California Mental Health Services Authority
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EHR Multi-County Innovation (INN) Project
(DRAFT for 30 Day Public Comment)
Appendix and Budget Template

APPENDIX: Siskiyou County

1. COUNTY CONTACT INFORMATION

- **Primary Project Lead—** Sarah Collard, HHSA Director – scollard@co.siskiyou.ca.us
- **Secondary Project Lead—** Tara Ames, Project Coordinator — tames@co.siskiyou.ca.us
- **Information Systems (I.S.) Project Lead—**Mark Halsebo – mhalsebo@co.siskiyou.ca.us

2. KEY DATES:

Local Review Process	Dates
30-day Public Comment Period (begin and end dates)	9/3/2022 – 10/3/2022
Public Hearing by Local Mental Health Board	Anticipated 10/3/2022
County Board of Supervisors' Approval	Anticipated 10/18

This INN Proposal is included in:

	Title of Document	Fiscal Year(s)
	MHSA 3-Year Program & Expenditure Plan	
X	MHSA Annual Update	*Revised MHSA Plan (Mid-Year Adjustment to 22-23 Annual Update), currently in 30 day Public Comment*
	Stand-alone INN Project Plan	

3. DESCRIPTION OF THE LOCAL NEED(S)

Siskiyou County Behavioral Health (SCBH) hosted four community stakeholder activities to present the INN Project and receive feedback.

1. Six Stones Wellness Center: Consumer/Family Member Stakeholder Surveys August 29th through August 31st, 2022.
2. SCBH Consumer surveys— August 29th through August 31st, 2022.

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3. SCBH Supervisors Meeting (Zoom)– September 1, 2022 – 8:15 am
4. SCBH All-Staff stakeholder surveys—August 29th through August 31st, 2022.

All stakeholder activities included key questions related to the current EHR System.

- How many attendees utilize SCBH Electronic Health Records?
- What Challenges exist with the current SCBH EHR?
- What Improvements can be made to enhance user experience? Consumer and Family Member Experience? Contractor Experience?
- What other systems do you utilize to document consumer/client information or to generate reports for quarterly data reports/outcomes?

Below are the nine categories of challenges with the current EHR system and the qualitative responses from the surveys:

1. Inefficient documentation
   - Too much time every day is spent doing documentation. It is unnecessary.
   - Too much repeat information gathering for staff.
   - The system is not user friendly and extremely slow to navigate.
   - It is slow to respond at times and the need for multiple electronic signature or passwords is very annoying.
   - It should load faster.
   - Takes additional time, thus time away from clients and collaborating with staff
   - Hard to find old records easily, old labs new labs, difficult in how meds are accessed. Doing a diagnosis we should not be doing anything but writing it out someone else should code and bill it and it is so time consuming to change a diagnosis quickly and discontinue another one.
   - The staff have to repeat entering the same information in several places. In order to track information many screens have to be opened and closed just to find what is needed.
2. The EHR is too difficult to learn and detracts from client care
   - It is hard to train someone new on a system that does not always make sense. Having so many different procedures for inputting information is challenging to remember and track. There are new expectations being handed down through regulations on a regular basis that do not fit into the design of Anasazi. This makes it frustrating and hard to keep trying to learn the new processes when they do not actually fit.
   - I feel Anasazi is outdated and does not offer the best services for client care.
   - Not client or clinically oriented.

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- Getting behind in notes or assessment documentations can affect our ability to have availability for clients. Not having ease of access to prior notes through a more streamlined organizational flow is a challenge for being able to know what is going on and the history of a client.
- Anasazi is difficult to learn and teach for new/incoming providers and slows down the documentation process. Too many steps!
- I feel we spend more time on documentation than seeing the client.
- If we could focus more on the services we provide to clients instead of the need to use specific language to capture those services, and having to block out time to properly enter information into Anasazi, many of our clients would have more time dedicated to the services we provide
- I have witnessed several times clinicians being required to cancel clients to catch up on tardy documentation.
- I would argue that the client service to documentation time is very disproportionate.

3. The EHR creates needless barriers to reporting requirements
    - In regards to SUD, the barriers are several; Timelines are not flagged for staff to know when their 5-month additional medical necessity is due. CalOms is not flagged if the client has not been seen within the 30 days so that the 10-day letter can go out prior to the end of the 30 days.
    - Staff are forced to prioritize documentation over client care, even at the point of first contact. The EHR doesn't have a way to easily meet the state requirements by tracking client access data, such as timeliness and CSI Assessment Record data, without duplicating processes. New clients don't understand why they can't be scheduled for an assessment on their first phone call to the agency; instead, they are directed to access coordinator because scheduling within the system is very complicated.
    - Pulling data from the EHR is extremely challenging, and staff must be highly trained to extract accurate data. The dashboards are not built directly into the EHR, which limits who has access to them, and aggregated client data for managing staff caseloads doesn't exist. This EHR was never meant to be used for behavioral health purposes, and it is clear that it creates needless burdens for staff and excludes clients from seeing their health information online.
4. Lack of access to viewing the client's full chart at once
    - It is very time consuming all the signatures needed, all the different screens needed that have nothing to do with charting, Multiple screens needed to order a medication, consents, sending to pharmacy and to see your current medications quickly while in session. All very cumbersome. I have worked on many electronic records and none as difficult and non-necessary work to document.
    - Unable to view multiple clients at once.

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- There are so many steps involved with viewing, documenting, scheduling and navigation within the clients chart. unable to access multiple forms/pages or multiple clients at the same time.
- The staff have to repeat entering the same information in several places. In order to track information many screens have to be opened and closed just to find what is needed.
- Not being able to access multiple documents at once makes UR and Quality Improvement processes more time-consuming and difficult.
- Frustrating to navigate between different client charts as well as within individual charts. There are too many different screens to move around in to achieve complete and satisfactory documentation. Fluid real-time documentation is nearly impossible in clinical or medical settings using Anasazi.

5. Prescription and Medication management barriers
    - E-scripting limited to non-controlled medications which requires the use separate E-scripting service for controlled medications. That said, even non- controlled medications can be difficult for medical providers and nursing staff to use and manage using this program. Useful information is not easily accessed and is not well organized. Takes extensive and lengthy training to use proficiently. This EHR seems like a program for billing rather than for managing and documenting client care. Medical staff here have to maintain and use a paper chart in conjunction with the electronic record to be able to quickly reference medication orders and administration records. Maintaining a duplicate paper chart is extremely wasteful of staff time, space and paper.
    - It is a billing system built for billing purposes, NOT for clinicians or provider. It DOES NOT allow a provider to print a current med list for a client so that a client can leave with a clear understanding of their current medications.
6. Overcomplicated, not adaptable, and not intuitive for users
    - Anasazi has terrible spell check. It doesn't recognize common words. The font is super small and hard to read. It is embarrassing to have to move real close to the screen in front of clients. I have not found a way to zoom the screen or anything like you can in other computer platforms. The new EHR requirements have very limited Z codes that are appropriate or compliment SUD services.
    - The system is not user friendly for staff. It is difficult to navigate. It is hard to get the data needed out of it. It is hard to help staff understand that what they do effects the revenue.
    - I feel we could have a system that is much more user friendly.
    - This is by far the worst EHR in my 33 year career helping people. Completely distracts from being able to provide good quality care. Cumbersome and unintuitive is being kind here.

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- This program is not user friendly at all. There are too many places to get lost in this program that causes a lot of frustration.
- The amount of time it takes to access the chart, look for documentation, completing documentation, and too many documents to complete.
- Not a barrier to all around care but a barrier to efficient client care. Frustrating and time consuming to use this EHR.
- The font size is hard to read and small. It is a strain on my eyes and leads headaches and frustration.
- Anasazi is terrible to try and use via VPN because the font size cannot be adjusted and you can only have one item open at a time.

7. Poor caseload management
    - Not only do we have a lot of documentation, but the timelines are hard to keep track off.
    - Anasazi, is not user friendly and lack of reporting for Chart storage, lack of flagging system for Assessments...etc.
8. Contributes to staff burnout
    - So many tasks we should not be doing as the providers and it is so nonsensical to learn every single provider I worked with when I started said how they "hate it"
    - The amount of documentation and time spent documenting is problematic. It gets overwhelming and takes time away from spending quality time with the client. The stress of time lines follows me home at times because I feel like its so much.
    - It's cumbersome and time consuming which detracts from the time available for treatment. It contributes to staff burnout which in turn results in increased sick and other leave which reduces availability of staff who are providing services. Staff are unwilling to work in the public sector due to charting requirements and the challenges associated with use of the EHR and this creates a barrier to access.
    - We have even had new staff leave because learning the complex documentation process is too challenging for them, and it is not intuitive at all. Many of our staff do not meet their billable standards because they don't capture much of their time due to not wanting to waste their time documenting.
    - As someone who supports training these staff on documentation, I can tell you that not only is it the least favorite aspect of their job, but they spend nearly as much time doing it as seeing clients. Often times those who stay current on documentation, have to stay late or come in after hours in order to do so, which directly corresponds to increased levels of burn out!
    - I had already decided to leave my job within three weeks of being here until I was treated so kindly I didn't have the heart to pull the resignation trigger.
    - Being in front of a computer 25% of the time documenting client care and coordination of care is exhausting and brain numbing.

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- It is exhausting and not why I became a therapist.
- I feel that there is an overwhelming amount of documentation which leads many employees to feel overloaded and frustrated.

9. No access for client's to see their information
    - Consumers, family members, and community-based organizations reported the need for clients to have access to their own information through a portal.

SCBH Supervisors shared their experiences regarding challenges with onboarding new users, supervision, caseload management, compliance, functionality, and cultural competence.

1. New users
    - Not user friendly. It takes a long time to learn to navigate.
    - New people take a long time to see clients due to the time it takes to train them on the EHR. (weeks to get up to speed)
    - It takes a lot of supervisor time to get people set up in the system. If there are other challenges in the agency, it can sometimes take days before the staff can begin their training.
    - Heavy supervisor burden to train new staff.
    - Training depends heavily on the learning style of the staff.
    - The EHR is not an intuitive program. There is no draw to bring people into the agency when they hear that the EHR is a challenge to work with.
    - Cumbersome, it doesn't auto-populate which creates more work for providers. Very duplicative processes.
    - Other programs have formal trainings that are offered to staff; this is not available for our EHR.
2. Compliance
    - No flagging or warning system.
    - Challenges with scanning documents, time-consuming.
    - Records retention: the flagging system would tell you how long we've been holding on to records for. We have to do this manually.
    - Doesn't allow for scanning two-sided documents.
    - People print out attachments to read, which increases chance of a HIPAA breach.
    - Lack of security, you can still tell if someone is in SUD services.
    - Not set up for Title 42 protections.
    - Additional ROIs have to be made to protect liability between BH and SUD departments.
    - Staff want the system to be more secure for client data.
3. Functionality
    - The background contributes to eye fatigue.

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- Notifications are a huge problem. The agency spends a lot of money for staff to keep their notifications updated.
- Filters in every tab have to be changed.
- Client attachments are challenging to view and navigate, especially if you're on a VPN.
- Auto population doesn't go to all the places where data is stored.
- Can assign tasks/due dates to staff through the EHR or send notifications when tasks have been completed.
- Timeliness: sups aren't informed when services are scheduled outside of standards.
- You can't track urgent services or assessment updates, if staff never finalized a document.
- No plagiarizing notices (copy/paste).
- All staff use another program to use spell check.
- If staff are interrupted, it doesn't save or auto-save the progress.
- Hard to set up groups and adjust times.
- CalOMS is exceptionally challenging to pull out data for reporting.
- SUD notifications are not set up or easy to change.

4. Caseload Management
   - Case managers, peers, and nurses can't carry caseloads in the EHR. It's hard to find out to who people are assigned to.
   - A lot of workarounds are needed to make referrals to other agencies or even within different departments within the agency. There is no mechanism to track referrals or make them through the EHR.
   - Tasks cannot be assigned to other staff and monitored by supervisor via notifications and due dates.
   - Supervisors have to oversee the frequency of services and the EHR does not allow for this. They have to use multiple logs to track caseloads, referrals, special programs, etc.
5. Cultural Competence Concerns
   - No alias abilities
   - No preferred names or pronouns, only allows Medi-Cal Name to identify chart and has no way to give staff a heads-up that the client identifies by a different name or gender.

As evidenced above, the challenges with the current EHR are impactful for the entire SCBH system and the clients it services. Below are the recommended solutions for a new EHR that meets the needs of all SCBH staff and consumers.

- Full integration and portability of systems including android and apple application access for consumers/family members
- Link Health Information Exchange system into new EHR system so that staff and consumers can have access across the county.
- Fast connections to the server.

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- Improved CalOMS reporting, easier share of costs reporting, better fiscal and service reports.
- User friendly system
- Sequentially required forms to be available. Integrate new CalAIM Problem list as part of the clinical record, not a separate item in the database.
- Increase the number of templates for medical department. Include Medical ROI's on the front page, add a lab work template
- Ensure that information that can be duplicated from various forms is done so accurately.
- Increase functionality across systems
- Forms that pre-populate demographic information and other known information
- Have an EHR that is available to the user no matter where they are.
- Creating a portal system in which consumer/family members have the ability to access information on their health status, problem lists, aftercare, follow-up appointments and an application that will allow for ease of communication between provider and consumer through the portal system.
- Simple and Intuitive Platform
- IS Help Desk that is quick to respond – 24 hour Access
- System that connects and integrates with other counties across California

Quantitative data from the surveys showed that 60% of respondents use the current EHR in their daily work activities. Of those individuals, 90% of staff respondents were either neutral or dissatisfied with how Anasazi manages caseloads, and 88% of staff respondents reported that they were dissatisfied with Anasazi overall as an electronic health record. Additionally, 75% of psychiatric providers were dissatisfied with Anasazi's ability to monitor medications and medication refills.

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

As with many counties across California, SCBH and Community Partners are uniquely situated to participate in this Multi-County INN project. Stakeholders across our system have expressed deep concern about the inadequate 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, Siskiyou County can 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

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to program design, system design and evaluation alike. SCBH hopes to achieve the following learning goals in participation with this INN Project:

1. Using a Human-Centered Design approach, identify design elements of a new Electronic Health Record to improve our local behavioral health workforce's job effectiveness, satisfaction, and retention.
2. Implement a new EHR that is more efficient to use, resulting in a 30% reduction in time spent documenting services, thereby increasing the time spent providing direct care.
3. 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

SCBH recognizes the meaningful relationship and involvement in the MHSA Process and related behavioral health system. A partnership with constituents and stakeholders is key to the CPPP. SCBH hosted four community stakeholder activities to present the INN Project and receive feedback.

1. Six Stones Wellness Center: Consumer/Family Member Stakeholder Surveys August 29th through August 31st, 2022.
2. SCBH Consumer surveys— August 29th through August 31st, 2022.
3. SCBH Supervisors Meeting (Zoom)– September 1, 2022 – 8:15 am
4. SCBH All-Staff stakeholder surveys—August 29th through August 31st, 2022.

Stakeholder participation and demographics were tracked through Microsoft Forms. Stakeholder participants were demographically diverse and included representatives of unserved and underserved populations. The community activities had participation by 50 individuals; 11 were members of the Six Stone Wellness Center, 9 were SCBH clients, and 30 were SCBH and community-based organization staff. 72% of the participants self-identified as a consumer or as a family member of a consumer. All participants were adults, there were no youth surveys returned. Participants also represented the following stakeholder groups:

- Consumer Advocates/Family Members
- Community-Based Organizations

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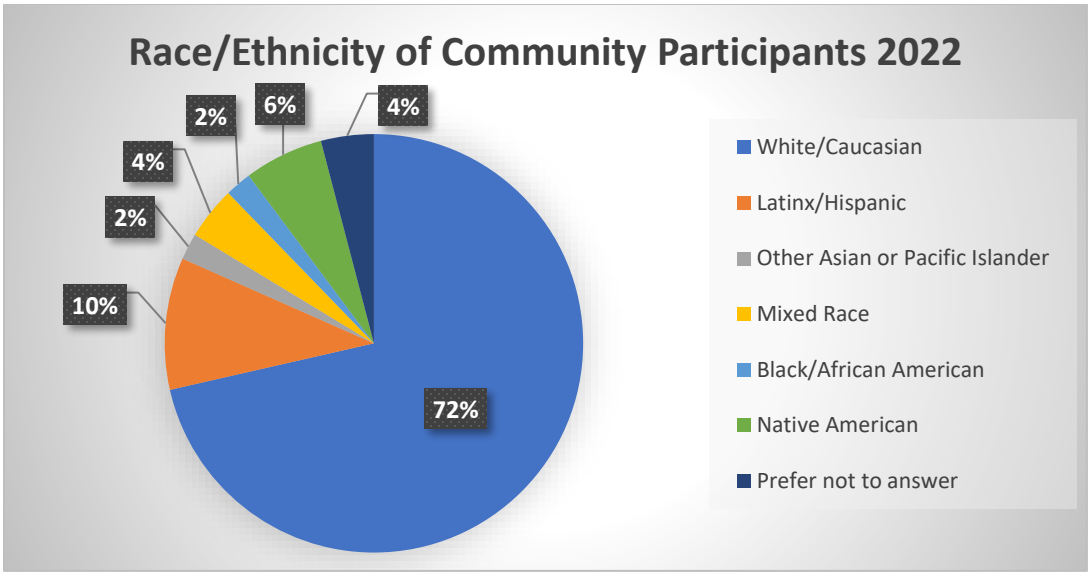
- Substance use disorder treatment providers
- Health Care Providers
- County Behavioral Health Department Staff
- LGBTQIA/Family member of LGBTQIA
- Professionals with lived experience with mental illness
- Family members of disabled veterans

A diverse range of individuals from racial and ethnic backgrounds attended the community activities. Similar to the County's demographic breakdown and those SCBH provides services to, the White/Caucasian group comprised a majority of participants (71%). However, the survey results included more racial and ethnic diversity than the County's demographics, as the White/Caucasian group typically represents 85% of the County population.



All community activities began with the purpose of the INN project and included key questions related to the current EHR System.

- How many attendees utilize SCBH Electronic Health Records?
- What Challenges exist with the current SCBH EHR?
- What Improvements can be made to enhance user experience? Consumer and Family Member Experience?

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- What other systems do you utilize to document consumer/client information or to generate reports for quarterly data reports/outcomes?

The SCBH supervisor discussion group was led Ashley Bray, Quality Assurance Manager. Sarah Collard, the HHSA Director, presented on the CalMHSA Multi-County EHR Project and qualitative feedback was documented via minutes and through the Zoom chat box. To gain consumer and family member feedback, SCBH distributed paper surveys at the Six Stones Wellness Center and at the North and South County SCBH offices. Each survey described the CalMHSA Multi-County EHR Project and included a mixed methods approach to collecting qualitative and quantitative responses.
Another survey was sent to all SCBH staff that utilize the current EHR (Anasazi). The survey described the CalMHSA Multi-County EHR Project and included a mixed methods approach to collecting qualitative and quantitative responses. Staff participants included peers, behavioral health specialist, clinicians, SUD counselors, nurses, psychiatric providers, health information technicians, fiscal technicians, telehealth providers, contracted providers, information system technicians, and receptionists.
There were 50 respondents to the surveys, which represented a broad range of SCBH staff, contract providers, community members, and consumer and family members.

A 30 day public comment period will commence on September 3rd through October 3rd, 2022 with the release of Siskiyou County's Revised (DRAFT) 2022-23 MHSA Annual Update to include this draft appendix, associated INN Budget summary and INN Project description. A Public Hearing is scheduled with the Siskiyou County Behavioral Health Board on October 3rd to finalize the 30 day public comment period. A final draft will be presented for approval to Siskiyou County Board of Supervisors at the next available meeting on October 18th, 2022.

6. CONTRACTING

Organizational Management:

- The HHSA Director and/or MHSA Coordinator will serve as Lead Contact for the EHR INN Project. These individuals are experienced in stakeholder engagement and chairs various stakeholder system committees such as MHSA Consortium of Providers & Community Stakeholders and the SCBH Cultural Competency Committee. The HHSA Director and/or MHSA Coordinator manage the MHSA 3 Year Plan and Annual Update Community

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Planning Process annually and additional stakeholder engagement projects as needed.

- The Project Director will serve as Alternate Contact for the INN Project and develops all SCBH programs.
- The Department Information Systems (IS) Supervisor will serve as IS Project Leads for EHR INN Project. The IS Supervisor is experienced in our current EHR systems and overall I.S. technology and have led system-wide projects through our I.S. Department.
- Department Fiscal Officer will provide direct feedback for platform upgrades/changes and analysis for the Finance/Billing department to insure proper integration through the Medi-Cal billing system.

Contract Monitoring:
Ongoing contract monitoring and quality control is undertaken through the SCBH administration team, per protocols outline by the organization. Protocols include comprehensive contract review and auditing protocols.

SCBH contract monitoring is a year-long process of evaluating a contract's performance based on measurable deliverables and verifying contractor compliance with term and conditions of the contract with the County. The purposes of the monitoring are to 1) improve program performance, thereby mitigating program inefficiencies; 2) evaluate contractor performance controls to ensure there is a reliable basis for validating service deliverables; 3) to assure that the financial documentation is adequate and accurate; 4) and review compliance with applicable regulatory requirements.

7. COMMUNICATION AND DISSEMINATION PLAN

Upon approval of the INN project, the HHSA Director (and once hired, the MHSA Coordinator) will create an EHR Community Stakeholder group. Stakeholders engaged in the EHR Community Stakeholder Group may include: staff, providers, consumers, and family members. The stakeholder group will play a critical role to serve as an essential feedback loop to program design, system design and evaluation alike.
The EHR Community Stakeholder Group will be included as a subcommittee to the Quality Improvement Committee to solidify commitment to the stakeholder process. The subcommittee will be scheduled on the agenda on a monthly basis to provide ongoing progress and quarterly feedback from the larger stakeholder committee.

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SCBH will work with CalMHSA and its program partners to disseminate information regarding the EHR Multi-County Innovation Project to local stakeholders and counties. In general, communication pertaining to evaluation findings, or the publication of research studies will occur through the following steps:

1. SCBH will post a public announcement to the SCBH MHSA Website https://www.co.siskiyou.ca.us/behavioralhealth/page/mental-health-services-act
2. MHSA Coordinator and/or program staff will provide annual presentation to stakeholder committees (Behavioral Health Board, MHSA Consortium of Providers (CBO's), Consumer/Family Member Stakeholders, and Quality Improvement Committee) on progress of the innovation project.
3. SCBH will partner with CalMHSA to further expand and provide related reports to social media outlets to announce findings and direct subscribers to the report.

8. COUNTY BUDGET NARRATIVE

Expenditure Category	***Expenditure Item***	***Description/Explanation of Expenditure Item***	***Total Project Cost***
Other Expenditures		*10% Annual Administration costs for management of the contract.*	*$97,556 ($99,457 - 646,361 Annually)*
Contract/ Consultation		*Contract/PA Agreement with CalMHSA*	*$975,550 for 5 Year span of INN funds ($90,415 - $587,601 Annually)*

9. BUDGET & FUNDING CONTRIBUTION BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY

Attached as requested

10. TOTAL BUDGET CONTEXT: EXPENDITURES BY FUNDING SOURCE & FISCAL YEAR

Attached as requested

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY

COUNTY: ***Siskiyou County***

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	587,601	116,505	90,415	90,481	90,548	975,550
12	Indirect Costs						-
13	**Total Consultant Costs**	**587,601**	**116,505**	**90,415**	**90,481**	**90,548**	**975,550**

	OTHER EXPENDITURES (explain in budget narrative)	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
14	Administrative Cost	58,760	11,651	9,042	9,048	9,055	97,556
15							
16	**Total Other Expenditures**	**58,760**	**11,651**	**9,042**	**9,048**	**9,055**	**97,556**

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 al	587,601	116,505	90,415	90,481	90,548	975,550
Indirect Costs (add lines 3, 6, and 12 from	-	-	-	-	-	-
Non-recurring costs (total of line 10)						-
Other Expenditures (total of line 16)	58,760	11,651	9,042	9,048	9,055	97,556
TOTAL INDIVIDUAL COUNTY INNOVATION	**646,361**	**128,156**	**99,457**	**99,529**	**99,603**	**1,073,106**

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						

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
COUNTY:	***Siskiyou County***						
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	646,361	128,156	99,457	99,529	99,603	1,073,106
2	Federal Financial Participation						
3	1991 Realignment						
4	Behavioral Health Subaccount						
5	Other funding						
6	Total Proposed Administration	**646,361**	**128,156**	**99,457**	**99,529**	**99,603**	**1,073,106**
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*	646,361	128,156	99,457	99,529	99,603	1,073,106
2	Federal Financial Participation	-	-	-	-	-	-
3	1991 Realignment	-	-	-	-	-	-
4	Behavioral Health Subaccount	-	-	-	-	-	-
5	Other funding**	-	-	-	-	-	-
6	Total Proposed Expenditures	**646,361**	**128,156**	**99,457**	**99,529**	**99,603**	**1,073,106**
* 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.							