MENTAL HEALTH SERVICES ACT (MHSA)
INNOVATION 7 PROJECT -THERAPEUTIC TRANSPORTATION (TT)

The Innovation

Los Angeles County Department of Mental Health (LACDMH) proposes a countywide project to transform the County's approach to responding to individuals placed on an involuntary hold or at significant risk of being placed on a hold through engagement, support and recovery-focused interventions delivered using specially outfitted vans, staffed with Mental Health Clinicians, Mental Health Counselor, RNs (MHC, RN) and peer support specialists. Staff would offer a supportive and expedited response to transportation as well as initiate supportive case management in order to begin the healing and recovery from the exacerbation of mental health symptoms from the first point of contact. This mobile mental health van concept, modeled after the PAM (Psychiatric Emergency Response) ambulances of Stockholm, Sweden, provide supportive services delivered to individuals in crisis. Similar to the Sweden program, the LACDMH team will respond to the Psychiatric Mobile Response Team's (PMRT) request either to transport a client who is on a hold or to intervene on the streets to avoid the need for an involuntary hold. The team will provide a supportive and therapeutic environment consisting of a clinician, MHC, RN and peer support specialist as well as the capacity for tele-psychiatry services.

Through this project, LACDMH will introduce a therapeutic environment in the form of a specially outfitted van, a concept driven by community input and needs and a Board of Supervisor motion. Not only do we anticipate that this approach will shorten the wait time for an ambulance for medically stable, non-combative and cooperative individuals, therefore reducing the utilization of ambulance and law enforcement resources for 5150/5585 transportation, it will frontload the recovery process through a caring, non-restraining and supportive mobile environment. Ultimately, LACDMH anticipates, by changing the current transportation and engagement practices to a more consumer friendly and private, less traumatizing and less stigmatizing approach, this practice will frame and center the involuntary hospitalization process. TT will support clients and their families from the point of transportation to the hospital, as the first step toward recovery, contributing to increased consumer trust, reduced wait times to the hospital and reduced stigma. In the process of response, the teams may also serve to reduce the need for psychiatric hospitalizations.

Why the Need for Therapeutic Transportation in L.A. County

A motion was adopted by the Los Angeles County Board of Supervisors in 2017 to improve the standard of care for mentally ill individuals. The motion directed LACDMH to develop recommendations to adopt "humane treatment for those suffering from mental illness and are unwilling and/or incapable of accepting care." This proposed Innovation project was developed in partial response to that motion.

Between PMRT and law enforcement response teams a total of 13,253 holds were written in LA County last year (11,817 5150s/1,436 5585s). Many clients in Los Angeles County are reluctant to utilize mental health services, particularly in a mental health crisis. LACDMH crisis response teams often experience long waiting periods for transport of individuals placed on involuntary holds. It is common for the staff and client to wait several hours for an ambulance. This waiting period poses an array of challenges in ensuring safety and wellness of everyone involved in the process. LACDMH relies upon ambulance or law enforcement transportation for all individuals placed on an involuntary hold, including those individuals who are medically stable, cooperative with the process, and are neither combative nor violent.

Individuals placed on holds in LA County have often believed there is disregard for their dignity and rights, and the mere incident of transport via ambulance or law enforcement can make their mental health issues unwantedly visible to others in the neighborhood. This may aggravate the trauma and indignation they may have already experienced within their community. These transports may often increase stigma held by the community toward mental health consumers. Transports conducted by law enforcement are often misunderstood by the community, and might be interpreted to be the result of criminal activities rather than mental health matters. These negative impacts can further discourage underserved groups, clients and families from seeking necessary mental health services, possibly increasing trauma, especially through the use of restraints when in crisis. It is envisioned the use of TT will prove to be a more cost-effective approach for LAC, reducing time spent waiting for transport by law enforcement and other mental health professionals, allowing them to assist others in the community in need of crisis stabilization while TT handles the transport and linkage/admission process. This innovation project proposes to have a response time of within one hour of the request, and to allow for the transport of clients who meet specified criteria placed on involuntary holds. LACDMH has revised it's policy regarding the transportation of clients in order to implement this project.

Innovation Criteria

This proposal qualifies as an Innovation Project, through the introduction of an improved mode of transportation and therapeutic support for clients on involuntary holds. The project approach introduces a new application to the mental health system of a promising community-driven practice and approach that has been successful in a non-mental health context or setting by way of utilizing peers, decreasing wait times, and reducing the effects of trauma on individuals.

This mobile mental health van concept would provide supportive services delivered to individuals in crisis by having staff offer a supportive and immediate response to transportation as well as in initiating healing and recovery from the exacerbation of mental health symptoms and/or trauma. Another innovative approach to this project is the use of unmarked county vehicles designed with a therapeutic interior to ease the stress of the situation for clients. Multidisciplinary transport teams will be dressed in casual attire, trained for multiple crisis scenarios, focused on engagement, therapeutic support and trained in de-escalation approaches such as Mental Health First Aid among other approaches. For clients transported to an inpatient facility, there will be no gurney or restraints used. The van will be equipped with technology, making it possible for clients and team to communicate with tele-psychiatry services as needed. Additionally, this team will operate in a way that would provide further comprehensive information, education and advocacy for the individuals as a support system during transport, while also communicating and collaborating directly with hospital staff, intended to result in a more effective and efficient patient treatment transfer.

In response to community needs for greater efficiency, some states/counties are trying new pilot programs for alternative transportation; however, few agencies have developed an internal transportation team equipped with both multidisciplinary mental health professionals and peers. Based on the current practices of most agencies, alternative transportation utilization serves individuals who are 1) medically stable, 2) non-combative/violent and 3) cooperative with the involuntary hold process. Ultimately, the goal is for the agency initiating the 5150/5585 hold to make the assessment and decision on whether to use ambulance, law enforcement or the alternative TT team.

In reviewing the recent Innovations proposal submitted by Alameda County, the major differences between the plans of LACDMH and Alameda were interpreted as follows:

- The higher demand and volume of clients proposed to serve due to size and population of LA County being so expansive, the implementation of TT would greatly alleviate the impact of using

Law Enforcement and First Responders (due to already high demands in such a populated County)
- The use of peers on teams

Primary Purpose

The primary purpose of the project is to increase access and the quality of mental health services to underserved, unengaged groups. We anticipate this coming to fruition through the introduction of a more supportive and efficient way to intervene and, when needed, transport clients, while also reducing the risk for further trauma, and ensuring the client a TT member remains with them until the admission process is complete. When a mental health staff or team makes the determination to initiate an involuntary hold (5150 or 5585), the team can wait as long as 5-6 hours for an ambulance to arrive for transportation to the hospital. There are a number of problems with this practice; including (1) the inefficient use of staff that must stay with the client, (2) the client's own comfort is compromised, (3) once the client is placed in an ambulance or police car for transport, they are secured in such a manner that promotes safety to the exclusion of recovery.

LACDMH intends for these teams to improve the services and supports provided for the individual placed on a hold, provide linkage between the individuals and mental health services, and provide coordination of and connection to services across all services and supports, including psychiatry. The transport team will serve as a back-up team (not first responders) and would work with the LACDMH PMRT and Law Enforcement crisis response teams exclusively, resulting in better availability and more efficient dispatches in transporting individuals to the closest facility. Through decreasing the use of ambulance and law enforcement for the transport of individuals who are medically stable, non-combative/violent and cooperative during the hold process, we hope to see results of improved response times and the ability to respond to a greater number of calls for PMRT. Ambulances and law enforcement having the opportunity to move on to other challenging cases will be realized. Currently, Los Angeles County's revised policy to allow employees to transport individuals placed on 5150/5585 holds is at final review with County Council for approval. This is intended to support providing an innovative approach to greater communication and a reduction in unnecessary fear and anxiety towards hospitalization during the hold process.

The wished for outcome of this multidisciplinary transport team is to encourage the consumer to consent to the involvement of their support system in the care, treatment and discharge plan at the hospital, as well as educate on processes regarding their hold, hospitalization and discharge. The linkage process across all services is a vital component to this project, another opportunity this team will need to collaborate with the hospital staff on both current and/or available LACDMH services for the individual. With up-to-date information provided by the transport team, a hospital can establish services or make contact with the appropriate provider(s) early on, and establish an effective treatment and discharge plan for the client during hospitalization.

How the Teams Will Operate

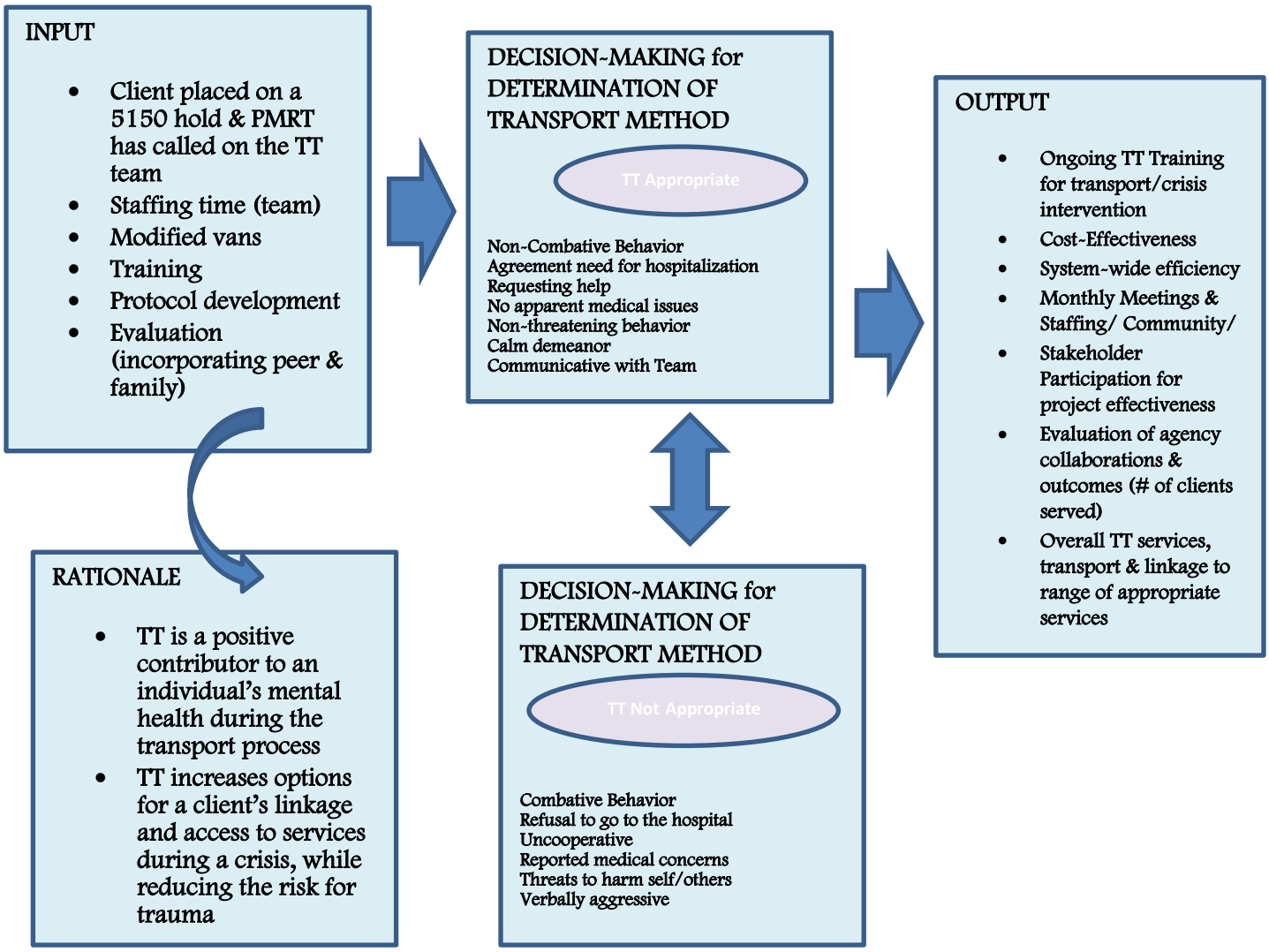
Teams will respond to requests from PMRT to transport clients who either have been placed on a hold and deemed safe for TT or at risk of being placed on a hold with the risk being mitigated by team intervention. During transport, the team will explain what has transpired, answer any questions the client may have, monitor vitals as indicated and consult and engage with tele-psych support as warranted, and with client consent, and assist with any urgent case management matters. The team or a team member will remain with the client in the setting during transport and through admission completion. LACDMH anticipates that the addition of a peer on the team will allow for a stronger, more relatable connection of trust for the client, while allowing the clinician to communicate clinical impressions during transport and

waiting, and the team to make calls, linkages, and appointments/cancellations necessary during their encounter.

Each team would have the capacity to intervene and/or transport at least 3 individuals daily. Minimally each Supervisorial District (SD) TT would consist of two (2) vans and four (4) teams of three (3) members each. These teams will also be supported, trained and directed by 4.0 Mental Health Clinical Supervisors and 1.0 Mental Health Clinical Program Manager II. The protocol would be for this team to respond to transport requests of clients placed on a 5150/5585 deemed safe for transport and approved for inpatient hospital admission. This team, or at minimum, one member of the team would remain with the client until admission is complete, should the team have another request for transport.

We envision the hours of operation for the teams to be daily from 10:00 am to 8:30 pm., and consisting of two (2) teams of three (3) team members, per SD. LACDMH is comprised of five (5) SDs; therefore, each SD will be comprised of four (4) teams working ten (10) hour shifts, with two (2) teams working Sunday through Wednesday and the other teams, Wednesday through Saturday. Wednesdays will be ideal for TT staff meetings and in-service trainings, as all team members will overlap on that day. We anticipate the need is for ten (10) vans and seventy-one (71) staff, (Twelve (12) per SD, in addition to the five (5) supervisory staff, five (5) administrative support staff and one (1) evaluation staff.) for the successful implementation of this proposed pilot plan.

LOGIC MODEL



Capacity

It is projected the TT teams will transport 11,000 clients annually, with projected numbers lower in the initial six months with start-up, allowing for the PMRT to respond to a greater number of clients in need of their services.

How the Project Meets MHSA Values

The Los Angeles County Department of Mental Health understands the importance of MHSA roots and core values when planning for services, and in developing this project, has incorporated principles and practices of recovery for mental health consumer as the pinnacle of this project, including:

- **Cultural Competence:** Initiating the addition of a peer on a multidisciplinary transport team, will allow for a stronger connection and trust for the client, knowing this individual has a better understanding of consumer services and delivery. A concentrated effort will be made during the recruitment and hiring of the teams, to match the ethnic and cultural makeup of each individual

SD. We anticipate the teams to be reflective of the cultural, ethnic and racial diversity of mental health consumers served in Los Angeles County.

- **Mental Health Care is Consumer and Family-Driven:** Planning for each consumer's individual needs on a customized basis will be the hallmark of this project, as it is critically important to involve the consumer needs and their families during times of crisis, and to ease the worry of all parties involved during a client hold. In the event of transport, we envision the team explaining what has transpired and why, answer questions the client may have, and through client consent assist with any urgent case management matters.
- **Focus on Recovery, Resilience and Wellness:** Clients will have decreased levels of trauma and an increased level of support from the multidisciplinary transport team, allowing for a greater level of focus on their recovery, resilience and overall wellness during an acute occurrence. Through decreasing long wait times, as well as stress of restraints used during transport, clients will experience a greater level of support throughout the transport. Clients will be empowered through a new level of comfort to ask questions or contact providers and/or family to inform them of the current situation. The conversations during transport will focus around wellness, recovery, resilience and planning next steps for their journey ahead.
- **Service Integration:** Supported transport from point of initial contact until admission completion, will create a stronger connection of trust between client, professional, peer and community resources. The TT team, advocating for and connection to appropriate supports will decrease wait times and trauma, while increasing efficiencies across systems community-wide. The clinician will communicate clinical impressions during transport and waiting, the case manager will make calls, linkages, and appointments/cancellations necessary during their time together. The team or the peer team member will remain with the client through the admission process, to assure collaboration, plan and connection is solid.

Target Population

The target population of this project will be Los Angeles County residents experiencing a behavioral health crisis within their community, not resulting in the need for emergency medical services; therefore, placed on an involuntary psychiatric hold or at risk of being placed on a hold by the LACDMH PMRT. Additionally, this team envisions working with the families of these individuals, in order to provide support, information and beneficial feedback for all affected parties. To be clear this TT project will be separate from any and all SB 82 projects currently being implemented in Los Angeles County.

Goals of This Project

The Los Angeles County Department of Mental Health envisions continued growth in the peer role, becoming an even greater integral component throughout the LACDMH service delivery system. Introducing peers into emergency services, we predict, ultimately improves a timely connection to clients in urgent situations, based on an increased level of trust between peers. We visualize this model informing emergency services of the need to integrate peers onto PMRT teams, conceptually leading TT to decreased client trauma, lower number of clients falling through the cracks, improved access to care, decreased hospital stays, enhanced support and empowerment of client needs, all of which are imperative long-term goals of the LACDMH system. The project also hopes to make an impact upon other systems, freeing up law enforcement to focus upon the safety of the community and increasing ambulance transport availability for health emergencies. Finally, an ability to respond to emergent calls, in a timely and as needed manner, projects improved access to this level of care and improved services provided. In summary, TT would:

- Decrease wait time and improve response times for PMRT and transportation

- Provide opportunity for team to remain with client until admission is complete
- Provide services and supports throughout the transport process
- Decrease trauma throughout the hold and transport process
- Incorporate peer support staff on the team to allow better understanding of each situation and establish peer-to-peer support.
- Improve collaboration across systems and efficiency in connection to supportive services
- Decrease the average number of inpatient days for clients transported by the TT team, as compared to alternate forms of emergency transport

Overarching Learning Questions and Evaluation

1) Will PMRT teams be more efficient in responding to a greater number of field calls with the implementation of Therapeutic Transportation teams?
    a. A comparison made quarterly, as compared to the previous year, analyzing the request for calls in contrast to actual response calls
    b. Track and record the number of TT provided, per SD, on a quarterly basis
2) Will there be a decrease in adverse events for clients during the waits for TT transport to hospitals, as compared to alternate forms of transportation?
    a. All adverse events occurring for clients placed on holds and waiting for transport, will be tracked and reported on a quarterly basis
    b. A comparison will be made between events occurring while clients are waiting for TT, as opposed to individuals waiting for alternate forms of transportation
3) Will wait times be decreased between the written hold and transportation arrival, based on the introduction of the therapeutic transportation team, and how will this impact the number of requests for alternate forms of transportation?
    a. Track and report on a quarterly basis the length of time it takes TT to arrive to calls as compared to alternate forms of transportation.
    b. Analyze if alternate forms of transportation times are improving, as compared to previous reported wait times
    c. Track and report the number of TT, ambulance, law enforcement and other forms of transportation for clients on holds on a quarterly basis.
4) Will utilizing peer support staff on the team, and encouraging primary interaction between the peer and the client during transport improve personal empowerment and buffer the negative impacts that may otherwise affect trauma during the hold and transport process?
    a. Complete a questionnaire with all clients receiving TT regarding their experience and the impact by the addition of a peer on the team
5) Will the length of hospitalization days decrease with positive effects of therapeutically transporting (i.e., trusted, timely, professional interactions between transport team and client) as well as providing a compassionate presence, problem resolution, and providing linkage throughout the process from TT arrival until the client has completed hospital admission?
    a. Compare the number of days hospitalized after a 5150, between TT and alternate modes of transportation; determine if the correlation between transportation and number of days hospitalized is significant and contributes to a cost savings
6) Will TT recipients obtain more timely and consistent connection to services?
    a. Track and compare when appointments are made for clients receiving TT opposed to other forms of transport; track this through SRTS and IBHIS and report on a quarterly basis
    b. Track the rate at which clients receiving TT keep appointments, opposed to other forms of transport by capturing this information through SRTS and IBHIS; report on a quarterly basis

Throughout the three (3) year implementation of the TT project, the Department will focus on learning, addressing barriers to implementation, identifying and promote successful strategies, and using outcomes to guide learning. As with all components of MHSA, implementation and preliminary outcome reviews with LACDMH's System Leadership Team (SLT) will occur periodically and reported upon through the MHSA Annual Updates/MHSA Three Year Program and Expenditures Plan. A shared, in-house, psychologist and analyst, who are dedicated solely to INN evaluation, will support outcome collection and analysis efforts. Results will be reflective of a set of common measures, record review, as well as data specific to the TT project.

Stakeholder Involvement in Proposed Innovation Project

The LACDMH Program Development and Outcomes Division (PDOD) began the outreach and development of the INN Pipeline Group in December, 2017. The group was established in an effort to expedite the creation, vetting and development of INN projects in Los Angeles County. A "quick guide" to INN guidelines and an "INN feedback form" were developed and posted on the LACDMH website in early January, to cast a wide net and encourage countywide participation and feedback. The form remains posted in a click and submit format, and upon completion, is sent directly to the bureau and taken to the pipeline for review and discussion. Both the pipeline group and feedback form provide ongoing and diverse stakeholder input, feedback and contribution. The pipeline group initially met on January 9, 2018, and has met on the following dates: January 23, February 6 and 13, March 6 and 20, April 3, May 1 and 29 and June 26th. The group will continue to meet ongoing, at least monthly, with meetings scheduled through the end of the calendar year

The pipeline group has grown to 45 members, and is open to others joining. These individuals represent the following constituencies: Peers, peer services, the mental health commission, contracted agencies, veterans, transitional age youth services, family members, older adult services, education and employment, housing, emergency services, directly operated agencies, LGBTQ population and services, Asian Pacific Islander population, African African-American population, Latino population, Children's services, Schools, NAMI, Service Area Advisory Committee members, Urgent Care Centers, community consultants/activists and ACHSA.

The TT proposal was presented on January 23, 2018 and February 20, 2018 and was vetted at the February 20th pipeline group. Presentations made to the SLT in January, April and June of 2018, and generated useful feedback and suggestions. These discussions intended to encourage participation and gain input into the Pipeline group, as well as share the posted AB 114 INN proposed spending plan (posted 03/23/2018). The TT plan was posted for public comment on May 25, 2018 and no substantiate public comment which led to changes in the plan were received. Both groups are composed of diverse community stakeholders, county staff, family members and individuals who receive mental health services in Los Angeles County. Further stakeholder involvement was stimulated through discussion and distribution of INN pipeline information and feedback forms to the following groups for presentation: The Client Advisory Board Meeting, The Peer Resources Center, The Disability Underserved Cultural Community Meeting/Group, Service Area Advisory Committee (SAAC) Chairs, NAMI Chairs, and the Program Manager III's to inform various clinics across the county.

The INN Team presented to the Underserved Cultural Communities (UsCC) group on May 14, 2018 and at the Cultural Competency Committee meeting on June 13, 2018. This effort intends to bridge Los Angeles's diverse cultures and communities and ensure that needs and concerns of the diverse cultures in Los Angeles are weaved throughout the development and implementation of all INN projects. Work with these groups will remain ongoing at the community level, and throughout the implementation phase.

UsCC subcommittee meetings have been attended by the INN team to discuss community needs and input, at the Native American, Eastern/Middle Eastern and Asian Pacific Islanders, and the Deaf, Hard of Hearing, Blind, and Physical Disabilities and are scheduled with both the African African-American and Latino subcommittees.

The only public comment received recommended increasing the number of teams as well as the infrastructure. LAC DMH acted on part of the recommendation, doubling the initially proposed program and adding four (4) supervisors and an entry level program manager to ensure appropriate supervision and oversight.

Timeframe and Project Milestones
This project proposes a three (3) year Innovation project.

A timeline, as systems allow, anticipates:

- September 2018: Present proposal to OAC
- October 2018: Submit Board Letter to Board of Supervisors for position approvals.
- October 2018: Order vans, develop policies, procedures and training
- January 2019: Hire staff
- January 2019: Implement the countywide TT project (dependent upon outfitted vans' arrival)

Board of Supervisor and Mental Health Commission Endorsement
The Los Angeles County Board of Supervisors adopted this project, along with other AB 114 Innovation projects, at its June 6, 2018 meeting. This project, along with other AB 114 Innovation projects, were presented to the Mental Health Commission on June 28, 2018. The Commission supported the projects and had one of its Commissioners regularly attend Innovation Pipeline workgroup meetings as these projects were developed and vetted.

Disseminating Successful Learning
The Department of Mental Health will assess real-time effectiveness of service provision, the support and training needed for TT team members and will incorporate learning and successful approaches into the Department's service array. Throughout the three (3) year project, a comparison study of the average length of hospitalization will begin to inform if decreasing trauma and wait times, while utilizing a multidisciplinary team of peers and clinical staff combined would lessen the severity of otherwise acute case outcomes. Outcomes will also reflect decreased wait times and improved response times, the effects of providing supportive services while decreasing trauma during the transport process, and utilizing peer support staff members to facilitate in creating a difference in both understanding the crisis and relating to the client. Learning shared with providers and the state through provider meetings, learning seminars, workshops and conference presentations will be of great importance to share findings regarding the incorporation of peers into the emergency service level of care, across the country, and to continue to inform systems regarding the importance of peers at all levels of mental health services.

Sustainability
This project will establish ten (10) fully equipped therapeutic vans that will continue provision of safe and efficient transportation of clients in MHSA funded programs, on involuntary holds at the completion of the INN project. Based on the learning from this project, LACDMH will attempt to acquire funds through outreach and engagement dollars, in order to continue and/or expand these established teams. If funding is not available, TT staff will integrate into existing PMRTs, and will utilize vans and the therapeutic transportation model in MHSA programs, within SDs with the highest demand for TT services.

Budget Narrative

The budget for this project includes staffing and therapeutically outfitted vans for the supportive transport of cooperative, non-combative clients on involuntary holds. The outfitted vans will depreciate by $35,000 annually and be worth approximately $45,000 at the end of the project. The list price of the vans includes maintenance and the cost of running the vans. On the attached detailed budget sheet, there are two separate line items indicated for training, one designated for the annual required staff training and the other for project specified training.

The following staffing items will be responsible for the following duties:

The MHC Program Manager II (PM II) will oversee the teams across the county, covering all five (5) SDs in the County. They will provide oversight and support to their assigned teams, and clinical direction as needed and in times of crisis. They will supervise the four (4) supervisors and assist them on a weekly basis with in-service trainings and team meetings.

The *four (4) Mental Health Clinical Supervisors* will supervise a team of fifteen (15) individuals, across the SDs. They will be responsible for clinical and/or administrative supervision of all staff on their SD team. They will coordinate, develop and/or organize weekly staff meetings, which will minimally include in-service trainings each week and focus on staff support and avoiding burnout. They will plan team assignments, be responsible for team rotations and assure mentoring relationships are positive and supportive. They will consult with staff as needed regarding direction to take out in the field and will go out to meet the team if this is the most clinically sound decision to ensure the best outcome for the client, family and team. They will also support the team periodically on calls and/or on bridging efforts in order to observe staff interventions, strengths and possible challenges to be worked on. This will benefit the team in rotating staff to support and balance one another's strengths and challenges and encourage learning and ultimately inform the supervisor on what is necessary to focus on during weekly in-service training and support meetings. They will consult with the PM II, as needed and share collaborative challenges across programs. Responsibility for the ongoing UR/QA monitoring and training of staff will lay with each SD supervisor with oversight from the PM II.

There will be *five (5) Administrative Support staff,* 1.0 Secretary III will be assigned to the PM II to assist with communication, coordination and organization matters, each of the 4.0 Supervisors will have 1.0 Intermediate Typist Clerks work with them to support the team with any questions they may have as well as organization and collection of outcomes, etc.

The twenty *(20) Mental Health Clinician IIs, Mental Health Counselor, RNs (MHC, RN) and Community Workers (CW)* will make up twenty (20), three (3) person teams that will function seven days a week between the hours of 10:00 a.m. and 8:30 p.m., within each of the five (5) SDs. These teams will be responsible for responding to requests from PMRT and other emergency response teams, to support clients and their families through urgent/emergent situations in the field and transport clients on hold to the hospital. Should the client be in need of being connected, and is not currently open in the system, they would assist in setting up services for the client upon discharge from the hospital. Should the client be open in the system, the clinician may contact their provider to gain important clinical information to share with the hospital upon admit. The MHC, RN may take vitals, consult with assigned psychiatrist or through tele-psychiatry capabilities as is indicated. CW's will focus on connecting and supporting clients as needed, sharing lived experience as indicated to assist in supporting the client through the process. The team will be responsible for driving the van, connecting to services, explaining the process to the client and lending support and connection to any services and/or individuals the client is in need of

communication with or connection to. The teams will provide a mentoring and supportive relationship, along with an environment for didactic learning for both parties. The team, or a member of the team will remain with the client until the hospital admission process in complete, all information has been communicated and the client has been therapeutically supported through the entire process.

Below indicates the specific needs and costs associated with the project *that are not claimable to Medi-Cal and claimable only to MHSA*, followed by an attached budget worksheet.

The total MHSA Only budget for this project is $18,342,400.

- Evaluation Staff (Clinical Psychologist II): $171,285
- Outfitted Van x 10: ($150,000), $1,500,000 (MHSA Only/One Time Funds)
- Tele-Psychiatry Equipment x 10: ($10,000), $100,000 MHSA Only/One Time Funds)
- Mental Health Clinical Program Manager II: $208,324
- Mental Health Clinical Supervisor x 4: ($151,166), $604,664
- PSW II x 20: ($137,435), $2,748,700
- Community Worker x 20: ($81,158), $1,623,160
- Mental Health Counselor, RN x 20: ($190,901), $3,818,030
- Training Expenses: $175,000 across the span of the project
- Secretary III: $89,285
- Intermediate Typist Clerk x 4: ($73,834), $295,338

Estimated MHSA Only Budget, Last 6 Months of Fiscal Year 2018-19: $3,340,144

- $85,642 Evaluation Staffing (MHSA Only)
- $104,162 Mental Health Clinical Program Manager II
- $192,312 Administrative Support Staff
- $302,332 Mental Health Clinical Supervisors
- $50,000 Training

Estimated MHSA Only Budget Fiscal Year 2019-20: $5,831,056

- $171,285 Evaluation Staffing
- $208,324 Mental Health Clinical Program Manager II
- $384,623 Administrative Support Staff
- $604,664 Mental Health Clinical Supervisors
- $50,000 Training

Estimated MHSA Only Budget Fiscal Year 2020-21: *$5,831,056*

- $171,285 Evaluation Staffing
- $208,324 Mental Health Clinical Program Manager II
- $384,623 Administrative Support Staff
- $604,664 Mental Health Clinical Supervisors
- $50,000 Training

Estimated MHSA Only Budget, First 6 Months of Fiscal Year 2021-22: $3,340,144

- $85,642 Evaluation Staffing

- $208,324 Mental Health Clinical Manager II
- $192,312 Administrative Support Staff
- $604,664 Mental Health Clinical Supervisors
- $25,000 Training

*Staffing includes annual salaries, employee benefits and services & supplies
Please see attached budget worksheet for further detailed budget information.

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
PROGRAM DEVELOPMENT AND OUTCOMES DIVISION
INNOVATION 7 (INN 7) - THERAPEUTIC TRANSPORTATION - GRANT PROPOSAL

INN 7 - Budget Worksheet - ATTACHMENT

MHSA 3 YEAR BUDGET PLAN - $ 18,342,400

SALARIES & EMPLOYEE BENEFITS (EB)	ITEM & DESCRIPTION		FTE's	*FY 2018-19 TOTAL SALARY & EB Jan 1, 2019 thru Jun 30 2019	FY 2019-20 TOTAL SALARY & EB	FY 2020-21 TOTAL SALARY & EB	*FY 2021-22 TOTAL SALARY & EB Jul 1, 2021 thru Dec 31 2021
	CLINICAL						
ITEM NO.							
9035N	PSYCHIATRIC SOCIAL WORKER II		20.0	$1,170,847	$ 2,341,693	$ 2,341,693	$1,170,847
8103N	COMMUNITY WORKER		20.0	$608,079	$ 1,216,158	$ 1,216,158	$608,079
5278N	MENTAL HEALTH COUNSELOR, RN		20.0	$1,705,515	$ 3,411,030	$ 3,411,030	$1,705,515
8697N	CLINICAL PSYCHOLOGIST II*		1.0	$75,468	$ 150,936	$ 150,936	$75,468
4741N	MENTAL HEALTH PROGRAM MANAGER II		1.0	$93,987	$ 187,974	$ 187,974	$93,987
9038N	MENTAL HEALTH CLINICAL SUPERVISOR		4.0	$261,633	$ 523,265	$ 523,265	$261,633
2214N	INTERMEDIATE TYPIST CLERK		4.0	$114,969	$ 229,939	$ 229,939	$114,969
2096N	SECRETARY III		1.0	$36,467	$ 72,935	$ 72,935	$36,467
	Clinical FTE Subtotal		**71.0**				
TOTAL SALARIES & EMPLOYEE BENEFITS FTEs		**$ 24,401,787**	**71.0**	**$4,066,965**	**$ 8,133,929**	**$ 8,133,929**	**$4,066,965**
TOTAL CAPITAL ASSETS & SPECIALIZED TRAINING				**S&S Including ONE TIME**	**ONGOING S&S**	**ONGOING S&S**	**ONGOING S&S**
CAPITAL ASSETS:							
	VANS 10 @ $150,000.00 (One Time Cost)	1,500,000		$ 1,500,000			
	TELE-PSYCHIATRY EQUIPMENT 10 @$10,000 (One Time Cost	100,000.00		100,000			
*** SPECIALIZED ANNUAL TRAINING							
	3.5 @ $50,000.00 (1 per Fy)	175,000		***50,000***	50,000	50,000	25,000
TOTAL CAPITAL ASSETS & SPECIALIZED TRAINING		**$ 1,675,000**		**$ 1,650,000**	**$ 50,000**	**$ 50,000**	**$ 25,000**
SERVICES & SUPPLIES: ONGOING COST	*County Telephone*		800	*$ 28,400*	*$ 56,800*	*$ 56,800*	*$ 28,400*
	Telecommunication (Cell Phone/Pagers)		700	*$ 24,850*	*49,700*	*49,700*	*$ 24,850*
	Office Supplies		600	*$ 21,300*	*42,600*	*42,600*	*$ 21,300*
	Personal Computer Software		500	*$ 17,750*	*35,500*	*35,500*	*$ 17,750*
	Computers		1000	*$ 35,500*	*71,000*	*71,000*	*$ 35,500*
	Printer/Peripherals		400	*$ 14,200*	*28,400*	*28,400*	*$ 14,200*
	*Space **(Clinical)***		15000	*$ 495,000*	*990,000*	*990,000*	*$ 495,000*
	*Space **(Admn)***		11000	*$ 27,500*	*55,000*	*55,000*	*$ 27,500*
	*** Training*		800	*$ 28,400*	*56,800*	*56,800*	*$ 28,400*
	Utilities		250	*$ 8,875*	*17,750*	*17,750*	*$ 8,875*
	Mileage		200	*$ 7,100*	*14,200*	*14,200*	*$ 7,100*
	Travel		100	*$ 3,550*	*7,100*	*7,100*	*$ 3,550*
TOTAL SERVICES & SUPPLIES - ONGOING COST		**$ 4,274,550**		**$ 712,425**	**$ 1,424,850**	**$ 1,424,850**	**$ 712,425**
GROSS PROGRAM COST		**$ 28,967,556**		**$ 6,429,390**	**$ 9,608,779**	**$ 9,608,779**	**$ 4,804,390**
							REVENUE
REVENUE (MEDICAL/FFP/NON EPSDT):		**$ 10,625,156**					
	MCE @ 27%			$ 1,235,396	$ 2,539,331	$ 2,539,331	$ 1,235,396
	Non-EPSDT			503,309	1,034,542	1,034,542	503,309
TOTAL REVENUE				**$ 1,738,705**	**$ 3,573,873**	**$ 3,573,873**	**$ 1,738,705**
NET PROGRAM COST		**$ 18,342,400**		**$ 3,340,144**	**$ 5,831,056**	**$ 5,831,056**	**$ 3,340,144**
	9911 MHSA ONLY						**18,342,400**
						TOTAL MHSA COST	**$ 18,342,400**

*** DENOTES LAST HALF OF FY 2018-19 & FIRST HALF OF FY 2021-22**

**** Mandatory staff training** ***** Specialized Project Training Cost *(inclusive of $25,000 additional startup cost for FY18/19)***