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INNOVATIVE PROJECT PLAN

Section 0: Multi-County Innovative Project Plan Participants

PROJECT TITLE:
Semi-Statewide Enterprise Health Record (EHR) Innovation

PROJECT DURATION:
FY 22/23-FY26/27

PARTICIPATING COUNTIES AND OVERVIEW:
Currently, there are 23 California Counties participating in the Semi-Statewide EHR project. This project brings Counties together to implement the CalMHSA build of the Streamline Healthcare Solutions Behavioral Health EHR "SmartCare". One Pilot and two implementation phases are planned: the Pilot Phase (go-live January 2023) and Phase I (go-live July 2023), with a projected Phase II planned for July 2024. Three counties are going live with SmartCare in the Pilot Phase: Glenn, Imperial, and Lake, with these remaining 20 counties going live in Phase I: Colusa, Contra Costa, Fresno, Humboldt, Kern, Kings, Marin, Mono, Nevada, Placer, Sacramento, San Benito, San Joaquin, San Luis Obispo, Santa Barbara, Siskiyou, Sonoma, Stanislaus, Tulare, and Ventura. Together, these counties are responsible for close to 4,000,000 beneficiaries, or 27% of the statewide Medi-Cal population. Nearly 14,000 staff members in these counties rely on EHRs as a key tool for accomplishing their work in the provision of behavioral health services.
Of the above counties, eleven have expressed interest in participating in this Innovative Project Plan and are preparing appendices to this submission. This month we are submitting the appendices for the three counties that have completed their full Community Program Planning Process (CPPP) per MHSOAC staff guidance. We intend to submit the County-specific narrative and budget appendices for the remaining eight counties in the upcoming months as they complete their CPPP.

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- ☒ **Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population**
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

CHOOSE A PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☐ 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

Section 2: Project Overview

PRIMARY PROBLEM OR CHALLENGE

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county. NOTE: the Appendices for each County using INN funds for this Project provide the reason(s) why they have prioritized this Project.

The Mental Health Services Oversight & Accountability Commission (MHSOAC) has long been a key facilitator of investments in the California Public Behavioral Health System. These investments are tuned to deliver on the promise of the Mental Health Services Act (MHSA), which envisioned transforming an under-resourced safety net system into a holistic, well-functioning and responsive array of services to meet the current and emerging needs of California residents. The MHSOAC has

identified levers for enabling transformational change, many of which rely on robust technology and data systems. Of utmost importance among county data systems is the Electronic Health Record (EHR). These records are used to document and claim Medi-Cal services that County Behavioral Health Plans (BHPs) provide and, if properly enhanced, can capture vital data and performance metrics across the entire suite of activities and responsibilities shouldered by BHPs.

California counties have joined together to envision an enterprise solution where the EHR goes far beyond its original purpose as a claiming system to a tool that helps counties manage the diverse needs of their population. The counties participating in the Semi-Statewide EHR have reimagined what is possible from the typical EHR system. We have identified three key aims:

1. Reduce documentation burden by 30% to increase the time our scarce workforce has to provide treatment services to our client population.
2. Facilitate cross county learning by standardizing data collection and outcomes comparisons so best practices can be scaled quickly.
3. Form a greater economy of scale so counties are able to test and adopt innovative practices with reduced administrative burden.

Currently, EHRs fall short in several important ways. Cumbersome designs result in delays and inefficiencies in accessing and documenting the information needed to make sound clinical decisions. Sub-optimal configurations for data tracking and reporting, leading to use of external spreadsheets and add-on databases, contribute to difficulties in evaluating individual client progress, monitoring program outcomes, and meeting crucial state and federal reporting requirements. Additionally, limited interoperability solutions impede timely data exchange to support effective clinical processes and managed care business functions, such as care coordination and provider network management.

Until now, BHPs have had limited options from which to choose when seeking to implement a new EHR. The majority of EHR vendors develop products to meet the needs of the much larger physical health care market, while the few national vendors that cater to the behavioral health market have been disincentivized from operating in California by the many unique aspects of the California behavioral health landscape. This has resulted in the majority of county BHPs being largely dissatisfied with their current EHRs, while having few viable choices when it comes to implementing new solutions.

In addition to the data and outcomes limitations detailed above, EHRs have also been identified as a source of burnout and dissatisfaction among healthcare staff that provide direct service to those seeking care. EHRs, which were first and foremost designed as billing engines, have not evolved to prioritize the user experience of either the providers or recipients of care. The impact of this design issue is telling – an estimated 40% of a healthcare staff person's workday is currently spent in documenting encounters, instead of providing direct client care.

The pervasive difficulties of 1) configuring the existing EHRs to meet the everchanging California requirements, 2) collecting and reporting on meaningful outcomes for all of the county BH services (including MHSA-funded activities), and 3) providing direct service staff and the clients they serve

with tools that enhance rather than hinder care have been difficult and costly to tackle on an individual county basis.

Clearly, this current moment provides both the opportunity and the imperative for counties to take a substantial leap forward with regard to EHRs. BHPs are treating an expanded Medi-Cal population in an increasing amount of distress and are being asked to provide meaningful solutions for societal issues from homelessness to mental health impacts of COVID-19. The California Advancing and Innovating Medi-Cal (CalAIM) initiatives are requiring swift adoption of highly technical changes and transformation of County BH service delivery systems. Clinical documentation redesign, payment reform and data exchange requirements to bring California BH requirements into greater alignment with national physical healthcare standards, thereby creating a lower-barrier entry to EHR vendors seeking to serve California. At the same time, the COVID-19 pandemic has increased the demand for behavioral health services, has disproportionately impacted communities of color, and has factored into the staggering workforce shortages faced by counties throughout California. BHPs need to foundationally revamp their primary service tool to meet the challenges and opportunities of this moment. BHPs, in partnership with CalMHSA are positioned to do just that through the Semi-Statewide Enterprise Health Record initiative.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) Provide a brief narrative overview description of the proposed project.

This is a multi-county, scalable INN project that stems from a larger, Semi-Statewide Enterprise Health Record Project CalMHSA is concurrently leading (hereafter referred to the EHR Project). CalMHSA is currently partnering with 23 California Counties – collectively responsible for twenty-seven percent (27%) of the state's Medi-Cal beneficiaries – to join together as a Semi-Statewide Enterprise Health Record project. This project is unique in that it engages counties to collaboratively design a lean and modern EHR to meet the needs of counties and the communities they serve both now and into the intermediate future. The key principles of the EHR project include:

- Enterprise Solution: Acquisition of an EHR that supports the entirety of the complex business needs (the entire "enterprise") of County BHPs. This approach also facilitates data sharing between counties for patient's treatment and payment purposes as patients move from one county to another.
- Collective Learning and Scalable Solutions: Moving from solutions developed within individual counties to a semi-statewide cohort allows counties to achieve alignment, pool resources, and bring forward scaled solutions to current problems, thus reducing waste, mitigating risk, and improving quality.
- Leveraging CalAIM: CalAIM implementation represents a transformative moment when primary components within an EHR are being re-designed (clinical documentation and Medi-

Cal claiming) while data exchange and interoperability with physical health care towards improving care coordination and client outcomes are being both required and supported by the State.

- Lean and Human Centered: CalMHSA will engage with experts in human centered design to reimagine the clinical workflow in a way that both reduces "clicks" (the documentation burden), increases client safety and natively collects outcomes.
- Interoperable: Typically, behavioral health has, in response to state regulations, developed documentation that is out of alignment with data exchange standards. We are reimagining the clinical workflow so critical information about the people we serve is formatted in a way that will be interoperable (standardized and ready to participate in key initiatives like Health Information Exchanges (HIEs).

CalMHSA will serve as the Administrative Entity and Project Manager. Counties have previously participated in and provided robust input to CalMHSA during the collaborative learning phase that culminated in the Request for Proposal (RFP) seeking a new EHR vendor. Counties additionally participated in the EHR vendor selection process and will continue to provide their input throughout implementation of the EHR project.

Streamline Healthcare Solutions, LLC is the vendor selected for the development, implementation, and maintenance of the Semi-Statewide EHR.

As the Evaluation vendor, RAND will assist in ensuring the INN project is congruent with quantitative and qualitative data reporting on key indicators, as determined by the INN project. These indicators include, but may not be limited to, impacts of human-centered design principles with emphasis on provider satisfaction, efficiencies, and retention. In addition, RAND will subcontract with a subject matter expert in the science of human-centered design to ensure the project is developed in a manner that is most congruent to the needs of the behavioral health workforce and the diverse communities they serve.

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

This project will meet the general requirements by: making a change to an existing practice in the field of mental health, specifically, the practice of documentation of care provision in an Electronic Health Record.

C) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

This project aims to employ a human-centered approach to guide the development and rollout of a new EHR system that will be implemented by 23 or more County BHPs. Through the identification of challenges/shortcomings within existing (legacy) EHRs that contribute to key indicators of provider burnout, this information will be utilized to implement solutions within the new EHR that are compatible with the needs of the County BHPs' workforce as well as the clients they serve.

Optimizing Health Information Technology procedures and technologies used by providers to meet their daily workflow needs can enhance working conditions, increase efficiencies, and reduce burnout, ultimately improving the conditions under which direct client care is provided. With the input of provider stakeholders and best practice experts in the field of human-centered design, the new EHR will be collaboratively and intentionally designed to improve the method and ease of documenting into the EHR as well as gathering pertinent clinical information from the EHR, which will promote less time spent on "treating the chart" and more time spent on "treating individuals" in need of care.

An editorial titled "Health information technology and clinician burnout: Current understanding, emerging solutions, and future directions", appearing in the Journal of the American Medical Informatics Association (JAMIA) published in March 2021 by Oxford University Press, the authors assert that "innovative solutions to prevent or mitigate burnout are urgently needed."

As noted in the Section below, also in the same JAMIA publication, is a documented example of using human-centered design being used effectively to improve the functionality of an EHR – in this instance, through the development of an application for use by Emergency Department physicians treating children with asthma-related conditions.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

This project focuses on transforming current EHR systems and processes counties utilize for the provision of behavioral health services. Accordingly, we have not estimated the number of individuals expected to be served annually. As noted previously, the participating counties in the Semi-Statewide Enterprise Health Record project are collectively responsible to serve more than 27% California's Medi-Cal beneficiaries, or approximately 4,000,000 people.

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

This project focuses on transforming the current EHR system and the processes California BHPs utilize for the provision of behavioral health services rather than directly testing an innovative approach to service delivery.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

This project will employ the Human-Centered Design (HCD) approach which is supported by research and is a key component of this project. Enlisting providers' knowledge and expertise of their daily clinical operations in order to inform solutions in the Design Phase is a critical component to ensuring the new EHR is responsive to the needs of the BHP workforce as well as the clients they serve.

Counties have attempted to adapt and/or develop workarounds to improve the functionality of their legacy EHRs, however, none have previously used the HCD approach to develop a new EHR.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

This Semi-Statewide Enterprise Health Record project will address gaps in the literature and existing practice by incorporating human-centered design processes to develop a new EHR system for California County Behavioral Health Plans.

The following are a few examples of the use of human-centered design processes in settings *other than* behavioral health:

1. "Human-centered development of an electronic health record-embedded, interactive information visualization in the emergency department using fast healthcare interoperability resources", published in March 2021 in the Journal of the American Medical Informatics Association. The research involved the development of The Asthma Timeline Application for use in the Emergency Department of the Children's Hospital of Philadelphia (CHOP), a large, academic, tertiary care children's hospital.
   https://academic.oup.com/jamia/article-abstract/28/7/1401/6157802

2. Health+™, pronounced "health plus," is a human-centered design and research model sponsored by the U.S. Department of Health & Human Services (HHS) to co-create solutions with—not for—people impacted by the most pressing healthcare challenges. The Health+ model positions people as active participants—experts in their own life challenges—listening and learning from their lived experiences, to uncover their needs and understand their challenges. Currently, the HHS team is running the first-ever Health+ effort to better understand Long COVID. Previously, HHS applied these human-centered design methods for sickle cell disease and Lyme and tick-borne disease. The Health+ model works best when applied to complex, multi-systemic, multi-disciplinary challenges with diverse stakeholder communities.
   https://www.hhs.gov/ash/osm/innovationx/human-centered-design/index.html

3. "Why Patients And Care Teams Should Co-Design Healthcare Technologies", a December 2019 Forbes post. The author states: "Technology designed for its own sake, rather than with the needs of workers in mind, is how we have ended up with too many healthcare technologies that complicate clinical workflows and turn many nurses and doctors into data entry clerks. The better approach is to observe users in their working environments, engage with them, understand their processes and needs, and see how they're connected to other people's jobs. Then, find the best, most efficient ways to improve their lives".
   https://www.forbes.com/sites/forbestechcouncil/2019/12/09/why-patients-and-care-teams-should-co-design-healthcare-technologies/?sh=58d8509bf4a7

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

EHR design and user experience have far-reaching impacts on individual treatment providers, treatment teams and provider/client relationships. These impacts range from the quality of the provider/client interaction to clinical outcomes and client safety. As a result, we are evaluating the impact of EHR design on:

Quality:

- Comprehensiveness of client care
- Efficiency of clinical practice
- Interactions within the health care team
- Clinicians' access to up-to-date knowledge

Safety/Privacy:

- Avoiding errors (i.e.: drug interaction)
- Ability to use clinical data for safety
- Personal and professional privacy

Satisfaction:

- Ease of use
- Clinicians' stress level
- Rapport between clinicians and clients
- Clients' satisfaction with the quality of care they receive
- Interface Quality

Outcomes:

- Communication between clinicians and staff
- Analyzing outcomes of care
- System Usefulness
- Information Quality

The pre-go live survey will establish which issues/task/workflows impact the above conditions and focus the human-centered design work on the highest-value items. Iterative design work will allow for cross-county learning that will inform the design of the new EHR. The post go live survey will measure how effectively we have addressed the identified EHR issues and our progress towards the goal of reducing documentation burden by 30%.

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

This project will employ the Human-Centered Design (HCD) approach which is supported by research and is a key component of this project. Enlisting providers' knowledge and expertise of their daily clinical operations in order to inform solutions in the Design Phase is a critical component to ensuring the new EHR is responsive to the needs of the BHP workforce as well as the clients they serve.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

OBJECTIVE I: Evaluate stakeholder perceptions of and satisfaction with the decision-making process
OBJECTIVE II: Conduct formative assessments to iteratively improve the design and usability of the new EHR
OBJECTIVE III: Conduct summative assessment of user experience and satisfaction with the new EHR versus existing EHRs and change in burden

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

CalMHSA will serve as the Administrative Entity and Project Manager, and Participation Agreements will be executed with each County. Streamline Healthcare Solutions, LLC is the vendor selected for the development, implementation, and maintenance of the Semi-Statewide EHR. As the Evaluation vendor, RAND will assist in ensuring the INN project is congruent with quantitative and qualitative data reporting on key indicators, as determined by the INN project. See county-specific appendices for additional information.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

See county-specific appendices.

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration: Each participating County will provide updates on the project to their Behavioral Health staff and community-based partners who are part of the Mental Health Plan as well as consumers and family members.

B) Cultural Competency: Each participating County convenes a Cultural Competency Committee which meets regularly and is made up of peer specialists, community organizations, clinicians, and County staff. These committees will be informed on a regular basis as to the status of the project and will be invited to provide their input.

C) Client-Driven: The focus of the project is to improve the quality of specialty mental health and substance use services by improving the documentation input into the EHR, improving the communication between providers and teams, and improving timely access for consumers and clients.

D) Family-Driven: Families will have the opportunity to provide input into the project and will experience the improvement in the quality of services as well, as a part of improved communication efforts.

E) Wellness, Recovery, and Resilience-Focused: The project will include wellness and recovery outcomes and performance measures that are currently difficult to input or add to existing EHRs.

F) Integrated Service Experience for Clients and Families: If the project is successful in integrating the many required responsibilities and roles of BHPs, the ability to address the whole person's needs will be a measurable outcome. Referrals and linkages to other non-mental health providers will be easily tracked and reported to see where improvements can be made.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation

This project evaluation supports cultural competence and stakeholder involvement in evaluation in two crucial ways. Meaningful work towards improving the health outcomes of all beneficiaries relies on having accurate information on the treatment access and outcomes that can be analyzed by racial, ethnic and sexual orientation/gender identify variables. When BHPs report data regarding the clients they serve and the impact of services on the wellbeing of those clients, that data has been documented in and reported out of that BHP's EHR. By undergoing a design process which is built on

consensus decision-making guided by subject matter expert advice and grounded in current day best practices, the quality of the data available in the semi-statewide EHR and the ability to examine outcomes across a large swath of California will be significantly improved. From a direct service perspective, the total population of EHR end users (+/- 14,000 individuals) will have the opportunity to participate in the formative and summative assessments which will identify design, usability and satisfaction issues with the legacy EHRs and evaluate the new EHR along the same variables.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.

Following project completion, participating counties will utilize other sources of funds to support the on-going maintenance of the newly developed EHR.

Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

This project focuses on transforming current Electronic Health Record system and processes counties utilize for the provision of behavioral health services.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) *How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?*

See county-specific appendices

B) *KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.*

Human-Centered Design; Semi-Statewide Enterprise Health Record.

TIMELINE

A) *Specify the expected start date and end date of your INN Project*

Upon approval in Calendar Year 2022 through 6/30/2027.

B) *Specify the total timeframe (duration) of the INN Project*

Not to exceed five (5) years (FY22-23 through FY26-27).

C) *Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.*

A tentative project plan for the first eight quarters is available below. The project plan is expected to change and evolve as the multi-county innovation activities and learnings continue. CalMHSA and participating counties will convene at a minimum annually beyond the first eight quarters to examine and evaluate learnings and will continue to set goals during the project period.

FY 22/23	EHR INN Project Plan	Semi-Statewide EHR Project Plan: Pilot Phase	Semi-Statewide EHR Project Plan: Phase I
Q1 July - Aug	Consensus Gathering Landscape Analysis	Requirements Gathering	Requirements Gathering
Q2 Sept - Dec	Pre- Go Live Survey Period (Formative Assessment)	Analysis and Design Development/Configuration Testing/Training	Requirements Gathering
Q3 Jan - March	Human-Centered Design Process	Go Live	Analysis and Design
Q4 April - June	Human – Centered Design Process	Optimization	Development/Configuration Testing/Training
FY 23/24			
Q1 July - Aug	Design Optimization	Monitoring/Controlling	Phase I Go Live
Q2 Sept - Dec	Design Optimization	Monitoring/Controlling	Optimization
Q3 Jan - March	Post-Go Live Survey Period (Summative Assessment)		Monitoring/Controlling
Q4 April - June	Evaluation, Learnings and Recommendations		Monitoring/Controlling

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) *BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)*

B) *BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)*

C) *BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)*

See county-specific appendices.

APPENDICIES AND BUDGETS INCLUDED IN THIS SUBMISSION:

- Humboldt
- Sonoma
- Tulare

APPENDIX: HUMBOLDT COUNTY

1. **COUNTY CONTACT INFORMATION**

Oliver Gonzalez Bobadilla, MHSA Program Manager: Lead related to Innovation reporting
Scott Irvin, Medical Records Manager: Lead related to EHR implementation

2. KEY DATES:

Local Review Process	**Dates**
30-day Public Comment Period (begin and end dates)	May 25-June 23, 2022
Public Hearing by Local Mental Health Board	June 23, 2022
County Board of Supervisors' Approval	July 19, 2022

This INN Proposal is included in: (*Check all that apply*)

	Title of Document	**Fiscal Year(s)**
	MHSA 3-Year Program & Expenditure Plan	
X	MHSA Annual Update	2022-2023
	Stand-alone INN Project Plan	

3. DESCRIPTION OF THE LOCAL NEED(S)

Humboldt County Behavioral Health has been experiencing challenges in hiring and retaining clinicians for the past several years. Our current vacancy rate for our clinician job classes is 33.7%. Since going live with the current EHR product in 2014 a frequent complaint by our clinical staff has been the difficulties associated with using that system. A common complaint has been that the system is "not intuitive," it is difficult to find information within the system quickly and that practitioners suffer from "click fatigue." There are significant limitations with making modifications to the existing system to improve upon these negative aspects. As a result, the current EHR has negatively impacted the overall job satisfaction of the practitioners and may be a contributing factor to workforce retention. The resolution of these issues will contribute to improving the workforce's job effectiveness, satisfaction and retention.

Behavioral Health staff feedback over the years has indicated that the user interface of the current EHR is not intuitive or user friendly. Required fields are not logically programmed leading to increased data entry errors. Database tables are not properly linked to one another so the same service information data must be entered in multiple locations. This is particularly problematic with updates to client information. The current EHR requires double and sometime triple entry into the progress notes with approval codes for missed and rescheduled appointments. This is an occurrence that happens every day for staff.

The scheduling calendar lacks the functionality of sorting by location, which makes appointments hard to track and causes double booking. The complexity of the scheduling calendar causes some staff to not use the function all together, which also creates the opportunity for appointments to be missed and fall through the cracks.

The current EHR does not possess a case load management system. This makes it extremely difficult to see who has interacted with the clients or who else is on a client's treatment team. This hinders communication and care coordination and causes duplicative efforts.

The current EHR requires significant administrative overhead to cover the deficiencies in the back end set up and lack of intuitive user reports. A new EHR that is more efficient to use should decrease the time documenting direct services and increase time spent providing direct services. It is anticipated that a new EHR will facilitate a client-centered approach that is founded upon creating and supporting a positive therapeutic alliance between the provider and client.

The current EHR is built on an archaic version of JAVA script which can no longer be updated. It means the software cannot be adapted to the everchanging hardware landscape such as tablets and portable devices, which would be more portable and user friendly. The JAVA script structure causes the software to be difficult to navigate, not ADA compatible and is practically illegible on portable devices.

There is currently no way to give community- based organizations (CBOs) access with the current EHR that would be compliant with our privacy and security practices. This makes sharing client information with our CBOs less streamlined and inefficient.

The structure of the current EHR also does not contain a patient portal. This prevents the county from adapting to the current digital landscape. It also prevents clients from having easy access to their digital record and prevents updating their client information efficiently. Many of the forms necessary must therefore still be completed on hardcopy, then entered into the system manually.

With the current roll out of California Advancing and Innovating Medi-Cal (CalAIM) by the Department of Health Care Services (DHCS), many changes are necessary in the EHR to be compliant with new requirements surrounding payment reform, documentation and policy updates, and data exchange. California Mental Health Services Authority's (CalMHSA) goal in working with Counties to roll out this semi-statewide collaborative EHR is to require the EHR to meet all regulatory requirements placed on Mental Health Plans (MHPs). Since multiple counties, with the same regulatory and clinical needs, will be participating in this collaborative EHR, it is likely that the vendor will be more diligent about making the needed changes.

4. DESCRIPTION OF THE RESPONSE TO LOCAL NEED(S) AND REASON(S) WHY YOUR COUNTY HAS PRIORITIZED THIS PROJECT OVER OTHER CHALLENGES IDENTIFIED IN YOUR COUNTY

Participation in this project is anticipated to increase direct mental health services by decreasing the time a provider spends in documenting encounters, thus addressing the learning goal of a projected 30% reduction in time spent documenting services. This will increase the time spent providing direct client care, addressing the learning goal of facilitating the achievement of a client-centered approach to service delivery founded upon creating and supporting a positive therapeutic alliance between the service provider and the client. The project is also anticipated to increase workforce satisfaction with their jobs. This meets the learning goal to improve California's public mental health workforce's job effectiveness, satisfaction and retention. In addition, this project will increase the efficiency and effectiveness of local data exchange, including through the Health Information Exchange, that is critical to support care of mental health patients in the Emergency Departments and with other service providers.

The information from the new EHR will be available for decision making on all levels and will support the efforts of the Humboldt County Behavioral Health Cultural Responsiveness Committee (BHCRC) in recommending system improvements to reach underserved communities.

Participating in this project was prioritized because it will meet a portion of the needs and challenges expressed by community and staff stakeholders as described in section 5 below.

Humboldt County will work with CalMHSA and the project evaluator to provide the information needed for the project evaluation.

5. DESCRIPTION OF THE LOCAL COMMUNITY PLANNING PROCESS

Humboldt County's participation in this project will address some of the needs and themes expressed by community stakeholders during the last several years. In the community program planning process for the 2020-2023 Three Year Plan the top-ranking theme was to expand and increase mental health services and access to services. This was the second ranking theme in the 2022-2023 CPPP. The third-ranking theme for the 2020-2023 Three Year Plan was to increase support for the behavioral health workforce. This was the fourth ranking theme in the 2022-2023 CPPP. The participation in this project will contribute to expanding and increasing access to mental health services because staff will spend less time navigating an obsolete EHR and have more time to provide direct client care, thus increasing support for the workforce as well as increasing access to services.

Increasing bilingual and culturally competent services was also among the top needs identified in the 2020-2023 Three Year Plan and in the 2022-2023 Annual Update CPPP. One of the foundations of providing such services is having accurate data on what populations are underserved or unserved. This data has been difficult to obtain in the current EHR. The new EHR will provide more accurate data on these populations and help in planning for expanded services for them.

Stakeholder involvement. The CPPP for the 2022-2023 MHSA Annual Update began in August 2021 with the gathering of reports from MHSA program staff on the activities of

fiscal year 2020-2021 and updates on planned activities for 2022-2023. After the last of this information was received a draft Annual Update was written and dates were scheduled for regional and community meetings.

All information about meetings dates and other opportunities to participate in the CPPP was disseminated through the following avenues: DHHS Media issued a news release to fourteen media outlets, Facebook and Instagram; flyers and invitations were disseminated to several local distribution lists; and the announcements were posted on the County website and blog.

The draft Annual Update was presented at the quarterly MHSA Community Meeting in November 2021. This was a Zoom meeting attended by four individuals.

Regional meetings were scheduled in December 2021 and January 2022 for Southern Humboldt, Eel River Valley, Eureka, Eastern Humboldt and Northern Humboldt. Due to COVID-19, all meetings were scheduled and held via Zoom. A total of twelve individuals attended the regional meetings.

The MHSA Program Manager contacted community groups and organizations to ask for agenda time at their regularly scheduled meetings, or to request their assistance in setting up a special meeting to gather stakeholder input. In December 2021 and January 2022 three stakeholder meetings were held via Zoom with the Youth Advocacy Board, the DHHS/Education Leadership Team, and the Behavioral Health Board. A total of 47 individuals attended these meetings.

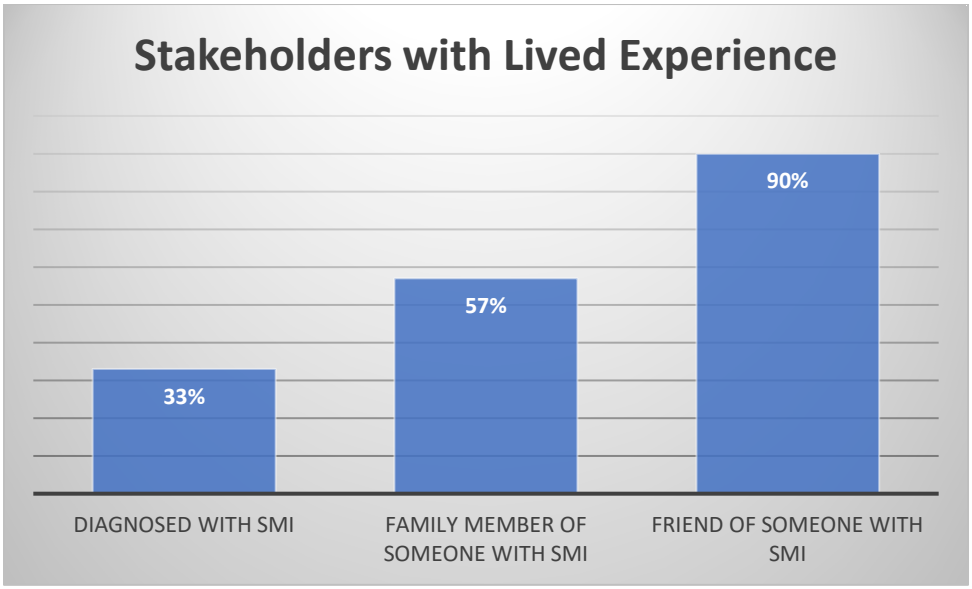
The results of the 2022-2023 CPPP and of the CPPP activities since the development of the Three Year Plan for 2020-2023 was presented at the quarterly MHSA Community Meeting in February 2022. This was a Zoom meeting attended by nine community members.

A total of 72 individuals attended stakeholder meetings during the 2022-2023 CPPP. Three stakeholders provided input through emails to the MHSA Comment Email address.

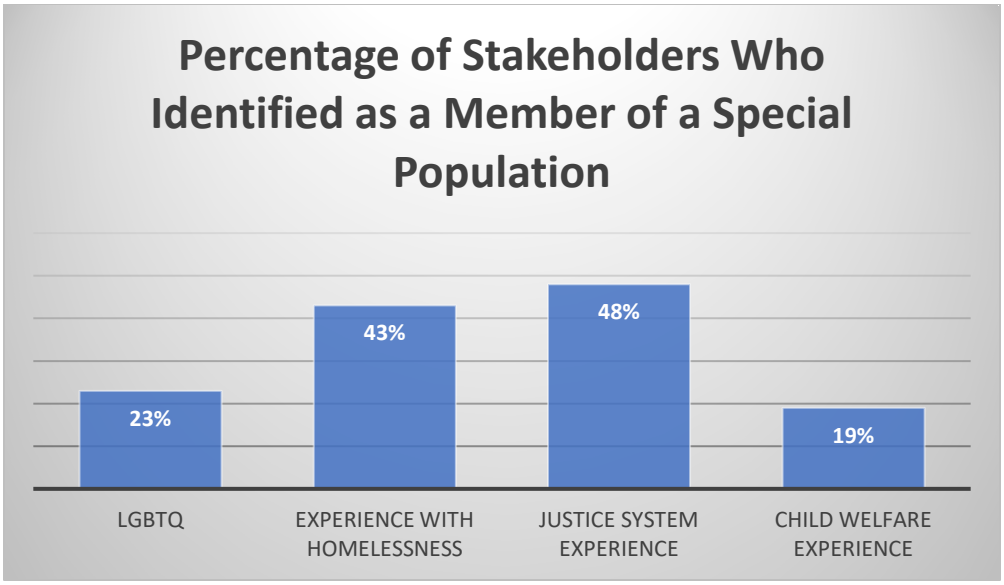
Stakeholder Demographics

Stakeholders attending meetings were asked to complete a MHSA demographic form. Completion of the form was voluntary, and responses were anonymous. A total of 22 individuals, 31% of those attending, completed a demographic form at the stakeholder meetings.

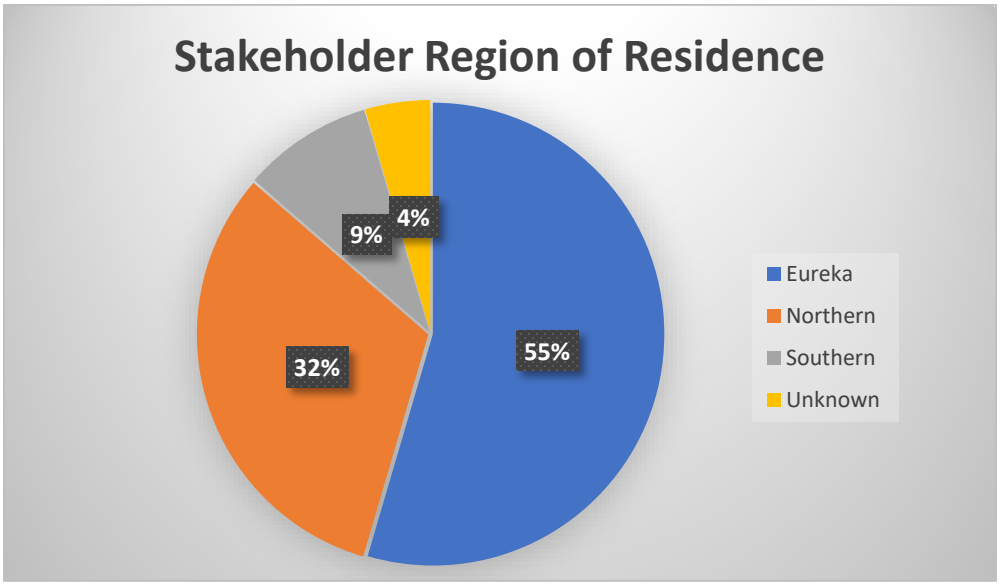
Individuals with lived experience of a serious mental illness (SMI) and their family members are a vital voice in the MHSA CPP. As seen in the chart below, 33% identified as having a mental illness, and 57% identified as a family member of someone with a mental illness. In addition, 90% of those attending the stakeholder meetings said they were a friend of someone with a SMI.



Additional life experiences have been identified as important voices for the CPPP. Sexual orientation and gender identity, homelessness, experience with the justice system, experience with Child Welfare, and those whose primary language is not English have life experiences or conditions that can result in challenges to successful mental health access and treatment. The chart below illustrates the inclusion of people with these life experiences in the CPPP. Twenty-three percent identified as LGBTQ; 43% identified as having experience with homelessness; 48% had justice system experience; and 19% had Child Welfare experience. Because only one stakeholder stated their primary language was a language other than English this is not indicated on the chart.

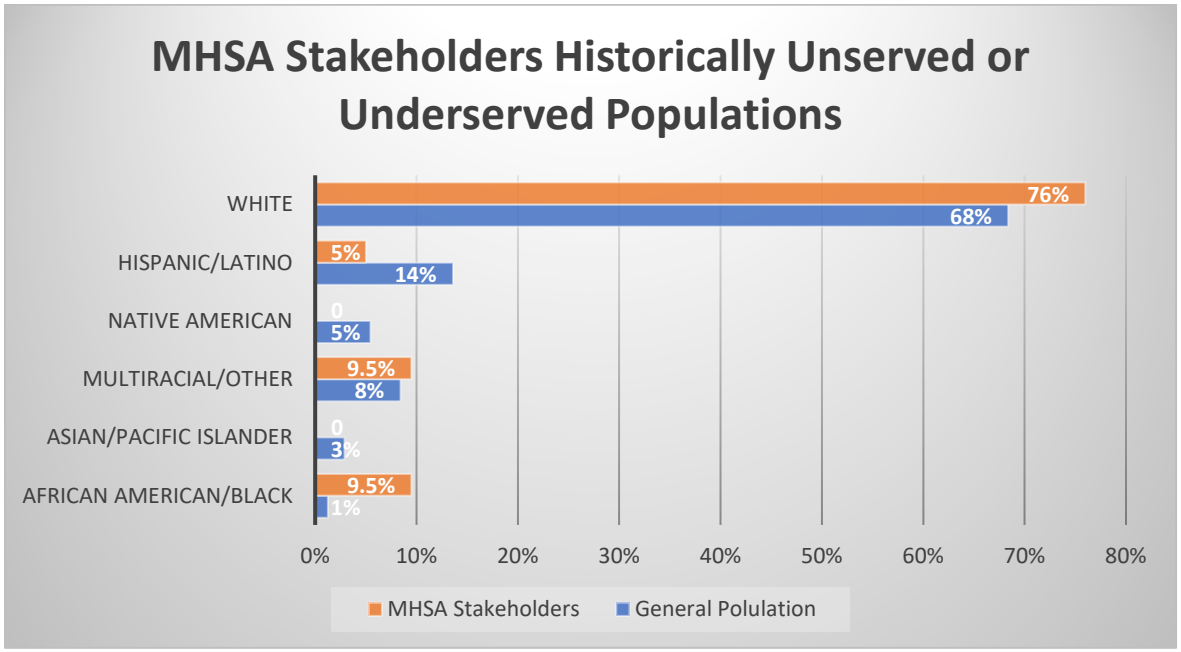


In these stakeholder meetings, 32% of participants resided in the Northern Humboldt region, which includes Arcata, Blue Lake, McKinleyville, and areas north, and 55% of participants resided in Eureka. Nine percent resided in Southern Humboldt, which includes Redway, Petrolia and Garberville. Four percent provided no answer. There were no attendees reporting their residence in the Eel River Valley or Eastern Humboldt.

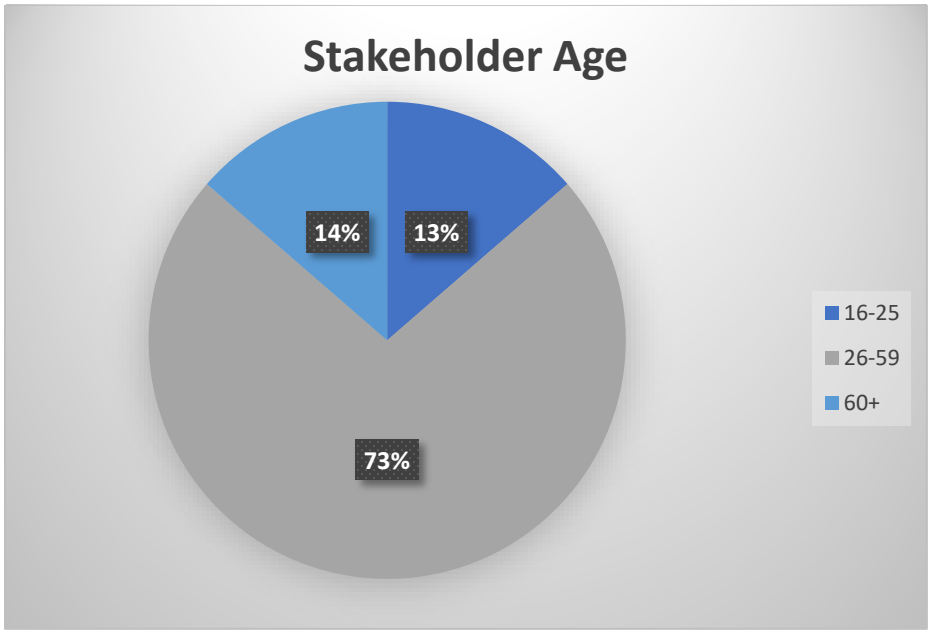


Efforts are made to reach participants that reflect the racial and ethnic diversity of Humboldt County. Of those attending stakeholder meetings, 5% were Hispanic/Latino as compared to 14% of the Humboldt County general population; 9.5% were Multiracial/Other as compared to 8% of the County general population; and 9.5% were

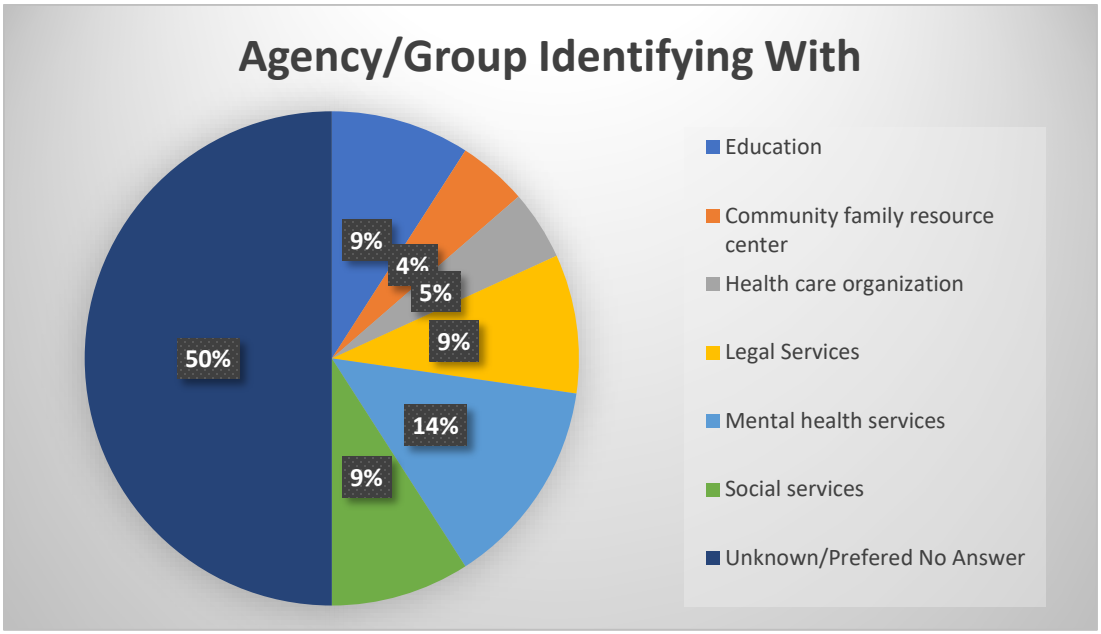
Black/African as compared to 1% of the general population. There were no Native American or Asian/Pacific Islander stakeholders completing the demographic form.



Thirteen percent of those completing the demographic form were ages 16-25; 73% were ages 26-59, and 14% were age 60+.



The chart below illustrates the representation from community agencies participating in the stakeholder meetings. It shows that the process included individuals from mental health services, 14%; education, 9%; health care organizations, 5%; social services, 9%; Community and Family Resource Centers (CRC/FRC), 4%; Legal Services, 9%. Fifty percent provided no response.



After the stakeholder meetings were completed, the notes from each meeting, comments on the demographic/comment form, and the comments received from the MHSA Email were reviewed. This review resulted in a grouping of comments and input by the overall themes/topics of the services and supports that community stakeholders would like to see more of, or changes within. These themes included increasing community input and engagement; expanding and increasing access to services; increasing support for the seriously mentally ill; increasing workforce education, support and training; increasing pregnancy and postpartum support; making facility Improvements; increasing bilingual and culturally competent services; increasing services for those experiencing homelessness; strengthening Substance Use Disorder Services; increasing investment in early childhood mental health services.

During the 30 day public comment period there were no comments made about the proposed Innovation project. At the Public Hearing hosted by the Behavioral Health Board on June 23, 2022, there was one question about the proposed Innovation project, and that question was to clarify that the project would be to replace the current EHR with a new EHR. When confirmed that this was the case, this individual expressed support.

Sustainability. Innovation funds will be tapped in fiscal year 2022-2023 for this project. Humboldt County anticipates an additional $666,170 from American Rescue Act grant funds for project years 2 and 3.

6. CONTRACTING

Humboldt County will be contracting with CalMHSA for this project. The BH Medical Records Manager is taking the lead on this project and will act as a liaison between the Mental Health Plan (MHP) and CalMHSA. We have a biweekly meeting where important EHR stakeholders meet to discuss, coordinate and approve projects tied to the EHR. This group includes BH Leadership (managers and deputies), Quality Improvement, Information Services, DHHS Quality Management, Claims Data Management, and Fiscal staff. This team will shift its focus to the rollout of the CalMHSA Semi-Statewide collaborative EHR by the July 1, 2023 go-live date and onward.

CalMHSA has started working with the MHP to identify points of contact regarding particular topics as we begin to engage in rollout. Our lead has provided CalMHSA with documents associated with our current processes and our current EHR. Moving forward we plan to engage the group listed above in ongoing discussions internally, using the biweekly meeting time and additional time as needed, and with CalMHSA as we work toward roll-out and maintenance thereafter. Each point of contact will also be utilized to share their expertise and to work with CalMHSA in establishing what it is we need from the Semi-Statewide Collaborative EHR.

7. COMMUNICATION AND DISSEMINATION PLAN

Quality Improvement uses Bulletins in order to communicate changes to our provider network, which includes BH staff and Organizational Providers. QI plans to release a bulletin to all impacted stakeholders regarding the transition to the Semi-Statewide Collaborative EHR and to update on any ongoing changes thereafter. QI also uses an e-learning system, called Relias, in order to track and train staff. Trainings will be built into Relias as needed along the course of rollout and maintenance thereafter. The MHP has adopted the CalMHSA Documentation Manual as our own and it has been indicated that for those counties opting into the collaborative EHR, there will also be an EHR guide. We plan on using resources developed by CalMHSA to train and/or communicate whenever applicable. Our biweekly stakeholder meeting will consist of discussions surrounding roll-out and ongoing efforts surrounding this new EHR and the minutes will reflect on results, successes, and lessons learned as we work through this project.

Information will also be communicated through quarterly MHSA meetings; the MHSA CPPP; through interim reports included in Annual Updates and Three Year Plans; through a final report in an Annual Update or Three Year Plan. These interim and final reports are posted to the County website at https://humboldtgov.org/430/Mental-Health-Services-Act-MHSA and shared with stakeholders through existing distribution lists.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY

COUNTY: ***HUMBOLDT***

EXPENDITURES

	PERSONNEL COSTS (salaries, wages, benefits)	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1	Salaries						
2	Direct Costs						
3	Indirect Costs						
4	**Total Personnel Costs**						$
	OPERATING COSTS*	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
5	Direct Costs						
6	Indirect Costs						
7	**Total Operating Costs**						$
	NON-RECURRING COSTS (equipment, technology)	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
8							
9							
10	**Total non-recurring costs**						$
	CONSULTANT COSTS/CONTRACTS	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
11	Direct Costs	608,678					
12	Indirect Costs						
13	**Total Consultant Costs**	608,678					608,678
	OTHER EXPENDITURES (explain in budget narrative)	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
14							
15							
16	Total Other Expenditures						$

	EXPENDITURE TOTALS	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
	Personnel (total of line 1)						
	Direct Costs (add lines 2, 5, and 11 from above)						
	Indirect Costs (add lines 3, 6, and 12 from above)						
	Non-recurring costs (total of line 10)						
	Consultant Costs/Contracts (total of line 13)	608,678					608,678
	Other Expenditures (total of line 16)						
	TOTAL INDIVIDUAL COUNTY INNOVATION BUDGET	**608,678**					**608,678**

	CONTRIBUTION TOTALS**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
	County Committed Funds	1,062,134	353,721	312,458	312,742	313,034	2,354,087
	Additional Contingency Funding for County-Specific Project Costs						
	TOTAL COUNTY FUNDING CONTRIBUTION	1,062,134	353,721	312,458	312,742	313,034	2,354,087

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

COUNTY: ***HUMBOLDT***

ADMINISTRATION:

A.	Estimated total mental health expenditures for administration for the entire duration of this INN Project by FY & the following funding sources:	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1	Innovation (INN) MHSA Funds	458,678	-	-	-	-	458,678
2	Federal Financial Participation	142,839	111,422	98,424	98,514	98,606	549,805
3	1991 Realignment	-	-	-	-	-	-
4	Behavioral Health Subaccount	80,242	196,924	168,659	214,228	214,428	874,480
5	Other funding	230,375	45,375	45,375	-	-	321,125
6	Total Proposed Administration	912,134	353,721	312,458	312,742	313,034	2,204,088

EVALUATION:

B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1	Innovation (INN) MHSA Funds	150,000					150,000
2	Federal Financial Participation						
3	1991 Realignment						
4	Behavioral Health Subaccount						
5	Other funding						
6	Total Proposed Evaluation	150,000	-	-	-	-	150,000

TOTALS:

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 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1	Innovation(INN) MHSA Funds*	608,678					608,678
2	Federal Financial Participation	142,839	111,422	98,424	98,514	98,606	549,805
3	1991 Realignment						-
4	Behavioral Health Subaccount	80,242	196,924	168,659	214,228	214,428	874,480
5	Other funding**	230,375	45,375	45,375			321,125
6	Total Proposed Expenditures	1,062,134	353,721	312,458	312,742	313,034	2,354,088

* INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting approval to spend.

** If "other funding" is included, please explain within budget narrative.

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EHR Multi-County Innovation (INN) Project

Appendix and Budget Template – Guidelines

APPENDIX: **_SONOMA COUNTY**

1. **COUNTY CONTACT INFORMATION** (*who is your Project Lead, as provided to CalMHSA*)**:**

Name of Contact	Role	Email
Jan Cobaleda-Kegler	Behavioral Health Director	Jan.Cobaleda-Kegler@sonoma-county.org
Christina Marlow	QAPI Section Manager	Christina.Marlow@sonoma-county.org>
Melissa Ladrech	MHSA Coordinator	Melissa.Ladrech@sonoma-county.org

2. **KEY DATES:** (*Include actual dates and/or expected dates, as per your local timeline)*

Local Review Process	Dates
30-day Public Comment Period (begin and end dates)	June 20, 2022- July 19, 2022
Public Hearing by Local Mental Health Board	July 19, 2022
County Board of Supervisors' Approval	Scheduled for September 13, 2022

This INN Proposal is included in: (*Check all that apply*)

Title of Document		Fiscal Year(s)
X	MHSA 3-Year Program & Expenditure Plan	2023-2026 (will be included)

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X	MHSA Annual Update	2024-2027 (will be included)
X	Stand-alone INN Project Plan	See Local Review Process above

3. DESCRIPTION OF THE LOCAL NEED(S) (*Include specifics from your local MHSA community program planning process (CPPP), e.g., comments about your current EHR system, suggestions from stakeholders, e.g. County staff, contracted providers, system partners, clients, family members and other interested parties. Include challenges meeting current and future reporting requirements and business needs, past efforts to address local needs, etc.*)

Sonoma County Behavioral Health currently utilizes 3 primary systems (Avatar, SWITS, and DCAR) to manage clinical documentation, mandated data reporting, and billing/claiming (primarily Medi-Cal). The FY 21-22 contract amounts for these systems totals of $857,701, $91,970, and $34,500, respectively.

Sonoma County, like many California Counties, has struggled with implementing Federal and State requirements with our current EHR vendors and systems. The Division has minimal resources to administer our systems, and lack technical expertise in the areas of modification, enhancement, implementation and maintenance of our EHR systems.

The Division's efforts over the years to implement Avatar has been challenging and expensive, and there have been significant delays with project timelines and deliverables. SWITS provides a basic system that has been used for over a decade. As we move towards implementing the Drug Medi-Cal Organized Delivery System (DMC-ODS), SWITS will require significant and expensive upgrades, changes to configuration, and enhancements in order to comply with the various regulatory requirements associated with DMC-ODS.

The Division has been unsuccessful with implementing the use of Avatar with our community-based organizations, which provide approximately 40% of our mental health services. As a result, we have continued to use the CANS/ANSA Data Collection and Reporting (DCAR) System in order to track and submit required CANS/ANSA outcomes data.

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The primary barriers to implementing AVATAR with county contractors comprise three domains: IT infrastructure, IT support, and cost. While some of our partnering CBOs utilize electronic health record systems already, many do not have sufficiently advanced computing and network capabilities to connect to a hosted system in a secure way, and instead remain on hybrid or paper-based systems. It is cost-prohibitive for them to purchase their own licenses/instances of AVATAR, and the county lacked sufficient funding resources to assist. Lastly, many CBOs do not have sufficient IT resources to support the ongoing testing and maintenance of an EHR system, and the county does not have sufficient internal resources to support the significantly increased volume of users resulting from CBO participation in the county's EHR. Our current EHRs are not configured for full-system use, leaving us to manage via external spreadsheets, workarounds, and add-on databases.

On 5/24/22, the Quality Assessment Performance Improvement (QAPI) section facilitated a CBO CalAIM stakeholder meeting to provide an overview of anticipated system changes, and conduct 3 listening sessions (Adult MH Providers, Youth MH Providers, Substance Use Disorder service providers). CBO attendees included Program Directors, Clinical Directors, Quality Management Teams, and Billing/Claiming Teams. Many CBOs indicated a desire to participate in the semi-statewide EHR project to increase interoperability and efficiency of care coordination. They identified challenges that multi-county CBOs encounter when attempting to interface with different county EHRs. They stated their need for support from the County on implementation and requested inclusion in the project. They were invited to the Quality Improvement Committee as the forum to continue discussions on CalAIM changes and EHR project updates.

Additionally Sonoma County, like many California Counties, has struggled with hiring and retaining staff. Currently 26% of the behavioral health positions are vacant. One of the reasons that staff state as a contributing factor for terminating employment with the county is the cumbersome and time-consuming electronic health record, Avatar. Having an electronic health record that is more user friendly and less time consuming will ease the administrative burden on staff and we expect that this will help with both retaining and hiring staff.

4. DESCRIPTION OF THE RESPONSE TO LOCAL NEED(S) AND REASON(S) WHY YOUR COUNTY HAS PRIORITIZED THIS PROJECT OVER OTHER CHALLENGES IDENTIFIED IN YOUR COUNTY (*Include information describing what your County hopes to achieve by participating in the INN project, referencing the learning goals included at the end of the "Project Brief" document.)*

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Response to local need: Sonoma County Department of Health Services, Behavioral Health Division plans to participate in the Semi-Statewide Enterprise Health Record Project.

Sonoma County Behavioral Health Division is proposing to use MHSA Innovation (INN) funds to contract and participate with California Mental Health Services Authority (CalMHSA) to implement a Semi-Statewide Electronic Health Record (EHR) that meets the new CalAIM requirements.

Sonoma County Behavioral Health Division has prioritized this project over other identified challenges because implementing a Semi-Statewide Electronic Health Record (EHR) that meets the new CalAIM requirements will address many of the barriers discussed in this proposal by providing the following:

- User friendly EHR system that reduces staff time spent on data input, and can assist with retaining staff
- CBO direct entry and interface with the county EHR
- Consolidation of the three current EHR platforms into one centralized system
- Compliance with CalAIM requirements on payment reform, policy changes, and data exchange
- Client Portal interface capability, which will increase client access and transparency

5. **DESCRIPTION OF THE LOCAL COMMUNITY PLANNING PROCESS** (*Describe the County's CPPP for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic, and racial diversity of the County's community. Include details of stakeholder meetings, i.e. number and demographics of participants, community groups and system partners, methods of dissemination of information about the proposed project and comments received regarding the INN project.)*

Since April of 2022 the County has been discussing the project with a variety of stakeholders including; MHSA Community Program Planning (CPP) Workgroup, MHSA Steering Committee, Mental Health Board, Department of Health Services leadership, Division Management Team, Division CBO contractors and Board of Supervisors.

Date	Committee	Feedback

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4/7/22	MHSA Community Program Planning (CPP) Workgroup	One CPP Workgroup member stated that she supported the plan since it was being designed to help retain staff and allow staff to focus on clients and spend less time on entering data.
5/11/2022	MHSA Steering Committee	One member stated that she was an intern at the county and Avatar, the county's current EHR, was very difficult and time consuming to use. She was very exited about the project.
5/22/22	CBO CalAIM Stakeholder Meeting	Many CBOs indicated a desire to participate in the semi-statewide EHR project to increase interoperability and efficiency of care coordination. They identified challenges that multi-county CBOs encounter when attempting to interface with different county EHRs. They stated their need for support from the County on implementation and requested inclusion in the project. They were invited to the Quality Improvement Committee as the forum to continue discussions on CalAIM changes and EHR project updates.
5/26/22	Department of Health Services Leadership	Department Director, Tina Rivera, reviewed the proposal, including the budget and the risks and benefits associated with the project. After reviewing all of the data the Department Director approved moving forward with the project.
6/20/2022	Posted on Behavioral Health Division Website and notified	No comments were received about the posting.

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	over 2000 MHSA stakeholders via the MHSA listserv	The Steering Committee, CPP Workgroup and MHB were provided with the proposal to review.
6/22/2022	Quality Improvement Committee	Announcement of upcoming changes through CalAIM and inclusion of additional members of QIC
7/19/2022	Mental Health Board Public Hearing	One member was very interested in the client portal capacity that the new EHR is planned to have. This member stated how important a client portal is to transparency.
7/26/22	Quality Assessment and Performance Improvement Section Meeting	Announced plans to collaborate with CalMHSA and other counties to implement new semi State-wide EHR. Received requests for further details about system and support for implementing new, improved system.
7/27/22	Quality Improvement Committee	Focused discussion of CalAIM and EHR Project. Participants identified the importance of meaningful participation from peers and family members in the project.
8/10/2022	MHSA Steering Committee	One member had questions about the use of CFTN funds and how the county was funding Avatar. Avatar and the County staff are currently both being funded by CFTN.
9/13/2022	Sonoma County Board of Supervisors Meeting	Agenda item detailing EHR plan and receiving approval to enter into Participation agreement with CalMHSA for development and implementation.

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6. CONTRACTING *(What project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?)*

The QAPI Section Manager is leading the EHR project, as the senior manager responsible for CalAIM implementation. The current AVATAR Clinical Implementation Lead is providing back-up support, and the MHSA Coordinator is providing additional support. The current Implementation Team and supporting subject matter experts are as follows:

Name	Position	Project Role
Chris Marlow	QAPI Section Manager (MH and SUD)	Lead Coordinator
Wendy Wheelwright	Adult Services Section Manager	Clinical Implementation Lead for legacy system
Waheed Bhatti	Systems Service Analyst	IT Implementation Lead for legacy system
Heather Meyers	Revenue and Claiming Manager	Billing/Claiming Implementation Lead for legacy system
To Be Assigned	EHR Clinical Lead Resource	Dedicated support for clinical system implementation and maintenance
To Be Assigned	EHR IT Lead Resource	Dedicated support for IT system implementation and maintenance
To Be Assigned	EHR Billing/Claiming Lead Resource	Dedicated support for Billing/Claiming system implementation and maintenance
Melissa Ladrech	MHSA Coordinator	MHSA Innovation project liaison
Lisa Nosal	Documentation and UR Manager	Content expert – documentation
Katrina Suprise	Quality Assurance MH	Content expert – forms development, policy, and procedures
Nathan Hobbs	Quality Improvement MH	Content expert – system workflows, provider network, data reporting
Will Gayowski	Quality Assurance SUD	Content expert – DMC-ODS
Jennifer Pimentel	Compliance	Content expert – billing/claiming, compliance review

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Ken Tasseff	Privacy and Security Officer	Content expert – patient privacy, record sharing, system interoperability
Roy Dajalos	Assistant Director of Department	Fiscal oversight, executive authority
Kelley Ritter	Deputy Chief Financial Officer	Content expert – fiscal
Michele Bowman	Administrative Services Officer	Contract oversight and authority

7. COMMUNICATION AND DISSEMINATION PLAN (*Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project. How do you plan to disseminate information to stakeholders within your County and (if applicable) to other Counties? How will program participants or other stakeholders be involved in the communication efforts?*

The MHSA Coordinator will be primarily responsible for communicating the progress, results, and lessons learned to community stakeholders, including the County Mental Health Board, Board of Supervisors, MHSA Steering Committee, CBHDA meetings, Quality Improvement Committee, and other community leaders/stakeholders. The MHSA Coordinator will leverage the MHSA Newsletter and MHSA listserv (with over 2,000 contacts) to inform stakeholders about the results, newly demonstrated successful practices, and lessons learned from the project.

8. COUNTY BUDGET NARRATIVE (*Include description of expenses for local Personnel, Operating and Consultant Costs, as well as the source(s) of funds to be used to support this multi-County collaborative. Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant,*

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part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project, and the dissemination of the Innovative project results.

Expenditure Category	Expenditure Item	Description/Explanation of Expenditure Item	Total Project Cost
Consultant	Consultant Services	In collaboration with other California counties, contract with CalMHSA for development, implementation, and maintenance of the new Semi-Statewide EHR system in our county.	Total $4,420,407.54 Per year - 22-23 $1,789.644.60 23-24 $ 703,111.14 24-25 $ 642,051.98 25-26 $ 642,545.66 26-27 $ 643,054.16

9. BUDGET & FUNDING CONTRIBUTION BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (*Please complete the Excel file for this portion of the Appendix)*

Attached

10. TOTAL BUDGET CONTEXT: EXPENDITURES BY FUNDING SOURCE & FISCAL YEAR
(*Please complete the Excel file for this portion of the Appendix).*

Attached

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY

COUNTY: **Sonoma**

EXPENDITURES

	PERSONNEL COSTS (salaries, wages, benefits)	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
1	Salaries						
2	Direct Costs						
3	Indirect Costs						
4	**Total Personnel Costs**						$
	OPERATING COSTS*	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
5	Direct Costs						
6	Indirect Costs						
7	**Total Operating Costs**						$
	NON-RECURRING COSTS (equipment, technology)	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
8							
9							
10	**Total non-recurring costs**						$
	CONSULTANT COSTS/CONTRACTS	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
11	Direct Costs	$ 1,789,664.60	$ 703,131.14	$ 642,051.98	$ 642,545.66	$ 643,054.16	$ 4,420,447.54
12	Indirect Costs						
13	**Total Consultant Costs**						$ 4,420,447.54
	OTHER EXPENDITURES (explain in budget narrative)	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
14							
15							
16	Total Other Expenditures						$

EXPENDITURE TOTALS	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
Personnel (total of line 1)						
Direct Costs (add lines 2, 5, and 11 from above)						
Indirect Costs (add lines 3, 6, and 12 from above)						
Non-recurring costs (total of line 10)						
Other Expenditures (total of line 16)						
TOTAL INDIVIDUAL COUNTY INNOVATION BUDGET						

CONTRIBUTION TOTALS**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
County Committed Funds						
Additional Contingency Funding for County-Specific Project Costs						
TOTAL COUNTY FUNDING CONTRIBUTION						$ 4,420,447.54

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

COUNTY: **Sonoma**

ADMINISTRATION:

A.	Estimated total mental health expenditures for administration for the entire duration of this INN Project by FY & the following funding sources:	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1	Innovation (INN) MHSA Funds						
2	Federal Financial Participation						
3	1991 Realignment						
4	Behavioral Health Subaccount						
5	Other funding						
6	Total Proposed Administration						

EVALUATION:

B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1	Innovation (INN) MHSA Funds						
2	Federal Financial Participation						
3	1991 Realignment						
4	Behavioral Health Subaccount						
5	Other funding						
6	Total Proposed Evaluation						

TOTALS:

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 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1	Innovation(INN) MHSA Funds*	$ 1,789,664.60	$ 703,131.14	$ 642,051.98	$ 642,545.66	$ 643,054.16	$ 4,420,447.54
2	Federal Financial Participation						
3	1991 Realignment						
4	Behavioral Health Subaccount						
5	Other funding**						
6	Total Proposed Expenditures	$ 1,789,664.60	$ 703,131.14	$ 642,051.98	$ 642,545.66	$ 643,054.16	$ 4,420,447.54

* INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting approval to spend.
** If "other funding" is included, please explain within budget narrative.

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EHR Multi-County Innovation (INN) Project
(DRAFT for 30 Day Public Comment)
Appendix and Budget Template – Guidelines

APPENDIX: TULARE COUNTY

1. **COUNTY CONTACT INFORMATION** (*who is your Project Lead, as provided to CalMHSA*)**:**

   - **Primary Project Lead- Michele Cruz, MHSA Manager – mcruz2@tularecounty.ca.gov**
   - **Secondary Project Lead– Angela Sahagun, Electronic Health Records Manager – asahagun@tularecounty.ca.gov**

2. **KEY DATES:** (*Include actual dates and/or expected dates, as per your local timeline)*

Local Review Process	Dates
30-day Public Comment Period (begin and end dates)	3/8/2022 – 4/8/2022
Public Hearing by Local Mental Health Board	4/5/2022
County Board of Supervisors' Approval	6/14/2022

This INN Proposal is included in: (*Check all that apply*)

	Title of Document	Fiscal Year(s)
	MHSA 3-Year Program & Expenditure Plan	
X	MHSA Annual Update	22/23
X	Stand-alone INN Project Plan	22/23

3. DESCRIPTION OF THE LOCAL NEED(S) (*Include specifics from your local MHSA community program planning process (CPPP), e.g., comments about your current EHR system, suggestions from stakeholders, e.g. County staff, contracted providers, system partners,*

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clients, family members and other interested parties. Include challenges meeting current and future reporting requirements and business needs, past efforts to address local needs, etc.)

- Tulare County MH/MHSA hosted three community stakeholder meetings to present the INN Project and receive feedback.
    - Porterville Wellness Center, Consumer/Family Member Stakeholders (Zoom) – March 14, 2022 – 1pm
    - Visalia Wellness Center, Consumer/Family Member Stakeholders (Zoom) – March 14, 2022 – 2:30pm
    - Tulare County Mental Health Board Meeting (Zoom)– April 5, 2022 – 3pm

  Tulare County Mental Health Branch faces an increasingly complex task in the upcoming years to 1) successfully integrate the California Advancing and Improving Medi-Cal state initiatives; 2) successfully integrate the Substance Use Disorder treatment and services provided within the Branch; 3) grow and retain a robust and dynamic workforce in a Health Provider Shortage Area; and 4) modernize an integrated health record system that can efficiently and effectively provide data for decision making, not just for care provision for the consumers served but also for administration as the Branch looks to performance outcomes and measures to successfully implement payment reform.

  In addition to those demands on Tulare County Mental Health, the civilian labor force peaks at 9.6% unemployment rate, which is significantly higher than the State's average of 4.1%. Tulare County is also a Health Provider Shortage Area (HPSA) which means it is harder to attract and retain a health provider workforce. With this Project, the Branch hopes to improve the work experience, reducing the challenges and barriers in providing services, and retain and grow a robust and dynamic workforce.

  The current electronic health records system, Avatar, is an antiquated system that requires cumbersome documentation from clinical users which can lead to significant burnout and attrition. Additionally, poorly designed system configurations create barriers for accessing data and timely decision making. Finally, the current system is not designed to support interoperability, critical data exchange opportunities, and Substance User Disorder treatment integration that would lead to improved health outcomes for consumers. With CalMHSA's assistance in this Human Centered Design approach, and working with our providers as subject matter experts in their daily clinical operations, Tulare County MH anticipates the new enterprise health records system will be responsive to the needs of the workforce as well as the consumers they serve.

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There are two goals locally. In Phase One, Tulare County Mental Health would like to focus on growing and retaining our local workforce, providing a tool with this Project, that is user-friendly, efficient and effective in communicating between providers and teams in order to be able to provide the best possible care for consumers. Tulare County Mental Health is hopeful that employee retention will improve as this Project provides opportunities for eliminating redundancy, improved communication, improved documentation to reduce staff burden, and improved data collection and reporting.

In May 2021, the Branch brought in a consulting firm to survey employees in an effort to gauge employee satisfaction. Overall, 66% of employees surveyed were somewhat-engaged or not engaged. The Administration group had the largest percentage of those not engaged (32%), while the Case Management group had the largest percentage of those only somewhat-engaged (70%). Additionally, when asked about whether employees were considering leaving their current position within the next year, 29% responded yes, and 14% preferred not to say. Drilling down on those responses showed that majority of those considering leaving were not engaged or somewhat-engaged. While there are many varied factors that were assessed in this employee engagement survey, Tulare County Mental Health looks to this Innovation Project as a step to improving employee satisfaction and retention.

A second goal is to continue integrating SUD services with mental health services for providing care that addresses all the needs of an individual, in tandem with CalAIM changes. Tulare County Mental Health is hopeful that this Project will provide opportunities for eliminating redundancy, improved communication, improved documentation to reduce staff burden, and improved data collection and reporting.

The Branch looks to provide a business solution to the challenges facing behavioral health plans across the state that supports the breadth and scope of the needs of provider staff, administrative leaders, and ultimately the consumers; improving the quality of mental health programs and services by allowing providers the ability to receive data and other information in a timely manner to make decisions for administering appropriate care, and advancing a Whole Person Care delivery system model to include Substance Use Disorder treatment and services seamlessly. With CalMHSA assistance through this Innovation project, Tulare County MH anticipates improvement in workforce satisfaction and retention. Tulare County Mental Health would like to effect local level system change with the goal of improving the quality of behavioral health services while maintaining workforce development, satisfaction, and retention.

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4. DESCRIPTION OF THE RESPONSE TO LOCAL NEED(S) AND REASON(S) WHY YOUR COUNTY HAS PRIORITIZED THIS PROJECT OVER OTHER CHALLENGES IDENTIFIED IN YOUR COUNTY (*Include information describing what your County hopes to achieve by participating in the INN project, referencing the learning goals included at the end of the "Project Brief" document.)*

- As with many counties across California, Tulare County Mental Health and Community Partners are uniquely situated to participate in this Multi-County INN project. Stakeholders across our system have expressed deep concern on the volatile and antiquated EHR system that is currently utilized. Stakeholders have prioritized this project to improve and enhance the EHR system to meet the needs of the provider and consumer community alike. With this unique multi-county collaborative, Tulare County will gain an opportunity to provide continuous feedback through system end-users, providers, contractors, consumer/family member staff and recipients of care. This broad stakeholder group will serve as an essential feedback loop to program design, system design and evaluation alike. Tulare County Mental Health hopes to achieve the following learning goals in participation with this INN Project:
    - Using a Human Centered Design approach, identify design elements of a new Enterprise Health Records to improve our local behavioral health workforce's job effectiveness, satisfaction, and retention
    - Implement a new EHR this is more efficient to use, resulting in a 30% reduction in time spent documenting services, thereby increasing the time spent providing direct care
    - Implement a new EHR that facilitates a client-centered approach to service delivery, founded upon creating and supporting a positive therapeutic alliance between the service provider and the client.

5. DESCRIPTION OF THE LOCAL COMMUNITY PLANNING PROCESS (*Describe the County's CPPP for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic, and racial diversity of the County's community. Include details of stakeholder meetings, i.e. number and demographics of participants, community groups and system partners, methods of dissemination of information about the proposed project and comments received regarding the INN project.)*

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This Innovation Project plan was presented to MHSA stakeholders during the Community Planning Process (CPP) for the Annual Update Plan for Fiscal Year 2022/2023. The project was discussed at stakeholder meetings at the wellness centers on March 14, 2022.

Stakeholders at these meetings included consumers, family members, and providers. Total stakeholders in attendance were 20. No specific comments on the Innovation project were made during those meetings. Prior to this stakeholder meeting, the wellness center staff advertised the meetings on their calendar of events along with flyers. MHSA staff also shared information about the meetings through external website, social media postings, and with committees.

Tulare County Behavioral Health staff also discussed the project at the Adults and Children's System Improvement Committees as well as the Quality Improvement Committee, at earlier meetings (prior to March and April) and questions were asked about time frames, implementation, vendor selection. All questions were answered during those meetings. These meetings include providers, agency partners, and peers. Attendance varies between 15-30 attendees, and includes partners from outlying, underserved areas within Tulare County.

The Annual Update Plan was circulated for 30 days for review and comment, via the County Health & Human Services Agency external website; notices posted in local newspapers; electronic copies emailed to stakeholders; with hard copies distributed upon request. The 30-day stakeholder review and public comment period took place from March 8, 2022 to April 8, 2022. A public hearing was then held during the Mental Health Board meeting on April 5, 2022. Discussion was held during the April 5 Mental Health Board meeting on this action item. Three public comments were received during the 30-day public comment period; none addressed the Innovation Project specifically. No public comments were received during the public hearing held at the April 5 Mental Health Board meeting, and the Mental Health Board reached a quorum and voted to move the Annual Update Plan forward to the Board of Supervisors. The Tulare County MHSA Annual Update Plan for Fiscal Year 2022/2023 was approved by the Board of Supervisors on June 14, 2022.

The Innovation project was separately highlighted during the April 5 Mental Health Board meeting, and all board members approved it for submission to the Board of Supervisors and the Mental Health Services Oversight and Accountability Commission.

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6. CONTRACTING *(What project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?)*

- **Organizational Management:**
  - MHSA Manager will serve as Lead Contact for the EHR INN Project.
    - Experienced in stakeholder engagement and chairs the following stakeholder system committees such as: MHSA Providers, Wellness & Recovery Committee.
    - Manages the MHSA 3 Year Plan and Annual Update Community Planning Process annually and additional stakeholder engagement projects as needed.
  - Electronic Health Records Manager will serve as Alternate Contact for the INN Project.
    - Oversees EHR programs and implementation of new programs, processes, etc., within the electronic health record system.
  - An Electronic Health Records Specialist Supervisor and an Administrative Specialists will serve as project management and fiscal oversight.
    - EHR Specialist Supervisor oversees program design and data collection methods implementation.
    - Administrative Specialists are experienced in project management, state reporting requirements both programmatic and fiscal, and development of policies, procedures, etc., within the Agency.
  - Electronic Health Records Specialists (3) will be utilized for program design, data collection methods, trainings.

- **Contract Monitoring:**

  The MH Administration Team will provide updates on the Project at the Quality Improvement Committee, the Adult and Children's System Improvement Committees, as well as the MHSA Provider meetings. These meetings are attended by community-based partners who are part of the Mental Health Plan as well as consumers and family members. Tulare County Mental Health also has an established Mental Health Cultural Competency Committee which meets regularly and is made up of peer specialists, community organizations, clinicians and county staff. This committee will be informed on a regular basis as to the status and outcomes of the project.

  Evaluation of the project will also be shared with the Mental Health Board, with recommendations from the committees mentioned above regarding the project success

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and continuation, to be shared with the Mental Health Board for their advice and action.

7. COMMUNICATION AND DISSEMINATION PLAN (*Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project. How do you plan to disseminate information to stakeholders within your County and (if applicable) to other Counties? How will program participants or other stakeholders be involved in the communication efforts?*

- Annual reports on the project will be shared with the Mental Health Board, and publicly available on the Tulare County HHSA website. Program participants, family members, and stakeholders will be encouraged to participate in stakeholder meetings. Shared experiences on the project's impact in the lives of our community will be welcomed. Additionally, Tulare County Mental Health will share findings statewide with county counterparts through making the project evaluation available online as well as through email listings and state MHSA associations.

- Tulare County Mental Health will work with CalMHSA and its program partners to disseminate information regarding the EHR Multi-County Innovation Project to local stakeholders and counties.

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

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Tulare County Phase 1 was submitted separately for planning purposes and was approved by the MHSOAC on June 20, 2022, for $1 million.

Phase 2 will cover the implementation of the Semi-Statewide EHR Innovation project.

Tulare County anticipates continued investment of $1.3 million in this project after the INN 5-year project period through CFTN funding in years 6 and 7.

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Tulare County Phase 2 Budget Narrative

PERSONNEL

Classifications:

MHSA Manager: $26,699
0.1 FTE will provide oversight and manage the stakeholder engagement and collaboration within our county.

Electronic Health Records (EHR) Manager $52,439
0.1 FTE will provide oversight in the implementation of the new Semi-Statewide EHR system in our county.

EHR Specialist Supervisor $113,075
0.25 FTE will provide support of the new Semi-Statewide EHR system in our county.

EHR Specialist $1,171,906
3.0 FTEs will provide support of the new Semi-Statewide EHR system in our county.

Administrative Specialist $93,569
0.2 FTE will provide administrative and fiscal support to the new Semi-Statewide EHR system in our county.

Payroll Taxes and Benefits: $559,534
Costs are identified by forecasting of actual benefit costs and assumes continued employment of existing staff.

TOTAL PERSONNEL EXPENSES **$2,017,221**

OPERATING EXPENSES

Direct Costs:
Communication: $35,500
Includes phones, cell phones, data lines, etc.
Office Expenses: $77,500
Includes general office supplies and
expenses. Training: $5,000
Includes any trainings associated with the Semi-Statewide EHR system.
Travel/Transportation: $15,000
Includes any travel associated with the Semi-Statewide EHR system.

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TOTAL DIRECT OPERATING EXPENSES	$133,000
INDIRECT OPERATING EXPENSES	$280,000
TOTAL OPERATING EXPENSES	**$413,000**
CONSULTATION/CONTRACT EXPENSES	**$3,850,800**
TOTAL PHASE 2 BUDGET	**$6,281,021**

9. BUDGET & FUNDING CONTRIBUTION BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (*Please complete the Excel file for this portion of the Appendix)*

- *Attached as requested*

10. TOTAL BUDGET CONTEXT: EXPENDITURES BY FUNDING SOURCE & FISCAL YEAR (*Please complete the Excel file for this portion of the Appendix).*

- *Attached as requested*

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY

COUNTY: *TULARE*

EXPENDITURES

	PERSONNEL COSTS (salaries, wages, benefits)	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1	Salaries	$ 163,495	$ 309,834	$ 319,783	$ 328,998	$ 335,577	**$ 1,457,687**
2	Direct Costs						**$ -**
3	Indirect Costs	$ 62,861	$ 118,972	$ 122,729	$ 126,224	$ 128,748	**$ 559,534**
4	**Total Personnel Costs**	**$ 226,356**	**$ 428,806**	**$ 442,512**	**$ 455,222**	**$ 464,325**	**$ 2,017,221**

	OPERATING COSTS*	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
5	Direct Costs	$ 26,600	$ 26,600	$ 26,600	$ 26,600	$ 26,600	**$ 133,000**
6	Indirect Costs	$ 80,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000	**$ 280,000**
7	**Total Operating Costs**	**$ 106,600**	**$ 76,600**	**$ 76,600**	**$ 76,600**	**$ 76,600**	**$ 413,000**

	NON-RECURRING COSTS (equipment, technology)	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
8							**$ -**
9							**$ -**
10	**Total non-recurring costs**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

	CONSULTANT COSTS/CONTRACTS	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
11	Direct Costs	$ 876,474	$ 788,899	$ 727,907	$ 728,470	$ 729,050	**$ 3,850,800**
12	Indirect Costs						**$ -**
13	**Total Consultant Costs**	**$ 876,474**	**$ 788,899**	**$ 727,907**	**$ 728,470**	**$ 729,050**	**$ 3,850,800**

	OTHER EXPENDITURES (explain in budget narrative)	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
14							**$ -**
15							**$ -**
16	Total Other Expenditures	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

EXPENDITURE TOTALS	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
Personnel (total of line 1)	$ 163,495	$ 309,834	$ 319,783	$ 328,998	$ 335,577	**$ 1,457,687**
Direct Costs (add lines 2, 5, and 11 from above)	$ 903,074	$ 815,499	$ 754,507	$ 755,070	$ 755,650	**$ 3,983,800**
Indirect Costs (add lines 3, 6, and 12 from above)	$ 142,861	$ 168,972	$ 172,729	$ 176,224	$ 178,748	**$ 839,534**
Non-recurring costs (total of line 10)	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Expenditures (total of line 16)	$ -	$ -	$ -	$ -	$ -	**$ -**
TOTAL INDIVIDUAL COUNTY INNOVATION BUDGET	**$ 1,209,430**	**$ 1,294,305**	**$ 1,247,019**	**$ 1,260,292**	**$ 1,269,975**	**$ 6,281,021**

CONTRIBUTION TOTALS**	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
County Committed Funds	$ 1,209,430	$ 1,294,305	$ 1,247,019	$ 1,260,292	$ 1,269,975	$ 6,281,021
Additional Contingency Funding for County-Specific Project Costs						
TOTAL COUNTY FUNDING CONTRIBUTION	$ 1,209,430	$ 1,294,305	$ 1,247,019	$ 1,260,292	$ 1,269,975	$ 6,281,021

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

COUNTY: ***TULARE***

ADMINISTRATION:

		FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
A.	Estimated total mental health expenditures for administration for the entire duration of this INN Project by FY & the following funding sources:						
1	Innovation (INN) MHSA Funds	$ 959,430	$ 1,294,305	$ 1,247,019	$ 1,260,292	$ 1,269,975	$ 6,031,021
2	Federal Financial Participation						$ -
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding						$ -
6	Total Proposed Administration	$ 959,430	$ 1,294,305	$ 1,247,019	$ 1,260,292	$ 1,269,975	$ 6,031,021

EVALUATION:

		FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:						
1	Innovation (INN) MHSA Funds	$ 250,000	$ -	$ -	$ -	$ -	$ 250,000
2	Federal Financial Participation						$ -
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding						$ -
6	Total Proposed Evaluation	$ 250,000	$ -	$ -	$ -	$ -	$ 250,000

TOTALS:

		FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	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:						
1	Innovation(INN) MHSA Funds*	$ 1,209,430	$ 1,294,305	$ 1,247,019	$ 1,260,292	$ 1,269,975	$ 6,281,021
2	Federal Financial Participation						$ -
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding**						$ -
6	Total Proposed Expenditures	$ 1,209,430	$ 1,294,305	$ 1,247,019	$ 1,260,292	$ 1,269,975	$ 6,281,021

* INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting approval to spend.
** If "other funding" is included, please explain within budget narrative.