



**STANISLAUS COUNTY
BEHAVIORAL HEALTH AND RECOVERY SERVICES
INNOVATION PROJECT**

A Proposal to the
Mental Health Services Oversight and Accountability Commission
in Accordance with the Mental Health Services Act

**September 13, 2010
REVISED DURING APPROVAL**

**STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES
INNOVATION PROJECT**

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EXHIBIT A

Innovation Work Plan County Certification

**EXHIBIT A
 Innovation Work Plan County Certification**

County Name: Stanislaus

County Mental Health Director	Project Lead
Name: Denise Hunt, RN, MFT	Name: Karen Hurley
Telephone Number: (209) 525-6205	Telephone Number: (209) 525-6229
E-mail: dhunt@stanbhrs.org	E-mail: khurley@stanbhrs.org
Mailing Address: Stanislaus County Behavioral Health and Recovery Services 800 Scenic Drive Modesto CA 95350	Mailing Address: Stanislaus County Behavioral Health and Recovery Services 800 Scenic Drive Modesto CA 95350

I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this 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, California Code of Regulations (CCR), Section 3410, Non-Supplant.

This Work Plan has been developed with the participation of stakeholders, in accordance with Title 9, CCR Sections 3300, 3310(d) and 3315(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 or 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.

_____	_____	Behavioral Health Director
Signature (Local Mental Health Director/Designee)	Date	Title

EXHIBIT B

Community Program Planning and Local Review Processes

EXHIBIT B

Description of Community Program Planning and Local Review Processes

County Name: Stanislaus County

Work Plan Name: Evolving a Community-Owned Behavioral Health System of Supports and Services

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)

The Community Program Planning process for this Innovation Work Plan has engaged stakeholders in several ways. As with previous Mental Health Services Act (MHSA) planning efforts, we have actively engaged the Representative Stakeholder Steering Committee (RSSC). The RSSC is comprised of 43 individuals representing a diverse spectrum of community interests in accordance with MHSA guidelines. Three stakeholder meetings—convened on January 21, January 26, and July 29, 2010—helped shape this Innovation Work Plan. The agendas for these meetings are included in PowerPoint slides available on the BHRS website www.stanislausmhsa.com.

Beyond these stakeholder meetings, a variety of individual and small group meetings with stakeholders helped deepen the process of discernment and design for this project.

BHRS also engaged over 300 community stakeholders through a Behavioral Health Summit on May 10, 2010. The summit was focused on three elements of BHRS' long-term transformation efforts: community capacity-building, results-based accountability, and leadership development. During the summit we engaged participants in a variety of ways, including:

- Large group question and answer sessions;
- Table and small group discussions;
- Written table discussion summary forms; and
- Confidential participant feedback forms.

Two major themes were voiced repeatedly by summit participants: (1) deep concern about the cascading budgetary shortfalls and the resulting reductions in services, and (2) a growing excitement and hope about the emerging community capacity-building efforts and collaborative partnerships focused on improving communities' behavioral health and emotional well-being. These themes are at the heart of the design of this Innovation Work Plan.

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

The stakeholder meetings, small group meetings, and the Behavioral Health Summit engaged representatives from the following constituencies:

- Individuals who have or are receiving services, including youth, TAYA, and adults;
- Family members of youth, adults, and older adults who have or are receiving services;
- Traditionally unserved and under-served communities, including African American, Assyrian, Latino, LGBTQ, Native American, and Southeast Asian communities;
- Faith-based organizations, including Interfaith Ministries and United Samaritans;
- Mental Health Board members;
- Education, including Modesto City Schools, Stanislaus County Department of Education, and CSU Stanislaus;
- Employment and housing institutions, including DRAIL and Stanislaus Housing and Supportive Services Collaborative;
- Health care services (both public and private), including Stanislaus County Health Services Agency and Public Health, Golden Valley Health Centers, Doctors Medical Center, and Psychiatric Medical Group;
- Senior services, including the Area Agency on Aging, Veterans' Affairs, and the Commission on Aging;
- Social services, including Stanislaus County Community Service Agency and Children and Families Commission;
- Justice system, including courts, District Attorney, and Public Defenders Office;
- Law enforcement, including Modesto Police Department and Stanislaus County Sheriff's Office;
- Probation and juvenile justice, including the Chief Probation Officer;
- Labor organizations, including SEIU Local 521;
- Regional areas (South and Westside), including the Turlock Collaborative and the Westside Community Alliance;
- Stanislaus County Chief Executive Office;
- Contract providers delivering public mental health services, including children's services, adult services, and CSS outreach and engagement services; and
- BHRS staff, including staff from the Children's System of Care, Adult System of Care, Older Adult services, prevention services, clinic-based services, and Stanislaus Recovery Center-AOD/Co-occurring Treatment Center.

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.

The thirty-day review process occurred between July 26 and August 26, 2010. A public information meeting was held on August 17, 2010. The public hearing was held on August 26, 2010. Discussion during the information meeting and public hearing, support the project going forward. No substantial comments were received.

EXHIBIT C

Innovation Work Plan Narrative

EXHIBIT C Innovation Work Plan Narrative

Date: July 26, 2010

County: Stanislaus County
Work Plan #: SCINN-01
Work Plan Name: Evolving a Community-Owned Behavioral Health System of Supports and Services

Purpose of Proposed Innovation Project (check all that apply)

- Increase Access to Underserved Groups
- Increase the Quality of Services, including Better Outcomes
- Promote Interagency (and Community) Collaboration
- Increase Access to Services

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

Stanislaus County Behavioral Health and Recovery Services (BHRS) provides both mental health and alcohol and other drug services for residents of Stanislaus County. Over the past several years, BHRS leaders and staff have become convinced that BHRS faces an adaptive dilemma. Even with the infusion of new funding from the Mental Health Services Act (MHSA), the county behavioral health budget has been shrinking, dramatically so in the past two years as state and federal funding streams have contracted as a consequence of the worldwide recession. Current projections indicate that funding will continue to decline precipitously for several more years.

At the same time, the cost of delivering services is continuing to rise, driven by increasing health care costs, public pension costs, costs of providing care to the uninsured, and other costs of doing business. And while revenues are declining and costs rising, the numbers of people struggling with mental health issues are increasing significantly, caused in part by families in our county struggling with the financial and personal stresses of the recession, as well as veterans returning home from the wars in Iraq and Afghanistan.

This dilemma of rapidly declining revenues, steadily increasing costs, and rapidly increasing need is made worse by the expectations created by the passage of the Mental Health Services Act. With the passage of Proposition 63 in 2004, many people expected a dramatic expansion of services for people suffering from mental health issues or co-occurring mental health and substance use disorders, and now struggle to understand why clinics have been closed and other services reduced or eliminated.

We describe this dilemma as adaptive because we believe we cannot resolve these challenges *and* improve behavioral health outcomes through traditional strategies for managing budget shortfalls. Acknowledging the reality of this dilemma, and working to

understand the growing scope of unmet need, have led BHRS leaders to the conclusion that BHRS can never serve all people who struggle with mental health and substance abuse issues in Stanislaus County. The gap is too large, even when limited only to people who struggle with serious and persistent mental illness and severe addictions. This was true before the most recent budget contractions; it is simply more true now.¹

The reality of this yawning gap of unmet need has led us to a second conclusion: that BHRS leaders and staff are not, and cannot be, solely responsible for the behavioral health and emotional well-being of all county residents, and that the Department's budget is not the only resource available for this purpose. The BHRS budget is one part of an array of resources—including private sector resources, non-profit and community resources, volunteer resources and others—that county residents allocate to support their behavioral and emotional well-being.

While BHRS leaders and staff, by ourselves, cannot meet the behavioral health needs of all Stanislaus County residents, we believe BHRS can be a catalyst for creating better alignment and more effective leveraging of the array of resources present in the County. To play such a role, however, will require BHRS leaders to improve our capacity to collaborate with other county agencies, non-profit and community-based organizations, and community leaders, one of the primary purposes for this Innovation Project.

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 MHS Act and Title 9, CCR, section 3320. (suggested length—one page)

To bridge the gap of unmet need in Stanislaus County will require engaging communities and countywide stakeholders in very different processes than have been our norm. While we have successfully engaged stakeholders in Mental Health Services Act planning efforts, we have not helped stakeholders understand the nuances of the overall Department budget, or the interdependencies among mental health and other behavioral health programs and their respective budgets. Nor have we created structures to engage stakeholders in more expansive explorations of how all of us,

¹ An illustration of this gap: Focusing only on people who receive mental health services, BHRS currently serves approximately 9,000 people. The County's population is estimated at 530,000. Current prevalence rates for Stanislaus County place the estimated number of people suffering severe and persistent mental illness or severe emotional disturbances at well over 30,000, indicating a gap of over 20,000 people. Moreover, if we include less severe mental and behavioral health issues, the number of people affected by these issues would be substantially more than 30,000, meaning that the gap between those who could benefit from services and the number of people receiving services is even larger.

together, can evolve a more effective system of supports and services within the realities of rapidly declining public resources.

This is the focus of our first Innovation Project: to develop stakeholder processes that enable community and county partners to join with BHRS leaders in developing an integrated, financially sustainable behavioral health system committed to results.

We believe this is precisely the right time to initiate this project. The awareness among our stakeholders and community leaders of the worldwide recession, the ongoing budget stalemate in Sacramento, and the adverse impact of both on the BHRS budget, creates an opening for us to engage these partners in a fundamentally different conversation about our respective roles and responsibilities. Moreover, this project will build upon our work over the past five years to expand the Department's role from providing services to individuals who meet eligibility criteria, to implementing multiple strategies to increase the capacity of communities to promote the behavioral health and emotional well-being of their members independent of services.

We will begin this effort by creating an expansive stakeholder process to build consensus among community and countywide stakeholders about how to address the emerging budget shortfalls across both the mental health and the alcohol and other drug (AOD) budgets, and how to leverage all available resources to improve behavioral health outcomes across the county. (See page 6 for a detailed discussion of the timeline for this project.)

Any recommendations that emerge from a stakeholder budget process must be consistent with regulatory and statutory requirements governing County budgets, as well as the Department's (and others') ability to implement and manage the proposed changes. The processes we design through this project will of course be grounded in these requirements and understandings. Our intention is not to relinquish our statutory and regulatory authority; rather, our intention is to help BHRS leaders and our partners build shared understanding and ownership of the BHRS budget, and the array of other community, private, and county resources available to improve residents' behavioral health and emotional well-being. We believe such shared understanding and ownership are essential if we are to fashion long-term collaborative responses to the adaptive dilemma we now face as a behavioral health system.

We will evolve this project in ways that are consistent with the general standards and core values of the Mental Health Services Act and Title 9, CCR, section 3320, including the values of community collaboration, creating integrated service experiences, promoting wellness, recovery, and resiliency, creating a consumer- and family-driven mental health system, and creating a culturally competent system of care.

First, we will engage people who receive services, family members, and representatives from ethnic and other unserved and under-served communities from the outset of this project. Specifically, we will conduct multiple community meetings and training sessions to ensure that participants from these constituencies fully engage in the stakeholder deliberations as full-on partners. Some of the practical supports that we will offer to help

achieve this full-on partnership with diverse stakeholders include:

- Translating materials into Spanish and other needed languages;
- Providing simultaneous translation in meetings when needed;
- Conducting multiple in-community meetings to help prepare delegates and their constituencies to participate effectively in the budget deliberations;
- Conducting meetings at times that are convenient for stakeholders who have other responsibilities during the day, including evening and/or weekend meetings;
- Providing childcare for those who require this support to participate in the stakeholder deliberations; and
- And other supports and structures we discover as essential as we begin implementation of the project.

Second, these processes will focus explicitly on the question of how to improve behavioral health and emotional well-being in the context of rapidly declining public resources. Third, this focus on well-being will necessitate deliberations grounded in different cultural and community understandings of well-being and health. Finally, if successful, these processes will create or improve ways to integrate multiple program and community supports, and deepen program and community commitments to results of wellness, recovery and resiliency, in ways that are appropriate for diverse communities within Stanislaus County.

Contribution to Learning

Describe how the Innovation Project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length – one page)

Consistent with the Innovation guidelines, this project explores new approaches to stakeholder processes that will impact:

- Governance and organizational processes and procedures;
- Educational efforts for service providers, community leaders, and other traditional and non-traditional stakeholders;
- Planning processes; and
- Policy and system development processes.

The processes we will design and implement for stakeholder engagement and collaborative decision-making related to BHRS budgets will constitute a new practice or approach. While we are aware of various efforts by mental health and other systems to engage stakeholders in various feedback or circumscribed decision-making processes,²

² Los Angeles County Department of Mental Health (LACDMH) implemented a stakeholder process for one budget cycle—in the spring of 2004 focused on a portion of its core budget for FY 2004-05. That process was highly successful, and our efforts will clearly build upon the lessons learned from that

we are not aware of any system that has designed comprehensive stakeholder processes focused on all Department budgets, including MHSA, non-MHSA, co-occurring, and AOD budgets.

The overarching questions we will explore through this project include:

- Can we engage community partners and stakeholders in processes that, over time, develop shared understanding and *ownership* of the BHRS budget, as well as the array of other community, private, and county resources available to improve residents' behavioral health and emotional well-being?
- Can the emergence of this felt sense of shared ownership lead to more creative and expansive responses to the adaptive dilemma currently confronting the behavioral health system that, over time, improve the behavioral health and emotional well-being of increasing numbers of residents across the County?

Through our efforts to address these two overarching questions, we expect that BHRS leaders and staff members, and our community partners and stakeholders, will learn a great deal about how to promote effective interagency and community collaboration. Specifically, we expect BHRS leaders and staff members to learn:

- About the array of community-based and other non-County supports available to promote behavioral and emotional well-being across Stanislaus County;
- How to involve community leaders, representatives from community-based organizations, and countywide stakeholders in collaborative decision-making processes focused on the BHRS budget and larger system design issues, including how to achieve a more integrated behavioral health system;
- What processes and structures are needed to successfully engage diverse community members as full-on partners and, in particular, address the imbalance of authority inherent in this process;
- How to educate community stakeholders and providers about the nuances of the various components of the BHRS budget;
- How to evolve the Mental Health Board, Advisory Board for Substance Abuse Programs (ABSAP), MHSA representative stakeholders group, and other ad hoc advisory boards into a stakeholder body that joins with BHRS leaders in developing an integrated, financially sustainable behavioral health system committed to results;
- How to align and integrate public and community-based resources—including MHSA, non-MHSA, AOD, and community-based resources—into a more effective continuum of care and support; and
- How to create leadership and learning structures to sustain this effort over time.

process. Two characteristics distinguish the BHRS effort: the scope of our intended process (including all mental health and AOD programs and services), and our intention to use this as an opportunity to create a more integrated and community-focused, community-based system.

Similarly, we expect community leaders and stakeholders to learn:

- About the multiple funding sources that support the mental health and AOD budgets;
- About county, state, and federal regulations and other considerations that govern decisions about the mental health and AOD budgets;
- How to participate in multi-stakeholder budget processes; and
- How to align public and community-based resources into a more effective continuum of care and support.

Beyond our answers to the two overarching questions, and the specific learning we expect will unfold through this project, we also intend that the processes we design and implement will produce tangible benefits, including:

- The development of fiscally sustainable budgets for mental health and AOD service systems;
- The establishment of an on-going community stakeholder body, including community partners and mental health and AOD stakeholders, that has a clearly articulated role in budget deliberations and program development; and
- Written descriptions of integrated mental health and AOD service continuums that include community supports, county-funded services, and resources provided by other funders (non-profits, other governmental agencies, and private provider resources).

Over the course of the three-year project, we will develop annual lessons learned documents and other products to document the tangible benefits, emerging challenges, and deepening learning by Department leaders and staff members, community and county stakeholders, and others who participate in the project.

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. (suggested length – one page)

1. The emerging timeline: overview

- a. Start date: July 2010 (supported with Innovation planning funds until project is approved by the Oversight and Accountability Commission)
- b. End date: June 30, 2013
- c. Summary: This project is a three-year effort, beginning in July 2010.
 - (1) During the first year of the project, we will develop the design for the stakeholder process, and begin limited tests of this design focused on essential revisions to our Community Services and Supports (CSS) and the FY 2011-12 AOD budgets. These first efforts will allow us to test various process designs aimed at educating community members and stakeholders about budget and program design issues within the realities of regulatory

- requirements and revenue constraints. At the end of the first year, we will produce our first lessons learned document.
- (2) During the second year, we will fully implement the stakeholder process, focused on the entire FY 2012-13 BHRS budget, including the MHSA, core mental health, co-occurring and AOD budgets. At the end of the second year, we will assess the process, make revisions, and prepare for the third year. We will also produce our second lessons learned document.
 - (3) During the third year, we will implement a revised stakeholder process focused on the FY 2013-14 mental health and AOD budgets. At the end of this process, we will assess the project and decide whether to continue the effort without Innovation funding. We will also produce our final lessons learned document.

2. Emerging timeline: detail

a. Year 1: FY 2010-11

- (1) Work with Senior Leadership Team members to map the FY 2011-12 mental health and AOD budget decisions that need to be made before the stakeholder process is underway, and the FY 2012-13 budget decisions that will be the focus of the stakeholder process to begin in July 2011.
- (2) Develop an initial list of stakeholders who will participate in the process, including community leaders, people who receive services, family members, community, ethnic, and faith-based organizations, Mental Health Board members, ABSAP members, county departments, the County CEO's office, and others.
- (3) Develop training materials for stakeholders, including materials on the:
 - (a) Values and current vision of the behavioral health system;
 - (b) Current continuums of care for mental health and AOD programs, and the interdependencies among them;
 - (c) Current budgets for mental health and AOD programs;
 - (d) Future revenue projections for mental health and AOD programs;
 - (e) Applicable regulatory and funding stream parameters; and
 - (f) Skill sets needed for the success of this effort.
- (4) Convene orientation meetings for stakeholders, explaining the process and the timeline.
- (5) Design and implement a limited stakeholder processes focused on the MHSA CSS and AOD budget decisions needed for FY 2011-12. Deadline for developing actionable recommendations for CSS: December 2010; deadline for developing actionable recommendations for AOD: March 2011.
- (6) Assess results from CSS and AOD processes and training sessions, and finalize design for stakeholder process to begin in July 2011.
- (7) Conduct training sessions with BHRS leaders and staff, community leaders, and countywide stakeholders to prepare for the second year process.
- (8) Complete first lessons learned document.

b. Year 2: FY 2011-12

- (1) Implement stakeholder process focused on decisions for the FY 2012-13 BHRS budgets, including the MHSA, core mental health, co-occurring and AOD budgets. Deadline for developing actionable budget recommendations: January 2012.
- (2) Implement follow-up learning circles and processes to address priority system and community issues identified through the budget process.
- (3) Assess the first stakeholder process and develop revisions for year 3, including additions to stakeholders, revisions to process design, and others.
- (4) Complete second lessons learned document.

c. Year 3: FY 2012-13

- (1) Implement revised stakeholder process focused on decisions for the FY 2013-14 budgets for mental health and AOD. Deadline for developing actionable budget recommendations: January 2013.
- (2) Implement follow-up learning circles and processes to address priority system and community issues identified through the budget process.
- (3) Assess the second stakeholder process and decide if and how to continue the process(es) once Innovation funding is no longer available.
- (4) Complete final lessons learned document.

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.

We will pursue multiple strategies to assess the effectiveness of this project, including:

- Feedback forms after each stakeholder meeting and training;
- Regular 1-1 interviews among BHRS leaders, staff members, community leaders, and countywide stakeholders;
- Regularly scheduled group discussions among stakeholders; and
- Written lessons learned documents at the end of each year of the three-year project that incorporate data from the feedback forms, 1-1 interviews, and group discussions. These annual lessons learned documents (and other written and visual products we develop) will document the tangible benefits, emerging challenges, and deepening learning by Department leaders and staff members, community and county stakeholders, and others who participate in the project.

Additionally, each stakeholder process will culminate in one or more reports documenting the consensus and divergent recommendations among stakeholders and the actions taken by relevant decision-makers on the stakeholder recommendations. These reports also will become part of the assessment process.

These various forms of measurement will help us discern the answers to the two overarching questions articulated on pages 12-13, and whether we produced the expected benefits from this project outlined on pages 13-14.

Leveraging Resources

Provide a list of resources expected to be leveraged, if applicable.

In preparation for and during the stakeholder processes, we will hold a number of meetings in community settings identified and contributed by our partners. Many of the participants in the stakeholder process will donate their time, and all will invest their knowledge, experience, and passion in this effort.

More to the point, however, the focus of this project is to build shared understanding and ownership of the BHRS budget, and the array of other community, private, and county resources available to improve behavioral health and emotional well-being. We believe such shared understanding and ownership will help BHRS leaders and our partners more effectively integrate this array of resources to promote behavioral health and emotional well-being for residents across the county.

EXHIBIT D Innovation Work Plan Description

EXHIBIT D
Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Stanislaus

Annual number of clients to be served (if applicable): NA

Work Plan Name: SCINN 01

Evolving a Community-Owned System of Behavioral Health Supports and Services

Population to be served (if applicable): N/A

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

Stanislaus County Behavioral Health system, like all such systems in California faces an adaptive dilemma of rapidly declining revenues, steadily increasing costs, and rapidly increasing need. We describe this dilemma as adaptive because we believe we cannot resolve these challenges *and* improve behavioral health outcomes through traditional strategies for managing budget shortfalls.

Acknowledging the reality of this dilemma, and working to understand the growing scope of unmet need, have led BHRS leaders to the conclusion that BHRS can never serve all people who struggle with mental health and substance abuse issues in Stanislaus County. The gap is too large, even when limited only to people who struggle with serious and persistent mental illness and severe addictions. To bridge the gap of unmet need in Stanislaus County will require engaging communities and countywide stakeholders in very different processes than have been our norm. While we have successfully engaged stakeholders in Mental Health Services Act planning efforts, we have not helped stakeholders understand the nuances of the overall Department budget, or the interdependencies among mental health and other behavioral health programs and their respective budgets. Nor have we created structures to engage stakeholders in more expansive explorations of how all of us, together, can evolve a more effective system of supports and services within the realities of rapidly declining public resources.

This is the focus of our first Innovation Project: to develop stakeholder processes that enable community and county partners to join with BHRS leaders in developing an integrated, financially sustainable behavioral health system committed to results.

EXHIBIT E

Innovation Funding Request

EXHIBIT E - REVISED
Mental Health Services Act Innovation Funding Request

County Name: Stanislaus

Date: September 9, 2010

Innovation Work Plans			FY 10-11 Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
No.	Name			Children, Youth + Families	Transition Age Youth	Adult	Older Adult
1	SCINN 01	Evolving a Community-Owned Behavioral Health System of Supports and Services	563,400	Not applicable to the proposed Innovation Project			
2							
3	Sub-total: Work Plans		563,400				
4	Plus County Administration		84,509				
5	Plus Optional 10% Operating Reserve		64,791				
6	Total MHSA Funds Required for Innovation		\$712,700				

EXHIBIT F

Innovation Projected Revenues And Expenditures

EXHIBIT F - REVISED
Innovation Projected Revenues And Expenditures

County Name: Stanislaus **Fiscal Year:** FY 2010-11
Work Plan #: SCINN-01 through FY 2012-13
Work Plan Name: Evolving a Community-Owned Behavioral Health System of Supports and Services
New Work Plan:
Expansion:
Months of Operation: 11/2010 – 06/2013

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	112,273			112,273
2. Operating Expenditures	69,744			69,744
3. Non-recurring expenditures	0			0
4. Training Consultant Contracts	272,700			272,700
5. Work Plan Management	108,683			108,683
6. Total Proposed Work Plan Expenditures	\$563,400	\$0	\$0	\$563,400
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	\$563,400	\$0	\$0	\$563,400

Prepared by: Vicki Peitz, Accountant III
 Telephone Number: (209) 525-7446

Date: 9/9/10

Prepared by: Vicki Peitz, Accountant III Date: 7/19/10
Telephone Number: (209) 525-7446

BUDGET NARRATIVE FOR FY 2010-11

A. Expenditures	Budget Amount
1. Personnel Expenditures	\$27,698
Estimated 8 months salaries and county benefits for .20 FTE MHSA Coordinator and two Facilitator positions at .05 FTE each. Salaries are based on the most recent county position rates. Fringe benefits are calculated as a percentage of salaries based on the FY 2010/2011 average rates and include: Retirement, Group Health Insurance, FICA, Medicare, Workers Comp, Disability, Health and Dental Insurance, Employee Assistance Program and Deferred Comp Part Time.	
2. Operating Expenditures	\$19,600
Estimated 8 months cost of program printing, stipends, meeting/training supplies, food for stakeholder and In-community meetings, employee mileage reimbursement and translation services.	
3. Non-recurring expenditures	\$0
Not applicable.	
4. Training Consultant Contracts	\$60,300
Estimated 8 months cost for two consultants, one who will co-lead the project in conjunction with Coordinator, and one who will document project work plan processes. Costs are calculated using current hourly rates times estimated consultant project hours.	
5. Work Plan Management	\$24,317
Estimated 8 months costs for twelve Senior Leadership Team Members' participation in the project. Costs calculated using the department's most recent indirect cost rate (ICR=22.6% of program personnel, operating and contract costs).	
6. Total Proposed Work Plan Expenditures	\$131,915
B. Revenues	
None anticipated at this time. Stakeholder meetings and trainings to be held at community facilities with community members' assistance provided as in-kind at a value we are unable to determine at this time. Stakeholders will also donate their time to this project, again at a value we are unable to determine at this time.	
1. Existing Revenues	\$0
2. Additional Revenues	\$0
3. Total New Revenue	\$0
4. Total Revenues	\$0
C. Total Funding Requirements – Work Plan only	\$131,915
D. Additional Required Funding for FY 2010-11 (per Exhibit E)	

1. Administration Budget	\$19,787
Includes estimated 8 months cost for .05 FTE Manager III to inform and educate various committee members of project implementation, goals and status; .05 FTE MHA Accountant III to provide program fiscal support for budgeting and reporting; and .25 FTE Administrative Clerk III to provide program clerical support for meeting preparations and materials. Salaries and benefits based on the most recent county rates. Includes 2% of salaries for A-87 Countywide costs and 22.6% of salaries for department indirect costs based on FY 08/09 County Cost Report ICR.	
2. Operating Reserve	\$15,170
10% of Work Plan and Administration Budgets is requested for unplanned contingencies and unexpected increases in costs.	
E. Total Year 1 Work Plan, Administration and Operating Reserve	\$166,872
F. Total MHA Funds Required for Innovation Project SCINN 01 – Year 1	\$166,872

NARRATIVE FOR PROJECTED FY 2011-12 AND FY 2012-13 BUDGETS

We expect this Innovation Project to extend over three years, concluding in June 2013. While Exhibit F only requires us to submit a request for our first year budget, for planning purposes we have calculated our projected budgets for FY 2011-12 and FY 2012-13, and estimated the total cost of the project for the three years.

For FY 2011-12, we estimate a total budget of \$269,422. This estimate includes 12 months of salary and benefit costs for the staff positions noted above. A 5% COLA has been added to year 1 staff costs, operating costs, and overhead/indirect costs. Training consultant contract costs reflect 12 months of estimated hours for year 2 times consultants' hourly rate. Operating costs have also been increased to reflect 12 months of stakeholder meeting expenses. These changes from the FY 2010-11 budget produce the following FY 2011-12 estimates:

A. FY 2011-12	
1. Work Plan	\$212,982
2. Administration	31,947
3. Operating Reserve	24,493
4. Estimated total for FY 2011-12	\$269,422

For FY 2012-13, we estimate a total budget of \$276,406. This estimate includes 12 months of salary and benefit costs for the staff positions noted above. A 5% COLA has been added to year 2 staff hourly rates, operating costs, and overhead/indirect costs. Training consultant contract costs reflect 12 months of estimated hours for year 3 times consultants' hourly rate. These changes from the FY 2011-12 budget produce the following FY 2012-13 estimates:

B. FY 2012-13	
1. Work Plan	\$218,503
2. Administration	32,775
3. Operating Reserve	25,128
4. Estimated total for FY 2011-12	\$276,406

With these additional estimates, we project the total cost of Project SCINN-01 to be \$712,700.

C. Grand Total Innovation Funds Expected to be Required for Project SCINN 01

1. FY 2010-11 (this request)	\$166,872
2. FY 2011-12 estimate	269,422
3. FY 2012-13 estimate	276,406
4. Projected three year total:	\$712,700