Lassen County Behavioral Health Innovation Plan

2015

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EXHIBIT A

INNOVATION WORK PLAN
COUNTY CERTIFICATION

County Name: Lassen County

Health and Social Service Director	County Mental Health Director
Name: Melody Brawley Telephone Number: 530-251-8134 E-mail: mbrawley@co.lassen.ca.us	Name: Pam Grosso Telephone Number: 530-251-8108 E-mail: pgrosso@co.lassen.ca.us
Project Lead	**Mailing Address:**
Name: Tiffany Armstrong Telephone Number: 530-251-2627 E-mail: tarmstrong@co.lassen.ca.us	Lassen County Mental Health 555 Hospital Lane Susanville, Ca 96130

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations, laws and statutes for this annual update/update, including all requirements for the Innovation Work Plan. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

This Work Plan has been developed with the participation of stakeholders, in accordance with sections 3300, 3310, subdivision (d), and 3315, subdivision (a). The draft Work Plan was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board of commission. All input has been considered with adjustments made, as appropriate. Any Work Plan requiring participation from individuals has been designed for voluntary participation therefore all participation by individuals in the proposed Work Plan is voluntary pursuant to Title 9, CCR, Section 3400 (b) (2).

All documents in the attached Work Plan are true and correct.

_____ _____
Signature Date Health and Social Service Director

_____ _____
Signature Date Mental Health Director

_____ _____
Signature Date County Auditor

INNOVATION WORK PLAN

Description of Community Program Planning and Local Review Processes

County Name: Lassen

Work Plan Name: Integration with Primary Health via Virtual Coordinated Care Team

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this Annual Update.

1. Briefly describe the Community Program Planning Process for development of the Innovation Work Plan. It shall include the methods for obtaining stakeholder input. (suggested length – one-half page)

Demographic

Lassen County is located in the northeastern portion of California with a population of 34,895 (2010 US Census Data). Geographically, it is among the largest counties in California incorporating 4,547 square miles. The county's terrain consists of forest land and high desert plateaus. Susanville is the county seat and the main population center. Susanville is located near the center of Lassen County and approximately 80 miles north of Reno, Nevada. There are other small unincorporated outposts throughout the county. They include Bieber, some 80 miles to the north of Susanville, and three small unincorporated towns over 70 miles from Susanville to the northeast, Westwood 22.6 miles to the west and Herlong 40 miles to the south. Major routes leading to Susanville include Highway 395 from the south and Highway 36 from the west and a minor road Highway 139 leads to the Bieber / Big Valley area. Severe winter weather frequently impacts travel on these highways making travel from outlying areas difficult or impossible. Public transportation is available on a limited basis within the Susanville area and transportation services to the outlining areas are generally limited to morning and evening service runs.

The economy of Lassen County is primarily supported by government services, the community hospital and the community junior college. The county hosts three prisons, High Desert State Prison (Population approximately 4500), California Correctional Center (Population approximately 5700) and Herlong Federal Prison (Population approximately 1484) which opened in May of 2005. It should be noted the US Census data incorporates data from the three prison systems which skews Lassen County data (i.e. population, ethnicity, and gender) as it relates to general population services.

Stakeholder Process

Lassen County has developed a strong and functioning stakeholder group to provide assessment, information and implementation support for all elements of the Mental Health Services Act (MHSA) programs. Lassen County contracted with Lassen Aurora Network (non-profit consumer run organization) to be lead facilitators for obtaining stakeholder input. Trained peer counselors from Lassen Aurora Network worked with MHSA staff to organize and facilitate stakeholder meetings for Lassen County Behavioral Health. Lassen Aurora Network encouraged un-served and underserved populations of the community to participate. Attendees of the Stakeholder meetings included individuals from a wide variety of community organizations, clients and family members, and representatives from underserved communities. Ideas were selected from the surveys and meetings, reflecting an expansion of existing programs.

The MHSA Support Team, consisting of the MHSA Coordinator, Health and Social Service Director, Bheahvioral Health Director, Lassen Aurora Network members and MHSA Support Staff reviewed recent and past MHSA community program planning processes to identify innovative ideas or needs discussed among stakeholders, and analyze trends for projects that met the MHSA Innovations guidelines. After years of discussion regarding possible ideas for Lassen County Innovation projects and a number of "dead ends" with projects that simply weren't innovative, the support team decided to move forward on integration with primary care using innovative technology

Lassen County Behavioral Health placed advertisements and articles in the Lassen County Times regarding MHSA Community Stakeholder input. The method for obtaining stakeholder input was through stakeholder meetings.

The proposed Innovation Plan was posted for a 30-day public review process. A review of the document and public hearing was conducted by the Lassen County Behavioral Health Advisory Board.

2. Identify the stakeholder entities involved in the Community Program Planning Process.

Consumers and family members, including representatives of Lassen Aurora Network, a consumer-run organization implementing consumer support services under MHSA

- Office of Education
- Susanville Indian Rancheria
- Family Resource Centers (Westwood, Fort Sage and Big Valley)
- Lassen College
- NAMI

Representatives of partner agencies, including:

Lassen County Health and Social Services which incorporates the departments listed below:

- Lassen County Behavioral Health (Alcohol and Drug Program and the Mental Health department have integrated and are now called Behavioral Health)
- Lassen County Veteran Services Office
- Lassen County Public Health Programs
- Lassen Works Employment Program
- Lassen County Social Services, Adult and Child Protection

Departments and Agencies who were invited to the stakeholder process but could not attend were law enforcement (Susanville Police Department/Lassen County Sheriff Department), Lassen Family Services (Non Profit Domestic Violence Services), Banner Hospital, Northeastern Rural Health clinic, Crossroad Homeless shelter, local primary care doctors, and all community churches. Even though the departments/agencies could not attend the Stakeholder process they were informed, notified, and allowed to provide feedback about the Innovation plan through separate ongoing (every other week) Adult System of Care meetings.

Lassen Aurora Network also reached out to un-served and underserved individuals (primarily the Hispanic populations in North County) about the Innovation Plan through already existing Outreach and Engagement services.

3. List the dates of the 30-day stakeholder review and public hearing. Attach substantive comments received during the stakeholder review and public hearing and responses to those comments. Indicate if none received.

Preliminary discussions regarding Innovations were held May 7, 2009 and the Administrative Review Committee (ART) meeting on May 26, 2009. This was followed by a series of stakeholder meetings to obtain community input regarding workforce, education and training. Stakeholder meeting were held for each underserved community: Big Valley (May 19, 2009 and June 12, 2009), Westwood (May 15, 2009 and June 10, 2009, and Fort Sage (May 13, 2009 and June 9, 2009). Additional meetings were also held at Crossroads Ministries (May 19, 2009) and in the Susanville area (June 9, 2009).

Stakeholder discussion regarding Innovation was held in Big Valley Area (February 16, 2010). Fort Sage (February 17, 2010), Westwood (February, 18 2010), Susanville (February 23, 2010).

Stakeholder discussion regarding Innovation occurred in October 2011: Big Valley (October 17, 2011), Fort Sage (October 18, 2011), Westwood (October 19, 2011) and Susanville (October 20, 2011).

A final set of Stakeholder meetings Big Valley (July 10, 2014), Fort Sage (July 8, 2014), Westwood (July 9, 2014) and Susanville (July 7, 2014).

MHSA Innovation was circulated using the following methods:

* An electronic copy was posted on the My Network of Care website: www.lassenmynetworkofcare.com

30-day Public Comment period was opened on November 1, 2014 and closed on November 30, 2014. A Public Hearing was held at the Behavioral Health Advisory Board meeting on 12-8-2014 and 1-12-2015.

Public Comment: No comments were made

Innovative Work Plan Narrative

County: Lassen
Work Plan # 1
Work Plan Name: Integration with Primary Care via Virtual Coordinated Care Team

Purpose of Proposed Innovation Project (check all that apply)

☐ INCREASE ACCESS TO UNDERSERVED GROUPS
☒ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
☒ PROMPTED INTERAGENCY COLLABORATION
☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

This program seeks to increase the quality of care services provided by physical health and mental health professionals by establishing a specialty team that will facilitate the integration of physical health, mental health, and substance use/abuse services. It also seeks to promote interagency collaboration as providers are better able to coordinate care across disciplines. As a result, consumers should experience easier access to care through warm linkage and care coordination services.

Recent studies have demonstrated that people living with serious and persistent mental illness (SPMI) die twenty-five years earlier than the general population, due in large measure to unmanaged and untreated physical health conditions. People living with SPMI have an average life expectancy of 51 years compared with 76 years for the general population. Moreover, people living with SPMI are 3.4 times more likely to die of heart disease, 6.6 times more likely to die of pneumonia and influenza, and 5 times more likely to die of other respiratory ailments (C. Colton "Mortality: Health Status of the Served Population, Sixteen State Pilot Study on Mental Health Performance Measures", based on 1997-2000 data). Therefore, providing access to medical care for unmanaged health conditions, including heart disease, smoking, obesity, and substance use, is an important step to addressing this health disparity for people living with SPMI.

SAMHSA National Survey on Drug Use and Health (NSDUH) Report “Physical Conditions Among Adults with Mental Illness” found those with any mental illness, severe mental illness or major depressive episode were more likely than adults with without these mental illnesses to use an emergency room and to be hospitalized

Lassen County recognizes the need to improve care at the interface of physical health, mental health, and substance use in order to increase efficiencies, improve health outcomes for clients, and – ultimately – cost reductions and revenue maximization. The coordination of services between primary care and behavioral health is lacking and is not adequately meeting the needs of the un-served and underserved populations. Behavioral Health staff, consumers and family members, reveals that a lack of coordination between both agencies is resulting in poor quality of care. Clients are

leaving with conflicting information, symptoms/aliments not fully addressed and confusion about treatment. Clients often question how they could be sure they were getting quality services "when their psychiatrists and family doctors never talk to each other."

This project proposes to work on collaborating with primary care to build a better system where mutual clients are provided better quality services (i.e. medication monitoring, chronic disease management education and counseling, and attention to co-occurring needs. We will learn whether integration with health care (virtual coordinated care team) can promote interagency collaboration between community health centers and Behavioral Health service providers and if it will increase access and quality of services for those individuals with acute illness who we are currently unable to serve adequately due to an overburdened Behavioral Health system.

Project Description

Describe the innovation, the issue it addresses and the expected outcome, i.e. how the innovation project can create positive change. Include a statement of how the innovation project supports and is consistent with the general standards identified in the MHSA and title 9 CCR Section 3320.

Integration with primary care is not a new innovative idea however developing concrete integrative models and processes that meet the needs of a rural, frontier setting, in a very ambiguous health care delivery system environment, are scarce to nonexistent. We intend to take our success in building collaborative partnership with primary care to the next level. The key to integration is establishing a "*virtual medical team*" which will develop processes and protocols to collaboratively integrate mental health services, alcohol and other drug services, and physical health services as needed to deliver consumer-centered, holistic wellness and recovery treatment.

A virtual coordinated care team combines physical health, mental health, substance use/abuse, medication management, and warm-linkage services in community-based sites (e.g., a physical health care clinic and a mental health clinic), to ameliorate current fragmentation of service delivery and create pathways of communication between physical health and mental health providers. While other efforts to integrate care exist, our model is innovative in that a virtual coordination care team (nurse, case manager, SUD counselor, therapist, psychiatrist, consumer and family/natural supports) will provide consultation and coordination of physical health and mental health medications between systems. The virtual coordinated care team will:

- Provide specialty consultation to clinic staff and assist in treatment planning that encompasses both mental health and physical health care, including substance use/abuse.
- Act as referral agents to assist clinic staff in making referrals to either physical health or mental health clinics, as needed.
- Implement *Grand Care Electronic System* in the consumer's home. *Grand Care* addresses the societal need to reduce the cost of chronic conditions and long

term, post-acute, and hospital care by providing a fully featured, residential home system to support individuals in their natural environment. The judicious use of technology can help professional caregivers, family caregivers, and individuals who want to maintain their own wellness.
    - ***Interactive Medication Reminders:*** *Grand Care* can prompt a resident when it is time to take medications. The resident can press a button to indicate whether medications were taken.
    - ***Interactive Assessments***: Multiple providers can be doing or observing simultaneous assessments which can aid in assessing lifestyle habits and managing chronic conditions.
    - ***Care Coordination:*** The Care Coordination Notes feature allows both family members and professional caregivers to coordinate schedules, view assessment data, exchange notes on care, and share relevant information.
- The virtual coordinated care team will foster collaboration among services providers and the client, increase education, quality of services delivered, and referrals to other community-based organizations. *This project supports and is consistent with the MHSA general standards set forth in Title 9, California Code of Regulations (CCR), Section 3320.* The model is grounded in the following specific principles and values:
    - Prospective care is planned, facilitated, and coordinated.
    - Networks for clinical, non-traditional, or community-based referrals are established.
    - Services are timely;
    - Data- driven outcomes are both systems focused and client-centered.
    - Services are culturally competent.
    - Education/Motivation

The proposed Innovation plan is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320, including:

- **Community Collaboration:** Consumers and family members will be integrated into the delivery of recovery- and community-based approach. The concept for this work plan was developed with community participation and supports an interagency collaboration between a number of different service providers from the mental and physical health fields.
- **Cultural Competence:** Involvement of consumers and families along with trained behavioral health staff will ensure that individuals have improved access to culturally and linguistically appropriate community-based services. The focus is to include mentally ill individuals from different cultures/languages to participate in all stages of programming, including design, implementation, and evaluation. We are focused on targeting un-served and underserved Hispanic populations and individuals who embrace the rural culture.
- **Client and Family-Driven Mental Health System:** Consumers and family are core members of the innovation plan and will be involved in all stages of programming, including design, implementation, and evaluation. Although family

members have been involved in the process, we recognize the need for additional outreach to encourage more family involvement. Consumers and family members will continue to play a key role in the Innovative plan, including planning and oversight.

- **Wellness, Recovery, and Resilience Focused:** The Innovation plan addresses these principles by incorporating consumers and family members as core members who understand that recovery is possible. This program increases resilience and promotes recovery and wellness for individuals with serious mental illness by providing a continuum of care ranging from specialty mental health services to recovery oriented, medication and chronic disease management addresses overall health and wellness.
- **Integrated Service Experience:** The Innovative plan will ensure that all individuals are referred to comprehensive services that address wellness, recovery, and resilience. The driving value underlying this Innovative plan is integration of services for holistic healthcare through a collaborative, integrated approach. This program encourages and provides for access to a full range of services provided by multiple agencies, programs and funding sources for clients. Clients have access to multiple levels of care for their mental and physical health care needs.

Contribution to Learning:

Describe how the innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches that have been successful in non-mental health contexts.

It is believed that virtual coordinated care team will improve their understanding of mental health issues, chronic physical health issues, and substance abuse. Better coordination of care is projected along with increased communication, planning, and shared clinical information between providers. Specific learning questions to be answered by this model include:

1. Will having virtual coordinated care team with linguistically and culturally competent staff meet all the needs of clients using *Grand Care*? Can coordination of services by multiple providers be accessible to all clients virtually?
2. Can emergency department (ED) visits be reduced for individuals with SMI receiving ongoing physical health care compared to the current rate for clients in the MH system?
3. How do we coordinate services so they are easily accessible and convenient for the client?
4. Can integrated physical health, mental health and substance use/abuse services be provided at the home settings? To what extent can they provide care for the Seriously Mentally ill patients, and when will those patients need to be referred out to specialty mental health centers?
5. Will consultation and referral services in a primary care setting increase referrals for mental health services, and vice versa?
6. Will persons who receive coordinated medication management services achieve positive outcomes (e.g., improved mental health status toward a wellness goal,

improved physical health status, and decreased utilization or need for crisis care)?

7. Can integrated services in both mental health and physical health settings result in cost-effective health care, (e.g. reduced overall cost of health care, yet improve overall quality of care?)

Timeline:

Outline the timeframe within which the Innovation Project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication.

Implementation/Completion Dates: 07/01/2015-06/30/2019

07/01/2015	Anticipated OAC approval
07/01/2015-09/30/2015	Contract procurement with *Grand Care*, order equipment
10/01/2015-06/30/2016	Initiation of project, staff trainings, initiation of process to identify co-occurring clients, begin services.
01/01/2016- 06/30/2016	Develop a program assessment with the inclusion of stakeholders
07/01/2016-06/30/2019	Program in place, quarterly assessment of numbers of clients served to assure that sufficient clients being followed by for virtual coordinated care team for comprehensive treatment.
07/2016-07/2019	Review quarterly assessments and yearly learning outcomes measures with panel to evaluate results.
07/2016-07/2019	Make program adjustments as necessary based on evaluation
Annually	Evaluate the comprehensive program assessment design and present to community stakeholders.
07/2019	Evaluation by Behavioral Health Services research provider, determination of efficacy and feasibility of replication with other funding, dissemination of results to stakeholders

We believe this timeline is sufficient to determine whether barriers can be eliminated, fragmentation of services decreased, and replication is feasible. At the end of each year implementation results and lessons learned will be provided to stakeholders. The final year of this project, will allow sufficient time for learning and drafting a guide for replication, if appropriate.

Project Measurement:

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

The project will be reviewed annually with a final comprehensive assessment after four full years of operation. Stakeholders, including clients and providers, will be involved in the design of this project's assessment and surveyed as part of the evaluation process. Specific learning questions will be measured through systems-wide and/or client centered analysis.

Outcomes measures will include, but not be limited to:

1. Effective treatment and improved outcomes for clients served by the virtual coordinated care team.
2. Improved mental health outcomes due to integrated treatment and disease management support.
3. Client satisfaction with virtual coordinated care team.
4. Physical health parameters (blood pressure, Glucose, body mass index, lipid profiles, etc.) of clients as identified in the BH clinic by the virtual coordinated care team.
5. Increase in number of clients served by virtual coordinated care team.
6. Staff satisfaction with virtual coordinated care team.
7. Numbers of clients referred from MH to PC for physical health needs only.
8. Numbers of clients successfully referred from MH and maintained in PC medical "home" for comprehensive attention by PC providers to medical needs and SMI monitoring.
9. Number of emergency services visits of referred clients for both mental and physical health issues.
10. Client's compliance with treatment goals
11. Other outcomes as indicated by stakeholders during the review process.
12. Virtual Coordinated teams having a common goal, communicating and providing culturally competent services.
13. How and to what extent did Virtual Coordinated Teams promote interagency collaboration?

The days of treating mentally ill individuals with multiple complex medical issues with providers who are not really coordinating appropriate “whole person” care will not continue to work. Once implemented it will become clear whether or not Virtual Coordinated Teams using *Grand Care* will, in fact, improve the delivery of mental/physical health services and whether or not this kind of approach can lead to better and more effective practices. In implementing this innovative idea with community partners, the County hopes to demonstrate that Virtual Coordinated Teams improves collaboration between mental health and primary care and better outcomes/services for mentally ill un-served and underserved individuals living in rural areas.

Leveraging Resources (if applicable):
Provide a list of resources expected to be leveraged, if applicable.

To be determined.

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Lassen

Work Plan Name

Integration with Primary Care

Annual Number of Clients to Be Served (If Applicable)
100 Total

Population to Be Served (if applicable):

This work plan is designed to serve 100 transition age youth (TAY, 18-25 years), adults, and older adults with serious mental illness (SMI) who are clients in an outpatient mental health clinic. These individuals are typically underserved or unserved by the mental health system.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

This project intends to improve the quality of care for those individuals with serious mental health issues who have difficulty accessing health care, have chronic medical issues or who do not access regular primary health care. It will test whether an innovative, holistic approach to empowering consumers to access health care while ensuring coordinated care between mental health, physical health and other providers leads to improved physical and mental health outcomes for individuals with serious mental illness.

The Virtual Coordinated Care Team proposes an innovative collaboration between an existing mental health clinic and local primary care (PC) clinic to create a new patient-centered medical home for SMI individuals. This structure will provide clients with a unique, innovative continuum of care, depending on the acuity of their illness – ranging from specialty mental health services in the MH clinic when they are acutely ill, to medication maintenance and recovery-oriented chronic disease management. The Virtual Coordinated Care team will meet the mental health needs of underserved community who typically present in the primary care setting.

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Lassen

Fiscal Year: 2015-2016

Work Plan #: 1

Work Plan Name: Virtual Coordinate

New Work Plan ☑

Expansion ☐

Months of Operation: 7/2015-6/2016

MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	$2,500			$2,500
2. Operating Expenditures	$20,000			$20,000
3. Non-recurring expenditures	$35,000			$35,000
4. Training Consultant Contracts			$10,000	$10,000
5. Work Plan Management	$83,171			$83,171
6. Total Proposed Work Plan Expenditures	**$140,671**	**$0**	**$10,000**	**$150,671**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$140,671**	**$0**	**$10,000**	**$150,671**

Revised

Prepared by: Corrine Reed

Date: 5/8/2015

Telephone Number: 530-251-8355

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Lassen

Fiscal Year: 2016-2017

Work Plan #: 1

Work Plan Name: Virtual Coordinate

New Work Plan ☑

Expansion ☐

Months of Operation: 7/2016-6/2017

MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	$2,500			$2,500
2. Operating Expenditures	$20,000			$20,000
3. Non-recurring expenditures	$15,000			$15,000
4. Training Consultant Contracts			$5,000	$5,000
5. Work Plan Management	$75,000			$75,000
6. Total Proposed Work Plan Expenditures	**$112,500**	**$0**	**$5,000**	**$117,500**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$112,500**	**$0**	**$5,000**	**$117,500**

Revised

Prepared by: Corrine Reed

Date: 5/8/2015

Telephone Number: 530-251-8355

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Lassen

Fiscal Year: 2017-2018

Work Plan #: 2

Work Plan Name: Virtual Coordinate

New Work Plan ☑

Expansion ☐

Months of Operation: 7/2017-6/2018

MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	$2,500			$2,500
2. Operating Expenditures	$20,000			$20,000
3. Non-recurring expenditures	$15,000			$15,000
4. Training Consultant Contracts			$2,500	$2,500
5. Work Plan Management	$75,000			$75,000
6. Total Proposed Work Plan Expenditures	**$112,500**	**$0**	**$2,500**	**$115,000**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$112,500**	**$0**	**$2,500**	**$115,000**

Revised

Prepared by: Corrine Reed

Date: 5/8/2015

Telephone Number: 530-251-8355

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Lassen

Fiscal Year: 2018-2019

Work Plan #: 1

Work Plan Name: Virtual Coordinate

New Work Plan ☑

Expansion ☐

Months of Operation: 7/2018-6/2019

MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	$2,500			$2,500
2. Operating Expenditures	$20,000			$20,000
3. Non-recurring expenditures	$20,000			$20,000
4. Training Consultant Contracts			$2,500	$2,500
5. Work Plan Management	$75,000			$75,000
6. Total Proposed Work Plan Expenditures	**$112,500**	**$0**	**$2,500**	**$115,000**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$112,500**	**$0**	**$2,500**	**$115,000**

Revised

Prepared by: Corrine Reed

Date: 5/8/2015

Telephone Number: 530-251-8355

Attachment A

Lassen County
Board of Supervisors
Minute Order

Tuesday, February 24, 2015

PRESENT: Supervisors Bob Pyle, Jim Chapman, Jeff Hemphill and Aaron Albaugh. Supervisor Tom Hammond is absent for the day. Also Present: County Administrative Officer Richard Egan, County Counsel Robert Burns, and Deputy Clerk of the Board Susan Osgood.

Present: 4 - Supervisor Bob Pyle, Supervisor Jim Chapman, Supervisor Jeff Hemphill and Supervisor Aaron Albaugh

Absent: 1 - Supervisor Tom Hammond

Excuse: 0

HEALTH & SOCIAL SERVICES

BEHAVIORAL HEALTH/MENTAL HEALTH SERVICES ACT (MHSA)

SUBJECT: Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan FY 2014-2017, 2015 MHSA Innovation Plan, and MHSA 2012-2013 Annual Update.

ACTION REQUESTED: Adopt the MHSA Three Year Program Expenditure Plan FY 2014-2017, the 2015 MHSA Innovation Plan, and MHSA 2012-2013 Annual Update and approve their submission to MHSOAC.

A motion was made by Supervisor Chapman, seconded by Supervisor Hemphill, that the Plans be adopted and their submission be approved. The motion carried by the following vote:

Aye: 4 - Pyle, Chapman, Hemphill and Albaugh

Absent: 1 - Hammond

County of Lassen County)
State of California) ss.

I, SUSAN OSGOOD, Deputy Clerk of the Board of the Board of Supervisors, County of Lassen, State of California, do hereby certify the foregoing to be a full, true and correct copy of the minute order of said Board of Supervisors on above date.

IN TESTIMONY WHEREOF, I have hereunto set my hand, and affixed the Official Seal of the said Board of Supervisors this 26th day of Feb., 2015.

By Susan Osgood
Deputy Clerk of the Board, County of Lassen,
Board of Supervisors