Yolo County MHSA FY 2017-2020 Innovation Program Plan Description

First Responders Initiative

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First Responders Initiative

Executive Summary

In 2013-14, Yolo County Health and Human Services Agency (HHSA) engaged in a Community Program Planning (CPP) process to develop its Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for 2014-2017. As a part of the planning process, stakeholders identified gaps in the crisis continuum of care as a critical need. To address this need, HHSA applied for and received Mental Health Services Act Oversight and Accountability Commission (MHSOAC) Triage Grant funding to develop the Crisis Intervention Program (CIP) that provides clinical staff to respond to mental health crises in partnership with five law enforcement agencies (LEA) in the County. The CIP program has been successful in 1) avoiding unnecessary Emergency Department (ED) and psychiatric hospitalization for persons served, and 2) building LEA capacity to respond to mental health emergencies and increasing collaboration between HHSA and LEAs. During this most recent CPP process to develop the MHSA Three-Year Program and Expenditure Plan for 2017-2020, stakeholders acknowledged CIP's successes and identified the need to 1) expand the collaboration and capacity beyond LEAs to address mental health crises and 2) develop alternative drop-off locations for people who do not need emergency intervention but are too acute to remain where they are.

As such, HHSA and stakeholders developed the First Responders Initiative, which has three primary components.

1. **Multidisciplinary Forensic Team (MDFT):** HHSA plans to modify the existing MDFT practice that exists in other California counties of facilitating a regular, ongoing case conference between LEAs and behavioral health staff to include all first responders (i.e. EMS, EDs, and fire). The purpose of the modified MDFT is to gather all emergency personnel who may encounter someone experiencing a mental health crisis with HHSA and contracted providers to develop a coordinated response for individuals who are likely to come into contact with first responders or have a history of repeated contact.
2. **Mental Health Urgent Care (MHUC):** Currently, LEAs and other first responders only have one option for people experiencing crisis who cannot remain where they are, which is transportation to the ED. HHSA has explored the feasibility of a Crisis Stabilization Unit (CSU), but has determined that the County is too small to support a 24/7 CSU. Instead, the County has designed a MHUC program that can provide crisis intervention services to individuals and their families who do not meet criteria for a 5150 hold but require additional support. This also provides an additional location for first repsonders to drop off someone in need of mental health support; the facility

also plans to accept walk-ins and family members dropping someone off, thereby providing an alternative to the ED for consumers and their families.

3. **Health Information Exchange (HIE):** HHSA and the EDs each maintain their own Electronic Health Records (EHRs), and each of the LEAs and first responder agencies maintain separate dispatch and call records. In order to support a coordinated response for people with frequent contact with first responders, EDs, and HHSA crisis and other behavioral health services, HHSA and partners have identified a need to support health information sharing. Recognizing that this is a significant investment of time and resources, HHSA has reached out to the ED partners and health plans to begin the process of including this project as a part of a larger HIE initiative, currently underway.

To this end, Yolo County is interested in learning how the MDFT, MHUC, and HIE components and the First Responders Initiative (FRI) initiative deepen shared understanding of the extent to which the FRI 1) reduces the avoidable use of ED, hospital, and jail admissions for people with serious mental illness, 2) increases access to planned and ongoing mental health services following a crisis event, 3) promotes wellness and recovery for people experiencing a mental health crisis, and 4) promotes and strengthens collaboration amongst HHSA, behavioral health providers, and first responders (i.e. LEAs, EMS, EDs, and fire) as well as between consumers and providers. This project is a collaborative public and private partnership that respresents a commitment amongst all participating agencies as well as the County, HHSA, and stakeholders to continuously improve crisis services, promote collaboration, and ensure that Yolo County residents have access to coordinated, quality services during and following a crisis event.

County:	Yolo County
Project Name:	First Responders Initiative
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Project Overview

Primary Problem

Yolo County, with its distinct geographic, cultural, and socioeconomic characteristics, has the unique challenge of providing services to diverse groups and communities that are also geographically varied. Services must contend with the need for flexible service delivery, cultural competency across groups, transportation, and access across a vast territory.

Yolo County currently utilizes partnerships between law enforcement and mental health professionals to provide prompt, evidence-based, mobile crisis services to consumers in the community. Though initial response services are strong, when first responders encounter someone experiencing a mental health crisis the options for intervention are limited to supporting the person to remain where they are or transporting them to the emergency department (ED). If the person has a co-occurring disorder and is in possession of substances and/or paraphernalia, or if they are suspected of committing a crime, they may also be arrested and taken to jail. If taken to the ED, discharge options after business hours are limited in that the person may either be discharged back to the community, hospitalized, or referred to crisis residential services. During the 2017-2020 Yolo County MHSA Three-Year Plan Community Program Planning (CPP) process, stakeholders identified these gaps in both the disposition options available to psychiatric emergency responders, as well as in connecting people transitioning from hospitals and/or jails to mental health services beyond the immediate crisis instance.

During this CPP process, stakeholders expressed a wish to solve these issues by better integrating non-law enforcement first responders into the larger mental health team, and by providing an additional option for them to intervene in a crisis besides leaving consumers where they are or taking them to the ED. The proposed Innovation plan seeks to alleviate both of these issues, the first by modifying the multi-disciplinary forensic team (MDFT) model to incorporate Yolo County's non-law enforcement first responders. The project will address the second issue by also creating a short-term, supportive drop-in urgent care center where first responders can transport consumers who are not able to remain where they are but do not need to go to the ED or do not meet criteria for an involuntary hold.

What Has Been Done Elsewhere to Address Your Primary Problem?

Literature and Existing Practices Review

Methods

As the innovative component of the proposed program focuses on the multidisciplinary teams (MDTs) modification, the literature and existing practices review concentrated on this topic. We primarily focused on the current body of knowledge regarding multidisciplinary teams in general and multidisciplinary forensic teams specifically (MDTs incorporating law enforcement) as the closest models to the proposed Innovation, and then searched for information on MDTs that utilize non-law enforcement first responders. Our secondary focus was empirical research and current practices supporting Mental Health Urgent Care Centers (MHUCs). The goal of the literature and existing practices review was to gain a thorough understanding of how MDT meetings are used in a variety of settings applying to Yolo County, and to help formulate an efficient, effective structure for the proposed MDFT and accompanying MHUC.

Findings

General literature supporting the practice of multidisciplinary teams abounds, but the law enforcement modification (multidisciplinary forensic teams, or MDFTs) do not have a strong peer-reviewed research base. Instead, support for this modification is mainly descriptive of MDFT structure, process, anecdotal consumer results, and professional efficiency. In contrast to MDT literature and MDFT practices, multidisciplinary non-law-enforcement (non-LE) first responder teams do not appear in either the peer-reviewed literature or as an existing practice.

MDT Research Base

Multidisciplinary teams are commonly used in contexts where applying a diversity of resources, knowledge, skills, and abilities to case planning and treatment is beneficial. There are several uses for the term "multidisciplinary team," spanning informal day-to-day working arrangements to carefully designed, formalized, and scheduled meetings between members who work in different roles and for different organizations to review cases and create and update intervention plans. The First Responders Initiative intends to use the latter structure, and the research and practices discussed below refer to this type of MDT.

Liberman et al., describe MDTs as "[combining] the expert contributions of professionals and paraprofessionals who can individualize a comprehensive array of evidence-based services with competency, consistency, continuity, coordination, collaboration, and fidelity."[1] The core principle behind the model is that consumers who receive multiple services from different providers with complimentary but separate disciplinary perspectives benefit when those providers meet to coordinate services.

[1]Liberman, R. P., Hilty, D. M., Drake, R. E., & Tsang, H. W. (2001). Requirements for Multidisciplinary Teamwork in Psychiatric Rehabilitation. *Psychiatric Services*, 52(10), 1331-1342. doi:10.1176/appi.ps.52.10.1331

Regardless of overarching goal, context, and specific group composition, MDTs are comprised of members from different professional fields and organizations and typically meet in intervals ranging from once per month to weekly to review cases and create or modify a treatment or intervention plan. Though MDT practices appear to be similar regardless of end goal, note that most of the research base refers to MDTs in the context of medical treatment.

The literature suggests recommendations regarding MDT specifics around philosophy, size, composition/roles, core competencies, non-case activities, tools, and resources.

Philosophy: Another important aspect of effective MDTs is a membership that shares a common philosophy in the care of consumers that is flexible enough to customize their philosophy to the needs of the individual[2]. Teams that are not unified in their philosophy and approach may struggle to create effective plans for the people they serve, as when philosophy is not in alignment, not all members will be invested in adhering to the plan agreed upon by the MDT.

Size: The literature around MDTs advises careful thought around the size of the team, as diversity of disciplines and number of people in attendance is not proportional to effectiveness[3]. Other factors are more critical to the effectiveness of the team, specifically ensuring that the team is compromised of the right membership. Size is also a factor in considering: 1) the logistical burden of arranging for the meeting, 2) the number of cases that the team is expected to work with, 3) issues around team building activities, and 4) training needs/delivery.

Composition/roles: Staffing by the most appropriate providers working within a clearly defined set of objectives and relevant roles is one of the most important factors in the success of an MDT[4]. In successful MDTs, participants who are critical to meeting the goals of the team, as well as members who are mandated to be part of the team, are considered "core members." These members attend all meetings, or ensure that an appropriate replacement attends in their place. In addition, the MDT Coordinator, MDT Facilitator, and— when appropriate— Key Worker play critical roles; on smaller teams, these roles may overlap. The Coordinator is responsible for administrative duties related to the scheduling and logistics of the team and its activities, whereas the Facilitator runs the meeting itself.[5] When a Key Worker is used,

[2] Orovwuje, P. (2008) Contemporary challenges in forensic mental health: The ingenuity of the Multidisciplinary team. *Mental Health Review Journal*, 13(2), pp. 24–34.
[3] Fay, D., Borrill, C., Amir, Z., Haward, R. and West, M. A. (2006), Getting the most out of multidisciplinary teams: A multi-sample study of team innovation in health care. *Journal of Occupational and Organizational Psychology*, 79: 553–567.
[4] Nic a Bháird, C., Xanthopoulou, P., Black, G., Michie, S., Pashayan, N. and Raine, R. (2016) Multidisciplinary team meetings in community mental health: A systematic review of their functions. *Mental Health Review Journal*, 21(2), pp. 119–140.
[5] Fisher, T., Fontenot, G., and Woodcock, N. (2012) A Collaborative Approach to Multidisciplinary Teams in Sonoma County. *County of Sonoma, Human Services Department*, Adult and Aging Services Division.

their task is to act as a main point of contact for the consumer, through which most of the care services are coordinated[6].

Core competencies: Complimentary to issues around composition and roles, MDTs focusing on mental health require specific competencies. In 2006, the Mental Health Commission (Ireland), adapted 1997 guidance from another agency and listed these competencies as, "assessment, treatment and care management, collaborative working, management and administration, and interpersonal skills."[7] There is no expectation that all members be equally proficient in all of these competencies or that they bring the same perspective to operationalizing them. Instead, these competencies are most important in creating a shared language and basic level of understanding to create plans that can be operationalized by all members.

Non-case activities: Trainings, team-building, data gathering and other activities that do not directly relate to consumer care also have a traditional place in the MDT model. Though there have been mixed results in the literature regarding the effectiveness of non-case activities, specifically trainings, some studies have found there to be improvements to MDTs resulting from these.[8]

Tools: Developing tools for team processes allows for a certain degree of process standardization, and theoretically increases MDT efficiency and improves the depth and quality of program evaluation. However, a review of relevant literature around the relationship of tool use on team effectiveness was conducted by Buljac-Samardzic et al., which found that though tool use had a positive effect on communication and team unity, the quality of the evidence supporting the effect was quite low[9]. This suggests that in the evaluation of this project, special attention paid to the evaluation of MDT tools would contribute to general learning in this area.

Resources: Most research does not speak specifically to resource allocation and funding for MDTs, but one source focused upon MDT in the adult protective services field noted that most resources allocated were in-kind, generally in the form of staff time[10]. Though most MDTs do not receive abundant direct funding, this support is useful in providing opportunities for members to develop professionally, such as by attending trainings and conferences.

MDT/MDFT Existing Practices

In California, the use of MDFTs to serve justice-involved mental health consumers originated in Marin County in 1999. Since that time, other counties have modified the Marin model to suit their local needs,

[6] Multidisciplinary Team Working: From Theory to Practice: Discussion Paper. (2006). *Mental Health Commission*. Retrieved from http://www.mhcirl.ie/File/discusspapmultiteam.pdf
[7] *Mental Health Commission*, 2006.
[8] Buljac-Samardzic, M., Doorn, C. M., Wijngaarden, J. D., & Wijk, K. P. (2010). Interventions to improve team effectiveness: A systematic review. *Health Policy*, 94(3), 183-195.
[9] Buljac-Samardzic et. al., 2010.
[10] Teaster, P. B., Nerenberg, L., & Stansbury, K. L. (2003). A National Look at Elder Abuse Multidisciplinary Teams. *Journal of Elder Abuse & Neglect*, 15(3-4), 91-107.

either in a purely mental health context or, as in San Francisco and Sonoma Counties, specifically around adult protection. Multiple California counties also utilize the MDT model in child protection. MDT is by no means localized to California, however, and is an established and accepted practice in other locations worldwide, such as the UK and Ireland. Regardless of location, generally MDT is structured into four steps:

1. *Intake and Assessment*. Once the MDT Coordinator receives a referral, the consumer is evaluated for key areas of need utilizing a broad assessment of all life areas. There may or may not be specific criteria for acceptance beyond meeting the general mission of the MDT.
2. *Presentation*. Following completion of the assessment, the consumer's case is presented to the MDT for review and, if a Key Worker is used in the model, one is allocated based on the specific needs of the consumer. The Key Worker collaborates with other team members to coordinate deeper assessments for the consumer as appropriate.
3. *Care Plan*. Either immediately or following further completed assessments, the case is presented for action at the MDT. The MDT formulates a unified plan for the consumer, which is accessible to all team members.
4. *Review*. Once goals, actions, person(s) responsible, and date of each goal's review are established, a formal review date is set. In the time between the establishment of the Care Plan and the formal review date, the key worker coordinates with other team members to provide care for the consumer according to the plan requirements[11],[12].

MDFTs integrate law enforcement into the MDT model to best plan for and serve consumers who frequently interact with law enforcement. These teams plan specifically for handling crises or emergencies from the perspective of law enforcement. The principle underlying the use of the MDFT is that law enforcement is in frequent contact with mental health consumers, but that as a standalone, is unable to provide ongoing care and often has limited choices about how to respond to these situations. When a consumer is experiencing a crisis that is too acute to remain in the community but does not currently reach the threshold of a psychiatric hold, responding law enforcement often feel they have little alternative than to involve consumers with the criminal justice system[13]. To help alleviate this issue, law enforcement integrated into the MDT model provide their perspectives and support to the team, form stronger connections to mental health colleagues, refine their skills with mental health consumers in general, and become more planful around interactions with the specific consumer at hand.

One main difference between MDTs and MDFTs is the definition of success: in the Marin County MDFT model, success is defined as resolving the legal issue and linking a consumer to the appropriate mental

[11] *Mental Health Commission*, 2006.
[12] Todt, J. *Mental Health and Law Enforcement Working Together*. Retrieved from California Institute for Behavioral Health Solutions Web Site: http://www.cibhs.org/sites/main/files/file-attachments/thurs_215_edge_c_community_based_todt.pdf
[13] Police-Medical Collaboration: Dealing With Mental Health. (2015). *California State Association of Counties*. Summary Notes and Resources: Conversations on the Emerging Issues. Retrieved from http://www.counties.org/sites/main/files/file-attachments/police-medical_collaboration.pdf.

health services. Additionally, in this model, no referral to the team is rejected and none are closed until success is achieved[14].

First-Responder Enhanced MDT

We were unable to locate existing literature or practices in another location specifically addressing the addition of non-law enforcement first responders to the MDT; however, in researching to support this program, we consider the MDFT model to be an adequate allegory for the FRI MDT. The limitations applying to law enforcement and non-law enforcement first responders are similar; the only substantive exception to this is that law enforcement first responders have the option to take consumers to jail or the hospital, whereas non-law enforcement first responders are unable to take consumers in crisis to jail.

Though it has not previously been tried, the FRI MDT practice would be allowable under the same section of the law that allows for MDFTs: "(2) (A) Persons who are trained and qualified to serve on multidisciplinary personnel teams may disclose to one another information and records that are relevant to the prevention, identification, or treatment of abuse of elderly or dependent persons." [15]

Mental Health Urgent Care

Though not an innovative practice, the Mental Health Urgent Care (MHUC) is integral to the FRI. It provides a location for first responders and community members alike to bring consumers who need structured support but do not meet criteria for a psychiatric hold. As a "no refusal drop-off site," a MHUC would not only support consumers but also allow first responders to return to their duties more quickly than if they bring the consumer to the ER or take them to jail.[16] The MHUC model is used in various locations nationally and globally, and is an accepted practice.

Proposed Project

During the CPP process for the Yolo County MHSA Three-Year Program & Expenditure Plan for 2017-2020, stakeholders acknowledged the group of individuals throughout the County who have repeated, regular contact with first responders, including at EDs. The local Crisis Intervention Program (CIP) is an effective and critical program serving this population, but it is limited by geography, operating hours, and participating agencies. The MHUC aspect of the First Responders Initiative (FRI) will not be limited by these factors, creating an option for consumers that may involve first responders but does not require their involvement to access services.

As access to MHUC services will not be limited by referral source, consumers will be able to receive the support they need with fewer limitations. However, recognizing that first responders are likely to be involved most of time, the FRI simultaneously presents an opportunity for the MDT component of the

[14] ibid
[15] California WIC § 15633(2)(A).
[16] Steadman, H. J., Stainbrook, K. A., Griffin, P., Draine, J., Dupont, R., & Horey, C. (2001). A specialized crisis response site as a core element of police-based diversion programs. *Psychiatric Services*, 52, 219–222.

program. The MDT will assist first responders in proactively identifying these individuals and developing shared plans for the next first responder contact to divert them from EDs, jail, and hospital stays.

The First Responders Initiative (FRI) responds to these two complimentary needs by:

1. Improving collaboration and information sharing between non-law enforcement first responders, other service providers, and consumers;
2. Strengthening the shared ability of first responders to address immediate needs and divert people who do not require an involuntary hold or incarceration to another alternative space; and
3. Providing a safe, supportive location for consumers when experiencing a crisis too acute to remain in the community, yet not acute enough to require hospitalization.

The FRI responds to these needs by creating two complimentary services and participation in a Health Information Exchange (HIE) to facilitate real-time data sharing. First, the FRI modifies the forensic multidisciplinary team (MDFT) model currently used in other California counties and abroad to integrate non-law enforcement first responders such as EDs, EMS/paramedics/fire, dispatch, and CIP homeless outreach staff into a multidisciplinary team. Second, the FRI establishes a Mental Health Urgent Care center, which may be co-located with a community-based drop-in navigation center, to provide a new alternative for consumers in crisis in Yolo County. The MHUC provides a safe space to meet the immediate stabilization needs of consumers while also providing opportunities for linkages to further services after the immediate incident has resolved.

Services Description

This project builds upon the well-established practice of the multidisciplinary team model, specifically the MDFT, and reacts with a first responder innovation specific to the identified needs in Yolo County. Though the FRI features two new services to Yolo County, the first-responder enhanced MDT and the Mental Health Urgent Care (MHUC), only the former is an innovative strategy. Though MDFTs are used in various locations, non-law enforcement first-responder membership is innovative.

The FRI will improve consumer recovery outcomes by: 1) interrupting the cycle of first response calls that result in removal from the community, 2) combining the FRI with the MHUC resources to provide a safe alternative to the ED, and 3) increasing intervention skills and knowledge for non-law enforcement first responders.

First-Responder Enhanced MDT

The Yolo County FRI rests on the concept of the First-Responder Enhanced MDT. The MDT will meet on a twice-monthly basis; in the initial stages while a base of consumer cases is being developed, there will be sufficient time in the meetings to conduct initial trainings; reach shared working agreements; make assignments regarding the development of policies, procedures, tools; and to review all of these elements. Specifics regarding these activities will be partially dependent upon the needs of the membership; for

example, if the first responders placed on the MDT have limited mental health training, additional education will be provided according to their individual needs.

The First-Responder Enhanced MDT will follow the established, current practice structures outlined in the Literature and Existing Practices Review discussed above, in order to create an effective, collaborative structure to meet the needs of Yolo County mental health consumers.

Mental Health Urgent Care

The Mental Health Urgent Care is also a critical component of the FRI. Consumers with a mental health need that do not meet criteria for a psychiatric hold and who are willing to accept help voluntarily would have access to the MHUC, where they could de-escalate and receive a variety of supportive services. As part of the plan developed during the MDT meeting, (e.g., a WRAP plan) or on an *ad hoc* basis, first responders and loved ones will have the option to bring a consumer to the MHUC instead of the ED. Consumers themselves can also utilize services on a walk-in basis.

MHUC services represent a significant expansion of service scope and availability for this consumer population, who previously relied heavily upon the Crisis Intervention Program (CIP) for community-based intervention. Though highly valuable, the CIP is more limited in service hours than the FRI and is subject to participating agency availability, and the only options available for CIP responders are to transport consumers to the hospital or leave them where they are. The MHUC represents a third option for providing support to consumers and would operate 12-16 hours per day, 7 days per week. The MHUC will offer the following services:

- **Intake Assessment**. MHUC staff will provide an assessment at intake to understand the current crisis situation, what led up to the crisis, and other relevant information about the person's history and needs. As permitted by existing privacy laws, family members and other loved ones may participate to provide information about the consumer, the current crisis, and their understanding of need.
- **Crisis Intervention Counseling**. Staff will provide support in resolving the current crisis, identifying and planning around what led up to the crisis, and arranging follow up services to address immediate needs (e.g., CRT, shelter). This may include one-on-one and, as appropriate, family counseling to consumers and their loved ones. Counseling services will be designed to alleviate the current crisis and to avoid escalation to hospitalization, promoting a safe return to the community.
- **Peer support**. Peer support staff will provide structured and floating support to consumers to resolve the crisis, practice *in-vivo* coping skills, and developing a Wellness Recovery Action Plan (WRAP), particularly as it relates to recognizing the early signs and symptoms of a crisis as well as coping skills the consumer may choose to implement and other supports that may be helpful in a crisis.
- **Limited medication support**. The MHUC will have an on-site Nurse Practitioner who can prescribe medications. Substantive counseling or medication support beyond what can be safely provided

at the MHUC will trigger referrals to the appropriate services, but the on-site services will provide consumers with refills and new medications as needed to stabilize the current situation.

- **Groups and activities**. Groups and activities at the MHUC will be focused around providing coping skills, WRAP, and creating supportive individual interactions to assist the consumer in resolving their immediate need.
- **Discharge Planning**. Based on an assessment of the current crisis and the consumer's needs and resources, staff may arrange follow up appointments and referrals to supportive services.

In order to encourage community buy-in and consumer willingness to attend the MHUC as needed, the facility will hold periodic open houses so that consumers, families, and professionals can learn about the MHUC and its services. Additionally, the MHUC will further raise awareness by performing outreach to community organizations who interact with consumers who may benefit from MHUC services.

Implementation Considerations

Implementation considerations for the FRI are three-fold: those that involve the launch of the MDT, those that involve the launch of the MHUC, and those that apply to both components.

MDT considerations include:

- **Forming the MDT membership**. Criteria for all members on the MDT will be developed according to the research and current practices discussed above around appropriate membership, including non-law enforcement first responders.
- **Establishing working guidelines**. According to research and best practices, before implementing the MDT guidelines must be created to guide the work and to provide context to the team, including written interagency agreements.
- **Training**. Individuals identified for membership on the MDT will be provided with relevant training before becoming active on the MDT.
- **Implementing the MDT.** During the first 30 months of implementation, ongoing as well as interval process and outcome studies will be performed to provide continuous quality improvement to the project. Any factors that have shown to limit implementation scope or program capacity will be carefully evaluated and considered during implementation, and modifications will be made as necessary.

MHUC considerations include:

- **Identifying a service provider**. Utilizing the standard County process for creating a Request for Proposals and evaluating proposals submitted, Yolo County will select a service provider for the MHUC.
- **Obtaining space and staff**. The MHUC may be be co-located with one of the County's new navigation centers, if possible once the navigation center spaces are secured. The space requires welcoming common areas for consumers in the mental health urgent care setting. Staff will

include a Clinical Manager, Assistant Clinical Manager, Peer Support workers, non-medical mental health professional staff such as social workers and counselors, a Public Health Nurse, and support staff.

- **Conditonal Use Permit (CUP) and Medi-Cal Certification**. The MHUC will need to obtain the appropriate conditional use permits, if needed, and Medi-Cal certification as an outpatient clinic to allow for crisis intervention service billing for eligible staff and services.
- **Training**. Before the MHUC opens, all staff will need to be trained on processes as well as policies and procedures, and first responders will also need to be trained on when bringing a consumer to the MHUC is appropriate.
- **Raising awareness**. As discussed above, before opening, during initial stages of operation, and on an ongoing basis, the MHUC will perform community outreach to consumers, families, and relevant local service organizations to raise awareness in the community around the new services and alternatives that the MHUC will offer.

Some considerations apply to both components of the project:

- **Establishing policies, procedures, and parameters**. Parameters, including policies and procedures, will be developed prior to the implementation of the FRI as appropriate for both components of the project. These will be continually developed and updated as part of an ongoing Continuous Quality Improvement (CQI) effort.
- **Privacy Issues**. Both the MDFT and HIE components of this project require sharing of protected health information under HIPAA and 42CFR. The County plans to work with partners and counsel to consider ways to ensure compliance with state and federal law regarding health information sharing and may seek guidance from other jurisdictions with active MDFT and HIE programs that have fully developed and implemented privacy guidelines for these activities.

Innovative Component

First Responders Modification

The multi-disciplinary forensic team (MDFT) is a robust practice that provides a treatment team integrating law enforcement and multiple other disciplines (often psychiatry, social work, nursing, occupational therapists, etc.) in support of community members with identified mental health needs who have frequent interactions with the criminal justice system. Traditionally, the MDFT model excluded non-law enforcement first responders such as EMS/paramedics/firefighters and EDs; FRI will utilize an MDT approach similar to the MDFT, but including non-law enforcement first responders in order to meet the needs of consumers who frequently interact with EMT/paramedics and fire services.

The FRI model will bridge the gap stakeholders repeatedly identified during the CPP process between first response services and mental health services by integrating non-law enforcement first responders into MDT teams. The purpose of the modification is for the MDT to be able to respond to the needs of consumers who frequently interact with all first responders due to mental health crises. The MDT,

including the first responders, will create a unified intervention plan for the consumer that provides for future encounters.

Learning Goals/Project Aims

Implementation of integrative care via multidisciplinary team approaches has been shown to have positive impacts on health outcomes and behavior changes when used in the management of complicated mental health conditions. The aim of this integration is to improve the experience of the consumer while engaging with a first responder in a crisis situation. This program meets Innovation criteria by adapting the proven MDFT approach and adding other groups to the team that have not previously been part of a mental health-focused MDT. The project will contribute to learning on integrating non-law enforcement first responders into a community mental health setting. Research has not been conducted on the mental and behavioral health impacts of first responder interventions outside of a law enforcement context, however, the process of engaging relevant professionals in the management of consumers has been shown to have positive impacts on health and behavior outcomes. For some consumers who have frequent or significant contacts with first responders, this project holds the potential for significant quality of encounter improvement, decreases in hospital admissions and arrests, and improved mental health outcomes. Additionally, information gained from having first responders on consumer's MDTs will aid in the continuous quality improvement process by adding a fresh perspective to the teams. Finally, engaging County first responders in a consumer-driven care management system will facilitate their professional growth and expand their knowledge, skills, and abilities.

Evaluation Plan

During INN program implementation, HHSA will conduct a concurrent evaluation process, beginning with a design utilizing information from initial implementation to concretize process and outcome measures. Planning and implementation of the evaluation will be informed through a continuous quality improvement process, including incorporation of feedback from first responders, providers, consumers, and consumers' loved ones. Evaluation activities will be grounded in MHSA values by ensuring data collection tools and stakeholder engagement activities are conducted in a culturally appropriate manner.

Key Learning Questions

- Does utilizing the FRI lead to decreased hospital admissions and arrests related to first response situations?
- Does utilizing the FRI lead to increased non-hospital service access and utilization following a first response situation?
- How will implementation of the FRI increase the wellness and recovery of participating consumers?
- How does FRI implementation contribute to improved collaboration 1) between providers and 2) between consumers and their providers?

The County will measure program success using both process and outcome indicators. Process indicators measure to what extent the program was implemented as intended, while outcome measures will provide information on the effect of the program on consumers, community, and the mental health system overall. Evaluators will work to identify data points and evaluation methods to measure program implementation and impact. Data points may include baseline and ongoing individual-level consumer data from wellness surveys, service utilization records, hospitalization and ED records, and incarceration records; these data will be obtained from HHSA, Sheriff's Office records, hospitalization records, and other data sources as identified during the evaluation design. Quantitative data will be collected regularly to assess program progress and outcomes. Qualitative evaluation activities, including focus groups and key informant interviews, will be conducted annually.

The First Responders Initiative INN Project will employ a pre/post mixed-methods study design to evaluate changes in program-level outcome measures related to the MDT and MHUC, as well as individual-level outcome measures among consumers. Evaluation methods will be administered before and after implementation activities. The target population demographics will be analyzed to assess characteristics of consumers. In addition, the evaluation team will analyze process measure data to characterize and report on implementation activities. Data management and analysis methods will be determined based on quality and quantity of data collected.

Evaluation activities will aim to address the key learning questions of the project. The following table outlines the data to be collected (i.e., process measures and outcome measures) and potential data sources listed by their respective key learning question (Table 1).

Table 1. First Responders Initiative INN Project Evaluation Questions and Outcomes

Key Learning Question	Potential Process Measures	Potential Outcome Measures	Potential Data Source(s)
1. Does utilizing the FRI lead to decreased hospital admissions and arrests related to first response situations?	• MDT participation • # of hospital admissions • # of arrests • # of mental health urgent care visits	• # of closed encounters without removal from the community • # of closed encounters with transport to the mental health urgent care • # of closed encounters with hospital or arrest outcome • Perceptions of service quality and relevance	• FRI usage data • FRI referral data • HHSA utilization data • Sheriff's Office incarceration records • Hospitalization and ED records
2. Does utilizing the FRI lead to increased non-hospital service access and utilization following a first response situation?	• # of non-hospital services referred during FR encounter • # of referred services utilized following FR encounter • # of non-hospital services referred at MHUC • # of referred services utilized following MHUC	• Service receipt by FRI users following encounter • Perceptions of service quality and relevance	• FRI usage data • FRI referral data • HHSA service utilization data
3. How will implementation of the FRI increase the wellness and recovery of participating consumers?	• # of hospital admissions • # of arrests • # of mental health urgent care visits • # of consumers participating in follow-up MH services • # consumers with WRAP	• Consumer experience of care • Consumer perceptions of wellness/recovery	• FRI usage data • FRI referral data • HHSA utilization data • Consumer survey • Consumer focus groups
4. How does FRI implementation contribute to improved collaboration 1) between providers, and 2) between consumers and their providers?	• # of MDT meetings attended by non-LE first responder members • # of MDT meetings integrating non-LE first responders	• Awareness of appropriate services for non-LE first responders • Increased stakeholder perceptions of system-wide collaboration • Consumer perception of collaboration with first responders	• FRI usage data • FRI tool data • Collaboration survey • Focus groups/interviews with MDFT members • Focus Groups with consumers, families, and staff

The County will measure program success by engaging stakeholders to design and implement an evaluation of the FRI in a collaborative evaluation. Stakeholders will be asked to provide feedback on their experiences, and modifications to the process will be made as necessary to respond to the expressed needs. Stakeholders may include individuals from a wide variety of affiliations and demographics, including homeless, LGBT+, Latino, Russian, youth, transition-aged youth, older adults, consumers, thier family members, peer support workers, county staff, and mental health providers. Stakeholders will be recruited using a similar outreach approach employed in the MHSA Community Program Planning process.

Findings from evaluation activities will be reported to HHSA, partners, and stakeholders through interim reports. Interim reports will provide updates on program progress through process measures. Upon completion of the Innovation project, findings from overall evaluation activities, including pre/post data analysis, will be summarized in a final report to HHSA, partners, and stakeholders. The final report will summarize findings related to program process, program outcomes, collaboration partners, impact on overall mental health system, and resources (e.g., funding, staff) invested in the Innovation project. The final report will also serve as a documentation of the innovative practices implemented in the Innovation project, which can serve as a model for other counties in California to implement the approach within their jurisdiction. Successful outcomes from the project would support broader implementation of an FRI model in community mental health settings with consumers who utilize emergency response services in the context of their mental health needs.

Contracting

Yolo County HHSA will utilize data from evaluation activities and stakeholder engagement activities to ensure continuous quality improvement throughout the project period. Yolo County will apply MHSA INN funds to support contracts to fulfill key roles and functions, as needed. Yolo County will keep contract partners informed of regulatory compliance policies relevant to the project.

Additional Information for Regulatory Requirements

Certifications

Certifications and assurance of compliance with MHSA Innovative Project regulatory requirements are documented in the Yolo County Mental Health Services Act (MHSA) *Three-Year Program and Expenditure Plan 2017 – 2020*.

Community Program Planning

Yolo County conducted a Community Program Planning (CPP) process for its Mental Health Services Act (MHSA) *Three-Year Program and Expenditure Plan 2017 – 2020* between September 2016 and February 2017. During the MHSA CPP, stakeholders identified the gap between first response services and mental health services as well as the need to integrate non-law enforcement first responders into MDT teams.

Stakeholders highlighted the need to improve support for consumers who frequently interact with first responders due to mental health crises. Thus, community input from the MHSA CPP process informed the development of the First Responders Initiative Innovation Project.

The community program planning team was led by Karen Larsen, Department of Health and Human Services Director; Sandra Sigrist, Adult & Aging Branch Director; Joan Beesley, MHSA Coordinator; and Resource Development Associates (RDA), a consulting firm with mental health planning expertise. In order to ensure the planning process reached a broad spectrum of stakeholders, the planning team employed the following outreach efforts: flyers, email distribution lists, phone calls, and announcements for the MHSA planning summit. Materials were made available in Spanish, when applicable. Stakeholders included individuals from multiple communities, including homeless, LGBT+, transitional age youth, youth, older adults, consumers, consumers' family members, peer support workers, county staff, Latino, and mental health providers. In addition, stakeholder input was gathered from individuals with a wide spectrum of affiliations including: government agency, community-based provider, law enforcement agency, education agency, social services agency, veterans organizations, and medical or health care organization. Furthermore, efforts were made to include participants throughout the County, including CPP activities and events held at different locations throughout the County and at different times of day to promote opportunities for participation.

The CPP incorporated a participatory framework to encourage buy-in and involvement from stakeholders including service providers, consumers, family members, other professionals likely to have contact with people with mental health needs, and interested community members. Throughout the planning process, the planning team made presentations to the Yolo County Local Mental Health Board (LMHB) and Board of Supervisors (BOS), both of which reviewed and helped to refine the recommendations made by the MHSA planning team. All meetings of the LMHB and BOS are open to the public. All participants in the planning process were provided with feedback forms and comment boxes for RDA staff to use a guiding and input tool throughout the process. All forms were anonymous to protect participant privacy and confidentiality.

Yolo County's MHSA CPP was built upon the meaningful involvement and participation of mental health consumers, family members, county staff, providers, and many other stakeholders. The planning team carried out a set of community meetings and information-gathering activities to engage stakeholders in all stages of the planning and strategy development process in order to ensure that the planned activities reflected stakeholders' experiences and suggestions.

The MHSA CPP was comprised of a variety of meetings and activities, as described in Table 2.

Table 2. Community Program Planning Process

Activity	Purpose
Community Meetings	
Kickoff Meetings (Local Mental Health Board, Board of Supervisors, MHSA Stakeholders)	The Kickoff Meetings provided information about the proposed planning process timeline, and to gather feedback about what was missing or suggestions to improve the proposed process.
Board and Committee Meetings	
Local Mental Health Board	Members of the Local Mental Health Board calendared CPP activities to discuss and provide feedback on MHSA planning processes, progress, and input.
Community Corrections Partnership	Members of the Community Corrections Partnership calendared CPP activities to discuss and provide feedback on MHSA planning processes, progress, and input.
Board of Supervisors	Members of the Board of Supervisors calendared CPP activities to discuss and provide feedback on MHSA planning processes, progress, and input.
Needs Assessment	
Focus Groups	The focus groups gathered input from providers and community members about their experiences with the mental health system and their recommendations for improvement.
Leadership Interviews	The leadership interviews facilitated understanding of the types and levels of services in each system of care across MHSA components, access points into each system, referral pathways, and touch points with services outside of the mental health system.
Stakeholder Surveys	The stakeholder surveys collected information from a wider audience beyond the focus groups, including the Russian community, consumers and families, and parents with minor children.
Quantitative Data Analysis	HHSA provided data regarding services supported by MHSA funds. Quantitative data analysis was conducted to characterize the number and profile of persons served as well as outcomes.
Strategy Development	
System of Care and Component (i.e., Child/TAY, Adult/OA, CFTN, WET, INN) Summits	The System of Care Summits built on from the leadership interviews and focus group information to identify key mental health service needs, unserved and underserved populations and geographic areas, barriers to entry and ongoing access of mental health services, workforce shortages, and needs related to capital facilities and technology.
Community Report Back Meetings	The Community Report Back Meetings presented the results of the system of care summits to stakeholders.
Board of Supervisors Meeting	Members of the Board of Supervisors calendared CPP activities to discuss stakeholder feedback, strategic planning, and MHSA plan development.

Public Review Process	
30-Day Review Period (February 17, 2017 – March 20, 2017)	The 30-Day Review period allowed for a draft plan to be distributed to the Board of Supervisors, Local Mental Health Board, county staff, service providers, consumers and family members, and those whose email addresses are associated with the stakeholder listserv. A public notice was also submitted and published through The Davis Enterprise and The Woodland Daily Democrat newspapers, county website, paper copies at HHSA department headquarters in Woodland and other sites throughout Yolo County
Public Hearing (March 22, 2017)	Stakeholders were engaged to provide feedback about the Yolo County MHSA *Three-Year Program and Expenditure Plan 2017 – 2020* . Four stakeholders attended the public hearing, representing county staff, the local mental health board, and consumers and family members. The full MHSA plan document, which summarizes public comment, is available at: http://www.yolocounty.org/health-human-services/agency-information/mental-health-services-act-mhsa

CPP participants were trained on the specific purposes and MHSA INN projects during the MHSA Component Planning Summit, which followed the system of care and component planning summits and addressed WET, CFTN, and INN. In response to the recent regulatory changes to the PEI and INN components, RDA staff reviewed program alignment with the new MHSA regulations and discussed options to bring services into alignment with these. During this summit, RDA reviewed findings from the needs assessment in each of these areas as well as findings and recommendations that emerged from the two system of care planning summits. The component work session resulted in a set of consolidated ideas, programs, and recommendations for HHSA have considered in the feasibility analysis.

Primary Purpose

The primary purpose of the First Responders Initiative (FRI) Innovation Project is: 1) to improve collaboration between non-law enforcement first responders, other service providers, and consumers via the MDT modification, and 2) to increase the quality of mental health services (including measurable outcomes) via the MDT modification and the MHUC. Both components of the FRI aim to improve outcomes for individuals who have repeated, regular contact with first responders and who typically present with a mental health crisis that is too severe to remain where they are but not critical enough for a psychiatric hold.

MHSA Innovative Project Category

The Yolo County MHSA Innovation First Responders Initiative makes a change to the MDT model, an existing mental health practice with an empirical base. The modification is unique and has not been implemented in other jurisdictions, so has not yet been demonstrated to be effective. Together, the MDFT and MHUC center are expected to 1) improve collaboration between mental health and first responder agencies through the MDFT process, and 2) improve consumer outcomes through a decrease in incarcerations, hospitalizations, and ED visits and increase in service connectedness, consumer recovery, and collaboration between staff as well as between staff and consumers.

Target Population

The First Responders Initiative will focus on individuals throughout Yolo County who have repeated, regular contact with first responders, including at EDs and in the community, but whose need is too acute to remain where they are and not acute enough for a psychiatric hold. Yolo County estimates that law enforcement alone respond to over 4,000 mental health related calls annually. In 2016, the Davis, West Sacramento, Winters, and Woodland Police Departments and the County Sheriff had 4,081 calls for service related to mental health. While likely an underestimate, this establishes a baseline for how many interactions local law enforcement agencies may have with persons experiencing mental health problems. This estimate does not include police calls that were not initially reported as mental health-related requests for service or people who went directly to an ED.

Target population demographic information may vary in age, gender identity, race, ethnicity, sexual orientation, and language, but is expected to reflect the demographics of all MHSA adult (18 years or older) consumers.

MHSA General Standards

This project is consistent with the following MHSA general standards set forth in Title 9 California Code of Regulations, Section 3320:

- **Community Collaboration**. This project contributes to increased engagement of County first responders into the behavioral health community structure, thus improving communication across providers and emergency care services.
- **Cultural Competence**. The varied demographic characteristics of County behavioral health consumers contribute to the need for culturally appropriate services and supports for these populations. This INN project will increase consumers and their families' ability to access relevant services by improving first responders' understanding of consumer needs and providing a recovery based location for crisis intervention that police as well as consumers and families can access in advance of or during a mental health crisis not requiring 5150 intervention.
- **Client-Driven:** This project will gather input from consumers participating in project-related services. Information regarding consumers' experiences and perceptions, gathered through evaluation activities, will inform program planning, procedures, and evaluation strategies.
- **Family-Driven:** The First Responders Initiative fosters family support and involvement at the Mental Health Urgent Care, where families will be integrated into the consumer's process as well as be able to bring consumers there before it escalates to requiring involuntary hold (i.e., 5150).
- **Wellness, Recovery, and Resiliency-focused**. The proposed INN program focuses on wellness and recovery as it encourages first responders to take an active role in consumer case planning, expanding their understanding of mental health and feeding back their unique perspective as first responders into the MDT. The FRI allows the first responder to engage in wellness and recovery goals as a member of the MDT, and provides access to the resources and services that are

necessary to reach those goals. It also provides the mental health urgent care as a community-based option for supporting consumers in recovering from crisis without the need for hospitalization.

- **Integrated Service Experience for Clients and Families**. The project supports the capacity of providers to engage with each other collaboratively to provide the services necessary to address consumer needs. FRI increases information sharing to the network of individuals important to the consumer's recovery to integrate input from first responders when appropriate.

Continuity of Care for Individuals with Serious Mental Illness

The FRI directly serves individuals with Serious Mental Illness (SMI). It seeks to provide increased and improved collaboration between professionals and to provide consumers with a new direct service, the Mental Health Urgent Care, to serve those at risk of a psychiatric hold who do not meet the criteria for a psychiatric hold. In addition, the MDFT and MHUC will increase service connectedness for consumers by bridging the gap between crisis intervention and follow up services. Increased connection to services will support continuity of care for individuals with serious mental illness. If the project proves to be successful based on measurable outcomes, the County will ensure continuity for consumers after the conclusion of the INN project by funding the continuation of the services under another MHSA component, with Medi-Cal billing, or Realignment funds as appropriate.

INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement

In order to ensure cultural competence and meaningful stakeholder participation in the planning activities and evaluation activities, the First Responders Initiative Project will rely on a steering committee formed by those stakeholders who participated in the planning and design of this initiative or will participate in the implementation of the INN plan. Stakeholders may include county staff, providers, other professionals (i.e. law enforcement, fire, EMS, EDs), consumers, and consumers' families. The steering committee will serve as the body that enacts and monitors the continuous quality improvement efforts for the project. Evaluation findings will be communicated to stakeholders, and stakeholders will have the opportunity to contribute to interpretation reporting as well as inform any plan modifications. HHSA will also provide training and technical assistance to the steering committee throughout the project to support meaningful stakeholder participation.

Targeted actions will be made to ensure that consumers are represented in all phases of the planning process and evaluation activities. Yolo HHSA and provider staff will reach out to linguistically isolated communities, particularly for Yolo County's large Latino/Hispanic and Russian populations. Interpreters will be available at community meetings and flyers related to stakeholder engagement will be made available in Spanish and Russian. In addition, HHSA staff will reach out to the homeless and LGBT+ communities to identify potential participants to represent their respective communities' perspectives. Evaluation tools and planning tools will be vetted with minority groups represented in the target

population or stakeholder group. Furthermore, planning activities and evaluation activities will request participants to complete an anonymous demographic form, which will gather information about participants' age, sexual orientation, gender identity, race/ethnicity, residency (e.g., urban or rural), and whether they identified as a consumer, family member, or service provider. Disparities revealed through evaluation findings will be addressed by modifying planning activities to increase meaningful stakeholder involvement across diverse populations.

Deciding Whether and How to Continue the Project Without INN Funds

If effectiveness for the FRI is established via the CQI process, the County will explore funding options, including Medi-Cal and CSS funds, for continuing the project. If the FRI is not shown to be an effective program, the consumers who utilize it will be referred to other local services as appropriate for their needs. As part of the learning component of this project, Yolo County will explore if mental health urgent care can be billed to Medi-Cal under crisis intervention.

Communication and Dissemination Plan

Updates, communication, and information around the FRI will be disseminated through an initial outreach and education process so that the broad stakeholder community is aware of this initiative and how to access services, including the MHSA distribution list maintained by the County, as well as MHSA Annual Updates that follow the procedures and requirements for the CPP, approval, and dissemination. Additionally, Yolo County will post all information about FRI on the MHSA website, including information about how to access mental health urgent care services and evaluation reports. Keywords or phrases for searching for the project:

- Multidisciplinary Team/MDT/MDFT Yolo County
- Mental Health First Responders Yolo County
- Mental Health Urgent Care Yolo County
- Mental Health Crisis Yolo County

Timeline

The total duration for the project is three years, and Yolo County anticipates full operation for the pilot phase within six months of MHOAC approval. The following timeline provides a breakdown of planned activities for the first six months of the project (Table 3).

Table 3. First Responders Initiative Project Timeline for First Six Months, July 2017 – Feb 2018

	Project Month							
	2017						2018	
Milestone/Deliverable	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
MHSA ACTIVITIES FOR ALL INN PROJECTS								
MHOAC approval	■							
Quarterly Continuous Quality Improvement Activities				■			■	
INN Annual Report							■	
MENTAL HEALTH URGENT CARE (MHUC) CENTER								
Hire or reassign HHSA staff for MHUC		■	■					
Identify building space or co-locate with Navigation Centers		■	■					
Procure external evaluation services		■	■					
Design program			■	■				
Establish policies, procedures, and parameters			■	■				
Obtain permits and licensing (e.g., CUP, Medi-Cal Certification)				■	■			
Purchasing for building remodeling, office furniture, supplies, etc.					■	■		
Onboard and train staff						■	■	
Community outreach to raise awareness of program							■	
Pilot MHUC (ongoing for 30 months)							■	■
FORENSIC MULTIDISCIPLINARY TEAM (MDFT)								
Identify and Recruit MDFT members		■						
Establish working guidelines, policies, and procedures.		■	■					
Form MDFT membership			■					
MDFT Kickoff Meeting				■				
Training and technical assistance to MDFT					■	■		
Pilot MDFT (ongoing for 30 months)							■	■

The following timeline provides an overview of planned activities throughout the three years of the project (Table 4).

Table 4. First Responders Initiative Project Timeline, July 2017 – June 2020

Milestone/Deliverable	Year 1				Year 2				Year 3			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
MHUC Project Launch (6 months)												
MHUC Pilot Implementation (30 months)												
MDFT Project Launch (6 months)												
MDFT Pilot Implementation (30 months)												
Quarterly Continuous Quality Improvement Activities												
INN Annual Report												

Project Budget

INN Project Budget and Source of Expenditures

A. Budget Narrative:

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

Budget Narrative:

Section B.

1. $790,630 per year represents salary and benefits for 4.0 FTE Clinicians, 3.0 FTE Case Managers and 0.25 FTE Analyst.
2. N/A
3. $75,000 in FY 17-18, $75,075 in FY 18-19 and $75,064 in FY 19-20 represents administrative costs at 15%.
4. Total
5. $200,000 represents in-kind operating costs. Revenue from IGT funds are included below.
6. N/A
7. N/A
8. N/A
9. N/A
10. N/A
11. Annual cost of $520,000 represents $500,000 in contracts with local hospitals for 4.0 FTE Nurse Practitioners and $20,000 in consultant fees for program evaluation.
12. N/A
13. Total
14. N/A
15. N/A
16. N/A

Budget Narrative, Continued.

Section C.

Part A.

A.1 $75,000 in FY 17-18, $75,075 in FY 18-19 and $75,064 in FY 19-20 represents administrative costs at 15%.
A.2 N/A
A.3 N/A
A.4 N/A
A.5 N/A
A.6 N/A Total

Part B.

B.1 $35,000 annually is estimated for consultant fees for program evaluation.
B.2 N/A
B.3 N/A
B.4 N/A
B.5 N/A
B.6 Total

Part C.

C.1 Total MHSA INN funds for FY 17-18 is estimated at $575,000; total MHSA INN funds for FY 18-19 is estimated at $575,075; total MHSA INN funds for FY 19-20 estimated at $575,064.
C.2 Anticipated Federal Financial Participation is estimated at $300,630 per year.
C.3 N/A
C.4 N/A
C.5 Other funding is estimated at $725,000 per year in Maddy Emergency Medical Services (Maddy EMS) funds ($1,500,000 total over three years), $215,000 per year in IGT funds (for operating and evaluation), and $10,000 per year in Mental Health Medi-Cal Administrative Activities (MAA) billing ($30,000 total over three years).
C.6 Total

B. New Innovative Project Budget By FISCAL YEAR (FY)*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xx	FY xxxx	**Total**
1.	Salaries	**790,630**	**790,630**	**790,630**			**2,371,890**
2.	Direct Costs						
3.	Indirect Costs	**75,000**	**75,075**	**75,064**			**225,139**
4.	Total Personnel Costs	**865,630**	**865,705**	**865,694**			**2,597,029**
OPERATING COSTS					FY xxxx	FY xxxx	**Total**
5.	Direct Costs	**200,000**	**200,000**	**200,000**			**600,000**
6.	Indirect Costs						
7.	Total Operating Costs	**200,000**	**200,000**	**200,000**			**600,000**

NON-RECURRING COSTS (equipment, technology)		**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
8.							
9.							
10.	Total Non-recurring costs						
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
11.	Direct Costs	**535,000**	**535,000**	**535,000**			**1,605,000**
12.	Indirect Costs						
13.	Total Consultant Costs	**535,000**	**535,000**	**535,000**			**1,605,000**

OTHER EXPENDITURES (please explain in budget narrative)	**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
14.						
15.						
16. Total Other expenditures						

BUDGET TOTALS						
Personnel (line 1)	**790,630**	**790,630**	**790,630**			**2,371,890**
Direct Costs (add lines 2, 5 and 11)	**735,000**	**735,000**	**735,000**			**2,205,000**
Indirect Costs (add lines 3, 6 and 12)	**75,000**	**75,075**	**75,064**			**225,139**
Non-recurring costs (line 10)						
Other Expenditures (line 16)						
TOTAL INNOVATION BUDGET	**1,600,630**	**1,600,705**	**1,600,694**			**4,802,029***

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

C. *Expenditures By Funding Source and FISCAL YEAR (FY)*

Administration:

A.	**Estimated total mental health expenditures <u>for ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
1.	Innovative MHSA Funds	75,000	75,075	75,064			225,514
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	**75,000**	**75,075**	**75,064**			**225,514**

Evaluation:

B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
1.	Innovative MHSA Funds	35,000	35,000	35,000			105,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**	**35,000**	**35,000**	**35,000**			**105,000**

TOTAL:

C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
1.	Innovative MHSA Funds	**575,000**	**575,075**	**575,064**			**1,725,139**
2.	Federal Financial Participation	**300,630**	**300,630**	**300,630**			**901,890**
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	**725,000**	**725,000**	**725,000**			**2,175,000**
6.	**Total Proposed Expenditures**	**1,600,630**	**1,600,705**	**1,600,694**			**4,802,029**

*If "Other funding" is included, please explain.