PEI PROJECT SUMMARY

PEI Project Name: Rural Integrated Behavioral Health & Primary Care Services

County: San Diego

Date: 11/19/08

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☒	☒	☒
2. Psycho-Social Impact of Trauma	☒	☒	☒	☒
3. At-Risk Children, Youth and Young Adult Populations	☒	☒		
4. Stigma and Discrimination	☒	☒	☒	☒
5. Suicide Risk	☐	☐	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☒	☒
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☐	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐		
6. Underserved Cultural Populations	☒	☒	☒	☒

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B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Rural Community as one of our 10 priority focus areas. Below is a summary of stakeholder input and background information.

The following input was provided by stakeholders at several community forums, including those held in five rural community sites:

- Educate/train community residents and service workers (postal carriers, beauticians, law enforcement, pet groomers, food delivery, and visiting nurses) to recognize at-risk warning signs (overfull mailbox) and provide written resource information to at risk individuals;
- Link with exiting rural organizations (Planning, Community Emergency Response Team "CERT," Senior Centers, Community Centers, Fire Protection, and Faith-Based) to promote and engage the community in PEI activity;
- Provide mobile services or tag-along with existing mobile services (book mobile, food services) to outreach, educate, and engage at-risk persons and their families/friends at locations where they live/work/visit (e.g. trailer parks, restaurants, churches, libraries, hair salons);
- Utilize community locations to advertise services such as the post office, community bulletin boards, and back country newspapers to provide prevention information and information about community prevention events;
- Develop in-home screening and assessment;
- Provide short-term intervention with information on follow-up resources and services to reach the population where they reside;
- Team mental health service provider staff (may be on-call) with Sheriffs Deputies to assist in responding to situations that are traumatic or involve persons with behavioral health problems;
- Initiate regular (monthly, quarterly) meetings with rural behavioral health service provider staff and first responders (fire and Sheriff) to improve collaboration through joint training and information sharing;
- Educate/train community members to identify at-risk neighbors and help them access services, "neighbors-helping-neighbors;"
- Co-locate PEI services with other services to address the shortage of suitable facilities and to reduce stigma;

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Community input received at the Child/Youth and Family Forum:

- Serve children/families in communities (where they are),
- Develop outreach and screening services for children and families,
- Bring outreach services to neighborhoods, and
- Develop marketing and outreach to general population on developmentally specific mental health issues.

Community input received at the Co-occurring Disorders Forum:

- Create mobile teams and fixed centers to provide outreach and engagement and as needed, immediate response to trauma (suicide, death, domestic violence) or disaster (fire, flood, accident);
- Mobile teams to attend community events, casinos, and "go-to" locations;
- Expand public access to mental health information, self-screening tools, and lists of appropriate resources such as County on-line resources (Network of Care) and public TV;
- Advertise access in high traffic locations;
- Use creative arts (music, art, poetry) to engage at-risk persons;
- Educate/train staff of organizations in contact with specialized populations such as community organizations (e.g. meals on wheels), faith-based, businesses (hairdressers, native food stores), public systems (schools, law enforcement), and physical health service providers to be sensitive/accepting, identify at-risk persons, and help them build resilience to stress and trauma and access services;
- Educate/train community members to be peer counselors/mentors and trainers of other community members and non-community service providers; and
- Develop and distribute public service announcements to reduce stigma and help the public identify at-risk persons and help them access services.

Other data supporting this program include:

- 2006 American Psychiatric Association Report – Behavioral Health Outreach: Integrating Medical and Behavioral Health Care. There is a high co-morbidity of depression and chronic medical disorders that has led to the development of depression management programs that integrate mental health services into primary care settings.

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- September, 2006 United Behavioral Health Report – Improving Total Health & Well-Being: An Innovative Approach That Integrates Behavioral Health Across the Health Care Continuum. "The prevalence of depression, anxiety, and substance abuse in the population with chronic conditions is two to three times that in the general population and has a dramatic impact on the clinical and financial outcomes of these conditions," said David Whitehouse, M.D., Chief Medical Officer for strategy and innovation for United Behavioral Health.
- 1998 American Psychiatric Association report – Linking Primary Care and Rural Psychiatry: Where Have We Been and Where Are We Going? A National survey identified 53 successfully linked programs, ranging from small local efforts to sophisticated multipoint networks. A concern in rural areas is how to improve access to mental health care. Limited access stems from problems in the availability and acceptability of mental health care. Rural areas are considered medically underserved communities and that includes behavioral health services. Generally, few mental health providers, particularly psychiatrists, work in rural areas. Rural persons are often unwilling to seek mental health care from available providers because of the stigma that may result from being identified as a mental health consumer. In general, stigma may be more strongly experienced in rural areas where people know whose vehicle is parked by the mental health center. Policy makers have promoted linking primary care with mental health care for more than 30 years to improve access to mental health care in rural areas.
- San Diego County has twice implemented a Federal Emergency Management Agency (FEMA)/Substance Abuse and Mental Health Services Agency (SAMHSA) grant to provide outreach and support to wildfire survivors after two devastating wildfires within the County. The Wildfire Recovery Project model of outreach and supportive counseling has been highly successful in providing preventative services to reduce the trauma effects of the wildfire losses. The model includes outreach workers that are hired from the community. These community workers have knowledge and relationships within their community, which facilitates engagement of the community members in prevention and early intervention services. The community members are also able to identify community residents at risk for behavioral health issues.
- Poverty and lack of access to services is an extreme issue in the unincorporated rural Mountain Empire of San Diego. Of the 11,708 residents, Census 2000 shows at least 63% are at or below the 200% federal poverty level. The California Department of Education shows the Mountain Empire Unified School District as having 69% of its students eligible for free or reduced price lunch, higher than the average for the both the state and county. Access to care in these communities is limited due to a lack of facilities and transportation, thus posing a greater need for adequate mental health care to be serviced in the area. Native Americans comprise 4% of the population in this isolated rural mountain region with several reservations and 17 tribes represented. The entire rural ethnic/cultural makeup in San Diego County is predominantly white (75%) with Hispanic (16%), Asian/other (5%; this includes Native American), and African American (4%) residents.

- Access to appropriate healthcare is an ongoing problem for the rural mountain empire and mental health services are nearly non-existent. In 2000, the Scripps Hospital East closed it doors resulting in a 45 to 90 minute drive to access the nearest emergency medical facility. Public transportation consists of one bus to service a portion of the area making a stop early in the morning and again in the late evening.

A PEI workgroup began to construct and facilitate a program design based upon community need and response. Group members included Juvenile Probation, Child and Adolescent Services Research Center (CASRC), Adult Mental Health, Children's Mental Health, Alcohol and Drug Services, and representatives from both East and North Inland regions of HHSA. Stakeholder and community input was reviewed and indicated that behavioral health prevention and early intervention services were needed for all age groups in rural underserved communities. As a result of this process, the Rural Integrated Community Behavioral and Primary Care Services plan was formulated to provide mobile outreach to underserved populations. This model is consistent with the PEI Community Needs, Priority Populations and principles.

3. PEI Project Description: (attach additional pages, if necessary)

The focus of this PEI Plan is to establish fully integrated, behavioral health/primary care services for children, adolescents, transitional age youth, adults, and older adults in a rural community clinic. The plan model supports early intervention of individuals with risk of mental health and drug and alcohol use issues within a primary care context before their condition worsens and they could require specialty services. The plan is designed to implement a seamless integration of medical and behavioral health care that will reduce the stigma associated with seeking help for a range of behavioral health issues. Addressing behavioral health is increasingly recognized as an important aspect of dealing with overall physical health and well-being of individuals. The model will be transformational, enhancing services to patients, and will promote environmental/cultural change within the clinic. Community clinics offer a natural setting for promotion of optimal mental health. The program will increase the provider's capacity to offer effective mental health guidance and early intervention treatment through implementation of routine screening, education, consultation, and referral. The Group Health Collaborative of Puget Sound has had, for more than a decade, a similar successful model for integrated behavioral health within the primary care setting. In that model, behavioral health professionals with special skills in consultation and primary care liaison are actually integrated within the primary care team.

The proposed program will implement services that prevent patients within the community clinic from developing an increased level of behavioral health issues, severe mental illness, or addiction by addressing behavioral health needs early. Primary care patients with risk factors can benefit from a psycho-educational intervention to manage mental and

emotional stress and unhealthy behavioral patterns, including those associated with various medical conditions. The plan will also include a mobile outreach component for prevention and early intervention through the use of a team of licensed behavioral health staff and para-professional outreach specialists who will engage clinic patients and the broader rural communities.

The model for identification of risk shall be the universal Screening Brief Intervention and Referral (SBIR) tool. The SBIR model is a method for identification of persons at risk for a behavioral health condition. SBIR shall be implemented routinely within the clinic(s) for patients who have not been screened within the past sixty days. The goal of the brief screening is to identify behavioral health issues as a routine part of medical care. SBIR includes screening plus immediate feedback, which serves as an intervention and is tailored to the patient's level of illness or risk. Brief intervention feedback raises awareness of risks and seeks to motivate the patient toward acknowledgement of the problem. It offers a menu of change options and places the responsibility to change on the patient. Critical to brief screening is the incorporation of five basic steps:

- Introducing the issue in the context of the patients health;
- Screening, evaluating, and assessing;
- Providing feedback, talking about change, and setting goals;
- Summarizing and reaching closure; and
- Follow up care management contacts.

Brief intervention and prevention typically last one to three sessions and not more than five sessions. It utilizes a motivational interviewing style that incorporates a readiness to change model based upon the work of Prochaska and DiClemente. Their stages of change model tailors brief interventions to patient needs and the current stage of change. Brief intervention is low cost, low intensity, and of short duration. Using the results of a screening questionnaire, an individual may receive brief intervention(s) or be referred to specialized treatment. A key concept in the delivery of brief intervention is respect for the patient and confidentiality. Interventions need to be in a space with privacy and no interruptions.

An integrated model will include licensed behavioral health specialist(s) as part of the primary care team. The licensed behavioral health specialist(s) shall provide consultation and professional development to primary care providers and participate in team meetings to address integrated patient care. The integrated model shall increase the competence of primary care teams to recognize early signs of at-risk behaviors and early psychiatric illness and/or addictions through the screening of clinic patients. Healthcare staff shall utilize evidence-based, age-appropriate, and culturally sensitive screening instruments that identify alcohol and drug issues, gambling issues, early mental health risk factors, and the

strengths of the patients. Examples of such tools are depression screening tools, brief version of the Parent Stress Index, Alcohol Use Disorder Identification Test (AUDIT), CRAFFT, and the brief screening developed by the Behavioral Health Co-occurring Initiative to identify either drug and alcohol or mental health issues. Time shall be allocated for the primary care physicians to consult with behavioral health specialists and participate in ongoing education in order to develop a holistic approach to prevention and to intervention treatment of uncomplicated serious psychiatric illness.

Priority risk factors to be targeted by SBIR include, but are not limited to, depression; suicidal ideation; impact of stressors on daily life; post-partum depression; isolation, caregiver burden, problems with substances and other conditions of older adults; drug and alcohol use; mental illness; early signs of behavior problems in children; stress level related to parenting, unhealthy lifestyle choices including poor nutrition and lack of physical activity; and problem gambling.

Behavioral health specialists shall model a strengths-based approach to instill a sense of optimism and hope in the patients and their ability to overcome the risk factors and stresses they are experiencing.

Integrated licensed behavioral health specialists shall provide consultation with the primary care team(s). The licensed behavioral health specialists shall train and supervise paraprofessional outreach behavioral health specialists to provide preventative and early intervention services within the clinic or through outreach in rural communities. All healthcare staff may screen and provide brief intervention in order to promote healthy living choices, good problem solving skills, and emotional wellness. The licensed behavioral health and outreach specialists shall assist primary care providers in understanding the range of alternative healing modalities that may be utilized, especially by Latino and Native American patients, such as use of herbal remedies. The licensed behavioral health specialists shall be available on-site to provide additional assessment if needed, referral, and linkage to services for those patients identified as needing treatment. Referrals of patients for assessment and linkage may also be made through other community services and schools.

A culture shall be created where primary care physicians shall provide early intervention treatment of mentally ill patients before their condition worsens to avoid the need for specialty mental health services. Psychiatric consultation and consultation with the licensed behavioral health specialists on the team shall promote the capability of primary care physicians to provide these early intervention services. A liaison will be established between community clinics, county mental health clinics and Alcohol and Drug Services (ADS) personnel in order to improve linkage and referral between the community clinics and the traditional mental health and alcohol and drug service systems. A structure shall be developed to coordinate care, cross refer, and provide consultation between traditional mental health and ADS primary care team.

Due to transportation issues in rural communities, access to services is limited. To improve access to service for patients at risk of behavioral health conditions, the plan includes a mobile outreach component. Community liaisons shall be hired from the rural communities and reflect the cultural/ethnic composition, language needs, gender, and generational needs of

the targeted population. Community liaisons shall be trained in brief screening by licensed behavioral health staff. They may provide screening and brief intervention services that focus on fostering resiliency and wellness. They shall design interventions that are tailored to the individual's current stage of change, sensitive to the various cultural norms of patients, and that reduce the stigma associated with behavioral health issues. The community liaisons may conduct follow up with patients through telephone contact or in-home visits to reinforce the intervention strategies resulting from early screening.

While the community liaisons shall target clinic patients, they shall also develop public awareness activities that promote wellness and healthy living choices for the broader community in which patients reside. Community liaisons shall work with community partners to assess community needs in relation to such activities. Activities may include the following:

- Psycho-educational classes on parenting, stress management, dealing with loss, healthy relationships, teen relationship violence, drug and alcohol use, promotion of abstinence, and good nutrition;
- Psycho-educational information to families and individuals experiencing first onset of psychosis;
- Promotion of healthy recreational activities such as yoga or other physical fitness activities;
- Use of expressive arts and crafts with children activities to reduce mental health stigma;
- Support groups for caretakers of older adults or family members with chronic illness;
- Activities to prevent children and adolescents from engaging in risk taking behaviors such as under age drinking or early sexual activity;
- Focused skill building and problem solving groups with children and youth; these psycho-educational groups may be provided for clinic patients at the school; and
- Parent/child interaction such as playing interactive games to help parents learn and understand their child's emotional cues.

Outreach services to reduce stigma may be in the patient's home, or other community locations such as community centers, libraries, and faith organizations. Intervention activities shall be developmentally age appropriate for the entire age range of patients served.

Another component of the plan is for the program to develop a structure to include other community residents as volunteers. This strategy may be a means of sustaining the project as well.

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As part of a brief intervention, healthcare staff shall provide written wellness materials at the clinic site(s) and community venues. Resource materials may also be distributed to law enforcement and other first responders who interact with at-risk individuals. Community liaisons shall function as gatekeepers to identify community residents in need of prevention services. A community liaison may identify changes in behavior by observing the appearance of older adults: their mental and emotional state, personality changes, physical changes, social problems; potential problems with substance use, condition of the home, domestic violence, caregiver burden, financial hardship and suicide risk. Community liaisons and others involved in the community, such as postal workers or law enforcement, may be trained in a model such as the Gatekeeper Training Manual developed by Raschko, Raymond, and Francie Coleman of Spokane, WA (Spokane Mental Health, Elder Services, 1998).

The PEI plan shall target a community clinic(s) that could include a Native American health center in one of the rural areas of San Diego County. The prospective service provider shall propose the rural geographical area to be served. These areas will have a high concentration of ethnic minorities, older adults, and low income residents. Screening, brief intervention services, and outreach shall be available evenings and weekends to meet the needs of the working population.

The incorporation of information technology and healthcare, known as telemedicine, has set the stage for an innovative and effective way of delivering healthcare across large geographical areas and increases access to care. The PEI plan must link patients to treatment, but treatment services are not part of the PEI plan. Telemedicine may be utilized for psychiatric consultation to primary care physicians. The community clinic may also utilize telemedicine as part of any treatment services they provide separate from PEI. Another component for workgroup to consider is a website to access wellness information or that links patients to other sites.

Key dates and milestones include:

- Receive California DMH approval for plan – Month 1
- RFP developed, competitive procurement process completed – Month 9
- Contract awarded – Month 10
- Hire staff – Month 10-11
- Staff training and certification (including cultural and linguistic needs of population) begins – Month 10-11
- Begin development of policies and procedures – Month 10
- Draft policies and procedures submitted to County for approval – Month 10
- Develop program materials including materials in multiple languages – Month 10

- Outcome tools identified, surveys created – Month 10
- Delivery of Services – Month 11

4. Programs (program is not starting until July 1, 2009). The number of patients served through prevention and prevention/early intervention is duplicated. The patients receiving intervention other than screening are a sub-set of the total number of patients served

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Rural Integrated Community Behavioral Health and Primary Care Services – East, North Inland, Mountain Communities	Individuals: 3800 (all TAY, Adult, & OA) Families:2020 (all children <18)	Individuals: 1550 (40% of individuals) Families: 808 (40% of families)	
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 3800** **Families: 2020**	**Individuals: 1550** (duplicated) **Families: 808** (duplicated)	

5. Linkages to County Mental Health and Providers of Other Needed Services

Clients shall be screened for priority risk factors including, at a minimum, mental health, alcohol and drug use; domestic violence; elder abuse; and problem gambling. Children and parents shall be screened for risk factors related to family stress and transitions. A portion of the patients screened may be identified as needing treatment services. Patients may be linked to regional treatment providers with support from a liaison to traditional mental health, as well as drug and alcohol services. The clinic is also able to provide direct treatment services through Mental Health Services Act (MHSA)

and Medi-Cal. With the establishment of internal behavioral health consultation, as well as linkages to traditional mental health clinics, the primary care providers will be better able to serve all clients with mental illness, including Seriously Mentally Ill (SMI) individuals whose condition is stable and who do not yet meet Medi-Cal criteria for specialty mental health services.

Licensed behavioral health specialists hired through the PEI plan may conduct an assessment to determine if more intensive services are needed and to make appropriate referrals. Provider will establish partnerships with community based organizations, as well as County programs. Key members of the community will be used to help assist in identifying at risk individuals.

The provider shall identify community partners. The role within the partnership shall be described including the leveraging of resources and matching funds. The provider may also seek other grant and funding opportunities to enhance this integrated effort.

The activities of this PEI Plan also fit into the San Diego County Health and Human Services Agency public health and regional activities looking at environmental approaches to chronic disease prevention.

Individuals in need of resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues. While the County-funded Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline as appropriate. This will then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services.

6. Collaboration and System Enhancements:

A mental health provider could partner with a rural community clinic to provide the services described in the PEI plan or a rural clinic could provide these services directly. The program shall collaborate with local leaders in the community in order to recruit outreach workers. These community leaders and organizations may promote PEI activities in their community(s). Examples of partners might be faith based leaders, Community Emergency response Teams (CERT), or community organizations such as Kiwanis. Collaboration is vital to identify community needs in relation to building individual and community resilience/wellness. Other collaborative partners may include local law enforcement, and first responders such as fire departments and California Department of Forestry (CDF) who may have firsthand knowledge of

the community. The program may provide training and resource materials for these first responders to offer to community members.

The provider shall liaison with Child and Adult Mental Health clinics, Alcohol and Drug Services (ADS) and public health to facilitate referral for patients in need of treatment services. The provider shall also partner with other county programs such as Aging and Independent Services (AIS), child Welfare Services (CWS), and other regional County Health and Human Services Agency (HHSA) services. Currently the rural Public Health Nurses conduct home visits and these home visits are another opportunity for linkage and outreach.

A liaison relationship will be established between the primary care clinic(s) and geographically proximate traditional mental health clinics and drug and alcohol programs for the purpose of providing mutual support and consultation. This will enhance the ability of mental health clinics to have the medical needs of their clients addressed. In turn, the primary care providers will have easier access to mental health and drug and alcohol providers for consultation regarding early intervention in emerging, uncomplicated mental illness prior to development of more severe symptoms and for referral of their client.

Partnerships will be developed with the other community-based agencies in rural areas and schools to provide brief mental health wellness education. Other community partners may include Senior Centers and self help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).

The liaison position between the community clinic and traditional mental health and ADS treatment programs will strengthen mutual referral and begin to integrate community clinics into the mental health system. The program will expand the continuum of behavioral health care by funding positions to provide prevention and early intervention services to community clinic patients within an integrated model. It will strengthen the ability of primary care to identify risk factors and intervene early to avoid or alleviate the need for specialty mental health services or alcohol and drug treatment.

Within San Diego County there are several existing rural collaborative groups that meet on a regular basis including the San Diego County Rural Health Network (RHN), which covers the rural communities of East, North Coastal, and North Inland regions. This network is currently developing a webpage for the RHN to increase collaboration and communication among rural providers. PEI information on the webpage could be an avenue for outreach and wellness information.

The rural health clinics are also involved in the broader California State Rural Health Association (CSRHA) and the Southern California Rural Roundtable, which covers all counties in Southern California.

It will be the responsibility of the organization providing the service in this PEI plan to identify primary partners and ways in which they will leverage resources. One expectation is that they will need to provide in-kind resources such as space, share supplies etc.

The County will continue to fund this PEI program if it achieves the outcomes established for the service. The service provider may also seek other grants geared toward enhancing the integration of the behavioral health and primary care model. Enhancing the program with volunteers to do outreach and community education is an example of sustainability.

7. Intended Outcomes

Individual and Family Outcomes

- Primary care providers shall actively identify mental health risk factors;
- Report the number of patients who are screened for risk factors;
- Report the number of patients who receive brief interventions by licensed behavioral health specialists and community liaisons;
- Report the number of referrals made for behavioral health services and where they were referred to;
- Report the percentage of patients of each age group who were referred to more intensive services;
- Primary care and behavioral health staff shall report their satisfaction with the integrated model and the impact on patient care and clinic functioning;
- In the first year, collect and report data on the number of psychotherapeutic drugs prescribed in the clinic;
- Administer satisfaction surveys for staff in the community clinic and at traditional mental health and drug and alcohol clinic services regarding mutual referral;
- Report satisfaction of patients on the integrated approach to behavioral health care;
- Increase access to mental health wellness information by increasing the number of mental health wellness events; report the number and type of events provided;
- Implement or support a collaborative informational website that provides resource information or links to prevention resources; and
- Demonstrate improved awareness of primary care providers in early intervention treatment of mentally patients by utilizing appropriate survey instruments.

System/Program Outcomes

- The primary prevention/early intervention services in a rural community clinic shall broaden the continuum of services to clinic patients and rural residents and increase access to wellness information;
- Report the number of people attending community wellness events;
- Primary health care personnel (including medical, front desk etc.) shall increase awareness of risk factors as a result of professional development offered by behavioral health specialists; and
- Clinic will screen patients for risk and provide brief intervention that demonstrates an integrated primary care behavioral health approach with patients.

8. Coordination with Other MHSA Components

This PEI Plan shall link to Community Services and Supports services through referral to treatment services in the community and within the clinic. Community clinics can link Medi-Cal patients to treatment within the clinic as they are a federally funded health clinic. They can link patients without funding to treatment within the clinic through the Council of Community Clinics CSS services for patients that meet the criteria for CSS. Patients may also be referred to the regional outpatient clinic(s) for assessment, brief treatment, psychiatric evaluation, and medication services. Patients of all ages including children, TAY, adults, and older adult, are eligible for the above referral.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3
Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
Workgroup - Focus Area (Cnty PEI List): Rural East, North Inland & Mountain Communities
Program ID/Name: **RC01** **Rural Integrated Behavioral Health and Primary Care Services**

Provider Name (if known): Pending Competitive Procurement
Provider Category (DMH List): Primary Health Care Provider

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	5820
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansic	0	5820
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues			**Est Annual $**	**FY 07-08**	**FY 08-09**	**Total**
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
Classification		FTE	Per FTE			
Program Manager		1.00	$84,000	$0	$84,000	$84,000
Licensed MH Direct Srvc Staff		2.00	$70,000	$0	$140,000	$140,000
Admin Support (Admin Asst,Secr,Clrk)		2.00	$40,000	$0	$80,000	$80,000
Health Care Direct Srvc Staff		6.50	$43,000	$0	$279,500	$279,500
		0.00	$0	$0	$0	$0
	Total FTE	11.50	Sub-Total	$0	$583,500	$583,500
b. Benefits%	@	30.0%		$0	$175,050	$175,050
c. Total Personnel/Staffing Expenses				$0	$758,550	$758,550
2. Operating Expenditures						
Indirect/Administrative Costs		15.5%	$216,450	$0	$216,450	$216,450
Operating Costs (includes Facility Costs)		19.9%	$278,000	$0	$278,000	$278,000
Start-Up/One-Time Only Costs*		12%	$168,000	$0	$168,000	$168,000
c. Total Operating Expenses				$0	$662,450	$662,450
3. Subcontracts/Professional Services (list/itemize)						
Consulting Psychiatrist			$72,000	$0	$72,000	$72,000
Physician		.25 FTE	$75,000	$0	$75,000	$75,000
			$0	$0	$0	$0
a. Total Subcontract/Professional Svcs Expenses				$0	$147,000	$147,000
4. Total Proposed PEI Program Budget				**$0**	**$1,568,000**	**$1,568,000**
B. Revenues (list/itemize by fund source)						
			$0	$0	$0	$0
			$0	$0	$0	$0
			$0	$0	$0	$0
1. Total Revenue				**$0**	**$0**	**$0**
C. Total Funding Requested for Proposed PEI Program				**$0**	**$1,568,000**	**$1,568,000**
D. Total In-Kind Contributions				$0	$0	$0