BEHAVIORAL HEALTH AND RECOVERY SERVICES
A Mental Health and Substance Use Disorder Services Organization

Ruben Imperial, MBA
Interim Director

800 Scenic Drive, Modesto, CA 95350
Phone: 209-525-6225 Fax: 209-558-4326

RE: MHSA Plan Update FY 19-20

Dear Colleagues:

Per statute AB1467, Counties are required to submit Annual Updates and Plan Updates to the MHSOAC. Attached please find our Mental Health Services Act (MHSA) Plan Update FY 2019-2020 for Stanislaus County.

This Plan Update includes two Innovation proposals to address the priority areas of increasing the quality of mental health services and increasing the access to mental health services in Stanislaus County.

Attached please find the MHSA Plan Update FY 19-20 for Innovation Projects. On July 23rd 2019, the MHSA Stakeholder Steering Committee was convened to review the proposed Plan Update and engage in meaningful dialogue. The MHSA Plan Update was available for 30-day public review and comment from August 28th 2019 to September 26th 2019. A public hearing was held by the Behavioral Health Board on September 26th where the item was presented to members of the board and the community. The Stanislaus County Board of Supervisors approved the Plan Update on October 22, 2019.

We trust this fulfills the requirement for submission of an MHSA Plan Update and would appreciate an acknowledgement that you have received this document. If you have any questions regarding the Plan Update and our activities, please contact me at (209) 525-6225 or Leng Power, MHSA Planning Coordinator, at (209) 525-5324.

Sincerely,

Ruben Imperial, MBA
Interim Behavioral Health Director

Cc: Leng Power
Attachments

THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
BOARD ACTION SUMMARY

DEPT: Behavioral Health & Recovery Services BOARD AGENDA:5.B.10
AGENDA DATE: October 22, 2019

SUBJECT:
Approval to Adopt the Mental Health Services Act Plan Update for Fiscal Year 2019-2020 to Allow Expenditure of MHSA Funds for Innovations Project Agreements

BOARD ACTION AS FOLLOWS: **RESOLUTION NO. 2019-0644**

On motion of Supervisor Berryhill , **Seconded by Supervisor** Chiesa
and approved by the following vote,
Ayes: Supervisors: Olsen, Chiesa, Berryhill, DeMartini, and Chairman Withrow
Noes: Supervisors: None
Excused or Absent: Supervisors: None
Abstaining: Supervisor: None

1) X **Approved as recommended**
2) _____ **Denied**
3) _____ **Approved as amended**
4) _____ **Other:**

MOTION:

ATTEST: ELIZABETH A. KING, Clerk of the Board of Supervisors File No.

THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
AGENDA ITEM

DEPT: Behavioral Health & Recovery Services BOARD AGENDA:5.B.10
AGENDA DATE: October 22, 2019

CONSENT: ☑

CEO CONCURRENCE: YES 4/5 Vote Required: No

SUBJECT:

Approval to Adopt the Mental Health Services Act Plan Update for Fiscal Year 2019-2020 to Allow Expenditure of MHSA Funds for Innovations Project Agreements

STAFF RECOMMENDATION:

1. Adopt the Mental Health Services Act Plan Update for Fiscal Year 2019-2020 to allow the expenditure of MHSA funds for Innovations Projects agreements in the amount of $4,442,259 over the term of the agreements.

2. Authorize the Interim Behavioral Health Director, or his designee, to sign and submit the Mental Health Services Act Plan to the Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission.

3. Authorize the Auditor-Controller or designee to sign the Mental Health Services Act County Fiscal Accountability Certification certifying that the fiscal requirements have been met.

4. Approve the award of the agreements to Romeo Medical Clinic and Stanislaus County Office of Education for the provision of Mental Health Services Act (MHSA) Innovations Projects.

5. Authorize the Interim Behavioral Health Director, or his designee, to sign the agreements, and any amendments to add services and payments for services up to $200,000, budget permitting, throughout the term of the agreements.

DISCUSSION:

On January 30, 2009, the California State Department of Mental Health and Mental Health Services Act Oversight and Accountability Commission issued Information Notice 09-02 for California counties to use in preparation of project proposals for the Innovation (INN) component of the Mental Health Services Act (MHSA). Stanislaus County subsequently received funding to conduct community planning with meaningful stakeholder involvement leading to the development of Innovation projects.

Beginning in July 2009, Behavioral Health and Recovery Services (BHRS) conducted ongoing community processes designed to educate stakeholders about the unique focus of the Innovation component and to solicit project proposal ideas. To date, seventeen Innovation projects have been developed and conducted in Stanislaus County.

The Innovation component of MHSA focuses on contributions to learning in mental health/behavioral health, rather than solely on the provision of services. For example, mental health services may be delivered as a method for trying out new practices, learning and collecting outcomes data. Project evaluation is a significant element of Innovation projects. Once the project is completed, services will either end or, upon decision by BHRS, continued with other non-Innovation funding. Innovation projects can result in sustainable changes through the use of new models or can result in new strategies applied to that which BHRS and community partners already do well.

Local Stakeholder Process

On March 23, 2018, the Representative Stakeholder Steering Committee (RSSC), which is a vital part of the local MHSA planning process and is made up of community members and agency partners from diverse backgrounds that have an interest in mental health and wellness in Stanislaus County, was convened. The RSSC members provide key input on all proposed plan updates and annual updates, as well as share information about MHSA planning activities with members of their represented sector or group. The three-hour meeting included discussion regarding the proposal of project planning for community-based Innovation projects. In July of 2018, the RSSC was invited to provide stakeholder input for the Innovation project opportunities.

On August 21, 2018, the Board of Supervisors authorized the General Services Agency (GSA) Purchasing Division to issue a Request for Proposal (RFP) on behalf of BHRS for the provision of community-based Innovation projects, as part of the Mental Health Services Act (MHSA) Annual Update and Three-Year Program and Expenditure Plan (Resolution 2018-0427).

The goal of the RFP was to seek respondents who were interested in designing and implementing an Innovation project for a defined period of time, and then evaluating it to develop new best practices in mental health services and supports. The focus of projects is on learning throughout project implementation, incorporating the Mental Health Services Act standards, including community collaboration, a culturally competent and consumer and family driven system, an integrated service experience, and a focus on wellness, recovery, and resiliency.

On November 6, 2018 and November 8, 2018, Potential Contractor Outreach Workshops were conducted for potential contractors prior to the release of the RFP. The outreach workshops were informational in nature and were not part of the formal RFP bid process.

The RFP was issued on December 5, 2018 and was sent electronically to 266 vendors, 22 of which downloaded the RFP. A non-mandatory proposal conference was held on December 14, 2018. The RFP closed on January 18, 2019 and GSA received complete responses from the proposers listed below:

- Cambridge Academies – Modesto, CA
- The Catholic Council for the Spanish Speaking of the Diocese of Stockton dba El Concilio – Modesto, CA
- MoPride, Inc. – Modesto, CA
- Peer Recovery Art Project, Inc. – Modesto, CA
- Romeo Medical Clinic – Turlock, CA
- Stanislaus County Office of Education (SCOE) – Modesto, CA
- West Modesto Community Collaborative – Modesto, CA

The proposers met the minimum qualifications set forth in Phase I of the Evaluation Phase, which included a financial review. A committee of three evaluators was selected to further evaluate the proposals. The Evaluation Committee was comprised of representatives from BHRS, a former Director of BHRS, and the MHSA Coordinator from Merced County.

The Evaluation Committee completed Phase II, which consisted of a review and evaluation of the proposers' qualification proposal budgets. MoPride, Inc., Romeo Medical Clinic, and SCOE received a score of 50% or above the available 1,130 points and were deemed eligible to participate in the interview and background check process of Phase III. The scores of each member of the Evaluation Committee were averaged to determine the actual scores for the proposers.

The following table displays the total average score of each proposer:

Vendor	Grand Total
Cambridge Academies	205.17
El Concilio	524.00
MoPride, Inc.	1,215.00
Peer Recovery Art Project, Inc.	242.17
Romeo Medical Clinic	1,150.00
Stanislaus County Office of Education	1,170.83
West Modesto Community Collaborative	241.83

Evaluation results determined that the Romeo Medical Clinic Whole Health Approach to Improve Mental Health Outcomes and the SCOE NAMI on High School Campus projects met the criteria set forth in the RFP and the underlying goals of MHSA Innovations regulations. A third project from MoPride, Inc. met the criteria, but the proposal was subsequently withdrawn from consideration by the proposer. Intent to Award Notices were issued to Romeo Medical Clinic and SCOE on May 9, 2019.

On July 18, 2019 BHRS staff participated in a technical assistance call with a representative from the Mental Health Services Oversight and Accountability Commission (MHSOAC) Innovation Team to receive feedback on project drafts.

On July 25, 2019, the selected projects were shared with the RSSC and input solicited on the projects and planning process thus far. Overall input from stakeholders was affirming of the process and projects. Some stakeholder input reflected concern that Innovations funds were not being used to directly serve individuals with serious mental illness and stated that MHSA funds were not intended to serve individuals who do not have a severe mental illness. BHRS facilitators validated the concern, shared that no projects were received in the RFP process that were strongly focused on serious mentally ill individuals, and that statute allows for MHSA Innovations funding to support strategies across the mental health spectrum of care, including prevention, early intervention and treatment. Additionally, the department is currently in a strategic planning process with the intention of developing plans that will prioritize serving individuals with severe mental illness who are also experiencing homelessness. In the interim, BHRS has responded by developing proposals that will leverage MHSA and No Place Like Home funding with strategies approved by the Board of Supervisors on October 1, 2019, that include funding to acquire emergency shelter beds, transitional housing units, permanent supportive housing units, and a housing support services team to support clients with a serious mental illness transitioning from living homeless to living housed. These proposals were presented to the RSSC on October 18th and will be brought to the Board of Supervisors for consideration after the MHSA public comment and hearing process is concluded.

The MHSA Plan Update for Fiscal Year 2019-2020 was available for 30-day public review and comment from August 28, 2019 to September 26, 2019. A public hearing was held on September 26, 2019 by the Behavioral Health Board.

Finalization of these projects are subject to the review and approval of the MHSOAC, which BHRS hopes to obtain in November 2019 for the two projects to begin on December 1, 2019.

POLICY ISSUE:

Approval of the agreements with Romeo Medical Clinic and SCOE as a result of a Request for Proposal (RFP) is in alignment with the County Purchasing Department's procurement guidelines that state that non-professional contracted services with a cumulative value over $200,000 shall be competitively procured.

MHSA Plans and Updates must be adopted by the County Board of Supervisors and submitted to the MHSOAC within 30 days after Board of Supervisors' adoption.

FISCAL IMPACT:

A proposed budget of $3,519,000 was submitted by Romeo Medical Clinic for the Whole Health Approach to Improve Mental Health Outcomes project for a five-year period. SCOE submitted a budget of $923,259 for the NAMI on High School Campus for a five-year period. Projects will be funded by MHSA Innovations revenue. Appropriations and estimated revenue for the agreements with Romeo Medical Clinic and SCOE were included in the BHRS Fiscal Year 2019-2020 Adopted Final Budget. Appropriations and estimated revenue for subsequent periods will be included in future budget cycles. In the event that these two Innovations projects are not approved, approximately $1.2 million in Innovations revenue will be subject to reversion on June 30, 2020. Due to the lengthy process of obtaining meaningful MHSA stakeholder input while navigating the County's procurement guidelines, an additional $1.3 million could potentially be subject to reversion on June 30, 2021 if these plans are not approved. There is no impact to the County General Fund.

BOARD OF SUPERVISORS' PRIORITY:

The recommended actions are consistent with the Board's priorities of *Supporting Community Health* and *Delivering Efficient Public Services and Community Infrastructure* by providing mental health services in the community through vendor partnerships.

STAFFING IMPACT:

Existing BHRS staff are available to monitor these agreements and support the projects contained herein.

CONTACT PERSON:

Ruben Imperial, MBA Interim Behavioral Health Director (209) 525-6205

ATTACHMENT(S):

1. Stanislaus County Office of Education Agreement
2. Romeo Medical Clinic Agreement
3. Mental Health Services Act Plan Update

Stanislaus County
Behavioral Health and Recovery Services

Mental Health Services Act

Plan Update FY19-20
INNOVATION

October 2019

WELLNESS • RECOVERY • RESILIENCE

Stanislaus County Behavioral Health and Recovery Services
800 Scenic Drive, Modesto, 95350, 209.525.6247

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COUNTY COMPLIANCE CERTIFICATION

County: Stanislaus

County Mental Health Director	Project Lead
Name: Ruben Imperial Telephone Number: (209) 525-6225 E-mail: Rimperial@stanbhrs.org	Name: Leng Power Telephone Number: (209) 525-5324 E-mail: Lpower@stanbhrs.org
Mailing Address: Stanislaus County Behavioral Health and Recovery Services 800 Scenic Drive Modesto, CA 95350	

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

This Plan Update has been developed with the participation of stakeholders, in accordance with Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft FY 2019-20 Plan Update was circulated to representatives of stakeholder interests and any interested party for 30 days for public review and comment. All input has been considered with adjustments made, as appropriate.

A.B. 100 (Committee on Budget – 2011) significantly amended the Mental Health Services Act to streamline the approval processes of programs developed. Among other changes, A.B. 100 deleted the requirement that the three year plan and updates be approved by the Department of Mental Health after review and comment by the Mental Health Services Oversight and Accountability Commission. In light of this change, the goal of this update is to provide stakeholders with meaningful information about the status of local programs and expenditures.

A.B. 1467 (Committee on Budget – 2012) significantly amended the Mental Health Services Act which requires three-year plans and Annual Updates to be adopted by the County Board of Supervisors; requires the Board of Supervisors to authorize the Behavioral Health Director to submit the annual Plan Update to the Mental Health Services Oversight and Accountability Commission (MHSOAC); and requires the Board of Supervisors to authorize the Auditor-Controller to certify that the county has complied with any fiscal accountability requirements and that all expenditures are consistent with the requirements of the Mental Health Services Act.

The information provided for each work plan is true and correct.

All documents in the attached Plan Update FY 2019-20 are true and correct.

Ruben Imperial
Mental Health Director/Designee (PRINT)

Signature

10/25/2019
Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Stanislaus

☐ Three-Year Program and Expenditure Plan
☐ Annual Update
☐ Annual Revenue and ExpenditureReport

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Ruben Imperial, MBA	Name: Kashmir Gill
Telephone Number: 209-525-6225	Telephone Number: 209-525-5673
E-mail: Rimperial@stanbhrs.org	E-mail: Kgill@stancounty.com
Local Mental Health Mailing Address: 800 Scenic Drive Modesto, CA 95350	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Ruben Imperial, MBA — 11/4/2019

Local Mental Health Director (PRINT) | Signature | Date

I hereby certify that for the fiscal year ended June 30, 2019, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 2018 for the fiscal year ended June 30, 2018. I further certify that for the fiscal year ended June 30, 2019, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Kashmir Gill — 11/5/19

County Auditor Controller / City Financial Officer (PRINT) | Signature | Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

INNOVATION OVERVIEW

Innovation is one of five components of Proposition 63, the Mental Health Services Act (MHSA), passed by California voters in 2004. It provides funds and evaluates new approaches in mental health. The projects are intended to contribute to learning and address unmet needs rather than having a primary focus on providing services.

As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Innovation funding is uniquely focused and intended for projects that demonstrate one of the following primary purposes:

a) Increase access to mental health services to underserved groups.

b) Increase the quality of mental health services, including measurable outcomes.

c) Promote interagency and community collaboration related to mental health services, supports, or outcomes.

d) Increase access to mental health services.

In addition, Innovation projects are expected to contribute to learning in the following ways:

a) Introduce a new mental health practice/approach that has never been done before.

b) Make a change to an existing mental health practice/approach, including an adaptation for a new setting or community.

c) Introduce a new application to the mental health system of a promising, community driven practice/approach or a practice/approach that's been successful in a non-mental health context or setting.

An Innovative Project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solve persistent mental health challenges; including but not limited to, administrative, governance, and organizational practices, processes, or procedures; advocacy; education and training for service providers, including nontraditional mental health practitioners; outreach, capacity building, and community development; system development; public education efforts; research; services and interventions, including prevention, early intervention, and treatment. (Section 9, Part 3.2, 5830c)

As with all MHSA components, Innovation projects must be guided by MHSA values:

- ✓ Community collaboration - Initiates, supports and expands collaboration and linkages, especially connections with systems, organizations, and practitioners not traditionally defined as mental health entities;
- ✓ Cultural competence - Demonstrates cultural competency and capacity to reduce disparities in mental health services and outcomes;

- ✓ Client driven mental health system - Includes ongoing involvement of clients, including but not limited to implementation, staffing, evaluation and dissemination;

- ✓ Family driven mental health system - Includes ongoing involvement of family members, including but not limited to implementation, staffing, evaluation and dissemination;

- ✓ Wellness, recovery, and resiliency focus - Prevent mental health problems, increase resilience and/or promote health recovery;

- ✓ Integrated service experiences for clients and family - Encourages and provides for access to a full range of services provided by multiple agencies, programs and funding sources for clients and family members

Innovation projects are developed through input from community planning processes and are reflective of the unmet need identified by inclusive and diverse stakeholder input. Innovation funding makes it possible to try out new approaches, gather data, define and measure the success of the new approach or practice without taking funds away from other necessary services. Since January 2010, Stanislaus County has conducted community planning for Innovation funding that resulted in the development of 17 new projects to date.

Round 1 of Innovation Funding

The first round of planning in 2009 resulted in one (1), three-year project with learning goals related to stakeholder and agency partner participation in understanding public funding processes and how these community partners may contribute to decision-making.

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

Concluding in FY 2012-13, the final report was submitted to the MHSOAC in June 2013.

Round 2 of Innovation Funding

Stanislaus County's unique second round of Innovation planning began with the BHRS Leadership Team's intention to bring project ideas in behavioral health with the county's commitment to community capacity building, increasing protective factors, and advancing of non-stigmatizing early intervention approaches. On October 26, 2010, the Stanislaus County Board of Supervisors authorized the first Request for Proposals (RFP) process for the Innovation learning projects. It resulted in the selection and funding of nine (9) new projects operated by six (6) unique community-based organizations and one county agency. Implementation began in August 2011.

Two (2) year projects:

- Center for Human Services/Building Support Systems for Troubled Children.
- Center for Human Services/Civility School Learning Project
- Center for Human Services/Revolution Project.
- Stanislaus County Health Services Agency/Integration Innovations.
- Sierra Vista Child and Family Services/Connecting Youth to Community Supports.
- Tuolumne River Trust/Promoting Community Wellness through Nature.

Three (3) year projects:

- National Alliance for Mental Illness (NAMI)/Beth and Joanna Friends in Recovery.
- West Modesto King Kennedy Neighborhood Collaborative/Families in the Park.
- Peer Recovery Art Project/Arts for Freedom.

Final reports may be viewed on-line by going to www.stanislausmhsa.com

Round 3 of Innovation Funding

A third round of Innovation planning was conducted in FY 2012-13 and resulted in two (2) three-year projects:

- Center for Collective Wisdom/Stanislaus County Wisdom Transformation Initiative
- Turning Point Community Programs /Garden Gate Innovative Respite Project

Final reports may be viewed on-line by going to www.stanislausmhsa.com

Round 4 of Innovation Funding

A fourth round of Innovation planning was conducted in FY 2013-14 and resulted in three (3) two-year projects:

- Center for Human Services/Father Involvement Project.
- BHRS Juvenile Justice Program /Youth Peer Navigator Project
- Sierra Vista Child and Family Services/Quiet Time Project.

Final reports may be viewed on-line by going to www.stanislausmhsa.com
Ultimately, the Quiet Time Project was terminated early due to significant implementation barriers in public schools and there is no final report posted.

Round 5 of Innovation Funding

A fifth round of Innovation planning was conducted FY 2015-16 and resulted in two (2) three-year projects:

- BHRS/Full Service Partnership (FSP) Co-Occurring Disorders Innovation Project
- BHRS/Suicide Prevention Innovation Project (SPIP)

Final reports for these projects are pending until in FY 2019-20 after the projects end.

Round 6 of Innovation Funding

A sixth round of Innovation planning has been conducted in FY 2018-19 that has resulted in two (2) five-year projects being selected:

- Romeo Medical Clinic/ Whole Health Approach to Improve Mental Health Outcomes
- Stanislaus County Office of Education/NAMI on High School Campus

This Plan Update FY 2019-20 describes the community planning process and each of the two project proposals in detail.

Community Program Planning Background in Stanislaus:

Over the years, planning by BHRS for MHSA funds has included collaborative partnerships with local community members and agencies. Several key elements are central to the mission of BHRS to be successful in these processes; strive to present information as transparently as possible, manage expectations in public planning processes related to what can reasonably and legally be done within a government organization, follow the guidelines given by the State, honor community input, ensure that when plans are posted for public review and comment, stakeholders can recognize community input in the plan, post documents and conduct meetings in understandable language that avoids use of excessive technical jargon and provides appropriately fluent speakers for diverse populations when needed.

Compelling community input obtained at the original launch of MHSA community planning in 2005 developed core guiding principles that serve to inform all subsequent planning processes. Whenever feasible, MHSA plans, processes, and programs should address inclusion and service to, all age groups and all geographic areas of the county, be based on existing community assets, not exceed the community's or BHRS' capacity to organizationally or fiscally sustain programs and be compatible with the statutory responsibility BHRS holds to administer MHSA funds.

The Representative Stakeholder Steering Committee (RSSC) is actively engaged in identifying needs, priorities, and guiding principles during planning processes. The RSSC is comprised of approximately 40 individuals representing a diverse spectrum of community interests in accordance with MHSA guidelines. In Stanislaus County diverse participants have included, but are not limited to, consumers and family members, social services, education, underserved communities, providers of health care, contract providers of public mental health services, representatives from diverse communities, law enforcement, courts, probation, faith-based community, disability serving organizations, labor organizations, Stanislaus County Chief Executive Office, Behavioral Health Department staff, Area Agency on Aging, and regional geographical areas of Stanislaus County including South and Westside of the county. The primary language spoken in these meetings is English unless other languages or methods of communication are requested.

Representative Stakeholder's role includes giving input on all plans and updates to be submitted, reviewing outcome data in the annual update, sharing information about MHSA plan processes and results with the constituency/community they represent.

Community Program Planning for Innovation in 2019:

Planning for this round of Innovation Projects has engaged stakeholders to ensure diverse input. This component of MHSA has expanded our scope toward identifying a need in the county and unique strategies to address the need and contribute to learning in the field of behavioral health.

Across the State, Innovation has been the most challenging component of MHSA primarily because the focus is on contribution to learning, not simply on expanding services to address unmet need. Counties can deliver a service with Innovation as the method of learning and contributing to the practice of mental/behavioral health. Communicating this difference is central to the community planning process for Innovations. The BHRS Leadership Team has the ongoing intention to gather ideas from stakeholders for new INN projects that are unique to our county. In recent years, an increased emphasis by the Mental Health Oversight and Accountability Commission (MHSOAC) is to pose the question, "What problem does this innovation fix?"

In FY2018-19 stakeholder engagement and input was sought to identify possible areas of focus (problem areas that would benefit from an innovation) to be included in a Request for Proposal (RFP) procurement process. Stanislaus County Board of Supervisors approved the proposed RFP process on June 28, 2019, allowing planning to go forward.

The RFP process was structured and conducted to allow all interested and qualified potential bidders to submit project proposals. An announcement was made to stakeholders in February 2018 that set forth a tentative timeline.

In a county the size of Stanislaus it is important to protect any/all potential proposers from conflict of interest when developing an RFP. As a way to do so, predetermined project ideas from stakeholders were not part of the approach. To ensure an open and robust process, the planning process began with a meeting to identify a broad range of local needs/issues to be addressed.

Initial Stakeholder Input Phase:

July 13, 2018, a stakeholder meeting was conducted. The meeting was announced with an open call to all interested stakeholders to attend. The meeting agenda included information about MHSA, Innovation project guidelines and a proposed timeline for project development.

The central part of the meeting included discussion and input from participants on two (2) questions:

- "What challenging mental health issues exist in Stanislaus County that could be addressed through an innovative approach?" and;
- "If we knew we could successfully address a challenge, within 5 years, what learning question(s) would we propose as the focus of an INN project?"

A table top Design Thinking process was used to encourage "yes and" instead of "yes but" thinking and discussion among participants. It was anticipated that many participants would eventually submit proposals in the competitive bid process.

Fifty-seven individuals attended the meeting. Groups/communities represented included; family members, consumer partners, CBO partners serving adults and children, substance use providers, representatives from diverse communities including LGBTQ community, African American, Hispanic, Chief Executive Office, Behavioral Health Board members, private primary care, education, prevention programs, BHRS Leadership. We also solicited input from those who could not attend the meeting.

32 participants at eight tables provided 42 unique questions and 29 issue inputs. When that data was organized by similarities, the following four broad themes emerged

1. Access to service and support
2. Diverse populations
3. Homelessness, housing and employment
4. Education and Training for service providers

From the broad issue themes and learning questions given at the Design Thinking workshop the BHRS MHSA Manager and MHSA Consultant developed issue areas specific enough to represent stakeholder input and broad enough to include many project ideas in a County procurement process.

Local Issues Identified to be Addressed in INN proposals:

The following issues were developed from stakeholder input. Additionally, the learning questions developed with stakeholders and refined by BHRS were included to assist with potential bidder proposal development. (Project proposers were not limited to these learning questions and were encouraged to develop, with their participants/stakeholders, additional learning questions.) The issues are numbered, but in no particular order or priority:

1. Issue: Accessing needed behavioral health services is problematic for people. Related learning questions:

    - Can adopting new and expanded outreach strategies improve overall access for people in need of services?
    - Can a community-based outreach navigation effort affect timeliness and identification of needs and access?
    - Using current data collected, what can we extract to show relevant outcomes related to access improvements?

2. Issue: (There are not sufficient) Services and interventions to diverse populations e.g. African American, Asian, Hispanic, Native American, LGBTQ+ Communities. Related learning questions:

    - Can adopting specific strategies to create culturally sensitive environments and resources reduce behavioral health disparities?
    - What culturally congruent methods could be used within diverse communities to educate and reduce stigma about behavioral health services in order to improve utilization of needed services?
    - What methods improve the wellbeing of children and transition age youth and strengthen developmental assets?

3. Issue: Homeless individuals with or at risk for serious mental illness lack access to services and supports such as housing and employment. Related learning questions:

    - What methods are effective to connect homeless individuals with or at risk of serious mental illness to services and supports?
    - Can landlords and employers be engaged to create opportunities for homeless individuals with or at risk of serious mental illness?
    - What will help develop community and peer support among or for homeless with serious mental illness?

4. Issue: Education & training for service providers (is needed) including nontraditional behavioral health practitioners (e.g. mental health peers, alternative health practitioners, primary care providers). Related learning questions:

    - Can increasing behavioral health competencies among health care providers increase early identification and reduce the necessity for crisis-oriented care?
    - What methods can be used to identify and assist with navigation for those with mild/moderate mental health needs to prevent long term effects of untreated behavioral health issues?
    - What will help clinicians and other service providers become more open and receptive to whole person approaches to wellbeing and become better able to link their clients to appropriate information and support?

Next Phase: Potential Contractor Outreach Workshops:

BHRS conducted two potential contractor outreach workshops (dubbed "PCOWs"). The intention of these workshops was to deepen understanding of the uniqueness of Innovation and how to approach developing a proposal that met Innovation and RFP requirements. Workshops were open to all stakeholders regardless of their intention to submit a proposal.

A total of 38 potential bidders participated at two PCOW on November 6 and 8, 2018. PCOW attendance was not a requirement to submit a proposal in the RFP process. The following stakeholder groups were represented by 1 or more individuals Primary Health Care, consumers, family members, education, public health, diverse communities, private providers of social services and mental health services.

The workshop content focused on these key elements: Stanislaus County Request for Proposal (RFP) process; e.g. how to register and receive announcement of release of the Request for Proposal; Innovation regulations; local areas of focus identified by stakeholders; a proposed timeline and funds anticipated to be available for projects through FY2022-23.

The workshops were co-conducted by Leng Power MHSA Planning/Innovation Manager, Delayne Olivia BHRS Contracts Department Manager, and Karen Cronian Hurley MFT, MHSA Consultant. Additionally, one or more of BHRS Senior Leadership were present.

The workshops engaged participants using a variety of methods, including:

- PowerPoint presentation with accompanying handouts;
- Informal didactic approach that allowed for discussion and extensive question and answer process;
- Confidential participant feedback forms to assess effectiveness of the workshops. Overall satisfaction rating was on a 1 – 5 scale in which 1 is not satisfied and 5 is very satisfied. Responses were aggregated and a rating of satisfied (4) was achieved.
- Presenters contact information given for post workshop input and additional questions

Additional BHRS Priorities for Project Proposals:

In addition to the local areas of focus and learning questions, BHRS Senior Leadership Team identified several priority characteristics of Innovation Projects they hope to receive, including:

- Projects that are a result of collaboration among community-based groups/agencies
- Projects that achieve their learning in 3-5 years.
- Projects that can quickly complete start-up phase.

The RFP asked proposers to describe the need identified, strategy for addressing the need, and establish through data/research why the current strategy to address the problem is too expensive, not effective or ineffective with some individuals/consumers.

Next Phase: RFP Procurement, Scoring, Selection and Project Refinement for 30-day review/comment & Public Hearing:

Following the outreach workshops, on December 5, 2018, Stanislaus County General Services Agency released an RFP with a submission deadline of January 18, 2019. During the open

bidding process BHRS staff were required to defer all questions to the Stanislaus County General Services Agency (GSA).

Seven (7) project proposals were received, reviewed and scored. Three (3) projects met all thresholds to be eligible for funding.

BHRS Senior Leadership Team discussed and considered the projects and determined that other funds were not available to address the issues identified and that BHRS/County could utilize Innovation funding for the projects. All three (3) projects were selected to received Intent to Award letters on May 9, 2019.

The MHSA Manager and MHSA Consultant began to work with the project proposers, using the MHSOAC Innovation Tool Kit and Innovation Project Template, to convert the projects into the template and refine them for the review and approval processes to come.

Next Phase: Stakeholder Reviews and Approvals:

On July 18, 2019 Leng Power and Karen Hurley participated in a technical assistance call with representative from the MHSOAC Innovation Team to receive feedback on project drafts. During the call MHSOAC team members gave inputs and suggested refinements to the three projects. This is an important step in the process to ensure that projects comply with Innovation regulation and to avoid delay of local and State approval processes.

On July 25, 2019, the selected projects were shared with interested stakeholders and input solicited on the projects and planning process thus far. Overall input from stakeholders was affirming of the process and projects. Some inputs reflected concern that innovation funds were not being used to directly serve individuals with serious mental illness. BHRS facilitators validated the concern, shared that no projects were received in the RFP process that were strongly focused on serious mentally ill individuals and further that attention to this population is ongoing and future projects may be developed to address issues with the population directly.

The next month was devoted to preparing this document; Plan Update FY19-20 which includes all parts required by statute, including but not limited to, Community Program Planning section, project proposals and budgets. Ultimately in this phase, one of the three projects withdrew from the process and the project did not go forward.

Next steps involved working directly with project implementors to make final refinements and prepare projects for 30-day public review and comment, public hearing, Board of Supervisors and OAC approval.

Two (2) projects are included in this Plan Update FY19-20.

Local Review Process:

MHSA Plan Update FY19-20 is available for 30-day public review and comment August 28, 2019 – September 26, 2019. Notifications of the public review dates and access to copies of the document have been made available through the following methods:

- An electronic copy was posted on the county's MHSA website: www.stanislausmhsa.com.
- Paper copies of the MHSA Plan to Spend were distributed to Stanislaus County Public Libraries throughout the county where the report was available at resource desks.

- Electronic notification was sent to all BHRS service sites with a link to www.stanislausmhsa.com announcing the posting of this document.
- Representative Stakeholder Steering Committee, Behavioral Health Board members, as well as other community stakeholders were sent an email informing them of the start of the 30-day review, and how to obtain a copy of the MHSA Plan Update.
- Public Notices were posted in nine newspapers throughout Stanislaus County including a newspaper serving the Spanish speaking community. The Public Notice included access to the MHSA Plan Update, on-line at www.stanislausmhsa.com and a phone number to request a copy of the document.

Public Comment and Responses:

The following comments were submitted in writing and as part of the public hearing;

- There was disappointment expressed that the proposed innovation projects did not have a closer focus on serving the seriously mentally ill population.
- There was a suggestion that the technology platform proposed by the Romeo Medical Clinic strongly emphasize the clients informed consent when interfacing with the application.
- There was a point of clarification regarding the Innovative component in the Stanislaus County Office Of Education, NAMI on Campus Project.

New/Revised Program Description
INNOVATION (INN)

County: Stanislaus

Program Number/Name: Whole Health Approach to Improve Mental Health Outcomes

Date: August 2019

1. **Select one of the following purposes that most closely corresponds to the Innovation Program's learning goal and that will be a key focus of your evaluation**

   - ☐ **Increases access to mental health services to underserved groups**
   - ☒ **Increases the quality of mental health services, including measured outcomes**
   - ☐ **Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes**
   - ☐ **Increases access to mental health services, including but not limited to, services provided through permanent supportive housing**

2. **Describe the reasons that your selected primary purpose is a priority for your county for which there is a need to design, develop, pilot, and evaluate approaches not already demonstrated as successful within the mental health system.**

Stanislaus County BHRS conducted a Request for Proposal (RFP) process, open to all qualified bidders, that included local issues to be addressed as well as INN regulations to be addressed. Local issues were developed with Stanislaus County stakeholders prior to beginning the RFP process. This new INN project "Whole Health Approach to Improve Mental Health Outcomes" submitted by Romeo Medical Clinic was selected in the RFP process to address the following local issue: Education Training (is needed) for Service Providers Including Nontraditional Behavioral Health Practitioners.

Problem/Need to be addressed:

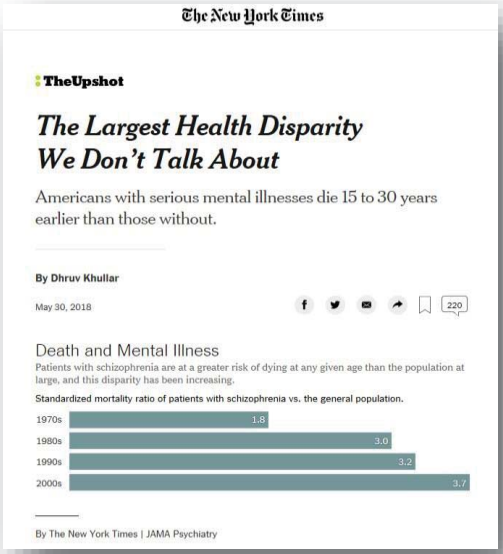
It is a priority for Stanislaus County Behavioral Health and Recovery Services (BHRS), that has been validated through local MHSA stakeholder processes, to learn new ways to increase access to necessary behavioral health services for adult and transition aged adult individuals with serious mental illness as well as mild/moderate mental illness. BHRS in partnership with community stakeholders has recognized the need to expand from a solely traditional model of service delivery to one that offers a more holistic and preventative feature. Education and training of service providers is a cornerstone of this expanded shift.

This new project proposes to address the challenge of starting a paradigm leap in behavioral health that places a prevention-oriented whole health model of care alongside treatment and recovery approach. The specialized treatment and recovery models of today were historically a leap forward and continue to be effective for many individuals with serious mental illness and co-occurring issues of mental illness and substance use. Traditional mental health treatment has not addressed a significant problem among the population of an effective whole health preventative approach that has the potential to change the course of and lengthen life for individuals with serious mental illness.

This project proposes to begin to address, locally, the largest health disparity in the United States; the 25 year-life expectancy difference for those with mental illness due to preventable, chronic disease. These early deaths are typically from lifestyle related diseases such as heart disease, strokes,

diabetes, and lung disease. For individuals suffering from a serious mental illness, the mental illness often takes center stage, and other health factors that determine life-expectancy and quality of life are neglected. There is currently no strategy for address for addressing this issue in a preventative way.

A landmark study on these issues was published by the Center of Disease Control in 2006, but only began receiving popular attention after a New York Times article raised awareness in 2018. [1,2]


The New York Times

TheUpshot

The Largest Health Disparity We Don't Talk About

Americans with serious mental illnesses die 15 to 30 years earlier than those without.

By Dhruv Khullar

May 30, 2018

220

Death and Mental Illness

Patients with schizophrenia are at a greater risk of dying at any given age than the population at large, and this disparity has been increasing.

Standardized mortality ratio of patients with schizophrenia vs. the general population.

By The New York Times | JAMA Psychiatry

1. Colton CW, Manderscheid RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. Prev Chronic Dis [serial online] 2006 Apr [date cited]. Available from: URL: http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm

2. Khullar, D., the Largest Health Disparity We Don't Talk About: Americans with serious mental illnesses die 15 to 30 years earlier than those without. The New York Times, May 30,2018. https://www.nytimes.com/2018/05/30/upshot/mental-illness-health-disparity-longevity.html

3. Which MHSA definition of an Innovation Program applies to your new program, i.e. how does the Innovation Program a) introduce a new mental health practice or approach; or b) make a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community; or c) introduce a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting? How do you expect your Innovation Program to contribute to the development and evaluation of a new or changed practice within the field of mental health?

This new INN project makes a change to the existing mental health practice by introducing a framework for a whole health approach that educates providers first and teaches them to use the approach with the individuals they serve. While there is growing awareness of the need to shift care paradigms towards whole health, both health care and mental health are in the very early stages of seeing this vision realized. Other projects that have been tested can be categorized as small care process changes, such as adding peer support in mental health care clinics to encourage clients to seek needed medical care. Those types of projects provide valuable learning but are not a wholesale commitment to a paradigm shift with accompanying service provider training, matching technology platform, client engagement tools, and clinical outcomes evaluation.

This Innovation Project differs from other whole health projects as it addresses many of the identified quality issues in mental health, while making a care paradigm shift towards whole health. Distinguishing features of this project include the learning and testing of all of the features needed to make this shift:

1. An evidence-based whole health model
2. Train-the trainer approach for providers to learn while experiencing the model for themselves
3. Whole health technology platform for consistent engagement beyond the context of traditional office visits
4. Using validated quality of life measures for clinical outcomes evaluation while also introducing new outcome measures that are engaging for clients (personal level of Energy, Direction, Belonging and Joy)
5. Participation and collaboration with three diverse behavioral health settings for implementation:
    a. Federally Qualified Health Center
    b. Non-profit behavioral health clinic
    c. College student health counseling center

In reviewing the research literature and other projects done in behavioral health with a whole health focus, examples are few. The reason there are very few projects is that behavioral health is in the early stages of this paradigm shift.

This project proposes a five-year learning approach that uses a whole health support platform with behavioral health providers and the individuals they serve. In order to successfully implement a whole health solution for clients, training for service providers on a whole health model is needed, including how to integrate these concepts and technology with traditional care. The goal of this project is to learn whether supporting a client's whole health yields better mental health outcomes and quality and length of life. It is anticipated that this project will secondarily address the problem of access to support and engagement outside of traditional treatment settings using web and mobile applications. The overarching goal of this project is to learn whether supporting a client's whole health yields better mental health outcomes and quality and length of life.

4. Describe the new or changed mental health approach you will develop, pilot, and evaluate. Differentiate the elements that are new or changed from existing practices in the field of mental health already known to be effective.

Moving towards a whole person orientation in mental health is a movement endorsed by many national and international health organizations, but this vision has struggled to become a reality. The importance of transitioning to whole person model of care was made more urgent by the 2006 Report by the National Association of State Mental Health Program Directors[1]. This report demonstrates that people suffering from serious mental illness have a 25-year reduction in life expectancy due to co-morbid medical conditions, particularly diabetes and coronary artery disease. As more than 75% of chronic diseases are preventable with a healthy lifestyle, and many of these lifestyle factors that prevent disease such as exercise, healthy nutrition, and financial wellness also improve mental health outcomes, whole health promotion holds significant promise for improving quality of life and outcomes for clients receiving behavioral health services.

This project will focus on providing three necessary elements needed to transition from a traditional behavioral health model into a whole health model of care:

[1] National Association of State Mental Health Program Directors (2006, October) Morbidity and Mortality in People with Serious Mental Illness Retrieved from https://nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf

- Training for service providers on an evidence-based whole health model of care;
- Providing standardized whole health assessment tools for service recipients;
- Adapting an existing electronic whole health engagement platform to meet the needs of mental and behavioral health service providers and their service recipients.

The whole health model and platform was developed locally by physicians from Romeo Medical Clinic in Turlock, CA. They began developing a whole health model in 2006 as a response to several local employers that wanted assistance promoting healthier lifestyles for their employees and lowering preventable health care costs. The whole health model has been implemented as a corporate wellness program since 2009 and has evolved into a scalable electronic platform named Seity Health that has resulted in significant improvements in whole health and decreased medical care costs.

Whole health training for service providers will be provided by the physicians who created the model. This will begin using a "train-the-trainer" approach by first implementing the platform with service providers, staff, and administrators. This method is also intended to improve the whole health and quality of life of participants within each organization. As their familiarity with the model and tools grows, preparations will be made for integrating this into patient and client care.

The five-year project will include adapting the platform to meet threshold languages of their patient populations and building electronic interfaces from the Seity Health platform to their respective Electronic Health Records to make Whole Health data easily accessible at the point of care. With continuous training, evaluation, and adaptation among three diverse mental health delivery systems, best practices will emerge. The outcomes assessment will be done by two local university research psychologists with extensive experience in Innovation Project Assessment and familiarity with Romeo Medical Clinic's platform and whole health model, Seity Health.

Naming of the platform as 'seity' (pronounced "see-tee") was inspired by an old word, rarely heard today, but commonly used in the 1800's. 'Seity' is defined as 'an expression of your true self'. This authentic expression of self can be unhealthy or healthy. The core philosophy of Seity Health is to discover who you are on the inside, then live out your true self in a healthy way.

The Seity Health program is comprehensive in approach and supports whole person development through these aspects:

- World (relationships, work/school, finances, safety, environment, and community);
- Body (exercise, nutrition, sleep, healthcare, biometrics, and addiction prevention);
- Mind (thoughts, emotions, memories, and knowledge);
- Spirit (spirit lifting practices that are consistent with a person's values);
- Core (knowing your unique four Core Values and expressing them in a healthy way)

The Science of Core Values: The Key to Seity Health Effectiveness

Core Values describe what most motivates and inspires a person. They are a deeper level of identity than most people are used to thinking about themselves. When people know who they are at their core, as described by their Core Values, they are empowered to live better and healthier lives that are authentic to their deepest form of identity. The Core Value selection process utilized by the Seity Health platform offers an innovative and efficient design for participants to find their four Core Values in minutes from a possible 37 million value combinations. This selection process was recently presented by Drs. Harold Stanislaw and Jamie McCreary at the 2018 International Congress of Applied

Psychology annual scientific meeting. Knowing your Core Values and regularly reflecting on who you are has been shown to produce powerful performance results.

Core Value Reflection Effects:

1) **Rewards:** Stimulates the reward center of the brain on functional MRI scans
2) **Lowers Stress:** Decreases production of stress hormones
3) **Increases Self-Control:** Replenishes willpower during activities requiring self-control
4) **Increases Discernment:** Improves ability to assess strengths and weakness of arguments made by others
5) **Improves Performance**: Improves recognition of personal errors and openness to coaching
6) **Overcome Stereotypes**: Improves performance of ethnic minority students and females in math and science classes

The Whole Health Process:

The Seity Health process teaches people to understand who they are at their Core and live this out in a healthy way. Our experience is that when people know who they are at their Core, this affects them at every level. It inspires their Spirit, brings greater clarity and direction for their Mind, and gives energy for their Body so they can shape the World around them in a healthier way. As people grow in their ability to live out their Core, this impacts their quality of life in immediate and tangible ways. We teach participants to measure their Quality of Life using four factors that are easily discernible and desirable by everyone. When people are experiencing high levels of Energy, Direction, Belonging, and Joy, they are experiencing the benefits of whole health.

Seity Whole Health Engagement:

The Seity platform supports whole health through a variety of engagement methods to fit a wide variety of lifestyles including web, email, smartphone, and tablet applications for Android and Apple products. These activities are available in thoughtful intervals to maximize engagement and effectiveness without overwhelming participants.

Bi-annual Whole Health Assessment:

These assessments determine or update your Core Values, provide lifestyle evaluation at every level of your practices (World, Body, Mind, and Spirit), and evaluate functional health outcomes in a unique way that is relevant for moment- to-moment experience of health as measured by four factors (Energy, Direction, Belonging, and Joy).

Goal Generator:
Each participant can build goals for each level of their lifestyle (World, Body, Mind, and Spirit) for the next 6 months. The Goal Generator module walks participants through barriers, strengths, resources, and connection to their Core Values to improve their ability to meet their goals. The Goal Generator module can be completed alone or with the assistance of a wellness coach, patient navigator, therapist, or physician.

Daily Check In:
Participants complete a 20 second check in using smartphone or web applications on how well they are experiencing four whole health outcomes (Energy, Direction, Belonging, and Joy). This allows participants to track individual (and group) trends over time to see how well lifestyle changes and life challenges are affecting their outcomes.

Quarterly Health Challenges:
Challenges are creative, theme-based, and video-based, lasting 2-4 weeks with participants learning by doing. These integrated whole health lifestyle actions offer guided support to improve a participant's World, Body, Mind, and Spirit enhancing practices.

Annual Group Summary:
The Seity platform aggregates group data while maintaining individual confidentiality to measure participation rates, lifestyle changes, group Core Values, biometrics (blood pressure, cholesterol, glucose, and body mass index), and functional outcomes (Energy, Direction, Belonging, and Joy).

The Promising Aspects of this Community-Driven Approach for Mental Health Care:

1. Whole Health Training for Organizations Providing Mental Health Services:

As the field of mental health desires to expand from a recovery model of mental illness to include a whole health model to maximize outcomes and quality of life, the Seity Health model and platform provides a practical approach to operationalizing this goal. The physicians of Romeo Medical Clinic have more than a decade of experience training non-healthcare employees at Turlock Irrigation District and the City of Turlock. As family physicians who care for the whole person, they are well-equipped to adapt this model to the mental health setting. Currently, there are no whole health trainings, models, and scalable platforms for mental health providers to promote whole health for their patients. The heart of this proposal is to address this deficiency.

2. Accelerating the Therapeutic Relationship:

The process of discovering what uniquely inspires and empowers a patient can take many sessions to discover. The Seity Health platform and Core Value discovery process allows a therapist and patient to discover this within minutes. As there are more than 37 million different combinations of Core Value sets, the likelihood of a therapist seeing the same value set twice in their career is unlikely. The Core Value discovery process will allow therapists to develop treatment, recovery, and wellness plans that match their patient's Core Values on the first visit.

3. Whole Person Assessment Data at the Point-of-Care:

Because patients will be able to complete whole health assessments prior to visits using the Seity Health web, smartphone, or tablet-based assessments, disruption to traditional care processes will be minimized. Knowing a patient's Core Values and lifestyle practices at a World, Body, Mind, and Spirit level at the point-of-care holds great promise in expanding the breadth and effectiveness of mental health care.

4. Goal Setting for Whole Health:

The Seity Goal Generator module walks patients through goal setting, barriers, and available resources based on their Core Values and current lifestyle challenges at every level (World, Body, Mind, and Spirit). This can be done with a patient by therapists as part of a counseling session or by using non-licensed patient advocates/staff. This can also be assigned as "homework" for the more motivated patients.

5. Preserving Resources Using Electronic Patient Engagement Tools:

The Seity Health platform augments the care provided by processionals and organizations in a non-disruptive manner to improve outcomes. By using digital tools, care organizations are able to reach out to their patients without taxing their professionals.

6. Improving Outcomes by Promoting Whole Health:

Many of the lifestyle factors that affect mental health outcomes are beyond the scope of traditional mental health care. For example, it is well known that optimizing nutritional choices, exercise, improving wellness skills, and having healthy spiritual practices improves outcomes. This model includes scalable tools for mental health care to improve the quality of life for individuals by leveraging whole health factors beyond the scope of traditional health care.

4a. If applicable, describe the population to be served, including demographic information relevant to the specific Innovation Program such as age, gender identify, race, ethnicity, sexual orientation, and language used to communicate.

The Seity Health project will provide whole health promotion services to all clients at each of the three organizations (Golden Valley Health Centers, Center for Human Services, and CSUS Counseling Centers) regardless of mental illness severity (participation is voluntary).

Adult participants of all ages including Transition Aged Young Adults (TAYA) may have severe to mild mental illness. Whole health services will be available for all interested clients based on the project philosophy that improving whole health is relevant for every person. A whole health model can be compatible with existing treatment and recovery practices of individual clients. Whole health factors such as relationship building, exercise, nutrition, addiction prevention, emotional awareness, spiritual practices, and Core Value connections have relevance for every person regardless of mental health severity status.

The Seity Health platform and whole health approach is not a replacement of the therapist-patient relationship and patient's continuity of care will not be threatened by this project completion. At the conclusion of this project, we anticipate each organization will have established a whole health model of care that results in improved outcomes, increased provider satisfaction, and financial sustainability.

Three organizations in Stanislaus County that provide behavioral health services have contributed to the development of this project and expressed interest in participation. The Seity Health tools and outcomes have generated interest and excitement among them. They share the belief that this approach could be integrated into patient and client care and also support the health of their providers and staff. They each possess a substantial population of behavioral and mental health providers, support staff, and service recipients from which we can evaluate appropriate learning questions and measure improved mental health outcomes. Three local behavioral health organizations will participate in this Inn project:

1) **Golden Valley Health Centers** – The largest non-profit provider of general, mental, and behavioral health services to a diverse underserved population in Stanislaus County. Most have mild to moderate mental health issues and a smaller portion have severe mental health issues.

2) **Center for Human Services** – Non-profit provider and facilitator of behavioral health resources, including counseling and Family Resource Centers for the underserved population in Stanislaus County. CHS serves a diverse population of individuals of all ages with mostly mild to moderate and a smaller portion of individuals with severe mental illness.

Phase 3: Platform Interfaces and Ongoing Training and Evaluation

This phase will involve continuous and longitudinal evaluation of quality of life and mental health outcomes of both service providers and clients. Training, refinement of processes and platform will be included in this phase as final best practices are developed. In addition, interfaces between Seity Health platform and respective participant Electronic Health Records will be completed to make patient whole health data even easier to access and integrate into their documentation system. This will further decrease electronic documentation burdens by clinicians and staff, the largest cause of burnout. Final outcomes assessment will be completed at the end of the 5-year project by research psychologists experienced in program evaluations.

After this project is completed, three behavioral health organizations in Stanislaus County serving more than 100,000 patients will have participated.

1) **Golden Valley Health Centers (GVHC)** – A Federally Qualified Health Center with 26 behavioral health providers accompanied by approximately 100 supporting staff members, serving over 20,000 low income behavioral health patients annually at 9 different clinic locations within Stanislaus County. GVHC serves a diverse population of individuals of all ages.

2) **Center for Human Services (CHS)**– A non-profit behavioral health center with a mission to serve the underserved, staffed by 250 employees serving over 20,000 patients and clients annually.

3) **California State University Stanislaus (CSUS), Psychological Counseling Services** – A unique and diverse university where 74% of students are the first in their family to attend college. The incidence of new onset mental illness and distress is cared for by 8 service providers and 5 supporting staff members, for over 10,000 enrolled students annually.

4c. Describe briefly, with specific examples, how the Innovation Program will reflect and be consistent with all relevant (potentially applicable) Mental Health Services Act General Standards set forth in Title 9 California Code of Regulations, Section 3320. If a General Standard does not apply to your Innovation Program, explain why.

1. Community Collaboration

This project proposal is representative of the collaborative spirit and intent of the California Code of Regulations as five Stanislaus County organizations (Golden Valley Health Centers, Center for Human Services, California State University Stanislaus, Romeo Medical Clinic, and Seity Health) are all combining their strengths and resources to better serve mental and behavioral health patients and clients in a shared vision of improving our community's health. By using a shared whole health model and common platform, this will facilitate our community in becoming healthier, together.

2. Cultural Competence

This Innovation Project has identified three local organizations that provide services to a diverse population. Two organizations (GVHC and CHS) have a mission to care for the underserved and California State University Stanislaus' Counseling Center serves a student body where 74% are the first in their family to attend college and over 75% are of ethnic descent. The five-year project will include adapting the Seity Health platform to meet threshold languages of their patient and client populations, compliance with ADA standards, and best practices learned for continuous participation among the uniquely diverse and underserved of our community. The health practices promoted in the whole health model were designed with a wide diversity of beliefs, customs, and cultures in mind. The Seity Health model, assessments, and health activities do not discriminate on the basis of race, creed, color, ethnicity, national origin, religion, sex, sexual orientation, gender expression, age, height, weight, physical or mental ability, veteran status, military obligations, or marital status.

3. Client-Driven

The Seity Health platform was developed to educate and empower an individual with the knowledge of who they are at their Core, identify their unique source of inspiration, provide an assessment of their whole health lifestyle practices, and support individuals in enhancing their own well-being and contribution to their community. Participants have the opportunity to access the platform on their own (via web, smartphone, or tablet) for an enriched independent experience.

4. Family-Driven;

Immediate family members, caregivers or personal support providers will be offered an opportunity to participate in the self-directed Core Value identification and whole health lifestyle assessments. Families are encouraged, but not required, to discuss their individual Core Values with each other to accelerate relationships and empower one another to live their best lives. Families are empowered to make healthy changes together as they understand each other better as individuals.

5. Wellness, Recovery, Resilience-Focused;

The focus of a whole health model is understanding who you are at your Core, then improving your lifestyle and health on every level including your Spirit, Mind, Body, and surrounding World. As health gains are made, recovery is facilitated, and resiliency is gained as participants learn to live out their Core Values in a healthy way. The goal is to live in a way that inspires your Spirit, brings clarity and focus to your Mind, Energy for your body, so that you can impact your World in a healthy way. This whole health model is a shift from the traditional diagnose and treat model to a wellness enhancement model. People are more likely to create a healthier lifestyle when they focus on interests and strengths rather than infirmities and challenges.

6. Integrated Service Experience for Clients and Families;

The Seity Health platform will provide organizations and individuals with a common whole health assessment and engagement tool. The whole health model will incorporate an evidence-based in-common data set that integrates "social, physical, mental, spiritual, and core identity" health to facilitate collaboration with traditional healthcare, social services, education, environmental, and housing agencies within our community. The Seity Goal Generator will match a client's Core Values and goals to community resources (both within and outside behavioral health organizations). This five-year project will also increase the number of indexed resources and facilitate electronic matching for behavioral health clients and their families in our community.

4d. If applicable, describe how you plan to protect and provide continuity for individuals with serious mental illness who are receiving services from the Innovative Project after the end of implementation with Innovation funds.

The Seity Health platform is not a replacement of the therapist-patient relationship and patient's continuity of care will not be threatened by this project completion. At the conclusion of this project, we anticipate each organization will have established a whole health model of care that results in improved outcomes, increased provider satisfaction, and financial sustainability.

5. **Project Timeline: Specify the total timeframe of the Innovation program. Provide a brief explanation of how this timeframe will allow sufficient time for the development, time-limited implementation, evaluation, decision-making, and communication of results and lessons learned. Include a timeline that specifies key milestones for all of the above, including meaningful stakeholder involvement.**

The project is anticipated to begin December 2019. This ambitious 5-year INN project will require several distinct phases of implementation and evaluation that cannot be compressed.

Key Activity:
August 2019: 30-day public review/comment period
September 2019: Public Hearing by Behavioral Health Board
October 2019: Obtain Board of Supervisors Approval
November 2019: Obtain State-MHSOAC approval of the INN project

First Year of INN project:

Phase one (Year 1) involves training service providers and support staff on a whole health model of care. Phase one includes onboarding organizations onto the Seity Health platform and using a "learn-by-doing" approach as they use the platform and curriculum for their own person wellbeing. This year will also include training of service providers to use the platform and with clients and adapting the platform to accommodate diverse languages and physical abilities.

First Quarter

- Selected contract provider to begin implementing the INN project
- Start-up activities; finalize onboarding process with 3 Behavioral Health Organizations (BHO) and begin enrollment of providers, staff and administrators onto the Seity Health platform for baseline whole health assessment and activities, develop evaluation tools
- Meet with BHRS Innovation Project Manager for contract monitoring and mentoring
- Participate in regular reporting to MHSA stakeholder group

Second Quarter

- Providers in 3 BHOs begin receiving Seity whole health model of care training from Romeo Medical Clinic (RMC) physicians and other project staff
- Meet with BHRS Innovation Project Manager for contract monitoring and mentoring

Third Quarter

- On-boarding of service providers onto Seity Health Platform for baseline whole health assessments and well-being promotion activities
- Meet with BHRS Innovation Project Manager for contract monitoring and mentoring

Fourth Quarter

- Focus groups to evaluate perceived benefits and barriers of personal use and upcoming client use. Develop survey instrument for evaluation

- Meet with BHRS Innovation Project Manager for contract monitoring and mentoring
- Participate in regular reporting to MHSA stakeholder group

Phase two (Year 2) will begin onboarding behavioral health clients onto the platform while continuing to train service providers in using the model and platform with small numbers of clients. Phase 2 will consist of developing best practices for operationalizing the model for the distinct practice environments. Once these operational issues are fine-tuned and best practices are developed, it is expected that anticipate a higher volume of clients will engage in the program in Year 3. Phase 2 also includes building electronic interfaces from the Seity Health platform to partner agency's electronic health records so providers can integrate whole health data into their usual charting to decrease administrative burdens.

Year 2 milestones:

- Provide training on the implementation and utilization of Seity Health Platform for service recipients
- Onboarding of first service recipients onto Seity Health Platform for baseline whole health assessments and well- being promotion activities. First service provider survey begins and repeated every 6-months.
- Assess discovery of best practices for increasing participation and whole health outcomes. Quarterly quality of life and well-being surveys begin for clients.
- Assess lessons learned and whole health outcomes through analysis of bi-annual surveys, Seity Health platform data, and quarterly client surveys.
- Meet with County for contract monitoring and mentoring
- Participate in regular reporting to MHSA stakeholder group

Phase 3 (Years 3-4.5) will include higher numbers of clients on the platform while integrating behavioral health and whole health. 18 months will be needed to ensure enough clients have one continuous year of whole health support to evaluate the effectiveness on mental health outcomes and well-being. The length of time for Phase 2 and 3 is also necessary to evaluate the evolving service provider perceptions of barriers and benefits of a whole health model of care. If the time frame is too short, there will be no maturation of perceptions and adequate evaluation of sustainability

Year 3 milestones:

- Continue ongoing service provider support, training and evaluation process for both service providers and clients.
- Begin developing interfaces for service provider electronic health records (EHR) and Seity whole health data.
- Continuous maintenance and services for database, website, web-services, iOS, and Android platforms.
- User-interface testing begins for interfaces for electronic charting, expand available whole health data at the point of care.
- Assess lessons learned and whole health outcomes through analysis of bi-annual surveys, Seity Health platform data, and quarterly client surveys. Service provider training on integration of whole health data and their EHR.
- Meet with BHRS Innovation Project Manager for contract monitoring and mentoring
- Participate in regular reporting to MHSA stakeholder group

Year 4 milestones:

- Continue ongoing support, evaluation, and training on whole health model and best practice adaptations. Continuous enrollment.
- Continuous maintenance and services for database, website, web-services, iOS, and Android platforms. Refinement of whole health model of care to encourage continual use of whole health platform.
- Continuous and longitudinal evaluation of outcomes of provider, staff and service recipient whole health outcomes.
- Meet with BHRS Innovation Project Manager for contract monitoring and mentoring
- Participate in regular reporting to MHSA stakeholder group

Year 5 final six months (Phase 4) is needed for final evaluation and dissemination of findings. While 5 years is too short of a time frame to evaluate life expectancy, providing a whole solution integrated into mental health services is an important advancement to address the factors leading to chronic disease and early death.

Year 5 milestones:

- Continue use of whole health platform, assess lessons learned and plan for sustainability.
- Final client and service provider surveys administered.
- Meet with BHRS Innovation Project Manager for contract monitoring and mentoring
- Evaluation of learning goals, final report preparations, and sustainability planning begins.
- Participate in regular reporting to MHSA stakeholder group
- Final report of project outcomes and lessons learned.

6. Describe how you plan to measure the results, impact, and lessons learned from your Innovation Program. Specify your intended outcomes, including at least one outcome relevant to the selected primary purpose, and explain how you will measure those outcomes, including specific indicators for each intended outcome. Explain the methods you will use to assess the elements that contributed to outcomes. Explain how the evaluation will assess the effectiveness of the element(s) of the Innovative Project that are new or changed compared to relevant existing mental health practices. Describe how stakeholders' perspectives will be included in the evaluation and in communicating results. Explain how your evaluation will be culturally competent.

This INN project will address the primary purpose of increasing the quality of mental health services, including measured outcomes. The learning goals are focused initially on providing education and training for service providers including nontraditional behavioral health practitioners in a whole health model of care. Mid to later phases of the project involve service providers utilizing the whole health care model with individuals they serve.

The lessons learned from this innovation project will assist other organizations in solving the problem of how to integrate a preventative whole health care approach alongside existing treatment and recovery services.

The evaluation will address diverse participation by including multiple language options for survey instrument, health materials, adaptations for people of diverse abilities, and inclusions of participation sites that specialize in underserved populations.

The learning plan of this project will have a direct benefit for consumers, families, and underrepresented groups by providing a prevention-oriented whole person approach to care in mental health supported by providers who are familiar with the approach.

There will be four primary outcomes tracked throughout the duration of the project:

1. **Mental health outcomes of service providers and clients**

   Mental health outcomes for both service providers and clients will be evaluated using the Warwick-Edinburgh Mental Wellbeing Scale (WEMBWBS). This validated instrument results in mental health outcome scores ranging from 14 to a high of 70, with a mean of 52 and a standard deviation of 9. Categories have been established to determine “low, medium, and high” mental wellbeing. We anticipate that most service providers will begin the project in the medium range and clients in the low range. Our expectation is that both service provider and client wellbeing scores will improve linearly over the duration of the project. An increase of 2 points per year would yield an 8-point improvement by the end of the project. This would meet the threshold of demonstrating a statistically “large” effect size of improving scores by almost one standard deviation above baseline scores.

2. **Quality of Life outcomes for service providers and clients**

   Quality of Life (QOL) outcomes for both service providers and clients will be evaluated using the Satisfaction with Life Scale (SLS). This scientifically validated instrument yields scores that range from 5 to 35, with a mean score of 25 and standard deviation of 6. We anticipate QOL will increase linearly for service providers and clients throughout the life of the project. Scores are expected to increase by 1.5 points per year in years 2-5, yielding a statistically “large” effect size of one standard deviation above baseline.

3. **Service provider perception of benefits and barriers to implementing a whole health model**

   During the first year of the project, focus groups will be conducted with participating service providers to discover the perceived benefits and barriers to implementing a whole health model in behavior health. Using these initial perceptions, the evaluation team will develop a survey instrument to monitor changing perceptions throughout the life of the project and adjust the whole health model as needed. This survey will be administered every six months.

4. **Utilization of whole health model and technology by service providers and clients**

   The adoption and utilization rates of the Seity whole health program components will be measured using quarterly reports from the Seity Health platform database. We anticipate an annual linear increase in utilization by both service providers and clients as the project progresses. Benchmarks for this platform exist for use in corporate wellness settings with 50% overall participation being the gold standard, but this has never been done in a behavioral health setting. Lessons will be learned from overall participation rates and utilization rates of various platform elements (syncs, journals, challenges, whole health assessments, etc.).

Issue	Related Learning Question	Expected Outcome	Performance Measure	Measurement Frequency – Methodology	Measurement Tool/Data Source
There is a 25-year life expectancy gap for people with mental illness due to unmet whole health issues.	What are the mental health outcomes and quality of life differences for Clients receiving traditional behavioral health care versus whole health care?	Clients participating in a whole health model of care will show improvements in quality of life and mental health outcomes (10% increase in WEMWBS, SLS scores) compared to those participating in a control (traditional) environment.	1) Client mental health outcomes (WEMWBS Score) 2) Client quality of life (SLS Score)	Clients in intervention and control groups surveyed every 3 months.	1) Warwick-Edinburgh Mental Well-being Scale (WEMWBS). 2) Satisfaction with Life Scale (SLS).
With high rates of service provider burnout in public health settings, there is a need to improve the quality of life and mental health outcomes of service providers.	What are the mental health outcomes and quality of life differences for Service Providers participating in traditional mental health care versus whole health care?	Service providers participating in a whole health model of care will show improvements in quality of life and mental health outcomes (10% increase in WEMWBS, SLS scores) compared to those participating in a control (traditional) environment.	1) Service provider mental health outcomes (WEMWBS Score) 2) Service provider quality of life (SLS Score)	Service providers in intervention and control groups surveyed every 3 months	1) Warwick-Edinburgh Mental Well-being Scale (WEMWBS). 2) Satisfaction with Life Scale (SLS).
Education and training on a whole health model of care for service providers, including nontraditional behavioral health practitioners is needed.	What will help clinicians and other service providers become more open and receptive to whole person approaches to well-being?	Linear increase in benefits of model and decrease in barriers as project progresses.	Increased realization of the benefits of whole health model of care while overcoming barriers to implementation.	Service providers complete survey every 6 months as a source of feedback regarding strengths of program and areas of weakness.	Written survey instrument developed by evaluators using feedback from service provider focused groups. The survey will focus on initial and ongoing perceptions of benefits and barriers to using a whole health model and electronic platform for care.

There is currently no framework or technology to assist organizations serving those with mental and behavioral health needs to shift to a whole health model, increasing the quality of services with measurable outcomes.	What will be the adoption and utilization rates of a whole health technology platform for both service providers and clients?	Service providers and client utilization of whole health framework and technology platform will grow over the life of the project. A 50% utilization rate is the expected outcome.	1) Service Provider participation rates on whole health platform. 2) Client participation rates on whole health platform.	Quarterly report from Seity Health platform on service provider and client utilization rates of whole health program elements.	Seity Health platform tracks utilization rates of all whole health program elements (syncs, challenges, journal articles, etc)

5. **Project Sustainability and Continuity of Care: Describe how the County will decide whether and how to continue the Innovative Project, or elements of the Project, without Innovation Funds. Specify how stakeholders will contribute to this decision.**

Project milestones and data will be shared with stakeholders in the MHSA Annual Update each year of the project. At the project's end in FY 23-24, the final evaluation report along with BHRS recommendations will be shared with stakeholders and the general public. If the project demonstrates a measurable effect, the program may be considered for further funding under MHSA funding (PEI or CSS).

To facilitate continuity of care for provider and client participants this project will include the development of online training modules and electronic interfaces to the agency partner's behavioral health Electronic Health Records that can be continuously used by behavioral health sites long after the Innovation Project has finished.

6. **Communication and Dissemination Plan**

The findings from this project will be distributed as final written report to the MHSOAC, published on the Stanislaus County Behavioral Health and Recovery web site and a PowerPoint presentation at MHSA stakeholder meeting. Project findings will be shared at agency partner websites, as well as other organizations already using the Seity Health platform such as the Stanislaus County Office of Education. The research evaluators of the project routinely present their work at international mental health and psychology conferences and anticipate sharing the learnings from this innovation project.

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

This innovation project is leveraged by the existing administrative, fiscal, technological, support and expertise of Romeo Medical Clinic (RMC). RMC is a well-established partner to many private organizations and community-based behavioral health organizations in the communities of Stanislaus County. Existing physician and other staff are able to train mental health providers, staff, and administrators on the whole health model as well as the existing electronic platform for whole health assessment that is compatible across multiple platforms. See budget narrative for details.

8. **Provide an estimated annual and total budget for this Innovation Program, utilizing the following line items. Please include information for each fiscal year or partial fiscal year for the Innovation Program.**

WHOLE HEALTH APPROACH TO MENTAL HEALTH OUTCOMES INNOVATION PROJECT

BUDGET NARRATIVE

The proposed budget for the Romeo Medical Clinic Innovation Project is broken down into personnel, operating, consultant, non-recurring, and other expenditures. The total proposed budget for this five-year Innovation Project is $4,499,000 with $88,000 allocated to Administration (approximately 2% of the total budget) and $252,000 allocated to Evaluation. The total amount of MHSA Innovative Funds requested is $3,519,000 with $980,000 being supported by **Other Funding (Romeo Medical Clinic)*. RMC is committed to this project and is allocating resources and subsidies from its clinical practice to defray the total cost of this program. RMC has borne the indirect costs (health and benefits) associated with the personnel costs as well as annual increases for inflation and performance. RMC will also subsidize the entire cost of licensing fees associated with using the Seity Health platform for involved stakeholders and will contribute to additional administrative and equipment costs.

Costs associated with the grant include:

Adapting the existing whole person health program and Seity platform to function in the mental and behavioral health system. The development of specific program and platform elements needed to support the innovation grant project such as:

- Training programs for mental and behavioral health providers
- Development of the platform in Spanish to meet the unique needs of Stanislaus County
- Development of reports to compile relevant whole person health data to mental and behavioral health providers
- Back-end interfacing to seamlessly integrate patient's and client's whole person data into the electronic information systems of the behavioral health providers
- The costs of maintaining and supporting the multiple platforms needed to deliver a robust operating system in the mental and behavioral health arena including: the database, website, web-services, iOS, and Android platforms

Expenditures and Funding of our proposed budget are as follows:

PERSONNEL COSTS for the five years amount to $2,099,000 including **Indirect Costs** (health, benefits, annual increases) at $85,000 per year *(*RMC Funding)* and the following **Salaries**:

- 1.0 FTE Program Manager, full time at $50,000 per year
- 1.0 FTE User Support, full time at $37,000 per year
- 0.25 FTE Client Engagement and Development, 1 part time contributor at $30,000 per year
- 0.20 FTE Medical Directors, 2 part time contributors at $60,000 per year
- 0.50 FTE Content Development, 1 part time contributor in year 1 at $35,000 and 2 part time contributors in years 2-5 at $70,000 per year
- 0.50 FTE Data Base Manager, 1 part time at $30,000 per year
- 0.50 FTE Platform Specialists (database, website, iOS and Android), 1 part time contributor in year 1 at $36,000 and 2 part time contributors in years 2-5 at $72,000

Expenditure		MHSA Funding	**RMC Funding*
Salaries	$1,674,000.00	$1,674,000.00	0
Indirect (Health & Benefits)	$425,000.00	0	$425,000.00

OPERATING COSTS for the five years amount to $613,000 and are broken down by each category as listed below:

- Building Rent and Utilities at $48,000 per year
- Furniture and Equipment Leases at $10,000 per year
- Telecommunication at $12,000 per year
- IT Support at $12,000 per year
- Office Supplies at $6,000 per year
- Travel Expenses at $5,000 per year
- Interpreters at $12,000 per year
- Insurance at $3,600 per year
- Accounting/Finance at $2,400 per year
- Legal at $10,000 in years 1-2, $5,000 in year 3 and $1,500 in years 4-5
- Public Relations and Marketing at $5,000 in years 1-4 and $10,000 in year 5 *(*RMC Funding)*

Expenditure		MHSA Funding	*RMC Funding
Operating Costs	$613,000.00	$583,000.00	$30,000.00

NON-RECURRING COSTS for the five years amount to $35,000 and includes the following:

- Start Up at $10,000 in year 1
- Equipment at $5,000 per year *(*RMC Funding)*

Expenditure		MHSA Funding	*RMC Funding
Non-Recurring Costs	$35,000.00	$10,000.00	$25,000.00

CONSULTANT COSTS for the five years amount to $1,647,000 and includes non-RMC salaried individuals working on the product. These include individuals working on the training program for behavioral health providers, development of the platform, service/maintenance/support for the platform (including database, website, web-services, iOS, and Android), report writing for data analytics, database interface specialist to deliver data to mental and behavioral health providers at the point of care, evaluators and data scientists.

Romeo Medical Clinic has an established process for producing video-based quarterly health challenges for the corporate wellness setting. A similar production and engineering process will be used for original challenges adapted to the mental health setting. Each challenge is 4 weeks in length and includes 6 videos each: 1) a kick-off video, 2) four weekly instructional videos, and 3) a wrap-up video to solidify teaching points and congratulate participants. Each challenge requires professional video production (including direction, actors, animation) and post-production (sound engineering and editing services). These are made using a financially lean video production process and average $13,500 per quarterly project.

The consultant costs are as follows:

- Seity Enterprise license fees at $100,000 per year *(*RMC Funding)*
- Developers at $85,000 in years 1-4 and $50,000 in year 5
- User Experience at $35,000 per year

- Video Production at $30,000 per year
- Sound Engineering at $25,000 per year
- Training Development at $30,000 in year 1 and $25,000 in year 2
- Evaluators/Researchers/Data Scientists at $12,000 in year 1 and $60,000 in years 2-5

Expenditure		MHSA Funding	*RMC Funding
Consultant Costs	$1,647,000.00	$1,147,000.00	$500,000.00

OTHER EXPENDITURES $105,000 for five years, including the following:

- Participation Incentives (monthly & quarterly drawings) at $6,000 per year
- Stakeholder Stipends at $5,000 per year for each of the 3 stakeholders ($15,000 per year)

Expenditure		MHSA Funding	RMC Funding
Other Expenditures	$105,000.00	$105,000.00	0

ADMINISTRATION Expenditures for the five years amounts to $88,000. This amount accounts for approximately 2% of the total budget. Accounted for in the Operating Costs, Administration Expenditures include: Insurance, Accounting/Finance, Legal, Public Relations and Marketing. Requested MHSA funds for the Administration Expenditures is $58,000, Romeo Medical Clinic will fund $30,000 of the Administration Expenditures (public relations and marketing).

EVALUATION Expenditures for the five years amounts to $252,000. Evaluation is accounted for in the Consultant Costs and MHSA funds are requested for the entire Evaluation Expenditure.

***OTHER FUNDING** (elaborated throughout the narrative) will be supported by Romeo Medical Clinic for a total of $980,000. The financial commitment to this Innovation Project includes additional administrative costs, all indirect costs for personnel, additional equipment and the Seity Enterprise license fees. The Other Funding contributions are as follows:

- Seity Enterprise license fees at $100,000 per year
- Personnel Indirect Costs (health and benefits) at $85,000 per year
- Additional Operating Costs (public relations and marketing) at $5,000 in years 1-4 and $10,000 in year 5 for a total of $30,000 for duration of project
- Equipment at $5,000 per year

EXPENDITURE		MHSA FUNDS	*RMC FUNDS
Fiscal Year 2019/2020	$842,000.00	**$647,000.00**	$195,000.00
Fiscal Year 2020/2021	$946,000.00	**$751,000.00**	$195,000.00
Fiscal Year 2021/2022	$916,000.00	**$721,000.00**	$195,000.00
Fiscal Year 2022/2023	$912,500.00	**$717,500.00**	$195,000.00
Fiscal Year 2023/2024	$882,500.00	**$682,000.00**	$200,000.00
TOTAL BUDGET	$4,499,000.00	**$3,519,000.00**	$980,000.00

WHOLE HEALTH APPROACH TO MENTAL HEALTH OUTCOMES INNOVATION PROJECT

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
1	Salaries	278,000	349,000	349,000	349,000	349,000	$ 1,674,000.00
2	Direct Costs	0	0	0	0	0	$ -
3	Indirect Costs	85,000	85,000	85,000	85,000	85,000	$ 425,000.00
4	Total Personnel Costs	363,000	434,000	434,000	434,000	434,000	$ 2,099,000.00
OPERATING COSTS		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
5	Direct Costs	126,000	126,000	121,000	117,500	122,500	$ 613,000.00
6	Indirect Costs	0	0	0	0	0	$ -
7	Total Operating Costs	126,000	126,000	121,000	117,500	122,500	$ 613,000.00
NON-RECURRING COSTS (equipment, technology)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
8	Start Up	10,000	0	0	0	0	$ 10,000.00
9	Equipment	5,000	5,000	5,000	5,000	5,000	$ 25,000.00
10	Total Non-Recurring Costs	15,000	5,000	5,000	5,000	5,000	$ 35,000.00
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
11	Direct Costs	317,000	360,000	335,000	335,000	300,000	$ 1,647,000.00
12	Indirect Costs	0	0	0	0	0	$ -
13	Total Consultant Costs	317,000	360,000	335,000	335,000	300,000	$ 1,647,000.00
OTHER EXPENDITURES (please explain in budget narrative)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
14	Participation Incentives	6,000	6,000	6,000	6,000	6,000	$ 30,000.00
15	Stakeholder Stipends	15,000	15,000	15,000	15,000	15,000	$ 75,000.00
16	Total Other Expenditures	21,000	21,000	21,000	21,000	21,000	$ 105,000.00
BUDGET TOTALS		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
Personnel (line 1)		278,000	349,000	349,000	349,000	349,000	$ 1,674,000.00
Direct Costs (add lines 2, 5 and 11)		443,000	486,000	456,000	452,500	422,500	$ 2,260,000.00
Indirect Costs (add lines 3, 6 and 12)		85,000	85,000	85,000	85,000	85,000	$ 425,000.00
Non-Recurring Costs (line 10)		15,000	5,000	5,000	5,000	5,000	$ 35,000.00
Other Expenditures (line 16)		21,000	21,000	21,000	21,000	21,000	$ 105,000.00
TOTAL INNOVATION BUDGET		842,000	946,000	916,000	912,500	882,500	$ 4,499,000.00

WHOLE HEALTH APPROACH TO MENTAL HEALTH OUTCOMES INNOVATION PROJECT

BUDGET CONTEXT- EXPEDNITURES BY FUNDING SOURCE AND FISCAL YEAR FY							
ADMINISTRATION:							
A.	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
1	Innovative MHSA Funds	16,000	16,000	11,000	7,500	7,500	$ 58,000.00
2	Federal Financial Participation	0	0	0	0	0	$ -
3	1991 Realignment	0	0	0	0	0	$ -
4	Behavioral Health Subaccount	0	0	0	0	0	$ -
5	Other funding*	5,000	5,000	5,000	5,000	10,000	$ 30,000.00
6	Total Proposed Administration	21,000	21,000	16,000	12,500	17,500	$ 88,000.00
EVALUATION:							
B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
1	Innovative MHSA Funds	12,000	60,000	60,000	60,000	60,000	$ 252,000.00
2	Federal Financial Participation	0	0	0	0	0	$ -
3	1991 Realignment	0	0	0	0	0	$ -
4	Behavioral Health Subaccount	0	0	0	0	0	$ -
5	Other funding*	0	0	0	0	0	$ -
6	Total Proposed Evaluation	12,000	60,000	60,000	60,000	60,000	$ 252,000.00
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 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
1	Innovative MHSA Funds	647,000	751,000	721,000	717,500	682,500	$ 3,519,000.00
2	Federal Financial Participation	0	0	0	0	0	$ -
3	1991 Realignment	0	0	0	0	0	$ -
4	Behavioral Health Subaccount	0	0	0	0	0	$ -
5	Other funding*	195,000	195,000	195,000	195,000	200,000	$ 980,000.00
6	Total Proposed Expenditures	842,000	946,000	916,000	912,500	882,500	$ 4,499,000.00

* Other Funding: Romeo Medical Clinic

New/Revised Program Description
INNOVATION

County: Stanislaus

Program Number/Name: NAMI on Campus High School

Date: August 2019

1. **Select one of the following purposes that most closely corresponds to the Innovation Program's learning goal and that will be a key focus of your evaluation**

   ☐ **Increases access to mental health services to underserved groups**
   ☐ **Increases the quality of mental health services, including measured outcomes**
   ☐ **Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes**
   ☒ **Increases access to mental health services, including but not limited to, services provided through permanent supportive housing**

2. **Describe the reasons that your selected primary purpose is a priority for your county for which there is a need to design, develop, pilot, and evaluate approaches not already demonstrated as successful within the mental health system. If your Innovation Program reflects more than one primary purpose in addition to the one you have selected, you may explain how and why each also applies.**

   Stanislaus County BHRS conducted a Request for Proposal (RFP) process, open to all qualified bidders, that included local priorities to be addressed as well as INN regulations to be addressed.

   Local issues were developed with Stanislaus County stakeholders prior to beginning the RFP process. This new INN project "NAMI on Campus – High School" submitted by Stanislaus County Office of Education (SCOE) was selected in the RFP process to address the following local issue: accessing needed behavioral health services is problematic for people.

   Problem to be addressed:

   It is a priority for Stanislaus County Behavioral Health and Recovery Services (BHRS) that has been validated through local MHSA stakeholder processes, to learn new ways to increase access to necessary behavioral health services for individuals of all ages.

   Nearly 20 percent of youth in the United States experience a mental, emotional or behavioral health condition every year. Yet according to the Centers for Disease Control and Prevention, nearly half of those kids do not receive any kind of mental health services. The reasons are varied: Social stigma, high costs, lack of insurance, and school staff and parents who may lack recognition and awareness of symptoms. Without diagnosis and treatment, mental health conditions can affect a student's performance and ability to learn and grow.

   Information from the California Health Kids Survey (CHKS) conducted during the 2016-17 school year, the California School Dashboard 2018 and the MHSA BHRS Suicide Innovation Project are three sources of data to define the problem. Some of the data collected indicates nearly one third of students across school districts considered suicide and felt chronically sad, hopeless and these feelings interfered with their ability to go to school or do things they enjoy for a period of two weeks

or more. Alarmingly the rate of one in six students reported they seriously considered suicide in the past 12 months. This finding is further complicated by reported low levels of caring adult relationships and feelings of school safety. The CHKS includes three questions that ask students to rate the level of caring adult relationships available for students. The question specifically asks if there is an adult who really cares about them, notices when they are not there and listens when they have something to say. The responses provided are used to set a rating of low, medium or high. In 2016-17, fewer than one third of all students reported high levels of caring adult relationships with only 59 percent of students reporting feeling safe or very safe.

According to the California Dashboard, Stanislaus County across all districts in the 2018-19 school year is in the orange performance level for chronic absenteeism and suspensions. The dashboard colors read from top to bottom: Blue, Green, Yellow, Orange, and Red. Blue represents the highest performance level while Red represents the lowest performance level.

These gaps were also discovered in the countywide suicide prevention needs assessment, conducted by the MHSA BHRS Suicide Prevention Innovation Project, which identified insufficient protective factors and under-utilized preventive services as the top two first level causes of the rising suicide rate in Stanislaus County. The low levels of school safety and caring adult relationships are just two examples of insufficient protective factors among students.

This new project proposes to address the issue that exists among high school students in which access to information and support for mental health issues is insufficient. This project will use NAMI on Campus a peer-led, mental health awareness club to address the issue. Student members/leaders are trained and guided by club advisors to raise awareness on their campuses about mental health, reduce stigma, and suicide prevention. NAMI on Campus Clubs are not support groups or therapy groups. Clubs are open to all students, faculty and staff, regardless of their own experiences with mental health or illness.

This project is not intended to serve as a full system navigation function however, it will assist school districts to communicate with students and families about the available resources and access points in the county. It is a requirement under Education Code 49428 that states schools are to inform students and families, at least twice per year, how to access available mental health services on campus or in the community. The primary method most schools use is the parent and student handbook and their website. These tools are minimally accepted as sufficient.

In 2017, Stanislaus County Office of Education (SCOE) became acquainted with NAMI on Campus when Stanislaus was invited to host an event in Central California to introduce Nami on Campus. The one-time event, a collaboration between NAMI California and California Dept. of Education (CDE), was free to the local high school chosen. Stanislaus County Office of Education's role was to provide local level coordination for NAMI California to present their Campus High School program to Stanislaus County high schools. SCOE arranged for a venue (Patterson High School) and helped coordinate the training by distributing the invitation to local high schools. Seventy-six (76) students representing seven (7) high schools participated. Though the response was very positive, there was no local funding, administrative or systemic structures in place to sustain the interest.

In Stanislaus County there is now a need to enhance and expand communication about mental health issues among students. The best method for sharing information on high school campuses is through student leadership and peers through schoolwide outreach events. The Countywide NAMI on Campus coalition proposed here would conduct new and expanded outreach strategies to help reduce stigma and educate peers on how to access mental health services.

3. **Which MHSA definition of an Innovation Program applies to your new program, i.e. how does the Innovation Program a) introduce a new mental health practice or approach; or b) make a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community; or c) introduce a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting? How do you expect your Innovation Program to contribute to the development and evaluation of a new or changed practice within the field of mental health?**

   This project introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting by starting a NAMI on Campus club on high school campuses in Stanislaus County using Protecting Health and Slamming Tobacco (PHAST) Youth Coalition. PHAST is proven effective model for youth leadership, development and organization that paired with NAMI on Campus Clubs will advance the mental health outreach efforts in high schools across the county.

   PHAST is a 1,200-member coalition of very committed students who promote healthy lifestyles and the avoidance of tobacco products. A key factor to the success of this program is the strong countywide coordination of student clubs organized at all high school in Stanislaus County. The backbone organization is SCOE and an effective collaborative leadership network also includes the Stanislaus County Health Services Agency (HSA) and Sutter Health's Memorial Medical Center. This strengthened level of countywide coordination, when applied to NAMI on Campus, is expected to propel and sustain the local growth of student organizations in high schools that will equip and train students to conduct mental health outreach and destigmatize mental illness.

   This approach has the potential to create a culture shift on campuses. As with the PHAST model the impact of the work of students is evident in the fact that youth tobacco-use rates continue to decline across Stanislaus County and consistently fall below the statewide average which saw a significant drop in tobacco product usage. This model of county-coordination and support of a youth club network has proven so highly effective in the tobacco prevention field that the California Department of Education (CDE) now requires a youth development component of all Tobacco-Use Prevention Education (TUPE) grants across the state. Applying this model to NAMI on Campus High School (NCHS) project is an innovation that is expected to succeed.

4. **Describe the new or changed mental health approach you will develop, pilot, and evaluate. Differentiate the elements that are new or changed from existing practices in the field of mental health already known to be effective.**

   NAMI on Campus High School was developed by the National Alliance on Mental Illness (NAMI) with the goal to "end stigma by raising awareness that mental illness is not rare and should be treated like any other kind of medical condition" (NCHS Affiliate Coordinator Manual 2017, Volume 2).

   Originally developed for colleges, NAMI on Campus was later adapted for and tested in high schools through a partnership between the California Department of Education and Placer County Office of Education. The NAMI California website describes the program as "student-led clubs that raise mental health awareness and reduce stigma on campus through peer led activities and education. Student Leaders will be empowered with toolkits, materials, templates and resources to make running the club a fun and educational process. Student leaders attend training to learn about mental health and being advocates on campus. The Club is open to all students--those with mental health conditions, those with family members with a condition, or students who are interested in the field or in advocacy. Club leaders and members become advocates within their school and local community, and work towards creating a more positive and mental health-

supportive school environment". This statement aligns with the intent of this project.

The PHAST Coalition in Stanislaus County was formed in 2004 with an initial group of four schools and 35 student members. Through the coordinated support of SCOE serving as a backbone organization to all clubs and partner organizations, PHAST grew to a booming 1,200 students from 73 junior and senior high schools across Stanislaus County. Members educate their peers through direct peer-training and campus outreach events, which they organize at their school sites regularly throughout the year and created a culture shift regarding tobacco use. With the exception of perhaps Future Farmers of America, PHAST model is unrivaled by any other school extracurricular club.

This INN project "Countywide NAMI on Campus" blends the two programs; PHAST model for proven effective structure and NAMI on Campus for creating greater access to mental health and a culture shift regarding seeking help for mental health issues. In the development of this project, there was no finding to indicate that this combination has ever been done before.

Strategic collaboration with NAMI Stanislaus and NAMI California, SCOE intends to ensure the values and resources of NAMI are effectively represented in the NAMI on Campus High School Project. Local collaboration proposes to eliminate gaps and increase coordination between local NAMI affiliate and individual school districts throughout Stanislaus County.

To develop this project, SCOE staff researched the effectiveness of NAMI on Campus High School, evidence available on the impact of youth advocacy and local project evaluation reports produced during implementation of PHAST over the past 15 years.

NAMI California succinctly states the purpose of NCHS Clubs:

- Educate and increase the awareness of students, teachers, faculty, and school administration about mental health and wellness
- Be supportive of students who are living with mental illness
- Provide information on school and community resources
- Encourage people to recognize early signs of mental illness
- Encourage students who are having mental health issues to get help
- Work to end the stigma that surrounds mental illness
- Create an inclusive, safe, and supportive school environment
- Let students know there is help available if they need it

Academic research journals were also reviewed, with one specific article including a solid literature review of the positive outcomes of Youth Participatory Action Research (YPAR). This article was published in the *Journal of Research on Educational Effectiveness*, v11 n3 p433-451 2018 and is specifically referenced in the next section of this narrative, "Expected Mental Health Outcomes".

Project Description:

Through this INN project, SCOE will build a countywide NAMI on Campus High School hub to help strengthen the combined efforts and leverage resources across 15 high schools in Stanislaus County.

A county-wide network of NCHS clubs in 15 high schools across the county with more than 150 students will be recruited, trained and equipped to organize on-campus mental health outreach and advocacy activities at their respective schools. Each school district currently has a crisis intervention policy and procedure in place, as required by AB 2246. Each district's crisis intervention policy and procedure will be reviewed as a part of the NCHS student leader training to provide a safety net for students in crisis.

This INN project anticipates reaching thousands of students through two annual outreach campaigns; one focusing on suicide prevention and the other focusing on general mental health awareness and stigma reduction. Students will lead communication efforts to inform peers on how to access available mental health services in the county. This work will contribute to learning about reducing stigma, increasing knowledge on the signs and symptoms of mental health problems and how to improve access to mental health services.

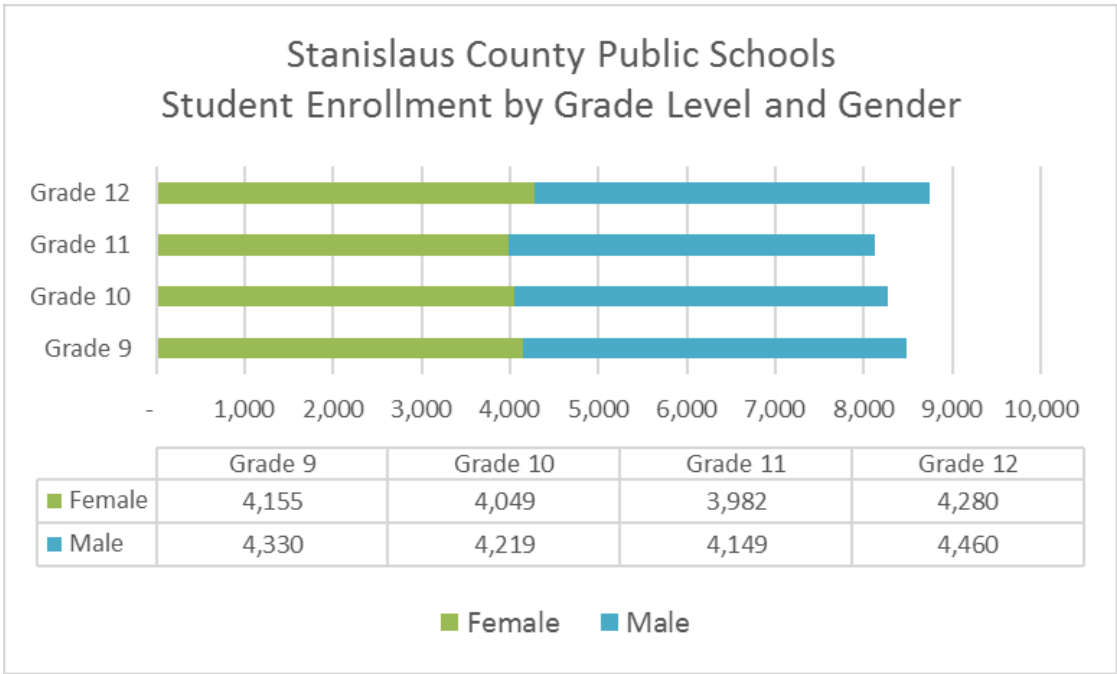
The learning described in this proposal is important to our community because we often find schools, agencies and other groups of concerned people frustrated by the difficulties of collaboration. Their efforts to make a difference in the community can be strengthened by binding together their work through a hub of coordinated supports and resources. This is hoped to help maximize impact in achieving the desired outcome to destigmatize mental health problems and increase access to services.

An effectively coordinated network by SCOE, the "backbone" organization will also demonstrate the importance and value of a countywide support structure to lead the coordination work of NCHS. Successful implementation and significant outcomes may also show the value of investing in this type of high school project and help in sustaining the countywide network into the future.

4a. If applicable, describe the population to be served, including demographic information relevant to the specific Innovation Program such as age, gender identify, race, ethnicity, sexual orientation, and language used to communicate.

It is not known which 150 students in the 15 High Schools, Continuation, Community or Alternative Education schools, throughout Stanislaus County will come forth to take a leadership role in the NCHS INN project. SCOE is committed in its efforts to seek a diverse group of students to participate in leadership roles within the INN project. To account for and be responsive to the cultural needs of the student populations at the various sites, the project will utilize the existing support structure in each district inclusive of any parent teacher groups as well as student liaisons.

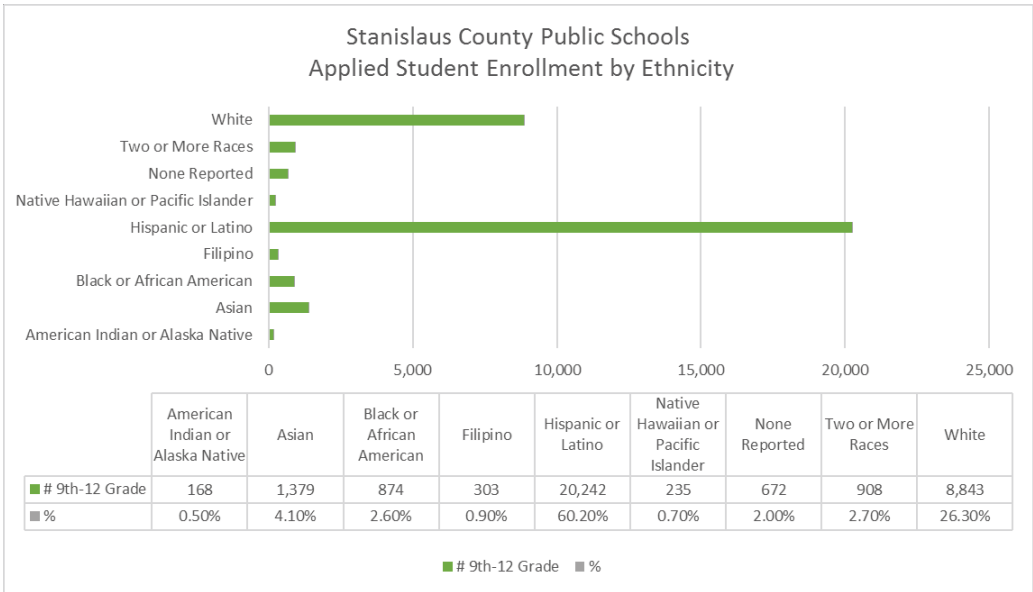
County-wide student demographics are presented in the following graphs:



	Grade 9	Grade 10	Grade 11	Grade 12
Female	4,155	4,049	3,982	4,280
Male	4,330	4,219	4,149	4,460

A total of 33,624 students, grades 9th-12th, were identified in the 2017-2018 CDE, California Longitudinal Pupil Achievement Data System (CalPADS) collection-day survey in October 2017. Student enrollment data for Stanislaus County public schools across grades Kindergarten-12th, find that 48.97 percent are female, and 51.03 percent are male. These percentages have been applied to represent the Stanislaus County public school students, grades 9th-12th enrollment data.

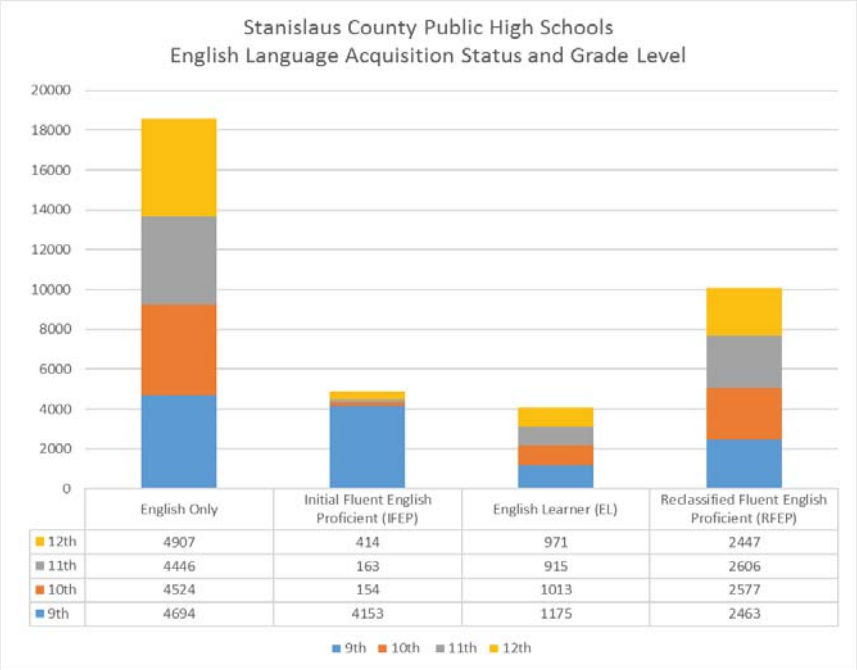
The general population of Stanislaus County high school students who may participate in the NCHS outreach campaigns are demonstrated in the 2017-2018 county-wide summary data from the California Department of Education (CDE) retrieved from Ed-Data.org on June 7, 2019.



	American Indian or Alaska Native	Asian	Black or African American	Filipino	Hispanic or Latino	Native Hawaiian or Pacific Islander	None Reported	Two or More Races	White
# 9th-12 Grade	168	1,379	874	303	20,242	235	672	908	8,843
%	0.50%	4.10%	2.60%	0.90%	60.20%	0.70%	2.00%	2.70%	26.30%

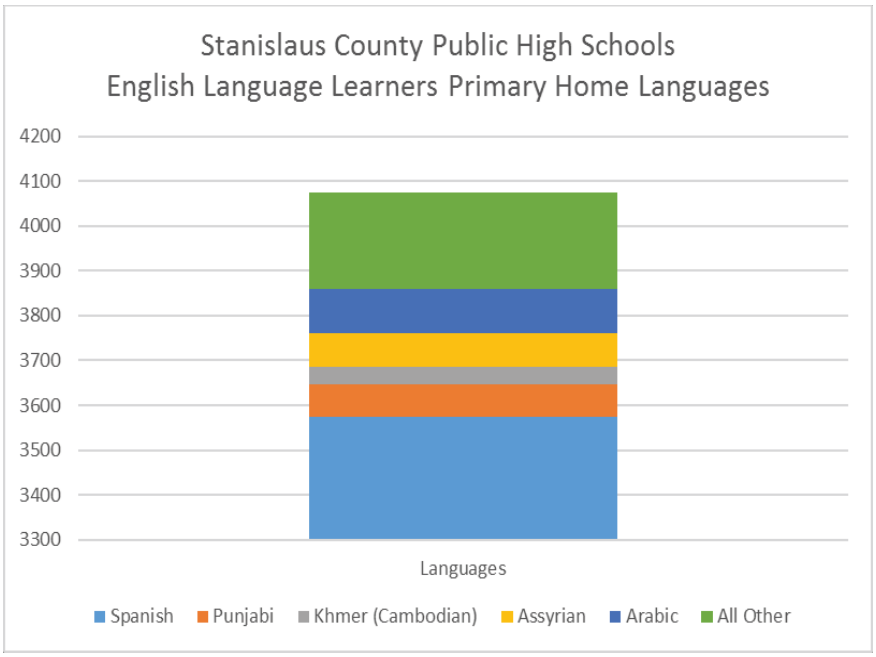
Enrollment data of Stanislaus County Public School students demonstrate an ethnically diverse group. The graph above applies the percentage of enrollment by ethnicity of the general Stanislaus County public school student population to the 9th-12th grade enrollment data.

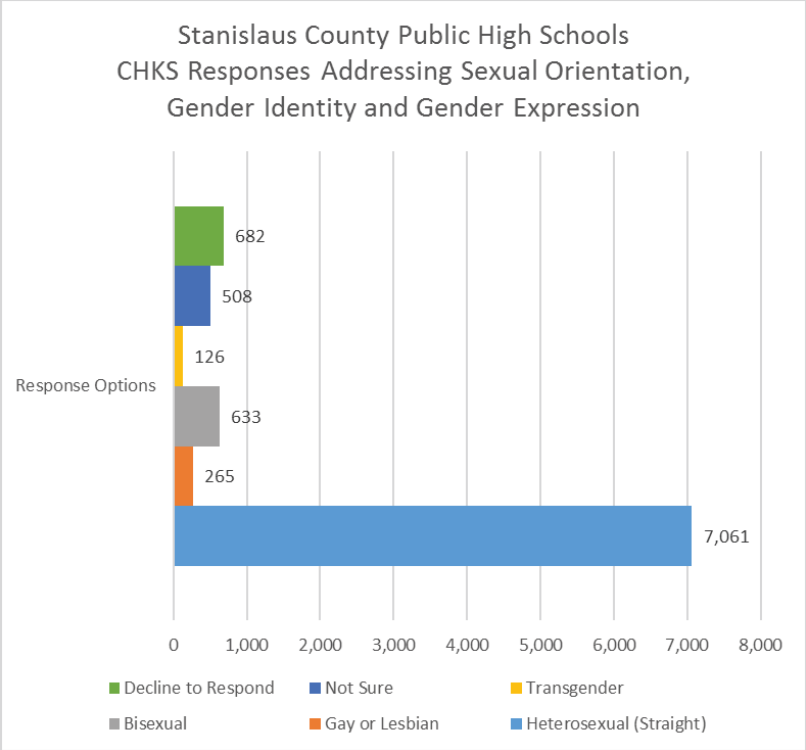
In addition to “English Language Learners” (EL), students reporting a language other than English is spoken at home may also be classified as “Initial English Fluent Proficient” (IFEP) and “Reclassified Fluent English Proficient” (RFEP). The following chart demonstrates 9th-12th grade enrollment of Stanislaus County Public High School students on the spectrum of English language proficiency.



	English Only	Initial Fluent English Proficient (IFEP)	English Learner (EL)	Reclassified Fluent English Proficient (RFEP)
12th	4907	414	971	2447
11th	4446	163	915	2606
10th	4524	154	1013	2577
9th	4694	4153	1175	2463

More than 2.6 million California public school students speak a language other than English in their homes. This number represents 42.8 percent of the state’s public school enrollment. In Stanislaus County the five predominant non-English languages include: Spanish, Punjabi, Khmer (Cambodian), Assyrian and Arabic. The graph below identifies the 2017-2018 proportion of languages spoken for Stanislaus County High Schools students who are identified as “English Learners”. The “All Other” category encompasses over 65 languages not including those listed above.





In 2016-2017 a question addressing sexual orientation, gender identity and gender expression was included in the 118-question California Healthy Kids Survey (CHKS) administered to 9th and 11th grade students in eleven Stanislaus County school districts. The multiple-choice question, "Which of the following best describes you? *(Mark All That Apply)*" was administered to 8,529 students (52.34 percent of the 9th and 11th graders). The responses in the CHKS can be used to examine sexual orientation of high schools students in Stanislaus County. The survey response options were, "Heterosexual", "Gay or Lesbian", Bisexual, Transgender", "Not Sure" or "Decline to Respond". The responses are summarized in the chart below. *Note: students were able to choose more than one answer, resulting in approximately 9,275 responses.*

4b. If applicable, describe the estimated number of clients expected to be served annually.

This INN project takes a county-wide focus that involves recruitment of 15 high schools within Stanislaus County to participate in the project and launch NCHS clubs. Project activities include mental health outreach and education activities at these 15 high schools with the potential to reach 100 percent of the student population within those schools. More than 150 students will be recruited, trained and equipped to organize on-campus mental health outreach and advocacy activities at their respective schools. Through this outreach we expect to reach thousands of students throughout Stanislaus County and among those students there are individuals with or at risk of mental illness.

Each participating campus will have a NCHS Club with a club advisor (school faculty) who is familiar with the school's mental health resources and student safety plan.

4c. Describe briefly, with specific examples, how the Innovation Program will reflect and be consistent with all relevant (potentially applicable) Mental Health Services Act General Standards set forth in Title 9 California Code of Regulations, Section 3320. If a General Standard does not apply to your Innovation Program, explain why.

Community Collaboration: This proposal is designed around a model proven to be effective in strengthening cross-system collaboration among a broad range of stakeholders. Through effective collaboration and coordination of resources from multiple community stakeholders, SCOE has built a network of tobacco prevention clubs that has amassed a coalition membership of 1,200 students across 73 schools. This same model of collaboration, applied to mental health outreach, is the focus of innovation in this proposal.

Cultural Competence: SCOE works to ensure student recruitment in leadership programs represents a county-wide and culturally diverse community. Student demographics are collected both in membership forms and through the survey data collected during regular program implementation. SCOE also contracts at least annually with experts in the field of cultural competency to ensure staff are trained in the latest emerging trends and proven practices to ensure the diverse needs of our population are met. SCOE will continue to implement these standards in the management of this project.

Client-Driven: The very heart of the PHAST model is the recruitment and empowerment of the students we serve. The target population in this project is high school students. Students will regularly be involved in program planning and development, training and capacity building, carrying out project activities, and project evaluation. Students are and will always be the drivers and focus of these projects.

Family-Driven: Each NCHS club will use a membership form to formally welcome students into the club. This form will not only serve as a parental permission slip and photo release, it will also be used to communicate with families about the leadership role their child will assume within the program. Additionally, NCHS clubs will participate in the development and dissemination of materials to inform fellow students and their families how to access mental health supports in schools. In the development of these materials, drafts will be field tested with families to ensure the information is clear and easy to understand.

Wellness, Recovery and Resilience-Focused: Some of the top factors in building resilience is helping students identify protective factors in their lives. A key component in the outreach of NCHS clubs is helping students identify supports and how to identify signs of potential mental health problems. NCHS also promotes a message that mental illness is not uncommon and could be seen like other illnesses. This helps normalize the experience of mental health problems and promote wellness through access to treatment and other appropriate supports.

Integrated Services Experience for clients and families: While this project will not specifically focus on providing services, it will strive to offer access and information that communicates the best strategies and sources of support to assist people with mental health problems.

4d. If applicable, describe how you plan to protect and provide continuity for individuals with serious mental illness who are receiving services from the Innovative Project after the end of implementation with Innovation funds.

The INN project does not include direct clinical or medical services of any kind. Additionally, there are no support groups or sources of treatment within the INN project. There are, however, club advisors, school counselors, and student safety plans to support the Innovation Project. As an INN project offering

The INN Project Coordinator will identify existing SCOE policy/procedure and develop new policy/procedure related to how students, advisors and other project staff will handle service referrals in the community. Training for all INN project staff will include information on how to assist students needing referral to other agencies and steps to manage crisis. Student leaders will be trained in offering crisis support and referral processes as well. The project will also engage the school safety plans currently in place for students.

Data collection for measurement of project outcomes and learning objectives will include tracking all referrals out and (if possible) whether the referral was successful.

5. **Specify the total timeframe of the Innovation program. Provide a brief explanation of how this timeframe will allow sufficient time for the development, time-limited implementation, evaluation, decision-making, and communication of results and lessons learned. Include a timeline that specifies key milestones for all of the above, including meaningful stakeholder involvement.**

The project is proposed to be a five-year project. It is an ambitious 5-year innovation project to cause a culture shift in participating high schools throughout Stanislaus County and demonstrate to other County's what is possible with NAMI on Campus.

Key Activity:
August 2019: 30-day public review/comment period
September 2019: Public Hearing by Behavioral Health Board
October 2019: Board of Supervisors Approval
November 2019: Obtain State-MHSOAC approval of the INN project.

First Year of INN project:

First Quarter
- Selected contract provider to begin implementing the INN project
- Start-up activities; develop mental health education and other informational materials, establish policy/procedures for referrals and handling crisis, develop evaluation tools
- Host an advisor orientation and training for all club advisors from each participating site
- Provide mental health educational and other information materials to all advisors for dissemination through their campus activities
- Meet with BHRS Innovation Project Manager for contract monitoring and mentoring
- Participate in reporting to MHSA Stakeholder group

Second Quarter
- Host the first of three advisors network leadership meetings
- Hold the annual Stanislaus County NAMI on Campus Leadership Conference
- Provide mental health campaign and outreach materials for the first annual campaign
- Campus clubs will carry out activities in support of the first of two annual mental health outreach campaigns to focus on suicide prevention or general mental health awareness
- Club advisors to submit first bi-annual activity report to SCOE
- Project Evaluator finalizes methodology for data collection including measurement tools, frequency of measurement, sources of data and expected outcomes in project evaluation
- Meet with BHRS Innovation Project Manager for contract monitoring and mentoring
- Participate in reporting to MHSA Stakeholder group

Third Quarter

- Host the second of three advisors network leadership meetings
- Provide mental health campaign and outreach materials for the second annual campaign
- Campus clubs will carry out activities in support of the second of two annual mental health outreach campaigns to focus on suicide prevention or general mental health awareness
- Project Evaluator and Project Director meet with student stakeholders to begin assessment of project outcomes and related data
- Project Evaluator begins to compile and make any adjustments to data collection and analysis
- Meet with BHRS Innovation Project Manager for contract monitoring and mentoring
- Participate in reporting to MHSA Stakeholder group

Fourth Quarter

- Host the third of three advisors network leadership meetings
- Organize a countywide social media campaign among youth to promote mental health awareness month
- Recruit NCHS student members to participate in community-based mental health awareness month events
- Prepare annual reports for dissemination then develop and schedule outreach presentations to communicate successes to partner agencies, stakeholders and school boards
- Meet with BHRS Innovation Project Manager for contract monitoring and mentoring
- Participate in reporting to MHSA Stakeholder group

Key Activities in Overall Project Timeline

Year 1 (2019-2020)

- Launch the project, hire staff and recruit 10 school sites to organize NCHS clubs
- Develop evaluation tools and train staff and students on use
- Establish partnership with NAMI Stanislaus to collaborate on training and support for NCHS clubs

Year 2 (2020-2021)

- Stabilize 10 initial NCHS clubs, assist with recruit to boost membership levels and ensure sustained participation
- Make any grant work plan adjustments to ensure success through the end of the project term

Years 3-5 (2021-2024)

- Recruit an additional 5 school sites to organize NCHS clubs, use lessons learned during initial recruitment and startup to strengthen the process of adding new clubs
- Evaluator and Project Director meet with student stakeholders to assess project and how final data has answered learning questions
- Complete data collection from referral partners & other stakeholders
- Evaluator begins final evaluation of project outcomes and contribution to learning
- Complete end of project transition for participants and staff
- Explore funding opportunities that will allow for ongoing support of the project

6. **Describe how you plan to measure the results, impact, and lessons learned from your Innovation Program. Specify your intended outcomes, including at least one outcome relevant to the selected primary purpose, and explain how you will measure those outcomes, including specific indicators for each intended outcome. Explain the methods you will use to assess the elements that contributed to outcomes. Explain how the evaluation will assess the effectiveness of the element(s) of the Innovative Project that are new or changed compared to relevant existing mental health practices. Describe how stakeholders' perspectives will be included in the evaluation and in communicating results. Explain how your evaluation will be culturally competent.**

The INN Project will address the primary purpose of increasing access to mental health services and the local learning question of "accessing needed behavioral health services is problematic for people". The main focus of this project is to study if new and expanded outreach activities can increase access to mental health services.

The INN project will utilize a mixed methods evaluation that incorporates both process evaluation and outcome evaluation components. A mixed methods approach includes collecting data related to quantitative measures of numbers served, while also gathering qualitative input from student attitudinal surveys in participating student groups and non-participating student groups. Using multiple sources to explore the evaluation questions also enables comparison and corroboration of findings across the data sources.

Data regarding how much (quantitative) program activity occurs includes: number of student leaders recruited, trained and equipped to organize on-campus mental health outreach and advocacy activities at their respective schools, as well as number of students reached in through two annual outreach campaigns information, demographic information describing students, number of activities completed.

The learning questions to be studied through this innovation project are:

1) Can adopting new and expanded outreach strategies improve overall access for people in need of services?
2) Can adopting new and expanded outreach strategies decrease stigma of mental health problems among high school students?
3) Will coordinated cross collaboration among SCOE, NAMI and school districts increase and sustain mental health outreach and education at high school campuses?
4) Will student participation in mental health outreach increase protective factors* and improve well-being** among high school students?

* Protective factors including caring relationships, healthy habits, Interpersonal skills, self-management skills, opportunity for participation

**Well-being - a feeling of satisfaction in regard to relationships, goals, health, safety, success... among others. Well-Being Survey attached.

Defining and Measuring Success:

Issue	Related Learning Question	Expected Outcomes	Performance Measures	Measurement/ Frequency/ Methodology	Measurement Tool/Data Source
Students have limited **access** to information and support to seek help	#1 Can adopting new and expanded outreach strategies **improve overall access** for people in need of services?	Increase in knowledge regarding accessing mental health services	# of students reached # of mental health outreach and education events	Twice per school year Annually	Project to track actions taken to connect student to services (# of activities) Activity Reports
Stigma prevents students from asking for help	#2 Can adopting new and expanded outreach strategies **decrease stigma** of mental health problems among high school students?	Change in attitudes and knowledge regarding stigma about mental health	# of students reporting harassment in the past 12 months due to mental health illness	Every-other year	Student attitudinal survey - California Healthy Kids Survey (CHKS)
There is no coordinated cross-collaboration to provide mental health **outreach and education** at local high schools.	#3 Will coordinated cross-collaboration among SCOE, NAMI and school districts increase and sustain mental health outreach and education at high school campuses?	Increase student access to available resources Increase the number of student advocates to support their peers seeking help. Increase the number of students that believe there are support systems on campus, and someone on	# of students reached # of mental health outreach and education events # of student leaders # of students expressing there is someone on campus that cares about them	Annually/ Twice per school year/ Every-other year	Activity reports Key informant interviews Satisfaction survey Student attitudinal survey (CHKS)

		campus cares about them.			
Uncoordinated outreach and support contribute to students not seeking support	#4 Will student participation in mental health outreach increase protective factors and improve well-being among high school students?	Increase protective factors (Caring Relationships, Healthy Habits, Interpersonal Skills, Self-Management Skills, Opportunity for Participation) among students and improve well being	Self-reported well-being rating among students # of protective factors (Caring Relationships, Healthy Habits, Interpersonal Skills, Self-Management Skills, Opportunity for Participation) reported among students	Annually Every other year	Community Wellbeing Survey Student attitudinal surveys (CHKS)

7. Project Sustainability and Continuity of Care: Describe how the County will decide whether and how to continue the Innovative Project, or elements of the Project, without Innovation Funds. Specify how stakeholders will contribute to this decision.

Project milestones and data will be shared with stakeholders in the MHSA Annual Update reach year of the project. At the project's end in FY 23-24, the final evaluation report along with BHRS' recommendations will be shared with stakeholders and the general public. If the project demonstrates a measurable effect, the program may be considered for further funding under MHSA funding (PEI or CSS).

8. Communication and Dissemination Plan

The findings from this project will be distributed as final written report to the MHSOAC, published on the Stanislaus County Behavioral Health and Recovery web site and a PowerPoint presentation at MHSA stakeholder meeting. Project findings will be shared at agency partner websites, as well as other organizations; NAMI on Campus, individual school districts. Presentations at state-wide education (e.g. CDE) and mental health conferences (e.g.CMHACY) may also be included.

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

   This innovation project is leveraged by the existing program supervision, fiscal and administrative support and expertise of Stanislaus County Office of Education funded through federal and state sources. See budget narrative for details.

10. **Provide an estimated annual and total budget for this Innovation Program, utilizing the following line items. Please include information for each fiscal year or partial fiscal year for the Innovation Program.**

NAMI ON CAMPUS HIGH SCHOOL INNOVATION PROJECT

BUDGET NARRATIVE

The proposed budget for Countywide NAMI on Campus is intended to improve mental health awareness and reduce the stigma on high school campuses throughout Stanislaus County.

PERSONNEL COSTS **$145,562 year 1**
$151,658 year 2
$158,095 year 3
$163,647 year 4
$169,471 year 5

Countywide NAMI on Campus will be implemented and managed by the Youth Programs Coordinator working within the Stanislaus County Office of Education, Prevention Programs department, focused on awareness, education, stigma reduction and advocacy. Personnel costs include full-time salary and benefits for the Youth Programs Coordinator (1.0 FTE) at $113,370 annual salary, year 1 ($69,885 annual salary; $33,366 fringe benefits, and indirect costs $10,740 (9.8%) for 261 workdays (2,088 hours annually). With annual step increases of 5% projected through-out the five-year cycle, personnel costs for the Youth Programs Coordinator are anticipated to be: year 2, $118,368 ($73,372 salary, $34,431 fringe, $10,565 indirect); year 3, $123,650 ($77,047 salary, $35,567 fringe, $11,036 indirect); year 4, $129,203 ($80,910 salary, $36,761 fringe, $11,532 indirect); year 5, $135,026 ($84,961 salary, $38,014 fringe, $12,051 indirect).

Other funding is provided for program supervision, fiscal and administrative support through federal and state funding sources, in accordance with their directive and apart from Innovative MHSA Funds. Personnel costs from other funding for direct supervision and support for NAMI on Campus includes the Director of Safe and Supportive Schools (.05 FTE), Fiscal and Grants Analyst (.05 FTE) and Event Planning Specialist (.20 FTE), with annual step increases as required. Personnel costs are projected to be: year 1, $32,193 ($29,320 salary and fringe, $2,873 indirect); year 2, $33,291 ($30,320 salary and fringe, $2,971 indirect); years 3-5 show no anticipated COLA or step increases, and will remain constant at, $34,445 annually ($31,371 salary and fringe, $3,074 indirect). Total personnel costs, including salaries, benefits and indirect costs are $788,484 for the five-year cycle.

OPERATING COSTS **$31,505 annually, years 1-2**
$37,956 annually, years 3-5

Operating costs will remain mostly constant during the five-year span with an exception in the areas of event supplies and promotional outreach materials due to anticipated program expansion. Annual operating costs for projected participation of 10 schools with 10 students, and 1 advisor per NAMI on Campus club for years one and two, and 15 schools with 10 students, and 1 advisor for years three through five.

- General office supplies, such as paper, pens, presentation folders to be purchased for program support including, but not limited to quarterly advisor meetings, orientations, contract generation and administration by the Youth Programs Coordinator ($400 annually across all five years).
- Duplication costs for student event materials, evaluation and advisor communication, training manual and recruitment resources ($200 annually across all five years).
- NAMI on Campus Leadership Conference participant supplies such as, but not limited to lanyards, notepads, pens will be provided to students attending the annual event (100 students x $5 = $500 per year in years one and two, and 150 students x $5 = $750 for years three through five).
- NAMI on Campus Club t-shirts will be distributed to students attending the leadership conference and affirming their membership in the school's club ($1,000 in years one and two, $1,500 in years three through five).
- Meals for annual NAMI on Campus conference for student leaders and club advisors attending the full-day conference hosted by Stanislaus County Office of Education annually. ($25/person for breakfast and lunch x 110 students and advisors = $2,750 per year in years one and two, and $25/person x 165 students and advisors = $4,125 for years three through five).
- Mental Health outreach and campaign materials such as, but not limited to pens, pencils, ribbons and wristbands for NAMI on Campus clubs to distribute during campus Mental Health Awareness Month and Suicide Prevention Week campaign activities ($750 per year for 10 schools in years one and two = $7,500, and 15 schools in years three through five = $11,250).
- Mental health education materials such as, but not limited to brochures, reference cards and fliers will be distributed and serve to promote available services and provided parents information about how to access community resources at all targeted schools ($1 each for 11,211 high school students, annually).
- Stanislaus County Office of Education Network Services provides and maintains standard network software and offers unlimited hardware and software support and service calls. This includes internet usage/access and setup and support all technology devices for the Youth Programs Coordinator ($1,000 annually)
- Youth Programs Coordinator's annual membership of the NAMI California affiliate for years one through five ($40).
- Travel and registration for the Youth Programs Coordinator to attend statewide training for NAMI on Campus Annual State Conference. (NAMI California 2-day

Conference registration 1 @ $170; Lodging for 2 nights @ $194/night x 2 = $388; Roundtrip airfare = $364; Parking = $10/day x 3 days = $30; 2 breakfast @ $13 x 2 = $26; 2 lunch @ $15 = $30; 2 dinner @ $27 x 2 = $54; Personal auto mileage to and from Sacramento 180 miles @ .58/mile = $98 for years one through five = $1,160).

- Travel and registration for the Youth Programs Coordinator to attend the California Mental Health Advocate for Children and Youth (CMHACY) Annual Conference (CMHACY 4-day Conference registration and meals = $450; Lodging for 3 nights @ $317/night x 3 = $951; Personal auto mileage to and from Monterey 254 miles @ .58/mile = $139; Conference total for years one through five = $1,540).
- Local mileage for Youth Programs Coordinator to travel among targeted school sites and participating districts to provide support and training to NAMI on Campus high school clubs for years one through five ($.58/mile x 200 miles per month x 12 months = $1,392 annually).
- Indirect costs attributed to the Operating Costs are $2,812 ($28,693 x 9.8%) annually for years one and two, and $3,388 ($34,568 x 9.8%) annually for years three through five ($ x 9.8%).

NON-RECURRING COSTS **$8,730, year 1**
$2,745, year 3

- Workstation equipment for newly hired Youth Programs Coordinator including a Dell laptop computer, monitor, docking station ($2,732) and desktop phone ($219) for year one.
- NAMI on Campus Club Toolkits will be assembled and distributed to high school sites who agree to participate and promote Mental Health Awareness activities on their campus at events such as, but not limited to informational booths, health fairs, pledge walls, carnivals, rallies and other school or community events. Projected participation is 10 high schools during years one and two and 15 schools for years three through five. NAMI on Campus Toolkits consist of items such as, but not limited to a Prize Wheel, Tablecloth with logo, promotional outreach materials, informational brochures and posters and flags (10 toolkits x $500 for year one = $5,000 and 5 toolkits x $500 = $2,500 for year three)
- Indirect costs attributed to the Non-Recurring Costs are $779 ($7,951 x 9.8%) for year one and $245 ($2,500 x 9.8%) for year three.

CONSULTANT COSTS/CONTRACTS **$19,764 annually, years 1-2**
$25,254 annually, years 3-5

- A Project Evaluator will be contracted, whose primary role is to compile and analyze data using proven statistical models. The Project Evaluator will develop tools and analyze project data collected by the Youth Programs Coordinator and NAMI Club Advisors. The Evaluator will produce annual evaluation reports

detailing the project process and outcome measures. The Evaluator will work closely with the Youth Programs Coordinator to ensure the project is implemented with fidelity and to promote project success over the five-year project. (100 hours x $60/hour = $6,000).

- A keynote speaker will be contracted to deliver presentations at the annual NAMI on Campus student leadership conference for years one through five and provide information such as but not limited to coping with mental health, supporting peers and leading youth outreach activities ($2,000 annually).
- NAMI on Campus school clubs will be supported by a club advisor who will work closely with site administrators to create support for the program, advise students in the coordination for school site activities for Mental Health Awareness Month and Suicide Prevention Week events, file monthly activity reports deemed essential for project evaluation, assist in the coordination of the annual NAMI on Campus student leadership conference and attend quarterly NAMI on Campus Advisor meetings. The NAMI on Campus Club Advisor will receive a stipend in the amount of $1,000 annually. Allocation is based on projected participation of 10 high schools for years one and two ($1,000 x 10 schools = $10,000) and 15 schools for years three through five ($1,000 x 15 schools = $15,000).
- Indirect costs attributed to the Consultant Costs and Contract are $1,764 ($18,000 x 9.8%) annually for years one and two, and $2,254 ($23,000 x 9.8%) annually for years three through five ($ x 9.8%).

OTHER EXPENDITURES

No other expenditures are attributed to this project.

NAMI ON CAMPUS HIGH SCHOOL INNOVATION PROJECT

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Salaries	**$132,570**	**$138,122**	**$143,984**	**$149,041**	**$154,345**	**$718,064**
2.	Direct Costs	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
3.	Indirect Costs	**$12,992**	**$13,536**	**$14,110**	**$14,606**	**$15,126**	**$70,370**
4.	Total Personnel Costs	**$145,562**	**$151,658**	**$158,095**	**$163,647**	**$169,471**	**$788,434**
OPERATING COSTS		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
5.	Direct Costs	**$28,693**	**$28,693**	**$34,568**	**$34,568**	**$34,568**	**$161,090**
6.	Indirect Costs	**$2,812**	**$2,812**	**$3,388**	**$3,388**	**$3,388**	**$15,788**
7.	Total Operating Costs	**$31,505**	**$31,505**	**$37,956**	**$37,956**	**$37,956**	**$176,878**
NON RECURRING COSTS (equipment, technology)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
8.	Direct Costs	**$7,951**	**$0**	**$2,500**	**$0**	**$0**	**$10,451**
9.	Indirect Costs	**$779**	**$0**	**$245**	**$0**	**$0**	**$1,024**
10.	Total Non-recurring costs	**$8,730**	**$0**	**$2,745**	**$0**	**$0**	**$11,475**
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
11.	Direct Costs	**$18,000**	**$18,000**	**$23,000**	**$23,000**	**$23,000**	**$105,000**
12.	Indirect Costs	**$1,764**	**$1,764**	**$2,254**	**$2,254**	**$2,254**	**$10,290**
13.	Total Consultant Costs	**$19,764**	**$19,764**	**$25,254**	**$25,254**	**$25,254**	**$115,290**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
14.		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
15.		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
16.	Total Other Expenditures	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
BUDGET TOTALS							
Personnel (line 1)		**$132,570**	**$138,122**	**$143,984**	**$149,041**	**$154,345**	**$718,064**
Direct Costs (add lines 2, 5 and 11 from above)		**$46,693**	**$46,693**	**$57,568**	**$57,568**	**$57,568**	**$266,090**
Indirect Costs (add lines 3, 6 and 12 from above)		**$17,568**	**$18,112**	**$19,752**	**$20,248**	**$20,768**	**$96,447**
Non-recurring costs (line 10)		**$8,730**	**$0**	**$2,745**	**$0**	**$0**	**$11,475**
Other Expenditures (line 16)		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
TOTAL INNOVATION BUDGET		**$205,561**	**$202,927**	**$224,050**	**$226,857**	**$232,681**	**$1,092,076**

*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.

NAMI ON CAMPUS HIGH SCHOOL INNOVATION PROJECT

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)

ADMINISTRATION:

A.	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
1.	Innovative MHSA Funds	$167,369	$163,637	$183,605	$186,412	$192,236	$893,259
2.	Federal Financial Participation	$0	$0	$0	$0	$0	$0
3.	1991 Realignment	$0	$0	$0	$0	$0	$0
4.	Behavioral Health Subaccount	$0	$0	$0	$0	$0	$0
5.	Other funding*	$32,193	$33,291	$34,445	$34,445	$34,445	168,817
6.	**Total Proposed Administration**	$199,561	$196,927	$218,050	$220,857	$226,681	$1,062,076

EVALUATION:

B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
1.	Innovative MHSA Funds	$6,000	$6,000	$6,000	$6,000	$6,000	$30,000
2.	Federal Financial Participation	$0	$0	$0	$0	$0	$0
3.	1991 Realignment	$0	$0	$0	$0	$0	$0
4.	Behavioral Health Subaccount	$0	$0	$0	$0	$0	$0
5.	Other funding*	$0	$0	$0	$0	$0	$0
6.	**Total Proposed Evaluation**	$6,000	$6,000	$6,000	$6,000	$6,000	$30,000

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 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
1.	Innovative MHSA Funds	$173,369	$169,637	$189,605	$192,412	$198,236	$923,259
2.	Federal Financial Participation	$0	$0	$0	$0	$0	$0
3.	1991 Realignment	$0	$0	$0	$0	$0	$0
4.	Behavioral Health Subaccount	$0	$0	$0	$0	$0	$0
5.	Other funding*	$32,193	$33,291	$34,445	$34,445	$34,445	$168,817
6.	**Total Proposed Expenditures**	$205,561	$202,927	$224,050	$226,857	$232,681	$1,092,076

*If "Other funding" is included, please explain. ***Other funding is provided for program supervision, fiscal and administrative support through federal and state funding sources, in accordance with their directive and apart from Innovative MHSA Funds. (see Personnel Costs, in the budget narrative below)***