



**COMMUNITY**  
PARTNERS, INC.

Bernalillo County Behavioral Health Initiative

# Behavioral Health Business Plan

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*Prepared for Bernalillo County  
Board of County Commissioners*

Amended 12/28/15

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# Executive Summary

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Bernalillo County, the City of Albuquerque and the State of New Mexico have committed themselves to improving residents' lives and the public's safety by strategically evaluating and enhancing resources for mental health and substance abuse treatment.

They have recognized that their behavioral health care system is fragmented, difficult to navigate and lacking a full complement of care options, at times leading to no or insufficient treatment, and taken action to build a better safety net and more effectively deploy community resources.

Officials and community members have taken important steps to address this situation, including voter approval of a gross-receipts tax in part to generate funding for care. This has led to creation of a business plan for a comprehensive system and continuum of complementary behavioral health (mental health and substance abuse) care, with oversight that coordinates services and funding streams. The County also has taken the lead to initiate collaboration with the adjoining counties, including establishing a monthly forum to discuss these efforts and agree upon actions, as well as moving forward with many of the initial steps to foster sharing of information, contracting services and strategies among service providers to improve communication and coordination throughout the community. The County has also established specific goals for implementing the Behavioral Health Initiative that are further described in this plan.

Community Partners, Inc. (CPI), was selected to provide consultation and develop a business plan for a cohesive, regional system of behavioral health care, with an emphasis on coordinated crisis services. This document is the result of CPI's work with Bernalillo County, the Behavioral Health Resource Development Work Group and many other organizational and individual stakeholders (see Attachment 1). Government agencies and organizations such as the Greater Albuquerque Chamber of Commerce, Albuquerque Interfaith and the Greater Albuquerque Medical Association provided input and pledged their commitment toward a healthier, safer, family-friendly community in support of this initiative.

## ❖ Community Voice

The Behavioral Health Business Plan presents specific recommendations, explanations and anticipated costs for creating an effective and coordinated crisis-care system, with priorities and targeted populations determined by the community. Wherever possible, the plan points out opportunities for leveraging current services, resources, potential partnerships and funding streams. It also summarizes results of CPI's research in the community and information on effective behavioral health practices and/or standards for service.

Overwhelmingly, the community made clear that its highest priority is the creation of a crisis network that provides high-quality and coordinated care to anyone experiencing a psychiatric crisis, including those with a substance abuse condition. In addition, we were asked to recommend an administrative structure for the County to receive, administer, monitor and oversee behavioral health funds<sup>1</sup>.

Summarized below are the recommended steps and components of a system based on recovery-oriented care, assessment of current local and state services, and unmet needs identified by the community:

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<sup>1</sup> Bernalillo County, RFP #25-15-PL, Scope of Services, Phase 1 and Phase 2.

- Establish an **Administrative Structure** as defined by the Albuquerque Bernalillo County Government Commission (ABCGC).
- Expand **Crisis Stabilization Services** while exploring the potential for future development of a Crisis Stabilization Center.
- Establish a **Crisis Call Center** with a single telephone number for a crisis line and expanded services that include three-way calling, 911 transfers on non-emergency mental health calls, and dispatch of mobile crisis teams to the community.
- Create **Crisis Mobile Response Teams** to respond to people experiencing a psychiatric crisis in the community, independent of and/or in concert with Albuquerque Police Department's Crisis Intervention Unit (CIU) or Crisis Outreach and Support Teams (COAST).
- Develop **Crisis Respite Care** services for adults and youth, providing continued support and crisis stabilization after discharge from a higher level of care.
- Create **Intermediate Levels of Care** for adults with co-occurring disorders requiring clinically managed care for up to six months, as needed. Services are designed to help connect the person to community supports and services that promote recovery, as defined by the American Society of Addiction Medicine (ASAM) ([www.asam.org](http://www.asam.org)).
- Expand **Transitional Living Services** for female adolescents struggling with substance-use issues, providing treatment, education, life skills training, case management and employment-support services in a therapeutic setting for up to six months.
- Develop **Intensive Case Management Teams** for adults and youth that help them remain in their current place of residence through their recovery process, linking them to community and treatment resources.
- Create a **Forensic Assertive Community Treatment (FACT) Team** to work in concert with the adult detention center's discharge planner and the Supportive Housing Program, providing 24/7/365 treatment and support services for inmates recently released into the community who received mental health and/or substance abuse treatment while incarcerated.
- Develop **Substance Abuse Outpatient Services** for adults who require clinically managed outpatient care, also as defined by ASAM.
- Establish a pilot **Community Engagement Team (CET)** to conduct outreach to individuals with serious mental illness who are challenged to live safely in the community, and engage them voluntarily in treatment and/or other services. CET goals include reducing the individual's rate of law-enforcement interventions and decreasing hospitalizations.
- Develop **Crisis Transportation Services** providing urgent, unscheduled transportation to individuals and families needing immediate access to crisis stabilization care, including crisis respite care. This service is critical to people getting the right care at the right time, thus reducing access barriers.
- Expand **School-based Substance Abuse Intervention** services in the high schools to ensure each school has at least one dedicated substance abuse therapist who works with students and parents/guardians providing treatment, education and prevention strategies for reducing the student's substance use.

- Establish a pilot program for **Early Prevention and Family Intervention** services that address the needs of infants and children up to age 5 and their families, with a specialized, home-based treatment program to prevent or minimize the effects of childhood psychiatric disorders and/or traumatic events.

This business plan is based on national best-practice guidelines for crisis-care systems, as well as CPI's experience in developing and operating a comprehensive, coordinated system for crisis stabilization. A wealth of compelling, well-researched information on the value and efficacy of crisis stabilization services is available on websites for the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Registry of Evidence-Based Programs and Practices (NREPP) and the National Council for Behavioral Health, as well as other noteworthy references cited throughout this document.

CPI recommends building a solid foundation through implementation of these service components to create a cohesive, comprehensive and sustainable behavioral health care system. This business plan is intended to be flexible in scope to meet the growing behavioral health needs and funding considerations of Bernalillo County and surrounding communities.

# Background

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The greater Albuquerque area has taken important actions toward addressing the need for a coordinated system of behavioral health care, with an emphasis on crisis stabilization.

In February 2015, the Bernalillo County Commission and voters approved a new gross-receipts tax (GRT) expected to generate up to \$17 million each year, to improve access to care throughout the region and to develop a unified and coordinated behavioral health system in the County and surrounding area.

In late April 2015, the Commission, through the County's Request for Proposal (RFP) process, contracted with CPI to provide consultation and develop a business plan for a regional, cohesive system of behavioral health care. The Behavioral Health System and Stabilization Consulting Project, commonly referred to as the Bernalillo County Behavioral Health Initiative, comprises three distinct phases:

1. Assessment of the current behavioral health care delivery system and providing a preliminary plan based on initial findings, with recommendations for a governing board structure;
2. Development of a comprehensive regional behavioral health business plan; and
3. Gathering of community input on the plan and beginning implementation of approved service components.

In Phase 1, CPI developed and presented a Preliminary Plan on Behavioral Health to County Commissioners on June 23, 2015. The preliminary plan included assessment of system gaps and needs, recommendations for creating an administrative structure to monitor and oversee behavioral health funds generated by the behavioral health GRT, and identification of priority populations and services. The plan also summarized the many reports reviewed and community meetings held to obtain input, ideas and suggestions for improving the behavioral health continuum in the area. (The Preliminary Plan on Behavioral Health can be found on the Bernalillo County and City of Albuquerque web sites.)

Phase 2 has focused on greater outreach to state and community leaders, including convening the Behavioral Health Resource Development Work Group to gather input on system design, funding options and service priorities. Members of this group worked diligently to provide funding information and strategies for optimizing partnerships and resources. These discussions provided CPI with greater clarity about existing service infrastructure, resources and strengths, system gaps, workforce challenges, and a broader understanding of the current funding structure in New Mexico.

### Key State & Community Leader Meetings

- [The Honorable Michelle Lujan-Grisham, United States House of Representatives](#)
- [New Mexico Human Services Department](#)
- [New Mexico Behavioral Health Services Division](#)
- [New Mexico Medical Assistance Division](#)
- [Sandoval, Torrance & Valencia County Managers; Torrance Deputy County Manager](#)
- [UNM & Presbyterian Hospitals](#)
- [New Mexico Crisis and Access Line with first responders](#)
- [Sandoval County Health Council](#)

# Behavioral Health Business Plan Framework

The Behavioral Health Business Plan outlines the framework for a comprehensive system of care for people living with mental illness/substance use disorders in the greater Bernalillo County area. This region includes Bernalillo County, the City of Albuquerque and the neighboring counties of Sandoval, Torrance and Valencia. CPI supports an integrated approach to treatment of co-occurring mental illness and substance use disorders using the most effective treatment methods possible. As cited by SAMHSA, integrated treatment requires collaboration across disciplines with treatment planning that concurrently addresses both mental illness and substance use disorders. Treatment services that address both conditions at once are associated with lower costs and better outcomes ([www.SAMHSA.gov](http://www.SAMHSA.gov)), including:

Developing a well-coordinated regional plan requires a shared vision among community leaders with agreements to pool resources, as well as long-term commitments to work collaboratively to improve the system as it grows and evolves.

- Decreased hospitalizations;
- Fewer arrests;
- Improvement in psychiatric symptoms;
- Reduced substance use; and
- Improved quality of life.

Throughout this plan, the term “behavioral” is used to encompass both mental illness and substance use disorders.

The business plan provides strategies to leverage funding and programs to align more closely with the enhanced system of care, and steps necessary to implement a crisis network that is recovery-oriented, with strong ties to community-based services and supports.

Thoughtful consideration was given to recent community efforts that resulted in recommendations for system improvements, such as:

*Creating Community Solutions Dialogues on Mental Health*, sponsored by City of Albuquerque Mayor Richard J. Berry, making Albuquerque one of the first cities in the nation to host a dialogue on mental health. While the final report is pending publication, the initial report and subsequent action plans mirror many of the development strategies outlined in the Behavioral Health Business Plan.

*J. Paul Taylor Task Force*, an outcome of House Memorial 75 and continued in House Memorial 5, to create a public health-driven early childhood mental health action plan for infants and children up to age 8 years and their families, with an emphasis on early detection of behavioral health issues.

*The Center for Health & Justice at TASC*, sponsored by Bernalillo County to evaluate behavioral health service gaps for inmates released from the Metropolitan Detention Center (MDC), through a mapping and workflow exercise using MDC demographic and utilization data.

The regional business plan is intended to complement improvements already under way, while minimizing duplication and fostering partnerships. It also acknowledges other system mandates, such as the settlement agreement between the City of Albuquerque and the U.S. Department of Justice (DOJ) stemming from DOJ’s investigation of Albuquerque Police Department’s (APD) policies and practices regarding use of force.

The recommendations cited in this business plan are flexible, with the ability to scale up or down based on the various presenting needs of the community. The plan is a road map to successfully implement and sustain the initial phase of crisis services that collectively create a foundation for a crisis network of care. The plan is further detailed throughout the following sections:

- Evaluation and leveraging opportunities of state and local services and resources;
- Creation of an administrative structure;
- Development of a crisis-care system (with projected costs);
- Funding reimbursement options to manage the crisis system; and
- Strategy planning with initial implementation timelines.

# Evaluation of State and Local Resources

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During the first phase of this project, CPI conducted a preliminary assessment of state and local services, along with initial funding recommendations and potential leveraging opportunities. Priority populations identified include persons with a serious mental illness, homeless adults and families, persons with a substance use disorder, and youth transitioning into adulthood. Understanding that these populations are more likely to intersect with the criminal justice system, especially during a psychiatric crisis, further supports development of a comprehensive crisis service continuum available to anyone across the region.

Using information gathered in the first phase, CPI:

- Dove deeper to evaluate the state-funded behavioral health benefit and gain a better understanding of the array of allowable covered behavioral health services in New Mexico;
- Took a closer look at statewide workforce issues that impact behavioral health services in the region; and
- Analyzed local behavioral health funding, with a focus on opportunities to leverage these resources to strengthen the crisis-services system.

## ❖ New Mexico Behavioral Health Services

Understanding the structure of state-funded health care in New Mexico and the recent changes in its Medicaid program was an important step in evaluating the behavioral health service array and determining opportunities for service expansion and leveraging of current services to align with a cohesive crisis system.

In 2004, legislation established the state's Interagency Behavioral Health Purchasing Collaborative (Collaborative) to bring together other state agencies, from health care to finance, and build an innovative, cost-effective, united system to address the mental health and substance abuse needs in New Mexico. The Collaborative, overseen by the Director of the Behavioral Health Services Department, manages behavioral health funds from the Human Services Department (HSD); Children, Youth and Families Department (CYFD); and Corrections Department, and works to develop culturally relevant behavioral health services for all populations, including rural and urban communities. The Collaborative also supports the Medicaid and non-Medicaid program described below, and assists communities with developing local collaboratives.

In 2013, New Mexico opted to expand its Medicaid program to extend coverage to adults earning up to 138% of the federal poverty level. Since then, more than 225,000 newly eligible adults have enrolled in the program<sup>2</sup>, with recent projections by HSD of having more than 919,000 enrollees by June 2017<sup>3</sup>. This equates to more than 1 out of 3 New Mexicans being eligible for Centennial Care, the state's Medicaid program, including behavioral health care.

Utilization reports provided by HSD for calendar year 2014 provided insight into how services are used throughout the greater Albuquerque and Bernalillo County area. The report included

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<sup>2</sup> Rayburn, R. (September 24, 2015) Working Adults Large Share of Medicaid Expansion, Study Says, *Albuquerque Journal*.

<sup>3</sup> Boyd, D. (October 28, 2015) Medicaid Costs a "Runaway Train," *Albuquerque Journal*, October 28, 2015.

Centennial Care data for the Medicaid populations and limited data on non-Medicaid populations receiving care under the oversight of Optum Healthcare. No data was available for Medicaid Fee-for-Service populations.

Analysis of this data revealed a behavioral health care penetration rate<sup>4</sup> of 27% for adults and 21.2% for children/adolescents, with a total penetration rate of 23.9%. This suggests people are able to access care initially, whether through an outpatient setting or a higher level of care such as a hospital. However, the need for services continues to grow: More than 50% of adults who have a mental illness and more than 80% of individuals ages 12 and older who have illicit-drug dependence or abuse are not receiving treatment, as cited in the *2014 SAMHSA Behavioral Health Barometer* report for New Mexico. This report also states that 81% of adults and 84% of youth who did receive treatment in the state's public behavioral health system reported improved functioning. Thus, the importance of getting more persons into treatment is clearly supported.

In the *State of Mental Health in America*<sup>5</sup> report, which ranks states' mental health status and access to care, New Mexico continues to show some improvement in accessing public behavioral health care. The state improved its rankings on overall mental health, as well as in the Adult, Youth, Need and Access categories. This is encouraging, yet more changes are needed to fully meet the demand for behavioral health services.

In an effort to serve the increased Medicaid enrollment while controlling costs and increasing accountability, New Mexico introduced Centennial Care as its statewide managed-care delivery system, under which contracted health plans provide the full array of physical health, behavioral health and long-term care. Centennial Care began in January 2014 with four contracted Managed Care Organizations (MCOs) providing integrated physical and behavioral health care throughout the state: Blue Cross Blue Shield of New Mexico, Molina Healthcare, Presbyterian Health Plan and UnitedHealthcare. For individuals not eligible for Medicaid, the state provides limited behavioral health coverage with non-Medicaid funding through Optum Healthcare.

During this period, HSD expanded peer-based services – an evidence-based program of support and other assistance from individuals and/or families with lived experience in the behavioral health care system – and increased behavioral health Medicaid reimbursement rates by 12.5%.

Along with the continued increase in the number of Medicaid-enrolled New Mexicans, the state faces new funding challenges to meet the demand for health care. Federal matching funds for Medicaid will decrease from 100% to 95% in 2017 and to 90% by 2020, requiring increased contribution from the state. These significant funding changes make it unlikely any action will be taken to amend the state's Medicaid waiver to expand behavioral health services or service codes. However, as part of HSD's FY15 Strategic Plan, the Collaborative adopted the following projects and initiatives to improve behavioral health services:

- **HB 0212 Crisis Triage Center Services** – Develop rules related to the licensure and Medicaid reimbursement of crisis triage centers by July 1, 2016.
- **Peer Certification** – Expand the number of certified peer workers throughout the state and identify employment opportunities for them.

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<sup>4</sup> Penetration rates refer to the percentage of enrolled individuals who received a behavioral health service.

<sup>5</sup> Mental Health America. (2016) *The State of Mental Health in America*.

- **New Mexico Crisis and Access Line**– Initiate a statewide awareness campaign for the state’s crisis-line services, including new warm-line support services.
- **New Mexico Network of Care** – Operationalize a statewide, web-based resource directory for all behavioral health care providers, regardless of funding source or eligibility requirements.
- **Core Service Agency** – Explore overlaying the Core Service Agency (CSA) requirements with Certified Community Mental Health Clinics and a possible tier system. This could expand the number of providers eligible to provide Comprehensive Community Support Services (CCSS), New Mexico’s equivalent of case management.
- **SB 666 Behavioral Health Incentive Zones** – Consider an alternative method of allocating non-Medicaid funding that takes into account the risks and needs of the area, by July 1, 2016.

These measures may improve access to care for Medicaid-enrolled persons. However, there are further unmet needs expressed by community leaders and stakeholders, which are discussed below.

## ❖ New Mexico Workforce

Assessing the state’s behavioral health workforce capacity is critically important to designing and creating a crisis-care system.

As noted in the recently published *New Mexico Health Care Workforce Committee 2015 Annual Report*, the state struggles to keep up with the growing demand for behavioral health professionals, especially in rural communities. In comparison to the national average, New Mexico has fewer psychiatrists per 100,000 population, at 13.8 as compared to 14.2 nationwide. However, given its vast rural landscape, access to a psychiatrist outside urban communities like Albuquerque, Santa Fe, and Las Cruces is challenging.

Another workforce consideration is availability of and access to physicians. The national physician search and consulting firm Merritt Hawkins recently issued a report ranking states in this area<sup>6</sup>, based on 33 related factors that included physicians per 100,000 population, the percentage of state residents without health insurance, and federal poverty rates. New Mexico was ranked among the 10 states with the lowest access to physicians, at 48th out of 50 states.

Other statewide workforce challenges include:

- High turnover among clinicians in public behavioral health settings, compared to primary-care settings;
- Limited number of providers specializing in child and adolescent psychiatry; and
- Limited access to independently licensed, master’s-level clinicians.

While the report cites an “extreme shortage of behavioral health providers” throughout New Mexico, Bernalillo County – one of the largest metropolitan areas in the state – fares better than its more

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<sup>6</sup> Merritt Hawkins, *2015 Physician Access Index Map*, retrieved from [http://www.merrithawkins.com/uploadedFiles/MerrittHawkins/Pdf/Merritt\\_Hawkins\\_Physician\\_Access\\_Index\\_Infographic.pdf](http://www.merrithawkins.com/uploadedFiles/MerrittHawkins/Pdf/Merritt_Hawkins_Physician_Access_Index_Infographic.pdf)

rural counterparts, with the majority of behavioral health professionals, such as psychiatrists, psychologists, social workers and mental health counselors, practicing within the County.

Other states face many of these same challenges in building a workforce adequate to the needs of individuals seeking behavioral health care. New Mexico's experience may be more severe given the extent of its rural landscape, which includes 17 frontier counties, and the disparity between its urban and rural communities.

Proven strategies that can help address this shortage include expanding:

- Certified Peer Support and/or Community Mental Health workers to provide support and recovery-related services;
- Telepsychiatry in clinic settings to increase access to psychiatrists; and
- Residency and intern programs through the University of New Mexico (UNM), to include underserved community-based settings.

These recommendations, along with other short-term and longer-range solutions, were also cited in the workforce report, which included the Collaborative's involvement in developing reimbursement mechanisms for services provided by interns and establishing financial systems that promote sustainability and staff retention.

## ❖ Local Behavioral Health Services

In Bernalillo County and surrounding counties of Sandoval, Torrance and Valencia, an ever-growing population receives behavioral health services through the state's Medicaid plan administered by Centennial Care. In this region, Optum Healthcare, as a non-Medicaid safety-net provider, covers behavioral health care for individuals who do not meet eligibility requirements for Centennial Care, but for a much smaller population of approximately 9,300 members in calendar year 2014<sup>7</sup>.

MCOs Presbyterian and Molina Healthcare have the greatest presence, with reported Medicaid enrollments of 101,398 and 81,358 members respectively<sup>8</sup>. In total, this represents more than 68% of all Medicaid members in this region.

Under contract with the MCOs, state-designated CSAs coordinate behavioral health services for adults, children and youth within their service area. CSAs provide a range of behavioral health treatment and recovery services that may include psychiatric services, medication management and CCSS that supports a person's recovery goals. In

### Program Highlights

- Fast Track program in concert with the Metropolitan Detention Center
- Supportive Housing Program for homeless inmates
- The Crossroads program in some local high schools
- Assertive Community Treatment teams that meet SAMHSA fidelity
- Centro Savila, serving the South Valley
- Mental Health Court and diversion programs
- First Choice Community Healthcare & Duke City Tool Box for Medication Assisted Treatment programs for opioid dependence
- Bernalillo County's Public Inebriate Intervention Program
- First Nations HealthSource

<sup>7</sup> HSD Utilization Data for Optum Healthcare, January-December 2014.

<sup>8</sup> Medicaid Enrollment Report, Enrollment by County, as of 10/1/15.

the current model, only certified CSAs, Community Mental Health Centers, Federally Qualified Health Centers (FQHCs) and Indian Health Service or 638 Tribal Facilities are eligible to bill Medicaid for CCSS, limiting access for many who could benefit from this service.

One of the largest health care delivery systems in the region is operated by UNM, which is home to the Health Sciences Center, an extensive academic health complex that includes UNM hospitals; UNM Sandoval Regional Medical Center; the College of Nursing; and the School of Medicine. With funding from Bernalillo County's Mill Levy tax and other funding sources, the UNM Psychiatric Center (part of the UNM Hospital structure) provides inpatient care to adults (including older adults), while its Children's Psychiatric Center provides inpatient services to youth and children. UNM also operates a 24/7/365 Psychiatric Emergency Services center for all ages and a Psychiatric Urgent Care program for adults. UNM Hospital's Behavioral Health Services is currently the largest community mental health service provider in New Mexico, a CSA as well as a provider of outpatient services and supports.

Local behavioral health services also currently include an array of acute inpatient care, social and medical detoxification services, residential care and treatment for youth, substance abuse treatment, outpatient services and prevention programs serving individuals and families with mental illness and/or substance use issues. In addition, a new addiction treatment service provider offers three levels of care to adults with a substance use disorder.<sup>9</sup> Its services include medical detoxification, inpatient residential care and an intensive outpatient program. Providing such a continuum of addiction treatment services will help address the state's high death rate for drug overdose, as cited in the *New Mexico Substance Abuse Epidemiology Report 2014*.

Services that target a specific population or need in the community include programs that work with individuals who are homeless to provide housing with supportive, wrap-around care; programs assisting inmates who are transitioning out of jail; and diversion programs such as mental health court that order and fund treatment as an alternative to jail. These services include SAMHSA-recognized programs such as Medication Assisted Treatment (MAT) for opioid dependence and Assertive Community Treatment (ACT) teams for high-risk individuals with a serious mental illness ([www.SAMHSA.gov](http://www.SAMHSA.gov)). There are also a number of Community Health Centers (CHCs) and FQHCs in the region that offer integrated care, with one health center serving Native Americans and another health center located in the underserved area of the South Valley.

In an effort to better align its grant-making to the behavioral health redesign in Bernalillo County, United Way of Central New Mexico (United Way), is seeking proposals for prevention of substance abuse and mental illness, early intervention and education to children, adolescents and their immediate communities through its Impact Project Multi-year grant-making process. The scope of this grant includes Bernalillo, Sandoval, Tarrant and Valencia counties. It requires applicants to draw upon evidence-informed strategies, use a logic model to develop goals and outcomes, and implement performance measures with data collection and analysis.

CPI also met with Native American service providers during initial community meetings and reached out to engage these providers to gain a greater understanding of their mental health and substance abuse needs, as well as the current access to services throughout Bernalillo County. We recognize

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<sup>9</sup> Sinovic, S. (December 18, 2015) Closed ABQ rehab center expands, reopens, *Albuquerque Journal*.

the importance of tribal participation in this process and of working together to develop services that are culturally diverse.

## ❖ Unmet Needs

Another step in evaluating local behavioral health services is to identify unmet service needs. During the first phase of this project, CPI provided an initial assessment of gaps in the service continuum that could impact a person accessing care and/or continuing care as part of their recovery process. With this project's priority focus on developing a crisis continuum, we compared key components needed for an effective crisis-care network with existing behavioral health services regardless of funding source. This comparison identified two types of service gaps: the service does not currently exist, or the service exists but with limited scope due to factors such as provider qualifications and requirements, service delivery requirements and/or physical space limitations.

Below are important crisis services that CPI found do not currently exist but that should be established as part of a regional crisis network:

- Intermediate levels of care for adults;
- Crisis respite care;
- Crisis response mobile teams;
- Community engagement pilot team;
- Intensive case management teams; and
- Crisis transports.

Services that are in place but require programmatic enhancements to support and strengthen the crisis continuum include:

- Accessible and available crisis intervention and stabilization services;
- A crisis telephone line dedicated to behavioral health;
- Outpatient services for the treatment of substance use disorders;
- Case management or comprehensive community support services;
- Prevention/early intervention services; and
- Housing with wrap-around services.

In the Crisis Network section below, additional detail is provided on the crisis network service descriptions, as well as funding projections. In addition, CPI recommends taking a strategic approach to a comprehensive community prevention planning process that is described in the Strategic Planning and Implementation section of this plan.

## ❖ Bernalillo County Actions and Priorities

Bernalillo County has taken action to further develop a system of care in its area, with a focus on community partnership and collaboration, as follows:

- Realigned current behavioral health dollars spent in Bernalillo County to assist in creating a continuum of care for behavioral health services.
- Worked with the City of Albuquerque and interested surrounding counties to establish common service definitions, key data to collect and share, data definitions and oversight structures.

- Worked with UNM to develop/enhance the intermediate level of behavioral health services.
- Created and executed a Memorandum of Understanding between New Mexico Crisis and Access Line (NMCAL), Bernalillo County and the HSD regarding use of the crisis/warm lines in the 911 system and use of and access to the Network of Care (NOC) program database, along with ownership/use of data.
- Fully partnered with the state-funded crisis and warm line provider.
- Established and maintained a behavioral health provider database.
- Promoted the NMCAL behavioral health crisis and warm line services and supports.
- Promoted behavioral health advance directives to ensure individuals have a voice regarding their care and services if/when they have a behavioral health crisis. Also created agreements and releases of information that provide the opportunity for individuals to have their advance directives uploaded into the NOC and other crisis systems, so law enforcement and first responders have immediate access to the individual's wishes.
- Provided initial and ongoing training to staff and contracted behavioral health providers on behavioral health services and Mental Health First Aid.
- Identified funding gaps in Medicaid behavioral health benefits in the areas of crisis and substance abuse for the adult and adolescent populations.
- Established standard protocols to enroll qualified Metropolitan Detention Center (MDC) inmates in Medicaid.
- Identified and aligned behavioral health data sources within Bernalillo County, as well as other behavioral health stakeholders.
- Created, advocated and partnered on supportive housing options for individuals who are homeless and receiving behavioral health services.

## ❖ Leveraging Federal, State and Local Resources

CPI assessed opportunities to leverage existing state and local resources to further refine services that are part of a crisis continuum. CPI's approach to addressing priority service gaps with revenue generated from the behavioral health GRT is to first identify existing state and local resources that can serve as the foundation of a crisis-service network, rather than building from the ground up.

The state and local resources listed below could provide opportunities to advance development of a unified and comprehensive system of crisis care. Many of these opportunities already are advancing, as described below.

The federal **Excellence in Mental Health Act** provides planning grants to states, with opportunities for funding demonstration projects that develop Certified Community Behavioral Health Clinics (CCBHCs). New Mexico was one of 24 states awarded a planning grant to integrate behavioral and physical health care through CCBHCs, along with development of a prospective payment system. As such, the state may apply for a two-year demonstration program beginning in January 2017. Development of CCBHCs will strengthen the crisis-service foundation through adoption of evidence-based practices, including 24/7/365 crisis services and mobile team response. Thoughtful alignment of these services as part of a regional crisis network has the potential to increase access to care while minimizing any duplication of services.

**New Mexico Access and Crisis Line** is funded by the state and operated by ProtoCall Services. This service is available 24/7/365 and staffed with highly trained individuals and counselors to help de-escalate callers' crises and connect them to community resources as needed. A warm line, staffed by peers, is also available to provide emotional support, comfort and information to callers with a mental illness. The County and local providers are promoting NMCAL as the single-point-of-contact for behavioral health crisis services. This effort includes working with community leaders to establish protocols for handling non-emergency behavioral health-related 911 calls that do not warrant a law enforcement response.

**New Mexico Network of Care for Behavioral Health Services** is the HSD/Behavioral Health Services Division's statewide resource directory for behavioral health-related programs. Part of a larger plan to use the website for the state's Behavioral Health Collaborative, the NOC offers functions including a personal health record, legislative tool, quick reference to emergency and crisis services, and a library of health-related resources. Participation in this directory is free and voluntary, and it is promoted by Bernalillo County to local providers in Albuquerque and surrounding communities as an excellent referral tool. NMCAL uses the NOC to link callers to services in the community.

**SHARE New Mexico** is a statewide information-sharing website that aims to provide resources to communities, social service and health care organizations to foster communication among and connection to needed services. Resource information includes transportation, child care, housing, food, employment and legal services. Expanding awareness of this resource, in alignment with the NOC, will further strengthen the ability of stakeholders, providers, families and individuals to access care and/or other services they need.

**Mental Health First Aid (MHFA)** is a community-education program that trains people to recognize the early warning signs of mental illness or distress. It increases public understanding and provides strategies for supporting a person with a mental illness, by offering initial help and/or connecting the person to resources in the community. MHFA is supported by the National Council for Behavioral Health as a national model for community education on mental illness.

The CYFD, under the auspices of two SAMHSA grants for MHFA, has certified approximately 139 MHFA trainers (who in turn train community members), and trained more than 6,000 individuals throughout the state. A recent grant supports partnering with law enforcement agencies in Bernalillo and Santa Fe counties (APD and state police), with a goal of training more than 500 individuals over the next three years. Bernalillo County's Public Safety Department will also participate in this grant, with the two-year goal of training staff from MDC, the Department of Substance Abuse Programs, Youth Service Center, the sheriff's department, the fire and rescue department, communications and animal control. Albuquerque Public Schools (APS) also received a grant for MHFA training of individuals who work with youth ages 12-18. More than 100 school resource officers have been trained to date.

CPI encourages continuation of MHFA training throughout the community to increase awareness of the early signs and symptoms of mental illness and help reduce the stigma of such illness, increasing early identification and intervention.

The **UNM Psychiatric Center** currently provides 24/7/365 psychiatric emergency services for youth and adults with a capacity of six observation rooms, along with psychiatric urgent care for adults during business hours. UNM is in the planning stage of building a new psychiatric emergency center on campus within the next five years. The County may choose to consider partnering with UNM on this project, in an effort to leverage available funding for a crisis stabilization center.

**City of Albuquerque CIU/COAST** APD's CIU consists of a team of trained officers who are dispatched to assist other officers who are responding to someone who may be mentally ill or in a psychiatric crisis. APD also offers information on resources and follows up with the individual after initial contact. CIU provides support through on-call coverage, and the COAST team operates during regular weekday business hours.

CPI is aware of the DOJ settlement agreement requiring APD to retain these teams in the community and expand them as needed, based on call volume. CPI values the services provided by the CIU and COAST teams and supports augmenting them with crisis-response mobile teams comprising mental health professionals trained and experienced in community crisis response, assessment and resolution. These teams would complement APD's efforts and provide additional resources to field officers.

## Administrative Structure

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For the Phase 1 Preliminary Plan on Behavioral Health, CPI researched several administrative structures with governing boards similar in size and scope to Bernalillo County. The Preliminary Plan provided the County with six examples of governance boards from three different states, including administrative structures such as New Mexico's Lottery Authority and Water Quality Control Commission. These were presented as options for the County to consider as it develops an administrative structure to receive, administer and monitor behavioral health funds generated by the GRT.

Recently, Bernalillo County Commissioners passed resolutions designating the Albuquerque Bernalillo County Government Commission (ABCGC) as the lead agency, with representation from the County and City, to collaboratively "create a regional authority with a governing board structure."<sup>10</sup> The County resolution also establishes a Behavioral Health Office under its Public Safety Division, with support from the County Manager and Community Service Division.

The ABCGC met in November 2015 to begin these discussions and was designated as the interim authority until a final decision is made on the specific administrative structure and scope with input from County and City representatives. During the December meeting, the ABCGC selected one of three options presented for the administrative structure<sup>11</sup>.

CPI encourages the ABCGC to consider the involvement of peers, families and consumers as participants in the administrative structure to ensure they an active voice in the process. Creating a structure that is inclusive of people with first-hand experience of living with mental illness and/or substance abuse, along with community leaders and stakeholders is a valuable component of a recovery-oriented system of care. Department of Health and Human Services (DHHS) and SAMSHA support integration of peers not only in the direct service continuum, but also as program decision makers and participants in the development and implementation of peer support services<sup>12</sup>.

In addition, CPI supports a structure that is based on robust data management and compliance functions that ensures desired program outcomes are continuously met and sound fiscal management with accountability to all funding sources.

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<sup>10</sup> Regional Collaborative Process for Behavioral Health, AR 2015-57, September 8, 2015, & City of Albuquerque Council Bill No. R-15-253.

<sup>11</sup> ABCGC Meeting Minutes, December 17, 2015, as retrieved from <http://www.bernco.gov>.

<sup>12</sup> DHSS/SAMHSA (2015). *Targeted Capacity Expansion-Peer-to-Peer*, Funding Opportunity Announcement No. TI-16-008.

## Crisis Network

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There is widespread consensus among stakeholders and community leaders in the Bernalillo County region that a centralized hub for crisis services is a priority need, to ensure individuals and families can access and receive immediate care in a behavioral health crisis. This need was echoed by criminal justice, law-enforcement, first responder and detention center stakeholders, who have first-hand experience with the limited options for crisis stabilization care in the community. But building and operating a new crisis center is fiscally challenging, even with the dedicated GRT for behavioral health.

Creating a stand-alone center without a sound service continuum to support an individual once their crisis is stabilized, or diverts them from a crisis episode, will not adequately meet the individual's behavioral health needs. Prioritizing the development of a "friendly front door" to an effective, community-based crisis system with a crisis-call-and-command center is a crucial first step to better meet the needs of the community, law enforcement, first responders and individuals in crisis.

When individuals experience a behavioral health crisis and call 911 for help, the caller often is taken to an emergency department (ED) or, at times, to jail. Limited support is provided to link the person with treatment following an inpatient stay or upon release from jail, whether for outpatient care, a follow-up visit with a doctor, or a referral for shelter or temporary housing. This increases the likelihood that the individual will experience another crisis, creating a revolving door of treatment/release and/or jail/release. Developing a network that provides access to follow-up care will reduce the incidence of crises, avoid use of higher-level community resources such as EDs or jail, and overall improve lives and public safety in the community<sup>13</sup>.

This network must include available, accessible and appropriate levels of care in the community to serve people who are stepping down from a crisis setting. These supporting levels of care help people remain stable in the community, reduce their dependency on hospital EDs, and avoid potential involvement with law enforcement<sup>14,15</sup>.

Service components for a comprehensive crisis-care network that provides immediate response, evaluation and treatment for those in crisis are essential for a successful, centralized crisis hub within a coordinated service continuum. These services are intended to be easily accessible and available to anyone experiencing a psychiatric crisis (including people with mental illness and co-occurring substance use disorders), regardless of payer source or ability to pay.

Crisis-service provision is based on the individual's medical necessity, as driven by clinical assessment and admission criteria.

Program descriptions for each of these services should be developed, to include:

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<sup>13</sup> Task Force on the Plan to Guide the Future Mental Health Service Continuum. (2008). *Best Practices: Crisis Response and Diversion Strategies*, retrieved from [http://mhcc.dhmm.maryland.gov/mentalhealth/Documents/sp.mhcc.maryland.gov/mental\\_health\\_services/presentations/whitepaper\\_practices\\_0508.pdf](http://mhcc.dhmm.maryland.gov/mentalhealth/Documents/sp.mhcc.maryland.gov/mental_health_services/presentations/whitepaper_practices_0508.pdf)

<sup>14</sup> SAMHSA. (Fall 2014). "Crisis response": An alternative, *SAMHSA News*. (Vol. 22, #4), retrieved from [http://www.samhsa.gov/samhsaNewsLetter/Volume\\_22\\_Number\\_4/crisis\\_response\\_an\\_alternative/](http://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_4/crisis_response_an_alternative/).

<sup>15</sup> Sheedy C. K., and Whitter M. (2009) Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know From the Research? *HHS Publication No. (SMA) 09-4439*. Rockville, MD: Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA).

- Population served;
- Program goals/outcomes;
- Expected length of stay;
- Scope of work to be performed, with identified clinical assessment tools;
- Admission criteria; and
- Referral source.

In keeping with CPI’s framework strategies, current service components that could be leveraged to fill a service gap or create needed service components are noted throughout this section, with estimated funding amounts. Budget models for each service component were developed from salary data provided by the City, using leased-space occupancy and applying common operational costs as applicable. Details on these operating budgets with staffing models and, where appropriate, staffing schedules are included as Attachment 3.

These recommendations are the first phase of service development priorities using braided funding from other resources, with the behavioral health GRT as the last resort for funding allocation. Additional resources may include contributory funds from adjoining counties.

The services recommended below can be scaled up or down to best meet the need of the community, as determined by the County.

### ❖ Administrative Structure

The County has taken steps to develop an administrative structure to manage, monitor and oversee the behavioral health funds generated by the GRT, by naming ABCGC as the interim authority, selecting an administrative framework and designating a Behavioral Health Office as part of its Public Safety Department .

In accordance with CPI’s contract with the County<sup>16</sup> and based on the Phase 1 Preliminary Plan suggestions for an administrative structure, CPI estimated costs that include dedicated staff with specific administrative and compliance functions. The staffing model and projected costs are provided as options for the ABCGC and/or the County to consider as they further define the administrative framework role and function to best fit the needs of the community.

**Estimated annual cost for Administrative Structure: \$572,000**

### ❖ Crisis Stabilization Services

Crisis stabilization services provide 24/7/365 psychiatric crisis care to any community member needing help, including persons with a substance use disorder or a co-occurring disorder. Services include walk-in triage with 23-hour crisis stabilization and intervention services, and short-term crisis inpatient care for persons who need additional time for stabilization. SAMHSA’s practice guidelines support creating crisis services that embrace 10 essential values, which include addressing the person’s underlying trauma, providing treatment based on the person’s strengths, working with the whole person (whose needs may go beyond the presenting crisis), and using strategies based on recovery, resilience and natural supports, such as involving peers in the recovery process<sup>17</sup>.

<sup>16</sup> Bernalillo County, RFP #25-15-PL, Scope of Services, Phase 2, A.1.

<sup>17</sup> SAMHSA (2009). *Practice Guidelines: Core Elements in Responding to Mental Health Crisis*.

Community stakeholders indicated a need for expanded capacity. Currently, crisis stabilization services exist for adults and youth, with a capacity of six rooms, at the UNM Psychiatric Center. Space restrictions at the current site may need to be addressed to fully meet the community's needs. One option the County may consider is leveraging existing infrastructure at UNM to expand crisis-care capacity to serve as many as 20 adults and 10 youth. This option allows for greater service capacity, decrease utilization of EDs and divert individuals from more expensive inpatient hospitalization.

Another option the County may want to consider is to pursue establishing joint venture partnerships with existing partners/entities to leverage current resources, such as the Mill Levy funds, in combination with the behavioral health GRT funds, to either build a crisis facility or support the operations of a redesigned current facility for crisis care.

While the County explores the potential for pursuing any one of these options, CPI recommends using initial behavioral health GRT funds to create a solid foundation of community-based services that will support and complement a crisis-care continuum in the community, as described below.

### **Estimated annual cost for Crisis Stabilization Services: To be determined by the County**

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#### **❖ Crisis Call Center**

Designating a single crisis hotline for anyone in the community to call during a psychiatric crisis is a critical component of a cohesive and coordinated system of care<sup>18</sup>. For a comprehensive crisis network, the crisis call center should be accessible to anyone in the community 24/7/365 and staffed with specially trained crisis specialists and mental health clinicians who can immediately assess caller needs and respond appropriately<sup>19,20</sup>.

The crisis call center also functions as the single point of contact for crisis resources, with real-time, specific information on available services/facilities. Staff can then direct law enforcement officers and/or ambulance services to the most appropriate, immediately available facility for transference of individuals needing behavioral health crisis care. This requires the call center to have the most up-to-date census and facility availability information possible. The crisis call center also would accept non-emergency behavioral health calls from 911 dispatchers and have the ability to tie into 911 for calls requiring a law-enforcement or emergency medical response. The crisis call center also would dispatch mobile crisis teams throughout the community, taking crisis services directly to the person in distress.

There are several crisis-related telephone lines in the greater Albuquerque area, including a suicide hotline, a nurse-advice line for medical concerns and the NMCAL, a statewide crisis line established in 2013. NMCAL is funded solely by the state of New Mexico to take crisis calls from across the state. Based in Albuquerque, NMCAL provides 24/7/365 access to staff trained to assess and quickly address high-risk behaviors that often can be stabilized over the telephone, thereby decreasing the number of people needing additional, higher-cost services.

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<sup>18</sup> U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. (September 2012). *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Washington, DC: HHS.

<sup>19</sup> Gould, M., Kalafat, J., Kleinman, M., & Munfakh J. (2007). An evaluation of crisis hotline outcomes. Part 1: Nonsuicidal crisis callers. *Suicide and Life Threatening Behavior*. 37(3), 322-37.

<sup>20</sup> Gould, M., Harris Munfakh, J., Kalafat, J, Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 2: Suicidal callers. *Suicide and Life Threatening Behavior* 37(3), 338-52.

NMCAL also provides peer-staffed warm-line services seven days a week to callers who are not experiencing an immediate crisis, but who need some level of support and/or referrals to community-based services. NMCAL partners with the MCOs to provide call information regarding their members that is used by the MCOs to ensure appropriate follow-up contact is made with the member. NMCAL collaborates closely with UNM's Agora suicide line and Nurse Advise, to provide after-hours coverage and coordinate resources as needed. NMCAL is strengthening its public awareness through a series of public service announcements and on-line advertisements.

NMCAL is an existing resource, funded by the State, that should be expanded to function at the needed capacity to support a cohesive crisis system of care. CPI recommends that all local behavioral health care providers and funders, such as Bernalillo and surrounding counties and the City of Albuquerque, support and promote the use of this single crisis line whenever possible on their websites, in contractual language and in publications related to behavioral health crisis services.

Recommended next steps include designation of NMCAL as the regional crisis call center with enhanced functionality to:

- Accept non-emergency calls transferred from 911 dispatchers.
- Dispatch crisis response mobile teams, community engagement teams and non-emergency crisis transportation in response to community needs.
- Provide mobile teams with state-of-the-art crisis-response mobile telephone devices capable of receiving dispatch orders and sending responses as needed. Ideally, telephone devices should have an active global positioning system (GPS) that can be used by the dispatch team to accurately determine the location of each mobile team.
- Develop a robust data collection system (electronic medical record or EMR), metrics, analysis, and reporting of findings and outcomes.

Initially, there would be no cost to the community for some of these enhanced functions. However, expanding the call center's role to dispatching and monitoring availability of services creates a need for additional staff, technology and training.

**Estimated annual cost for expanded Crisis Call Center functions: \$232,000**

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## ❖ Crisis Response Mobile Teams

Training law enforcement officers and first responders to work with a person experiencing a behavioral health crisis is important for the safety of the person, the public and the responding officers and personnel<sup>21,22</sup>.

Currently, APD provides crisis intervention training to all new and current field officers. Recently, the training was expanded to include City firefighters and paramedics. In addition, APD's CIU and COAST teams are specially trained to assist officers responding to a person exhibiting signs of a behavioral health disorder or significant emotional distress. This training helps officers de-escalate the situation, allowing them to assess and resolve any law-enforcement issue(s).

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<sup>21</sup> Cusi, A., Kirst, M., Nakhost, A., O'Campo, P Shapiro, G., & Stergiopoulos, V. (2015). Co-responding Police-Mental Health Programs: A Review. *Administration and Policy in Mental Health and Mental Health Services Research*. 42(5), 606-620.

<sup>22</sup> Scott, R. (2000). Evaluation of a mobile crisis program: Effectiveness, efficiency, and consumer satisfaction. *Psychiatric Services*. 51(9), 1153-1156.

Crisis-response mobile teams would be an additional resource for the community and law enforcement, providing 24/7/365 clinical response to anyone experiencing or at risk of a behavioral health crisis in the community or the person's residence. These two-person teams, comprising a Licensed Mental Health Professional and a Behavioral Health Technician or Peer, can provide a range of services, such as initial triage and assessment, crisis intervention, brief stabilization, and transportation of the person to the facility providing the most appropriate level of care.

These mobile teams would work in conjunction with the CIU and/or COAST teams and could be called upon as an additional resource for any officer or first responder. Crisis response mobile teams would be located strategically across the community and dispatched by the call center, usually in response to calls received from concerned family members, neighbors, friends, clergy or other persons in the community. They are often able to respond to the scene within minutes<sup>23</sup>. When dispatched by the call center, crisis response mobile teams may respond with law enforcement or they may respond independently, depending on the situation<sup>24</sup>.

Based on our discussions with first responders and dispatch operators, many 911 calls are for non-emergency situations that may not initially need a law-enforcement response, such as a non-threatening person in a behavioral health crisis. In Bernalillo County, fire department call data from 2013 to 2015 suggests that, on average, 86 calls per month are for behavioral health emergencies, approximately 6.5% of all calls. Sheriff's department dispatch data for 2014 and 2015 indicates that, on average, more than 850 dispatches each year are for mental health issues, including suicide threats and attempts.

Diverting these calls to a team of behavioral health professionals would free up officers and first responders to attend to other, more appropriate calls, thus making the most of valuable resources<sup>25</sup>. Bernalillo County has initiated discussions with County dispatch, law enforcement and first responders to determine steps needed to transfer mental health calls from 911, including development of appropriate transfer procedures and protocols.

CPI also reviewed County and City 911 dispatch data presented to the ABCGC by the County's Harvard Fellow, identifying the volume of calls for non-emergent behavioral health related calls from January 2014 to September 2015. The analysis identified areas within Bernalillo County that have the highest number of mental health related calls per month, as shown below.

Location/Area	No. of Mental Health Calls per Month
South Valley	80.9
North Valley	35.4
East Mountains	11.7

<sup>23</sup> Response time standards are usually established based on reasonable expectations, such as within 1 hour for urban areas and within 2 hours for rural areas.

<sup>24</sup> Campbell, L., Hare, S., Kisely, S., Moore, B., Peddle, S., Pyche, M., & Spicer, D. (2010). A controlled before-and-after evaluation of a mobile crisis partnership between mental health and police services in Nova Scotia. *Canadian Journal of Psychiatry*. 55(10), 662-668.

<sup>25</sup> Hyde, P. (2012) Behavioral health and criminal justice: Challenges and opportunities. (Slides) Pub id: SMA12-PHYDE072112. Retrieved from <http://store.samhsa.gov/product/Behavioral-Health-and-Criminal-Justice-Challenges-and-Opportunities/SMA12-PHYDE072112>.

This equates to an average monthly call volume of up to 128 calls that could be diverted to a crisis response mobile team, rather than law enforcement and/or first responders.

Initially, CPI recommends establishing four crisis response mobile teams to be strategically located in Bernalillo County to respond to these calls, as well as non-911 calls dispatched from the crisis call center. The scheduling of teams for 24/7/365 coverage is dynamic, meaning the number of teams active at the same time varies throughout the 24-hour period, based on call volume. At all times there should be at least one active team on duty, with all four teams active during peak times as identified by the County.

Team composition and availability is based on targeting high-volume call times within the community to ensure coverage during these peak hours. Team schedules can be adjusted as needed based on call-data reports from the crisis call center. It is also important to note that the number of teams may need to increase, depending on continuing utilization data and/or expansion of this project's geographic coverage area to adjoining counties.

**Estimated annual cost for 4 crisis response mobile teams: \$1,800,000**

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## ❖ Acute Crisis Inpatient Care

Acute crisis inpatient is the highest level of care for the most acutely ill individuals who require intensive treatment and 24-hour nursing care with a longer stay to safely stabilize their crisis. Often, these individuals have not done well in their recovery with less intensive approaches and may have co-occurring medical and/or psychiatric disorders adding to the complexity of needs. In Bernalillo County there are currently 166 psychiatric hospital beds, comprising 82 adult beds, 49 geriatric beds and 35 child/adolescent beds, with 12 more geriatric beds located in Sandoval County.

Determining the number of beds sufficient for a population is a challenge. A 2012 report by the Treatment Advocacy Center suggests a minimum of 50 beds per 100,000 population is a consensus target for providing minimally adequate treatment<sup>26,27</sup>. Applying this same measure to approximately 904,587<sup>28</sup> people living in the region (Bernalillo, Sandoval, Tarrant and Valencia counties), equates to 19.67 beds per 100,000 residents. Nationally, there are about 26.1 inpatient psychiatric beds per 100,000 people, down from 29.9 in 2009, according to the American College of Emergency Physicians<sup>29</sup>. Using this measure alone illustrates a potential need for additional bed availability, it but does not necessarily address bed sufficiency. While there may be some concerns that the number of inpatient psychiatric beds in the region are insufficient; determining the right number of beds can only be achieved over time, based on service demand.

Looking closer at this demand, CPI reviewed Medicaid utilization data provided by HSD that indicates a moderate use of this level of care for all populations. Data from other funding sources

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<sup>26</sup> Torrey, E.F., Fuller, D.A., Geller, J., Jacobs, C. & Ragosta K. (2012). *No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals*.

<sup>27</sup> Hnatow, D. (November 2015). Emergency Psychiatry, Working with Law Enforcement to Provide Health Care for the Acute Mentally Ill. *Psychiatric Times*.

<sup>28</sup> US Census Bureau. (2014). *State & County Quick Facts, Bernalillo, Sandoval, Tarrant and Valencia County, New Mexico*.

<sup>29</sup> American College of Emergency Physicians (2014). *America's emergency care environment: a state-by-state report card*, retrieved from <http://www.emreportcard.org/uploadedFiles/EMReportCard2014.pdf>

such as Medicaid Fee-for-Service and Non-Medicaid funding was either not available, or limited information was provided.

The State's possible adoption of Assisted Outpatient Treatment (AOT) should be considered in any future sufficiency analysis. If enacted, this law could mandate treatment for any individual with mental illness who, while not meeting the State's current involuntary-commitment laws, is determined to be unable to live safely in the community without court-ordered outpatient treatment. Initial evaluations prior to the court order are often, but not always, done in an inpatient setting; it is possible, depending upon the statutory requirements, to complete evaluations in an outpatient setting for some individuals. Even once the court order is in force, individuals may need episodic inpatient treatment during the course of the court order. In some states, suspension of the outpatient order requires the individual be taken to an acute inpatient facility for the period of the suspension until the individual is able to be safely treated in the community or some less intense, less restrictive level of care. Ultimately, a well-implemented AOT statute and a well-designed and functioning continuum of care will decrease inpatient demand, but any projection of total inpatient days must consider the intermittent impact of AOT.

Persons affected by such court orders may need brief hospitalization for periods of time when inpatient care is determined to be the least-restrictive treatment to assist the person at this time of crisis. Alternatively, AOT may help prevent hospitalization of persons under a court order for community treatment requiring continuous treatment in the community and thus avoiding the revolving door described above.

Instead of increasing inpatient bed capacity, CPI recommends a more cost effective approach is to develop a crisis network that provides an array of services for early crisis intervention and stabilization which can decrease inpatient admissions by providing less-restrictive, easily accessible and highly supportive, recovery-oriented care. With these services in place, access to psychiatric inpatient beds for the most seriously and acutely mentally ill will increase and may lessen the need to expand capacity. A wealth of supporting literature can be found on the websites for the National Council for Behavioral Health ([www.thenationalcouncil.org](http://www.thenationalcouncil.org)) and the National Alliance for Mental Illness ([www.nami.org](http://www.nami.org)).

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## ❖ Crisis Respite Services

Crisis respite is a critical component of a cohesive system of crisis care<sup>30</sup>. Crisis respite is a brief, unplanned service that provides immediate, safe and structured care delivered in a home-like setting 24/7/365, to further stabilize the person's mental illness or substance use crisis in a recovery-oriented environment<sup>31</sup>.

With an average stay of 7 to 14 days, crisis respite provides medication management and group/family therapy with supportive services such as case management, service planning and access to outpatient services and housing options. Peers or Community Support Workers are part of the treatment team, offering additional supports and connections to community resources. Staff

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<sup>30</sup> SAMHSA. (2015) Person- and family-centered care and peer support. Retrieved from <http://www.samhsa.gov/section-223/care-coordination/person-family-centered>.

<sup>31</sup> Allen, M., Currier, G., Forster, P., & Zealburg, J. (2002). *American Psychiatric Association Task Force on Psychiatric Emergency Services*, retrieved from <http://www.emergencypsychiatry.org/data/tfr200201.pdf>.

facilitate planning and service coordination for the transition from respite care and a smooth step-down to home or community with wrap-around services.

Evidence-based practice supports creating this level of care as a possible step-down from crisis inpatient or 23-hour crisis stabilization care<sup>32</sup>. In fact, the federal Centers for Medicare & Medicaid Services have incorporated crisis-respite services into their Health Care Innovation Awards funding streams ([www.cms.gov](http://www.cms.gov)). Establishing two programs – one for adults and one for children/adolescents – with a capacity of 8-10 beds each, will continue behavioral health crisis stabilization care in the community, freeing up higher-level services and facilitating a warm hand-off from an inpatient stay.

Definition of this service, with protocols and admission criteria, is needed to ensure appropriate referrals and guidelines for services. After this service has been implemented for at least one year, consideration should be given to expanding access to the service by accepting direct admissions from the community. For some persons in a behavioral health crisis, this service can be an effective alternative to a hospital ED or an inpatient setting.

**Estimated cost per bed day: \$337**

**Estimated annual cost for 1 facility: \$1,108,000**

**Estimated annual cost for both facilities: \$2,216,000**

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## ❖ Adult Intermediate Level of Care

In New Mexico, an intermediate level of care is available to Medicaid-enrolled youth who are under age 21, but is not provided by Medicaid for adults age 21 and older. This has limited development of residential facilities for adults and created a significant gap in the service continuum. Adults may require this level of care to learn or re-learn certain life skills, modify maladaptive behaviors and cognitions, and further prepare for successful community living. This is especially important as New Mexico continues to have the second-highest drug-overdose death rate in the nation, with Bernalillo County leading the counties in numbers of deaths attributed to drug overdose<sup>33</sup>.

Community stakeholders indicated the lack of this level of care is a significant barrier to recovery for individuals with a substance abuse condition and/or mental illness. Intermediate or residential levels of care provide 24-hour services that include nursing support, life and coping skills education and group/family therapy, with linkages to community services and housing. Individuals can stay longer at this level of care – up to six months – while they gain stability and set up supports before returning to home or the community<sup>34</sup>. Such treatment is often needed for individuals with a substance use disorder who are stepping down from inpatient medical detoxification or from jail, and/or to help them avoid use of additional inpatient days. Length of stay will vary, based on the individual's clinical

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<sup>32</sup> SAMHSA (2001). Psychiatric rehabilitation process model, retrieved from <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=241>.

<sup>33</sup> *New Mexico Substance Abuse Epidemiology Report* 2014.

<sup>34</sup> American Society of Addiction Medicine (ASAM). (2015). Level 3 services, retrieved from <http://www.asam.org>

needs. Current research correlates positive outcomes with adequate treatment length<sup>35</sup>. This level of care is in line with national care trends and has proven to be cost-effective<sup>36</sup>.

To address this need, CPI recommends development of residential services that focus on adults with co-occurring mental health and substance use disorders, with referrals from higher levels of care such as inpatient or medical detoxification, the jail or directly from the community. Designating a minimum of two facilities with up to 10 beds each to serve adults with a co-occurring mental health and substance use disorder will begin to fill the need for this service.

Based on a bed utilization of 90% with a three-month average length of stay, these facilities together can serve close to 75 or more adults annually.

**Estimated cost per bed day: \$401**

**Estimated annual cost for 1 facility: \$1,318,000**

**Estimated annual cost for both facilities: \$ 2,636,000**

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## ❖ Youth Transitional Living Services

Transitional living services for adolescents and young adults struggling with substance use, who also may have a co-occurring mental disorder, provide a safe and sober living environment that promotes recovery and wellness through intensive substance-abuse and mental health treatment, life skills training, continuing education and employment support (job placement and training)<sup>37,38</sup>. Similar services exist in the Albuquerque area for male adolescents, but no such services are available for females.

CPI recommends expanding these services to include a 10-bed transitional program for female adolescents between the ages of 14 and 21, to help them transition back into the community with the supports needed for a successful recovery. Referrals for these services may originate from higher levels of care, juvenile detention and the community.

Providing this level of care will help divert this population from criminal justice involvement and reduce recidivism and/or use of higher and more expensive levels of care<sup>39</sup>. Based on a bed utilization of 90% and a four-month average length of stay, this program would serve approximately 27 or more youth annually.

**Estimated cost per bed day: \$302**

**Estimated annual cost for 1 facility: \$ 993,000**

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<sup>35</sup> National Institute on Drug Abuse (NIDA). (2012), <http://www.drugabuse.gov/publications/principles-drug-addiction-treatment>

<sup>36</sup> Thomas, K. & Rickwood, D. (2013). Clinical and cost-effectiveness of acute and subacute residential mental health services: A systematic review. *Psychiatric Services*, 64(11), 1140-1149.

<sup>37</sup> Naccarato, T., & DeLorenzo, E. (2008). Transitional youth services: Practice implications from a systematic review. *Child and Adolescent Social Work Journal*, 25(4), 287-308.

<sup>38</sup> Rashid, S. (2004). Evaluating a transitional living program for homeless, former foster care youth. *Research on Social Work Practice*, 14(4), 240-248.

<sup>39</sup> Koppelman, J. (2005, July). Mental health and juvenile justice: Moving toward more effective systems of care. *National Health Policy Forum Issue Brief* (Vol. 805, pp. 1-24).

## ❖ Intensive Case Management Services

Access to immediate, ongoing treatment following crisis stabilization is another important component of a cohesive crisis-care network. CPI's initial assessment of current outpatient programs and providers in the community indicates there may be a sufficient number of providers. However, reports of challenges have emerged in ensuring timely, ongoing support for treatment in the community. Without such ongoing care, individuals can repeatedly cycle through EDs or the criminal justice system<sup>40</sup>.

Consumers with high needs/high complexity, typically 5%<sup>41</sup> of the behavioral health population, could benefit from intensive case management services that provide immediate support, such as assistance with filling prescriptions, completing benefit applications and obtaining transportation to follow-up appointments. This means an estimated 2,900 people in Bernalillo County meet the definition of a high needs/high complexity, based on the total number of individuals (58,000) who received a behavioral health service in 2014<sup>42</sup>. Bridging this service gap with intensive case management could reduce this population's dependence on EDs and other high-level care<sup>43</sup>.

CPI recommends a first step of piloting two intensive case management teams – one for high needs/high complexity adults and one for high needs/high complexity youth. Each team would comprise four master's-level therapists, two registered nurses (RNs) and one behavioral health technician. With a caseload size of 40 people for each team member and assuming a three-month average length of stay, each team could serve 1,000 people annually.

CPI recognizes that demand for this level of case management may exceed the scope of two such teams; as a result, CPI recommends the number of teams be expanded over time, based on utilization and outcome data.

**Estimated annual cost for 1 intensive case management team: \$805,000**

**Estimated annual cost for both teams: \$1,610,000**

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<sup>40</sup> SAMHSA (Fall 2014). "Crisis response": An alternative, *SAMHSA News*. (Vol. 22, #4.), retrieved from [http://www.samhsa.gov/samhsaNewsLetter/Volume\\_22\\_Number\\_4/crisis\\_response\\_an\\_alternative/](http://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_4/crisis_response_an_alternative/)

<sup>41</sup> Department of Health and Human Services (DHHS). (July 24, 2013)/ *CMS Information Bulletin*.

<sup>42</sup> HSD Utilization Data for Centennial & Optum Healthcare January – December 2014.

<sup>43</sup> Quinlivan, R., Hough, R., Crowell, A., Beach, C., Hofstetter, R., & Kenworthy, K. (1995). Service utilization and costs of care for severely mentally ill clients in an intensive case management program. *Psychiatric Services*.

## ❖ Forensic Assertive Community Treatment

FACT teams are specialized ACT teams<sup>44</sup> designed to serve persons with serious mental illness (SMI) who have frequent contacts or complex histories of involvement with the criminal justice system. They may serve persons with SMI who are exiting prison or jail and have been diagnosed with an SMI with or without a co-occurring substance use disorder.

There is no eligibility standard for FACT, though it is generally agreed it can best serve individuals who have had at least three jail detentions in the past 12 months. FACT teams have the specific goals of preventing further incarceration of its members and reducing unnecessary hospitalizations<sup>45</sup>.

Persons are often referred to FACT teams by medical or/behavioral health providers in jails or prisons; additionally, they may be referred by other service providers, social service agencies, shelters, or parole/probation services. Persons with forensic psychiatric histories and treatment in the state hospital are also candidates for FACT services upon discharge from the state hospital; successful re-entry is dependent upon having a safe place to live, support services to help assure successful retention of housing, employment/meaningful activity, and provision of treatment services at the intensity and frequency needed by the person<sup>46</sup>.

To determine the need for this type of program, CPI partnered with The Center for Health and Justice/TASC in a mapping exercise at the MDC in September 2015, to identify gaps in services for individuals being released from the facility. A report compiled by MDC<sup>47</sup> using data from a two-week span in March 2015 indicates that 981 individuals were released, of which approximately one in four (25%) received psychiatric services while in custody. The data shows approximately 75 individuals are released each day, of which 17 individuals received mental health services while incarcerated. The data indicate that close to 25% of individuals MDC releases are transferred to the Department of Corrections (DOC) or other facilities, with the remaining inmates released into the community. The discharge planner for Correct Care Solutions (CCS), the contracted behavioral health services provider at MDC, works to connect inmates with services at release. Often the individual does not follow through with service referrals or obtain medication refills after discharge, which can lead to a recurrence of illness, crisis, hospitalization or re-incarceration.as a result of failure to comply with terms of parole.

A study conducted by the Illinois Department of Corrections<sup>48</sup> found that recidivism rates for inmates who completed or were still enrolled in substance abuse treatment after discharge were 44% lower than for those who did not participate in treatment. This supports the provision of immediate linkages to treatment after release to reduce re-incarceration rates over time.

A recent collaboration between Bernalillo County and the City of Albuquerque helps selected jail inmates or recently released individuals who have mental illness and are at risk of being homeless. It

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<sup>44</sup> SAMHSA. (2008). *Assertive Community Treatment: How to Use the Evidence-Based Practice Kits*. DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, SAMHSA, DHHS.

<sup>45</sup> Cuddeback, G., Wright, D., & Bisig, N. (2013). Characteristics of participants in jail diversion and prison reentry programs: Implications for forensic ACT. 64(10), 1043-1046, retrieved from <http://ps.psychiatryonline.org/doi/10.1176/appi.ps.201200333>

<sup>46</sup> Morrissey, J. P. (2013). Forensic Assertive Community Treatment: Updating the Evidence.

<sup>47</sup> Psychiatric Services Unit Caseload Details, September 14, 2015.

<sup>48</sup> Illinois Department of Corrections, *A Process and Impact Evaluation of the Sheridan Correctional Center, Therapeutic Community Program During Fiscal Years 2004 through 2010*.

provides housing with wrap-around services to help them remain stable and connected to treatment services and supports. This Supportive Housing Program, which started in July 2015, provides a fully stocked apartment and a case manager to help ex-offenders navigate the care system. With a capacity to serve 100 people, this is a promising approach to breaking the cycle of homelessness, reducing the potential for re-offense and increasing public safety.

CPI recommends that Bernalillo County develop one FACT team to work in concert with the CCS discharge planner and the Supportive Housing Program, providing 24/7/365 treatment and support services for up to 100 seriously mentally ill inmates released from MDC. Providing immediate entry into treatment, with ongoing engagement and a full array of services, should reduce dependency on higher levels of care, as well as repeated episodes of incarceration.

**Estimated annual cost for 1 FACT team: \$1,097,000**

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### ❖ Substance Abuse Outpatient Treatment Services

Substance use problems and disorders are preventable and treatable conditions. Research supports the effectiveness of substance abuse services provided within the framework of a recovery-oriented system of care that includes person-centered, individualized care based on the individual's strengths; involvement of family, friends and other supports; culturally appropriate care; and the inclusion of peers throughout the recovery process to achieve the best outcomes<sup>49</sup>. Input from the community identified a need for outpatient services specifically for substance use disorders that incorporate these concepts.

Bernalillo County's, Department of Substance Abuse Programs currently offers an ASAM Level 1 outpatient program for adults with addiction treatment needs after release from jail. This Community Addiction Program (CAP) serves individuals who do not require intensive outpatient services, but who need further treatment and support as they transition back to the community. CAP provides services that align with evidence-based practice, such as the Community Reinforcement Approach (CRA)<sup>50</sup>. CAP offers four service levels that in combination provide up to 24 weeks of programming, driven by the initial assessed needs of the person.

One option is for the County to expand eligibility for the CAP program to individuals who are not directly involved with the criminal justice system, allowing it to serve up to 300 community members by leveraging the program's current staffing capacity. If the County elects this option, CPI recommends enhancing CAP services, including assessment for and treatment of trauma, by incorporating culturally specific practices and gender-specific strategies for women<sup>51</sup>.

Staffing should include trained peers in a recovery-based treatment program with linkages to MCO navigators as an additional level of support and for coordination of care for individuals in treatment.

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<sup>49</sup> SAMHSA. (August 2009). *Guiding Principles and Elements of Recovery-Oriented Systems of Care: What do we know from the research?*

<sup>50</sup> National Registry of Evidence-based Programs and Practices (NREPP), retrieved from [https://www.google.com/?gws\\_rd=ssl#q=nrepp.samhsa.gov](https://www.google.com/?gws_rd=ssl#q=nrepp.samhsa.gov)

<sup>51</sup> SAMHSA. (2015). Substance Abuse Treatment: Addressing the Specific Needs of Women. *A Treatment Improvement Protocol TIP 51*, retrieved from <http://store.samhsa.gov/product/TIP-51-Substance-Abuse-Treatment-Addressing-the-Specific-Needs-of-Women/SMA15-4426>

Another option is to develop one or more substance abuse outpatient clinics, strategically located in underserved areas of the community (see Attachment 2). This program should, at minimum, utilize ASAM placement criteria, CRA or other evidence-based services that also include trauma-informed, culturally specific services for Native Americans and gender-specific services for women including assessment and treatment of trauma.

CPI recommends development of at least one program that is modeled after one of these options, as determined by the County.

For the purpose of this plan, CPI estimated costs for the second option that can be scaled up or down as needed, based on the targeted service capacity. The peer staffing portion of this operating budget can also be used to project costs for the first option (expanding the current CAP program).

**Estimated annual cost for Substance Abuse Outpatient Services: \$1,478,000**

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### ❖ Community Engagement Team

CETs conduct outreach to engage individuals with serious mental illness to voluntarily participate in treatment and/or other services. CET<sup>52</sup> goals include reducing the individual's rate of law enforcement contacts, and/or use of hospitalizations/crisis system and EDs. CETs comprise a mental health professional and a certified Peer or Family Specialist, who respond in the community upon a call center dispatch. CET is not a crisis response team, but rather a mobile engagement team that connects with individuals who are at-risk and not currently receiving treatment to offer treatment and/or community-based services. Referrals to the CET may also come from acute inpatient facilities, EDs or the crisis response mobile teams.

CPI recommends Bernalillo County develop one CET as a pilot project for a minimum of one year. We recommend establishment of standard outcome measurements with quarterly targeted and measurable goals and reporting to evaluate program effectiveness, with the option to increase the number of teams if needed.

**Estimated annual cost for 1 CET team: \$304,000**

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### ❖ School-Based Substance Abuse Intervention Services

As part of an overall prevention/early intervention focus, expansion of school-based substance abuse intervention programs should also be considered, leveraging existing programs in high schools to increase capacity and outreach to the students, faculty and parents<sup>53,54,55</sup>. More information on school-based prevention programs can be found at the website for the National Institute of Health's National Institute on Drug Abuse ([www.drugabuse.gov](http://www.drugabuse.gov)).

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<sup>52</sup> State of New Mexico, Behavioral Health Collaborative (July 2015), *Pilot Community Engagement Team Guidelines*.

<sup>53</sup> School-Based Substance Abuse Prevention and Intervention Program (SAPI) 2014-15 SAPI Annual Report, retrieved from <https://www.colorado.gov/pacific/hcpi/school-based-substance-abuse-prevention-and-intervention-program-sapi>.

<sup>54</sup> Gottfredson, D. C., & Wilson, D. B. (2003). Characteristics of effective school-based substance abuse prevention. *Prevention Science*, 4(1), 27-38.

<sup>55</sup> SAMHSA. (2015). *SAMHSA's efforts in schools and on college campuses*, retrieved from <http://www.samhsa.gov/school-campus-health/samhsas-efforts>

APS, the largest school district in New Mexico with approximately 93,000 students, provides counseling services in 105 schools throughout the County and a drug-use prevention and intervention program in 13 high schools. The drug intervention program requires students caught with drugs or using drugs on campus to participate, along with a parent, in drug and alcohol education with an emphasis on family relationships. In the last year more than 700 students and 150 families benefited from this program<sup>56</sup>.

Current staffing of this program is challenging, with seven master's-level therapists expected to cover 13 high schools. Expanding the staffing level by 6 FTEs to provide a dedicated therapist at each high school is recommended, with the potential to expand services into middle schools in future.

An agreement with APS should accompany this funding to ensure the school district will continue to use a portion of its Medicaid funds from special-education programs to help pay for this resource.

### **Estimated annual cost for 6 substance abuse therapists: \$663,000**

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#### **❖ Early Prevention and Family Intervention Services (Birth to 5 yrs.)**

Psychiatric disorders presenting in young children are a public-health concern, affecting children's developmental trajectories in all spheres: cognitive, emotional, behavioral and social.

Research shows many psychiatric disorders remain relatively stable in children aged 3 to 6 years, suggesting that young children do not outgrow psychiatric disorders. Bufferd (2012) found that children who met criteria for any psychiatric disorder at age 3 were nearly five times as likely as the control children to meet criteria for a mental health diagnosis at age 6<sup>57</sup>.

Challenging behaviors resulting from these disorders may include aggression toward others (e.g., biting, hitting, kicking) and emotional dysregulation (e.g., uncontrollable tantrums, crying). These behaviors can result in expulsion from child care, difficulty participating in family activities, and impaired peer relationships, with serious consequences if not addressed.

A well-known study on the effects of Adverse Childhood Experiences (ACEs) links childhood trauma to long-term health and social issues. The study included screening of more than 17,000 people and revealed staggering proof of the negative health, social and economic risks that result from childhood trauma and other adverse experiences such as death of a parent. An ACE study publication<sup>58</sup> cites a proportionate relationship between an individual's ACE score and psychiatric conditions such as depression, hallucinations and attempted suicide. Presenters at the National Council for Behavioral Health's 2012 conference<sup>59</sup> called ACEs "the prime determinant of the health, social and economic well-being of our nation."

Prevention and early intervention programs for this population need to have a wide scope and include efforts such as age-appropriate assessments, dyadic therapy, trauma-informed care, play

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<sup>56</sup> KRQE News 13, Albuquerque Public School's Crossroads Program Faces Funding Woes, September 2015.

<sup>57</sup> Bufferd, S., et al., *American Journal of Psychiatry*, November 2012.

<sup>58</sup> *The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders, and Sexual Behavior: Implications for Healthcare*, August 2009.

<sup>59</sup> Anda, R.F., Felitti, V.J. *Adverse Childhood Experiences and Their Relationship to Adult Well-Being and Disease*, from the National Council for Behavioral Health's webinar of August 27, 2012, retrieved from <http://www.thenationalcouncil.org/wp-content/uploads/2012/11/Natl-Council-Webinar-8-2012.pdf>

therapy and wrap-around services to support families/caregivers. Staff must receive special training in working with children in this age group, as well as with children in CYFD/Protective Services.

CPI recommends developing a pilot program to address the needs of infants and children 5 years old and younger and their families, with a specialized, home-based treatment program. This is crucial to preventing or minimizing the effect of childhood psychiatric disorders and/or traumatic events that, if left untreated, may lead to utilization of costlier treatment services.

**Estimated annual cost for pilot prevention program: \$784,000**

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### ❖ Crisis Transportation Services

Non-emergency crisis transportation services ensure people are able to access the behavioral health care they need when they need it. Providing this transportation removes a major barrier to a person's recovery, while supporting the individual's health and wellness<sup>60</sup>.

Transportation to routine scheduled appointments is a Medicaid behavioral health benefit that is accessed through the MCOs. However, transportation for urgent, unscheduled services is critically important for individuals and families in need of immediate crisis stabilization<sup>61</sup>.

Anyone may request this service through the call center if it is determined they need immediate (non-emergency) transportation to or from the crisis center. All other resources, such as transportation by a friend, family member, public transportation, etc., should be fully explored before dispatching the crisis transportation service.

CPI recommends co-location of a non-emergency transportation provider at the interim crisis center to fill this gap in care. Transportation services should be accessible 24/7/365, with on-site availability during high-demand hours and on-call coverage during low-demand hours. A two-person team can pick up/drop off the person in the community, home or facility.

The non-emergency transportation provider should make available three transport teams to take people to and from the crisis center and crisis respite programs in the community. Transport team members should receive extensive training in Mental Health First Aid and crisis intervention. CPI also recommends ongoing monitoring and oversight of this service, to evaluate utilization and determine whether to increase the number of teams going forward.

**Estimated annual cost for 3 crisis transportation teams: \$382,000**

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### ❖ Permanent Supportive Housing with Wrap-Around Services

Housing for people with mental illness and/or substance abuse issues is an essential part of a continuum of behavioral health care<sup>62</sup>.

In Bernalillo County, households that include persons with long-term behavioral health disabilities benefit from a variety of subsidized and low-income housing opportunities within the Linkages

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<sup>60</sup> DHHS. (2004). Getting There: Helping People With Mental Illnesses Access Transportation. *DHHS Pub. No. (SMA) 3948*. Rockville, MD. Center for Mental Health Services (CMHS), SAMHSA.

<sup>61</sup> Minnesota Emergency Medical Services Regulatory Board (2007). *EMS behavioral health report: An examination of the challenges of transporting behavioral health patients in Minnesota and recommendations for improvement*, retrieved from [http://www.emsrb.state.mn.us/docs/EMS\\_Behavioral\\_Health\\_Report.pdf](http://www.emsrb.state.mn.us/docs/EMS_Behavioral_Health_Report.pdf).

<sup>62</sup> SAMHSA. (2010). Permanent Supportive Housing: The Evidence. *HHS Pub. No. SMA-10-4509*, Rockville, MD: CMHS, SAMHSA, DHHS.

project, Low Income Housing Tax Credit (LIHTC) properties, Continuum of Care (“Shelter Plus Care”) homeless assistance grants, and Section 8 voucher preferences<sup>63</sup>. Additional assistance may come from New Mexico’s recent allocation of approximately \$2.3 million of HUD 811 Project Rental Assistance funds, which provide rental assistance to extremely low-income individuals with SMI who may be homeless, at risk of homelessness or at risk of institutionalization<sup>64</sup>. Up to 95 households across the state will receive this assistance.

In light of a tight apartment rental market<sup>65</sup>, an extensive housing cost burden on low-income households<sup>66</sup>, and a lack of landlord buy-in (according to County and other local housing experts), the County and/or City should continue to pursue additional affordable-housing units for low-income persons with long-term behavioral health disabilities.

There is an immediate need to expand affordable housing for persons with behavioral health conditions who are homeless or are at risk of becoming homeless. The New Mexico Senate Memorial 44 Working Group looked at homelessness in the State and formulated affordable-housing recommendations. Its report<sup>67</sup> cites the need for supportive housing in each county, based on population, poverty rate and the one-time count of homeless people conducted in January 2015. From this data, the report estimated that more than 1,680 homeless individuals in Bernalillo County need supportive housing.

Permanent Supportive Housing (PSH) combines affordable housing with wrap-around services to help people with behavioral health conditions live independently, increase stability and improve recovery outcomes. PSH curbs utilization of high-cost crisis and emergency services<sup>68</sup> and reduces overall costs of behavioral healthcare<sup>69</sup>. PSH is distinguished from other living arrangements for people with behavioral health disabilities in that tenants have independent leases with full rights of tenancy, pay 30% of income toward rent and utilities, are integrated in the community, and receive more or less intensive services based on their need. Access to housing is not contingent on “readiness,” nor do tenants lose their homes based on service participation<sup>70</sup>.

County and local housing experts expressed a need for 100 more housing units for this population, whether through new development with fully dedicated units (a congregate housing-like model), scattered-site rental assistance vouchers, or partially set-aside units in larger developments (as with Low Income Housing Tax Credit projects).

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<sup>63</sup>Albuquerque Housing Authority, retrieved from <http://www.abqha.org/eligibility.aspx>

<sup>64</sup> U.S. Department of Housing and Urban Development (HUD). March 2, 2015. HUD Awards \$150 Million to Provide Permanent Homes and Services to Extremely Low-Income Persons with Disabilities. *HUD No. 15-026*.

<sup>65</sup> HUD, retrieved from [http://www.huduser.gov/portal/ushmc/chma\\_archive.html](http://www.huduser.gov/portal/ushmc/chma_archive.html)

<sup>66</sup> City of Albuquerque, *Housing Needs*, retrieved from <http://www.cabq.gov/family/documents/albuquerque-housing-needs-final.pdf>

<sup>67</sup> Senate Memorial 44 Working Group Recommendations, November 2015.

<sup>68</sup> CHS, *What is Supportive Housing?*, retrieved from <http://www.csh.org/supportive-housing-facts/introduction-to-supportive-housing/>.

<sup>69</sup> National Alliance to End Homelessness. (March 1, 2010). *Cost Savings with Permanent Supportive Housing*, , retrieved from <http://www.endhomelessness.org/library/entry/cost-savings-with-permanent-supportive-housing>.

<sup>70</sup>SAMHSA (2010). *Permanent Supportive Housing, Evidence-Based Practice Kit*, retrieved from <http://store.samhsa.gov/shin/content/SMA10-4510/SMA10-4510-06-BuildingYourProgram-PSH.pdf>.

Advantages and disadvantages for each approach are described below:

- **New development** can be costly and may require partnering with a developer using creative funding strategies, but it provides immediate access to on-site behavioral health care.
- **Rental assistance vouchers for scattered-site units** face the barrier of low landlord buy-in and a limited rental market, but allows individuals to choose where to live in the community.
- **Partially set-aside units using LIHTC funds** are not only competitive statewide to obtain tax credits, but often fail to serve households most in need. Like scattered sites, this practice provides individual choice of units and/or housing location within the community.

The County may want to consider a shift away from congregate settings to individual, scattered-site units, based on the 1999 Supreme Court *Olmstead* ruling to reduce unnecessary institutionalization<sup>71</sup>.

Regardless of the approach chosen by the County to best fit community needs, CPI recommends development of 100 housing units that support the independence and integration of households with behavioral health disabilities. All these units require rental assistance subsidies to bridge the gap between the 30% of household income from service recipients and the cost of market rent or operating costs.

To help the individual or household remain stable and live independently, wrap-around services should be provided by a dedicated team of trained behavioral health staff, including peers who help them navigate the care system and link to other community resources. Essential wrap-around services include case management, child care, education services, peer support, employment assistance and job training (including supported employment opportunities), housing search and counseling, legal services, living skills (e.g., budgeting), substance use treatment, behavioral health services, and assistance with utilities and transportation.

**Estimated annual cost for 100 units of rental subsidy and wrap-around services: \$1,218,000**

### ❖ Wrap-Around Services for Existing Vulnerable Households

While PSH is a proven strategy for stabilizing vulnerable households with long-term disabilities, a primary concern identified by local service providers is a lack of wrap-around services and care coordination to help existing households retain affordable housing, increase the essential support of landlords, and ensure prioritization of PSH for households who need it most. Otherwise, higher-need households can return to homelessness because affordable units go to lower-need households. Some households may need more intensive ACT or Intensive Case Management approaches, while others will benefit from on-site or in-home wrap-around services such as case management, child care, education services, peer support, employment assistance and job training (including supported employment opportunities), housing search and counseling, legal services, living skills (e.g., budgeting), substance use treatment, behavioral health services, and utility and transportation assistance.

Wrap-around services should be available to Section 8, public housing, Continuum of Care, LIHTC, HUD 811 Project program, and other subsidized unit tenants who are also precariously housed and lack the supports necessary to achieve stability. By prioritizing, bolstering and better coordinating

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<sup>71</sup>National Council on Disability (2013), *NCD Urges HUD to Issue Olmstead Guidance*, retrieved from <http://www.ncd.gov/publications/2013/05212013/>.

availability of wrap-around services, the County may decrease costs to public systems (including the criminal justice system) and returns to homelessness, while increasing the stability, recovery and well-being of the most vulnerable residents.

CPI recommends developing wrap-around services for an additional 300 tenants who now are in supportive housing. These services should be targeted based on household need, determined in partnership with the local HUD Continuum of Care's prioritization process for highly vulnerable homeless households, or based on highest-cost utilizers of crisis services, with a model such as that used by the Corporation for Supportive Housing's Frequent Users Systems Engagement (FUSE) initiative<sup>72</sup>. Public Housing Authorities oversee a large number of subsidized units and can likely identify households that are most in need of these services.

**Estimated annual cost for wrap-around services for up to 300 tenants in affordable housing:  
\$905,000**

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<sup>72</sup> CHS (2011). *Blueprint for FUSE: Three Pillars and Nine Steps*, retrieved from <http://www.csh.org/resources/blueprint-for-fuse/>.

## ❖ Initial Implementation Phase Cost Summary

The list below shows total projected costs from the behavioral health GRT for developing the initial infrastructure of a cohesive crisis network in Bernalillo County.

Initial Implementation Summary of Operating Expenses	
Administrative Structure	\$572,000
Crisis Call Center (dispatch & call-transfer capability; all populations)	\$232,000
Crisis Response Mobile Teams (4 two-person teams; all populations)	\$1,800,000
Crisis Respite Services (2 facilities, 10 beds each; one adult & one youth)	\$2,216,000
Intermediate Levels of Care (2 facilities, 10 beds each; both for adults)	\$2,636,000
Youth Transitional Living Services (1 facility, 10 beds)	\$993,000
Intensive Case Management Teams (2 teams; one for adults & one for youth)	\$1,610,000
Forensic ACT Team (1 team; adult)	\$1,097,000
Substance Abuse Outpatient Treatment Services	\$1,478,000
Community Engagement Team (1 pilot team; all populations)	\$304,000
School-based Substance Abuse Intervention Program (expand existing services to 13 high schools)	\$663,000
Early Prevention/Family Intervention Services (birth to 5 years old)	\$784,000
Crisis Transportation Services (3 two-person teams; all populations)	\$382,000
Permanent Supportive Housing with Wrap-around Services (100 adults)	\$1,218,000
Wrap-around Services for Existing Vulnerable Households (300 adults)	\$905,000
<b>Total Operating Expenses</b>	<b>\$16,890,000</b>

It is expected that some of these costs will be offset through extensive coordination of benefits efforts to leverage all third-party payers prior to accessing the behavioral health GRT funds to pay for these services.

## Funding Reimbursement Options

Total annual projected costs for developing the first phase of crisis services are estimated to be \$16,890,000, which may be funded in whole or in part from the expected \$17 million in revenue from the behavioral health GRT or other funding resources. This cost estimate does not factor in collection of funds from other responsible payers, such as Medicare, Medicaid, non-Medicaid and other third-party insurers. CPI strongly supports exploring all alternative funding sources before spending any of the behavioral health GRT on service provision.

Opportunities exist to maximize funding reimbursement from these sources. Understanding coordination of benefits for all populations served at the service agency level is critically important to the success of billing and collecting these funds in a timely manner.

A subcommittee of the Behavioral Health Resource Work Group is collaborating to identify Medicaid covered behavioral health services, service providers and consumer populations to further define this benefit, as well as any benefit paid under Medicare, to leverage reimbursement for these services. Below are the subcommittee's initial findings on potential funding resources that should be billed initially before accessing the behavioral health GRT, as part of a coordination of benefit effort at the agency level, along with matching Healthcare Common Procedure Coding (HCPC).

Crisis Service Component	HCPC Code <sup>73</sup>	Medicaid Covered
Crisis Triage, Stabilization & Intervention (face-to-face; up to 24 hrs.)	H2011*	Yes
Crisis Stabilization & Intervention over the telephone (crisis calls)	H2011*	Yes
Crisis Response Mobile Teams (face-to-face)	H2011*	Yes
Crisis Respite – Adults	None	No
Crisis Respite – Youth	None	No
Intermediate Levels of Care – Adult	None	No
Transitional Living Services	None	No
Intensive Case Management	None	No
Forensic Assertive Community Treatment team	H0039*	Yes
Substance Abuse Outpatient Treatment Services	Various	Partially
Community Engagement Teams (case management, peer services)	None	No
School-based Substance Abuse Intervention Services	None	No
Early Prevention & Family Intervention Services (birth to 5 yrs.)	None	No
Crisis Transportation (24/7/365, immediate access)	None	No
Housing Support Services (wrap-around services)	None	No

\*HCPC Code may require a modifier when billing Centennial Care/Medicaid

<sup>73</sup> HCPC codes based on HSD Report 41; Current Procedural Terminology (CPT) professional codes may also be billed.

Claims/billing methodologies should establish the behavioral health GRT as the payer of last resort, only available after all other payers have been exhausted. To effectively and efficiently maximize funding reimbursement, the provider agency claims/billing system should interface with coordination of benefits policies prior to service delivery. Implementing this infrastructure, with the expectation that all crisis services delivered be reported using HIPAA standard code sets, would create a uniform platform for services to be billed to multiple payers, such as Medicaid and private insurers.

## ❖ Local Funding of Behavioral Health Services

In addition to priority billing other payers, another option to maximize funding resources is to evaluate local spending on behavioral health-related services that could be re-aligned to help fund crisis service priorities. CPI collected funding data from Bernalillo County, the City of Albuquerque, United Way and Sandoval County to determine the total amount of local funding currently allocated to behavioral health services<sup>74</sup>. Data was also collected from UNM specific to how it uses current funding, whether from the Bernalillo County Mill Levy tax, Medicaid or third-party payers, to fund UNM behavioral health programs.

This data provides insight on the types of programs now funded, targeted populations, and expected outcomes to be accomplished and reported to the funding agency.

In partnership with funding agencies, data were grouped based on agreed upon service definitions to generate a like comparison. The final data reflect total funding allocations from Bernalillo County and the City of Albuquerque of approximately \$29 million, from United Way at approximately \$1.4 million, and from Sandoval County at approximately \$400,000.<sup>75</sup>

Significant opportunity exists for these agencies to collaboratively re-align their funding to further support development of a crisis-care network. Benefits of this type of programmatic streamlining include:

- Eliminating funding redundancies;
- Focusing funds to enhance the crisis-care continuum;
- Expanding contract language to include similar service definitions; and
- Setting service expectations with clearly defined, measurable outcomes.

Developing and implementing this type of consistent structure will strengthen the funding agencies' ability to measure successes, identify areas for improvement, and promote accountability and robust reporting.

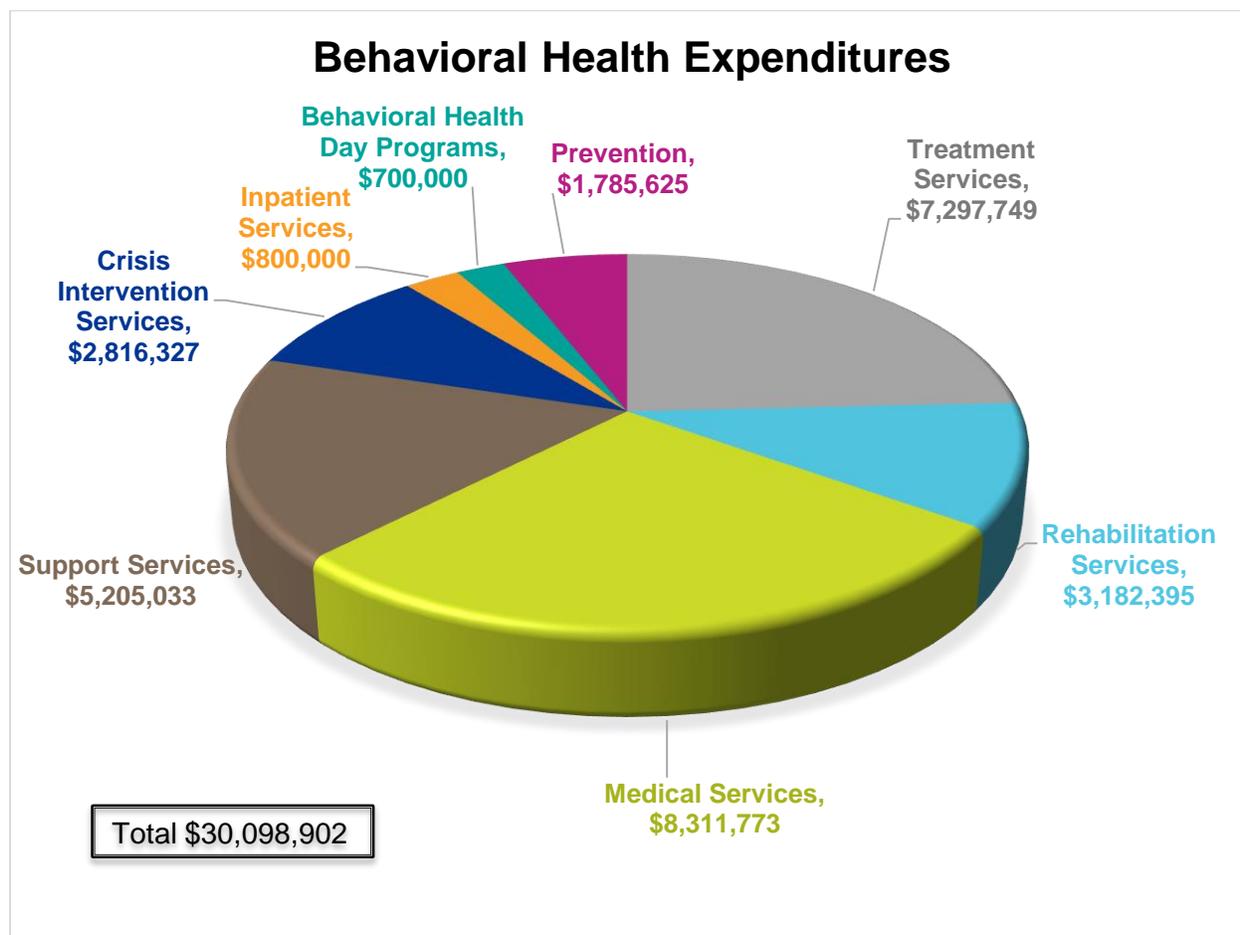
The City and County have a proven track record in similar collaborations, such as the Supportive Housing program that began in July 2015, for which both entities allocated funding to support an innovative housing program for homeless persons being released from jail. CPI encourages a similar effort for this project, as these local resources could strategically align their funding strategies beginning in fiscal year 2017.

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<sup>74</sup> Housing funds are not included in these figures because they are dedicated to a specific population -- individuals who are homeless -- and as such have less flexibility to realign to other populations

<sup>75</sup> *New Mexico Substance Abuse Epidemiology Profile*, August 2014

The illustration below shows combined expenditures of Bernalillo County, City of Albuquerque and United Way, grouped by like programs.



The County, City and United Way have already begun looking at opportunities to align their contracts, using like behavioral health service definitions and scopes of work that focus on similar program goals and requirements that contractors participate in the New Mexico Network of Care database.

In addition to these efforts to maximize funding reimbursement options, additional commitments are needed from State leadership to explore all options for funding construction of a stand-alone crisis center to serve the greater Bernalillo County region (if the County elects to do so), with additional contributions to fund the annual operating budget of such a center.

Bernalillo County’s financial commitment is strong, but assistance is needed from the adjoining counties to either pool unspent funds or provide like services using local resources that are coordinated with this plan. With these partnerships in place, the County can fully develop a mature system of care with ample community-based service capacity that is easily accessible to anyone experiencing a psychiatric crisis.

CPI believes the creation of the system should start with developing the prioritized crisis services described in this plan. Strategies for a coordinated implementation process are described below.

## Strategy Planning and System Implementation

Bernalillo County is at a tipping point. With a fair number of mental health and substance abuse programs in the region, coordination of services from the point of referral to service delivery often does not occur. Reforming the current services into a cohesive, coordinated crisis network can produce positive outcomes not only for service recipients, but also for their families and the entire community.

With a comprehensive crisis network in place, the most vulnerable citizens of Albuquerque and surrounding areas could receive the care and support they need to remain safe and stable within their community. Such a system could also have a positive impact on public safety, as well as the criminal justice system and EDs.

Creating a unified and comprehensive crisis network includes initial funding of key crisis services that provide immediate access to care when a person is experiencing a psychiatric crisis and in need of stabilization services. The crisis network continuum includes building service capacity to support people in the community who may need intensive case management services to maintain care, Crisis response mobile teams working in concert with law enforcement to provide immediate interventions, and expanding and building upon existing resources to support people who have initially been stabilized.

Developing a coordinated approach to implementing these services with a strategic, well-thought-out plan is critically important to maintain sufficient access to the existing service array during the incremental development of new services. CPI identified services that are dependent on one another, which will help define development priorities. For example, expanding the crisis call center function to include dispatching of mobile teams in the community must be in place before activating the crisis response mobile teams.



CPI identified four stages of development as illustrated above. These development stages establish minimal timeframes for procuring a new service or expanding an existing service, as described in the Crisis Network section of this business plan. Achieving timely implementation of the service continuum requires the overlapping of development activities (stages) from a dedicated team in collaboration with the County. CPI recommends the County seek service contracts with qualified providers through a competitive bidding process that, at minimum, embraces:

- Recovery-oriented services that focus on the person's strengths;
- Use of Peer and/or Family Specialists for support and navigation throughout all levels of care;
- Culturally competent services and programming inclusive of languages other than English; and
- A "no wrong door" approach to meeting the needs of individuals and families in crisis.

It is also recommended that, whenever possible and allowed by established policy, the procurement process be shortened to a single-source selection, in place of a request for proposal process that can be quite lengthy. While it is preferable to use a competitive bidding process, in some situations the funding agency needs to respond swiftly to community needs and flexibility in procurement of services is advisable.

Presenting the staging priorities below helps illustrate the development timeline:

Crisis System Component*	2016				2017			
	Jan.- March	April- June	July- Sept.	Oct.- Dec.	Jan.- March	April- June	July- Sept.	Oct.- Dec.
<b>Administrative Structure</b>	Stage 1							
Hire staff								
<b>Crisis Call Line-NMCAL</b>	Stage 1							
3-way calls								
911 transfer protocols								
Dispatch mobile teams								
<b>Substance Abuse OP Services</b>	Stage 1							
Hire staff & implement program								
<b>Permanent Supportive Housing</b>	Stage 1							
RFP								
Implement program								
<b>Wrap-around Services Only</b>	Stage 1							
RFP								
Implement program								
<b>Crisis Response Mobile Teams</b>	Stage 2							
RFP								
Implement two teams								
Implement two teams								
<b>Crisis Respite</b>	Stage 2							
RFP								
Two 10-bed facilities for adult & youth								
<b>Intermediate Level of Care</b>				Stage 3				
RFP								
Two 10-bed facilities for adults								
<b>Intensive Case Management</b>				Stage 3				
RFP								
Two 7-person teams for adult & youth								
<b>School-based Substance Abuse Intervention</b>				Stage 3				
RFP								
Hire staff & implement program								
<b>Prevention &amp; Early Intervention (Birth to 5 yrs.)</b>				Stage 3				
RFP								
Hire staff & implement program								
<b>Forensic ACT Teams</b>						Stage 4		
RFP								
One team								
<b>Community Engagement Team</b>						Stage 4		
RFP								
One pilot team								
<b>Transitional Living Services</b>						Stage 4		
RFP								
One 10-bed facility for female youth								
<b>Crisis Transportation</b>						Stage 4		
RFP								
Three 2-person teams								

Note: Numbers within the timeline indicate the staging level of the action.\*

Based on the County's experience with its procurement process, adjustments to this timeline can be made.

Another recommended development strategy is to consider geographic location of service sites in relationship to areas of higher poverty, to ensure greater accessibility to crisis services for individuals who may find it difficult to arrange transport or take off time from work, and who are less likely to have access to ongoing behavioral health care. Steps should be taken during the solicitation-development process to prioritize expanded and/or newly funded services to areas of moderate to high poverty rates. Using federal poverty data from the US Census Bureau's 2009-2013 5-Year American Community Survey, CPI mapped Albuquerque's poverty rates by zip code and overlaid current service sites, identified through our research and the 2014 site inventory published by UNM Albuquerque Mental Health Services Gaps Project (see Attachment 2).

## ❖ Prevention Planning – A Pathway to Healthier Communities

Prevention and early intervention programs are important components of a recovery-oriented system of behavioral health care. Mental illness and substance abuse are costly to government, families and individuals, in treatment dollars and income/taxes/other lost productivity.

The state's most recent epidemiology report<sup>76</sup> ranks New Mexico as having the:

- Highest alcohol-related death rate in the U.S. every year since 1997;
- Second-highest rate of drug overdose deaths in the country (with Bernalillo County having the highest number of deaths of the state's counties); and
- One of the highest suicide rates in the nation.

Unintentional drug overdoses accounted for more than 80% of the state's total drug overdoses. The three most common drugs involved in unintentional-overdose deaths were prescription opioids (49%) and heroin (29%), followed by tranquilizers/muscle relaxants (28%).

At the same time, New Mexico has had remarkable success in decreasing the rate of deaths from motor vehicle accidents attributed to alcohol, following a community campaign to prevent driving while intoxicated.

In addition to substance abuse issues, mental health issues are also of concern. Upon recommendation of the federal Centers for Disease Control and Prevention (CDC), the epidemiology report gauged well-being and mental health by asking respondents how many days, in the previous month, their "mental health has not been not good." After responses were grouped into levels of frequency, it was found that 15.1% of adults aged 25 to 64 and 10.8% of youth aged 18 to 24 fell into the "Frequent Mental Distress" category.

The County and City has taken steps to develop priorities for prevention services, and several such programs are in place, including ones implemented at schools. United Way supports prevention programs, as well.

Prevention services may be most effective when they work at the population level<sup>77</sup>, focusing on changing community conditions to create overall healthier communities. This can be achieved using

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<sup>76</sup> *New Mexico Substance Abuse Epidemiology Profile*, August 2014.

<sup>77</sup> SAMHSA. (January 2009). *Identifying and Selecting Evidence-based Interventions*.

a proactive approach that includes assessment of community conditions, identifying desired outcomes and evidence-based strategies to implement, and developing tools that measure results.

Approaching these issues within a strategic prevention planning framework will complement traditional, individual-focused programs and foster cohesive prevention/early intervention programming focused on early identification of problems and access to treatment, and education and empowerment of individuals, communities and systems. It will help create and reinforce conditions that promote healthy behaviors and lifestyles and produce outcomes that are sustainable over time.

A strategic prevention planning process led by Bernalillo County, in partnership with the City of Albuquerque and other prevention leaders and stakeholders, should be initiated to:

- Identify and/or contribute sources of data;
- Design a community survey and focus-group questions with a strategy for administration;
- Facilitate data collection and analysis;
- Identify areas of greatest need and highest community capacity and strength;
- Identify the most applicable evidence-based interventions (those research has found effective);
- Develop and implement a plan to deliver the intervention to areas and/or populations of greatest need;
- Develop a sustainability plan for the project; and
- Prepare to implement the project.

In addition, training for current and new prevention staff members on the concepts and implementation of community/population-level prevention strategies would help ensure a comprehensive approach to prevention is adopted system-wide.

Use of SAMHSA resources such as the Strategic Prevention Framework<sup>78</sup> and the Substance Abuse Prevention Skills Training would provide the foundation needed to reduce behavioral health disparities and create a community culture that increases protective factors and reduces risk factors. The process would identify population needs and strengths, improve cultural competency of services, work toward sustainability through sharing of outcomes and stakeholder support, and improve the overall health and well-being of communities.

CPI recommends cost reimbursement for strategic prevention planning and staff training be shared among Bernalillo County, the City of Albuquerque and other prevention leaders using current prevention service allocations. Current funding data collected from the County and City combined represents approximately \$1.7 million that is allocated to prevention programs in the community.

Realignment of prevention dollars should be prioritized to fund the prevention strategies identified through the strategic planning process before utilizing the behavioral health GRT to fund these priorities.

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<sup>78</sup> SAMHSA (September 2015). *Applying the Strategic Prevention Framework*.

## Closing Statement

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Bernalillo County and central New Mexico are well on their way to improving the lives of residents and public safety through development of a system of behavioral health care that includes stabilization and other services for individuals experiencing a psychiatric crisis.

The dedication and leadership shown by the County and its officials, funders, care providers, other stakeholders and community members over this years-long process is an indication of ultimate success. It provides valuable momentum for creating a comprehensive, coordinated care system and related services, with administrative oversight of services, funding and contracting. Together, these steps will contribute to the region's overall health by improving access to services and easing demand on other community resources such as law enforcement, the MDC and hospital EDs.

CPI has been honored to work with County leadership over the past several months to develop this business plan for a recovery-focused system of behavioral health care. We believe the plan will help local leaders build upon current programs, initiatives, resources and funding, while addressing community priorities for both services and populations.

Guiding values of this plan include:

- Recommendations for service development to create a comprehensive, community-based care system, scalable to community needs;
- Opportunities to build on current collaborative relationships to pool funds and leverage existing resources;
- A focus on priority populations with most critical needs; and
- Integration of Peer and Family support and input throughout the care system – a foundational value of recovery-based care.

Over time, investment in these services will increase public safety while decreasing unnecessary use of higher-level, more expensive care as individuals access services before reaching a crisis point.

## Glossary of Acronyms

Acronym	Full Name
ABCGC	Albuquerque Bernalillo County Government Commission
ACE	Adverse Childhood Experiences
ACT	Assertive Community Treatment
AOT	Assisted Outpatient Treatment
APD	Albuquerque Police Department
APS	Albuquerque Public Schools
ASAM	American Society of Addiction Medicine
CCBHC	Certified Community Behavioral Health Clinic
CCS	Correct Care Solutions (MDC behavioral health care provider)
CCSS	Comprehensive Community Support Services
CDC	Centers for Disease Control and Prevention (federal)
CET	Community Engagement Team
CHC	Community Health Center
CIU	Crisis Intervention Unit (APD)
COAST	Crisis Outreach and Support Team (APD)
CPI	Community Partners, Inc.
CSA	Core Service Agency
CSAT	Center for Substance Abuse Treatment
CYFD	Children, Youth and Families Department
DOC	Department of Corrections (state)
DOJ	Department of Justice (federal)
ED	Emergency Department
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EMR	Electronic Medical Record
FACT	Forensic Assertive Community Treatment
FQHC	Federally Qualified Health Center
GPS	Global Positioning System
GRT	Gross-receipts Sales Tax
HIPAA	Health Insurance Portability and Accountability Act (federal)
HCPC	Healthcare Common Procedure Codes
HSD	Human Services Department (state)
MCO	Managed Care Organization

Acronym	Full Name
MDC	Metropolitan Detention Center
MHFA	Mental Health First Aid
NIDA	National Institute on Drug Abuse
NMCAL	New Mexico Access and Crisis Line
NOC	Network of Care
NREPP	National Registry of Evidence-Based Programs and Practices
PSH	Permanent Supportive Housing
PIIP	Public Inebriate Intervention Program
RFP	Request for Proposals
RN	Registered Nurse
SAMHSA	Substance Abuse and Mental Health Services Administration
SMI	Serious Mental Illness
UNM	University of New Mexico

## Attachment 1 – Community Stakeholders and Participants

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The CPI Team facilitated numerous community meetings and met with a total of 293 unduplicated stakeholders during Phase 1 and 2 of the Behavioral Health Initiative. CPI wishes to thank all stakeholders who participated in community meetings and discussions for their respective contributions to the development of the Behavioral Health Business Plan. Below is a list of the stakeholders with their agency affiliation.

## Stakeholder List

<b>Mark Abeyta, Clinical Manager, Optum Health New Mexico</b>
<b>Pam Acosta, Social Services Supervisor, Bernalillo County/MDC</b>
<b>Rick Adesso, Executive Director, El Pueblo Health Services</b>
<b>Jolene Aguilar, Program Manager, Partnership for Community Action</b>
<b>Giovanna Aguirre, Centro Savila</b>
<b>Henry Alaniz, Judge, Metro Court</b>
<b>John Ames, Director of Housing, Supportive Housing Coalition of New Mexico</b>
<b>Joy Ansley, County Manager, Torrance County</b>
<b>Debbie Armstrong, New Mexico State Representative, District 17, Bernalillo County</b>
<b>Linda Atkinson, Executive Director, DWI Resource Center</b>
<b>Heba Atwa-Kramer, Community Input and Policy Coordinator, United Way of Central New Mexico</b>
<b>Robert Baade, Director, RFK Charter School</b>
<b>Evan Baldwin, MD, General Practice, Recovery Services of New Mexico</b>
<b>Sylvia Barela, Chief Operations Officer, Santa Fe Recovery Center</b>
<b>Felicia Barnum, Treasurer, NAMI Albuquerque</b>
<b>Ben Michael Barreras, Pharmacist, Barreras Farmacia</b>
<b>Norm Becker, President/CEO, New Mexico Mutual Group</b>
<b>Esli Beltran, Community Organizer &amp; Medical Debt Assistant, VIDA Casa de Salud</b>
<b>Amber Bennett, Consumer, Peers or Family</b>
<b>Isaac Benton, City Councilor, City of Albuquerque</b>
<b>Rhonda Berg, Executive Director, Supportive Housing Coalition of New Mexico</b>
<b>Tia Bland, Director, Communications Services Bernalillo County</b>
<b>Caroline Bonham, MD Director, Community Behavioral Health, University of New Mexico</b>
<b>Kelly Bradford, Adult Detention Reform Coordinator, Bernalillo County</b>
<b>Lindsay Branine, Sr. Director, Customer Relations ProtoCall</b>
<b>Charlotte Breeden, Executive Director, Courageous Transformations</b>
<b>Suzie Briddsang, Admissions and Marketing Coordinator, Shadow Mountain Desert Oasis</b>
<b>Anita Briscoe, MS Psychiatric Nurse Practitioner/Chair, Albuquerque Mental Health Response Advisory Committee</b>
<b>Carl Broach, Assistant Director of SA Programs, Bernalillo County Metropolitan Assessment and Treatment Services</b>
<b>Minda Brown Jaramillo, Director of Behavioral Health, First Choice Community Health Care</b>
<b>Julia Buck, Director of Medical Specialty, Ambulatory Services Administration UNM, Sandoval Regional Medical Center</b>
<b>Carletta Bullock, M.D., Family Practice, RFK School-Based Health Center</b>
<b>Colleen Bultmann, Detective, Bernalillo County Sheriff's Office</b>
<b>Susannah Burke, Executive Director, PB&amp;J Family Services</b>
<b>Rebekka Burt, Policy Analyst, Councilor Winter's Office, City of Albuquerque</b>
<b>Paula Burton, Consumer, Peers or Family</b>
<b>Robert Buser, MD, Medical Director, United Healthcare NM</b>
<b>Dodi Camacho, Commander, Albuquerque Police Department - NW</b>
<b>Enrique Cardiel, Urban Health Extension Coordinator, International District Healthy Communities Coalition</b>
<b>Rosa Caro, Social Worker, South Valley Academy Charter School</b>
<b>Adan Carriaga, Behavioral Health Program Manager, Molina Health Care</b>
<b>Kim Carter, Deputy Bureau Chief, Centennial Care Bureau, NM Human Services Department</b>
<b>JR Cash, Detective, CIU Bernalillo County Sheriff's Office</b>
<b>Doug Chaplin, Director, Dept. of Family and Community Services, City of Albuquerque</b>
<b>Jac Charlier, Director, Consulting and Training, Center for Health &amp; Justice/TASC</b>
<b>Margarita Chavez, Social Services Benefit Program Coordinator, Bernalillo County</b>
<b>Mark Clark, Health Promotion Specialist, Southeast Heights Public Health Office</b>

## Stakeholder List

<b>Gray Clarke, Medical Director, Presbyterian Healthcare Services/MCO</b>
<b>Terri Cole, President &amp; CEO, Albuquerque Chamber of Commerce</b>
<b>Anita Cordova, Director of Development, Planning &amp; Evaluation, Albuquerque Health Care for the Homeless</b>
<b>Nina Cordova, Consumer, Peers or Family</b>
<b>Peggy Cote, Director of Community Services, Sandoval County</b>
<b>Jay P. Crowe, LISW, Behavioral Health Program Manager/Clinical Director, Albuquerque Healthcare for the Homeless</b>
<b>Theresa Cruz, PhD, Assistant Professor, University of New Mexico</b>
<b>Peter Cubra, Attorney, Law Office of Peter Cubra</b>
<b>John Dantis, Healing Addiction In Our Community</b>
<b>Art De La Cruz, Commissioner/Vice Chair, Bernalillo County Commission - District 2</b>
<b>Bob DeFelice, CEO, First Choice Community Healthcare</b>
<b>Pam Demarest, Chief Nursing Officer, Sandoval Regional Medical Center</b>
<b>Deborah DePalo, Second Judicial Chief Deputy District Attorney, Bernalillo County DA's Office</b>
<b>Stephen DeSaulniers, Director of Health Plan Operations, Molina Healthcare</b>
<b>Diane Dolan, Policy Analyst for Councilor Isaac Benton, Albuquerque City Council</b>
<b>Alex V. Dominguez, Operations Manager, Substance Abuse Programs, Bernalillo County</b>
<b>Lou Duran, Consumer, Peers or Family</b>
<b>Brent Earnest, Cabinet Secretary, State of New Mexico Human Services Department</b>
<b>Mary Eden, VP Government Programs, Presbyterian Health Plan</b>
<b>Ann Edenfeld Sweet, Executive Director, Wings For Life International</b>
<b>Ben Ekelund, Administrator, TASC, Inc.</b>
<b>Keith Elder, Lieutenant, Sandoval County Sheriff's Office</b>
<b>Marg Elliston, Consultant, Sandoval County Health Council</b>
<b>Lorette Enochs, Mental Health Attorney (retired) and Peer</b>
<b>Phil Evans, President/CEO, ProtoCall</b>
<b>Alyssa Ferda, Media/Outreach, U.S. Attorney's Office</b>
<b>Connie Fiorenzio, Program Director, Nurse Advise</b>
<b>Erinn Flynn, Case Manager, HSC Connections Program, University of New Mexico</b>
<b>Glenn Ford, Advocate, People and Families Living with Brain Injury</b>
<b>Krisztina Ford, CEO, All Faiths</b>
<b>Tara Ford, Attorney, Pegasus Legal Services for Children</b>
<b>Danny Frampton, Legislative Affairs and Communications Coordinator, National Association of Social Workers - New Mexico</b>
<b>Michelle Franowsky, Social Worker, Consultant, Law Offices of Public Defender</b>
<b>Amanda Frazier, Attorney, New Mexico Second Judicial District Court</b>
<b>Art Gallagher, DCED 2nd District</b>
<b>Tina Garcia, Albuquerque Holy Rosary</b>
<b>Rey Garduno, Council President, City of Albuquerque</b>
<b>Irini Georgas, Centro Savila</b>
<b>Kate Gibbons, Director of Clinical Programs, New Day Youth &amp; Family Services</b>
<b>Diane Gibson, City Councilor, City of Albuquerque</b>
<b>Jessica Gonzales, Policy Analyst, Albuquerque City Council</b>
<b>Paul Gonzales, DIC, Bernalillo County Sheriff's Office</b>
<b>Phillip Greer, Chief, Metropolitan Detention Center</b>
<b>Margaret Griffin, Consumer, Peers or Family</b>
<b>Richard Griffin, Consumer, Peers or Family</b>
<b>Robert Griffith, National Association of Social Workers, NM</b>
<b>Paul Guerin, Ph.D., Director, Center for Applied Research and Analysis, University of New Mexico Institute for Social Research</b>
<b>Tara Gutierrez, Supervising Clinical Therapist, Youth Development Institute (YDI)</b>
<b>Trey Hammond, Pastor, Albuquerque Interfaith/LaMesa Presbyterian</b>
<b>Jack Hancock, Intern, National Association of Social Workers - NM</b>

## Stakeholder List

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Joe Harris, Manager, Behavioral Healthcare Operations, University of New Mexico MH
Marcia Harris
Lea Harrison, Director, Business Development, Haven Behavioral Hospital
Shauna Hartley, Hospital Administrator, Turquoise Lodge
Maggie Hart-Stebbins, Commission Chair, Bernalillo County Commission - District 3
Ari Herring, Director of Community Impact, United Way of Central New Mexico
Jim Hinton, President & CEO, Presbyterian Healthcare Services
Paul Hopkins, Adult and Couples Psychotherapist
Katrina Hotrum, DSAP Director, Bernalillo County
Sam Howarth, Professor, University of New Mexico
Don Hume, Service Coordination, Molina Health Care of New Mexico
B. L. Hurt, MH Director, Correct Care Solutions
Lance Hurt, MD, Director of Mental Health, Correct Care Solutions
Cathy Imburgia, President, Creative Communications
Dr. Steven Jenkusky, Medical Director, Presbyterian Behavioral Health Services
Steve Johnson, Executive Director, New Day Youth & Family Services
Wayne Johnson, County Commissioner - District 5 Bernalillo County
Dr. Jeff Katzman, Medical Director, UPC Clinic, UNM Health Sciences Center
Joanna Katzman, Director, University of New Mexico Pain Center
Jane Keeports, Administrator, Behavioral Health Presbyterian Hospital
Krista Kelley, Consultant, First Choice Community Healthcare
Leslie Kelly, Director of Counseling, Albuquerque Public Schools
Jeanene Kerestes, Sr. Director of Medicaid Operations, Blue Cross Blue Shield New Mexico
Heath Kilgore, Chief Executive Officer, Agave Health
Jeff Kinney, Business Development Manager, Albuquerque Ambulance Service
Jean Klein, Program Manager, Metro Court
Nancy Koenigsberg, Esq. Lawyer, Disability Rights New Mexico
Ed Kossmann, Health Services Administrator, Correct Care Solutions
Adrienne Kozcak, Interim County Manager, Valencia County
Liz LaCouture, Executive Director, Behavioral Health, Presbyterian Health Plan
John Lahoff, IMC, LLC
Zachary Lardy, Lieutenant, Bernalillo County Fire Department
Sarah Lee, President & CEO, Samaritan Counseling Center
Mike Lewis, Assistant District Attorney, District Attorney's Office
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David Ley, Executive Director, New Mexico Solutions
Anne Liechty, Centro Savila
Russ Liles, Manager, Recovery United Healthcare
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Wendy Linebrink-Allison, Program Manager, NMCAL Protocol
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Michelle Lujan-Grisham, US Congresswoman, US House of Representatives
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Melissa Manlove, COO, First Choice Community Healthcare
Nevin Marquez, Program Director, St. Martin's Hospitality Center
Art Marshall, Programs Division Director, Public Safety Division, Pretrial Services Bernalillo County

## Stakeholder List

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Elizabeth Martinez, Executive Assistant, U.S. Attorney's Office

Lonnie Martinez, Department of Health

Rebecca Martinez, Discharge Planning, Correct Care Solutions

Sgt. Edward (Mike) Martinez, Bernalillo County Sheriff's Department

Sgt. Robert Martinez, Bernalillo County Sheriff's Department

Marcello Maviglia, MD, Medical Director, Molina Health Care

James Maxon, Fire Chief, Sandoval County

Bob Maxwell, Community Member

Becky Mayeaux, Housing Director, St. Martin's Hospitality Center

Ryan McCord, Assistant District Attorney, Metro DA's Office

Sherman McCorkle, Board Member, Greater Albuquerque Chamber of Commerce

Tracy McDaniel, Coordinator, Early Childhood Accountability Partnership

Maureen McDonnell, Director, Business & Health Care Strategy Development,  
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Jane McGrath, MD, Medical Director, UNM School-Based Health Clinic,  
UNM Health Sciences Center

Susan McKee Manager, Prevention/Intervention, Albuquerque Public Schools

Steve McKernan, CEO, UNM Hospital

Kerry McKinstry, EMS Captain, Albuquerque Fire Department

Marsha McMurray-Avila, Coordinator,  
Bernalillo Co. Community Health Council/Opioid Accountability Initiative

Rodney McNease, Executive Director, Behavioral Health Finance,  
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Kristine Meurer, Ph.D. Executive Director,  
Student, Family & Community Supports Albuquerque Public Schools

Rick Miera, Former Representative State of New Mexico

Monica Miura, Statewide Family Coordinator, New Mexico System of Care  
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Danny Monette, County Manager, Valencia County

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Carrie Moritomo, Cultural Services Marketing Specialist, Bernalillo County

Christopher Morris, PhD, Executive Director, Open Skies Healthcare

Lisa Mortensen, Sr. Manager, Behavioral Health, Blue Cross Blue Shield New Mexico

Peggy Muller-Aragon, Finance Chair, Albuquerque Public School Board

Vince Murphy, Deputy County Manager, Bernalillo County

Sarah Nance, Program Manager, New Life Homes

Nan Nash, Chief Judge, Second Judicial District Court

Michael Nelson, Deputy Secretary, New Mexico Human Services Department

Rose Nelson, United Health Care (MCO)

Hank Nguyen

Gabriel Nims, Special Projects Coordinator, Bernalillo County/MDC

Pari Noskin, Program Manager/Community Liaison, UNM Psychiatry & BBHI

Shawn O'Connell, Presbyterian Medical Services

James Ogle, President NAMI Albuquerque

Alma Olivas, Centro Savila

Cindy O'Neill, Student/Family Support Officer, RFK Charter School

## Stakeholder List

Fernando Ortega, South Valley Health Care Center  
Sabrina Owens, Coordinator, RFK Charter, School Based Health Clinic  
Mariana Padilla, District Director, Office of U.S. Rep. Michelle Lujan Grisham  
Scott Patterson, Sandoval County  
Suzanne Pearlman, Community Outreach, Communications and Training Manager,  
Children's Behavioral Health Division  
Tony Pedroncelli, Director of Business Operations, OptumHealth New Mexico  
Adrian Pedroza, Executive Director, Partnership for Community Action  
Delfy Pena Roach, Executive Director, New Mexico Brain Injury Alliance  
Greg Perez, Deputy Chief, Bernalillo County Fire Department  
Elise Perry, Research Scientist II, University of New Mexico/ISR  
Grace Phillips, General Counsel, New Mexico Association of Counties  
Carol Pierce, RN, UNM School-Based Health Clinic Program Manager,  
UNM Health Sciences Center  
Eric Pinon, Board Member, NAMI Westside  
Michael Pridham, Board Member/Secretary, New Mexico Chiropractic Association  
Trace Purlee, Outreach, Oxford House  
KC Quirk, Executive Director, Crossroads for Women  
Debi Randall, Executive Director, SHARE New Mexico  
Kristina Rewin Ciesielski, Associate Professor, UNM Department of Psychology  
Elma Reynolds, Joy Junction  
Jeremy Reynolds, CEO, Joy Junction  
Keith Riesberg, City Manager, City of Rio Rancho  
Cindy Rios, Community Member, Sandoval County Manager (retired)  
Phillip Rios, County Manager, Sandoval County  
Ed Rivera, President & CEO, United Way of Central New Mexico  
Matt Rivera, Assistant Chief of Ethics & Compliance,  
Bernalillo County Metropolitan Detention Center  
Barri G. Roberts, Executive Director, Bernalillo County Forensic Intervention Consortium  
Michael Robertson, PhD, Division Manager,  
Dept. of Family & Community Services, City of Albuquerque  
Dulce Rodriguez, Centro Savila  
Linda Rogers, Judge, Metro Court  
Ane Romero, Field Representative, Office of Senator Martin Heinrich  
Nils Rosenbaum, Crisis Outreach Psychiatrist, Albuquerque Police Department  
Paul Roth, Chancellor for Health Sciences, CE UNM Health Systems,  
University of New Mexico Health Sciences Center  
Carmela M. Roybal, Doctoral Fellow,  
Robert Wood Johnson Foundation/University of New Mexico  
Don Rupe, Specialty Courts Program Director, Bernalillo County Metropolitan Court  
Reed Russell, Social Services Manager, ABQ Health Care for the Homeless  
Robert Salazar, NAMI  
Jared Sanchez, QA Specialist, BC Communications  
Ken Sanchez, City Councilor, City of Albuquerque  
Nancy Sanchez, Grants Manager, Valencia County  
Noell Sauer, Assistant to Commissioner Talbert, District 4,  
Bernalillo County Commissioner Lonnie Talbert  
Laura Schaefer, Director of Sales, ProtoCall  
John Schoepfner, Special Master, Second Judicial District Court  
George Schroeder, Environmental Health Manager, Bernalillo County  
Dave Seely, Board Chair, United Way of Central New Mexico  
Jennifer Sena, Director, Community Based Services, University of New Mexico MH  
Catia Sharp, Harvard Innovation Fellow, Bernalillo County  
Harris Silver, MD, Co-Chair, Bernalillo Co. Opioid Abuse Accountability Initiative

## Stakeholder List

<b>Lisa Simpson, Technical Advisor to the Adult Reform Coordinator, Bernalillo County</b>
<b>Nancy Smith-Leslie, Director, State of New Mexico Medical Assistance Division</b>
<b>Martha Snow, Psychiatric Nurse Practitioner, New Mexico VA Medical Center</b>
<b>Diane Snyder, Executive Director, Greater Albuquerque Medical Association</b>
<b>Kathy Sotelo, Outreach Representative, Executive Assistant to CEO, Joy Junction</b>
<b>Frank Soto, Jr., EMS Division Commander, Albuquerque Fire Department</b>
<b>Craig Sparks, Director, Youth Services Center</b>
<b>Glenn St. Onge, Lieutenant, Albuquerque Police Department</b>
<b>Mike Stanford, President, Payday, Inc.</b>
<b>Michael Stanton, Almas de Amistad</b>
<b>W. Mark Stith, M.Ed., Children's Protection Center</b>
<b>Lisa Storey, Sr. Accountant &amp; Finance Director, Valencia County</b>
<b>Ron Storey, Indigent Administrator, Valencia County</b>
<b>Ambrozino Storr, CEO, Haven Behavioral Hospital</b>
<b>Deedee Stroud, COO, All Faiths</b>
<b>Rosemary Strunk, Chief Operations Officer, NMCAL</b>
<b>Reuben Sutter, MD, Medical Director, Sage Neuroscience Center</b>
<b>Marjorie Swartz</b>
<b>Forrest Sweet, Case Manager, Albuquerque Health Care for the Homeless</b>
<b>Tom Swisstack, Deputy County Manager, Public Safety Division Bernalillo County</b>
<b>Lonnie C. Talbert, County Commissioner - District 4 Bernalillo County</b>
<b>Anjali Taneja, Family Practitioner, Casa de Salud</b>
<b>Mika Tari, Clinical Services Manager, State of New Mexico, Behavioral Health Services Division</b>
<b>Nicole Taylor, Policy Analyst, Councilor Services, City of Albuquerque</b>
<b>Ann Taylor-Trujillo, Executive Director, University of New Mexico Psychiatric Center</b>
<b>Leonard Thomas, Acting Director and Chief Medical Officer, Indian Health Service</b>
<b>Candra Thompson, Executive Director of Ambulatory Services, UNM Sandoval Regional Medical Center</b>
<b>Kellie Tillerson, Housing &amp; Employment Director, St. Martin's Hospitality Center</b>
<b>Mauricio Tohen, Chair, UNM Dept. of Psychiatry, UNM Health Services Center</b>
<b>Jennifer Torrez, Clinical Director, Serenity Mesa/HAC</b>
<b>Alleyne Toya, Director, Behavioral Health Services, First Nations</b>
<b>Caryl Trotter, Program Operations Director, Albuquerque Metropolitan Central Intake</b>
<b>Paul Tucker, MS, LADAC, Owner and Founder, Turning Point Recovery Center</b>
<b>Betty M. Valdez, Housing Director, Bernalillo County</b>
<b>Andrew Vallejos, Consultant, City of Albuquerque/Bernalillo Task Force on Behavioral Health</b>
<b>John Vigil, MD, Medical Director, Epoch/NMSAM</b>
<b>Sophia Waara, Deputy Executive Director, Greater Albuquerque Medical Association</b>
<b>Bill Wagner, PhD, Executive Director, Centro Savila</b>
<b>Dr. Kari Ward-Kerr, Synchronicity, LLC</b>
<b>Dave Webster, Clinical Director, St. Martin's Hospitality Center</b>
<b>Kathryn Weil, PhD, Executive Director, Susan's Legacy</b>
<b>Jennifer Weiss-Burke, Executive Director, Serenity Mesa/HAC</b>
<b>Verner Westerberg, ASR Consulting</b>
<b>Ivan Westergaard, Member, St. Paul Lutheran</b>
<b>James Widner, Executive Director, Duke City Recovery Tool box</b>
<b>Bill Wiese, Co-Chair, Bernalillo Co. Opioid Abuse Accountability Initiative</b>
<b>Erika Wilson, Manager, Albuquerque Police Department 911</b>
<b>Mariana Wilson, Intern, Bernalillo County</b>
<b>Dr. Kathie Winograd, President, Central New Mexico Community College (CNM)</b>
<b>Robert Work, Attorney, Public Defender's Office</b>
<b>Kim Zamarin, Juntos Para la Salud</b>
<b>Tom Zdunek, County Manager, Bernalillo County</b>

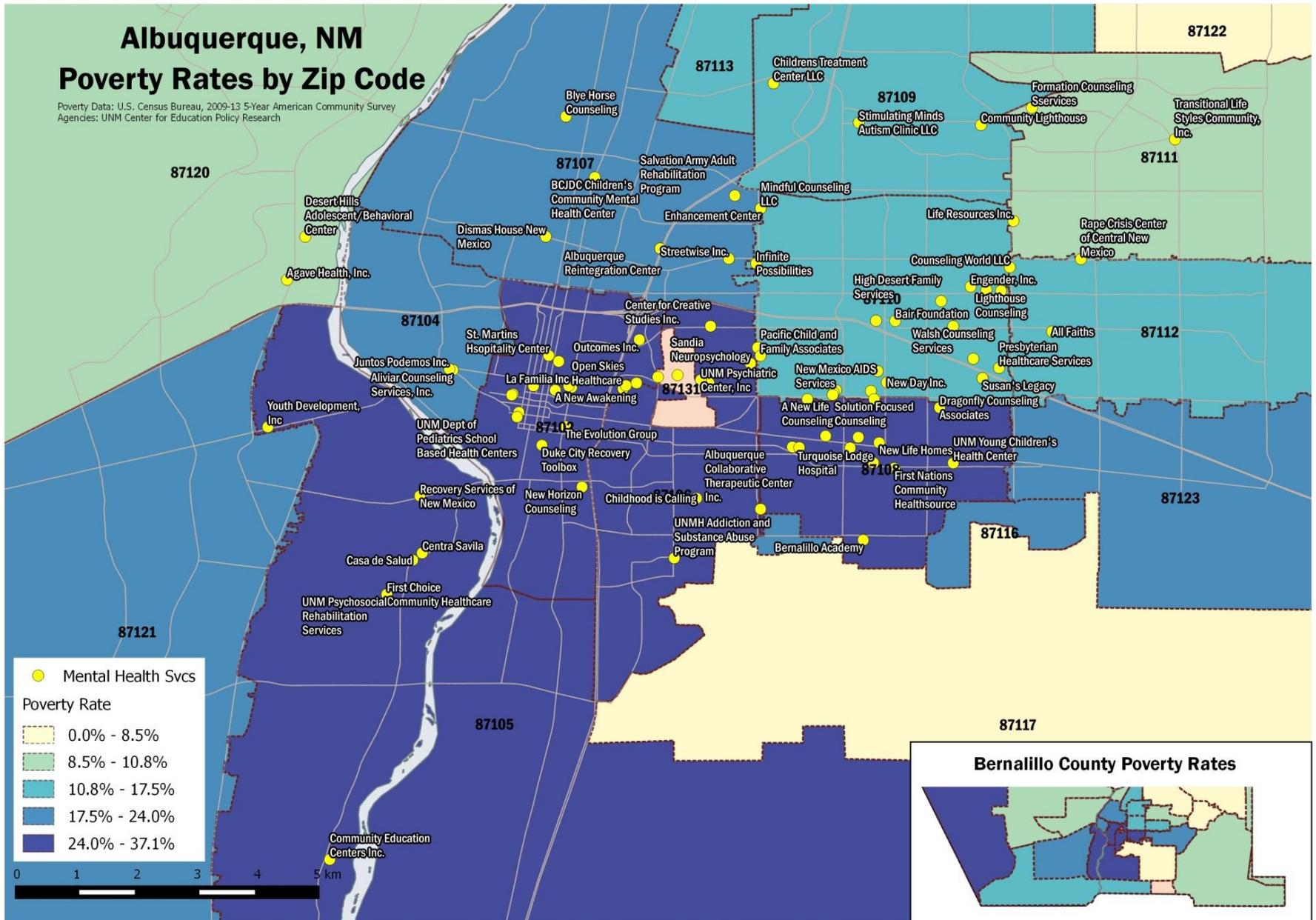
## Attachment 2 - Albuquerque Poverty Map with Service Locations

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The map on the following page illustrates current service site locations and rates of poverty in zip-code areas around Albuquerque, with the darkest blue representing the highest poverty rate.

# Albuquerque, NM Poverty Rates by Zip Code

Poverty Data: U.S. Census Bureau, 2009-13 5-Year American Community Survey  
Agencies: UNM Center for Education Policy Research



## Attachment 3 – Crisis Network Components Operating Budgets

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The following pages include the operating budgets for each of the crisis network components recommended for Initial Implementation Phase.

**OPERATING BUDGET**      JAN      FEB      MAR      APR      MAY      JUN      JUL      AUG      SEP      OCT      NOV      DEC      Total

**EXPENSES**      JAN      FEB      MAR      APR      MAY      JUN      JUL      AUG      SEP      OCT      NOV      DEC      Total

PERSONNEL													
Base Salary & ERE (see staffing model)	\$29,500	\$29,500	\$29,500	\$29,500	\$29,500	\$29,500	\$29,500	\$29,500	\$29,500	\$29,500	\$29,500	\$29,500	\$354,000
													\$0
<b>TOTAL</b>	<b>\$29,500</b>	<b>\$354,000</b>											

EQUIPMENT / SOFTWARE													
Fiscal/Operations Agent supported	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$18,000
Equipment Lease (1 copier, fax, Etc.)	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
Furn & Equip Under \$5,000	\$263	\$263	\$263	\$263	\$263	\$263	\$263	\$263	\$263	\$263	\$263	\$263	\$3,150
Computers, Lap tops	\$6,250	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$6,250
Claims Processing System / Third Party * * \$1.20 per claim	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$60,000
													\$0
<b>TOTAL</b>	<b>\$13,513</b>	<b>\$7,263</b>	<b>\$93,400</b>										

TRAINING													
Staff Development	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
													\$0
<b>TOTAL</b>	<b>\$500</b>	<b>\$6,000</b>											

TRAVEL													
Mileage / Parking	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$7,200
													\$0
<b>TOTAL</b>	<b>\$600</b>	<b>\$7,200</b>											

OCCUPANCY													
Building Occupancy (Full Service)	\$1,850	\$1,850	\$1,850	\$1,850	\$1,850	\$1,850	\$1,850	\$1,850	\$1,850	\$1,850	\$1,850	\$1,850	\$22,200
<i>Lease allocation is \$370/month/staff</i>													\$0
													\$0
<b>TOTAL</b>	<b>\$1,850</b>	<b>\$22,200</b>											

OPERATING SERVICES													
Supplies / Postage	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Telephones - Cell	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Copying and Printing	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
IT/Communications	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$30,000
													\$0
<b>TOTAL</b>	<b>\$3,100</b>	<b>\$37,200</b>											

<b>TOTAL DIRECT EXPENSES</b>	<b>\$49,063</b>	<b>\$42,813</b>	<b>\$520,000</b>										
<b>TOTAL INDIRECT EXPENSES (10%)</b>	<b>\$4,906</b>	<b>\$4,281</b>	<b>\$52,000</b>										
<b>TOTAL EXPENSES</b>	<b>\$53,969</b>	<b>\$47,094</b>	<b>\$572,000</b>										

**No Capitalized Expenses projected**

**REGIONAL ADMINISTRATIVE OFFICE**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate x Salary)	TOTAL Salary & ERE	Monthly
Executive Director	\$85,000	1.00	\$85,000	\$17,000	\$102,000	\$8,500
Administrative Assistant	\$30,000	1.00	\$30,000	\$6,000	\$36,000	\$3,000
Contract Compliance	\$60,000	1.00	\$60,000	\$12,000	\$72,000	\$6,000
Finance	\$60,000	1.00	\$60,000	\$12,000	\$72,000	\$6,000
QM & UM, Outcomes, Evaluation & Reporting	\$60,000	1.00	\$60,000	\$12,000	\$72,000	\$6,000
<b>PERSONNEL TOTALS</b>	<b>\$295,000</b>	<b>5.00</b>	<b>\$295,000</b>	<b>\$59,000</b>	<b>\$354,000</b>	<b>\$29,500</b>

OPERATING BUDGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
EXPENSES	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
PERSONNEL													
Base Salary & ERE (see staffing model)	\$11,200	\$11,200	\$11,200	\$11,200	\$11,200	\$11,200	\$11,200	\$11,200	\$11,200	\$11,200	\$11,200	\$11,200	\$134,400
TOTAL	\$11,200	\$11,200	\$11,200	\$11,200	\$11,200	\$11,200	\$11,200	\$11,200	\$11,200	\$11,200	\$11,200	\$11,200	\$134,400
EQUIPMENT / SOFTWARE													
Dispatch Software	\$44,800	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$44,800
Electronic Medical Records System (EMR) *	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
* online submission or HCFA emulators													\$0
TOTAL	\$45,000	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$47,200
OCCUPANCY													
Building Occupancy (Full Service)	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$11,100
Lease allocation is \$370/month/staff													\$0
TOTAL	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$11,100
OPERATING SERVICES													
Supplies / Postage	\$117	\$117	\$117	\$117	\$117	\$117	\$117	\$117	\$117	\$117	\$117	\$117	\$1,409
Copying and Printing	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$1,800
IT/Communications	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$15,000
TOTAL	\$1,517	\$1,517	\$1,517	\$1,517	\$1,517	\$1,517	\$1,517	\$1,517	\$1,517	\$1,517	\$1,517	\$1,517	\$18,209
TOTAL DIRECT EXPENSES	\$58,642	\$13,842	\$13,842	\$13,842	\$13,842	\$13,842	\$13,842	\$13,842	\$13,842	\$13,842	\$13,842	\$13,842	\$210,909
TOTAL INDIRECT EXPENSES (10%)	\$5,864	\$1,384	\$1,384	\$1,384	\$1,384	\$1,384	\$1,384	\$1,384	\$1,384	\$1,384	\$1,384	\$1,384	\$21,091
TOTAL EXPENSES	\$64,507	\$15,227	\$15,227	\$15,227	\$15,227	\$15,227	\$15,227	\$15,227	\$15,227	\$15,227	\$15,227	\$15,227	\$232,000

**No Capitalized Expenses projected**

**CRISIS CALL CENTER**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Clinical Supervisor	\$56,000	0.50	\$28,000	\$5,600	\$33,600	\$2,800
Mental Health Professional	\$42,000	2.00	\$84,000	\$16,800	\$100,800	\$8,400
<b>PERSONNEL TOTALS</b>		<b>2.50</b>	<b>\$112,000</b>	<b>\$22,400</b>	<b>\$134,400</b>	<b>\$11,200</b>

OPERATING BUDGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
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EXPENSES	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
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PERSONNEL													
Base Salary & ERE (see staffing model)	\$123,719	\$123,719	\$123,719	\$123,719	\$123,719	\$123,719	\$123,719	\$123,719	\$123,719	\$123,719	\$123,719	\$123,719	\$1,484,634
													\$0
<b>TOTAL</b>	<b>\$123,719</b>	<b>\$1,484,634</b>											

EQUIPMENT / SOFTWARE													
Equipment Lease	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$1,500
Furn & Equip Under \$5,000	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$3,000
Computers, Lap tops	\$23,750	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$23,750
Electronic Medical Records System (EMR) *	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
* online submission or HCFA emulators													
<b>TOTAL</b>	<b>\$24,325</b>	<b>\$575</b>	<b>\$30,650</b>										

TRAINING													
Staff Development	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
													\$0
<b>TOTAL</b>	<b>\$500</b>	<b>\$6,000</b>											

TRAVEL & TRANSPORTATION													
Leased Vehicle	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$4,800
Leased Vehicle	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$4,800
Leased Vehicle	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$4,800
Leased Vehicle	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$4,800
Auto Fuel	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
Auto Insurance	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
Auto Repair & Maintenance	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$1,500
Mileage / Parking	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$900
													\$0
<b>TOTAL</b>	<b>\$2,800</b>	<b>\$33,600</b>											

OCCUPANCY													
Building Occupancy (Full Service)	\$2,590	\$2,590	\$2,590	\$2,590	\$2,590	\$2,590	\$2,590	\$2,590	\$2,590	\$2,590	\$2,590	\$2,590	\$31,080
<i>Due to varying shifts there is only six staff and 1 management in office at one time.</i>													\$0
<i>Lease allocation is \$370/month/staff</i>													\$0
<b>TOTAL</b>	<b>\$2,590</b>	<b>\$31,080</b>											

OPERATING SERVICES													
Supplies / Postage	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Telephones - Cell	\$800	\$800	\$800	\$800	\$800	\$800	\$800	\$800	\$800	\$800	\$800	\$800	\$9,600
Copying and Printing	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
IT/Communications	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$36,000
<b>TOTAL</b>	<b>\$4,200</b>	<b>\$50,400</b>											

TOTAL DIRECT EXPENSES	\$158,134	\$134,384	\$134,384	\$134,384	\$134,384	\$134,384	\$134,384	\$134,384	\$134,384	\$134,384	\$134,384	\$134,384	\$1,636,364
TOTAL INDIRECT EXPENSES (10%)	\$15,813	\$13,438	\$13,438	\$13,438	\$13,438	\$13,438	\$13,438	\$13,438	\$13,438	\$13,438	\$13,438	\$13,438	\$163,636
<b>TOTAL EXPENSES</b>	<b>\$173,948</b>	<b>\$147,823</b>	<b>\$1,800,000</b>										

**No Capitalized Expenses projected**

**CRISIS RESPONSE MOBILE TEAMS (Four 2-Person Teams)**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	Shift, On Call, Overtime, Spanish differential	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Clinical Director	\$65,000	0.36	\$23,307	\$0	\$4,661	\$27,969	\$2,331
Clinical Supervisor	\$56,000	1.30	\$72,800	\$0	\$14,560	\$87,360	\$7,280
Psychiatrist	\$225,000	0.50	\$112,500	\$25,313	\$27,563	\$165,375	\$13,781
Licensed Mental Health Professional	\$56,000	9.00	\$504,000	\$113,400	\$123,480	\$740,880	\$61,740
Behavioral Health Technician	\$35,000	9.00	\$315,000	\$70,875	\$77,175	\$463,050	\$38,588
<b>PERSONNEL TOTALS</b>		<b>20.16</b>	<b>\$1,027,607</b>		<b>\$247,439</b>	<b>\$1,484,634</b>	<b>\$123,719</b>

Supports a maximum of four teams between 12 PM and 8 PM on weekdays.

**CRISIS RESPONSE MOBILE TEAMS (Four 2-Person Teams) - Shift Detail**

Time	Weekends				number teams active	Weekdays						number teams active	Total
	7AM - 5PM	11AM - 9PM	1PM - 11PM	10PM - 8AM		7AM - 5PM	10AM - 8PM	11AM - 9PM	12PM - 10PM	2PM - 12AM	10PM - 8AM		
7:00 AM	2			2	2	2					2	2	
8:00 AM	2				1	2						1	
9:00 AM	2				1	2						1	
10:00 AM	2				1	2	2					2	
11:00 AM	2	2			2	2	2	2				3	
12:00 PM	2	2			2	2	2	2	2			4	
1:00 PM	2	2	2		3	2	2	2	2			4	
2:00 PM	2	2	2		3	2	2	2	2			4	
3:00 PM	2	2	2		3	2	2	2	2			4	
4:00 PM	2	2	2		3	2	2	2	2			4	
5:00 PM		2	2		2		2	2	2	2		4	
6:00 PM		2	2		2		2	2	2	2		4	
7:00 PM		2	2		2		2	2	2	2		4	
8:00 PM		2	2		2			2	2	2		3	
9:00 PM			2		1				2	2		2	
10:00 PM			2	2	2					2	2	2	
11:00 PM				2	1					2	2	2	
12:00 AM				2	1						2	1	
1:00 AM				2	1						2	1	
2:00 AM				2	1						2	1	
3:00 AM				2	1						2	1	
4:00 AM				2	1						2	1	
5:00 AM				2	1						2	1	
6:00 AM				2	1						2	1	
Hours per shift	10.0	10.0	10.0	10.0		10.0	10.0	10.0	10.0	7.0	10.0		
FTE per day	2.0	2.0	2.0	2.0		2.0	2.0	2.0	2.0	2.0	2.0		
Hours	20.0	20.0	20.0	20.0		20.0	20.0	20.0	20.0	14.0	20.0		
Days per week <sup>1</sup>	2.0	2.0	2.0	2.0		5.0	5.0	5.0	5.0	5.0	5.0		
Duration hours	40.0	40.0	40.0	40.0		100.0	100.0	100.0	100.0	70.0	100.0		730.0
Available hrs/FTE													40.0
Required staff													18.3

<sup>1</sup> week end days X 2 and week days days X 5

OPERATING BUDGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>EXPENSES</b>	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>PERSONNEL</b>													
Base Salary & ERE (see staffing model)	\$54,500	\$54,500	\$54,500	\$54,500	\$54,500	\$54,500	\$54,500	\$54,500	\$54,500	\$54,500	\$54,500	\$54,500	\$654,000
Shift, On Call, Overtime, Spanish differential	\$2,725	\$2,725	\$2,725	\$2,725	\$2,725	\$2,725	\$2,725	\$2,725	\$2,725	\$2,725	\$2,725	\$2,725	\$32,700
													\$0
<b>TOTAL</b>	<b>\$57,225</b>	<b>\$57,225</b>	<b>\$57,225</b>	<b>\$57,225</b>	<b>\$57,225</b>	<b>\$57,225</b>	<b>\$57,225</b>	<b>\$57,225</b>	<b>\$57,225</b>	<b>\$57,225</b>	<b>\$57,225</b>	<b>\$57,225</b>	<b>\$686,700</b>
<b>PROFESSIONAL &amp; CONTRACTED SERVICES</b>													
Project Coordinator	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Outside medical staff - NP or Psychiatrist	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$45,000
Labs & Medical Supplies	\$202	\$202	\$202	\$202	\$202	\$202	\$202	\$202	\$202	\$202	\$202	\$202	\$2,423
													\$0
<b>TOTAL</b>	<b>\$4,152</b>	<b>\$4,152</b>	<b>\$4,152</b>	<b>\$4,152</b>	<b>\$4,152</b>	<b>\$4,152</b>	<b>\$4,152</b>	<b>\$4,152</b>	<b>\$4,152</b>	<b>\$4,152</b>	<b>\$4,152</b>	<b>\$4,152</b>	<b>\$49,823</b>
<b>EQUIPMENT / SOFTWARE</b>													
Equipment Lease (1 copier, fax, etc.)	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
Furniture & Equipment Under \$5,000	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$3,000
Computers, Lap tops	\$16,250	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$16,250
Electronic Medical Records System (EMR) *	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
* online submission or HCFA emulators													\$0
<b>TOTAL</b>	<b>\$17,200</b>	<b>\$950</b>	<b>\$27,650</b>										
<b>TRAINING</b>													
Staff Development	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
													\$0
<b>TOTAL</b>	<b>\$500</b>	<b>\$500</b>	<b>\$500</b>	<b>\$500</b>	<b>\$500</b>	<b>\$500</b>	<b>\$500</b>	<b>\$500</b>	<b>\$500</b>	<b>\$500</b>	<b>\$500</b>	<b>\$500</b>	<b>\$6,000</b>
<b>TRAVEL &amp; TRANSPORTATION</b>													
Mileage / Parking	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$3,600
													\$0
<b>TOTAL</b>	<b>\$300</b>	<b>\$300</b>	<b>\$300</b>	<b>\$300</b>	<b>\$300</b>	<b>\$300</b>	<b>\$300</b>	<b>\$300</b>	<b>\$300</b>	<b>\$300</b>	<b>\$300</b>	<b>\$300</b>	<b>\$3,600</b>
<b>OCCUPANCY</b>													
Building Occupancy (Full Service)	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$90,000
* 5,000 SF X \$18.00/SF													\$0
													\$0
<b>TOTAL</b>	<b>\$7,500</b>	<b>\$7,500</b>	<b>\$7,500</b>	<b>\$7,500</b>	<b>\$7,500</b>	<b>\$7,500</b>	<b>\$7,500</b>	<b>\$7,500</b>	<b>\$7,500</b>	<b>\$7,500</b>	<b>\$7,500</b>	<b>\$7,500</b>	<b>\$90,000</b>
<b>OPERATING SERVICES</b>													
Supplies / Postage	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Telephones - Cell	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$15,600
Copying and Printing	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
IT/Communications	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$42,000
													\$0
<b>TOTAL</b>	<b>\$5,200</b>	<b>\$5,200</b>	<b>\$5,200</b>	<b>\$5,200</b>	<b>\$5,200</b>	<b>\$5,200</b>	<b>\$5,200</b>	<b>\$5,200</b>	<b>\$5,200</b>	<b>\$5,200</b>	<b>\$5,200</b>	<b>\$5,200</b>	<b>\$62,400</b>
<b>Meals &amp; Housekeeping &amp; Clinical Ops</b>													
Meals	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$51,100
Housekeeping	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$30,000
													\$0
<b>TOTAL</b>	<b>\$6,758</b>	<b>\$6,758</b>	<b>\$6,758</b>	<b>\$6,758</b>	<b>\$6,758</b>	<b>\$6,758</b>	<b>\$6,758</b>	<b>\$6,758</b>	<b>\$6,758</b>	<b>\$6,758</b>	<b>\$6,758</b>	<b>\$6,758</b>	<b>\$81,100</b>
<b>TOTAL DIRECT EXPENSES</b>	<b>\$98,835</b>	<b>\$82,585</b>	<b>\$1,007,273</b>										
<b>TOTAL INDIRECT EXPENSES (10%)</b>	<b>\$9,884</b>	<b>\$8,259</b>	<b>\$100,727</b>										
<b>TOTAL EXPENSES</b>	<b>\$108,719</b>	<b>\$90,844</b>	<b>\$1,108,000</b>										

**No Capitalized Expenses projected**

**CRISIS RESPITE - ADULT (One 10-Bed Facility)**

**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Clinical Director	\$65,000	1.00	\$65,000	\$13,000	\$78,000	\$6,500
Licensed Mental Health Professional	\$56,000	2.00	\$112,000	\$22,400	\$134,400	\$11,200
Behavioral Health Technician	\$35,000	6.00	\$210,000	\$42,000	\$252,000	\$21,000
Nurse-RN	\$65,000	1.00	\$65,000	\$13,000	\$78,000	\$6,500
Peer Specialist	\$31,000	3.00	\$93,000	\$18,600	\$111,600	\$9,300
<b>PERSONNEL TOTALS</b>		<b>13.00</b>	<b>\$545,000</b>	<b>\$109,000</b>	<b>\$654,000</b>	<b>\$54,500</b>

**CRISIS RESPITE - ADULT (One 10-Bed Facility)**

Shift Detail	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Total
7:00 AM	2	2	2	2	2	2	2	
8:00 AM	2	6	6	6	6	6	4	
9:00 AM	3	6	6	6	6	6	3	
10:00 AM	3	6	6	6	6	6	3	
11:00 AM	3	6	6	6	6	6	3	
12:00 PM								
1:00 PM	3	6	6	6	6	6	3	
2:00 PM	3	6	6	6	6	6	3	
3:00 PM	3	6	6	6	6	6	3	
4:00 PM	3	6	6	6	6	6	3	
5:00 PM	3	3	3	3	3	3	3	
6:00 PM	2	3	3	3	3	3	3	
7:00 PM	2	3	3	3	3	3	3	
8:00 PM	2	3	3	3	3	3	3	
9:00 PM	2	2	2	2	2	2	2	
10:00 PM	2	2	2	2	2	2	2	
11:00 PM	2	2	2	2	2	2	2	
12:00 AM								
1:00 AM	2	2	2	2	2	2	2	
2:00 AM	2	2	2	2	2	2	2	
3:00 AM	2	2	2	2	2	2	2	
4:00 AM	2	2	2	2	2	2	2	
5:00 AM	2	2	2	2	2	2	2	
6:00 AM	2	2	2	2	2	2	2	
Hours	52.0	80.0	80.0	80.0	80.0	80.0	57.0	509.0
Hours available per FTE								40.0
Required staff								12.7

**OPERATING BUDGET**      JAN      FEB      MAR      APR      MAY      JUN      JUL      AUG      SEP      OCT      NOV      DEC      Total

**EXPENSES**      JAN      FEB      MAR      APR      MAY      JUN      JUL      AUG      SEP      OCT      NOV      DEC      Total

PERSONNEL													
Base Salary & ERE (see staffing model)	\$54,500	\$54,500	\$54,500	\$54,500	\$54,500	\$54,500	\$54,500	\$54,500	\$54,500	\$54,500	\$54,500	\$54,500	\$654,000
Shift, On Call, Overtime, Spanish differential	\$2,725	\$2,725	\$2,725	\$2,725	\$2,725	\$2,725	\$2,725	\$2,725	\$2,725	\$2,725	\$2,725	\$2,725	\$32,700
TOTAL	\$57,225	\$57,225	\$57,225	\$57,225	\$57,225	\$57,225	\$57,225	\$57,225	\$57,225	\$57,225	\$57,225	\$57,225	\$686,700

PROFESSIONAL & CONTRACTED SERVICES													
Project Coordinator	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Outside medical staff - NP or Psychiatrist	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$45,000
Labs & Medical Supplies	\$202	\$202	\$202	\$202	\$202	\$202	\$202	\$202	\$202	\$202	\$202	\$202	\$2,423
TOTAL	\$4,152	\$4,152	\$4,152	\$4,152	\$4,152	\$4,152	\$4,152	\$4,152	\$4,152	\$4,152	\$4,152	\$4,152	\$49,823

EQUIPMENT / SOFTWARE													
Equipment Lease (1 copier, fax, etc.)	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
Furniture & Equipment Under \$5,000	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$3,000
Computers, Lap tops	\$16,250	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$16,250
Electronic Medical Records System (EMR) *	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
* online submission or HCFA emulators													\$0
TOTAL	\$17,200	\$950	\$950	\$950	\$950	\$950	\$950	\$950	\$950	\$950	\$950	\$950	\$27,650

TRAINING													
Staff Development	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
TOTAL	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000

TRAVEL & TRANSPORTATION													
Mileage / Parking	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$3,600
TOTAL	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$3,600

OCCUPANCY													
Building Occupancy (Full Service)	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$90,000
* 5,000 SF X \$18.00 /SF													\$0
TOTAL	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$90,000

OPERATING SERVICES													
Professional memberships	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Recruitment	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Supplies / Postage	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Telephones - Cell	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$15,600
Copying and Printing	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Liability Insurance	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
IT/Communications	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$42,000
TOTAL	\$5,200	\$5,200	\$5,200	\$5,200	\$5,200	\$5,200	\$5,200	\$5,200	\$5,200	\$5,200	\$5,200	\$5,200	\$62,400

Meals & Housekeeping & Clinical Ops													
Meals	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$51,100
Housekeeping	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$30,000
TOTAL	\$6,758	\$6,758	\$6,758	\$6,758	\$6,758	\$6,758	\$6,758	\$6,758	\$6,758	\$6,758	\$6,758	\$6,758	\$81,100

TOTAL DIRECT EXPENSES	\$98,835	\$82,585	\$82,585	\$82,585	\$82,585	\$82,585	\$82,585	\$82,585	\$82,585	\$82,585	\$82,585	\$82,585	\$1,007,273
TOTAL INDIRECT EXPENSES (10%)	\$9,884	\$8,259	\$8,259	\$8,259	\$8,259	\$8,259	\$8,259	\$8,259	\$8,259	\$8,259	\$8,259	\$8,259	\$100,727
TOTAL EXPENSES	\$108,719	\$90,844	\$90,844	\$90,844	\$90,844	\$90,844	\$90,844	\$90,844	\$90,844	\$90,844	\$90,844	\$90,844	\$1,108,000

**No Capitalized Expenses projected**

**CRISIS RESPITE - YOUTH (One 10-Bed Facility)**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Clinical Director	\$65,000	1.00	\$65,000	\$13,000	\$78,000	\$6,500
Licensed Mental Health Professional	\$56,000	2.00	\$112,000	\$22,400	\$134,400	\$11,200
Behavioral Health Technician	\$35,000	6.00	\$210,000	\$42,000	\$252,000	\$21,000
Nurse-RN	\$65,000	1.00	\$65,000	\$13,000	\$78,000	\$6,500
Family Specialist	\$31,000	3.00	\$93,000	\$18,600	\$111,600	\$9,300
<b>PERSONNEL TOTALS</b>		<b>13.00</b>	<b>\$545,000</b>	<b>\$109,000</b>	<b>\$654,000</b>	<b>\$54,500</b>

**CRISIS RESPITE - YOUTH (One 10-Bed Facility)**

Shift Detail								Total
	Sun	Mon	Tue	Wed	Thu	Fri	Sat	
7:00 AM	2	2	2	2	2	2	2	
8:00 AM	2	6	6	6	6	6	4	
9:00 AM	3	6	6	6	6	6	3	
10:00 AM	3	6	6	6	6	6	3	
11:00 AM	3	6	6	6	6	6	3	
12:00 PM								
1:00 PM	3	6	6	6	6	6	3	
2:00 PM	3	6	6	6	6	6	3	
3:00 PM	3	6	6	6	6	6	3	
4:00 PM	3	6	6	6	6	6	3	
5:00 PM	3	3	3	3	3	3	3	
6:00 PM	2	3	3	3	3	3	3	
7:00 PM	2	3	3	3	3	3	3	
8:00 PM	2	3	3	3	3	3	3	
9:00 PM	2	2	2	2	2	2	2	
10:00 PM	2	2	2	2	2	2	2	
11:00 PM	2	2	2	2	2	2	2	
12:00 AM								
1:00 AM	2	2	2	2	2	2	2	
2:00 AM	2	2	2	2	2	2	2	
3:00 AM	2	2	2	2	2	2	2	
4:00 AM	2	2	2	2	2	2	2	
5:00 AM	2	2	2	2	2	2	2	
6:00 AM	2	2	2	2	2	2	2	
Hours	52.0	80.0	80.0	80.0	80.0	80.0	57.0	509.0
Hours available per FTE								40.0
Required staff								12.7

OPERATING BUDGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>EXPENSES</b>	<b>JAN</b>	<b>FEB</b>	<b>MAR</b>	<b>APR</b>	<b>MAY</b>	<b>JUN</b>	<b>JUL</b>	<b>AUG</b>	<b>SEP</b>	<b>OCT</b>	<b>NOV</b>	<b>DEC</b>	<b>Total</b>
<b>PERSONNEL</b>													
Base Salary & ERE (see staffing model)	\$70,400	\$70,400	\$70,400	\$70,400	\$70,400	\$70,400	\$70,400	\$70,400	\$70,400	\$70,400	\$70,400	\$70,400	\$844,800
TOTAL	\$70,400	\$70,400	\$70,400	\$70,400	\$70,400	\$70,400	\$70,400	\$70,400	\$70,400	\$70,400	\$70,400	\$70,400	\$844,800
													\$0
<b>PROFESSIONAL &amp; CONTRACTED SERVICES</b>													
Project Coordinator	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Outside medical staff	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$15,000
Labs & Medical Supplies	\$123	\$123	\$123	\$123	\$123	\$123	\$123	\$123	\$123	\$123	\$123	\$123	\$1,482
TOTAL	\$1,573	\$1,573	\$1,573	\$1,573	\$1,573	\$1,573	\$1,573	\$1,573	\$1,573	\$1,573	\$1,573	\$1,573	\$18,882
													\$0
<b>EQUIPMENT / SOFTWARE</b>													
Equipment Lease (1 copier, fax, etc.)	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
Furniture & Equipment Under \$5,000	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$3,000
Computers, Lap tops	\$12,500	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$12,500
Electronic Medical Records System (EMR) *	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
* online submission or HCFA emulators													
TOTAL	\$13,450	\$950	\$950	\$950	\$950	\$950	\$950	\$950	\$950	\$950	\$950	\$950	\$23,900
													\$0
<b>TRAINING</b>													
Staff Development	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
TOTAL	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
													\$0
<b>TRAVEL &amp; TRANSPORTATION</b>													
Leased Vehicle	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$4,800
Auto Fuel	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$1,200
Auto Insurance	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$1,200
Auto Repair & Maintenance	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$300
Mileage / Parking	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$3,600
TOTAL	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$925	\$11,100
													\$0
<b>OCCUPANCY</b>													
Building Occupancy (Full Service)	\$10,500	\$10,500	\$10,500	\$10,500	\$10,500	\$10,500	\$10,500	\$10,500	\$10,500	\$10,500	\$10,500	\$10,500	\$126,000
* 7,000 SF X \$18.00/SF													\$0
TOTAL	\$10,500	\$10,500	\$10,500	\$10,500	\$10,500	\$10,500	\$10,500	\$10,500	\$10,500	\$10,500	\$10,500	\$10,500	\$126,000
													\$0
<b>OPERATING SERVICES</b>													
Supplies / Postage	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Telephones - Cell	\$1,700	\$1,700	\$1,700	\$1,700	\$1,700	\$1,700	\$1,700	\$1,700	\$1,700	\$1,700	\$1,700	\$1,700	\$20,400
Copying and Printing	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Liability Insurance	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$1,200
IT/Communications	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$60,000
TOTAL	\$7,200	\$7,200	\$7,200	\$7,200	\$7,200	\$7,200	\$7,200	\$7,200	\$7,200	\$7,200	\$7,200	\$7,200	\$86,400
													\$0
<b>Meals &amp; Housekeeping &amp; Clinical Ops</b>													
Meals	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$51,100
Housekeeping	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$30,000
TOTAL	\$6,758	\$6,758	\$6,758	\$6,758	\$6,758	\$6,758	\$6,758	\$6,758	\$6,758	\$6,758	\$6,758	\$6,758	\$81,100
													\$0
<b>TOTAL DIRECT EXPENSES</b>	<b>\$111,307</b>	<b>\$98,807</b>	<b>\$1,198,182</b>										
<b>TOTAL INDIRECT EXPENSES (10%)</b>	<b>\$11,131</b>	<b>\$9,881</b>	<b>\$119,818</b>										
<b>TOTAL EXPENSES</b>	<b>\$122,438</b>	<b>\$108,688</b>	<b>\$1,318,000</b>										

**No Capitalized Expenses projected**

**INTERMEDIATE LEVEL CARE - ADULT (One 10-Bed Facility)**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Clinical Director	\$65,000	1.00	\$65,000	\$13,000	\$78,000	\$6,500
Administrative Assistant	\$30,000	1.00	\$30,000	\$6,000	\$36,000	\$3,000
Nurse RN	\$65,000	1.00	\$65,000	\$13,000	\$78,000	\$6,500
Licensed Mental Health Professional	\$56,000	2.00	\$112,000	\$22,400	\$134,400	\$11,200
Behavioral Health Technician <sup>1</sup>	\$35,000	4.00	\$140,000	\$28,000	\$168,000	\$14,000
Substance Abuse Professional	\$42,000	2.00	\$84,000	\$16,800	\$100,800	\$8,400
Mental Health Professional	\$42,000	2.00	\$84,000	\$16,800	\$100,800	\$8,400
Peer Specialist	\$31,000	4.00	\$124,000	\$24,800	\$148,800	\$12,400
<b>PERSONNEL TOTALS</b>		<b>17.00</b>	<b>\$704,000</b>	<b>\$140,800</b>	<b>\$844,800</b>	<b>\$70,400</b>

<sup>1</sup> House Managers

**INTERMEDIATE LEVEL CARE - ADULT (One 10-Bed Facility)**

Shift Detail								Total
	Sun	Mon	Tue	Wed	Thu	Fri	Sat	
7:00 AM	2	2	2	2	2	2	2	
8:00 AM	4	9	9	9	9	9	4	
9:00 AM	4	9	9	9	9	9	4	
10:00 AM	4	9	9	9	9	9	4	
11:00 AM	4	9	9	9	9	9	4	
12:00 PM								
1:00 PM	4	9	9	9	9	9	4	
2:00 PM	4	9	9	9	9	9	4	
3:00 PM	4	9	9	9	9	9	4	
4:00 PM	4	9	9	9	9	9	4	
5:00 PM	4	4	4	4	4	4	4	
6:00 PM	4	4	4	4	4	4	4	
7:00 PM	4	4	4	4	4	4	4	
8:00 PM	4	4	4	4	4	4	4	
9:00 PM	2	2	2	2	2	2	2	
10:00 PM	2	2	2	2	2	2	2	
11:00 PM	2	2	2	2	2	2	2	
12:00 AM								
1:00 AM	2	2	2	2	2	2	2	
2:00 AM	2	2	2	2	2	2	2	
3:00 AM	2	2	2	2	2	2	2	
4:00 AM	2	2	2	2	2	2	2	
5:00 AM	2	2	2	2	2	2	2	
6:00 AM	2	2	2	2	2	2	2	
Hours	68.0	108.0	108.0	108.0	108.0	108.0	68.0	676.0
Hours available per FTE								40.0
Required staff								16.9

**OPERATING BUDGET**

**EXPENSES**

PERSONNEL	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Base Salary & ERE (see staffing model)	\$52,400	\$52,400	\$52,400	\$52,400	\$52,400	\$52,400	\$52,400	\$52,400	\$52,400	\$52,400	\$52,400	\$52,400	\$628,800
													\$0
<b>TOTAL</b>	<b>\$52,400</b>	<b>\$628,800</b>											

PROFESSIONAL & CONTRACTED SERVICES	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Project Coordinator	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Outside medical staff	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$15,000
Labs & Medical Supplies	\$136	\$136	\$136	\$136	\$136	\$136	\$136	\$136	\$136	\$136	\$136	\$136	\$1,627
													\$0
<b>TOTAL</b>	<b>\$1,586</b>	<b>\$19,027</b>											

EQUIPMENT / SOFTWARE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Equipment Lease (1 copier, fax, etc.)	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Furniture & Equipment Under \$5,000	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$3,000
Computers, Lap tops	\$10,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$10,000
Electronic Medical Records System (EMR) *	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
* online submission or HCFA emulators													
<b>TOTAL</b>	<b>\$10,450</b>	<b>\$450</b>	<b>\$15,400</b>										

TRAINING	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Staff Development	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
													\$0
<b>TOTAL</b>	<b>\$500</b>	<b>\$6,000</b>											

TRAVEL & TRANSPORTATION	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Mileage / Parking	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$3,600
													\$0
<b>TOTAL</b>	<b>\$300</b>	<b>\$3,600</b>											

OCCUPANCY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Building Occupancy (Full Service)	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$108,000
* 6,000 SF X \$18.00 /SF													\$0
													\$0
<b>TOTAL</b>	<b>\$9,000</b>	<b>\$108,000</b>											

OPERATING SERVICES	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Supplies / Postage	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Telephones - Cell	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$15,600
Copying and Printing	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Liability Insurance	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$1,200
IT/Communications	\$1,600	\$1,600	\$1,600	\$1,600	\$1,600	\$1,600	\$1,600	\$1,600	\$1,600	\$1,600	\$1,600	\$1,600	\$19,200
<b>TOTAL</b>	<b>\$3,400</b>	<b>\$40,800</b>											

Meals & Housekeeping & Clinical Ops	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Meals	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$4,258	\$51,100
Housekeeping	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$30,000
													\$0
<b>TOTAL</b>	<b>\$6,758</b>	<b>\$81,100</b>											

<b>TOTAL DIRECT EXPENSES</b>	<b>\$84,394</b>	<b>\$74,394</b>	<b>\$902,727</b>										
<b>TOTAL INDIRECT EXPENSES (10%)</b>	<b>\$8,439</b>	<b>\$7,439</b>	<b>\$90,273</b>										
<b>TOTAL EXPENSES</b>	<b>\$92,833</b>	<b>\$81,833</b>	<b>\$993,000</b>										

**No Capitalized Expenses projected**

**YOUTH TRANSITIONAL LIVING SERVICES (One 10-Bed Facility)**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Clinical Director	\$65,000	1.00	\$65,000	\$13,000	\$78,000	\$6,500
Administrative Assistant	\$30,000	1.00	\$30,000	\$6,000	\$36,000	\$3,000
Nurse RN	\$65,000	1.00	\$65,000	\$13,000	\$78,000	\$6,500
Mental Health Professional	\$42,000	2.00	\$84,000	\$16,800	\$100,800	\$8,400
Behavioral Health Technician	\$35,000	8.00	\$280,000	\$56,000	\$336,000	\$28,000
<b>PERSONNEL TOTALS</b>		<b>13.00</b>	<b>\$524,000</b>	<b>\$104,800</b>	<b>\$628,800</b>	<b>\$52,400</b>

**YOUTH TRANSITIONAL LIVING SERVICES (One 10-Bed Facility)**

Shift Detail								Total
	Sun	Mon	Tue	Wed	Thu	Fri	Sat	
7:00 AM	2	2	2	2	2	2	2	
8:00 AM	4	5	5	5	5	5	4	
9:00 AM	4	5	5	5	5	5	4	
10:00 AM	4	5	5	5	5	5	4	
11:00 AM	4	5	5	5	5	5	4	
12:00 PM								
1:00 PM	4	5	5	5	5	5	4	
2:00 PM	4	5	5	5	5	5	4	
3:00 PM	4	5	5	5	5	5	4	
4:00 PM	4	5	5	5	5	5	4	
5:00 PM	4	4	4	4	4	4	4	
6:00 PM	4	4	4	4	4	4	4	
7:00 PM	4	4	4	4	4	4	4	
8:00 PM	4	4	4	4	4	4	4	
9:00 PM	2	2	2	2	2	2	2	
10:00 PM	2	2	2	2	2	2	2	
11:00 PM	2	2	2	2	2	2	2	
12:00 AM								
1:00 AM	2	2	2	2	2	2	2	
2:00 AM	2	2	2	2	2	2	2	
3:00 AM	2	2	2	2	2	2	2	
4:00 AM	2	2	2	2	2	2	2	
5:00 AM	2	2	2	2	2	2	2	
6:00 AM	2	2	2	2	2	2	2	
Hours	68.0	76.0	76.0	76.0	76.0	76.0	68.0	516.0
Hours available per FTE								40.0
Required staff								12.9

OPERATING BUDGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>EXPENSES</b>	<b>JAN</b>	<b>FEB</b>	<b>MAR</b>	<b>APR</b>	<b>MAY</b>	<b>JUN</b>	<b>JUL</b>	<b>AUG</b>	<b>SEP</b>	<b>OCT</b>	<b>NOV</b>	<b>DEC</b>	<b>Total</b>
<b>PERSONNEL</b>													
Base Salary & ERE (see staffing model)	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$540,000
Shift, On Call, Overtime, Spanish differential *	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$27,000
													\$0
<b>TOTAL</b>	<b>\$47,250</b>	<b>\$567,000</b>											
<b>EQUIPMENT / SOFTWARE</b>													
Equipment Lease (1 copier, fax, etc.)	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
Furn & Equip Under \$5,000	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$3,000
Computers, Lap tops	\$11,250	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$11,250
Electronic Medical Records System (EMR) *	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
* online submission or HCFA emulators													
<b>TOTAL</b>	<b>\$12,200</b>	<b>\$950</b>	<b>\$22,650</b>										
<b>TRAINING</b>													
Staff Development	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
													\$0
<b>TOTAL</b>	<b>\$500</b>	<b>\$6,000</b>											
<b>TRAVEL &amp; TRANSPORTATION</b>													
Mileage / Parking	\$2,080	\$2,080	\$2,080	\$2,080	\$2,080	\$2,080	\$2,080	\$2,080	\$2,080	\$2,080	\$2,080	\$2,080	\$24,960
													\$0
<b>TOTAL</b>	<b>\$2,080</b>	<b>\$24,960</b>											
<b>OCCUPANCY</b>													
Building Occupancy (Full Service)	\$3,145	\$3,145	\$3,145	\$3,145	\$3,145	\$3,145	\$3,145	\$3,145	\$3,145	\$3,145	\$3,145	\$3,145	\$37,740
Lease allocation is \$370/month/staff													\$0
													\$0
<b>TOTAL</b>	<b>\$3,145</b>	<b>\$37,740</b>											
<b>OPERATING SERVICES</b>													
Supplies / Postage	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$2,668
Telephones - Cell	\$900	\$900	\$900	\$900	\$900	\$900	\$900	\$900	\$900	\$900	\$900	\$900	\$10,800
Copying and Printing	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
IT/Communications	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$54,000
<b>TOTAL</b>	<b>\$6,122</b>	<b>\$73,468</b>											
<b>TOTAL DIRECT EXPENSES</b>	<b>\$71,297</b>	<b>\$60,047</b>	<b>\$731,818</b>										
<b>TOTAL INDIRECT EXPENSES (10%)</b>	<b>\$7,130</b>	<b>\$6,005</b>	<b>\$73,182</b>										
<b>TOTAL EXPENSES</b>	<b>\$78,427</b>	<b>\$66,052</b>	<b>\$805,000</b>										

**No Capitalized Expenses projected**

**INTENSIVE CASE MANAGEMENT (One Adult Team)**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Clinical Director	\$65,000	1.00	\$65,000	\$13,000	\$78,000	\$6,500
Clinical Supervisor	\$56,000	1.00	\$56,000	\$11,200	\$67,200	\$5,600
Mental Health Professional	\$42,000	4.00	\$168,000	\$33,600	\$201,600	\$16,800
Nurse-RN	\$65,000	2.00	\$130,000	\$26,000	\$156,000	\$13,000
Peer Specialist	\$31,000	1.00	\$31,000	\$6,200	\$37,200	\$3,100
<b>PERSONNEL TOTALS</b>		<b>9.00</b>	<b>\$450,000</b>	<b>\$90,000</b>	<b>\$540,000</b>	<b>\$45,000</b>

OPERATING BUDGET													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>EXPENSES</b>													
<b>PERSONNEL</b>													
Base Salary & ERE (see staffing model)	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$540,000
Shift, On Call, Overtime, Spanish differential	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$27,000
													\$0
<b>TOTAL</b>	<b>\$47,250</b>	<b>\$567,000</b>											
<b>EQUIPMENT / SOFTWARE</b>													
Equipment Lease (1 copier, fax, etc.)	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
Furn & Equip Under \$5,000	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$3,000
Computers, Lap tops	\$11,250	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$11,250
Electronic Medical Records System (EMR) *	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
* online submission or HCFA emulators													
<b>TOTAL</b>	<b>\$12,200</b>	<b>\$950</b>	<b>\$22,650</b>										
<b>TRAINING</b>													
Staff Development	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
													\$0
<b>TOTAL</b>	<b>\$500</b>	<b>\$6,000</b>											
<b>TRAVEL &amp; TRANSPORTATION</b>													
Mileage / Parking	\$2,080	\$2,080	\$2,080	\$2,080	\$2,080	\$2,080	\$2,080	\$2,080	\$2,080	\$2,080	\$2,080	\$2,080	\$24,960
													\$0
<b>TOTAL</b>	<b>\$2,080</b>	<b>\$24,960</b>											
<b>OCCUPANCY</b>													
Building Occupancy (Full Service)	\$3,145	\$3,145	\$3,145	\$3,145	\$3,145	\$3,145	\$3,145	\$3,145	\$3,145	\$3,145	\$3,145	\$3,145	\$37,740
Lease allocation is \$370/month/staff													\$0
													\$0
<b>TOTAL</b>	<b>\$3,145</b>	<b>\$37,740</b>											
<b>OPERATING SERVICES</b>													
Supplies / Postage	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$2,668
Telephones - Cell	\$900	\$900	\$900	\$900	\$900	\$900	\$900	\$900	\$900	\$900	\$900	\$900	\$10,800
Copying and Printing	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
IT/Communications	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$54,000
<b>TOTAL</b>	<b>\$6,122</b>	<b>\$73,468</b>											
<b>TOTAL DIRECT EXPENSES</b>	<b>\$71,297</b>	<b>\$60,047</b>	<b>\$731,818</b>										
<b>TOTAL INDIRECT EXPENSES (10%)</b>	<b>\$7,130</b>	<b>\$6,005</b>	<b>\$73,182</b>										
<b>TOTAL EXPENSES</b>	<b>\$78,427</b>	<b>\$66,052</b>	<b>\$805,000</b>										

**No Capitalized Expenses projected**

**INTENSIVE CASE MANAGEMENT (One Child Team)**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Clinical Director	\$65,000	1.00	\$65,000	\$13,000	\$78,000	\$6,500
Clinical Supervisor	\$56,000	1.00	\$56,000	\$11,200	\$67,200	\$5,600
Mental Health Professional	\$42,000	4.00	\$168,000	\$33,600	\$201,600	\$16,800
Nurse-RN	\$65,000	2.00	\$130,000	\$26,000	\$156,000	\$13,000
Family Specialist	\$31,000	1.00	\$31,000	\$6,200	\$37,200	\$3,100
<b>PERSONNEL TOTALS</b>		<b>9.00</b>	<b>\$450,000</b>	<b>\$90,000</b>	<b>\$540,000</b>	<b>\$45,000</b>

**OPERATING BUDGET**

**EXPENSES**

PERSONNEL	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Base Salary & ERE (see staffing model)	\$59,950	\$59,950	\$59,950	\$59,950	\$59,950	\$59,950	\$59,950	\$59,950	\$59,950	\$59,950	\$59,950	\$59,950	\$719,400
Shift, On Call, Overtime, Spanish differential	\$8,993	\$8,993	\$8,993	\$8,993	\$8,993	\$8,993	\$8,993	\$8,993	\$8,993	\$8,993	\$8,993	\$8,993	\$107,910
TOTAL	\$68,943	\$68,943	\$68,943	\$68,943	\$68,943	\$68,943	\$68,943	\$68,943	\$68,943	\$68,943	\$68,943	\$68,943	\$827,310

EQUIPMENT / SOFTWARE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Equipment Lease (1 copier, fax, etc.)	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
Furn & Equip Under \$5,000	\$289	\$289	\$289	\$289	\$289	\$289	\$289	\$289	\$289	\$289	\$289	\$289	\$3,463
Computers, Lap tops	\$12,500	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$12,500
Electronic Medical Records System (EMR) *	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
* online submission or HCFA emulators													
TOTAL	\$13,489	\$989	\$989	\$989	\$989	\$989	\$989	\$989	\$989	\$989	\$989	\$989	\$24,363

TRAINING	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Staff Development	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
TOTAL	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000

TRAVEL & TRANSPORTATION	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Leased Vehicle	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$4,800
Leased Vehicle	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$4,800
Auto Fuel	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Auto Insurance	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Auto Repair & Maintenance	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$600
Mileage / Parking	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$900
TOTAL	\$1,325	\$1,325	\$1,325	\$1,325	\$1,325	\$1,325	\$1,325	\$1,325	\$1,325	\$1,325	\$1,325	\$1,325	\$15,900

OCCUPANCY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Building Occupancy (Full Service)	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$44,400
Lease allocation is \$370/month/staff													\$0
TOTAL	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$44,400

OPERATING SERVICES	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Supplies / Postage	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Telephones - Cell	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$12,000
Copying and Printing	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
IT/Communications	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$60,000
Liability Insurance	\$208	\$208	\$208	\$208	\$208	\$208	\$208	\$208	\$208	\$208	\$208	\$208	\$2,500
TOTAL	\$6,608	\$6,608	\$6,608	\$6,608	\$6,608	\$6,608	\$6,608	\$6,608	\$6,608	\$6,608	\$6,608	\$6,608	\$79,300

TOTAL DIRECT EXPENSES	\$94,564	\$82,064	\$82,064	\$82,064	\$82,064	\$82,064	\$82,064	\$82,064	\$82,064	\$82,064	\$82,064	\$82,064	\$997,273
TOTAL INDIRECT EXPENSES (10%)	\$9,456	\$8,206	\$8,206	\$8,206	\$8,206	\$8,206	\$8,206	\$8,206	\$8,206	\$8,206	\$8,206	\$8,206	\$99,727
TOTAL EXPENSES	\$104,021	\$90,271	\$90,271	\$90,271	\$90,271	\$90,271	\$90,271	\$90,271	\$90,271	\$90,271	\$90,271	\$90,271	\$1,097,000

**No Capitalized Expenses projected**

**FORENSIC ACT TEAM (One Team)**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Psychiatrist	\$225,000	0.50	\$112,500	\$22,500	\$135,000	\$11,250
Nurse RN	\$65,000	2.00	\$130,000	\$26,000	\$156,000	\$13,000
Peer Specialist	\$31,000	1.00	\$31,000	\$6,200	\$37,200	\$3,100
Licensed Mental Health Professional	\$56,000	2.00	\$112,000	\$22,400	\$134,400	\$11,200
Administrative Assistant	\$30,000	1.00	\$30,000	\$6,000	\$36,000	\$3,000
Employment Specialist	\$50,000	2.00	\$100,000	\$20,000	\$120,000	\$10,000
Substance Abuse Professional	\$42,000	2.00	\$84,000	\$16,800	\$100,800	\$8,400
<b>PERSONNEL TOTALS</b>		<b>10.50</b>	<b>\$599,500</b>	<b>\$119,900</b>	<b>\$719,400</b>	<b>\$59,950</b>

**SUBSTANCE ABUSE OUTPATIENT TREATMENT SERVICES**

OPERATING BUDGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>EXPENSES</b>	<b>JAN</b>	<b>FEB</b>	<b>MAR</b>	<b>APR</b>	<b>MAY</b>	<b>JUN</b>	<b>JUL</b>	<b>AUG</b>	<b>SEP</b>	<b>OCT</b>	<b>NOV</b>	<b>DEC</b>	<b>Total</b>
<b>PERSONNEL</b>													
Base Salary & ERE	\$74,900	\$74,900	\$74,900	\$74,900	\$74,900	\$74,900	\$74,900	\$74,900	\$74,900	\$74,900	\$74,900	\$74,900	\$898,800
Shift, On Call, Overtime, Spanish differential *	\$3,745	\$3,745	\$3,745	\$3,745	\$3,745	\$3,745	\$3,745	\$3,745	\$3,745	\$3,745	\$3,745	\$3,745	\$44,940
* 5%													\$0
													\$0
<b>TOTAL</b>	<b>\$78,645</b>	<b>\$943,740</b>											
<b>PROFESSIONAL &amp; CONTRACTED SERVICES</b>													
Outside medical staff	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$1,250	\$15,000
Labs & Medical Supplies	\$110	\$110	\$110	\$110	\$110	\$110	\$110	\$110	\$110	\$110	\$110	\$110	\$1,316
													\$0
<b>TOTAL</b>	<b>\$1,360</b>	<b>\$16,316</b>											
<b>EQUIPMENT / SOFTWARE</b>													
Equipment Lease (1 copier, fax, etc.)	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
Furn & Equip Under \$5,000	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$3,000
Computers, Lap tops	\$22,500	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$22,500
Electronic Medical Records System (EMR) *	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$7,200
* online submission or HCFA emulators													
<b>TOTAL</b>	<b>\$23,850</b>	<b>\$1,350</b>	<b>\$38,700</b>										
<b>TRAINING</b>													
Staff Development	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
													\$0
													\$0
<b>TOTAL</b>	<b>\$500</b>	<b>\$6,000</b>											
<b>TRAVEL &amp; TRANSPORTATION</b>													
Mileage / Parking	\$10,080	\$10,080	\$10,080	\$10,080	\$10,080	\$10,080	\$10,080	\$10,080	\$10,080	\$10,080	\$10,080	\$10,080	\$120,960
													\$0
<b>TOTAL</b>	<b>\$10,080</b>	<b>\$120,960</b>											
<b>OCCUPANCY</b>													
Building Occupancy (Full Service)	\$6,660	\$6,660	\$6,660	\$6,660	\$6,660	\$6,660	\$6,660	\$6,660	\$6,660	\$6,660	\$6,660	\$6,660	\$79,920
Lease allocation is \$370/month/staff													\$0
													\$0
													\$0
<b>TOTAL</b>	<b>\$6,660</b>	<b>\$79,920</b>											
<b>OPERATING SERVICES</b>													
Supplies / Postage	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Telephones - Cell	\$1,800	\$1,800	\$1,800	\$1,800	\$1,800	\$1,800	\$1,800	\$1,800	\$1,800	\$1,800	\$1,800	\$1,800	\$21,600
Copying and Printing	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
IT/Communications	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$108,000
Liability Insurance	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>\$11,500</b>	<b>\$138,000</b>											
<b>TOTAL DIRECT EXPENSES</b>	<b>\$132,595</b>	<b>\$110,095</b>	<b>\$1,343,636</b>										
<b>TOTAL INDIRECT EXPENSES (10%)</b>	<b>\$13,259</b>	<b>\$11,009</b>	<b>\$134,364</b>										
<b>TOTAL EXPENSES</b>	<b>\$145,854</b>	<b>\$121,104</b>	<b>\$1,478,000</b>										

No Capitalized Expenses projected

**SUBSTANCE ABUSE OUTPATIENT TREATMENT SERVICES**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Clinical Director	\$65,000	1.00	\$65,000	\$13,000	\$78,000	\$6,500
Clinical Supervisor	\$56,000	1.00	\$56,000	\$11,200	\$67,200	\$5,600
Licensed Substance Abuse Professional	\$56,000	4.00	\$224,000	\$44,800	\$268,800	\$22,400
Behavioral Health Technician	\$35,000	8.00	\$280,000	\$56,000	\$336,000	\$28,000
Peer Specialist	\$31,000	4.00	\$124,000	\$24,800	\$148,800	\$12,400
<b>PERSONNEL TOTALS</b>		<b>18.00</b>	<b>\$749,000</b>	<b>\$149,800</b>	<b>\$898,800</b>	<b>\$74,900</b>

**OPERATING BUDGET**

**EXPENSES**

PERSONNEL	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Base Salary & ERE (see staffing model)	\$16,800	\$16,800	\$16,800	\$16,800	\$16,800	\$16,800	\$16,800	\$16,800	\$16,800	\$16,800	\$16,800	\$16,800	\$201,600
Shift, On Call, Overtime, Spanish differential	\$2,520	\$2,520	\$2,520	\$2,520	\$2,520	\$2,520	\$2,520	\$2,520	\$2,520	\$2,520	\$2,520	\$2,520	\$30,240
TOTAL	\$19,320	\$19,320	\$19,320	\$19,320	\$19,320	\$19,320	\$19,320	\$19,320	\$19,320	\$19,320	\$19,320	\$19,320	\$231,840

EQUIPMENT / SOFTWARE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Equipment Lease	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$125	\$1,500
Furn & Equip Under \$5,000	\$237	\$237	\$237	\$237	\$237	\$237	\$237	\$237	\$237	\$237	\$237	\$237	\$2,844
Computers, Lap tops	\$2,500	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$2,500
Electronic Medical Records System (EMR) *	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
* online submission or HCFA emulators													
TOTAL	\$3,062	\$562	\$562	\$562	\$562	\$562	\$562	\$562	\$562	\$562	\$562	\$562	\$9,244

TRAINING	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Staff Development	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$3,000
TOTAL	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$3,000

TRAVEL & TRANSPORTATION	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Leased Vehicle	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$4,800
Auto Fuel	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$1,200
Auto Insurance	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$1,200
Auto Repair & Maintenance	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$300
Mileage / Parking	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$300
TOTAL	\$650	\$650	\$650	\$650	\$650	\$650	\$650	\$650	\$650	\$650	\$650	\$650	\$7,800

OCCUPANCY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Building Occupancy (Full Service)	\$740	\$740	\$740	\$740	\$740	\$740	\$740	\$740	\$740	\$740	\$740	\$740	\$8,880
Lease allocation is \$370/month/staff													\$0
TOTAL	\$740	\$740	\$740	\$740	\$740	\$740	\$740	\$740	\$740	\$740	\$740	\$740	\$8,880

OPERATING SERVICES	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Supplies / Postage	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$600
Telephones - Cell	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Copying and Printing	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$600
IT/Communications	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$12,000
TOTAL	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$1,300	\$15,600

TOTAL DIRECT EXPENSES	\$25,322	\$22,822	\$22,822	\$22,822	\$22,822	\$22,822	\$22,822	\$22,822	\$22,822	\$22,822	\$22,822	\$22,822	\$276,364
TOTAL INDIRECT EXPENSES (10%)	\$2,532	\$2,282	\$2,282	\$2,282	\$2,282	\$2,282	\$2,282	\$2,282	\$2,282	\$2,282	\$2,282	\$2,282	\$27,636
TOTAL EXPENSES	\$27,854	\$25,104	\$25,104	\$25,104	\$25,104	\$25,104	\$25,104	\$25,104	\$25,104	\$25,104	\$25,104	\$25,104	\$304,000

No Capitalized Expenses projected

**COMMUNITY ENGAGEMENT TEAM (One Pilot Team)**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Clinical Supervisor	\$65,000	1.00	\$65,000	\$13,000	\$78,000	\$6,500
Administrative Assistant	\$30,000	1.00	\$30,000	\$6,000	\$36,000	\$3,000
Mental Health Professional	\$42,000	1.00	\$42,000	\$8,400	\$50,400	\$4,200
Peer Specialist	\$31,000	1.00	\$31,000	\$6,200	\$37,200	\$3,100
<b>PERSONNEL TOTALS</b>		<b>4.00</b>	<b>\$168,000</b>	<b>\$33,600</b>	<b>\$201,600</b>	<b>\$16,800</b>

OPERATING BUDGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>EXPENSES</b>	<b>JAN</b>	<b>FEB</b>	<b>MAR</b>	<b>APR</b>	<b>MAY</b>	<b>JUN</b>	<b>JUL</b>	<b>AUG</b>	<b>SEP</b>	<b>OCT</b>	<b>NOV</b>	<b>DEC</b>	<b>Total</b>
<b>PERSONNEL</b>													
Base Salary & ERE (see staffing model)	\$40,100	\$40,100	\$40,100	\$40,100	\$40,100	\$40,100	\$40,100	\$40,100	\$40,100	\$40,100	\$40,100	\$40,100	\$481,200
TOTAL	\$40,100	\$40,100	\$40,100	\$40,100	\$40,100	\$40,100	\$40,100	\$40,100	\$40,100	\$40,100	\$40,100	\$40,100	\$481,200
													\$0
<b>EQUIPMENT / SOFTWARE</b>													
Equipment Lease (1 copier, fax, etc.)	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
Furn & Equip Under \$5,000	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$222	\$2,667
Computers, Lap tops	\$7,500	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$7,500
Electronic Medical Records System (EMR) *	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
* online submission or HCFA emulators													
TOTAL	\$8,422	\$922	\$922	\$922	\$922	\$922	\$922	\$922	\$922	\$922	\$922	\$922	\$18,567
<b>TRAINING</b>													
Staff Development	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
TOTAL	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
													\$0
<b>TRAVEL &amp; TRANSPORTATION</b>													
Mileage / Parking	\$1,560	\$1,560	\$1,560	\$1,560	\$1,560	\$1,560	\$1,560	\$1,560	\$1,560	\$1,560	\$1,560	\$1,560	\$18,720
TOTAL	\$1,560	\$1,560	\$1,560	\$1,560	\$1,560	\$1,560	\$1,560	\$1,560	\$1,560	\$1,560	\$1,560	\$1,560	\$18,720
													\$0
<b>OCCUPANCY</b>													
Building Occupancy (Full Service)	\$2,220	\$2,220	\$2,220	\$2,220	\$2,220	\$2,220	\$2,220	\$2,220	\$2,220	\$2,220	\$2,220	\$2,220	\$26,640
Lease allocation is \$370/month/staff													\$0
TOTAL	\$2,220	\$2,220	\$2,220	\$2,220	\$2,220	\$2,220	\$2,220	\$2,220	\$2,220	\$2,220	\$2,220	\$2,220	\$26,640
													\$0
<b>OPERATING SERVICES</b>													
Supplies / Postage	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Telephones - Cell	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$7,200
Copying and Printing	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
IT/Communications	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$36,000
TOTAL	\$4,300	\$4,300	\$4,300	\$4,300	\$4,300	\$4,300	\$4,300	\$4,300	\$4,300	\$4,300	\$4,300	\$4,300	\$51,600
													\$0
<b>TOTAL DIRECT EXPENSES</b>	<b>\$57,102</b>	<b>\$49,602</b>	<b>\$602,727</b>										
<b>TOTAL INDIRECT EXPENSES (10%)</b>	<b>\$5,710</b>	<b>\$4,960</b>	<b>\$60,273</b>										
<b>TOTAL EXPENSES</b>	<b>\$62,813</b>	<b>\$54,563</b>	<b>\$663,000</b>										

**No Capitalized Expenses projected**

**SCHOOL BASED SUBSTANCE ABUSE INTERVENTION (High School)**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Clinical Director	\$65,000	1.00	\$65,000	\$13,000	\$78,000	\$6,500
Licensed Mental Health Professional	\$56,000	6.00	\$336,000	\$67,200	\$403,200	\$33,600
<b>PERSONNEL TOTALS</b>		<b>7.00</b>	<b>\$401,000</b>	<b>\$80,200</b>	<b>\$481,200</b>	<b>\$40,100</b>

**OPERATING BUDGET**

**EXPENSES**

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>PERSONNEL</b>													
Base Salary & ERE (see staffing model)	\$40,900	\$40,900	\$40,900	\$40,900	\$40,900	\$40,900	\$40,900	\$40,900	\$40,900	\$40,900	\$40,900	\$40,900	\$490,800
Shift, On Call, Overtime, Spanish differential	\$4,090	\$4,090	\$4,090	\$4,090	\$4,090	\$4,090	\$4,090	\$4,090	\$4,090	\$4,090	\$4,090	\$4,090	\$49,080
													\$0
<b>TOTAL</b>	<b>\$44,990</b>	<b>\$539,880</b>											

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>EQUIPMENT / SOFTWARE</b>													
Equipment Lease (1 copier, fax, etc.)	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
Furn & Equip Under \$5,000	\$262	\$262	\$262	\$262	\$262	\$262	\$262	\$262	\$262	\$262	\$262	\$262	\$3,147
Computers, Lap tops	\$12,500	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$12,500
Electronic Medical Records System (EMR) *	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
* online submission or HCFA emulators													
<b>TOTAL</b>	<b>\$13,462</b>	<b>\$962</b>	<b>\$24,047</b>										

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>TRAINING</b>													
Staff Development	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
													\$0
<b>TOTAL</b>	<b>\$500</b>	<b>\$6,000</b>											

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>TRAVEL &amp; TRANSPORTATION</b>													
Leased Vehicle	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$4,800
Auto Fuel	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$4,800
Auto Insurance	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Auto Repair & Maintenance	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$600
Mileage / Parking	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$3,000
													\$0
<b>TOTAL</b>	<b>\$1,300</b>	<b>\$15,600</b>											

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>OCCUPANCY</b>													
Building Occupancy (Full Service)	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$3,700	\$44,400
Lease allocation is \$370/month/staff													\$0
													\$0
<b>TOTAL</b>	<b>\$3,700</b>	<b>\$44,400</b>											

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>OPERATING SERVICES</b>													
Supplies / Postage	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
Telephones - Cell	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$12,000
Copying and Printing	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
IT/Communications	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$60,000
Liability Insurance	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
<b>TOTAL</b>	<b>\$6,900</b>	<b>\$82,800</b>											

TOTAL DIRECT EXPENSES	\$70,852	\$58,352	\$58,352	\$58,352	\$58,352	\$58,352	\$58,352	\$58,352	\$58,352	\$58,352	\$58,352	\$58,352	\$712,727
TOTAL INDIRECT EXPENSES (10%)	\$7,085	\$5,835	\$5,835	\$5,835	\$5,835	\$5,835	\$5,835	\$5,835	\$5,835	\$5,835	\$5,835	\$5,835	\$71,273
<b>TOTAL EXPENSES</b>	<b>\$77,938</b>	<b>\$64,188</b>	<b>\$784,000</b>										

No Capitalized Expenses projected

**EARLY PREVENTION FAMILY INTERVENTION (Birth to 5yrs old)**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Clinical Director	\$65,000	1.00	\$65,000	\$13,000	\$78,000	\$6,500
Administrative Assistant	\$30,000	1.00	\$30,000	\$6,000	\$36,000	\$3,000
Licensed Mental Health Professional	\$56,000	2.00	\$112,000	\$22,400	\$134,400	\$11,200
Behavioral Health Technician	\$35,000	4.00	\$140,000	\$28,000	\$168,000	\$14,000
Family Specialist	\$31,000	2.00	\$62,000	\$12,400	\$74,400	\$6,200
<b>PERSONNEL TOTALS</b>		<b>10.00</b>	<b>\$409,000</b>	<b>\$81,800</b>	<b>\$490,800</b>	<b>\$40,900</b>

OPERATING BUDGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
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EXPENSES	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
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PERSONNEL													
Base Salary & ERE (see staffing model)	\$21,900	\$21,900	\$21,900	\$21,900	\$21,900	\$21,900	\$21,900	\$21,900	\$21,900	\$21,900	\$21,900	\$21,900	\$262,800
Shift, On Call, Overtime, Spanish differential	\$3,285	\$3,285	\$3,285	\$3,285	\$3,285	\$3,285	\$3,285	\$3,285	\$3,285	\$3,285	\$3,285	\$3,285	\$39,420
													\$0
<b>TOTAL</b>	<b>\$25,185</b>	<b>\$302,220</b>											

EQUIPMENT / SOFTWARE													
Equipment Lease	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Furn & Equip Under \$5,000	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$3,000
Computers, Lap tops	\$2,500	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$2,500
Electronic Medical Records System (EMR) *	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
* online submission or HCFA emulators													
<b>TOTAL</b>	<b>\$2,950</b>	<b>\$450</b>	<b>\$7,900</b>										

TRAINING													
Staff Development	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$1,200
													\$0
<b>TOTAL</b>	<b>\$100</b>	<b>\$1,200</b>											

TRAVEL & TRANSPORTATION													
Leased Vehicle	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$4,800
Leased Vehicle	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$4,800
Leased Vehicle	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$4,800
Auto Fuel	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$3,600
Auto Insurance	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$3,600
Auto Repair & Maintenance	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$1,800
Mileage / Parking	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$900
													\$0
<b>TOTAL</b>	<b>\$2,025</b>	<b>\$24,300</b>											

OCCUPANCY													
Building Occupancy (Full Service)	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
<i>Teams are mobile so limited space needed</i>													\$0
													\$0
<b>TOTAL</b>	<b>\$500</b>	<b>\$6,000</b>											

OPERATING SERVICES													
Supplies / Postage	\$46	\$46	\$46	\$46	\$46	\$46	\$46	\$46	\$46	\$46	\$46	\$46	\$553
Telephones - Cell	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$3,600
Copying and Printing	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$300
IT/Communications	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$1,200
<b>TOTAL</b>	<b>\$471</b>	<b>\$5,653</b>											

TOTAL DIRECT EXPENSES	\$31,231	\$28,731	\$28,731	\$28,731	\$28,731	\$28,731	\$28,731	\$28,731	\$28,731	\$28,731	\$28,731	\$28,731	\$347,273
TOTAL INDIRECT EXPENSES (10%)	\$3,123	\$2,873	\$2,873	\$2,873	\$2,873	\$2,873	\$2,873	\$2,873	\$2,873	\$2,873	\$2,873	\$2,873	\$34,727
<b>TOTAL EXPENSES</b>	<b>\$34,354</b>	<b>\$31,604</b>	<b>\$382,000</b>										

**No Capitalized Expenses projected**

**CRISIS TRANSPORTATION (Three 2-Person Teams)**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Supervisor	\$45,000	0.20	\$9,000	\$1,800	\$10,800	\$900
Drivers	\$35,000	6.00	\$210,000	\$42,000	\$252,000	\$21,000
<b>PERSONNEL TOTALS</b>		<b>6.20</b>	<b>\$219,000</b>	<b>\$43,800</b>	<b>\$262,800</b>	<b>\$21,900</b>

**OPERATING BUDGET**      JAN      FEB      MAR      APR      MAY      JUN      JUL      AUG      SEP      OCT      NOV      DEC      Total

**EXPENSES**      JAN      FEB      MAR      APR      MAY      JUN      JUL      AUG      SEP      OCT      NOV      DEC      Total

PERSONNEL													
Base Salary & ERE	\$15,800	\$15,800	\$15,800	\$15,800	\$15,800	\$15,800	\$15,800	\$15,800	\$15,800	\$15,800	\$15,800	\$15,800	\$189,600
													\$0
<b>TOTAL</b>	<b>\$15,800</b>	<b>\$189,600</b>											

EQUIPMENT / SOFTWARE													
Equipment Lease (1 copier, fax, etc.)	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
Furn & Equip Under \$5,000	\$203	\$203	\$203	\$203	\$203	\$203	\$203	\$203	\$203	\$203	\$203	\$203	\$2,433
Computers, Lap tops	\$5,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$5,000
<b>TOTAL</b>	<b>\$5,703</b>	<b>\$703</b>	<b>\$13,433</b>										

TRAINING													
Staff Development	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$3,600
													\$0
<b>TOTAL</b>	<b>\$300</b>	<b>\$3,600</b>											

TRAVEL													
Mileage / Parking	\$840	\$840	\$840	\$840	\$840	\$840	\$840	\$840	\$840	\$840	\$840	\$840	\$10,080
													\$0
<b>TOTAL</b>	<b>\$840</b>	<b>\$10,080</b>											

OCCUPANCY													
Building Occupancy (Full Service)	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$17,760
<i>Lease allocation is \$370/month/staff</i>													\$0
													\$0
<b>TOTAL</b>	<b>\$1,480</b>	<b>\$17,760</b>											

Housing Support Services:													
Rent Subsidy (including utilities)	\$42,500	\$42,500	\$42,500	\$42,500	\$42,500	\$42,500	\$42,500	\$42,500	\$42,500	\$42,500	\$42,500	\$42,500	\$510,000
Rental Assistance (Move-in kits, etc.,)	\$2,125	\$2,125	\$2,125	\$2,125	\$2,125	\$2,125	\$2,125	\$2,125	\$2,125	\$2,125	\$2,125	\$2,125	\$25,500
Eviction Prevention	\$2,125	\$2,125	\$2,125	\$2,125	\$2,125	\$2,125	\$2,125	\$2,125	\$2,125	\$2,125	\$2,125	\$2,125	\$25,500
<b>TOTAL</b>	<b>\$46,750</b>	<b>\$561,000</b>											

OPERATING SERVICES													
Supplies / Postage	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$1,800
Telephones - Cell	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$4,800
Copying and Printing	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$1,200
IT/Communications	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$24,000
													\$0
<b>TOTAL</b>	<b>\$2,650</b>	<b>\$31,800</b>											

<b>TOTAL DIRECT EXPENSES</b>	<b>73,523</b>	<b>68,523</b>	<b>827,273</b>										
<b>TOTAL INDIRECT EXPENSES (10%)</b>	<b>\$7,352</b>	<b>\$6,852</b>	<b>\$82,727</b>										
<b>TOTAL EXPENSES</b>	<b>\$80,875</b>	<b>\$75,375</b>	<b>\$910,000</b>										

**No Capitalized Expenses projected**

**PERMANENT SUPPORTIVE HOUSING (100 PERSONS)**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Housing Supervisor	\$50,000	1.00	\$50,000	\$10,000	\$60,000	\$5,000
Supportive Housing Specialist	\$36,000	2.00	\$72,000	\$14,400	\$86,400	\$7,200
Supportive Housing Inspector	\$36,000	1.00	\$36,000	\$7,200	\$43,200	\$3,600
<b>PERSONNEL TOTALS</b>		<b>4.00</b>	<b>\$158,000</b>	<b>\$31,600</b>	<b>\$189,600</b>	<b>\$15,800</b>

**PERMANENT SUPPORTIVE HOUSING (100 PERSONS)**
**Subsidy Payments**

	Average	Monthly
<b>Number of recipients</b>		<b>100</b>
Average Gross Rents	\$550.00	\$55,000.00
Average Tenant Responsibility @ 30% of income	(\$125.00)	(\$12,500.00)
<b>Rent Subsidy / Vouchers (including utilities)</b>	<b>\$425.00</b>	<b>\$42,500.00</b>
<b>Rental Assistance (Move-in kits, etc.)</b>	5% <b>\$21.25</b>	<b>\$2,125.00</b>
<b>Eviction Prevention</b>	5% <b>\$21.25</b>	<b>\$2,125.00</b>
<b>Totals</b>	<b>\$467.50</b>	<b>\$46,750.00</b>
<b>Annualized</b>		<b>\$561,000.00</b>

OPERATING BUDGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>EXPENSES</b>	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>PERSONNEL</b>													
Base Salary & ERE	\$16,500	\$16,500	\$16,500	\$16,500	\$16,500	\$16,500	\$16,500	\$16,500	\$16,500	\$16,500	\$16,500	\$16,500	\$198,000
TOTAL	\$16,500	\$16,500	\$16,500	\$16,500	\$16,500	\$16,500	\$16,500	\$16,500	\$16,500	\$16,500	\$16,500	\$16,500	\$198,000
													\$0
<b>EQUIPMENT / SOFTWARE</b>													
Equipment Lease (1 copier, fax, etc.)	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
Furn & Equip Under \$5,000	\$167	\$167	\$167	\$167	\$167	\$167	\$167	\$167	\$167	\$167	\$167	\$167	\$2,000
Computers, Lap tops	\$5,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$5,000
Electronic Medical Records System (EMR) *	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
* online submission or HCFA emulators													
TOTAL	\$5,867	\$867	\$867	\$867	\$867	\$867	\$867	\$867	\$867	\$867	\$867	\$867	\$15,400
<b>TRAINING</b>													
Staff Development	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$3,600
TOTAL	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$3,600
													\$0
<b>TRAVEL</b>													
Mileage / Parking	\$1,120	\$1,120	\$1,120	\$1,120	\$1,120	\$1,120	\$1,120	\$1,120	\$1,120	\$1,120	\$1,120	\$1,120	\$13,440
TOTAL	\$1,120	\$1,120	\$1,120	\$1,120	\$1,120	\$1,120	\$1,120	\$1,120	\$1,120	\$1,120	\$1,120	\$1,120	\$13,440
													\$0
<b>OCCUPANCY</b>													
Building Occupancy (Full Service)	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$17,760
Lease allocation is \$370/month/staff													\$0
TOTAL	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$1,480	\$17,760
<b>OPERATING SERVICES</b>													
Supplies / Postage	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$1,800
Telephones - Cell	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$4,800
Copying and Printing	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$1,200
IT/Communications	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$24,000
TOTAL	\$2,650	\$2,650	\$2,650	\$2,650	\$2,650	\$2,650	\$2,650	\$2,650	\$2,650	\$2,650	\$2,650	\$2,650	\$31,800
													\$0
TOTAL DIRECT EXPENSES	27,917	22,917	22,917	22,917	22,917	22,917	22,917	22,917	22,917	22,917	22,917	22,917	280,000
TOTAL INDIRECT EXPENSES (10%)	\$2,792	\$2,292	\$2,292	\$2,292	\$2,292	\$2,292	\$2,292	\$2,292	\$2,292	\$2,292	\$2,292	\$2,292	\$28,000
TOTAL EXPENSES	\$30,708	\$25,208	\$25,208	\$25,208	\$25,208	\$25,208	\$25,208	\$25,208	\$25,208	\$25,208	\$25,208	\$25,208	\$308,000

**No Capitalized Expenses projected**

**WRAP AROUND SERVICES (100 persons)**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Clinical Supervisor	\$50,000	1.00	\$50,000	\$10,000	\$60,000	\$5,000
Behavioral Health Technician	\$42,000	2.00	\$84,000	\$16,800	\$100,800	\$8,400
Peer Specialist - Navigator	\$31,000	1.00	\$31,000	\$6,200	\$37,200	\$3,100
<b>PERSONNEL TOTALS</b>		<b>4.00</b>	<b>\$165,000</b>	<b>\$33,000</b>	<b>\$198,000</b>	<b>\$16,500</b>

OPERATING BUDGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>EXPENSES</b>	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
<b>PERSONNEL</b>													
Base Salary & ERE	\$50,100	\$50,100	\$50,100	\$50,100	\$50,100	\$50,100	\$50,100	\$50,100	\$50,100	\$50,100	\$50,100	\$50,100	\$601,200
TOTAL	\$50,100	\$50,100	\$50,100	\$50,100	\$50,100	\$50,100	\$50,100	\$50,100	\$50,100	\$50,100	\$50,100	\$50,100	\$601,200
													\$0
<b>EQUIPMENT / SOFTWARE</b>													
Equipment Lease (1 copier, fax, etc.)	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
Furn & Equip Under \$5,000	\$161	\$161	\$161	\$161	\$161	\$161	\$161	\$161	\$161	\$161	\$161	\$161	\$1,927
Computers, Lap tops	\$15,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$15,000
Electronic Medical Records System (EMR) *	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$6,000
* online submission or HCFA emulators													
TOTAL	\$16,161	\$1,161	\$1,161	\$1,161	\$1,161	\$1,161	\$1,161	\$1,161	\$1,161	\$1,161	\$1,161	\$1,161	\$28,927
<b>TRAINING</b>													
Staff Development	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$7,200
TOTAL	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$600	\$7,200
													\$0
<b>TRAVEL</b>													
Mileage / Parking	\$3,360	\$3,360	\$3,360	\$3,360	\$3,360	\$3,360	\$3,360	\$3,360	\$3,360	\$3,360	\$3,360	\$3,360	\$40,320
TOTAL	\$3,360	\$3,360	\$3,360	\$3,360	\$3,360	\$3,360	\$3,360	\$3,360	\$3,360	\$3,360	\$3,360	\$3,360	\$40,320
													\$0
<b>OCCUPANCY</b>													
Building Occupancy (Full Service)	\$4,440	\$4,440	\$4,440	\$4,440	\$4,440	\$4,440	\$4,440	\$4,440	\$4,440	\$4,440	\$4,440	\$4,440	\$53,280
Lease allocation is \$370/month/staff													\$0
TOTAL	\$4,440	\$4,440	\$4,440	\$4,440	\$4,440	\$4,440	\$4,440	\$4,440	\$4,440	\$4,440	\$4,440	\$4,440	\$53,280
<b>OPERATING SERVICES</b>													
Supplies / Postage	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$3,000
Telephones - Cell	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$14,400
Copying and Printing	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$2,400
IT/Communications	\$6,000	\$6,000	\$6,000	\$6,000	\$6,000	\$6,000	\$6,000	\$6,000	\$6,000	\$6,000	\$6,000	\$6,000	\$72,000
TOTAL	\$7,650	\$7,650	\$7,650	\$7,650	\$7,650	\$7,650	\$7,650	\$7,650	\$7,650	\$7,650	\$7,650	\$7,650	\$91,800
													\$0
TOTAL DIRECT EXPENSES	82,311	67,311	67,311	67,311	67,311	67,311	67,311	67,311	67,311	67,311	67,311	67,311	822,727
TOTAL INDIRECT EXPENSES (10%)	\$8,231	\$6,731	\$6,731	\$6,731	\$6,731	\$6,731	\$6,731	\$6,731	\$6,731	\$6,731	\$6,731	\$6,731	\$82,273
TOTAL EXPENSES	\$90,542	\$74,042	\$74,042	\$74,042	\$74,042	\$74,042	\$74,042	\$74,042	\$74,042	\$74,042	\$74,042	\$74,042	\$905,000

**No Capitalized Expenses projected**

**WRAP AROUND SERVICES (300 persons)**
**STAFFING**

Position	ANNUAL BASE SALARY	FTE	SALARY	ERE (Rate 20% x Salary)	TOTAL Salary & ERE	Monthly
Clinical Supervisor	\$50,000	1.00	\$50,000	\$10,000	\$60,000	\$5,000
Behavioral Health Technician	\$42,000	10.00	\$420,000	\$84,000	\$504,000	\$42,000
Peer Specialist - Navigator	\$31,000	1.00	\$31,000	\$6,200	\$37,200	\$3,100
<b>PERSONNEL TOTALS</b>		<b>12.00</b>	<b>\$501,000</b>	<b>\$100,200</b>	<b>\$601,200</b>	<b>\$50,100</b>