Approved by BOS 2/26/2016 15/16 Annual Update

Lake County
Innovation
2016-2020
Projected Revenues and Expenditures

County: Lake Fiscal Years: 2016/2017

Work Plan #: 2

Work Plan Name: Full Cycle Referral and Care Coordination

New Work Plan ☑

Expansion ☐

Months of Operation: 07/16-06/17
MM/YY - MM/YY

	Lake County Behavioral Health	Program Years x Estimated Annual Allocation	Total Cumulative
A. Expenditures			
1. Personnel Expenditures	$ 85,000	(3.5 years)	$ 106,250
2. Operating Expenditures	$ 42,350	(3.5 years)	$ 52,938
3. Non-recurring expenditures	$ -	(Year 1-2)	$ 37,000
4. Training Expenses	$ 6,000	(3.5 years)	$ 7,500
5. Work Plan Management/Evaluation	$ 30,000	(3.5 years)	$ 37,500
6. Total Proposed Work Plan Expenditures	$ 163,350		$ 241,188
B. Revenues			$ -
1. Annual Innovation Distribution	$ 150,000	(3.5 years)	$ 300,000
2. Additional Revenues			
a. Unspent Innovation Funds	$ 72,163		$ 422,163
3. Total Revenue	$ 222,163		$ 722,163
Projected Innovation Reserve	$ 408,813		$ 408,813
C. Total Funding Requirements*	$ -		

*** Projected Innovation Reserve**

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Lake County
Innovation
2016-2020

Projected Revenues and Expenditures

County: Lake Fiscal Years: 2017/2018

Work Plan #: 2

Work Plan Name: Full Cycle Referral and Care Coordination

New Work Plan ☑

Expansion ☐

Months of Operation: 07/17-06/18
MM/YY - MM/YY

	Lake County Behavioral Health	Program Years x Estimated Annual Allocation	Total Cumulative
A. Expenditures			
1. Personnel Expenditures	$ 85,000	(3.5 years)	$ 191,250
2. Operating Expenditures	$ 42,350	(3.5 years)	$ 95,288
3. Non-recurring expenditures	$ -	(Year 1-2)	$ 37,000
4. Training Expenses	$ 6,000	(3.5 years)	$ 13,500
5. Work Plan Management/Evaluation	$ 30,000	(3.5 years)	$ 67,500
6. Total Proposed Work Plan Expenditures	$ 163,350		$ 404,538
B. Revenues			$ -
1. Annual Innovation Distribution	$ 150,000	(3.5 years)	$ 450,000
2. Additional Revenues			
a. Unspent Innovation Funds			$ 422,163
3. Total Revenue	$ 150,000		$ 872,163
Projected Innovation Reserve	$ 395,463		$ 395,463
C. Total Funding Requirements*			

*** Projected Innovation Reserve**

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Lake County
Innovation
2016-2020

Projected Revenues and Expenditures

County: Lake Fiscal Years: 2018/2019

Work Plan #: 2

Work Plan Name: Full Cycle Referral and Care Coordination

New Work Plan ☑

Expansion ☐

Months of Operation: 07/18-06/19
MM/YY - MM/YY

	Lake County Behavioral Health	Program Years x Estimated Annual Allocation	Total Cumulative
A. Expenditures			
1. Personnel Expenditures	$ 85,000	(3.5 years)	$ 276,250
2. Operating Expenditures	$ 42,350	(3.5 years)	$ 137,638
3. Non-recurring expenditures	$ -	(Year 1-2)	$ 37,000
4. Training Expenses	$ 6,000	(3.5 years)	$ 19,500
5. Work Plan Management/Evaluation	$ 30,000	(3.5 years)	$ 97,500
6. Total Proposed Work Plan Expenditures	$ 163,350		$ 567,888
B. Revenues			$ -
1. Annual Innovation Distribution	$ 150,000	(3.5 years)	$ 600,000
2. Additional Revenues			
a. Unspent Innovation Funds	$ -		$ 422,163
3. Total Revenue	$ 150,000		$ 1,022,163
Projected Innovation Reserve	$ 382,113		$ 382,113
C. Total Funding Requirements*			

*** Projected Innovation Reserve**

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Lake County
Innovation
2016-2020

Projected Revenues and Expenditures

County: Lake Fiscal Years: 2019/2020

Work Plan #: 2

Work Plan Name: Full Cycle Referral and Care Coordination

New Work Plan ☑

Expansion ☐

Months of Operation: 07/19-9/19
MM/YY - MM/YY

	Lake County Behavioral Health	Program Years x Estimated Annual Allocation	Total Cumulative
A. Expenditures			
1. Personnel Expenditures	$ 21,250	(3.5 years)	$ 297,500
2. Operating Expenditures	$ 10,588	(3.5 years)	$ 148,225
3. Non-recurring expenditures	$ -	(Year 1-2)	$ 37,000
4. Training Expenses	$ 1,500	(3.5 years)	$ 21,000
5. Work Plan Management/Evaluation	$ 7,500	(3.5 years)	$ 105,000
6. Total Proposed Work Plan Expenditures	$ 40,838		$ 608,725
B. Revenues			$ -
1. Annual Innovation Distribution	$ 150,000	(3.5 years)	$ 750,000
2. Additional Revenues			
a. Unspent Innovation Funds	$ -		$ 422,163
3. Total Revenue	$ 150,000		$ 1,172,163
Projected Innovation Reserve	$ 491,275		$ 491,275
C. Total Funding Requirements*			

*** Projected Innovation Reserve**

Above Approved by BOS 2/26/2016 15/16 Annual Update

Approved MHSOAC 3/24/16

Lake County
Innovation
2016-2020
Projected Revenues and Expenditures

County: Lake

Fiscal Years: 2019/2020

Work Plan #: 2

Work Plan Name: Full Cycle Referral and Care Coordination

New Work Plan ☑

Expansion ☐

Months of Operation: 07/19-6/20

MM/YY - MM/YY

	Lake County Behavioral Health	Program Years x Estimated Annual Allocation	Total Cumulative
A. Expenditures			
1. Personnel Expenditures	$ 85,000	(3.5 years)	$ 361,250
2. Operating Expenditures	$ 42,350	(3.5 years)	$ 179,988
3. Non-recurring expenditures	$ -	(Year 1-2)	$ 37,000
4. Training Expenses	$ 6,000	(3.5 years)	$ 25,500
5. Work Plan Management/Evaluation	$ 30,000	(3.5 years)	$ 127,500
6. Total Proposed Work Plan Expenditures	$ 163,350		$ 731,238
B. Revenues			$ -
1. Annual Innovation Distribution	$ 150,000	(3.5 years)	$ 750,000
2. Additional Revenues			
a. Unspent Innovation Funds	$ -		$ 422,163
3. Total Revenue	$ 150,000		$ 1,172,163
Projected Innovation Reserve	$ 368,763		$ 368,763
C. Total Funding Requirements*			

*** Projected Innovation Reserve**

** Years 4-6 Proposed Innovation Continuation – Next Lake 3-year 2018-20 MHSA Expenditure Plan

Approved MHSOAC 3/24/16

Lake County
Innovation
2016-2020
Projected Revenues and Expenditures

County: Lake Fiscal Years: 2020/2021

Work Plan #: 2

Work Plan Name: Full Cycle Referral and Care Coordination

New Work Plan ☑

Expansion ☐

Months of Operation: 07/19-03/20

MM/YY - MM/YY

	Lake County Behavioral Health	Program Years x Estimated Annual Allocation	Total Cumulative
A. Expenditures			
1. Personnel Expenditures	$ 63,750	(3.5 years)	$ 425,000
2. Operating Expenditures	$ 31,763	(3.5 years)	$ 211,750
3. Non-recurring expenditures	$ -	(Year 1-2)	$ 37,000
4. Training Expenses	$ 4,500	(3.5 years)	$ 30,000
5. Work Plan Management/Evaluation	$ 22,500	(3.5 years)	$ 150,000
6. Total Proposed Work Plan Expenditures	$ 122,513		$ 853,750
B. Revenues			$ -
1. Annual Innovation Distribution	$ 150,000	(3.5 years)	$ 900,000
2. Additional Revenues			
a. Unspent Innovation Funds	$ -		$ 422,163
3. Total Revenue	$ 150,000		$ 1,322,163
Projected Innovation Reserve	$ 396,250		$ 396,250
C. Total Funding Requirements*			

*** Projected Innovation Reserve**

** Years 4-6 Proposed Innovation Continuation – Next Lake 3-year 2018-20 MHSA Expenditure Plan

Lake County
Innovation
2016-2020

Budget Narrative

A. Expenditures	The expenditures described herein are estimated based on current salaries, quotes from contractors, and standard overhead costs for MHSA programming. These amounts will be updated each year via the required MHSA Annual Update.
1. Personnel Expenditures	Agency personnel will be involved in all aspects of the proposed program and include the following: Business Software Analyst - .50FTE, Staff Services Analyst - .20FTE, Program Supervision - .10FTE, and Administrative Support - .10FTE.
2. Operating Expenditures	Operating expenditures include direct program costs and administration expenses estimated at 35% for the purposes of this budget based on historical revenue and expenditure reporting.
3. Non-recurring expenditures	Non-recurring expenditures are included for the first year and possibly into the second (fiscal year). These include estimated initial set-up, development, training costs for the program. Other non-recurring costs will be addressed in the annual update process as needed
4. Training Expenses	This amount is included to support the steering committee that will comprise the peer led participatory evaluation process for the duration of the program.
5. Work Plan Management/Evaluation	This amount is identified as project management costs for program evaluation design, ongoing process evaluation, outcomes evaluation, and reporting.

Lake County
Innovation
2016-2020

Budget Narrative (continued)

6. Total Proposed Work Plan Expenditures	The proposed total is expected to be funded by current distribution estimates and will be adjusted accordingly if said estimates should flucuate.
B. Revenues	The expected funded by current distribution estimates and will be adjusted accordingly if said estimates should flucuate.
1. Annual Innovation Distribution	This amount is based on the average distributuion estimated by DHCS and CBHDA.
2. Additional Revenues	Other than unspent funds from prior years no additional revenues are expected.
a. Unspent Innovation Funds	Estimated Innovation unspent funds from prior years - estimated 2.5 years in reserve.
3. Total Revenue	Estimated distributions plus estimated unspent funds from prior years.
C. Total Funding Requirements*	The balance represented here is approximately 2 years of the estimated distribution amount. This will provide for additional programming and/or insurance against negative fluctuation.

Prepared by: JP Shute – Project Lead using numbers provided by James Isherwood, MSW 8/27/2015 3/8/2016

Telephone Number: 707-274-9101

Overview

RDA has significant experience supporting Lake County stakeholders with mental and behavioral health assessment, planning, and evaluation services. Beginning in 2012, RDA was contracted to provide facilitation and project management for the Peer Informed Access project, Lake County Behavioral Health's (LCBH) Mental Health Services Act (MHSA) Innovation. This project included forming a steering committee of representatives from the County's underserved communities, developing this committee into a learning community through training and technical assistance, and guiding the committee through evaluation and planning to ensure promotion of MHSA values in mental health service delivery. The project involved broad community participation from County staff, service providers, the Local Mental Health Board, consumers, and family members of consumers. These diverse stakeholders collaborated to implement an evaluation of mental health service facilities and make recommendations to promote service delivery experiences that are accessible, welcoming, engaging, culturally relevant, and integrated.

Throughout this project, RDA provided the steering committee with ongoing technical assistance through facilitating monthly meetings and learning communities on a range of topics. We began with a series of trainings around issues affecting mental health service consumers including assertive communication, stigma, socioeconomic conditions, service accessibility, and the signs and symptoms of mental illness. Subsequent trainings focused on participatory research and evaluation, data collection, and data interpretation, empowering committee members to design data collection tools and collect information about each mental health facility and community perceptions on mental health service sites. We assisted the steering committee with data collection, interpretation of results, and formulation of recommendations. The results of this process for each facility were written into standalone reports and synthesized for findings across service sites to develop a checklist of features that make mental health facilities more welcoming, accessible, engaging, culturally relevant, and integrated. As the project neared completion, RDA worked with LCBH staff to successfully transition the role of steering committee facilitation to the LCBH management team, supporting the Department's capacity through training and the development of a facilitation manual.

This project resulted in two distinct impacts to the Lake County community. LCBH concurrently made improvements to their mental health service facilities in accordance with the recommendations from the steering committee, bringing to life their work over a two-year engagement. In addition, the evaluation and training process itself yielded consumers, family members, providers, and community members with greater understanding of program evaluation and mental health advocacy.

Following this effort, in 2014 LCBH began an effort to integrate three separate committees of diverse community stakeholders into concurrent processes that utilize the participation of a core group of stakeholders, capturing the momentum of the prior effort to further the LCBH goal of promoting service delivery that is accessible, welcoming, engaging, culturally relevant, and integrated. The three committees were the Quality Improvement Committee, which reports out monthly on statutorily

defined metrics, including issues affecting consumers' experiences of mental health care provided by the County and its contracted providers; the Cultural Competency Committee, which ensures that mental health services in the County reflect and respond to the cultural, ethnic, and racial diversity of consumers; and the MHSA Innovation (INN) Committee, charged with developing and monitoring MHSA funded Innovation project(s).

RDA employed a mixed-methods approach to training for this effort that encompassed formal workshops led by RDA experts, facilitated work sessions where Committee members collaborated on planning and problem solving, and self-guided learning with how-to and step-by-step instruction guides. Our facilitation focused not only on meeting-by-meeting training, but also helped to support development of planning skills to engage across numerous meetings and accomplish larger, longer-term goals. We held a series of trainings focused on best practices in meeting preparation and facilitation for the expanded Committee to meaningfully engage these diverse stakeholders, as well as to increase the capacity for data-driven planning and decision-making. We also developed a "toolkit" of resources and a continuous quality improvement (CQI) process for the meetings to further strengthen their efforts. In the wake of this effort, LCBH and its stakeholders were equipped to continue the efforts of the committees' integrated processes. Particularly, the INN Committee was empowered to conduct a Community Program Planning (CPP) process that resulted in the County's next MHSA Innovation plan, which was then approved by the Mental Health Services Oversight and Accountability Commission.

Network of Care Innovation Program

The Lake County Behavioral Health Full Cycle Referral and Virtual Care Coordination portal directly addresses the identified need for a consumer-driven information system to increase communication and coordination between providers and directly engage consumers in the management of their own care by building on an existing and effective eHealth tool, the Network of Care (NOC). The NOC Program is an interactive web portal that can be used by consumers and those who support them to quickly access a variety of information relating to services and resources, engaging the consumer in the management of their care through the use of Personal Health Records (PHRs).

The aim of this project is to expand on and innovate the NOC model by establishing a robust online health portal and information management system that blends consumer education and resource awareness, service coordination and referral tracking, and treatment management and wellness tracking over time into a single system that is entirely consumer-driven. The web portal will become a central point of access for any behavioral health related referrals, providers, and clinicians in Lake County and/or surrounding areas that may serve LCBH clients. In addition to acting as a critical information resource for consumers, the portal will increase information sharing to the network of individuals important to the consumer's recovery, as identified by the consumer, and can include preventative and primary health care or other services as identified by the consumer, in addition to behavioral health care services.

LCBH has implemented the NOC Program in two phases. Implementation began with the initial adoption of the NOC web portal, which engages consumers in the management of their care and wellness

through a comprehensive directory of behavioral health resources within the service area of LCBH, and through the creation of consumer PHRs, which consumers can grant access to any relevant members of their care team. The PHR functionality includes initial and ongoing consumer health and wellness self-assessments to aid the tracking of progress and wellness over time.

During the initial phase, Trilogy Integrated Resources— the developers of NOC— have implemented a Network of Care referral "call center" that is specifically tailored to support the behavioral health community's needs by opening up communication between the agency making the referral and the provider accepting the referral. When a referral is made, the system automatically notifies the referred provider of the incoming referral. Providers can use the NOC to manage their referrals, update information about whether the client was a no-show or not, and indicate if they were able to assist the client, among other things. The system logs this information and makes it available via reports, allowing the County to measure outcomes and effectiveness.

Phase II includes implementation of the virtual care coordination platform, which allows a consumer and their care coordinator or care team to not only communicate with providers via the PHR, but also allows providers to communicate directly with each other about a specific consumer's identified unmet needs, care plan, and progress.

While the LCBH Network of Care Portal and PHR system are available for use by all County residents, implementation of the full-cycle referral module and virtual care coordination platform have been initially tested by a small group of consumers. After an initial testing phase, both modules will be piloted countywide. Each phase of implementation will be evaluated based on process and outcome measures identified by the peer-led MHSA INN Committee.

EHealth tools have been used to increase the capacity of both providers and consumers in a variety of health settings, though primarily in the arena of physical health for management of chronic conditions. EHealth tools are less widely implemented in behavioral health settings, especially community behavioral health settings. Patient web portals such as the NOC are gaining in popularity and usage, with a number of major health organizations creating and implementing portals for use by providers and consumers. Studies suggest that these portals show potential for facilitating communication between patients and providers, as well as offering a means for accessing educational materials to assist all populations in the management and care of their recovery and wellness.[1] Patient web portals have the potential to help patients manage their care across the continuum, and can be a key facilitator of linking behavioral health and primary/preventative health care services and service providers, allowing consumers to track progress on a variety of health and wellness goals.

Incorporating full cycle referral and virtual care coordination functionality into the NOC web portal is expected to improve the ability of County behavioral health consumers to access relevant and appropriate services by providing timely access to health information, including access via mobile platforms such as smart phones to individuals who may not have access to the internet or computers in

[1] eHealth Initiative (2012). *A Study and Report on the Use of eHealth Tools for Chronic Disease Care among Socially Disadvantaged Populations*.

their homes. As it is completely client-driven and tailored to a client's specific identified needs and wellness goals, this program is expected to result in more effective engagement of County behavioral health consumers and increased access to services by ensuring that providers have the ability to track referrals to services and follow-up with consumers via the portal if necessary, which may have a significant positive impact on mental health outcomes. Collaboration across service providers, consumers, and other members involved in a care plan will reduce redundancies in efforts to share information about treatment plans, crisis events, emergency department visits, and other services, and may reduce trauma associated with mental health crisis events when members of a care team have the information necessary to act quickly. This project is consistent with the following MHSA general standards:

- Community Collaboration: This project contributes to increased engagement of County behavioral health consumers across socio-demographic groups by engaging individuals in the management of their own care, providing up-to-date and relevant resource information, and enabling communication across providers involved in an individual's care plan.
- Cultural Competence: The varied demographic characteristics of County behavioral health consumers contribute to the need for culturally appropriate services and supports for these populations. This INN project will increase consumer's ability to access culturally relevant supports through providing accurate information about available services.
- Client-Driven: The consumer-driven PHR and care coordination platform ensures that consumers have the ability to direct every aspect of their wellness and recovery plan, including which providers can collaborate through the PHR and what information is shared.
- Family-Driven: Consumers will be able to engage family members through the platform as key members of their care team. Family members who act as the primary caregiver for a consumer will be encouraged to utilize the platform to aid in the management of the consumer's wellness and recovery.
- Wellness, Recovery, and Resiliency-Focused: The proposed INN program focuses on wellness and recovery by encouraging consumers to take an active role in setting and tracking wellness and recovery goals, and provides access to the resources and services that are necessary to reach those goals.
- Integrated Service Experience: The project supports the capacity of providers to engage with each other collaboratively to provide the services necessary to address an individual's specified needs. The platform increases information sharing to the network of individuals important to the consumer's recovery, as identified by the consumer, which may include primary health or other services.

Scope of Work

RDA's mission is to promote the welfare of our communities' most vulnerable populations by supporting the effective functioning of public and non-profit organizations. Thus, we believe that the function of evaluation is to strengthen the abilities of public agencies and service providers to fulfill their missions

and serve their communities. We design and implement our evaluations through a rigorous and consensus-driven process that is inclusive of the full range of stakeholders who services depend on the results. We understand that evaluations serve multiple purposes and that agencies seek data-driven findings in order to assess program progress, identify needs, and propose recommendations for improved program performance. We work closely with local partners to define evaluation measures, identify available data sources, and to develop a rigorous data collection process which employs a wide variety of data sources. Throughout the evaluation process we engage and collaborate with local stakeholders that that include community leaders, community-based organizations, and public agencies in order to collect data and input from the communities, families, and individuals the program we are evaluating serves. We believe this is a crucial component to ensuring that each assessment is culturally competent, informed by and accountable to the stakeholder community, and relevant for key decision-making activities.

We will apply this framework in designing and implementing an evaluation of the County's MHSA Innovation program, Network of Care (NOC). We will collaborate with the Steering Committee and other stakeholders to conduct an evaluation implementation process that will:

1. Meet MHSOAC and INN reporting guidelines
2. Evaluate the NOC Project's outcome
3. Contribute to the continuous learning of the MHSA INN Steering Committee
4. Inform continuous quality improvement practices, especially important for newer projects
5. Build the capacity of stakeholders to use data to inform decision-making

Phase I: Evaluation Planning

The purpose of Phase I is to prepare a plan for evaluating the NOC Program. This phase has both administrative and substantive purposes. Administratively, this phase lays the groundwork for agreeing upon the final workplan as well as communication procedures, invoicing, and contracting. Substantively, this phase will begin the process of identifying key contacts and stakeholders to engage, exploring available data and documentation to inform the evaluation, and reviewing and confirming the County's overall vision and goals for this project. This process will result in a comprehensive plan for evaluation of the NOC Program.

Project Launch Meeting

RDA will hold a project launch meeting with the Lake County Behavioral Health (LCBH) project lead, MHSA coordinator, INN plan coordinator, MHSA analyst, acting director, and other committee leads (as appropriate). This meeting will be held by phone via RDA's conference call hosting line. The project launch meeting will serve as the initial kickoff meeting to begin the project. During this meeting we will discuss the activities and timeline for the project in order to develop the final workplan; confirm the evaluation research questions; discuss potential data sources including key contacts and stakeholders to engage; and develop the communication protocols and pathways to support project success as well as identify and troubleshoots challenges as they arise. At this meeting, we will also select date, time, and location for the subsequent meetings with the network of care and quality improvement unit.

Data and Document Review

Following the kick off meeting, RDA will submit to the LCBH a request for documentation and data. This request will serve to broaden our understanding of the NOC Program as well as to identify what service utilization and program data is currently collected and available in both the LCBH's and NOC Program's respective data systems. For program documentation, we expect the following items:

- LCBH INN plan
- NOC program description
- Organizational charts
- Annual operating budget
- Policy and procedures
- Staffing rosters

For secondary data, we expect to use the data elements provided in the INN Evaluation outline in Table 1, which includes referral and usage data from the NOC Program database as well as client utilization data from the LCBH client data system. This outline serves as a preliminary list, we expect that we may identify during the evaluation planning additional data elements that we can use to answer the evaluation's research question. This initial request will help inform our understanding of the NOC program's services, operations, and available data. This information will help inform the development of relevant research questions and evaluation plan design.

Table 1. The NOC Evaluation Outline from LCBH's INN Program Plan

Key Learning Question	Potential Process Measures	Potential Outcome Measures	Potential Data Source(s)
1. Does closed-loop referral tracking support more successful referrals and lead to increased service access and receipt?	❖ # of consumer and provider users ❖ # of referrals made	# of closed referrals ↑ service receipt by NOC users ↑ perceptions of service quality and relevance	NOC usage data NOC referral data LCBH utilization data
2. How will system-wide tracking of closed-loop referrals increase capacity to engage in continuous quality improvement?	❖ Identification of CQI indicators ❖ # of CQI meetings ❖ # of CQI plans based on indicators	❖ Implementation of CQI plans based on indicators	NOC usage data NOC referral data LCBH utilization data
3. How will implementation of a virtual care coordination platform increase the wellness and recovery of participating consumers?	❖ # of consumer and provider users ❖ # and type of providers granted access by consumers ❖ # and type of communication points between participating	↑ service receipt by NOC users ↑ awareness of culturally appropriate services ↑ perceptions of service quality and relevance ↑ consumer perceptions of wellness/recovery	NOC usage data NOC referral data LCBH utilization data Consumer wellness survey

	users		
4. How does NOC implementation contribute to improved collaboration 1) amongst providers and 2) between consumers and their providers?	❖ # of consumer and provider users ❖ # and type of providers granted access by consumers ❖ # and type of communication points between participating users	↑ Increased stakeholder perceptions of system-wide collaboration	NOC usage data Collaboration survey tools (e.g., Wilder Collaboration Factors Inventory)
5. How does engaging consumers in the management of their own care via consumer-driven care coordination increase consumer perceptions of service quality and relevance?	❖ # of users with PHR ❖ Level of user engagement with PHR	↑ Increased consumer perception of service quality/relevance	NOC usage data Consumer wellness survey

Network of Care Meeting

RDA will hold an initial meeting via telephone conference call with leadership from the NOC Program. The purpose of this meeting will be to introduce program leadership to the evaluation and provide an overview of the evaluation's purpose, activities, and methods. We will also review the INN Plan in order to create a shared understanding of the NOC's purpose, services, and expected outcomes. During this discussion we will present the Evaluation Outline and review the types of use and referral data that the NOC program currently collects and identify any potential data collection challenges. We also see this meeting as an opportunity to collect initial qualitative information about NOC's implementation and the successes and challenges they have encountered since the program's start.

Quality Improvement Unit Meeting

We will hold a conference call with members of LCBH's quality improvement unit. The purpose of this call will be to assess LCBH's current data capacity and develop a plan for data collection and reporting over the course of the evaluation. We will discuss the types of data currently available in LCBH's data system and set up timeline for reporting. If necessary, we may ask relevant staff from the NOC Program to attend this call to better coordinate data collection and identify any challenges to data collection at the program level.

Evaluation Plan Development

After the meetings with NOC program and QI Unit, RDA will use the information collected to develop NOC evaluation plan and logic model. The plan will include

- ❖ NOC Program background and overview
- ❖ Purpose of evaluations for MHSA-funded programs
- ❖ Steering Committee's approach to evaluation

- Research questions
- Data sources
- Data collection activities
- Evaluation activities and methodology
- Timeline

This plan will serve as blue print for the NOC Program Evaluation, describing in detail the data collection methodology and timeline for each of the evaluation's components. We also expect the plan to identify potential implementation challenges and barriers, and recommend solutions and problem solving processes to effectively address them.

Presentation of Evaluation Plan

RDA will then submit a draft of the evaluation plan to the LCBH project leads and MHSA INN Committee for review and feedback. They will be asked to provide input aimed at refinement and validation of the evaluation process, timeline, data sources, and methods described in the plan. RDA will integrate all feedback into the plan and resubmit for finalization by LCBH Leadership.

Once LCBH approves the final version of the evaluation plan, RDA will develop a PowerPoint presentation to present the plan, timeline, and components to the INN Steering Committee. During this meeting, RDA will ask the Committee to provide any additional input regarding the plan. This meeting will also include a discussion of the Committee's role and next steps.

Phase II: Evaluation Implementation

To effectively conduct an evaluation of the NOC Program, RDA recommends an ongoing evaluation design that includes repetitive cycles of data collection, analysis, Committee review, and reporting. This approach serves as a continuous quality improvement (CQI) process that would allow LCBH to use the evaluation findings in each cycle to inform subsequent implementation and evaluation cycles.

Illustration 1. Evaluation as a Continuous Quality Improvement Cycle

This approach would satisfy the INN reporting requirements, allow LCBH to better understand the NOC Program's impact on outcomes, and further solidify a

practice of CQI among LCBH staff and the INN Steering Committee.

Data Collection

To effectively evaluate the NOC Program, RDA anticipates a data collection strategy that includes both quantitative and qualitative data collection activities. This approach will allow us to measure and correlate the outcomes and impacts of the NOC Program on participant wellness as well as to understand the strengths, weakness, challenges, and opportunities of the program's implementation process.

Quantitative Data Collection

RDA will rely heavily on the use of secondary data to measure the NOC Program's success, using both process and outcome measures. We expect that the two main secondary data sources will be:

- LCBH utilization data
- NOC Program data

We will collect baseline and ongoing individual-level data from both data sources, which will allow for study of the relationship between the NOC Program and utilization of LCBH services. We will employ complex data analysis activities to understand and integrate these data sets, including performing a correlational analysis.

We will also collect primary data from NOC consumers and providers through the administration of surveys. We plan to consider a consumer wellness survey for NOC clients at baseline and on an ongoing basis. We also anticipate collecting primary data from NOC providers and clients through the administration of the Wilder Collaboration Factors Inventory and a provider satisfaction survey. The Wilder Collaboration survey will be used to understand the extent to which implementation of the NOC has affected collaboration among providers, and between providers and consumers. Lastly, we anticipate a survey of both NOC clients and providers about their experience with the NOC Program. This survey would ask targeted questions to capture attitudes about strengths, challenges, and barriers of NOC implementation.

Qualitative Data Collection

The collection of qualitative data will allow the evaluation to explore specific facets of the NOC Program's implementation and outcomes as well as document the direct experiences of the NOC Program's clients and providers. Qualitative data methodologies provide access to in-depth information that can assist the LCBH and the MHSA INN Committee in both understanding and enhancing the quality of the NOC Program. This could include the following qualitative data collection activities:

- Program document review
- Consumer focus groups
- Key informant interviews with LCBH Leadership and NOC affiliated providers

Data Analysis

Quantitative Data Analysis

Once data collection is complete, RDA will conduct an analysis of all data collected. Analyses of quantitative data will be conducted using data analytic software such as SPSS or Microsoft Excel. RDA will clean each of the secondary and primary data sets by checking the distributions, ranges, outliers, discrepancies, reliability, and validity. We will work with Steering Committee and LCBH IT staff to identify a methodology to integrate the LCBH and NOC data sets. We will likely use a universal identifier such as Social Security Numbers or medical record numbers to match records. Once complete, we will screen the matched data sets for duplications and inaccuracy.

Data analysis will include both descriptive and inferential statistical analysis. We will use descriptive analytic methods to calculate the frequencies, confidence intervals, and measures of associate and serve to summarize the data and calculate comparisons of various outcomes at different point times. For instance, the committee may want to look at how client and provider ranked their satisfaction before, during, and after participation in the NOC Program to understand if program participation correlates with changes in satisfaction with LCBH services. If appropriate we will also conduct use inferential statistical analysis to understand the relationship between variables—more specifically the significance of participation in NOC Program on increases in LCBH utilization, client wellness, and satisfaction. Throughout all data analysis activities, RDA will create and maintain codebooks, data dictionaries, tracking logs, and syntax files to document all analysis activities such that they can be easily replicated.

Qualitative Data Analysis

Qualitative data collected from focus groups and key informant interviews will be compiled and organized thematically. RDA will conduct a conceptual analysis of qualitative data to determine the presence of salient concepts and themes for each of the evaluation's research questions, and to deepen our understanding of quantitative findings, discover underlying reasons that might help explain results, and identify prevalent trends. Findings from the quantitative analysis will also be used to help establish codes that can be applied during the qualitative analysis.

Development of Findings

Once the analysis is complete, RDA will develop a set of findings for each of the evaluation research questions. Evaluation findings will be designed to address the evaluation questions and provide nuance to explain the causes for a specific outcome as well as its potential implications. As needed, we will work with Committee members to develop recommendations that leverage strengths and/or address challenges to improve program performance in future years. These findings will be documented in a PowerPoint Presentation slide deck to be shared with the INN Committee.

Presentation of Findings and Recommendations Development

RDA will present the evaluation's data analysis and key findings in PowerPoint format at a MHSA INN Committee meeting. This presentation will be an opportunity for the INN Committee members to

discuss the findings and provide any additional input. This meeting will serve as a mechanism to support LCBH's CQI process by providing a venue for the Committee to explore the NOC Program's outcomes and ensure the program is meeting its intended objectives. The meeting will also serve to provide an opportunity for the INN Committee to reflect on the data, support its meaningful interpretation, and develop recommendations to improve performance, address gaps, and leverage strengths.

Report Development

After presentation of the findings, RDA will develop an evaluation report that documents the evaluation's findings and recommendations for the NOC Program. We expect the report to have the following sections:

- Evaluation Overview
- Methods
- Analysis
- Findings
- Recommendations

The INN Steering Committee will be given an opportunity to review drafts of the report and provide feedback that will be incorporated into a final document. RDA will develop all evaluation reports and deliverables in an accessible and clear format that is free of jargon and can be shared with lay audiences, consumers, families, policy makers, and the media.

Evaluation Planning – Year 1

Phase I: Evaluation Plan Development

Project Launch Meeting	2	3	2	7	$1,100
Document and Data Request	2	6	10	18	$2,550
Network of Care Meeting	3	3	2	8	$1,300
Quality Assurance Meeting	3	3	2	8	$1,300
Evaluation Plan Development	14	24	36	74	$10,900
Evaluation Plan Presentation Meeting	2	2	0	4	$700
PPT Development	2	2	6	10	$1,450
Travel	2	2	0	4	$700
Phase I Total	**30**	**45**	**58**		**$20,000**

Annual Evaluation Implementation – Years 2 and 3

Deliverable	*Project Director* ($2/hr)	*Project Manager* ($2/hr)	*RA* ($0/hr)	*Total Hours*	*Total Cost*
Phase II Evaluation Implementation					
Quantitative Data Collection	4	18	30	52	$7,250
Qualitative Data Collection	4	30	40	74	$10,300
Data Analysis	6	20	30	56	$7,950
Findings Development	6	14	16	36	$5,300
Presentation of Evaluation Findings	8	16	20	44	$6,500
Reporting	16	30	40	86	$12,700
Phase II Total	**44**	**128**	**176**	**348**	**$50,000**
Grand total	**44**	**128**	**176**	**348**	**$70,000**

Appendix - B

CalHFA California Housing Finance Agency

Save Our Water

Cover Letter TO MH Directors

April 27, 2016

To all Mental Health D inators:

The MHSA Housing Loan ...rogram) was created using a one time $400 million statewide appropriation of MHSA funds in 2008. The MHSA funds were used to create new permanent supportive housing opportunities for mentally-ill clients who were homeless, or at-risk of being homeless. The successful collaboration between the State Department of Health Care Services ("DHCS"), California Housing Finance Agency ("CalHFA"), local mental health agencies, developers and service providers is evidenced by current MHSA Program commitments totaling $399 million dollars for the development of over 2,600 new MHSA housing opportunities in 186 newly built or renovated housing developments statewide by 2018. The MHSA Program has leveraged public, local, state and federal funding to develop over 10,600 new affordable housing opportunities in California. CalHFA's website provides details and photographs of the variety of MHSA Projects financed through the MHSA Program and a number of these Projects have received local and regional awards. The MHSA Program even received recognition by the National Council of State Housing Agencies in 2011. Unfortunately, CalHFA must discontinue allocating further funds through the MHSA Program as the 8-year inter-agency agreement between State DHCS and CalHFA expires on May 30, 2016.

The success of the MHSA Program relied upon the ability of Mental Health Agencies to use a portion their MHSA Program funds for capital development loans (totaling $275.9MM). Loans allow for the recycling of MHSA Program funds over time and provide the financial leverage required to ensure compliance with the terms of each Project's Supportive Service Plan, and occupancy or rent restrictions for the life of the MHSA Program loan (20-55 years). MHSA rents were made affordable through commitments of project based rental subsidies (ie, Section 8) or with MHSA funds (totaling $123.2 MM) used to provide capitalized operating subsidy reserves ("COSR's") that were estimated to last 15-20 years. The continued affordability of the MHSA units relies upon the renewal of rent or operating subsidies prior to their depletion, so it is imperative that localities set aside MHSA funds now, to meet future COSR needs.

Local Government Special Needs Housing Program ("SNHP")

At the request of a number of counties, CalHFA created the "Local Government Special Needs Housing Program" ("SNHP") which builds upon the successes of the MHSA Housing Program and offers a more streamlined program that gives local government participants greater flexibility to approve funding for projects that meet local housing needs. Localities can assign MHSA or local funds as well as future MHSA Program loan repayments to CalHFA to develop new MHSA housing, to fund COSR's for new projects, or to replenish COSR's for projects financed through the MHSA Program. This voluntary program commences June 1, 2016 and to date 11 agencies have indicated they intend to commit over $39 million dollars in new MHSA funding in 2016 and authorize the transfer of $16-$18 million dollars in unused MHSA funding from the MHSA Program to the SNHP. **There is no deadline by which a locality must decide to participate in this Program, so as long as the SNHP is administered by CalHFA, a locality can opt to participate.**

CalHFA will administer assigned funds per the terms of the attached SNHP Term Sheet and Participation Agreement. Please note that the Term Sheet includes changes to the annual servicing fees that result in a reduction to the annual expense for rental housing projects with 5 or more units.

The Local Government SNHP Term Sheet suggests loan and COSR limits but allows participants to determine the maximum amount of funding to provide to each MHSA housing proposal. Another change is that participants can now locally approve each Project's Supportive Service Plan, Memorandum of Understanding, and local agencies' supportive service budget and staffing ratios. CalHFA's role is to analyze each development proposal selected for funding and recommend the final SNHP Loan and COSR amounts to ensure each project is not over subsidized. CalHFA will continue to: a) analyze the various rent and occupancy restrictions imposed by the other funding sources to ensure there are no conflicting provisions that would limit the ability to house the target MHSA population; b) prepare economic projections to analyze the financial viability of each proposal over time; c) issue commitment letters to approved proposals; d) close the SNHP Loan; e) fund and administer each COSR and keep the participant apprised of the projected number of years the COSR funds will last; f) monitor the progress of each project through construction; g) service each SNHP Loan, and h) review and approve annual project rents and operating budgets to ensure compliance with the terms of the SNHP Regulatory Agreement.

I hope you find this information enlightening and that the benefits of participating in the SNHP are clear. State DHCS intends to issue an Information Notice in the very near future that provides instructions and forms for mental health agencies (that had an allocation of MHSA funds managed by State DHCS and CalHFA) to complete and return with evidence of Board of Supervisor's approval. The deadline for submittal of these forms is September 30, 2016. One form will authorize the release of unused MHSA Program funds directly to the locality, or approve the transfer of these funds to existing COSR's or to the new SNHP. The other form provides authorization for future residual receipt loan payments to be returned to the locality or transferred to the SNHP (until such time as you provide further instructions).

CalHFA looks forward to the possibility of a renewed partnership with your Agency. Please email me once a decision has been made to participate in the SNHP. CalHFA will then prepare a SNHP Participation Agreement for each locality to execute and return with evidence of Board of Supervisor's approval. As always, feel free to call me with questions or concerns.

Sincerely,

Debra L. Starbuck

Debra L. Starbuck
CalHFA – Lead MHSA Housing Finance Officer
Office: 530-878-8075
dlstar@calhfa.ca.gov

cc: CBHDA, State DHCS, HCD, CTCAC
The Steinburg Institute

CalHFA
California Housing Finance Agency

SNHP Term sheet

LOCAL GOVERNMENT SPECIAL NEEDS HOUSING F
TERM SHEET FOR PARTICIPATING AGENCII

The California Housing Finance Agency ("CalHFA"), on behalf of jurisdictions throughout California, operates the Local Government Special Needs Housing Program ("SNHP"). The SNHP allows local governments ("LG") to use Mental Health Services Act (MHSA) funds with other local funds (collectively "SNHP Funds"), to provide financing for the development of permanent supportive rental housing ("Project") that includes units restricted for occupancy by individuals with serious mental illness (and their families) who are homeless or at risk of homelessness ("MHSA Clients"). To participate, an LG must enter into a SNHP Participation Agreement with CalHFA.

- A participating LG assigns funds to CalHFA in advance of approving financing for Projects in its jurisdiction.
- Eligible Projects are Rental Housing (5 or more units) or Shared Housing (1-4 units) for MHSA clients who rent lockable bedrooms within a single family home, duplex, tri-plex or four-plex. Projects must reserve a minimum of 5 units (or bedrooms in shared housing) for referred MHSA Clients (each a "SNHP Regulated Unit") and the minimum SNHP Loan amount per Project is $500,000. NOTE: Master Leasing is not a permitted use of funds.
- The LG may offer a capitalized operating subsidy reserve ("COSR") to subsidize operating costs for the SNHP Regulated Units – or to supplement an existing MHSA Housing Loan Program COSR serviced by CalHFA.
- MHSA Clients in SNHP funded one bedroom units assisted with COSR must pay a minimum rent that is the higher of 30% of SSI/SSP or 30% of their household income (less utilities). Larger units would pay rents that are the higher of an additional $100/month rent per additional bedroom, or 30% of household income (less utilities).
- MHSA rents may not exceed 30% of HUD published 30% AMI levels (adjusted by family size). NOTE: There are no income limits imposed by the SNHP Regulatory Agreement. Any income restrictions, or occupancy restrictions overlaying the SNHP Regulated Units must be approved by the LG.
- Developer/Borrowers are required to continually seek future commitments of rental or operating subsidies for the SNHP Regulated Units (*e.g.*, project based Section 8) for the life of the SNHP Loan.
- The LG and Developer jointly submit an application to CalHFA for analysis of the financial viability of a proposal. CalHFA's role is to recommend maximum loans and COSR funding levels so Projects aren't over subsidized; provide evidence of Loan/COSR approvals to LG and Borrower; Issue a Commitment Letter following receipt of tax credits (if applicable); close and fund the SNHP Loan and COSR; monitor the Project during construction through occupancy; and service the SNHP Loan and administer the COSR for as long as COSR funds are available.

County Participation Fees (non-refundable and payable upon receipt of LG funds assigned to CalHFA)

- **3% Program Participation Fee**: for all unencumbered MHSA funds that the LG authorizes be transferred from the MHSA Housing Loan Program to the SNHP before September 30, 2016.
- **5% Program Participation Fee:** for any new LG funds transferred to CalHFA for use in the SNHP (including future MHSA Residual Receipt Loan payments received by CalHFA and authorized by LG to be transferred to the SNHP).

Fees Paid By Developer/Borrower:

- **1% Local Government Ap Fee**: LG may recoup a portion of the Participation Fee by charging the Developer a 1% fee. This Fee is collected by CalHFA at SNHP Loan closing and deposited into the LG's SNHP Funds account at CalHFA.
- **$2,500 CalHFA Application Fee:** A non-refundable fee paid by the Developer at time of submittal of a SNHP Loan Application to CalHFA . This Fee is applied towards the 1% CalHFA Underwriting Fee.
- **1% CalHFA Underwriting Fee:** This Fee is based on the total sum of SNHP Funds provided by LG to a Project. Full payment is due at SNHP Loan closing.

SNHP Recommended Funding Amounts & Terms

SNHP Capital Development Loan & Required Reserves	Capitalized Operating Subsidy Reserve (COSR)
• Recommended 2016 SNHP Loan Limits - $140,000 per SNHP Regulated Unit (increasing by up to 4%/year) • Eligible Use: construction and/or permanent financing • Interest Rate: 3% simple interest loan; residual receipts payments required be paid from 50% of surplus cash flow • Loan Term: 20 to 55 years • Capitalized Operating Expense Reserve: 25% of the first year's approved operating and reserve budget • Required Replacement Reserve: $500 per unit/annually for all units in a Project, increasing by 5% every five years • MHSA Client Rent & Utility Assistance Reserve: reserve that Developer's should fund by completion of a Project. Reserve should equal 3 years' minimum rental income for the SNHP Regulated Units (assuming rents at 30% of SSI). Reserve held by Borrower for Project as a revolving fund to cover rent payments for MHSA Clients waiting for SSI approval. • CalHFA Annual Servicing Fee: $2,500 for Shared Housing Projects with 1-4 units; and $7,500 for five or more SNHP regulated units in a Rental Housing Development.	**For Projects with SNHP Loans:** • Recommended 2016 COSR Limit - $140,000 per assisted unit (increasing by up to 4% a year). • COSR Amount and Term: Each COSR is sized to pay a pro-rata share of the Project's operating expenses and sized to last a minimum of 17 years assuming a 10% vacancy rate* of the SNHP units; 1% SNHP rental income inflation rate; and a 3.5% operating budget inflation rate. (*a 30% vacancy rate is assumed for Transitional Aged Youth regulated units). • Funded: COSR's are capitalized at SNHP Loan closing and serviced by CalHFA. • Disbursements: COSR funds are disbursed beginning at Certificate of Occupancy, and reconciled annually prior to future COSR advancements. • CalHFA Annual COSR Servicing Fee: $5,000 **For Projects with MHSA Housing Program Loans:** • A deposit of any amount may be added to an existing COSR and administered by CalHFA per the terms of existing MHSA COSR Agreements.

Local Government Application & Approval Process

- LG solicits/selects proposals for the construction or acquisition and renovation of rental units using SNHP Funds.
- For each SNHP Project, LG determines: 1) the number and size units (bdrm count) of the Regulated Units; 2)occupancy restrictions and preferences; 3)the maximum SNHP Loan; and 4) the maximum COSR (if applicable).
- LG commits to provide supportive services that meet the needs of the MHSA Clients for the term of the SNHP Loan.
- LG approves each Project's Supportive Service Plan and negotiates a Memorandum of Understanding between the LG, Borrower, property manager, and primary service provider.
- LG obtains all necessary local approvals and completes the required public comment process prior to submitting a SNHP Application to CalHFA for underwriting.
- LG is responsible for reporting the use of MHSA funds as required by State DHCS or other state agency.

CalHFA Application Process

- LG and Developer/Borrower submit a CalHFA Application with required submittals and SNHP Application Fee.
- CalHFA analyzes the proposal and recommends the SNHP Loan and COSR amounts. Any recommended COSR funding level shortfalls must be contributed by the Borrower from other sources and administered by CalHFA subject to the terms of a SNHP COSR Agreement.
- The SNHP Application and checklist, SNHP Loan closing checklists, and boilerplate non-negotiable SNHP loan docs and COSR Agreement will be posted on the CalHFA website .
- The SNHP Regulatory Agreement and Deed of Trust will be recorded in lien priority based on the SNHP Loan size in relation to other residual receipt loans, unless otherwise approved by the LG.

CalHFA Contact Information:

Debra L. Starbuck, Lead SNHP Housing Finance Officer
Office: (530) 878-8075; dstarbuck@calhfa.ca.gov

Refer to Website for more Information:

http://www.calhfa.ca.gov/multifamily/mhsa/index.htm

Participation Agreement

Local Government Special Needs Housing Program

This Participation Agreement ("***Agreement***") for the Local Government Special Needs Housing Program ("***SNHP***" or "***Program***") is entered into and effective as of _____, 2016, by and between _____ ("***Participant***") and the California Housing Finance Agency ("***CalHFA***" or "***Agency***") (each a "***Party***", and collectively the "***Parties***").

RECITALS

A. In 2004, the people of the State of California passed Proposition 63, which established the Mental Health Services Act ("***MHSA***" or the "***Act***"), as subsequently amended. The Act creates the Mental Health Services Fund ("***MHSF***") within the State Treasury for the purposes of funding programs authorized under the Act.

B. Through a joint effort among the State Department of Mental Health (DMH), CalHFA, and the County Mental Health Directors Association, the MHSA housing program was created in 2008 as a limited term program to administer $400,000,000 of MHSA funds set aside to finance permanent supportive housing for individuals with mental illness (the "***MHSA Housing Program***"). With nearly all of the original funding expended or committed, no new financing for housing under the MHSA Housing Program shall be approved after May 30, 2016.

C. Safe, affordable, decent and stable housing is a critical element for wellness, recovery and resiliency for persons with mental illness. The Participant has determined that funds from the MHSF may be used to provide for such housing for persons qualified for services under the Act.

D. CalHFA is the state's affordable housing bank, with expertise in developing and administering real estate lending programs and products benefiting persons of low and moderate income. CalHFA is authorized to enter into contracts to create and administer housing and real estate lending programs for the benefit of other governmental entities in the State of California.

E. This purpose of this Program is to provide an option, subsequent to termination of approvals of new financing under the MHSA Housing Program, for Participants to continue partnering with CalHFA in the development of supportive housing for MHSA-eligible persons, and to more fully utilize MHSA funds for housing purposes.

F. The Participant and CalHFA enter into this Agreement for the purpose of authorizing Participant to provide funding to CalHFA to provide housing development expertise and real estate lending services to the Participant for the construction, rehabilitation, and/or development of housing for persons qualifying for mental health services under the Act.

AGREEMENT

1. Definitions.

"**Act**" is defined in Recital A.

"**Agreement**" means this Participation Agreement

"**Application**" means a Local Government Special Needs Housing Program Application submitted to CalHFA by the Participant and Developer(s).

"**Application Fee**" is defined in Section 4.6.2.

"**Area Median Income**" ("**AMI**")" means the median gross income of the area in which the Development is located as determined by the Secretary of the Treasury of the United States for the purposes of Section 42 of the Internal Revenue Code of 1986, adjusted for family size in accordance with 26 USC 42(g)(2)(c)(ii).

"**Assignment Agreement**" is defined in Section 4.1.

"**Borrower**" means the party, or parties, to whom a Loan is made under this Program.

"**CalHFA**" means the California Housing Finance Agency, a public instrumentality and political subdivision of the State of California.

"**Capitalized Operating Subsidy Reserve** ("**COSR**")" means a capitalized operating subsidy reserve held by CalHFA to cover deficits in operating expenses attributable to a portion or all of the COSR Regulated Units. The COSR will be subject to the terms of a Capitalized Operating Subsidy Reserve Agreement between the Borrower and CalHFA.

"**Certificate of Occupancy**" means a certificate, or equivalent, issued by a local building department to the Borrower that indicates that the Development has met all local code requirements and is ready for occupancy.

"**Concept Meeting**" is defined in Section 5.1.7.

"**COSR**" is defined in Section 2.8.

"**COSRA**" or "**COSR Agreement**" means the agreement between the Borrower and CalHFA governing the COSR.

"**COSR-Assisted Unit**" is defined in Section 2.8.

"**COSR Servicing Fee**" is defined in Section 4.6.5.

"**CTCAC**" means the California Tax Credit Allocation Committee, which approves the competitive allocation of state and federal tax credits to eligible developments.

"**Developer**" means the party selected by a Participant to acquire and renovate or build rental housing that includes rental units reserved for Eligible Clients.

"**Development**" means a housing development for which funds are provided under this Program.

"**Development Proposal**" means a financial proposal by a Developer to renovate or construct a rental or shared housing development that will include units reserved for occupancy by Eligible Clients. A Development Proposal includes the site location and environmental concerns, a summary of the proposed unit mix, rents, any income limits, the proposed sources and uses of funds needed to build the Development, operating expense and vacancy projections, and a 30-year cash flow analysis of the Development following issuance of a Certificate of Occupancy.

"**Eligible Clients**" means a person (including Veterans) who is Homeless or at Risk of Homelessness and who has a mental illness in accordance with California Welfare & Institutions Code Section 5600.3(a) and/or California Welfare & Institutions Code Section 5600.3(b).

"**Eligible Development**" means a Development eligible for financing under this Program, as described in Section 2.5.

"**Final Commitment Letter**" means a letter issued by CalHFA to memorialize the terms and conditions relating to the use of Program Funds and conditions relating to a proposed Development and units reserved for Eligible Clients, including (a) the terms and conditions of the Loan and COSR approval; (b) any reserve requirements, (c) the required Loan lien priority; and (d) any special conditions related to the Development financing or scope of rehabilitation or construction.

"**Financial Analysis**" means the comparison of the Development's anticipated sources of funds to the anticipated development costs, and an income and expense analysis based on proposed rents, utility allowances, vacancy assumptions, rental subsidies, operating expenses, debt service. This analysis allows CalHFA to determine the projected COSR funding levels needed to subsidize the MHSA COSR Assisted Units, and any subsidy, operating or replacement reserves needed to ensure the financial viability of the Development over the first 20-30 years of operations.

"**Homeless or at Risk of Homelessness**" means living on the streets or lacking a fixed and regular night-time residence. This includes living in a shelter, motel or other temporary living situation in which the individual has no tenant rights. "At Risk of Homelessness" may be due to one of the following situations: (a) transition age youth exiting the child welfare or juvenile justice systems; (b) discharge from crisis and transitional residential settings, a hospital, including acute psychiatric hospitals, psychiatric health facilities, skilled nursing facilities with a certified special treatment program for the mentally disordered, and mental health rehabilitation centers; (c) release from city or county jails, but not a parolee from state prison; (d) temporary placement in a residential care facility upon discharge from (b) or (c) above; and (e) individuals who have been assessed and are receiving services from the County Mental Health Department and who have been deemed to be at imminent risk of homelessness, as certified by the County Mental Health Director.

"**Loan**" means a secured loan financed with Program Funds under the terms of the Program.

"**Memorandum of Understanding**" or "**MOU**" means an agreement between the developer, the primary service provider(s), the property management company, and the Participant to ensure compliance with the Regulatory Agreement terms and other Development regulatory agreements that may impose income restrictions or more restrictive rent limits on the Regulated Units. The property management agent and the primary service provider may be related entities, provided there is a clear separation of staff and a clear delineation of their separate roles, staffing and responsibilities in the MOU.

"**MHSA Housing Program**" is defined in Recital B. . The MHSA Housing Program is governed by an Interagency Agreement solely between CalHFA and the State Department of Health Care Services ("***DHCS***") (the successor to DMH), with continuing obligations of CalHFA and DHCS. Housing financed under the MHSA Housing Program remains subject to the terms thereof.

"**MHSF**" is defined in Recital A.

"**Participant**" means any local mental health agency, or two local government agencies acting jointly, receiving MHSA funds pursuant to Welfare and Institutions Code Section 5701.5 (9 CCR § 3200.090) and which is a Party to this Agreement.

"**Participant Funds**" means MHSA or other funds transferred from the Participant to CalHFA for use per the terms of the Program and this Agreement, and may include residual receipt loan payments received by CalHFA for repayment of MHSA Housing Program loans or SNHP Loans that the Participant approves for transfer to CalHFA for use per the terms of the Program and this Agreement.

"**Participant's Account**" means an account established at CalHFA for the purpose of holding Participant Funds transferred to CalHFA under the terms of the Program and this Agreement, which may include sub-accounts. The Participant's Account includes quarterly interest earnings, disencumbered COSR funds, and may include residual receipt loan payments authorized by Participant to be deposited therein.

"**Party**" and "**Parties**" are defined in the first paragraph of this Agreement.

"**Permanent Loan Conversion**" means the conversion of construction loans to permanent status, and may include payment in full or part of the principal of a construction loan or the funding of additional loans upon completion of construction. Permanent Loan Conversion may be subject to additional due diligence requirements.

"**Primary Service Provider**" means the entity responsible for overall implementation and delivery of the supportive services to the Eligible Clients as specified in an Eligible Development's supportive services plan approved by the Participant.

"**Program**" or "**SNHP**" shall mean the Local Government Special Needs Housing Program administered by CalHFA in accordance with this Agreement.

"**Program Funds**" shall mean Participant Funds transferred to CalHFA, plus accrued interest, to be used to finance SNHP Loans or COSR's for Eligible Developments or such other purposes agreed upon by the Parties.

"**Program Participation Fee**" or "**PPF**" is defined in Section 4.5.

"**Regulated Unit**" means a rent and occupancy-restricted bedroom or unit in a Development reserved for Eligible Clients under the Program.

"**Regulatory Agreement**" means a Development-specific regulatory agreement that restricts occupancy of a specific number of units/bedrooms reserved for Eligible Clients. The Regulatory Agreement shall (a) identify the number, size (number of bedrooms), and use or occupancy restrictions of the Regulated Units; (b) specify the maximum rents for the regulated units; and (c) be recorded senior to the Loan deed of trust.

"**Rental Housing Development**" means an apartment building or buildings with five or more apartments. Individual apartments or bedrooms within an apartment may be rented to Eligible Clients as Shared Housing Units. A Rental Housing Development shall not include a Development which is subject to any State of California licensure requirements.

"**Servicing**" is defined in Section 6.2.

"**Servicing Fee**" is defined in Section 4.6.5.

"**Shared Housing Development**" means a residential building having less than five apartments (a single family home, duplex, tri-plex or four-plex), with each bedroom rented to an Eligible Client and is not subject to any State of California licensure requirements. Each bedroom within a Shared Housing Development is a Regulated Unit and considered a "**Shared Housing Unit**".

"**Shared Housing Unit**" means a bedroom that is leased to an Eligible Client living in a Shared Housing Development or a Rental Housing Development.

"**SNHP**" or "**Program**" means the Local Government Special Needs Housing Program developed and administered by CalHFA in accordance with this Agreement.

"**Term Sheet**" is defined in Section 2.10

"**Underwriting Fee**" is defined in Section 4.6.3.

"**Unit**" means (a) a traditional apartment residence containing at least one (1) bathroom and a kitchen in the case of Rental Housing Developments; or (b) a separate lockable bedroom in the case of Shared Housing Developments, with each bedroom being subject to a separate individual rental agreement.

2. General Program Description

2.1 Purpose. The purpose of the Program is to allow local government recipients of MHSA funds to partner with and utilize CalHFA's expertise to jointly provide supportive

housing and housing assistance for Eligible Clients (and their families). This Program is separate and independent from the MHSA Housing Program. This Program shall not affect the rights and obligations of any party under the MHSA Housing Program, and the MHSA Housing Program shall not affect the rights and obligations of any party under this Program.

2.2 Participant's Role. Eligible Participants include local governments that provide MHSA and/or other funds (collectively, the ***"Program Funds"***) to CalHFA for the purpose of providing financial assistance in accordance with this Agreement. Participant shall be responsible for those items listed in Section 3.1.

2.3 Eligible Use of Program Funds. Program Funds may be used to finance capital development loans for the development of new permanent supportive rental housing and to provide operating subsidies for some, or all of the rental housing units reserved for Eligible Clients. Subject to CalHFA approval, and such conditions deemed necessary or advisable by CalHFA, Program Funds may also be used to provide financial assistance to housing developments financed under the MHSA Housing Program.

2.4 Eligible Borrowers. The Borrower must be legally organized as a single-asset entity, or entity that holds title only to MHSA or SNHP Developments, or as otherwise approved by Participant.

2.5 Eligible Developments. Eligible Developments include new construction or the acquisition and rehabilitation of a Rental Housing Development or Shared Housing Development to provide new permanent supportive housing for Eligible Clients, which may include occupancy restrictions (including preferences or other restrictions), such as units for seniors, veterans, or transitional aged youth, as determined by Participant. Master leasing is not permitted.

2.6 Loans

2.6.1 Loans shall be fixed at 3% simple interest (unless otherwise approved by Participant), require annual residual receipt payments (in accordance with the Regulatory Agreement), and have a minimum term of twenty (20) years. Proposed Loans must be sized based on the recommended Loan Limits reflected on the most current Term Sheet, unless otherwise approved by Participant.

2.6.2 Accrued interest and principal payments on Loans will be required on an annual basis, payable from residual receipts (*i.e.*, from 50% of surplus cash after payment of approved operating expenses) to the extent available and in proportion to other residual receipts lenders' loan amounts, as more particularly described in the Regulatory Agreement and Loan documents.

2.6.3 Accrued and unpaid interest and principal shall be due and payable in full upon maturity of the Loan, except as otherwise approved by Participant.

2.6.4 The Loan term shall be coterminous with the term of the Development's shortest residual receipts or deferred loan, except as otherwise approved by Participant.

2.6.5 The Loan shall be secured against the fee interest in the property (or leasehold interest if approved by Participant) in a lien position based on size of the Loan compared to other residual receipt loans or as otherwise approved by Participant.

2.6.6 Predevelopment loans are not permitted under the Program. Loan closing may only occur prior to the start of construction or at Permanent Loan Conversion.

2.7 Regulated Units. A Regulatory Agreement will be recorded and will restrict the Development and the Regulated Units.

2.8 Capitalized Operating Subsidy Reserve. The Participant may elect to provide a capitalized operating subsidy reserve (the "***COSR***") funded with Program Funds to subsidize the rents of some or all of the Regulated Units (the "***COSR-Assisted Units***") by approving a maximum COSR as part of the Application.

2.8.1 COSR funds shall be held by CalHFA in a Development-specific reserve account subject to the terms of the COSR Agreement.

2.8.2 Except as otherwise approved by Participant, the rents for COSR-Assisted Units shall not exceed the greater of: (a) 30% of the current SSI/SSP grant amount for a single individual living independently (less CTCAC utility expenses and other mandatory fees); or (b) 30% of total household income (less CTCAC utility expense and other mandatory fees), whichever is higher (up to 30% of 30% of AMI adjusted for family size and determined annually by CTCAC).

2.8.3 CalHFA is responsible for advising the Participant of the continuing need for the COSR if a Development receives new operating or rental subsidies for the COSR-Assisted Units. If the COSR is no longer needed, the COSR funds shall be disencumbered and returned to Participant's Account.

2.9 MHSA Housing Program Development Assistance. As a convenience to Participants with housing developments financed under the MHSA Housing Program, CalHFA will permit a Participant to request that Program Funds in Participant's Account be transferred to and used to provide financial assistance for housing developments financed under the MHSA Housing Program. The use of Program Funds for such purpose shall be subject to CalHFA approval and to such conditions deemed necessary or advisable by CalHFA, or as otherwise required under the MHSA Housing Program.

2.9.1 Requests under this Section 2.9 shall be in written form acceptable to CalHFA and signed by an authorized representative of Participant.

2.9.2 Program Funds transferred under this Section 2.9 may be used for any purpose that benefits the development or the MHSA tenants, including without limitation providing additional funds for operating subsidy reserves, paying costs and expenses in

connection with ensuring the continued availability of the MHSA units, and protecting or preserving the security interest in the MHSA Housing Program development.

2.9.3 Program Funds transferred to or used for MHSA Housing Program developments shall thereafter be subject to the terms of the MHSA Housing Program.

2.10 Term Sheet. CalHFA shall publish a SNHP Term Sheet (the "***Term Sheet***") on its website (www.calhfa.ca.gov) providing details of the Program, including recommended Loan and COSR limits per Regulated Unit, required Borrower or Developer-paid fees, and reserve requirements. The Term Sheet is subject to change at CalHFA's discretion; Participants will be notified of changes. In the event of a conflict between this Agreement and Term Sheet, the provisions of this Agreement shall control. A Participant may provide its own term sheet to sponsors or developers detailing supplemental Program terms and conditions.

2.11 Lender. Program Funds being used under this Program are being provided by the Participant and are being loaned or otherwise used in accordance with the Participant's direction. All Loan payments, interest, and other income with respect to the Program Funds shall be deposited in the Participant's Account unless otherwise directed by Participant. Because CalHFA shall be underwriting and closing the Loans in accordance with this Agreement, the Loan documents shall be in the name of CalHFA, solely for ease of administration. CalHFA's obligations and responsibilities in this regard shall be limited as prescribed herein.

2.12 Collaborative Effort. As a jointly created and administered Program, the Parties shall continue to work together to address and resolve issues that may arise with respect to the Program or a particular Development.

3. General Responsibilities of the Parties

The general responsibilities of the Parties concerning the operation and implementation of the Program are listed below, subject to any specific requirements provided elsewhere in this Agreement, in statute and/or in regulation.

3.1 Participant Responsibilities. Participant shall be responsible for each of the following general matters with respect to the Program:

3.1.1 The interpretation and implementation of the terms of the Act with respect to matters relating to mental health programs and services contemplated by the Act, including the definition of persons qualifying for services under the Act, as such may affect the Program.

3.1.2 Determination of the qualification for and delivery of the mental health and supportive services under the Program and the Eligible Client population.

3.1.3 All agreements, contracts, consents, public notices, and approvals by or with local agencies, or other entities that may be required by the Act, or otherwise needed to implement the Program.

3.1.4 All matters related to Participant Funds (whether from MHSF or another source) provided to CalHFA for the Program, including approvals that may be required prior to the transfer of any such monies to the possession and control of CalHFA under the Program, and all matters relating to accounting, transfer and distribution of such Program Funds.

3.1.5 Determination of the following: (a) maximum SNHP Loan or COSR amount per Regulated Unit; (b) term of the COSR; (c) unit sizes and bedroom count permitted for Shared Housing occupancy; (d) lien priority of the Loan documents; (e) Loan interest rate, term and repayment requirements; and (f) maximum Regulated Unit rents.

3.1.6 All matters relating to Participant approvals and agreements regarding tenant selection and supportive services to be provided to Eligible Clients residing in Regulated Units, including supportive services plans, staffing ratios and budget appropriations, monitoring and implementation of services plans and tenant mental health outcomes reporting as required by Participant, the State Department of Health Care Services ("***DHCS***"), the County Behavioral Health Directors Association (CBHDA) or any other oversight committee or agency.

3.1.7 Executing a Memorandum of Understanding (or such other agreement), as Participant deems necessary, with the Borrower, property manager, primary service provider, and providing a copy of such agreement to CalHFA.

3.1.8 Reporting to CalHFA on matters listed in Section 8 of this Agreement.

3.2 CalHFA Responsibilities. CalHFA shall be responsible for each of the following general Program matters:

3.2.1 Development of such lending operations and protocols identified in Section 5.2 or as may be needed to implement the Program, including development of: (a) an Application; (b) specific Loan and COSR approvals; (c) the issuance of Loan commitments; (d) Loan and COSR documentation, including but not limited to escrow instructions, promissory note, deed of trust, regulatory agreement, and subordination agreements, as applicable.

3.2.2. Representation of Participant in negotiations with developers, borrowers, investors, other lenders, local governments, service providers and property management firms; issuing Loan and COSR commitments; closing Loans, and obtaining title insurance.

3.2.3 Underwriting the Development Proposal, including preparation of a Financial Analysis to determine the anticipated COSR needed to subsidize the COSR-Assisted Units for the term requested by Participant.

3.2.4 All matters related to the handling, investment and disbursement of Program Funds provided to CalHFA.

3.2.5 Reporting to Participant on matters listed in Section 7.

3.2.6 The Servicing responsibilities described in Section 6.2.

4. Financial Provisions

4.1 Participant shall obtain all consents, approvals or agreements necessary to transfer Program Funds to CalHFA for purposes of operating the Program. Transfers of such monies shall be made pursuant to a written assignment agreement (the "***Assignment Agreement***") submitted to and accepted by CalHFA.

4.2 Participant's assigned Program Funds shall be transferred to, and deposited with, CalHFA and held in the Participant's Account.

4.3 All monies transferred to CalHFA shall be considered expended for their intended purpose upon the date of receipt by CalHFA.

4.4 During the term of this Agreement, CalHFA shall have control of, and shall administer, all Program Funds on behalf of Participant. These funds shall be held by CalHFA for the exclusive purposes of the Program. Program Funds held by CalHFA shall be considered assets of CalHFA until such time as transferred to a Development or returned to Participant. CalHFA shall be responsible for the investment of all Program Funds. Interest earnings upon such investments shall be added to the Participant's Account for the purposes of the Program.

4.5 Participant shall pay CalHFA a program participation fee equal to five percent (5%) of the amount of Program Funds transferred from the Participant to CalHFA, (the "***Program Participation Fee***" or "***PPF***"). The PPF is due and payable upon receipt of Program Funds and shall be deducted from the Program Funds by CalHFA upon receipt, prior to deposit of the balance of the Program Funds into the Participant's Account. Notwithstanding the foregoing, Participant may transfer funds to CalHFA from the following sources subject to a reduced fee of three percent (3%) of the amount transferred: (a) any existing unencumbered funds from Participant's MHSA Housing Program account, until September 30, 2016; and (b) any COSR funds committed, or loan funds committed, to Participant's developments under the MHSA Housing Program that become disencumbered.

4.6 Developer or Borrower shall pay Project-Related Fees as listed in the Term Sheet, and as follows:

4.6.1 Participant Application Fee. Participant may, at its option, charge the Borrower a fee of up to one percent (1%) of the sum of all Program Funds provided to a Development (the "***Participant Application Fee***"). Such fee shall be due and payable to CalHFA at Loan closing and shall be paid from a source other than Program Funds. Upon receipt by CalHFA, this fee shall be deposited into the Participant's Account and held by CalHFA for eligible Program purposes, unless otherwise directed by Participant.

4.6.2 SNHP Application Fee. A non-refundable fee payable to CalHFA in the amount listed in the Term Sheet (the "***Application Fee***"). Such fee shall be due and payable with the submittal of an Application. The Application Fee shall be credited towards the Underwriting Fee.

4.6.3 CalHFA Underwriting Fee. A non-refundable fee payable to CalHFA at Loan closing equal to one percent (1%) of the sum of all Program Funds provided to a Development (the "***Underwriting Fee***"), less the Application Fee.

4.6.4. Escrow/Closing Fees. CalHFA may charge reasonable escrow and loan closing or disbursement administration fees to Borrower through escrow.

4.6.5. Servicing Fee and COSR Servicing Fee. Borrower shall pay CalHFA an annual servicing fee (the "***Servicing Fee***") for so long as CalHFA is providing Servicing for a Development, and Borrower shall pay CalHFA an annual COSR servicing fee (the "***COSR Servicing Fee***") for so long as a COSR exists and CalHFA is providing Servicing. For a Development of five or more rental units the Servicing Fee shall be $7,500 and the COSR Servicing Fee shall be $5,000. For a Development of one to four rental units the Servicing Fee shall be $2,500 and the COSR Servicing Fee shall be $5,000. The Servicing Fee and COSR Servicing Fee may be increased, in CalHFA's sole discretion, as necessary to cover CalHFA's costs upon a refinancing, restructuring, or other event requiring changes to the Loan documents. The Servicing Fee and COSR Servicing Fee shall be described in the Regulatory Agreement, shall be approved Development operating expenses, and shall be paid in advance annually from Development income. Failure to pay the Servicing Fee or COSR Servicing Fee shall be considered an event of default under the Development loan documents.

4.7 Other Costs/Responsibilities

4.7.1 Participant shall be responsible for and shall pay the cost of any litigation, action or proceeding relating to (a) the consistency of the Program with the terms of the Act or other provision of applicable law; (b) the authority of Participant to implement the Program or the validity, legality, applicability or interpretation of any regulation or programmatic requirement of Participant with respect to the Program; (c) the allocation, reallocation, distribution, return or transfer of Program Funds by Participant in connection with the Program; (d) the legal challenge concerning the legality of any use or occupancy restriction associated with the Program or Regulated Units; and (e) any other matters related to the terms or requirements of the Act as it may affect the Program. Participant shall indemnify, defend and hold harmless CalHFA, its officers, agents and employees for any and all claims and costs with respect to the above.

4.7.2 Participant shall be responsible for and shall pay for costs associated with enforcement of Development Loan documents, and for services outside the scope of this Agreement, as more fully described in Section 6.1.7. Such costs may be paid from Participant's Account upon Participant's approval.

4.7.3 CalHFA shall be responsible for and shall pay for costs related to actions due to CalHFA's gross negligence or willful misconduct in processing Program Loans or COSR.

4.7.4 If Program Funds in the Participant's Account are insufficient to make loans or otherwise pay any fees or costs payable therefrom, CalHFA shall have no obligation to contribute or advance any CalHFA funds to such accounts, nor shall CalHFA be required to take any action which would have been otherwise required if such funds were available.

5. Relationship of the Parties in the Application and Development Process

5.1 Participant shall be responsible for the following:

5.1.1 Completing a local review process to determine eligible Developments to receive Program Funds, including: (a) selecting the Developments to receive SNHP Funds, which assumes Participant acceptance of the development team (including the developer(s), property management firm and service provider if other than Participant); (b) approving the location of the Development; (c) identifying the number and size of Regulated Units (bedroom count), and any use or occupancy restrictions; (d) identifying the maximum rent; and (e) selecting the supportive services provider;

5.1.2 Seeking and obtaining all required Program Funds local approvals before executing and submitting the Application to CalHFA;

5.1.3 Preparing and submitting, jointly with the Borrower, an Application for CalHFA underwriting to include: (a) the maximum SNHP Loan being offered; (b) the number of Regulated Units and their maximum rent (not to exceed 30% of 30% AMI); (c) if applicable, the number of COSR Assisted Units, the maximum COSR funding available, and the maximum COSR subsidy term for the COSR-Assisted Units; and (d) any use or occupancy restrictions on the Regulated Units or unit sizes.

5.1.4 Developing and obtaining any required local approvals for each Development's supportive services plan, and annual budget and staffing required to ensure adequate supportive services are provided to the tenants in Regulated Units for the life of the Program Loan;

5.1.5 Developing a tenant selection plan for each Development, and ensuring compliance with all local, state and federal fair housing laws;

5.1.6 If desired, requiring Borrower to provide a purchase appraisal or real estate value analysis for CalHFA review, since the Program imposes no loan-to-value constraints;

5.1.7 Participating in CalHFA-required concept meetings for each Development, which shall include, as applicable, the developer(s), property manager, service provider(s), other lenders, and the investor (the "***Concept Meeting***"). The Concept Meeting provides an overview of the Development Proposal, including the Eligible Client supportive service needs, the experience of the property manager and primary service provider, and proximity to other resident service needs.

5.1.8 Reviewing CalHFA's recommended Loan and COSR amounts for each Development, and providing written acceptance or alternative amounts.

5.1.9 Prior to occupancy of a Development and release of the first COSR draw (if applicable), Participant shall provide to CalHFA the approved supportive services plan.

5.1.10 Participant shall be responsible for coordinating with Borrowers and property managers to ensure adequate numbers of Eligible Clients are referred to Developments to fill vacancies in a timely manner.

5.1.11 To ensure the financial success of each Development, Participant shall ensure that the MOU for each Development identifies which party is responsible for working with Eligible Clients to assist them in getting qualified for SSI or assists Borrower in locating alternative subsidies to cover the Eligible Client's minimum required rent payment. Participant shall provide a copy of the MOU to CalHFA.

5.2 CalHFA Responsibilities

5.2.1 CalHFA will review complete Applications and recommend and approve Loans and COSR amounts.

5.2.2 CalHFA will coordinate with Applicants to schedule a Concept Meeting, which shall typically be held within 30 days of receipt of a complete Application.

5.2.3 CalHFA will underwrite each Development Proposal and recommend to Participant the maximum Loan and minimum COSR's needed to subsidize all or a portion of the Regulated Units for a minimum of 17 years. CalHFA will also advise the Participant of any supplemental regulatory provisions or income restrictions imposed by other lenders or CTCAC that would potentially affect the rents, or impose income restrictions on the Regulated Units.

5.2.4 Following receipt of Participant's approval of a final Loan amount and COSR for a Development, CalHFA will issue an approval that authorizes the encumbrance of Participant Funds for the Development.

5.2.5 Following CalHFA approval and the Development's receipt of a CTCAC allocation (if applicable), CalHFA will issue a Final Commitment Letter.

5.2.6 Following receipt of the required Loan closing checklist items, as posted on the CalHFA website, CalHFA will close the Loan, release any approved draws and fund the COSR from the Participant's Account. The COSR funds will be held by CalHFA in a Development-specific account along with any Development-specific reserve accounts funded by the Borrower and held by CalHFA.

5.2.7 CalHFA will monitor the rehabilitation and construction of each Development, as necessary. Borrower shall be responsible for costs of any reports and inspections, which shall be paid prior to Loan closing and held by CalHFA.

5.2.8 CalHFA will participate in the Permanent Loan Conversion and require Borrower to submit all appropriate documentation.

6. Relationship of the Parties After Completion of Loan Transaction

The Parties shall have the following responsibilities after the completion of the Loan transaction, which shall be deemed to be the latest of Loan closing, Development completion and stabilized occupancy, or Permanent Loan Conversion, as applicable.

6.1 Participant Responsibilities

6.1.1 Providing mental health supportive services to the tenants of the Regulated Units. Participant shall also ensure that each Development has an acceptable supportive services plan, and that any modifications to the supportive services plan are appropriate to meet the needs of Eligible Clients and the Development(s);

6.1.2 Approving any modifications or amendments to the supportive services plan and providing a copy to CalHFA;

6.1.3 Monitoring outcome reporting data collection and compilation, as it deems necessary in order to meet all local and state MHSA reporting requirements, as applicable, and providing such information to local and state entities, if required;

6.1.4 Providing financial and other information as requested by CalHFA with respect to the Program or Development(s);

6.1.5 Coordinating with Borrowers and Development property managers to ensure adequate numbers of Eligible Clients are referred to Developments to fill vacancies in a timely manner;

6.1.6 Coordinating with the MOU parties to monitor the Development to ensure the MOU requirements are met;

6.1.7 Additional services beyond those specified in Section 6.2, including without limitation: (a) specific enforcement; (b) judicial or non-judicial foreclosure; (c) receivership; (d) legal fees; (e) Loan document changes related to a default, or potential default, under the Loan documents; (f) title insurance claims; and (g) advancement of funds to pay insurance and taxes (or as otherwise necessary to preserve the security interest in the Development) shall be the responsibility of Participant, including all associated costs. CalHFA will advise Participant with respect to real estate lending issues related to the foregoing. Subject to a separate agreement between the Parties, CalHFA may agree to assist Participant with the foregoing. Such costs may be paid from Participant's Account upon Participant's approval;

6.1.8 Advising CalHFA of changes, or proposed changes, to: (a) Eligible Client populations; (b) the number of Regulated Units, and use or occupancy restrictions, (c) the number of COSR-Assisted Units, (d) the Regulated Unit rents, (e) the Loan documents, such as related to a default or potential default under the Loan documents; and (e) other changes to a Development.

6.2 CalHFA Responsibilities. CalHFA shall provide the asset management services described below ("***Servicing***") for Participant's SNHP Loans, subject to the Servicing Fee and COSR Servicing Fee described in Section 4.6.5. The Servicing shall include the following:

6.2.1 Review and approval of the following required Borrower submittals (which Borrower must also submit to Participant), including: (a) annual SNHP self-certification Development report(s); (b) evidence of property and liability insurance; (c) Regulated Unit rent rolls and proposed rent increases; (d) current local Housing Authority utility allowances by unit size; (e) proposed line item operating budget; (f) evidence of rental subsidies; (g) annual Development audits showing actual rents and operating costs for the prior year; and (h) COSR draw requests;

6.2.2 Hold, control and approve disbursements of Development reserve accounts and COSR, as applicable;

6.2.3 Determine appropriate investment vehicles for the Agency-held Program Funds and deposit interest earnings into the applicable Participant or Development account;

6.2.4 Perform periodic reviews regarding the adequacy, use, disbursements, and need for COSR on any given Development, and annually provide the results of such reviews to Participant. Subject to Participant consent, the COSR may be reduced or eliminated and the funds reallocated as directed by Participant;

6.2.5 Perform inspections and prepare physical inspection reports biennially or as deemed necessary by CalHFA, and provide copies to Participant if requested.

6.2.6 Provide concurrently to Participant and the Borrower any statutory notices of default under the Loan documents;

6.2.7 Accept SNHP Loan or other payments from a Borrower or Development and disburse such funds at least annually to Participant. If instructed by Participant in writing, CalHFA may transfer such payments or other income to Participant's Account, subject to the Program Participation Fee.

6.2.8 Failure to pay the Servicing Fee or COSR Servicing Fee shall be considered an event of default under the Development loan documents. If the Borrower fails to pay the Servicing Fee or COSR Servicing Fee, CalHFA may, at its option, (a) deduct the fees from any CalHFA-held Development reserve account, and withhold future COSR disbursements (if applicable) until payment is received, or (b) deduct the fee from the Participant's Account following Participant notification.

6.2.9 Subject to an additional fee to be paid by Borrower, as necessary to cover CalHFA's costs as determined by CalHFA, CalHFA may agree to provide certain other administrative services in connection with the SNHP Loan, such as processing requests for approval of Borrower organizational changes, transfers of the Development or other ownership changes, and substitution of property management firms.

6.2.10 Subject to a separate agreement between the Parties if deemed necessary by CalHFA, CalHFA may agree to assist Participant with the services described in Section 6.1.7, as well as transactions related to refinancing, restructuring, or other changes to the Loan documents, Development or Borrower. Costs for such services will not exceed the amount necessary to cover CalHFA's costs as determined by CalHFA and may be paid from Participant's Account upon Participant's approval.

7. CalHFA Reporting Requirements

7.1 CalHFA shall keep such books and records of the operation of the Program and the Developments, pursuant to common accounting principles, practices and state laws.

7.2 CalHFA shall prepare annual reports to Participant that include key results and funding for the costs associated with Participant Developments. CalHFA shall provide such reports to Participant no later than March 31st of each year.

7.3 Commencing in 2017 and each fiscal year thereafter, CalHFA shall provide to Participant an accounting of Program Funds to include: (a) the amount of funds held by CalHFA at the beginning of the reporting term; (b) the amount of new funds received from Participant; (c) the amount of funds received from Loan repayments or unused COSR deposits to the Participant's Account; (d) the amount of interest earned on Program Funds by date posted; (e) the amount in the Participant's Account at the end of the reporting term; and (e) a report on the total amount of committed and uncommitted Participant Funds by Development.

8. Participant Reporting Requirements

8.1 Participant shall report to CalHFA by May 1st of each calendar year the anticipated amount of new Program Funds that will be assigned to CalHFA after July 1st of the same calendar year for Program purposes during the fiscal year commencing July 1st. Transfers of Program Funds may be made periodically, subject to an Assignment Agreement submitted to and accepted by CalHFA.

8.2 Participant shall provide all reports and other information to such parties as may be required under the Act, or as requested by CalHFA from time to time.

9. Return of Program Funds

Participant may request the return of any unencumbered Program Funds remaining in Participant's Account by providing sixty (60) days' written notice to CalHFA.

10. Miscellaneous

10.1 No Third Party Beneficiaries. This Agreement is for the exclusive benefit of the parties hereto and no rights of third party beneficiaries are created herein. This Agreement shall not benefit or create any implied or expressed rights of any third person or entity, including but not limited to the California Department of Health Care Services, the Borrower, Development sponsor, Development owner, service provider, or any tenant or applicant for tenancy of a Development.

10.2 Entirety, Amendments, Construction. This Agreement supersedes any and all other agreements, oral or in writing, between the parties hereto with respect to the subject matter hereof and contains all of the covenants and agreements between the parties with respect thereto. Each Party to this Agreement acknowledges that no representations, inducements, promises, or agreements, orally or otherwise, have been made by any Party, or anyone acting on behalf of any Party, which are not embodied or referred to herein, and that no other agreement, statement, or promise not contained or referred to in this Agreement shall be valid or binding. No amendment or modification of the provisions of this Agreement shall be valid unless made in writing and signed by the parties hereto. This Agreement shall not be construed as if it had been prepared by one of the parties, but rather as if both of the parties had prepared it.

10.3 Survival. The terms, conditions, and warranties contained in the Agreement that by their sense and context are intended to survive the performance hereof by the parties hereunder shall so survive the termination of the Agreement, whether by completion of the performance, cancellation, or otherwise.

10.4 Potential Conflict of Interest. If, in addition to a Loan pursuant to this Agreement, CalHFA provides a separate loan secured by a Development, it may create a perceived or actual conflict of interest. Participant hereby waives any such conflict of interest and agrees to execute any additional document as deemed reasonable or necessary by CalHFA. By executing this Agreement, Participant and CalHFA agree that CalHFA is not assuming any obligations beyond those required under California law applicable to senior lenders, unless expressly set forth herein.

11. Termination

11.1 Either Party may terminate this Agreement with or without cause by providing sixty (60) days' written notice to the other Party. However, any Developments with approved/encumbered SNHP Program Funds shall continue to be processed by CalHFA. Upon termination of this Agreement: (a) CalHFA's authority to lend Participant Funds under the Program shall cease; (b) CalHFA shall retain responsibility for the Servicing for Developments for which it is providing such services, subject to Section 11.2; (c) all uncommitted/unencumbered Program Funds held by CalHFA shall be returned to Participant; and (d) all future funds received from a Development, including payments, interest earned, and other income, shall be returned to Participant or transferred in accordance with Participant's written instructions. Upon termination of this Agreement, Participant's responsibilities under Sections 3.1, 4.7.1, and 4.7.2 and any responsibilities with respect to existing Developments shall remain in full force and effect.

11.2 Termination of Servicing

11.2.1 Participant may terminate CalHFA as the Servicer for all, but not less than all, of Participant's Developments under the Program by providing CalHFA with one hundred eighty (180) days' written notice. Upon such termination, CalHFA shall assign and Participant shall assume all Loans in accordance with Section 12, and CalHFA shall transfer to Participant all files and records related to the Developments, after which CalHFA shall have no further responsibilities and obligations with respect to the Developments.

11.2.2 CalHFA may terminate Servicing for one or more of Participant's Developments under the Program by providing Participant with one hundred and eighty (180) days' written notice if: (a) Participant breaches any provision of this Agreement and such breach is not cured within sixty (60) days; (b) CalHFA no longer has adequate staff to provide such services; or (c) Borrower is in default under the SNHP Loan and such default has not been cured within one hundred and eighty (180) days. Upon such termination, CalHFA shall assign and Participant shall assume such Loan(s) in accordance with Section 12, and CalHFA shall transfer to Participant all files and records related to the Development(s), after which CalHFA shall have no further responsibilities and obligations with respect to the Developments.

12. Assignments of Program Loans

In addition to any other assignment provision hereunder, if with respect to a particular Development Participant does not meet its obligations under the Agreement, or otherwise breaches the terms of this Agreement, CalHFA may assign, and Participant agrees to assume, the Loan and all related Development loan documents and associated responsibilities and obligations (including the Servicing). Upon any assignment of a Loan under this Agreement, CalHFA's responsibilities and obligations with respect to such Loan and Development shall cease. The Parties agree to take such steps as necessary to effect such assignment.

13. Notice

Any notice, tender, or delivery to be given hereunder by either Party to the other may be effected by personal delivery, in writing, by facsimile transmission, by e-mail or by mail, postage prepaid, and shall be deemed communicated as of the date of actual receipt. Mailed notices shall be addressed as set forth below, but each Party may change its address by written notice in accordance with this paragraph.

Participant Contact Information

_____
_____
_____
_____

CalHFA Contact Information

Executive Director
California Housing Finance Agency
500 Capital Mall, Suite 1420
Sacramento, California 95814

With copy to:
General Counsel
California Housing Finance Agency
500 Capital Mall, Suite 1420
Sacramento, California 95814

WHEREFORE, the parties hereto have executed this Agreement as of the date set forth above, and by their signatures acknowledge their understanding of and agreement to all of its provisions.

Participant

By: _____
Name: _____
Title: _____

Approved as to Form:

By: _____
Name: _____
Title: _____

CalHFA

CALIFORNIA HOUSING FINANCE AGENCY, a public instrumentality and political subdivision of the State of California

By: _____
_____, Executive Director

Appendix - C

EachMind MATTERS
California's Mental Health Movement

CalMHSA Statewide PEI Project 2015-2016 County Impact Report: **LAKE COUNTY**

County FY 2015/2016 contribution to Statewide PEI Project:
$27,028.00 (7% of local MHSA PEI Funds)

In fiscal year 2015-2016, 42 counties collectively pooled local PEI funds through CalMHSA to support the first year implementation of the Statewide PEI Project. Statewide, the funding supported programs such as maintaining and expanding social marketing campaigns, creating new outreach materials for diverse audiences, providing technical assistance and outreach to counties, schools and local community based organizations, providing stigma reduction trainings to diverse audiences, and building the capacities of higher education schools to address stigma reduction and suicide prevention.

Notably, CalMHSA funds significant contracts with organizations that have expertise in creating high quality culturally adapted materials. Those contracts allow for Lake County to have added-value components to outreach resources, tools and materials. Additionally, this reduced Lake County's cost for this critical investment in culturally adapted social marketing, outreach, trainings and stigma and discrimination reduction best practices. Lake County is able to access these partners and receive resources and services at a reduced rate.

The information below highlights some key activities that were specifically implemented within Lake County in 2015-2016.

Agencies, Schools and Organizations Reached with Statewide PEI Programs
Lake County Behavioral Health Services received outreach materials and technical assistance stigma reduction and suicide prevention through the collective efforts of all programs implemented under the Statewide PEI Project.

Technical Assistance

- Received monthly emails from Resource Navigator, which included Each Mind Matters updates, description of new resources, and identifying relevant resources that support specific target audiences.
- County had continual access to a designated Each Mind Matters Resource Navigator, which provided Lake County with support in orienting new staff to Each Mind Matters, and to help prepare local mental health awareness week activities.
- Had access to and participated in CalMHSA's monthly County Liaison calls.

Dissemination of outreach resources
Between July 1, 2015- June 30, 2016, 3,100 materials across Each Mind Matters programs and initiatives were disseminated throughout the county. In addition, the county received numerous reminders to access and share resources electronically via www.yourvoicecounts.org and http://catalogue.eachmindmatters.org/.

Directing Change Materials	81
Each Mind Matters Promotional Items	3,007
Know the Signs Outreach Materials	12

Directing Change
While Lake County was invited to promote and participate in Directing Change, there were no submissions from the county in FY 2015-2016.
View the previous winning Directing Change videos developed by other counties here: http://www.directingchange.org/films-by-county/.

Walk In Our Shoes
Although there were no Walk In Our Shoes performances conducted in the county, all counties had access to the parent and teacher tools and full Walk In Our Shoes performance on video at www.walkinourshoes.org.

Appendix - D

Lake County Behavioral Health
Mental Health Services Act
Fiscal Year 2016/17 Annual Update
Notice of 30-Day Comment
And Public Hearing
March 18, 2017

Lake County Behavioral Health is announcing the 30-day comment period from March 20 – April 19, 2017 for the FY 2016/17 Annual Update to the Mental Health Services Act Three-Year Program and Expenditure Plan.

The public hearing will be held at 4:00 PM on Thursday, April 20, 2017 at the Circle of Native Minds Wellness Center located at 845 Bevins Street in Lakeport.

The Mental Health Services Act has been providing funding to Lake County since 2005 to support a variety of initiatives to assist consumers and their families in the local community. These initiatives include direct services and supports as well as prevention, early intervention, and innovative programming. Input from consumers and their families, partner agencies, and representatives from cultural and ethnic populations in Lake County aided in the development of these programs through the Community Program Planning process as required by the Act. At this time, stakeholder participation is requested to provide input on proposed changes to the FY 2016/17 Annual Update.

The FY 2016/17 Annual Update may be viewed on the Lake County Behavioral Health website at http://www.co.lake.ca.us/Government/Directory/Behavioral_Health/MHSA.htm.

Hard copies may be accessed from the following locations:

- Lucerne Clinic, 6302 13th Avenue, Lucerne
- Clearlake Clinic, 7000-B South Center Drive, Clearlake
- The Bridge Peer Support Center, 14954 Burns Valley Road, Clearlake
- Circle of Native Minds Wellness Center, 845 Bevins Street, Lakeport
- The Harbor on Main Youth Resource Center, 16170 Main Street, Suite F, Lower Lake
- La Voz de la Esperanza Centro Latino, 14585 Olympic Drive, Clearlake

Copy requests by mail and any questions or comments about this document for Lake County may be directed to:

Kathy Herdman
Mental Health Services Act Coordinator
Lake County Behavioral Health
P.O. Box 1024
Lucerne, CA 95458
707-274-9101
kathy.herdman@lakecountyca.gov

####

Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
May 18, 2016

WELLNESS · RECOVERY · RESILIENCE

Welcome!

Please help yourself to something to eat. The meeting will start at 1pm.

Funded by Proposition 63

Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
May 18, 2016

WELLNESS · RECOVERY · RESILIENCE

Agenda:

- Introductions
- California Mental Health Services Authority
- *Break around 2:10 PM*
- Innovation Plan Update
- Peer Support Recovery Centers
- Funding
- Closing, Questions, and Feedback

Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
May 18, 2016

WELLNESS · RECOVERY · RESILIENCE

Overview:

Our intention is to use this planning meeting to provide information- about the programs, about the funding and about the changes in staffing.

The most obvious change is.....I am not James Isherwood ☺ After many years of building and shaping MHSA programs James has moved into clinical services where he continues to use his recovery philosophy to instill hope in those who are seeking mental health services.

We have a new Interim Director- Kevin Thompson, MPA.

You will meet some of the new staff at the Wellness Centers.

And we are all here to serve our community and continue the work of recovery.

Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
May 18, 2016

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Overview continued:

- Workforce Education and Training
- Prevention and Early Intervention
  - CalMHSA – programs and impact
  - Peer Support Recovery Centers – new faces and programs
- Innovation Project Update
- Funding Updates
- Closing, Questions, and Feedback

Mark Ragins, MD
Medical Director
MHA Village Integrated Service Agency
www.mhavillage.squarespace.com
mragins@mhala.org

- ***The Recovery Movement often seems idealistic and unrealistic to outsiders, but it has been built by people with severe mental illnesses and the people who live and work alongside them who deeply know the practical difficulties involved.***

- ***Our idealism comes not from a hopeful theoretical construct, but from the lived experience of overcoming the terrible suffering that often accompanies serious mental illnesses. When the hard work pays off and someone is able to enjoy life again and find meaning, it often feels miraculous.***

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What We Do

Meaningful Inclusion is What We're All About

We meet agencies where they're at, listen to their needs and what they want to accomplish, and find ways to help them reach their goals. We do this through:

- COLLABORATIVE LEARNING AND MUTUAL SUPPORT
- INDIVIDUALIZED ASSESSMENTS OF WORKPLACE NEEDS
- IN-PERSON AND ON-CALL TECHNICAL ASSISTANCE
- CUSTOM ONLINE AND INSTRUCTOR-LED TRAININGS
- RELEVANT RESEARCH AND EDUCATIONAL RESOURCES
- NETWORKING AND SOCIAL CONNECTIONS

NorCal MHA
Mental Health America

WISE is a program of NorCal MHA

OSHPD Office of Statewide Health Planning and Development

WISE is administered by OSHPD

WISE is funded by Prop 63

W·I·S·E
Workforce Integration Support and Education

1908 O STREET
SACRAMENTO, CA 95811

T. 916.366.4600
F. 916.855.5448

WWW.NORCALMHA.ORG/WISE

W·I·S·E

Workforce Integration Support and Education

STRENGTHENING CALIFORNIA'S PEER WORKFORCE ONE WORKPLACE AT A TIME

Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
May 18, 2016

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California Mental Health Services Authority

Theresa Ly, MPH
Program Manager

- Statewide PEI Programs
- Reach and Impact in Lake County
- Status of Programs for FY 15/16 and 16/17

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Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
May 18, 2016

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Break

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Mental Health Services Act
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Innovation Plan Update

Over the last year, the following have been completed:

- LCBH will work with RDA to develop the Innovation Plan in April and May 2015
- LCBH working to develop Line Item Budget
- Submit to MHSOAC prior to update process. MHSOAC reviewed the draft proposal and was very excited.
- Innovation Plan will be publicly posted with the MHSA Annual Update – Anticipated completion and Public Hearing

Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
May 18, 2016

WELLNESS · RECOVERY · RESILIENCE

Innovation Plan Update continued:

- Annual Update Signed off by Auditor's Office
- Submission to BOS for Adoption – 2/16/16
- Submission and Approval to/from MHSOAC – 3/24/16
- Managed Care is working on our contract with Trilogy Integrated Resources, LLC. in preparation to MHSOAC approval
- Contract submittal to County Counsel

Innovation Plan Update continued:

- Remaining before start work:
  - Contract submittal to BOS for consent 5/17/16
    Outcome TBD
- Network of Care – Moving Forward:
  - Services Directory
  - E-Learning Portal
  - Call Center – Full Cycle Referral
  - Personal Health Record – Care Coordination

Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
May 18, 2016

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Sheila Roseneau, Behavioral Health
MHSA Coordinator

- Prevention and Early Intervention
- Peer Support Recovery Centers
- Circle of Native Minds Center
- La Voz de la Esperanza
- The Bridge Peer Support Center
- Harbor on Main Transition Age Youth Peer Support
- PEI Mini-Grants

Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
May 18, 2016

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Teresa Massingill, Behavioral Health Cultural Specialist/Native American

- Circle of Native Minds Center
  845 Bevins Street
  Lakeport, CA 95453
  (707) 263-4880
  Monday – Friday 9 AM – 6 PM

Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
May 18, 2016

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Edgar Ontiveros, Behavioral Health Cultural Specialist/Latino

- La Voz de la Esperanza Centro Latino
  14585 Suite B Olympic Drive
  Clearlake, CA 95422
  Monday – Friday 8 AM – 5 PM

Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
May 18, 2016

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David Ables, Behavioral Health Peer Support Specialist

- The Bridge Peer Support Center
  14954 Burns Valley Road
  Clearlake, CA 95422
  (707) 995-2973
  Monday – Friday 8 AM – 5 PM

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Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
May 18, 2016

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Cary Manning, Harbor Program Supervisor
Redwood Community Services, Inc.

- Transition Age Youth Peer Support Center
  16170 Main Street, Suite F
  Lower Lake, CA 95457
  (707) 994-5486

Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
May 18, 2016

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Lauren Milano, Behavioral Health Prevention Specialist

- Prevention and Early Intervention MHSA Mini-Grants

http://www.co.lake.ca.us/Government/Directory/Behavioral_Health/MHSA.htm

- May is Mental Health Matters Month
- Event:
  May 24th, 2016 from 11 AM – 3 PM

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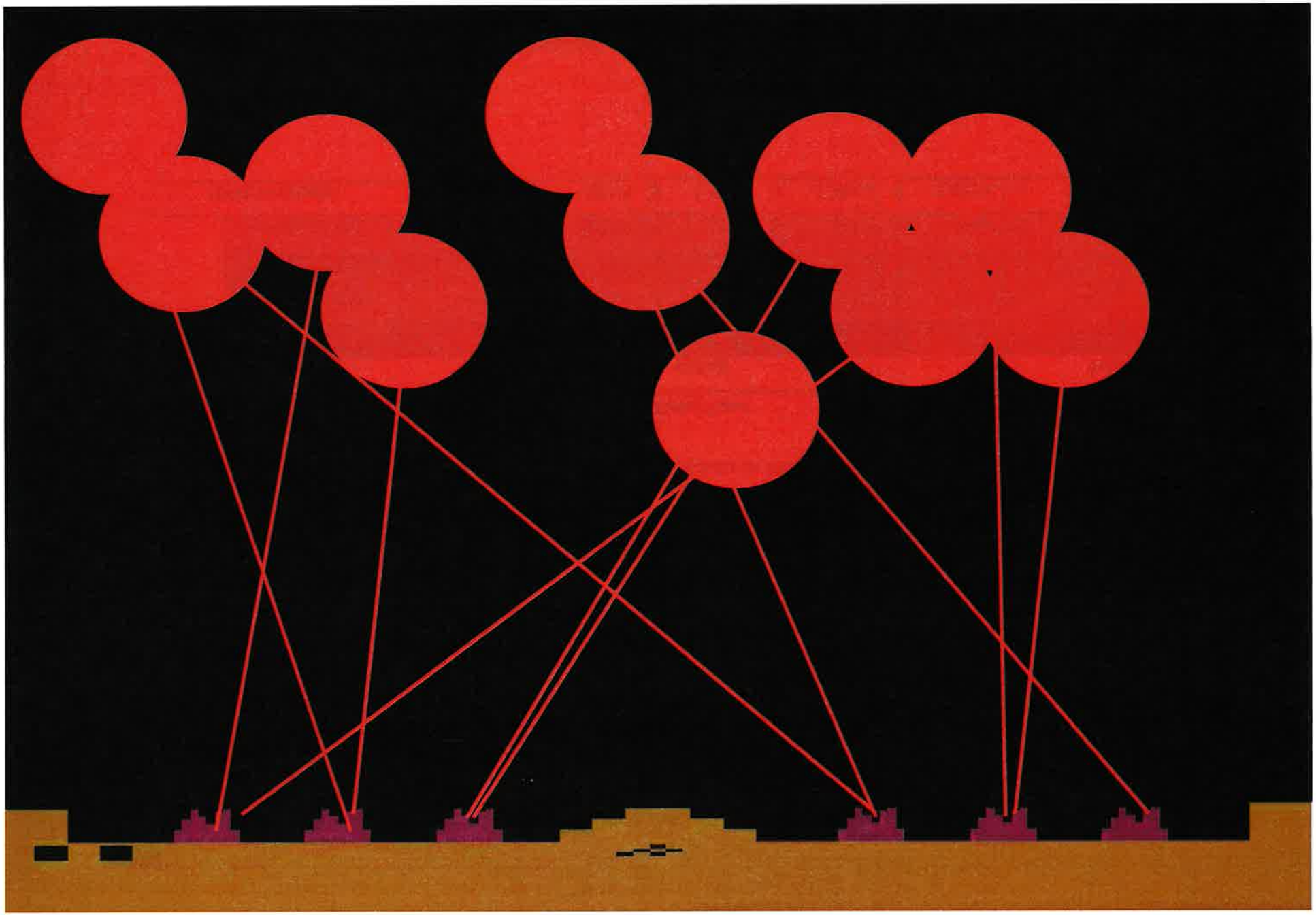
Funding for MHSA

- Governor's Budget Projects 2.051 Billion to be placed into the MHSA Fund.
  - This translates into Approximately 4.27 million for Lake County
    - CSS = 3.2 Million
    - PEI = 800 Thousand
    - INN = 200 Thousand
- Prudent Reserve Currently holds 1.15 Million



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Mental Health Services Act
Stakeholder Meeting
May 18, 2016

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MHSA Estimated Revenues

Cash Basis in Millions

	Fiscal Year						
	Actual					Estimated	
MHSA Estimated Revenues	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	Est. FY 15/16	Est. FY 16/17
Cash Transfers	$ 905.0	$ 910.0	$ 1,204.0	$ 1,189.0	$ 1,367.0	$ 1,462.0	$ 1,515.0
Interest	$ 9.7	$ 2.4	$ 0.7	$ 1.2	$ 0.8	$ 0.8	$ 0.8
Adjustment	$ 225.0	$ (64.5)	$ 157.0	$ 153.5	$ 484.0	$ 566.0	$ 536.0
Total Revenues	$ 1,139.7	$ 847.9	$ 1,361.7	$ 1,343.7	$ 1,851.8	$ 2,028.8	$ 2,051.8

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Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
May 18, 2016

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MHSA Estimated Revenues

	FY 12/13	FY 13/14	FY 14/15	Current Distribution FY 15/16 *	Estimated Year End FY 15/16 **
MHSA Allocation	$ 3,290,575	$ 2,557,999	$ 3,580,612	$ 2,233,914	$ 2,680,697
MHSA Allocation Statewide	$ 1,589,680,373	$ 1,235,772,421	$ 1,729,797,749	$ 1,061,605,409	$ 1,273,926,491

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Issues at the State

- Deficit of 1.9 Billion Dollars
  - According to the Governor's Budget (May Revise)
  - The State only cut spending by 500 Million

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County Allocation

		Totals to Date	State Projections
MHSA County Allocation		$ 2,233,914	$ 4,269,162
	CSS	$ 1,697,775	$ 3,244,563
	PEI	$ 424,444	$ 811,141
	INN	$ 111,696	$ 213,458
Total Statewide Allocation		$ 1,061,605,409	$ 2,028,800,000

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- Closing
  - Existing programs
    - Unmet Needs?
  - Questions and feedback

Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
May 18, 2016

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Kathy Herdman

Mental Health Services Act Coordinator

PO Box 1024/6302 Thirteenth Ave.

Lucerne, CA 95458

707-274-9101

Kathy.Herdman@lakecountyca.gov

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Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
November 2, 2016

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Welcome!

Please help yourself to something to eat. The meeting will start at 1pm.

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Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
November 2, 2016

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News and Reviews

- New Staff
- Funding
- Innovation
- Workforce Education and Training
  - Superior Region
- Prevention and Early Intervention
  - New Regulations
  - CalMHSA
  - Lake County Office of Education
  - Mother-Wise
- Community Services and Supports
  - Konocti Senior Support
  - Permanent Housing
  - NAMI
- Q & A, Wish List

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New Staff:

- Eric Kammersgard – Compliance Manager
- Lauren Milano – Workforce Education and Training Coordinator
- Wellness Centers
  - Guadalupe Gongora – Extra-Help Client Support Assistant at La Voz
  - Christina Orozco – Client Support Assistant at Circle of Native Minds
- Director?
- Parent Partner – Interviews next week

Funding for MHSA

- Manuel Orozco, Behavioral Health Fiscal Manager

Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
November 2, 2016

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Innovation Plan Update

Jeffrey Shute, Business Software Analyst
James Isherwood, Mental Health Specialist

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Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
November 2, 2016

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Workforce Education and Training (WET)

- Peer Core Competency Training via CASRA
- California Association of Social Rehabilitation Agencies
  - Dedicated to improving services and social conditions for people with psychiatric disabilities by promoting their wellness, recovery and civil rights.
  - A diagnosis is not a destiny.

WISE U

EDUCATION. EXPERIENCE. EMPOWERMENT.

- CAREER COUNSELING
- JOB TRAINING/FIELD WORK
- PEER TRAINING ACADEMY
- PLACEMENT ASSISTANCE

TRAINING DATES	LOCATION
11.28.16 – 12.9.16	SACRAMENTO. CA

WISE U is a program of NorCal MHA, the oldest peer-run consumer advocacy agency in Northern California. For decades, NorCal MHA has successfully hired, trained, supported, and advanced the careers of consumers, family members, parents/caregivers, and transition age youth working and volunteering in peer support roles in California's Public Mental Health System. Our primary goal is to place WISE U Graduates in permanent peer jobs and volunteering positions. To this end, we offer a full-service peer support training and placement academy, with wide array of career planning and educational opportunities, as well as job coaching, placement assistance, and ongoing support to help peers achieve workplace success.

APPLY TO JOIN WISE U AT: http://sgiz.mobi/s3/WISE-U-Application

FOR MORE INFORMATION, PLEASE VISIT www.wiseup.work

WISE U is a program of NorCal MHA funded by the California Mental Health Services Act (Prop 63) and administered by the Office of Statewide Health Planning and Development (OSHPD)

NorCal MHA Mental Health America

OSHPD Office of Statewide Health Planning and Development

Superior Region WET Partnership

- Distributed Learning, current statistics:
  - Humboldt
    - 77 Students graduated as of May 2016
      - 47 BSWs, 11 total for Lake County
      - 30 MSWs, 8 total for Lake County
    - 59 Students anticipated to graduate by May 2019
      - 19 BSWs
      - 40 MSWs (2 Lake County applicants offered admission)
  - Chico
    - 34 BSW Students
    - 40 MSW Students
    - 6-8 currently in recruitment pipeline

Lake County Behavioral Health
Mental Health Services Act
Stakeholder Meeting
November 2, 2016

WELLNESS · RECOVERY · RESILIENCE

Prevention and Early Intervention (PEI):

- New PEI Regulations (can be found at www.mhsoac.ca.gov)
  - Meaning
  - Impact

Article 2. Definitions

Adopt Section 3200.245 as follows:

Section 3200.245. Prevention and Early Intervention Component.

(a) "Prevention and Early Intervention Component" means the section of the Three-Year Program and Expenditure Plan intended to prevent mental illnesses from becoming severe and disabling.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840 and 5847, Welfare and Institutions Code.

Adopt Section 3200.246 as follows:

Section 3200.246. Prevention and Early Intervention Fund.

(a) "Prevention and Early Intervention funds" means the Mental Health Services funds allocated for prevention and early intervention programs pursuant to Welfare and Institutions Code section 5892, subdivision (a)(3).

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5892, Welfare and Institutions Code.

Article 5. Reporting Requirements

Adopt Section 3510.010 as follows:

Section 3510.010. Prevention and Early Intervention Annual Revenue and Expenditure Report.

(a) As part of the Mental Health Services Act Annual Revenue and Expenditure Report the County shall report the following:

(1) The total funding source dollar amounts expended during the reporting period, which is the previous fiscal year, on each Program funded with Prevention and Early Intervention funds by the following funding sources:

(A) Prevention and Early Intervention funds

1. The County shall identify each Program funded with Prevention and Early Intervention funds as a Prevention Program, Early Intervention Program, Outreach for Increasing Recognition of Early Signs of Mental Illness Program, Stigma and Discrimination Reduction Program, Suicide Prevention Program, Access and Linkage to Treatment Program, or Program to Improve Timely Access to Services for Underserved Populations. If the Programs are combined, the County shall estimate the percentage of funds dedicated to each Program.

(B) Medi-Cal Federal Financial Participation
(C) 1991 Realignment
(D) Behavioral Health Subaccount
(E) Any other funding

(2) The amount of funding expended for Prevention and Early Intervention Component Administration by the following funding sources:
(A) Prevention and Early Intervention funds
(B) Medi-Cal Federal Financial Participation
(C) 1991 Realignment
(D) Behavioral Health Subaccount
(E) Any other funding

(3) The amount of funding expended for evaluation of the Prevention and Early Intervention Component by the following funding sources:
(A) Prevention and Early Intervention funds
(B) Medi-Cal Federal Financial Participation
(C) 1991 Realignment
(D) Behavioral Health Subaccount
(E) Any other funds

(4) The amount of Prevention and Early Intervention funds voluntarily assigned by the County to California Mental Health Services Authority or any other organization in which counties are acting jointly.

(b) The County shall within 30 days of submitting to the state the Mental Health Services Act Annual Revenue and Expenditure Report:
(1) Post a copy on the County's website; and
(2) Provide a copy to the County's Mental Health Board

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5845, 5847, and 5899, Welfare and Institutions Code; Uncodified Sections 2 and 3 of Proposition 63, the Mental Health Services Act.

Adopt Section 3560 as follows:

Section 3560. Prevention and Early Intervention Reports.

(a) The County shall submit to the Mental Health Services Oversight and Accountability Commission the following Prevention and Early Intervention reports:
(1) The Annual Prevention and Early Intervention Program and Evaluation report as specified in Section 3560.010.
(2) The Three- Year Program and Evaluation Report as specified in Section 3560.020.

(A) The Program name
(B) The number of potential responders
(C) The setting(s) in which the potential responders were engaged
1. Settings providing opportunities to identify early signs of mental illness include, but are not limited to, family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics.
(D) The type(s) of potential responders engaged in each setting (e.g. nurses, principles, parents)

(3) For each Access and Linkage to Treatment Strategy or Program the County shall report:
(A) The Program name
(B) Number of individuals with serious mental illness referred to treatment, and the kind of treatment to which the individual was referred.
(C) Number of individuals who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the Program to which they were referred.
(D) Average duration of untreated mental illness as defined in Section 3750, subdivision (f)(3)(A) and standard deviation.
(E) Average interval between the referral and participation in treatment, defined as participating at least once in the treatment to which referred, and standard deviation.

(4) For each Improve Timely Access to Services for Underserved Populations Strategy or Program the County shall report:
(A) The program name
(B) Identify the specific underserved populations for whom the County intended to increase timely access to services.
(C) Number of referrals of members of underserved populations to a Prevention Program, an Early Intervention Program and/or to treatment beyond early onset.
(D) Number of individuals who followed through on the referral, defined as the number of individuals who participated at least once in the Program to which they were referred.
(E) Average interval between referral and participation in services to which referred, defined as participating at least once in the service to which referred, and standard deviation.
(F) Description of ways the County encouraged access to services and follow-through on referrals

(5) For the information reported under subdivisions (1) through (4) of this section, disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services by:
(A) The following age groups:
1. 0-15 (children/youth)
2. 16-25 (transition age youth)