

NEW/REVISED PROGRAM DESCRIPTION
Innovation

County: Stanislaus (Final)

Completely New Program

Program Number/Name: FSP Co-Occurring Disorders Project Revised Previously Approved Program

Date: 7/28/15

Complete this form for each new INN Program. For existing INN programs with changes to the primary¹ purpose and/or learning goal, please complete the sections of this form that are applicable to the proposed changes. If there are no changes in the applicable section, please state "No Changes."

Select **one** of the following purposes that most closely corresponds to the Innovation's learning goal.

- Increase access to underserved groups
- Increase the quality of services, including better outcomes
- Promote interagency collaboration
- Increase access to services

1. Describe why your selected primary purpose for Innovation is most relevant to your learning goal and why this primary purpose is a priority for your county.

Mental health treatment providers in Stanislaus County are seeing a great proportion of people with severe mental illness and co-occurring substance use disorders (SUDs). These co-occurring SUDs are substantially interfering with the effectiveness of their clients' mental health treatment. In Fiscal Year 2013/2014, 61% of adult Full Service Partnership (FSP) clients received a substance abuse/dependency diagnosis. While all adult FSPs work with this population and should have the capability to diagnose and treat SUDs (e.g. IDDT), there are some individuals for whom the extreme extent of their SUD behavior creates challenges and reduces the effectiveness of the FSP. As a result, this population is unserved or underserved. In fact, during the MHSa Stanislaus County Stakeholder process, "Treatment options for people struggling with both substance abuse and mental illness" was one of the priority mental health adaptive dilemmas that should be addressed in an innovative manner because it is a persistent mental health challenge that has not been successfully addressed by more traditional methods.

But what would happen if a combination of strategies were in place as part of a new FSP that, ultimately, could increase the quality of mental health services? This Innovation project has several elements, when combined, that could produce better outcomes and create a promising practice for residents suffering from severe mental illness and SUD. Many of these individuals are also involved with the criminal justice system, often directly related to their mental health and SUD symptoms and behaviors. Many are also homeless, at risk of homelessness, at risk of institutionalization, and/or frequent users of emergency services. Therefore, there is overlap with other existing adult FSPs. However, there is a gap in our continuum of FSP programs that this Innovation Project would address, and coordination with existing FSPs will be a key component to this project.

Mental health treatment and SUD treatment are similar and overlap each other. But there are some areas that are significantly different in approach, training, and philosophy. These areas include, but are not limited to, engagement versus enabling, abstinence versus meeting the client where they are at in their life, hopefulness for recovery versus the desire to drink or use drugs without consequence, empowerment of the individual versus acceptance of the individual's powerlessness over drugs and alcohol use. Through this Innovation project, our belief is that a client-centered, stage-based approach to mental health and SUD treatment and treatment planning, with a focus on shared understanding amongst staff and with client, will create a theoretical and practical framework that allows for both approaches to be fully tested and utilized.

Stanislaus County is proposing to test the efficacy of an FSP providing co-occurring disorder services by evaluating not only *what* is provided, "housing first" and primary care access on an SUD treatment and recovery campus, but *how* services are provided. The co-occurring disorder will be the first "lens" through which this Innovative FSP project views the clients' recovery needs and strengths. The primary focus will be on creating shared understanding and vision amongst staff and with clients through a client-centered, stage-based approach, enriched with primary care and housing services. We expect to learn whether this approach can make a true difference in the lives of people with mental illness and SUDs. This would make the Innovation project unique and different from other FSPs with the potential to advance knowledge and contribute something new to the field of mental health.

¹ The term "essential purpose" has been replaced with the term "primary purpose" for INN.

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This Innovative approach would create a unique FSP that integrates primary care access, a “housing first” approach, and co-location on an SUD/Co-occurring treatment site under a stage-based co-occurring treatment philosophy and practice.

2. Describe the INN Program, the issue and learning goal it addresses, and the expected learning outcomes. State specifically how the Innovation meets the definition of Innovation to create positive change; introduces a new mental health practice; integrates practices/approaches that are developed within communities through a process that is inclusive and representative of unserved and underserved individuals; makes a specific change to an existing mental health practice; or introduces to the mental health system a community defined approach that has been successful in a non-mental health context.

This Innovation project makes a change to an existing mental health practice that has not yet been demonstrated to be effective for the population experiencing both a serious mental illness as well as a co-occurring SUD. The FSP will be operated by Behavioral Health and Recovery Services and is expected to serve fifty (50) individuals at any one time.

Though BHRS currently has a small Co-occurring Treatment Program (COT), which is a primary substance use disorder treatment program with adjunct mental health services for clients in SUD residential and IOT, this new program will focus on the treatment team process(es) in testing/applying stage based engagement/treatment strategies at every level of client contact for both mental health and SUD with the goal of client recovery and wellness. In addition, the FSP model will address potential risks that all FSPs are designed to address: reduce homelessness, involvement with the criminal justice system, acute psychiatric hospitalizations, and institutionalization.

Additionally, this FSP will be co-located on an SUD treatment site in Ceres, California, where clients will have access to recovering peers and supports integrated primary care, and a dedicated “Housing First” approach. Again, an emphasis will be on using the Stage Based Treatment framework for both mental health and SUD concurrently and deliberately, addressing the sometimes contradictory strategies indicated for each stage separately.

These are the primary components of this Innovative FSP that substantively change the existing FSP model in our County:

Stage Based Treatment: Stage based treatment encompassing Mental Health Recovery Treatment assessment stages known as MHRTS and the Substance Abuse Treatment Scale known as SATS will be used for this at-risk population. We hope to discover that these dual stages and the strategies associated with each of them can impact individuals with co-occurring disorders. It is believed that once engaged, this population would benefit from stage-based mental health treatment and stage-based substance use disorder treatment concurrently and integrated. Too often, mental health treatment and substance use disorder treatment are provided sequentially, allowing progress to be undermined by issues stemming from the untreated aspect. Beginning where the client is in their stage of change process, whether that is more mental health related, or more substance use related, treatment will be guided by data that reflects that specific client’s readiness for treatment in both areas. Using peers who are in recovery as well as the SUD recovery environment and group-based treatment is expected to be particularly effective with this population. Staff will be trained in the Integrated Dual Diagnosis Treatment protocol. Ultimately, this approach should create positive change.

Primary Care: This FSP will integrate primary care in the continuum of care for this population. Broadening the focus beyond behavioral health to encompass physical health is becoming an expected standard of care in the health industry and is designed to reduce the silos that have often characterized behavioral and physical healthcare. Well-documented research has indicated that untreated behavioral health conditions lead to early death in individuals with mental health and/or substance abuse conditions. In addition, it is believed that the inclusion of physical health care in this INN project is a way to engage individuals that are resistant to behavioral health treatment. The experience of our outreach teams supports this assumption given that many individuals want assistance with health issues which are less stigmatizing. However they are engaged, many individuals are then more receptive to dealing with the root causes of their physical health issues.

Housing: A ‘housing first’ approach is also critical to engage this population and begin the treatment process. Experience in our other FSPs has demonstrated that clients often continue harmful substance use behaviors despite efforts to eliminate them. Consequently, they appear in temporary housing under the influence and, ultimately, lose the housing because the continued substance use has put the other clients in the housing at risk of relapse and using substances themselves. This FSP will develop housing engagement strategies that deal with continued substance use without resulting in the client losing their housing. At the same time, this will protect other clients from this behavior. It has been shown in other states that offering housing that does not require sobriety to begin with has resulted in the client actually working toward sobriety, i.e., engaging in treatment.

The learning goal of the project is to increase the effectiveness of an FSP program dedicated to difficult to engage individuals with severe mental illness and co-occurring SUDs by integrating primary care access, a “housing first” approach, and co-location on an SUD/Co-occurring treatment site under a stage-based co-occurring treatment philosophy and

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practice. What we learn from this project can be applied to other FSPs to successfully engage clients in treatment to addresses both their physical and behavioral health needs. In addition, it is expected that this innovative combination of services will yield better health and behavioral health outcomes for this population at risk of disabling conditions affecting the quality of their lives as well as the length of their lives. The learning questions we will explore through this project include:

1. Will clients be successfully engaged by receiving a combination of services through this new FSP?
2. Will using stage-based treatments for both mental health and SUD concurrently lead to improved outcomes for clients participating in the FSP project?
3. What engagement strategies and interventions will emerge from this concurrent stage-based approach that are most effective for this population?
4. While utilizing the concurrent stage-based approach, what practices/processes are most effective from staffs' perspective?
5. Will access to integrated primary care positively affect outcomes?
6. Will employing an integrated "Housing First" approach positively affect outcomes?
7. Will co-locating this FSP on an SUD/Co-Occurring treatment site lead to increased peer support, SUD treatment follow through and linkages to mental health and SUD resources?

The overarching learning outcome is to help inform the behavioral health field about what combination of strategies and services are most effective at the different concurrent mental health and SUD recovery stages.

2a. Include a description of how the project supports and is consistent with the applicable General Standards as set forth in CCR, Title 9, Section 3320.

Community Collaboration - BHRS is a strong collaborative agency with a long history of partnering with community based organizations to provide services to the mentally ill of Stanislaus County. This project will help "open doors" to clients and link them to other community resources in their treatment and recovery. Co-locating the FSP on a SUD treatment center site will allow clients to have access to other SUD programs on the campus. They will also have access to recovering peers, a drop-in center and supports.

Cultural Competence - Services will be provided in a culturally competent manner using individuals with lived experience to provide outreach and engagement to this target population. Since research has demonstrated that primary care is often a more acceptable resource to turn to for help for many ethnically diverse populations, it is expected that this component will overcome some of the stigma that is associated with behavioral health treatment. Our plans are to hire bilingual staff. And as part of our outreach efforts, we plan to partner with all FSPs and our Transition TRAC which includes a Latino outreach and access component. We also envision partnership opportunities with Golden Valley Health Centers, as well as our BHRS thriving Promotora/Community Outreach Worker countywide network to strengthen our efforts to provide outreach/access to the Latino community.

Client-Family Driven Mental Health System - The "housing first" component is a client-driven aspect of this project. We have budgeted a Peer/Volunteer organizer to strengthen the peer support for these individuals on the Stanislaus Recovery Center campus where the Innovation project will be housed. We plan to work with our BHRS Peer Committee to gain feedback on strategies and we will be partnering with our peer navigators and family advocates to work with individuals who would benefit from this program. In addition, BHRS has a strong partnership with NAMI and its In Our Own Voice program to provide training to all staff involved in this project.

Wellness and Recovery - BHRS is committed to client wellness and recovery in all of its community programs. The project will be collaboration with primary care with the shared vision of overall health and recovery.

Integrated Service Experiences - By offering a combination of services and strategies, the result will be an integrated experience for FSP clients. Physical health and behavioral health are integrated and mental health and substance use treatment are integrated. Ultimately, the outcomes should demonstrate that this approach leads to wellness and recovery in a very at risk population in an Integrated Dual Disorder Treatment (IDDT) trained Full Service Partnership (FSP) program.

2b. If applicable, describe the population to be served, number of clients to be served annually, and demographic information including age, gender, race, ethnicity, and language spoken.

This program will serve adults and transition age young adults with serious mental illness and co-occurring substance abuse disorders who are underserved and are either, homeless, at risk of homelessness (such as persons coming out of jail), involved in the criminal justice system, frequent users of hospital and emergency room services or who are so underserved they are at risk of homelessness, criminal justice involvement and institutionalization. Fifty (50) individuals are expected to be served at any one time through this Innovation project.

3. Describe the total timeframe of the program. In your description include key actions and milestones related to assessing your Innovation and communicating results and lessons learned. Provide a brief explanation of why this timeline will allow sufficient time for the desired learning to occur and to demonstrate the feasibility of replicating the

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Innovation. Please note that the timeline for your Innovation Program can be longer than the period for which you are currently requesting Innovation Component funds.

This project is expected to be completed in three years. DCR data will be monitored as will California Outcomes Measurement System (CalOMS) results on a quarterly basis. Engagement data, Level of Care data, service utilization data, and other client outcome data will be gathered at least quarterly. At 3 months the program should be fully operational and at least at 70% client capacity, engagement activities should be fully operational. At 6 months the program should be at 90% client capacity, data gathering fully in place. At 1 year initial data analysis of trends and outcomes will be reviewed. At 2 years full data analysis on years 1 and 2 of operation will be reviewed. At 2 ½ years data gathering for project study will be completed. At year 3 the full analysis of data and client outcomes will be completed.

4. Describe how you plan to measure the results, impacts, and lessons learned from your Innovation, with a focus on what is new or changed. Include in your description the expected outcomes of the Innovation program, how you will measure these outcomes, and how you will determine which elements of the Innovation Program contributed to successful outcomes. Include in your description how the perspectives of stakeholders will be included in assessing and communicating results.

Defining and measuring success for this Innovation Project is based on the learning questions described above and listed here:

1. Will clients be successfully engaged by receiving a combination of services through this new FSP?
2. Will using stage-based treatments for both mental health and SUD concurrently lead to improved outcomes for clients participating in the FSP project?
3. What engagement strategies and interventions will emerge from this concurrent stage-based approach that are most effective for this population?
4. While utilizing the concurrent stage-based approach, what practices/processes are most effective from staffs' perspective?
5. Will access to integrated primary care positively affect outcomes?
6. Will employing an integrated "Housing First" approach positively affect outcomes?
7. Will co-locating this FSP on an SUD/Co-Occurring treatment site lead to increased peer support and linkages to mental health resources?

The total estimated amount for evaluation of this Innovation project is \$47,648 over three years. This cost is included with the personnel expenditures.

Since this Innovation project makes a change to an existing mental health practice that has not yet been demonstrated to be effective for the population experiencing both a serious mental illness as well as a co-occurring SUD, it is important to learn about the effectiveness of processes as well as the impact on the quality of services. Therefore, both formative and summative aspects of evaluation will be included. For example, although Stages of Recovery frameworks have been used before for both Mental Health and SUD programs, it is expected that *how* they are being used by collaborating staff will make a difference in positively impacting client progress.

Both qualitative and quantitative methods will be utilized to address the learning questions and help answer the overall question of what combination of strategies and services are most effective at the different concurrent mental health and SUD recovery stages. Data collection methods will include: referral tracking; staff documentation of working with Stages of Recovery frameworks; Substance Abuse Treatment Scale (SATS) stages tracking and change; Mental Health Recovery Treatment Stages (MHRTS) stages tracking and change; documentation of strategy and service efficacy; client satisfaction surveys; DCR; and CalOMS.

The staff will be documenting the work surrounding the Stages of Recovery frameworks and how concurrent use of the frameworks affect their work and client outcomes. A qualitative analysis of this documentation will reveal the strengths and challenges of using the sometimes contradictory language and methods of the two frameworks. A focus group will be conducted at the end of the Innovation project to discuss the findings and explore the information collected further from a staff perspective. We will learn from this process how staff might best utilize the two frameworks to create shared understanding of clients' recovery needs, and most effectively impact client progress.

The MHRTS and the SATS will be used to track changes for individual clients. Documentation of both successful and unsuccessful interventions from multiple stages will be reviewed and analyzed for strong relationships between stages, interventions, engagement, and recovery outcomes. A list of engagement strategies and interventions and their effectiveness with this hard-to-engage SMI/SUD population in terms of engagement, retention, and outcomes will be

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created. We expect that these tools will show client recovery progress as measured by positive changes in stages of recovery as illustrated below:

MHRTS	Recovery Progress	SATS
0 – No mental health problems reported		1 – Pre-engagement
1 – Pre-engagement		2 – Engagement
2 – Engagement/Outreach		3 – Early Persuasion
3 – Contemplation/Exploration		4 – Late Persuasion
4 – Recovery Awareness		5 – Early Active Treatment
5 – Stabilization/Beginning Recovery		6 – Late Active Treatment
6 – Active Recovery		7 – Relapse Prevention
		8 – In Remission or Recovery

Utilizing the well-established DCR and CalOMS systems, it is expected that clients receiving services through this FSP will mirror, if not exceed, the success rate of other FSPs within BHRS. When applicable, outcome data will be compared for clients who previously received FSP services, and then are referred to and receive services through the Co-occurring FSP. It is expected that those who were previously not highly successful experience improved outcomes by receiving an appropriate and convenient combination of FSP services for co-occurring disorders. In addition, a comparison of DCR outcomes for clients in other FSPs will be made to client outcomes in this Innovative FSP that first focuses on co-occurring disorders. The outcomes measured include homelessness, incarceration, medical and psychiatric hospitalizations, state hospitalizations, and long-term hospitalizations.

In addition, client surveys will be administered quarterly to collect data regarding engagement and satisfaction. The survey data will be analyzed to discover what particular elements of the FSP (e.g. co-location, peer support, primary care, housing first) have been most instrumental for successful recovery from the clients' perspective. We expect to learn what elements or combination of elements are most impactful in order to use the information to improve FSP services in the future for clients with co-occurring disorders.

Throughout the project, an established peer group will be reviewing the data and progression of the project. This group will be requested to make suggestions regarding project processes and the evaluation of the new FSP. The Innovation project outcomes and evaluation will be shared with the peer group, BHRS staff, and stakeholders.

5. If applicable, provide a list of resources to be leveraged.

6. Please provide a budget narrative for total projected costs for the entire duration of the Innovation Program, and also provide projected expenditures by each fiscal year during the program time frame, including both the current and future funding years. (For Example, Program 01- XXXX, the entire project is \$1,000,000. The first year projected amount will be \$250,000, the second year projected amount is \$250,000, the third year is \$250,000 and the fourth year is \$250,000.) Please also describe briefly the logic for this budget: how your proposed expenditures will allow you to test your model and meet your learning and communication goals.

The total three year cost of this program is projected to be \$3,274,491 of which \$2,377,554 will be funded with Mental Health Services Act Innovation funding. Federal Financial Participation (FFP) funds generated by medically necessary Medi-Cal services provided by this Full Service Partnership program will offset an estimated \$896,937 over the three year period. The projected cost for the first year is \$1,114,600 of which \$815,621 will be funded by MHSA Innovations funding and \$298,979 is projected to be funded by FFP. The projected cost of the second year is \$1,078,444 of which \$779,465 will be funded by MHSA Innovation funding and \$298,979 is projected to be funded by FFP. The projected cost or the third year is \$1,081,447 of which \$782,468 will be funded by MHSA Innovation funding and \$298,979 is projected to be funded by FFP.

7. Provide an estimated annual program budget, utilizing the following line items.

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NEW ANNUAL PROGRAM BUDGET					
A. EXPENDITURES					
	Type of Expenditure	County Mental Health Department/Year 1	County Mental Health Department/Year 2	County Mental Health Department/Year 3	Total
1.	Personnel	\$886,609	\$895,475	\$922,339	\$2,704,423
2.	Operating Expenditures	\$86,863	\$87,969	\$89,108	\$263,940
3.	Non-recurring Expenditures	\$71,128	\$25,000	\$0	\$96,128
4.	Contracts (Training Consultant Contracts)	\$30,000	\$30,000	\$30,000	\$90,000
5.	Work Plan Management				
6.	Other Expenditures	\$40,000	\$40,000	\$40,000	\$120,000
	Total Proposed Expenditures	\$1,114,600	\$1,078,444	\$1,081,447	\$3,274,491
B. REVENUES					
1.	New Revenues				
	a. Medi-Cal (FFP only)	\$298,979	\$298,979	\$298,979	\$896,937
	b. State General Funds (MHSA-INN)				
	c. Other Revenues				
	Total Revenues				
	C. TOTAL FUNDING REQUESTED	\$815,621	\$779,465	\$782,468	\$2,377,554

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D. Budget Narrative

1. Provide a detailed budget narrative explaining the proposed annual program expenditures for each line item.

BUDGET NARRATIVE FOR YEAR 1

1 PERSONNEL

All personnel costs are estimated at Step V of the Classification range x 2080 working hours.

Annual benefit costs are approximately 37%.

Estimated overhead is calculated at approximately 30%

Mental Health Clinician II – Coordinator (MHC II) includes 10% supervision differential

Classification	FTE	Annual S/B Costs	Project Costs
County Mental Health Personnel:			
Behavioral Health Specialist II	3	\$95,939	\$287,818
Mental Health Clinician II	1	\$118,057	\$118,057
MHC II – Coordinator	1	\$130,178	\$130,178
Psychiatrist	0.15	\$299,275	\$44,891
Administrative Clerk III	1	\$77,599	\$77,599
Peer/Volunteer Organizer	0.5	\$78,123	\$39,062
Manager III	0.15	\$143,889	\$21,583
Staff Services Coordinator	0.10	\$117,198	\$11,720
Software Developer/Analyst III	0.03	\$130,028	<u>\$3,901</u>
Sub Total - County MHD Personnel			\$734,808
Other Government Personnel:			
RN/Public Health Nurse II contracted from County Public Health Department	1	\$151,800	<u>\$151,800</u>
1 Total Salary Costs			\$886,609
2 OPERATING EXPENDITURES			
Mileage - estimated mileage at \$.575/per mile			\$2,800
Office Supplies			\$2,500
Wraparound - includes support services to individuals such as housing and basic needs that are directly related to the client care plan.			\$50,000
Malpractice Insurance			570
SRC Rent/Utilities - approximately 1,940 square feet @ \$1.3313/sq x 12 months			<u>\$30,993</u>
2 Total Operating Costs			\$86,863
3 NON-RECURRING COSTS			
Desks – 8 @\$1,900 each			\$15,200
Chairs – 8 @ \$500 each			\$4,000
Desktop Computers, monitors, mouse, licenses – 8 @ \$2,400			\$19,200
Miscellaneous Office Equipment			\$928
Laptops – 2 @\$3,400			\$6,800
Vehicle - sedan or small van for outreach purposes			<u>\$25,000</u>
3 Total Non-Recurring Costs			\$71,128
4 CONTRACTS			
Consultation time from local Primary Care Physician			\$30,000
5 Work Plan Management			
			\$ - 0 -
6 Other Expenditures			
Treatment for substance use disorders purchased from county or community based providers			<u>\$40,000</u>
Total Expenditures			<u><u>\$1,114,600</u></u>
ESTIMATED REVENUE			
MHSA Innovations. Approximate 73% of program cost, including match for FFP			\$815,621

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Estimated Federal Financial Participation (FFP)	\$298,979
Total Revenue	<u>\$1,114,600</u>

BUDGET NARRATIVE FOR YEAR 2

1	PERSONNEL		
		All personnel costs are estimated at Step V of the Classification range x 2080 working hours.	
		Annual benefit costs are approximately 37%.	
		Estimated overhead is calculated at approximately 30%	
		Mental Health Clinician II – Coordinator (MHC II) includes 10% supervision differential	
		<u>Classification</u>	<u>FTE</u> <u>Annual S/B Costs</u> <u>Project Costs</u>
		County Mental Health Personnel:	
		Behavioral Health Specialist II	3 \$96,899 \$290,696
		Mental Health Clinician II	1 \$119,238 \$119,238
		MHC II – Coordinator	1 \$131,480 \$131,480
		Psychiatrist	0.15 \$302,268 \$45,340
		Administrative Clerk III	1 \$78,375 \$78,375
		Peer/Volunteer Organizer	0.5 \$78,904 \$39,452
		Manager III	0.15 \$145,328 \$21,799
		Staff Services Coordinator	0.10 \$118,370 \$11,837
		Software Developer/Analyst III	0.03 \$131,328 \$3,940
		Sub Total - County MHD Personnel	<u>\$742,157</u>
		Other Government Personnel:	
		RN/Public Health Nurse II contracted from County Public Health Department	1 \$153,318 \$153,318
1		Total Salary Costs	<u>\$895,475</u>
2		<u>OPERATING EXPENDITURES</u>	
		Mileage - estimated mileage at \$.575/per mile	\$2,884
		Office Supplies	\$2,575
		Wraparound - includes support services to individuals such as housing and basic needs that are directly related to the client care plan.	\$50,000
		Malpractice Insurance	587
		SRC Rent/Utilities - approximately 1,940 square feet @ \$1.3712/sq x 12 months	<u>\$31,923</u>
2		Total Operating Costs	<u>\$87,969</u>
3		<u>NON-RECURRING COSTS</u>	
		Vehicle - sedan or small van for outreach purposes	\$25,000
4		CONTRACTS	
		Consultation time from local Primary Care Physician	\$30,000
5		Work Plan Management	\$ - 0 -
6		Other Expenditures	
		Treatment for substance use disorders purchased from county or community based providers	<u>\$40,000</u>
		Total Expenditures	<u>\$1,078,444</u>
		 ESTIMATED REVENUE	
		MHSA Innovations. Approximate 72% of program cost, including match for FFP	\$779,465
		Estimated Federal Financial Participation (FFP)	<u>\$298,979</u>
		Total Revenue	<u>\$1,078,444</u>

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BUDGET NARRATIVE FOR YEAR 3

1 PERSONNEL

All personnel costs are estimated at Step V of the Classification range x 2080 working hours.

Annual benefit costs are approximately 37%.

Estimated overhead is calculated at approximately 30%

Mental Health Clinician II – Coordinator (MHC II) includes 10% supervision differential

Classification	FTE	Annual S/B Costs	Project Costs
County Mental Health Personnel:			
Behavioral Health Specialist II	3	\$99,806	\$299,417
Mental Health Clinician II	1	\$122,815	\$122,815
MHC II – Coordinator	1	\$135,424	\$135,424
Psychiatrist	0.15	\$311,336	\$46,700
Administrative Clerk III	1	\$80,726	\$80,726
Peer/Volunteer Organizer	0.5	\$81,272	\$40,636
Manager III	0.15	\$149,688	\$22,453
Staff Services Coordinator	0.10	\$121,921	\$12,192
Software Developer/Analyst III	0.03	\$135,268	\$4,058
Sub Total - County MHD Personnel			\$764,421
Other Government Personnel:			
RN/Public Health Nurse II contracted from County Public Health Department	1	\$153,318	\$157,918
1 Total Salary Costs			\$922,339

2 OPERATING EXPENDITURES

Mileage - estimated mileage at \$.575/per mile			\$2,971
Office Supplies			\$2,652
Wraparound - includes support services to individuals such as housing and basic needs that are directly related to the client care plan.			\$50,000
Malpractice Insurance			605
SRC Rent/Utilities - approximately 1,940 square feet @ \$1.412/sq x 12 months			\$32,880
2 Total Operating Costs			\$89,108

3 NON-RECURRING COSTS

\$ - 0 -

4 CONTRACTS

Consultation time from local Primary Care Physician			\$30,000
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5 Work Plan Management

\$ - 0 -

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6	Other Expenditures	
	Treatment for substance use disorders purchased from county or community based providers	<u>\$40,000</u>
	Total Expenditures	<u><u>\$1,081,447</u></u>
	ESTIMATED REVENUE	
	MHSA Innovations. Approximate 72% of program cost, including match for FFP	\$782,468
	Estimated Federal Financial Participation (FFP)	<u>\$298,979</u>
	Total Revenue	<u><u>\$1,081,447</u></u>