AMENDMENT NO. 2
TO
CONTRACT NO. MA-042-23010291
FOR
Mental Health and Recovery Services

This Amendment ("Amendment No. 2") to Contract No. MA-042-23010291 for Mental Health and Recovery Services is made and entered into as of the date fully executed ("Effective Date") between Mind OC ("Contractor"), with a place of business at 18650 MacArthur Blvd., Suite 350, Irvine, CA 92612, and the County of Orange, a political subdivision of the State of California ("County"), through its Health Care Agency, with a place of business at 405 W. 5th St., Ste. 600, Santa Ana, CA 92701. Contractor and County may sometimes be referred to individually as "Party" or collectively as "Parties".

RECITALS

WHEREAS, the Parties executed Contract No. MA-042-23010291 for Mental Health and Recovery Services, effective October 1, 2022 through June 30, 2025, in an amount not to exceed $63,832,280 ("Contract"); and

WHEREAS, the Parties executed Amendment No. 1 to amend Exhibit A to the Contract to update the budget table and language to the Budget paragraph; and

WHEREAS, the Parties now desire to enter into this Amendment No. 2 to increase the Period Three Amount Not to Exceed by $2,974,333, from $23,211,738 to $26,186,071, for a revised cumulative total amount to exceed $66,806,613, to amend and add various terms and conditions to the Contract, to replace Exhibit A with Exhibit A-1 of the Contract, to add Exhibit B to the Contract to separate out provider services in the Contract, and to move Exhibit B and Exhibit C of the Contract to Exhibit C and Exhibit D, respectively; and

NOW THEREFORE, Contractor and County agree to amend the Contract as follows:

1. All references to "Maximum Obligation" in the Contract are deleted and replaced with "Amount Not to Exceed".

2. Period Three Amount Not to Exceed is increased by $2,974,333, from $23,211,738 to $26,186,071, for a revised cumulative total amount not to exceed $66,806,613.

3. Referenced Contract Provisions, Maximum Obligation provision, of the Contract is deleted in its entirety and replaced with the following:

"Amount Not to Exceed:

Period One Amount Not to Exceed:	$17,408,804
Period Two Amount Not to Exceed:	$23,211,738
Period Three Amount Not to Exceed:	$26,186,071
TOTAL AMOUNT NOT TO EXCEED:	$66,806,613"

4. Referenced Contract Provisions, Notices to COUNTY and CONTRACTOR, of the Contract is deleted in its entirety and replaced with the following:

"COUNTY:	County of Orange: Health Care Agency Procurement & Contract Services 405 West 5th Street, Suite 600 Santa Ana, CA 92701–4637	CONTRACTOR:	Mind OC Phillip Franks 18650 MacArthur Blvd., Suite 350 Irvine, CA 92612 Phillip.Franks@Mind-OC.org "

4. Referenced Contract Provisions, CFDA Table, of the Contract is deleted in its entirety and replaced with the following:

"CFDA #	FAIN#	Program/ Service Title	Federal Funding Agency	Federal Award Date	Amount	R&D Award (Y/N)
93-959	VE2ZZY1ZHN19	SUBG – Substance Use Prevention, Treatment, and Recovery Services Block Grant	SAMHSA	(approval letter dated 08/11/2022) cover period 07/01/2022 to 06/30/2024	$19,306,499	N"
TBD	TBD	TBD	TBD	TBD	TBD	TBD

5. Paragraph II. Alteration of Terms, subparagraph A., of the Contract is deleted in its entirety and replaced with the following:

" A. This Contract, together with Exhibits A, B, C and D attached hereto and incorporated herein, fully expresses the complete understanding of COUNTY and CONTRACTOR with respect to the subject matter of this Contract."

6. Paragraph IV. Beneficiaries' Rights of the Contract is deleted in its entirety and replaced with the following:

"IV. BENEFICIARIES' RIGHTS

A. CONTRACTOR shall post the current Drug Medi-Cal Organized Delivery System (DMC-ODS) and Mental Health Plan (MHP) Grievance and Appeals poster in locations readily available to Members and staff and have Grievance and Appeal forms in the threshold languages and envelopes readily accessible to Members to take without having to request it on the unit.

B. In addition to those processes provided by ADMINISTRATOR, CONTRACTOR shall have an internal grievance process to address concerns that may be resolved internally within one business day approved by ADMINISTRATOR, to which the Member shall have access.

1. CONTRACTOR's grievance processes shall incorporate COUNTY's grievance and/or utilization management guidelines and procedures. The Member has the right to utilize either or both grievance process simultaneously in order to resolve their dissatisfaction.

2. Title IX Rights Advocacy. This process may be initiated by a Member who registers a statutory rights violation or a denial or abuse complaint with the County Patients' Rights Office. Patient's Rights Advocacy Services (PRAS) program. The Patients' Rights office shall investigate the complaint, and Title IX grievance procedures shall apply, which involve ADMINISTRATOR'S Director of Behavioral Health Care and the State Patients' Rights Office.

C. The parties agree that Members have recourse to initiate an expression of dissatisfaction to CONTRACTOR and file a grievance or complaint.

D. No provision of this Contract shall be construed as replacing or conflicting with the duties of County Patients' Rights Office pursuant to Welfare and Institutions Code Section 5500."

7. All references to Authority and Quality Improvement Services (AQIS) are deleted and replaced with Quality Management Services (QMS).

8. Paragraph XVII. Licenses and Laws of the Contract is deleted in its entirety and replaced with the following:

"I. LICENSES AND LAWS

A. CONTRACTOR, its officers, agents, employees, affiliates, and subcontractors shall, throughout the term of this Contract, maintain all necessary licenses, permits, approvals, certificates, accreditations, waivers, and exemptions necessary for the provision of the services hereunder and required by the laws, regulations and requirements of the United States, the State of California, COUNTY, and all other applicable governmental agencies. CONTRACTOR shall notify ADMINISTRATOR immediately and in writing of its inability to obtain or maintain,

irrespective of the pendency of any hearings or appeals, permits, licenses, approvals, certificates, accreditations, waivers and exemptions. Said inability shall be cause for termination of this Contract. In addition, all treatment providers will be certified by the State Department of Health Care Services as a Drug Medi–Cal provider and must meet any additional requirements established by COUNTY as part of this certification.

B. CONTRACTOR shall comply with all applicable governmental laws, regulations, and requirements as they exist now or may be hereafter amended or changed. These laws, regulations, and requirements shall include, but not be limited to, the following:

1. ARRA of 2009.
2. Trafficking Victims Protection Act of 2000.
3. CCC §§56 through 56.37, Confidentiality of Medical Information.
4. CCC §§1798.80 through 1798.84, Customer Records.
5. CCC §1798.85, Confidentiality of Social Security Numbers.
6. CCR, Title 9, Rehabilitative and Developmental Services, Division 4; and Title 22 Social Security.
7. HSC, Divisions 10.5 Alcohol and Drug Programs and 10.6. Drug and Alcohol Abuse Master Plans.
8. HSC, §§123110 through 123149.5, Patient Access to Health Records.
9. Code of Federal Regulations, Title 42, Public Health.
10. 2 CFR 230, Cost Principles for Nonprofit Organizations.
11. 2 CFR 376, Nonprocurement, Debarment and Suspension.
12. 41 CFR 50, Public Contracts and Property Management.
13. 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.
14. 42 CFR 54, Charitable choice regulations applicable to states receiving substance abuse prevention and treatment block grants and/or projects for assistance in transition from homelessness grants.
15. 45 CFR 93, New Restrictions on Lobbying.
16. 45 CFR 96.127, Requirements regarding Tuberculosis.
17. 45 CFR 96.132, Additional Contracts.
18. 45 CFR 96.135, Restrictions on Expenditure of Grant.
19. 45 CFR 160, General Administrative Requirements.
20. 45 CFR 162, Administrative Requirements.
21. 45 CFR 164, Security and Privacy.
22. 48 CFR 9.4, Debarment, Suspension, and Ineligibility.
23. 8 USC §1324 et seq., Immigration Reform and Control Act of 1986.

24. 31 USC §1352, Limitation on Use of Appropriated Funds to Influence Certain Federal Contracting and Financial Transactions.

25. 42 USC §§285n through 285o, National Institute on Alcohol Abuse and Alcoholism.

26. 42 USC §§290aa through 290kk-3, Substance Abuse and Mental Health Services Administration.

27. 42 USC §290dd-2, Confidentiality of Records.

28. 42 USC §1320(a), Uniform reporting systems for health services facilities and organizations.

29. 42 USC §§1320d through 1320d-9, Administrative Simplification.

30. 42 USC §12101 et seq., The Americans with Disabilities Act of 1990 as amended.

31. 42 USC §6101 et seq., Age Discrimination Act of 1975.

32. 42 USC §2000d, Civil Rights Act pf 1964.

33. 31 USC 7501 – 7507, as well as its implementing regulations under 2 CFR Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards

34. U.S. Department of Health and Human Services, National Institutes of Health (NIH), Grants Policy Statement (10/13).

35. Fact Sheet Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for Co-Occurring Disorders, Mental Health Services Oversight and Accountability Commission, 1/17/08.

36. State of California, Department of Health Care Services (DHCS), Alcohol and/or Other Drug Program Certification Standards, December 2020.

37. CCR Title 22, §§70751€, 71551(c), 73543(a), 74731(d), 75055(a), 75343(a), and 77143(a).

38. State of California, Department of Health Care Services ASRS Manual.

39. State of California, Department of Health Care Services DPFS Manual.

40. HSC §123145.

41. Title 45 CFR, §164.501; §164.524; §164.526; §164.530(c) and (j).

42. 5 USC §7321 – §7326, Political Activities (Hatch Act)

43. DMC Certification Title 22, California Code of Regulations (CCR).

44. DMC Billing Manual April 2019.

45. Federal Medicare Cost reimbursement principles and cost reporting standards.

46. Orange County Drug Medi-Cal Organized Delivery System Managed Care Plan

47. California Bridge to Health Reform DMC-ODS Waiver, Standard Terms and Conditions, August 2015, and subsequent versions.

48. Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8.

49. California Code of Regulations (CCR), Title 22, Section 51341.1; 51490.1; 51516.1 and the Drug Medi-Cal Certification Standards for Substance Abuse Clinics.

50. Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1.

51. Standards for Drug Treatment Programs (October 21, 1981).

52. Title 9, CCR, Division 4, Chapter 5, Subchapter 1, Sections 10000, et seq.

53. Title 22, CCR, Division 3, Chapter 3, sections 51000 et. seq.

54. Title 9, CCR, Section 1810.435.

55. Title 9, CCR, Section 1840.105.

56. Title 22, CCR, §51009, Confidentiality of Records.

57. California Welfare and Institutions Code, §14100.2, Medicaid Confidentiality.

58. 2 CFR 200.501 – Single Audit Act

59. Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.

60. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.

61. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.

62. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.

63. Fair Employment and Housing Act (Gov. Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (Cal. Code Regs., tit. 2, Div. 4 § 7285.0 et seq.).

64. Title 2, Division 3, Article 9.5 of the Gov. Code, commencing with Section 11135.

65. Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for state to withhold payments under this Agreement or terminate all, or any type, of funding provided hereunder.

66. Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.

67. Age Discrimination Act of 1975 (45 CFR Part 90), as amended 42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.

68. Age Discrimination in Employment Act (29 CFR Part 1625).

69. Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting

discrimination against the disabled in employment.

70. Title II of the Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.

71. Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.

72. Section 504 of the Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.

73. Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.

74. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.

75. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.

76. Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2, Subparts A – E).

77. Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (2 CCR 7285.0 et seq.).

78. Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.

79. Title 9, Division 4, Chapter 8 of the CCR, commencing with Section 13000.

80. No federal funds shall be used by CONTRACTOR or its subcontractors for sectarian worship, instruction, or proselytization. No federal funds shall be used by CONTRACTOR or its subcontractors to provide direct, immediate, or substantial support to any religious activity."

9. Paragraph XXVII. Revenue, subparagraph A., of the Contract is deleted in its entirety and replaced with the following:

" A. CLIENT FEES – CONTRACTOR shall not charge a fee to Clients to whom services are provided pursuant to this Contract, their estates and/or responsible relatives, unless a Share of Cost is determined per Medi-Cal eligibility."

10. Paragraph XXXV. – Paragraph XLV. are added to the Contract as follows:

"XXXV. YOUTH TREATMENT GUIDELINES

COUNTY must comply with DHCS guidelines in developing and implementing youth treatment programs funded under this Enclosure, until new Youth Treatment Guidelines are

stablished and adopted. Youth Treatment Guidelines are posted online at http://www.dhcs.ca.gov/provgovpart/Pages/Youth-Services.aspx

Adolescent Substance Use Disorder Best Practices Guide found here: https://www.dhcs.ca.gov/Documents/CSD_CMHCS/Adol%20Best%20Practices%20Guide/AdolBestPracGuideOCTOBER2020.pdf

XXXVI. PARTICIPATION OF COUNTY BEHAVIORAL HEALTH DIRECTOR'S ASSOCIATION OF CALIFORNIA

Participation of County Behavioral Health Director's Association of California: The County AOD Program Administrator shall participate and represent the County in meetings of the County Behavioral Health Director's Association of California for the purposes of representing the counties in their relationship with DHCS with respect to policies, standards, and administration for AOD abuse services.

The County AOD Program Administrator shall attend any special meetings called by the Director of DHCS. Participation and representation shall also be provided by the County Behavioral Health Director's Association of California.

XXXVII. NONDISCRIMINATION IN EMPLOYMENT AND SERVICES

COUNTY certifies that under the laws of the United States and the State of California, COUNTY will not unlawfully discriminate against any person.

XXXVIII. INTRAVENOUS DRUG USE (IVDU) TREATMENT

COUNTY shall ensure that individuals in need of IVDU treatment shall be encouraged to undergo AOD treatment (42 USC 300x-23 (45 CFR 96.126(e)).

XXXIX. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996:

All work performed under this Contract is subject to HIPAA, COUNTY shall perform the work in compliance with all applicable provisions of HIPAA. As identified in Exhibit E of DHCS Agreement #21-10100, DHCS and COUNTY shall cooperate to assure mutual agreement as to those transactions between them, to which this provision applies. Refer to Exhibit E of DHCS Agreement #21-10100 for additional information.

XL. DEBARMENT AND SUSPENSION

A. COUNTY shall not subcontract with or employ any party listed on the government wide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR part 1986 Comp. p. 189) and 12689 (3 CFR part 1989., p. 235), "Debarment and Suspension." SAM exclusions contain the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

B. COUNTY shall advise all subcontractors of their obligation to comply with applicable federal debarment and suspension regulations, in addition to the requirements set forth in 42 CFR Part 1001.

C. If COUNTY subcontracts or employs an excluded party, DHCS has the right to withhold payments, disallow costs, or issue a CAP, as appropriate, pursuant to HSC Code 11817.8(h).

XLI. LIMITATION ON USE OF FUNDS FOR PROMOTION OF LEGALIZATION OF CONTROLLED SUBSTANCES

None of the funds made available through this Contract may be used for any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substances Act (21 USC 812).

XLII. NONDISCRIMINATION AND INSTITUTIONAL SAFEGUARDS FOR RELIGIOUS PROVIDERS

COUNTY shall establish such processes and procedures as necessary to comply with the provisions of USC, Title 42, Section 300x-65 and CFR, Title 42, Part 54.

XLIII. NO UNLAWFUL USE OR UNLAWFUL USE MESSAGES REGARDING DRUGS

COUNTY agrees that information produced through these funds, and which pertains to drugs and alcohol-related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol-related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC, Division 10.7, Chapter 1429, Sections 11999-11999.3). By signing this Enclosure, COUNTY agrees that it will enforce, and will require its subcontractors to enforce, these requirements.

XLIX. RESTRICTION ON DISTRUBUTION OF STERILE NEEDLES

No SABG funds made available through this Contract shall be used to carry out any program

that includes the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug unless DHCS chooses to implement a demonstration syringe services program for injecting drug users.

XLV. TRAFFICKING VICTIMS PROTECTION ACT OF 2000

COUNTY and its subcontractors that provide services covered by this Contract shall comply with the Trafficking Victims Protection Act of 2000 (USC, Title 22, Chapter 78, Section 7104) as amended by section 1702 of Pub. L. 112-239."

11. Exhibit A of the Contract is deleted in its entirety and replaced with Exhibit A-1 attached hereto.

12. Exhibit B attached hereto is added to the Contract as Exhibit B.

13. Exhibit B. Business Associate Contract and Exhibit C. Personal Information Privacy and Security Contract of the Contract are renumbered Exhibit C. Business Associate Contract and Exhibit D. Personal Information Privacy and Security Contract.

This Amendment No. 2 modifies the Contract, including all previous Amendments, only as expressly set forth herein. Wherever there is a conflict in the terms or conditions between this Amendment No. 2 and the Contract, including all previous Amendments, the terms and conditions of this Amendment No. 2 prevail. In all other respects, the terms and conditions of the Contract, including all previous Amendments, not specifically changed by this Amendment No. 2 remain in full force and effect.

SIGNATURE PAGE FOLLOWS

SIGNATURE PAGE

IN WITNESS WHEREOF, the Parties have executed this Amendment No. 2. If Contractor is a corporation, Contractor shall provide two signatures as follows: 1) the first signature must be either the Chairman of the Board, the President, or any Vice President; 2) the second signature must be either the Secretary, an Assistant Secretary, the Chief Financial Officer, or any Assistant Treasurer. In the alternative, a single corporate signature is acceptable when accompanied by a corporate resolution or by-laws demonstrating the legal authority of the signature to bind the company.

Contractor: Mind OC

Phillip Franks Print Name	CEO Title
DocuSigned by: Phillip Franks 9333DD4EA1B44BE... Signature	5/1/2024 Date
Print Name	Title
Signature	Date

County of Orange, a political subdivision of the State of California

Purchasing Agent/Designee Authorized Signature:

Print Name	Title
Signature	Date

APPROVED AS TO FORM
Office of the County Counsel
Orange County, California

Brittany McLean Print Name	Deputy County Counsel Title
DocuSigned by: Brittany McLean 71CFE638662E411... Signature	5/2/2024 Date

EXHIBIT A-1

TO MASTER SERVICES AGREEMENT
FOR PROVISION OF
MENTAL HEALTH AND RECOVERY SERVICES
BETWEEN
COUNTY OF ORANGE
AND
MIND OC
OCTOBER 1, 2022 THROUGH JUNE 30, 2025

I. COMMON TERMS AND DEFINITIONS

A. The Parties agree to the following terms and definitions, and to those terms and definitions which, for convenience, are set forth elsewhere in this Contract.

1. AB109 means services for those Clients deemed eligible by Assembly Bill 109, Public Safety Realignment, under which the Client's last offense was non-violent, non-sexual, and non-serious.

2. AB109 Supervision means an offender released from prison to OCPD, or sentenced under AB109 and is doing their incarceration in jail instead of prison.

3. Access Log means data that is immediately entered into IRIS after the member/client has been screened for an appointment to access services to ensure timely access to MHP or DMC-ODS services.

4. Acute Administrative Day means those days authorized by a designated point of authorization or utilization review committee in an acute inpatient facility when, due to the lack of a payer approved and/or county approved lower level of care placement, the Client's stay at an acute inpatient facility must be continued beyond the Client's need for acute care.

5. Acute Psychiatric Inpatient Hospital Services means services provided either in an acute care hospital, a freestanding psychiatric hospital or psychiatric health facility for the care and treatment of an acute episode of mental illness meeting the medical necessity criteria covered by the Medi-Cal program. Services provided in a freestanding hospital may only be reimbursed for person's age 21 or younger and 65 or older, unless a letter of agreement (LOA) or other contract permits otherwise.

6. Adult Mental Health Inpatient (AMHI) means the County contracted hospital(s) that provide adult mental health inpatient services for unfunded clients.

7. Admission means documentation, by CONTRACTOR, for completion of entry and

evaluation services, provided to Clients seen in COUNTY and COUNTY-contracted services, into IRIS.

8. ART Team means a Health Care Agency Assessment for Residential Treatment team that conducts assessments and authorizes treatment for residential treatment services.

9. ASAM Criteria means a comprehensive set of guidelines for placement, continued stay and transfer/discharge of Clients with addiction and co-occurring conditions.

10. Authorizations means a unique individual's complete utilization management (UM) process, which includes reviewing clinical documents when clinically indicated, evaluating medical necessity and formally deciding to authorize/deny additional inpatient psychiatric services, that lasts for the duration of the inpatient stay, i.e. initial admission notification to discharge aftercare planning whichever comes first.

11. Bed Day means one (1) calendar day during which CONTRACTOR provides Residential Treatment Services within the Mental Health Plan as described in Exhibit A of the Contract. If admission and discharge occur on the same day, one (1) Bed Day will be charged.

12. Client-directed means services delivered in a therapeutic alliance between providers and Clients where both are partners in goal setting and treatment planning. The final decision for treatment options rests with the Client and designated family members.

13. Client Satisfaction Surveys means surveys to measure Clients' overall satisfaction with Mental Health Services, and with specific aspects of those services in order to identify problems and opportunities for improvement

14. Client Support System/Family means immediate family members, extended family members, significant others or other supports designated by the Client.

15. CalOMS means a statewide Client-based data collection and outcomes measurement system as required by the State to effectively manage and improve the provision of alcohol and drug treatment services at the State, COUNTY, and provider levels.

16. Case Management means the activities of managing services and coordinating care to Clients, including assessments, referrals, service planning, linkage, consultation, discharge planning and coordination. This definition applies to programs under the MHP.

17. Care Coordination means services that assist a Client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.This definition applies to programs under the DMC-ODS and MHP.

18. CAT means Crisis Assessment Team which provides twenty-four (24) hour mobile response services to anyone who has a psychiatric emergency. This program assists law enforcement, social service agencies, and families in providing crisis intervention services for individuals in behavioral health crisis in the community. CAT is a multi-disciplinary program

that conducts risk assessments, initiates involuntary hospitalizations, and provides linkage, follow ups for Clients evaluated.

19. Client means a person who has been deemed eligible, pursuant to this Contract, to receive Mental Health or Substance Use Disorder services regardless of funding source, and includes all Members.

20. Clinical Documents means any clinical information, documentation or data collected from the service provider for purposes of conducting concurrent review and coordinating treatment.

21. Closed-Loop Referral means the people, processes and technologies that are deployed to coordinate and refer Clients to available community resources (i.e., health care, behavioral health services, and/or other support services) and follow-up to verify if services were rendered.

22. Completion means the completion of a program whereby the Client has made adequate progress in treatment and no longer meets medical necessity for the Level of Care.

23. Concurrent Review means the review of treatment authorization requests for inpatient mental health services by providers in order to approve, modify, or deny requests based on medical necessity. The review of the treatment authorization requests is concurrent with the provision of services and is required after the first day of admission through discharge.

24. Contract Monitor means a person designated by COUNTY to consult with and assist both CONTRACTOR and any subcontractors in the provision of services to COUNTY Clients as specified herein. The Contract Monitor shall at no time be construed as being ADMINISTRATOR.

25. Co-Occurring means a person has at least one substance use disorder and one mental health disorder that can be diagnosed independently of each other.

26. Credentialing means a review process conducted by ADMINISTRATOR, including a peer review process, based upon specific criteria, standards and prerequisites, to approve a provider or professional who applies to be contracted to provide care in a hospital, clinic, medical group or in a health plan.

27. Client Statistical Information (CSI) means DHCS required data elements pertaining to mental health Clients.

28. Crisis Stabilization Unit (CSU) means a behavioral health crisis stabilization program that operates 24 hours a day that serves Orange County residents, aged 13 and older, who are experiencing behavioral health crises that cannot wait until regularly scheduled appointments. Crisis Stabilization services include psychiatric evaluations provided by Doctors of Medicine (MD), Nurse Practitioners (NP), Doctors of Osteopathic Medicine (DO, counseling/therapy provided by Licensed Clinical Social Workers or Marriage Family Therapists,

nursing assessments, collateral services that include consultations with family, significant others and outpatient providers, client and family education, crisis intervention services, basic medical services, medication services, and referrals and linkages to the appropriate level of continuing care and community services, including Peer Specialist and Peer Mentoring services. As a designated outpatient facility, the CSU may evaluate and treat Clients for no longer than 23 hours and 59 minutes. The primary goal of the CSU is to help stabilize the crises and begin treating Clients in order to refer them to the most appropriate, least restrictive, non-hospital setting when indicated or to facilitate admission to psychiatric inpatient units when the need for this level of care is present. Services Clients receive are formulated in a database and reported to the State.

29. CYS means the division of Behavioral Health Services responsible for the administration and oversight of Mental Health Services to children and adolescents.

30. DATAR means the DHCS system used to collect data on SUD treatment capacity and waiting lists.

31. DHCS Level of Care (LOC) means a designation that is issued by DHCS to a program based on the services provided at the facility. For the purposes of this Contract, CONTRACTOR shall provide services in accordance with one of the following DHCS-Designated Levels of Care:

a. 3.1 - Clinically Managed Low-Intensity Residential Services: 24-hour structure with available trained personnel; at least five (5) hours of clinical service/week and prepare for outpatient treatment and/or sober living.

b. 3.3 - Clinically Managed Population-Specific High-Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment with at least five (5) hours of clinical service/week for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.

c. 3.5 - Clinically Managed High-Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger, at least five (5) hours of clinical service/week, and prepare for outpatient treatment. Clients are able to tolerate and use full milieu or therapeutic community.

32. Diagnosis means the definition of the nature of the Client's disorder. When formulating the diagnosis of the Client, CONTRACTOR shall use the diagnostic codes as specified in the most current edition of the DSM published by the American Psychiatric Association. CONTRACTOR shall follow DSM procedures for all Clients.

33. DSH means Direct Service Hours and refers to a measure in minutes that a clinician spends providing Client services. DSH credit is obtained for providing mental health, case

management, medication support and a crisis intervention service to any Client open in IRIS, which includes both billable and non-billable services.

34. Engagement means the process where a trusting relationship is developed over a short period of time with the goal to link the Client(s) to appropriate services within the community. Engagement is the objective of a successful outreach.

35. EPSDT means the federally mandated Medicaid benefit that entitles full-scope Medi-Cal-covered members less than twenty-one (21) years of age to receive any Medicaid service necessary to correct or help to improve a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.

36. Family Member means any traditional or non-traditional support system, significant other or natural support designated by the Client.

37. FFS Provider means a Medi-Cal outpatient Fee-For-Service provider serving Clients in his or her own independent practice or in a group practice.

38. Head of Service means an individual ultimately responsible for overseeing the program and is required to be licensed as a mental health professional.

39. Health Care Practitioner (HCP) means a person duly licensed and regulated under Division 2 (commencing with Section 500) of the Business and Professions Code, who is acting within the scope of their license or certificate.

40. Incidental Medical Services (IMS) means optional services, approved by DHCS to be provided at a licensed adult alcoholism or drug use residential treatment facility by or under the supervision of a HCP that addresses medical issues associated with either detoxification or substance use.

41. Intake means the initial face-to-face meeting between a Client and CONTRACTOR staff in which specific information about the Client is gathered including the ability to pay and standard admission forms pursuant to this Contract.

42. IRIS means Integrated Records Information System, a collection of applications and databases that serve the needs of programs within HCA and includes functionality such as registration and scheduling, laboratory information system, invoices and reporting capabilities, compliance with regulatory requirements, electronic medical records and other relevant applications.

43. Linkage means when a Client has attended at least one appointment or made one visit to the identified program or service for which the Client has received a referral or to which they have self-referred.

44. Lanterman–Petris–Short (LPS) Act (Cal. Welf & Inst. Code, sec. 5000 et seq.) provides guidelines for handling involuntary civil commitment to a mental health institution in

the State of California.

45. Licensed Clinical Social Worker (LCSW) means a licensed individual, pursuant to the provisions of Chapter 14 of the California Business and Professions Code, who can provide clinical services to individuals they serve. The license must be current and in force, and has not been suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

46. Licensed Marriage Family Therapist (MFT) means a licensed individual, pursuant to the provisions of Chapter 13 of the California Business and Professions Code, who can provide clinical services to individuals they serve. The license must be current and in force, and has not been suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

47. Licensed Professional Clinical Counselor (LPCC) means a licensed individual, pursuant to the provisions of Chapter 13 and Chapter 16 of the California Business and Professions Code, who can provide clinical service to individuals they serve. The license must be current and in force and not suspended or revoked.

48. LPHA means any Physician, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists, Licensed Clinical Social Worker, Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapists, or Licensed Eligible Practitioners working under the supervision of Licensed Clinicians within their scope of practice.

49. Licensed Psychiatric Technician (LPT) means a licensed individual, pursuant to the provisions of Chapter 10 of the California Business and Professions Code, who can provide clinical services to individuals they serve. The license must be current and in force and not suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

50. Licensed Psychologist means a licensed individual, pursuant to the provisions of Chapter 6.6 of the California Business and Professions Code, who can provide clinical services to individuals they serve. The license must be current and in force, and has not been suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

51. Licensed Vocational Nurse (LVN) means a licensed individual, pursuant to the provisions of Chapter 6.5 of the California Business and Professions Code, who can provide clinical services to individuals they serve. The license must be current and in force, and has not been suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

52. Linkage means when a Client has attended at least one appointment or made one visit to the identified program or service for which the Client has received a referral or to which they have self-referred.

53. Live Scan means an inkless, electronic fingerprint which is transmitted directly to the Department of Justice (DOJ) for the completion of a criminal record check, typically required of employees who have direct contact with the individuals served.

54. Medi-Cal means the State of California's implementation of the federal Medicaid health care program which pays for a variety of medical services for children and adults who meet eligibility criteria.

55. Medication for Addiction Treatment (MAT) Services means the use of Federal Drug Administration-approved medications in combination with behavioral therapies to provide a whole Client approach to treating substance use disorders.

56. MEDS means the Medi-Cal Eligibility Data System information systems maintained by DHCS for all Medi-Cal recipient eligibility information and in Title 9, California Code of Regulations, Division 4 - Department of Alcohol and Drug Programs for DMC-ODS reimbursement for Substance Use Disorder (SUD) services.

57. Medical Necessity means criteria set forth by Title 9, California Code of Regulations, Chapter 11, Medi-Cal Specialty Mental Health Services for MHP reimbursement of Specialty Mental Health Services.

58. Medication Services means face-to-face or telehealth/telephone services provided by a licensed physician, licensed psychiatric nurse practitioner, or other qualified medical staff. This service shall include documentation of the clinical justification for use of the medication, dosage, side effects, compliance, and response to medication.

59. Member means the primary Orange County Medi-Cal eligible user of Mental Health Plan or Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan services.

60. MHP means COUNTY as the MHP Manager with COUNTY clinics as well as COUNTY contracted clinics, including CONTRACTOR, being providers in the Plan.

61. Mental Health Services means interventions designed to provide the maximum reduction of mental disability and restoration or maintenance of functioning consistent with the requirements for learning, development, and enhanced self-sufficiency. Services shall include:

a. Assessment/Mental Health Evaluation means services designed to provide formal, documented evaluation or analysis of the cause or nature of a Client's mental, emotional, or behavioral disorders. The Parties understand that such services shall be primarily limited to initial telephone intake examinations to triage and refer the Client to a Network Provider who shall develop the treatment/service plan. Cultural issues should be addressed where appropriate.

Additionally, this evaluation should include an appraisal of the individual's community functioning in several areas including living situation, daily activities, social support systems and health status.

b. Collateral Therapy means face-to-face or telephone contact(s) with significant others in the life of the Client necessary to meet the mental health needs of the Client.

c. Family Therapy means a clinical service that includes family members identified by the Client in the treatment process, providing education about factors important to the Client's treatment as well as holistic recovery of the family system.

d. Individual Therapy means a goal directed face-to-face therapeutic intervention with the Client which focuses on the mental health needs of the Client.

e. Group Therapy means a goal directed face-to-face therapeutic intervention with a group of no less than two (2), and for SUD no more than twelve (12), Clients receiving services at the same time. Such intervention shall be consistent with the Clients goals and focus primarily on symptom reduction as a means to improve functional impairments.

62. MMEF means Monthly MEDS Extract file. This file contains data of current month and previous fifteen (15) months which provides eligibility data for all Orange County residents.

63. National Provider Identifier (NPI) means the standard unique health identifier that was adopted by the Secretary of HHS Services under HIPAA for health care providers. All HIPAA covered healthcare providers, individuals, and organizations must obtain an NPI for use to identify themselves in HIPAA standard transactions. The NPI is assigned for life.

64. Network Provider means mental health service providers credentialed and under contract with CONTRACTOR. Such providers may be individual practitioners, provider groups, or clinics.

65. Notice of Privacy Practices (NPP) means a document that notifies individuals of uses and disclosures of PHI that may be made by or on behalf of the health plan or health care provided as set forth in HIPAA.

66. Notice of Adverse Benefit Determination (NOABD), as outlined in California Code of Regulations Title 9 Chapter 11 Section 1850.210 and Title 22, Section 50179 means to provide formal written notification via hand-delivery or mail to Medi-Cal Clients and faxed or mailed to the ADMINISTRATOR when services are denied, modified, reduced, delayed, suspended or terminated as specified by State standards.

67. Outreach means reaching out to potential Clients to help link them to appropriate Mental Health Services within the community. Outreach activities will include educating the community about the services offered and requirements for participation in the various mental health programs within the community. Such activities should result in CONTRACTOR

developing its own Referral sources for programs being offered within the community.

68. Peer Recovery Specialist/Counselor means an individual in a paid position who has been through the same or similar Recovery process as those being assisted to attain their Recovery goals in the programs. A peer Recovery Specialist practice is informed by personal experience.

69. Program Director means an individual who is responsible for all aspects of administration and clinical operations of the behavioral health program, including development and adherence to the annual budget. This individual will also be responsible for the following hiring, development and performance management of professional and support staff, and ensuring mental health treatment services are provided in concert with COUNTY and state rules and regulations.

70. Protected Health Information (PHI) means individually identifiable health information usually transmitted through electronic media. PHI can be maintained in any medium as defined in the regulations, or for an entity such as a health plan, transmitted or maintained in any other medium. It is created or received by a covered entity and is related to the past, present, or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present, or future payment for health care provided to an individual.

71. Psychiatrist means an individual who meets the minimum professional and licensure requirements set forth in Title 9, CCR, Section 623, and, preferably, has at least one (1) year of experience treating children and TAY.

72. Out-of-County means any California county other than COUNTY or border community.

73. Patients' Rights Advocacy means group responsible for providing outreach and educational materials to inform Clients about their rights and remedies in receiving mental health treatment; representing Clients' interests in fair hearings, grievances and other legal proceedings related to the provision of services; and monitoring mental health programs for compliance with patients' rights legal standards as the designee of the Local Mental Health Director.

74. Perinatal means the condition of being pregnant or postpartum. This condition must be documented to apply billing descriptor for perinatal attached to services.

75. Perinatal Residential Treatment Services means AOD treatment services that are provided to a woman, eighteen (18) years and older, who is pregnant and/or has custody of dependent children up to twelve (12) years of age, in her care; who has a primary problem of substance use disorder; and who demonstrates a need for perinatal substance use disorder residential treatment services. Services are provided in a twenty-four (24) hour residential program. These services are provided in a non-medical, residential setting that has been licensed and certified by DHCS to provide perinatal services. These treatment services are provided to

both perinatal and parenting women in accordance with the Perinatal Network Service Guidelines.

76. Postpartum means the twelve-month period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility shall end on the last day of the calendar month in which the twelfth month occurs.

77. Primary Source Verification means procedures for the review and direct verification of credentialing information submitted by care providers, including, but not limited to, confirmation of references, appointments, and licensure.

78. Quality Improvement (QI) means the use of interdisciplinary teams to review performance measures to identify opportunities for improvement. The teams use participatory processes to analyze and confirm causes for poor performance, design interventions to address causes, implement interventions, and measure improvement. Successful improvements are then implemented wherever appropriate. Where interventions are unsuccessful, the team again addresses the causes and designs new interventions until improvements are achieved.

79. Recovery Services means a level of care designed to support recovery and prevent relapse. It is not considered treatment. Services focus on restoring the Client to their best possible functional level and emphasize the Client's role in managing their health by using effective self-management support strategies.

80. Referral means the process of sending a Client from one service provider to another service provider for health care, behavioral health services, and/or other support services, by electronic transmission, in writing or verbally, regardless of linkage status.

81. Residential Treatment Authorization means the approval that is provided by the HCA ART team for a Client to receive residential services to ensure that the Client meets the requirements for the service.

82. Resource Recommendation means the process of providing a Client with one or more suggested resources, without plans and/or an ability to follow up on Linkage status.

83. Retrospective Review means determination of the appropriateness or necessity of services after they have been delivered, generally through the review of the medical or treatment record.

84. Token means the security device which allows an individual user to access IRIS.

85. RTS means alcohol and other drug treatment services that are provided to Clients at a twenty-four (24) hour residential program. Services are provided in an alcohol and drug free environment and support recovery from alcohol and/or other drug related problems. These services are provided in a non-medical, residential setting that has been licensed and certified by DHCS.

86. Registered Nurse (RN) means a licensed individual, pursuant to the provisions of

Chapter 6 of the California Business and Professions Code, who can provide clinical services to the Clients served. The license must be current and in force, and has not been suspended or revoked.

87. Seriously Emotionally Disturbed (SED) means children or adolescent minors under the age of eighteen (18) years who have a behavioral health disorder, as identified in the most recent edition of the DSM and/or the ICD 10, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. W&I 5 5600.3.

88. Self-Help Groups means a non-professional, peer participatory meeting formed by people with a common problem or situation offering mutual support to each other towards a goal or healing or recovery.

89. Self-Referral means when a Client or family member directly contacts a service provider with the goal of receiving services for themselves or a family member, regardless of Linkage status.

90. Service Authorization means the determination of appropriateness of services prior to the services being rendered, based upon medical or service necessity criteria. This includes the authorization of outpatient services authorized by CONTRACTOR.

91. Share of Cost means a monthly amount that the Client is to pay to receive Medi-Cal services.

92. SSA means COUNTY department responsible for child welfare services and Medi-Cal eligibility determination.

93. Structured Therapeutic Activities means organized program activities that are designed to meet treatment goals and objectives for increased social responsibility, self-motivation, and integration into the larger community. Such activities would include participation in the social structure of the residential program. It also includes the Client's progression, with increasing levels of responsibility and independence through job and other assignments culminating in employment seeking and employment-initiation activities in the community.

94. SUD means a condition in which the use of one or more substances leads to a clinically significant impairment or distress per the DSM-5.

95. Supervisory Review means ongoing clinical case reviews in accordance with procedures developed by ADMINISTRATOR, to determine the appropriateness of Diagnosis and treatment and to monitor compliance to the minimum ADMINISTRATOR and Medi-Cal charting standards. Supervisory review is conducted by the program/clinic director or designee.

96. Token means the security device which allows an individual user to access IRIS.

97. Uniform Method of Determining Ability to Pay (UMDAP) means the method used

for determining an individual's annual liability for Mental Health Services received from the COUNTY mental health system and is set by the State of California. Every Client seen in any COUNTY or COUNTY-contracted program needs an UMDAP regardless of contract payment structure, whether the contract is actual cost based or fee for service.

98. Unit of Service (UOS) means the measurement used to quantify services provided to a client/member; these units can vary depending on type of service in the MHP or DMC_ODS plans.

99. Wellness Action & Recovery Plan (WRAP) refers to a self-help technique for monitoring and responding to symptoms to achieve the highest possible levels of wellness, stability, and quality of life.

100. Utilization Management Program means the infrastructure required to carry out the concurrent review services according to this Contract including, but not limited to, policies and procedures, request staffing and information systems.

101. Warm Hand-off means the process to allow for in-person (or Telehealth/telephonic, if clinically appropriate) for care coordination and behavioral health linkages. For transitions of care, the warm handoff is the first step in establishing a trusted relationship between the Client and the new care provider to ensure seamless service delivery and coordination.

B. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Common Terms and Definitions Paragraph of this Exhibit A-1 to the Contract.

II. BUDGET

A. COUNTY shall pay CONTRACTOR in accordance with the Payments Paragraph of this Exhibit A-1 to the Contract and the following budget, which is set forth for informational purposes only and may be adjusted by mutual agreement, in writing, by ADMINISTRATOR and CONTRACTOR.

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	PERIOD ONE	PERIOD TWO	PERIOD THREE	TOTAL
ADMINISTRATIVE COSTS	$ 1,350,000	$ 1,800,000	$ 1,800,000	$ 4,950,000
PROGRAM COSTS				
Salaries	$ 1,279,495	$ 1,705,993	$ 1,857,714	$ 4,843,202
Benefits	548,355	731,140	464,429	1,743,924
Services and Supplies	14,230,954	18,974,605	1,718,774	34,924,333

Sobering Center Services	0	0	1,100,000	1,100,000
DMC Residential 3.1, 3.5	0	0	3,300,000	3,300,000
Adult Withdrawal Management	0	0	1,500,000	1,500,000
Facility Reserves	0	0	1,457,868	1,457,868
SUBTOTAL PROGRAM COSTS	$ 16,058,804	$ 21,411,738	$ 11,398,785	$ 48,869,327
TOTAL AMOUNT NOT TO EXCEED	$ 17,408,804	$ 23,211,738	$ 13,198,785	$ 53,819,327

B. CONTRACTOR and ADMINISTRATOR mutually agree that the Amount Not to Exceed identified in Subparagraph II.A. of this Exhibit A-1 to the Contract includes Indirect Costs not to exceed ten percent (10%) of Direct Costs, and which may include operating income estimated at two percent (2%). Final settlement paid to CONTRACTOR shall include Indirect Costs and such Indirect Costs may include operating income.

C. BUDGET/STAFFING MODIFICATIONS – CONTRACTOR may request to shift funds between programs, or between budgeted line items within a program, for the purpose of meeting specific program needs or for providing continuity of care to its Clients, by utilizing a Budget/Staffing Modification Request form provided by ADMINISTRATOR. CONTRACTOR shall submit a properly completed Budget/Staffing Modification Request to ADMINISTRATOR for consideration, in advance, which will include a justification narrative specifying the purpose of the request, the amount of said funds to be shifted, and the sustaining annual impact of the shift as may be applicable to the current contract period and/or future contract periods. CONTRACTOR shall obtain written approval of any Budget/Staffing Modification Request(s) from ADMINISTRATOR prior to implementation by CONTRACTOR. Failure of CONTRACTOR to obtain written approval from ADMINISTRATOR for any proposed Budget/Staffing Modification Request(s) may result in disallowance of those costs.

D. FINANCIAL RECORDS – CONTRACTOR shall prepare and maintain accurate and complete financial records of its cost and operating expenses. Such records will reflect the actual cost of the type of service for which payment is claimed. Any apportionment of or distribution of costs, including indirect costs, to or between programs or cost centers of CONTRACTOR shall be documented, and will be made in accordance with GAAP, and Medicare regulations. The Client eligibility determination and fee charged to and collected from Clients, together with a record of all billings rendered and revenues received from any source, on behalf of Clients treated

pursuant to the Contract, must be reflected in CONTRACTOR's financial records.

E. For all funds allocated to the Facility Reserves budgeted line items in Paragraph II.A, CONTRACTOR must obtain prior review and written approval by the County Chief Executive ("CEO") or Chief Financial Officer ("CFO"), or their designee, of any proposed use of such funds. CONTRACTOR's failure to obtain such prior review and written approval for use of funds allocated to the Facility Reserves budgeted line items may result in disallowance of the costs for such use.

F. With the exception of the review and approval requirement stated in Paragraph II.E. of this Exhibit A-1, CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Budget Paragraph of this Exhibit A-1 to the Contract. Any modification to Paragraph II.E. must be approved by the CEO or CFO, or their designee.

III. PAYMENTS

A. BASIS FOR REIMBURSEMENT –

1.Master Service Agreement: COUNTY shall pay CONTRACTOR monthly, in arrears, the provisional amount of $1,934,311 for Periods One and Two and $1,099,898 for Period Three. All payments are interim payments only and are subject to Final Settlement in accordance with the Cost Report Paragraph of the Contract for which CONTRACTOR shall be reimbursed for the actual cost of providing the services, which may include Indirect Administrative Costs, as identified in Paragraph II.A. of this Exhibit A-1 to the Contract; provided, however, the total of such payments does not exceed COUNTY's Amount Not to Exceed as specified in the Referenced Contract Provisions of the Contract and, provided further, CONTRACTOR's costs are reimbursable pursuant to COUNTY, State and/or Federal regulations. ADMINISTRATOR may, at its discretion, pay supplemental invoices or make advance payments for any month during the term.

a. Payments of claims to providers shall be at rates set by CONTRACTOR, with mutual agreement by ADMINISTRATOR, for all services.

b. In support of the monthly invoices, CONTRACTOR shall submit an Expenditure and Revenue Report as specified in the Reports Paragraph of this Exhibit A-1 to the Contract. ADMINISTRATOR shall use the Expenditure and Revenue Report to determine payment to CONTRACTOR as specified in Subparagraphs A.2. and A.3., below.

c. If, at any time, CONTRACTOR's Expenditure and Revenue Reports indicate that the provisional amount payments exceed the actual cost of providing services, ADMINISTRATOR may reduce COUNTY payments to CONTRACTOR by an amount not to exceed the difference between the year-to-date provisional amount payments to CONTRACTOR

and the year-to-date actual cost incurred by CONTRACTOR.

d. If, at any time, CONTRACTOR's Expenditure and Revenue Reports indicate that the provisional amount payments are less than the actual cost of providing services, ADMINISTRATOR may authorize an increase in the provisional amount payment to CONTRACTOR by an amount not to exceed the difference between the year-to-date provisional amount payments to CONTRACTOR and the year-to-date actual cost incurred by CONTRACTOR.

B. CONTRACTOR's invoices shall be on a form approved or supplied by COUNTY and provide such information as is required by ADMINISTRATOR. Invoices are due the twentieth (20th) calendar day of each month. Invoices received after the due date may not be paid within the same month. Payments to CONTRACTOR should be released by COUNTY no later than thirty (30) calendar days after receipt of the correctly completed invoice form.

C. All invoices to COUNTY shall be supported, at CONTRACTOR's facility, by source documentation including, but not limited to, ledgers, journals, time sheets, invoices, bank statements, canceled checks, receipts, receiving records and records of services provided.

D. ADMINISTRATOR may withhold or delay any payment if CONTRACTOR fails to comply with any provision of the Contract.

E. COUNTY shall not reimburse CONTRACTOR for services provided beyond the expiration and/or termination of the Contract, except as may otherwise be provided under the Contract, or specifically agreed upon in a subsequent contract.

F. In conjunction with Paragraph II.A above, CONTRACTOR shall not enter Units of Service into COUNTY's IRIS system for services not rendered. If such information has been entered, CONTRACTOR shall make corrections within ten (10) calendar days from notification by ADMINISTRATOR. Additionally, to assist in the protection of data integrity, CONTRACTOR shall create a procedure to ensure separation of duties between the individual performing direct services (LPHA, clinicians, counselors, etc.), and the clerical staff who enter claims into the IRIS system. Clerical staff shall enter billing into IRIS using the chart information provided by the direct service staff.

G. CONTRACTOR shall ensure compliance with all Medi-Cal and DMC billing and documentation requirements when entering Units of Service into COUNTY's IRIS system. ADMINISTRATOR shall withhold payment for non-compliant Units of Service, and may reduce, withhold or delay any payment associated with non-compliant billing practices.

H. CONTRACTOR may be required to have an audit conducted in accordance with federal OMB Circular A-133. CONTRACTOR shall be responsible for complying with any federal audit requirements within the reporting period specified by OMB Circular A-133.

I. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Payments Paragraph of this Exhibit A-1 to the Contract.

IV. REPORTS

A. CONTRACTOR shall maintain records, create and analyze statistical reports as required by ADMINISTRATOR and DHCS in a format approved by ADMINISTRATOR. CONTRACTOR shall provide ADMINISTRATOR with the following:

1. FISCAL

a. In support of the monthly invoice, CONTRACTOR shall submit monthly Expenditure and Revenue Reports to ADMINISTRATOR. These reports shall be on a form acceptable to, or provided by ADMINISTRATOR and shall report actual costs and revenues for each of CONTRACTOR's program(s) or cost center(s) described in the Services Paragraph of Exhibit A-1 to the Contract. CONTRACTOR shall submit these reports by no later than twenty (20) calendar days following the end of the month reported.

1). CONTRACTOR shall include third party payor information to be included in the Fiscal Expenditure and Revenue Report.

b. CONTRACTOR shall provide a check register and remittance summary by provider, as well as a turnaround summary, for services provided by Network Providers, to ADMINISTRATOR upon request.

c. CONTRACTOR shall track and provide Incurred but not Reported (IBNR) information on a monthly basis. Monthly IBNR shall be calculated and compared with the record of uncashed checks and stop-payment checks, as well as to the undeliverable check report and the donated checks report. CONTRACTOR shall prepare and submit to ADMINISTRATOR a monthly report showing total IBNR liability and revenue received based upon the provisional payments received from COUNTY.

d. CONTRACTOR shall submit Year-End Projection Reports to ADMINISTRATOR. These reports shall be on a form acceptable to, or provided by, ADMINISTRATOR and shall report anticipated year-end actual costs and revenues for CONTRACTOR's program(s) or cost center(s) described in the Services Paragraph of Exhibit A-1 to the Contract. Such reports shall include actual monthly costs and revenue to date and anticipated monthly costs and revenue to the end of the fiscal year. Year-End Projection Reports shall be submitted at the same time as the monthly Expenditure and Revenue Reports.

2. STAFFING REPORT – CONTRACTOR shall submit monthly Staffing Reports to ADMINISTRATOR. CONTRACTOR's reports shall contain required information, and be on a form acceptable to, or provided by ADMINISTRATOR. CONTRACTOR shall submit these

reports no later than twenty (20) calendar days following the end of the month being reported.

3. PROGRAMMATIC REPORTS – CONTRACTOR shall submit monthly Programmatic reports for sub-contractors and CONTRACTOR's direct services to ADMINISTRATOR. These reports shall be in a format approved by ADMINISTRATOR and shall include but not limited to, descriptions of any performance objectives, outcomes, and or interim findings as directed by ADMINISTRATOR. CONTRACTOR shall be prepared to present and discuss the programmatic reports at the monthly and quarterly meetings with ADMINISTRATOR, to include an analysis of data and findings, and whether or not CONTRACTOR is progressing satisfactorily and if not, specify what steps are being taken to achieve satisfactory progress.

a. CONTRACTOR is required to comply with all applicable reporting requirements, including the requirements set forth in Division 5 of the California Welfare Institutions Code and Division 1, Title 9 of the California Code of Regulations, as well as any reports required of LPS designated facilities in the County of Orange.

b. CONTRACTOR shall enter demographic information of all Clients served, direct services information, and other appropriate data into the COUNTY's data information system (IRIS), including the utilization of the Behavioral Health Services (BHS) Access Logs and Notice of Adverse Beneficiary Decision (NOABD) reporting as required for all programs.

B. CONTRACTOR shall provide records and program reports, as listed below, which shall be received by ADMINISTRATOR no later than twenty (20) calendar days following the end of the month being reported or as requested by ADMINISTRATOR. CONTRACTOR shall make additional reports, as required by ADMINISTRATOR, concerning CONTRACTOR's activities as they affect the services hereunder. ADMINISTRATOR will be specific as to the nature of information requested and the time frame the information is needed.

1. Mental Health Plan (MHP) Programs
    a. MONTHLY
        i. Provider Directories
        ii. Monthly Program Reporting spreadsheets
        iii. Transportation Log
        iv. Utilization Review
    b. QUARTERLY
        i. Change of Provider
        ii. Second Opinion Log
    c. ANNUALLY
        i. Medication Monitoring

ii. Sanction Screening tracker

2. Substance Use Disorder (SUD) Programs
   a. MONTHLY
      i. Provider Directories
      ii. Monthly Data & Performance Outcome Report (MDPOR)
      iii. Units of Service (UOS) IRIS
      iv. Transportation Log
      v. Utilization Review
   b. QUARTERLY
      i. Change of Provider Log
      ii. Second Opinion Log
   c. ANNUALLY
      i. Medication Monitoring
      ii. Sanction Screening tracker

3. ACCESS LOG – CONTRACTOR shall develop and maintain anAccess Log of all requests for services received via telephone, in writing, or in person. CONTRACTOR is responsible for this log that meets the DHCS regulations and requirements, as interpreted by COUNTY, and records all services requested twenty-four (24) hours-seven (7) days a week. The Access Log shall contain, at a minimum, whether or not the caller has Medi-Cal, the name of the individual, date of the request, nature of the request, call status (emergent, urgent, routine), if the request is an initial request for Specialty Mental Health Services or DMC-ODS, and the disposition of the request, which shall include interventions. CONTRACTOR must be able to produce a sortable log, for any time-period specified by COUNTY within twenty-four (24) hours of receiving the request from COUNTY. If the caller's name is not provided, then the log shall reflect that the caller did not provide a name. Access Logs shall be entered into IRIS within timelines stated above. CONTRACTOR shall make available to ADMINISTRATOR upon request, the most recent telephone log which shall include previous day's calls.

4. DATA COLLECTION AND REPORTING –

   a. ADMINISTRATOR shall provide CONTRACTOR with the exact specifications required to enter data into IRIS or other COUNTY approved CONTRACTOR reporting system, as deemed appropriate. The Parties understand that such requirements may be modified periodically by the State and those modifications shall automatically become requirements of this Contract.

   b. CONTRACTOR shall ensure the timely data entry of information into COUNTY approved CONTRACTOR reporting system.

c. CONTRACTOR shall use data collection and visualization systems identified by COUNTY including, but not limited to, the IRIS Electronic Health Record system and other electronic platforms for digitized program workflows

d. CONTRACTOR shall conduct up-front and retrospective auditing of data to ensure the accuracy, completeness, and timeliness of the information input into CONTRACTOR's reporting system. CONTRACTOR shall build in audit trails and reconciliation reports to ensure accuracy and comprehensiveness of the input data. In addition, transaction audit trails shall be thoroughly monitored for accuracy and conformance to operating procedures.

e. CONTRACTOR shall input all required data regarding services provided to Clients who are deemed, by the appropriate state or federal authorities, to be COUNTY's responsibility.

f. CONTRACTOR shall correct all input data resulting in CSI and 837 Medi-Cal claim denials and rejections. These errors will be communicated to CONTRACTOR immediately upon discovery and must be corrected in a timely manner. CONTRACTOR remains responsible for ongoing monitoring of billing queues to identify and correct billing errors within one week of posting.

g. CONTRACTOR shall ensure the confidentiality of all administrative and clinical data. This shall include both the electronic system as well as printed public reports. No identifying information or data on the system shall be exchanged with any external entity or other business, or among providers without prior written approval of the Client or ADMINISTRATOR. Confidentiality procedures shall meet all local, state, and federal requirements.

h. CONTRACTOR shall ensure that information is safeguarded in the event of a disaster and that appropriate service authorization and data collection continues.

C. CONTRACTOR shall be responsible to inform ADMINISTRATOR of any problems in collecting data, pertinent facts or interim findings, staff changes, status of license(s) and/or certification(s), changes in population served, and reasons for any changes. Additionally, a statement that CONTRACTOR is or is not progressing satisfactorily in achieving all the terms of the Contract shall be included.

D. CONTRACTOR shall respond to any requests that are needed with an immediate response time due to any requests from entities that could include but not be limited to DHCS, internal and/or external audits.

E. CONTRACTOR shall provide ADMINISTRATOR with a report key, established by CONTRACTOR, and as agreed upon by ADMINISTRATOR, that describes each report, its purpose and usefulness. CONTRACTOR shall update the report key when reports are added or deleted and provide updated report key to ADMINISTRATOR within thirty (30) calendar days.

F. CONTRACTOR shall upon ADMINISTRATOR's request revise and make changes to all reports as needed.

G. ADMINISTRATOR and CONTRACTOR may mutually agree, in writing, to modify the frequency of the reports. Each report shall include an unduplicated client count and a fiscal year-to-date summary and, unless otherwise specified, shall be reported in aggregate.

H. CONTRACTOR shall advise ADMINISTRATOR of any special incidents, conditions, or issue that materially or adversely affect the quality or accessibility of services provided by CONTRACTOR.

I. CONTRACTOR shall document all adverse incidents affecting the physical and/or emotional welfare of the Clients seen, including, but not limited to, serious physical harm to self or others, serious destruction of property, developments, etc., and which may raise liability issues with COUNTY. CONTRACTOR shall notify COUNTY within twenty-four (24) hours of any such serious adverse incident in the form of a Special Incident Report (SIR).

J. ADDITIONAL REPORTS – Upon ADMINISTRATOR's request, CONTRACTOR shall make such additional reports as required by ADMINISTRATOR concerning CONTRACTOR's activities as they affect the services hereunder. ADMINISTRATOR shall be specific as to the nature of information requested and allow thirty (30) calendar days for CONTRACTOR to respond.

K. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Reports Paragraph of this Exhibit A-1 to the Contract.

V. SERVICES

A. FACILITY OPERATIONS AND ASSET MANAGEMENT – Services shall be provided at the following locations, or at any other location approved in advance, in writing, by ADMINISTRATOR:

265 South Anita Drive
Orange, CA 92868

1. CONTRACTOR shall manage a diverse scope of facilities-related services, in four key areas:
    a. Facilities Management
    b. Property Accounting
    c. Capital Project Management
    d. Lease Management

2. CONTRACTOR shall ensure high-value, efficient and accountable oversight of facilities operations and asset management.

3. CONTRACTOR shall provide ongoing facility operations and asset management activities which include, but are not limited to:

4. FACILITIES MANAGEMENT

a. Manage and oversee the overall safety of the facility, including day-to-day maintenance and cleaning of the property, including all buildings, parking lots and landscaping;

b. Contract management for all property utilities, property insurance policies, building related services and maintenance, and supply procurement;

c. Ongoing property assessments to inform preventative maintenance needs, forecast capital repair and replacement schedules, and ensure adequate capital reserves are maintained; and

d. Key point of contact for all building-related requests and concerns.

5. PROPERTY ACCOUNTING

a. Financial management of all operating expenses and property taxes in a timely manner;

b. Prepare and provide monthly property financial reports and annual financial statements inclusive of balance sheet, income statement cash flow statement, variance report, rent roll, and detailed property activity summary;

c. Prepare and manage an annual operating budget for the property inclusive of a capital budget, detailed leasing and expense projections, and cash flow projections;

6. CAPITAL PROJECT MANAGEMENT

a. Solicit proposals from, engage, and manage architects, engineers and other design consultants as necessary for completion of the work;

b. Manage the process of securing all permits and other governmental approvals; and

c. Manage a competitive construction contractor bidding process and oversee construction and installation process to ensure all work is completed in a timely manner.

7. LEASE MANAGEMENT

a. Manage and enforce all tenant leases and rental agreements, and lead negotiations of lease renewals and extensions as they arise; and

b. Financial management of all rents and other receivables.

B. PROVIDER CONTRACTING

1. CONTRACTOR shall monitor and ensure operations at the Be Well Orange Campus meet the requirements of CMS, DHCS and BHS.

2. CONTRACTOR shall contract with providers for authorized substance use disorder treatment services as outlined in Exhibit A-1 Paragraphs VI. through IX. The contractor providers will meet state and federal requirements for Specialty Medi-Cal services inclusive of substance use disorder treatment.

a. The contractor providers must perform all activities and obligations, including services provided and related reporting responsibilities; and

b. The contractor providers must perform delegated activities and responsibilities in compliance with BHS' obligations to DHCS. The contractor providers must meet established requirements with reimbursement negotiated on state rates and costs only. CONTRACTOR must monitor and ensure that claims are entered accurately and in a timely manner.

2. PROVIDER CONTRACTING AND OVERSIGHT

a. As a partially delegated entity, CONTRACTOR will act on behalf of BHS in ensuring the following activities and responsibilities for authorized substance use disorder treatment services as outlined in Exhibit A-1 Paragraphs VI. through IX.:

1) Quality Management, including but not limited to;
   a) Provide Training on Documentation Requirements
   b) Documentation Review Tool for State Submission
   c) Quality Improvement comments related to documentation
   d) Corrective Action Plans
   e) Ensuring Fraud, Waste and Abuse is reported timely to HCA Compliance Department
   f) Ensure Compliance Investigation Follow-up within timeframes
   g) Inform Providers of new practice guidelines
   h) Ensure there is an appropriately qualified, licensed staff member to conduct documentation reviews at each program.
2) Program Integrity, including but not limited to;
   a) Site Reviews and completion of Monitoring Tool for SUD programs
   b) Maintain LPS designation of Staff and Site
   c) Ensure proper credentialing of staff with HCA
   d) Ensure Policies and Procedures are developed to address regulatory requirements
   e) Ensure provider job descriptions meet the minimum requirements for staff scope of practice
   f) Ensure PAVE enrollment of Providers
   g) Ensure Proper Clinical Supervision of Staff

h) Attend Monthly Quality Improvement meetings for both DMC and MH programs

3) Cultural Competency, including but not limited to;
   a) Mandatory Training is completed as assigned by ADMINISTRATOR
4) Training, including but not limited to;
   a) ASAM Training
   b) Motivational Interviewing Training
   c) Other required Evidence Based Practices
   d) Annual Compliance Training
   e) Annual Provider Training
   f) Documentation Training, as applicable (SUD/MHP)
   g) CEU/CME in addiction, as needed
5) Claiming, including but not limited to;
   a) Ensure Billing Training is completed
   b) Services entered correctly into the County IRIS system
   c) Ensure Client information entered correctly into the County IRIS system
6) Reports, including but not limited to;
   a) Participation in the OC Navigator
   b) NACT submissions
   c) Report of Billable Services
   d) Cost Reporting
   e) Access Log Reports
   f) NOABD Reports
   g) Grievance and Appeals Investigations
   h) Response to External Quality Review Organization Report; and
7) Data collection, including but not limited to:
   a) CalOMS
   b) DATAR
   c) Medication Monitoring Reports

b. All references to CONTRACTOR in Paragraph VI. Through IX. Of this Exhibit A-1 shall be references to contractor providers. CONTRACTOR must include the services and requirements set forth in Paragraph VI. Through IX. In the contracts with the provider.

3. REGULATORY COMPLIANCE, INSURANCE, AND INDEMNIFICATION

a. Compliance Program – CONTRACTOR will ensure providers have required policies and procedures and will reinforce federal and state requirements established in the

Contract, such as cultural competency trainings.

b. Sanction Screening – CONTRACTOR will ensure all applicable Covered Individuals are initially and routinely screened in accordance with requirements for MHPs and SUD contracts per DHCS and Contract requirements.

c. Insurance – CONTRACTOR will maintain insurance in compliance with the contractual requirements and will ensure that subcontractors' insurance is also in compliance. CONTRACTOR anticipates being able to support subcontractors in negotiating competitive rates for appropriate coverage.

d. Medi-Cal billing, Coding and Documentation Compliance Standards – CONTRACTOR will ensure that CONTRACTOR and subcontractor coding of health care claims, billings and/or invoices for same are prepared and submitted, are timely and accurate, and in compliance with the Contract requirements.

e. Indemnification – CONTRACTOR will provide indemnification pursuant to contractual requirements.

C. ACCESS AND PROGRAM MANAGEMENT

1. CONTRACTOR will ensure that an optimized mix of Clients with public and commercial coverage can access and enroll in services at the Orange Campus. Moreover, CONTRACTOR will ensure that CONTRACTOR and subcontractors receive referrals and that such referrals are accepted in accordance with the Contract(s), with appropriate contract monitoring based on the BHS provided monitoring tools(s).

2. PAYOR MIX OPTIMIZATION AND MANAGEMENT – CONTRACTOR will procure and support subcontractors in securing contracts with an array of commercial insurance plans, as well as manage and optimize the diverse public/commercial payer mix to achieve the original goals of Be Well and ensure whole community access while maintaining a commitment to serving the most vulnerable. Based on current projections, the initial target is a 26% commercial, 74% public ratio, which will be adjusted, as needed.

3. CARE COORDINATION AND TRANSITIONS MANGEMENT – CONTRACTOR will provide high level operational oversight to ensure contractual compliance and good business flow in a standardized, organized manner via reporting, meetings, and audits.

4. CLINICAL AND PROGRAM OPERATIONS – CONTRACTOR will attend required trainings and ensure that Be Well Campus and provider policies and practices meet contractual requirements for QI, authorization, clinical, billing, and administrative requirements. CONTRACTOR will ensure that subcontractors participate in required provider trainings offered by COUNTY and ensure subcontractors maintain client records in compliance with contractual requirements.

D. ESTIMATED COUNTY COST OFFSETS

1. CONTRACTOR will work closely with the providers to ensure third party revenues are maximized for both CONTRACTOR and sub-contractors. CONTRACTOR shall secure a Third-Party Administrator (TPA) license that will allow them to work to support commercial billing and collections.

2. CONTRACTOR will recover the value of the service when the service is rendered to a Client whenever the Client is covered for the same services, either fully or partially, under any other state or federal medical program or under other contractual or legal entitlement including but not limited to, a private group or indemnification program, but excluding instances of tort liability of a third party or casualty liability. The monies recovered are retained by CONTRACTOR. CONTRACTOR and COUNTY will establish a settlement process to ensure that COUNTY payments to CONTRACTOR are adjusted in a timely manner to reflect other monies recovered, pursuant to the above standards from other sources.

3. CONTRACTOR'S estimated offsets of per period Gross Costs are nine percent (9%) for Period One, fourteen percent (14%) for Period Two, and twenty two percent (22%) for Period Three.

E. PERFORMANCE OBJECTIVES AND OUTCOMES – CONTRACTOR will provide a comprehensive approach for performance and for monitoring and achieving outcome measures required by COUNTY, sought after by community stakeholders, and needed by the people being served. These requirements will be specified in subcontracts, with regular monitoring and oversight per contractual requirements, with outcome measures documented and communicated monthly in dashboards and other required reports.

1. CONTRACTOR staff will comply with COUNTY criteria for Federal law under HIPAA and 42CFR Part 2 and undergo COUNTY required training. CONTRACTOR will maintain an ongoing performance outcomes monitoring program using provider information, COUNTY required client satisfaction surveys, and documentation completed by providers, including utilization patterns, COUNTY required assessment and screening tools, peer review, and medical record audits. CONTRACTOR will identify specific outcomes for reporting and will make COUNTY data available upon request, pursuant to contract terms.

2. CONTRACTOR will periodically review provider performance using standard treatment and/or site review audits, along with claims and/or treatment-related data. CONTRACTOR will work with COUNTY to ensure compliance with updated state requirements and standards for performance outcome measures.

F. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Services Paragraph of this Exhibit A-1 to the Contract.

VI. SOBERING CENTER SERVICES

A. FACILITY –CONTRACTOR shall ensure facility remains clean, safe and in good repair. The Sobering Center consists of 12 cots, an intake station, showers, food storage, and a laundry facility. CONTRACTOR shall store client personal belongings while receiving services.

B. PERSONS TO BE SERVED – Sobering Center services shall be provided to adults 18 years of age and older, who present with intoxication and can safely be served at the facility. These persons might otherwise be detained by law enforcement or utilize hospital emergency departments for issues related to intoxication. Persons must arrive at the center by vehicle. Arriving on foot is not permitted. Referrals will include HCA identified referral sources and others. This service will be provided to all eligible clients regardless of payor status.

C. SERVICES

1. Screening - CONTRACTOR shall perform phone screening with referral source to determine if the individual can be safely served in the facility.

2. Admissions - CONTRACTOR shall ensure admissions are conducted 24 hours a day.

3. Intake – CONTRACTOR shall record demographics and past medical history.

4. Insurance Verification – CONTRACTOR will verify insurance coverage and/or Medi-Cal for each individual serviced to ensure that only non-insured or non-Medi-Cal clients paid for under this contract.

4. Engagement – CONTRACTOR shall utilize evidence based practices such as Motivational Interviewing and/ or Negotiated interviewing to engage Clients who may not wish to participate to assist with preventing Clients from leaving prior to it being safe for them to do so.

5. Monitoring – CONTRACTOR shall monitor of signs and symptoms of intoxication per protocols established by medical staff. CONTRACTOR shall incorporate blood pressure checks and the Clinical Opiate Withdrawal Scale (COWS) and/or Clinical Institute Withdrawal Assessment of Alcohol (CIWA) scale Clients who are sleeping will be monitored visually every 30 minutes.

6. Anticipated length of stay to last between 6 and 8 hours. Length of stay shall be less than 24 hours.

7. Ancillary Services – CONTRACTOR shall provide light snacks and hydration, temporary clean clothing, toiletries, clean linen and laundry service.

8. Discharge Planning – CONTRACTOR must begin Discharge Planning as soon as the Client enters Sobering Services. CONTRACTOR shall develop an exit/transition plan with

the Client. The exit/transition plan shall include:

a. A strategy or strategies to assist the Client in maintaining an alcohol and drug free lifestyle.

b. A plan for linkage and transition of the Client to appropriate services, including treatment services. When Residential Treatment services are appropriate, CONTRACTOR shall link Client to the residential access center by phone to complete an assessment and obtain residential authorization.

c. Linkage – CONTRACTOR shall provide a warm link transfer to ongoing physical health, and/or behavioral health treatment as appropriate utilizing ASAM criteria to determine appropriate level of care. Withdrawal management linkages are made directly to provider. Residential linkages are coordinated with the ART team unless the Client meets criteria for any of the higher acuity populations permitting a direct intake to residential treatment. CONTRACTOR shall provide referral and linkage to support group meetings, and Social Service benefits.

9. Transportation – CONTRACTOR shall arrange for or provide transportation to next care setting upon discharge.

10. Support Services – CONTRACTOR shall provide housekeeping, maintenance and arrangements for emergency and non-emergency medical services.

11. Follow-up – CONTRACTOR shall obtain consent to follow-up while Client is in services and shall follow up with Client at seven (7) and thirty (30) calendar days post-services.

D. PERFORMANCE OUTCOMES

1. Capture linkage rate to continuing MHRS (or BHS services)
2. Capture linkage rate to other medical, dental, social services or recovery supports.
2. Capture number of unduplicated clients served.
3. Capture number of admissions
4. Capture percentage of clients who accepted a referral appointment upon discharge
5. Capture percentage of clients who complete a relapse prevention plan prior to discharge
6. Future developing measures that attempt to improve the overall system of care may be added.

E. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Sobering Center Services paragraph of this Exhibit A-1 to the Contract.

VII. ADULT RESIDENTIAL SUD TREATMENT SERVICES

A. LENGTH OF STAY– Length of stay is based on medical necessity as determined by a

Licensed Practitioner of the Healing Arts. COUNTY is adhering to the State goal of a thirty (30) calendar day average in the residential level of care. The facility shall have a capacity of thirty (30) beds and include adequate physical space to support the services identified within the Contract.

1. Adults, ages eighteen (18) and older, may receive residential level SUD services based on medical necessity with no predetermined maximum days.

2. If determined to be medically necessary, perinatal clients may receive additional services and faster placement, in accordance with State perinatal guidelines.

B. PERSONS TO BE SERVED – All residents of Orange County are eligible to receive services despite the ability to pay. In order to receive services through the DMC-ODS, the Client must be enrolled in Medi-Cal, reside in Orange County, and meet medical necessity criteria.

C. RESIDENTIAL TREATMENT AUTHORIZATION - Clients will be authorized and referred to CONTRACTOR by the Assessment/Authorization for Residential Treatment (ART) Team. Clients who contact CONTRACTOR directly to request services shall be referred by CONTRACTOR to the ART Team. If Client is pregnant, and/or has a history of intravenous drug use, a person who has a recent history of fentanyl use disorder or a person linking to residential from any withdrawal management within the Orange County DMC-ODS system, and meets medical necessity for Residential Treatment, CONTRACTOR may directly admit the Client to treatment due to high acuity if provider has available bed slot. In this instance, CONTRACTOR must complete a SUD assessment and establish medical necessity for residential level of care. Assessment and authorization request must be submitted to the ART team for authorization within seventy-two (72) hours of Client admission. CONTRACTOR shall enter data regarding request for service into the IRIS access log established by ADMINISTRATOR for these Clients who access provider directly and bypass the ART team.

D. SERVICES – CONTRACTOR shall provide a non-institutional, twenty-four (24) hour non-medical, short-term residential program that provides rehabilitation services to Clients in accordance with an individualized plan. These services are intended to be individualized to treat the functional deficits identified in the ASAM Criteria. CONTRACTOR and Client work collaboratively to define barriers, set priorities, establish goals, create treatment plans/problem lists, and solve problems. Goals include sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care. CONTRACTOR shall provide services in accordance with DHCS-Designated Level of Care 3.1. Services shall include.

1. Intake: The process of determining that a Client meets the medical necessity criteria and a Client is admitted into a substance use disorder treatment program. Intake includes the

evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.

2. Individual Counseling: Contacts between a Client and a therapist or counselor.

3. Group Counseling: Face-to-face contacts in which one or more therapists or counselors treat two or more Clients at the same time with a maximum of twelve (12) in the group, focusing on the needs of the individuals served. Groups that count towards the structured service requirements shall not have a maximum limit for participants.

4. Family Therapy: As clinically appropriate, family members can provide social support to the Client, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

5. Client Education: Provide research-based education on addiction, treatment, recovery and associated health risks.

6. Medication Storage: Facilities will store all Client medication and facility staff members will oversee resident's self-administration of medication.

7. Collateral Services: Sessions with therapists or counselors and significant persons in the life of the Client, focused on the treatment needs of the Client in terms of supporting the achievement of the Client's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the Client.

8. Crisis Intervention Services: Contact between a therapist or counselor and a Client in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the Client an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the Client's emergency situation.

9. Treatment Planning: CONTRACTOR shall prepare an individualized written treatment plan or problem list, whichever applies, based upon information obtained in the intake and assessment process and in adherence to documentation standards set forth in QMSSUD documentation manual. The treatment plan/problem list will be consistent with the qualifying diagnosis and will be signed by the Client and the LPHA.

10. Structured Therapeutic Activities: Residential Treatment Services shall consist of a minimum of twenty (20) hours of structured activity per week.

11. EBPs: CONTRACTORs will implement at least two of the following EBPs, one of which must be Motivational Interviewing. The two EBPs are per CONTRACTOR per service modality. The required EBP include:

a. Motivational Interviewing: A Client-centered, empathetic, but directive

counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem-solving or solution-focused strategies that build on Clients' past successes.

b. Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.

c. Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.

d. Trauma-Informed Treatment: Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.

e. Psycho-Education: Psycho-educational groups are designed to educate Clients about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to Clients' lives; to instill self-awareness, suggest options for growth and change, identify community resources that can assist Clients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

12. Care Coordination: Care coordination services may be provided by a LPHA or registered/certified counselor or other eligible provider type and must be provided based on medical necessity. Care Coordination shall provide advocacy and care coordination to physical health, mental health, and transportation, housing, vocational, educational, and transition services for reintegration into the community. CONTRACTOR shall provide Care Coordination services for the Client during treatment, transition to other levels of care and follow ups, to encourage the Client to engage and participate in an appropriate level of care or Recovery Services after discharge. Care Coordination becomes the responsibility of the next treating provider after successful transition to a different level of care. CONTRACTOR shall ensure that Care Coordination services focus on coordination of SUD care, integration around primary care especially for Clients with a chronic SUD, and interaction with the criminal justice system, if needed. Care Coordination services may be provided face-to-face, by telephone, or by telehealth with the Client and may be provided anywhere in the community.

13. MAT: Services may be provided onsite with approval for Incidental Medical Services from DHCS. Medically necessary MAT services must be provided in accordance with an individualized treatment plan determined by a licensed physician or LPHA working within their scope of practice.

a. MAT services must be provided in compliance with Policy and Procedures

submitted to DHCS for IMS designation. CONTRACTOR must ensure ability to continue MAT after discharge through linkage to appropriate prescriber. MAT shall include the assessment, treatment planning, ordering, prescribing, administering, and monitoring of all medications for SUDs.

b. CONTRACTOR must provide administration of buprenorphine, naltrexone (oral and injectable), acamprosate, disulfiram, and naloxone. Other approved medications in the treatment of SUDs may also be prescribed and administered, as medically necessary.

c. CONTRACTOR must provide care coordination with treatment and ancillary service providers and facilitate transitions between levels of care. Clients may simultaneously participate in MAT services and other ASAM LOCs.

14. Care Coordination for Mental and Physical Health: Programs must screen for mental health issues and provide or refer for needed services. CONTRACTOR shall notify Client's medical home provider of Client's admission to treatment within seven (7) calendar days of admission and request medical records/ physical exam. If Client does not have a medical home, identifying one shall be on the treatment plan/problem list.

15. Physician/Clinician Consultation: Physician/Clinician Consultation Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists, or clinicians consulting with other clinicians on difficult cases. Physician/Clinician consultation services are designed to assist DMC physicians and clinicians by allowing them to seek expert advice with regards to designing treatment plans/problem lists for specific DMC-ODS members. Physician consultation services may address medication selection, dosing, side effect management, adherence, drug interactions, or level of care considerations. ADMINISTRATOR will provide one or more physicians or pharmacists to provide consultation services.

16. Discharge Services: The process to prepare the Client for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services. CONTRACTOR shall provide or arrange for transportation of Clients to aftercare destination. CONTRACTOR shall begin discharge planning immediately after enrollment. The exit plan shall be completed and signed by CONTRACTOR staff and Client. The exit plan shall be documented in the Client's chart.

17. Recovery Services: A level of care designed to support recovery and prevent relapse. It is not considered treatment. The focus is on restoring the Client to their best possible functional level and emphasizes the Client's role in managing their health by using effective self-management support strategies. The components of Recovery Services are:

a. Outpatient counseling services in the form of individual or group counseling to

stabilize the Client and then reassess if the Client needs further care;

b. Recovery Monitoring: Recovery coaching, monitoring via telephone and internet;

c. Substance Abuse Assistance: Peer-to-peer services and relapse prevention;

d. Education and Job Skills: Linkages to life skills, employment services, job training, and education services;

e. Family Support: Linkages to childcare, parent education, child development support services, family/marriage education;

f. Support Groups: Linkages to self-help and support, spiritual and faith-based support;

g. Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

18. Food and Other Services: CONTRACTOR shall provide a clean, safe environment, toiletries, clean linen, and food service.

19. Support Services: CONTRACTOR shall provide housekeeping, which may be done by Clients and laundry access.

20. Health, Medical, Psychiatric and Emergency Services – CONTRACTOR shall ensure that all persons admitted for Residential Treatment services have a health questionnaire completed using form DHCS 5103 form, or may develop their own form provided it contains, at a minimum, the information requested in the DHCS 5103 form.

a. The health questionnaire is a Client's self-assessment of his/her current health status and shall be completed by Client.

1) CONTRACTOR shall review and approve the health questionnaire form prior to Client's admission to the program. The completed health questionnaire shall be signed and dated by CONTRACTOR and Client, prior to admission.

2) A copy of the questionnaire shall be filed in the Client's record.

b. CONTRACTOR shall, based on information provided by Client on the health questionnaire form, refer Client to licensed medical professionals for physical and laboratory examinations as appropriate.

1) CONTRACTOR shall obtain a copy of Client's medical clearance or release prior to Client's admission to the program when applicable.

2) A copy of the referral and clearance shall be filed in the Client's file.

3) CONTRACTOR shall provide directly or by referral: HIV education, voluntary, HIV antibody testing and risk assessment and disclosure counseling.

4) The programs shall have written procedures for obtaining medical or

psychiatric evaluation and emergency and non-emergency services.

5) The programs shall post the name, address, and telephone number for the fire department, a crisis program, local law enforcement, and ambulance service.

6) CONTRACTOR shall provide TB services to the Clients by referral to the COUNTY or another appropriate provider. TB services shall be provided within seven (7) calendar days of admission. These TB services shall consist of the following:

a) Counseling with respect to TB;

b) Testing to determine whether the individual has been infected and to determine the appropriate form of treatment;

c) Provision for, or referral of, infected Clients for medical evaluation, treatment and clearance. CONTRACTOR shall ensure that a TB-infected Client is medically cleared prior to commencing treatment.

21. Transportation Services

a. COUNTY shall only pay for medical ambulance or medical van transportation to and from designated residential substance use disorder treatment programs or health facilities through the COUNTY's Medical Transportation Contract under the following conditions:

1) Ambulance transportation shall be used for services requiring immediate attention for a Client due to any sudden or serious illness or injury requiring immediate medical attention, where delay in providing such services may aggravate the medical condition or cause the loss of life.

2) When any Client needs non-emergency transportation as identified in Subparagraph 21.b below, and CONTRACTOR cannot transport Client due to unforeseen circumstances including, but not limited to, staffing constraints, CONTRACTOR vehicle access within a timely manner or Client's physical condition and/or limitations.

3) CONTRACTOR shall utilize the COUNTY's Ambulance Monthly Rotation Call Log to request transportation services from Ambulance Providers designated for transportation within the city of the CONTRACTOR's facility for each said month as identified on the log.

4) CONTRACTOR shall use its best efforts to contact Ambulance Providers identified on the Monthly Rotation Call Log as those providers who offer van transportation services if and when an ambulance is not required.

5) CONTRACTOR shall be held liable and may be billed by the Ambulance Provider for services requested by CONTRACTOR that are deemed inappropriate for use and not a covered service under this section by the COUNTY.

b. Non-Emergency Transportation – CONTRACTOR shall transport Client to

locations that are considered necessary and/or important to the Client's recovery plan including, but not limited to, Social Security Administration offices for Supplemental Security Income benefits and for non-emergency medical or mental health services not identified in Subparagraph 21.a. above, that require treatment at a physician office, urgent care, or emergency room when an ambulance provider is not necessary or required for transportation based on the level of severity and/or services required by the Client.

E. PERFORMANCE OUTCOMES

1. CONTRACTOR shall achieve performance objectives, tracking and reporting Performance Outcome Objective statistics in monthly programmatic reports, as appropriate. ADMINISTRATOR recognizes that alterations may be necessary to the following services to meet the objectives, and, therefore, revisions to objectives and services may be implemented by mutual agreement between CONTRACTOR and ADMINISTRATOR.

2. Performance Outcome Objectives

a. Objective 1: Provide effective residential substance abuse assessment, treatment, and counseling to Clients with identified alcohol and/or drug problems as measured by Completion Rate.

b. Objective 2: Completion Rates shall be calculated by using the number of Clients who leave with satisfactory progress divided by the total number of Clients discharged during the evaluation period. Seventy percent (70%) of Clients will complete residential treatment program.

c. Objective 3: Provide linkage to the next level of care for Medi-Cal Clients upon discharge. thirty percent (30%) of Clients who have discharged will be linked with a lower level of care within thirty (30) calendar days, as measured by charge data entered into the IRIS. Linkage rates for Clients who discharge will include all CalOMS standard discharge dispositions. All CalOMS administrative discharge dispositions will be excluded.

F. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Adult Residential SUD Treatment Services Paragraph of this Exhibit A-1 to the Contract.

VIII. ADULT CO-OCCURRING RESIDENTIAL TREATMENT SERVICES

A. LENGTH OF STAY – Length of stay is based on medical necessity as determined by a Licensed Practitioner of the Healing Arts. COUNTY is adhering to the state goal of a thirty (30) calendar day average in the residential level of care. The facility shall have a capacity of thirty (30) beds and include adequate physical space to support the services identified within the Contract.

B. PERSONS TO BE SERVED – All residents of Orange County are eligible to receive

services despite the ability to pay. In order to receive services through the DMC-ODS, the Client must be enrolled in Medi-Cal, reside in Orange County, and meet medical necessity criteria.

C. RESIDENTIAL TREATMENT AUTHORIZATION - Clients will be authorized and referred to CONTRACTOR by the ART Team. If Client is pregnant, and/or has a history of intravenous drug use, a person who has a recent history of fentanyl use disorder, or a person linking to residential from any withdrawal management within the Orange County DMC-ODS system, and meets medical necessity for Residential Treatment, CONTRACTOR may directly admit the Client to treatment due to high acuity if provider has available bed slot. Clients who contact CONTRACTOR directly to request services shall be referred by CONTRACTOR to the ART Team. If Client is pregnant or an intravenous drug user who meets medical necessity for Residential Treatment, CONTRACTOR may admit to treatment bypassing the ART Team due to acuity, if provider has available bed slot and if program is licensed/certified for perinatal services. In this instance, CONTRACTOR must complete a SUD assessment and establish medical necessity for residential level of care. Assessment and authorization request must be submitted to the ART team for authorization within seventy-two (72) hours of client admission. CONTRACTOR shall enter data regarding request for service into IRIS access log established by ADMINISTRATOR for these Clients who access provider directly and bypass the ART team.

D. SERVICES – CONTRACTOR shall provide a non-institutional, twenty-four (24) hour non-medical, short-term residential program that provides rehabilitation services to Client based on Client goals and objectives during treatment. These services are intended to be individualized to treat the functional deficits identified in the ASAM Criteria. CONTRACTOR and Client work collaboratively to define barriers, set priorities, establish goals, create goals and objectives, and solve problems. Goals include sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care. CONTRACTOR shall provide services in accordance with DHCS-Designated Levels of Care 3.3 or 3.5. Residential Treatment program shall consist of the following:

1. Intake: The process of determining that a Client meets the medical necessity criteria and a Client is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; the review and signing of legal and admission paperwork; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.

2. Individual Counseling: Contacts between a Client and a therapist or counselor.

3. Group Counseling: Face-to-face contacts in which one or more therapists or counselors treat two (2) or more Clients at the same time with a maximum of twelve (12) in the

group, focusing on the needs of the individuals served. Groups that count towards the structured service requirements shall not have a maximum limit for participants. 4.

Family Therapy: Family members can provide social support to the Client, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

5. Client Education: Provide research-based education on addiction, treatment, recovery and associated health risks.

6. Medication Storage: Facilities will store all Client medication and facility staff members will oversee resident's self-administration of medication.

7. Collateral Services: Sessions with therapists or counselors and significant persons in the life of the Client, focused on the treatment needs of the Client in terms of supporting the achievement of the Client's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the Client.

8. Crisis Intervention Services: Contact between a therapist or counselor and a Client in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the Client an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the Client's emergency situation.

9. Treatment Planning: CONTRACTOR shall collaborate with the Client on their progress in treatment in the current episode of care. Treatment planning activities include, but are not limited to, collaborating with the Client on problems for the development of the problem list, reviewing and/or updating the problem list; planning for the course of treatment using the information gathered about the Client's specific needs to determine what interventions may be needed to address those needs and promote progress towards improving level of functioning. Treatment planning activities will be consistent with the qualifying diagnosis.

10. Structured Therapeutic Activities: Residential Treatment Services shall consist of a minimum of twenty (20) hours of structured activity per week.

11.EBPs: CONTRACTORs will implement at least two of the following EBPs, one of which must be Motivational Interviewing. The two EBPs are per CONTRACTOR per service modality. The required EBP include:

a. Motivational Interviewing: A Client-centered, empathetic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem-solving or solution-focused strategies that build on Clients' past successes.

b. Cognitive-Behavioral Therapy: Based on the theory that most emotional and

behavioral reactions are learned and that new ways of reacting and behaving can be learned.

c. Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.

d. Trauma-Informed Treatment: Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.

e. Psycho-Education: Psycho-educational groups are designed to educate Clients about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to Clients' lives; to instill self-awareness, suggest options for growth and change, identify community resources that can assist Clients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

12. Care Coordination: Care coordination services must be provided based on the needs of the Client. Services shall provide advocacy and care coordination to physical health, mental health, and transportation, housing, vocational, educational, and transition services for reintegration into the community. CONTRACTOR shall provide Care Coordination services for the Client during treatment, transition to other levels of care and follow ups, and to encourage the Client to engage and participate in an appropriate level of care or Recovery Services after discharge. Care Coordination becomes the responsibility of the next treating provider after successful transition to a different level of care. CONTRACTOR shall ensure that Care Coordination services focus on coordination of SUD care, integration around primary care especially for Clients with a chronic SUD, and interaction with the criminal justice system, if needed. Care Coordination services may be provided face-to-face, by telephone, or by telehealth with the Client and may be provided anywhere in the community.

13. MAT: Services may be provided onsite with approval for Incidental Medical Services from DHCS. Medically necessary MAT services must be provided in accordance with the Client's individualized needs as determined by a licensed physician or LPHA working within their scope of practice.

a. MAT services must be provided in compliance with Policy and Procedures submitted to DHCS for IMS designation. CONTRACTOR must ensure ability to continue MAT after discharge through linkage to appropriate prescriber. MAT shall include the assessment, treatment planning, ordering, prescribing, administering, and monitoring of all medications for SUDs.

b. CONTRACTOR must provide administration of buprenorphine, naltrexone (oral

and injectable), acamprosate, disulfiram, and naloxone. Other approved medications in the treatment of SUDs may also be prescribed and administered, as medically necessary.

c. CONTRACTOR must provide care coordination with treatment and ancillary service providers and facilitate transitions between levels of care. Clients may simultaneously participate in MAT services and other ASAM LOCs.

14. Care Coordination for Mental and Physical Health: Programs must screen for mental health issues and provide or refer for needed services. CONTRACTOR shall notify Client's medical home provider of Client's admission to treatment within seven (7) calendar days of admission and request medical records/ physical exam. If Client does not have a medical home, identifying one shall be listed on the treatment plan or Problem List, whichever applies. Clients who are co-occurring with severe and persistent mental illness shall receive mental health services and support through Orange County Health Care Agency PACT program, if applicable, or other County or contracted programs designed to treat SPMI.

15. Physician/clinician Consultation: Physician Consultation Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists, or expert clinicians consulting with other clinicians on difficult cases. Physician consultation services are designed to assist DMC physicians by allowing them to seek expert advice with regards to designing treatment plans/problem lists for specific DMC-ODS members. Physician consultation services may address medication selection, dosing, side effect management, adherence, drug interactions, or level of care considerations. ADMINISTRATOR will provide one or more physicians or pharmacists to provide consultation services.

16. Discharge Services: The process to prepare the Client for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services. CONTRACTOR shall provide or arrange for transportation of Clients to aftercare destination. CONTRACTOR shall begin discharge planning immediately after enrollment. The exit plan shall be completed and signed by CONTRACTOR staff and Client. The exit plan shall be documented in the Client's chart.

17. Recovery Services: A level of care designed to support recovery and prevent relapse. It is not considered treatment. Recovery Services focus on restoring the Client to their best possible functional level and emphasizes the Client's role in managing their health by using effective self-management support strategies. Recovery services may be provided face-to-face, by telephone, or by telehealth with the Client and may be provided anywhere in the community. Recovery services shall be made available to DMC-ODS members when a Medical Director or LPHA has determined that recovery services are medically necessary in accordance with the Client's needs. Clients may enroll simultaneously in Recovery Services while receiving treatment

services at another level of care if found to be clinically appropriate. The components of Recovery Services are:

a. Assessment;

b. Outpatient counseling services in the form of individual, family or group counseling to stabilize the Client and then reassess if the Client needs further care;

c. Recovery Monitoring: Recovery coaching, monitoring which includes recovery coaching and monitoring designed for the maximum reduction of the Client's SUD.

d. Substance Abuse Assistance: Peer-to-peer services and relapse prevention;

e. Education and Job Skills: Linkages to life skills, employment services, job training, and education services;

f. Family Support: Linkages to childcare, parent education, child development support services, family/marriage education;

g. Support Groups: Linkages to self-help and support, spiritual and faith-based support;

h. Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination; and

i. Relapse Prevention, which includes interventions designed to teach Clients with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the Client's SUD.

18. Food and Other Services: CONTRACTOR shall provide a clean, safe environment, toiletries, clean linen, and food service.

19. Support Services: CONTRACTOR shall provide housekeeping, which may be done by Clients and laundry access.

20. Health, Medical, Psychiatric and Emergency Services – CONTRACTOR shall ensure that all persons admitted for Residential Treatment services have a health questionnaire completed using form DHCS 5103 form, or may develop their own form provided it contains, at a minimum, the information requested in the DHCS 5103 form.

a. The health questionnaire is a Client's self-assessment of his/her current health status and shall be completed by Client.

1) CONTRACTOR shall review and approve the health questionnaire form prior to Client's admission to the program. The completed health questionnaire shall be signed and dated by CONTRACTOR and Client, prior to admission.

2) A copy of the questionnaire shall be filed in the Client's record.

b. CONTRACTOR shall, based on information provided by Client on the health questionnaire form, refer Client to licensed medical professionals for physical and laboratory

examinations as appropriate.

1) CONTRACTOR shall obtain a copy of Client's medical clearance or release prior to Client's admission to the program when applicable.

2) A copy of the referral and clearance shall be filed in the Client's file.

3) CONTRACTOR shall provide directly or by referral: HIV education, voluntary, HIV antibody testing and risk assessment and disclosure counseling.

4) The programs shall have written procedures for obtaining medical or psychiatric evaluation and emergency and non-emergency services.

5) The programs shall post the name, address, and telephone number for the fire department, a crisis program, local law enforcement, and ambulance service.

6) CONTRACTOR shall provide TB services to the Clients by referral to the COUNTY or another appropriate provider. TB services shall be provided within seven (7) calendar days of admission. These TB services shall consist of the following:

a) Counseling with respect to TB;

b) Testing to determine whether the individual has been infected and to determine the appropriate form of treatment;

c) Provision for, or referral of, infected Clients for medical evaluation, treatment and clearance. CONTRACTOR shall ensure that a TB-infected Client is medically cleared prior to commencing treatment.

21. Transportation Services

a. COUNTY shall only pay for medical ambulance or medical van transportation to and from designated residential substance use disorder treatment programs or health facilities through the COUNTY's Medical Transportation Contract under the following conditions:

1) Ambulance transportation shall be used for services requiring immediate attention for a Client due to any sudden or serious illness or injury requiring immediate medical attention, where delay in providing such services may aggravate the medical condition or cause the loss of life.

5) CONTRACTOR shall be held liable and may be billed by the Ambulance Provider for services requested by CONTRACTOR that are deemed inappropriate for use and not a covered service under this section by the COUNTY.

E. PERFORMANCE OUTCOMES

1. CONTRACTOR shall achieve performance objectives, tracking and reporting Performance Outcome Objective statistics in monthly programmatic reports, as appropriate. ADMINISTRATOR recognizes that alterations may be necessary to the following services to meet the objectives, and, therefore, revisions to objectives and services may be implemented by

mutual agreement in writing between CONTRACTOR and ADMINISTRATOR.

2. Performance Outcome Objectives

a. Objective 1: CONTRACTOR shall provide effective residential substance abuse assessment, treatment, and counseling to Clients with identified alcohol and/or drug problems as measured by Retention and Completion Rates:

1) Retention Rates shall be calculated by using the number of Clients currently enrolled in or successfully completing the treatment program divided by the total number of Clients served during the evaluation period.

2) Completion Rates shall be calculated by using the number of Clients successfully completing the treatment program divided by the total number of Clients discharged during the evaluation period. Fifty percent (50%) of Clients will complete residential treatment program based on meeting established treatment goals.

b. CONTRACTOR shall provide linkage to the next level of care for Medi-Cal Clients upon discharge. Twenty percent (20%) of Clients who have discharged will be linked with a lower level of care within seven (7) calendar days, as measured by charge data entered into the IRIS. Linkage rates for Clients who discharge will include all CalOMS standard discharge dispositions. All CalOMS administrative discharge dispositions will be excluded.

F. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Adult Co-Occurring Residential Treatment Services Paragraph of this Exhibit A-1 to the Contract.

IX. ADULT CLINICALLY MANAGED WITHDRAWAL MANAGEMENT SERVICES

A. LENGTH OF STAY

1. Length of stay is based on medical necessity for withdrawal management in adherence with observation protocols established by Medical Director. The facility shall have a capacity of twelve (12) beds and include adequate physical space to support the services identified within the Contract.

B. PERSONS TO BE SERVED – All residents of Orange County are eligible to receive services despite ability to pay. For clients to receive services through the DMC-ODS, the Client must be enrolled in Medi-Cal, reside in Orange County, and meet medical necessity criteria.

C. SERVICES - Clinically managed withdrawal management services shall consist of the following:

1. Intake: The process of determining that a Client meets the medical necessity criteria and a Client is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and

the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.

2. Observation:

a. CONTRATOR shall ensure at least one staff member shall be assigned to the observation of Withdrawal Management Clients at all times and be certified in cardiopulmonary resuscitation, first aid, and Naloxone administration. In facilities with sixteen (16) or more Clients, two (2) staff or properly credentialed volunteers shall be present at all times.

b. Staff or volunteer shall physically check each Client for breathing by a face-to-face physical observation at least every thirty (30) minutes and vital signs every six (6) hours at a minimum during the first seventy-two (72) hours following admission. The close observation and physical checks shall continue beyond the initial seventy-two (72) hour period for as long as the withdrawal signs and symptoms warrant. After twenty-four (24) hours, close observations and physical checks may be discontinued or reduced based upon a determination by a staff member trained in providing Withdrawal Management Services. Documentation of the information that supports a decrease in close observation and physical checks shall be recorded in the Client's file.

c. Documentation of observations and physical checks shall be recorded in a systematic manner in the Client file including information supporting a decrease in observation and physical checks and signature of staff.

d. Only program staff that have been trained in the provisions of Withdrawal Management Services may conduct observations and physical checks of Clients receiving Withdrawal Management Services. Training shall include information on detoxification medications, and signs and symptoms that require referral to a higher level of care. Training shall also include first aid cardiopulmonary resuscitation, and Naloxone administration. Copies of detoxification training records shall be kept in personnel files.

e. CONTRACTOR shall track training and keep certificate of completions on file. Tracker and certificates must be made available to ADMINISTRATOR within two (2) business days, upon request.

3. Individual Counseling: Contacts between a Client and a therapist or counselor.

4. Group Counseling: Face-to-face contacts in which one or more therapists or counselors treat two or more Clients at the same time with a maximum of twelve (12) in the group, focusing on the needs of the individuals served.

5. Client Education: Provide research-based education on addiction, treatment, recovery and associated health risks.

6. Medication Storage: Facilities will store all Client medication and facility staff

members will oversee resident's self-administration of medication.

7. Collateral Services: Sessions with therapists or counselors and significant persons in the life of the Client, focused on the treatment needs of the Client in terms of supporting the achievement of the Client's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the Client.

8. Crisis Intervention Services: Contact between a therapist or counselor and a Client in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the Client an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the Client's emergency situation.

9. Treatment Planning: CONTRACTOR shall engage in treatment planning activities, based upon information obtained in the intake and assessment process and in adherence to documentation standards set forth in QMS SUD documentation manual. The goals and objectives will be consistent with the qualifying diagnosis and will be signed by the Client and the LPHA.

10. EBPs: CONTRACTORs will implement at least two of the following EBPs, one of which must be Motivational Interviewing. The two EBPs are per CONTRACTOR per service modality. The required EBP include:

a. Motivational Interviewing: A Client-centered, empathetic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem-solving or solution-focused strategies that build on Clients' past successes.

b. Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.

c. Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.

d. Trauma-Informed Treatment: Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.

e. Psycho-Education: Psycho-educational groups are designed to educate Clients about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to Clients' lives; to instill self-awareness, suggest options for growth and change, identify community resources that can assist Clients in recovery, develop an understanding of the process of recovery, and prompt people using

substances to take action on their own behalf.

11. Care Coordination: Care coordination services must be provided based on client need. Care coordination shall provide advocacy and care coordination to physical health, mental health, and transportation, housing, vocational, educational, and transition services for reintegration into the community. CONTRACTOR shall provide Care Coordination services for the Client during treatment, transition to other levels of care and follow ups, to encourage the Client to engage and participate in an appropriate level of care or Recovery Services after discharge. Care Coordination becomes the responsibility of the next treating provider after successful transition to a different level of care. CONTRACTOR shall ensure that Care Coordination services focus on coordination of SUD care, integration around primary care especially for Clients with a chronic SUD, and interaction with the criminal justice system, if needed. Care Coordination services may be provided face-to-face, by telephone, or by telehealth with the Client and may be provided anywhere in the community.

12. MAT: Services may be provided onsite with approval for Incidental Medical Services from DHCS. Medically necessary MAT services must be provided in accordance with an individualized treatment plan determined by a licensed physician or LPHA working within their scope of practice.

a. MAT services must be provided in compliance with Policy and Procedures submitted to DHCS for IMS designation. CONTRACTOR must ensure ability to continue MAT after discharge through linkage to appropriate prescriber. MAT shall include the assessment, treatment planning, ordering, prescribing, administering, and monitoring of all medications for SUDs.

b. CONTRACTOR must provide administration of buprenorphine, naltrexone (oral and injectable), acamprosate, disulfiram, and naloxone. Other approved medications in the treatment of SUDs may also be prescribed and administered, as medically necessary.

c. CONTRACTOR must provide care coordination with treatment and ancillary service providers and facilitate transitions between levels of care. Clients may simultaneously participate in MAT services and other ASAM LOCs.

13. Care Coordination for Mental and Physical Health: Programs must screen for mental health issues and provide or refer for needed services. CONTRACTOR shall notify Client's medical home provider of Client's admission to treatment within seven (7) calendar days of admission and request medical records/ physical exam. If Client does not have a medical home, this issue shall be identified on the Treatment Plan or Problem List, whichever applies.

14. Physician/Clinician Consultation: Physician/Clinician Consultation Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or

clinical pharmacists, or expert clinicians consulting with other clinicians on difficult cases. Physician/Clinician consultation services are designed to assist DMC physicians and clinicians by allowing them to seek expert advice with regards to designing treatment plans/problem lists for specific DMC-ODS members. Physician/Clinician consultation services may address medication selection, dosing, side effect management, adherence, drug interactions, or level of care considerations. ADMINISTRATOR will provide one or more physicians or pharmacists to provide consultation services.

15. Discharge Services: The process to prepare the Client for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services. CONTRACTOR shall provide or arrange for transportation of Clients to aftercare destination. CONTRACTOR shall begin discharge planning immediately after enrollment. The exit plan shall be completed and signed by CONTRACTOR staff and Client. The exit plan shall be documented in the Client's chart.

16. Food and Other Services: CONTRACTOR shall provide a clean, safe environment, toiletries, clean linen, and food service.

17. Support Services: CONTRACTOR shall provide housekeeping, which may be done by Clients and laundry access.

18. Health, Medical, Psychiatric and Emergency Services – CONTRACTOR shall ensure that all persons admitted for Residential Treatment services have a health questionnaire completed using form DHCS 5103 form, or may develop their own form provided it contains, at a minimum, the information requested in the DHCS 5103 form.

a. The health questionnaire is a Client's self-assessment of his/her current health status and shall be completed by Client.

1) CONTRACTOR shall review and approve the health questionnaire form prior to Client's admission to the program. The completed health questionnaire shall be signed and dated by CONTRACTOR and Client, prior to admission.

2) A copy of the questionnaire shall be filed in the Client's record.

b. CONTRACTOR shall, based on information provided by Client on the health questionnaire form, refer Client to licensed medical professionals for physical and laboratory examinations as appropriate.

1) CONTRACTOR shall obtain a copy of Client's medical clearance or release prior to Client's admission to the program when applicable.

2) A copy of the referral and clearance shall be filed in the Client's file.

3) CONTRACTOR shall provide directly or by referral: HIV education, voluntary, HIV antibody testing and risk assessment and disclosure counseling.

4) The programs shall have written procedures for obtaining medical or psychiatric evaluation and emergency and non-emergency services.

5) The programs shall post the name, address, and telephone number for the fire department, a crisis program, local law enforcement, and ambulance service.

6) CONTRACTOR shall provide TB services to the Clients by referral to the COUNTY or another appropriate provider. TB services shall be provided within seven (7) calendar days of admission. These TB services shall consist of the following:

a) Counseling with respect to TB;

b) Testing to determine whether the individual has been infected and to determine the appropriate form of treatment;

c) Provision for, or referral of, infected Clients for medical evaluation, treatment and clearance. CONTRACTOR shall ensure that a TB-infected Client is medically cleared prior to commencing treatment.

19. Transportation Services

a. COUNTY shall only pay for medical ambulance or medical van transportation to and from designated residential substance use disorder treatment programs or health facilities through the COUNTY's Medical Transportation Contract under the following conditions:

1) Ambulance transportation shall be used for services requiring immediate attention for a Client due to any sudden or serious illness or injury requiring immediate medical attention, where delay in providing such services may aggravate the medical condition or cause the loss of life.

2) When any Client needs non-emergency transportation as identified in Subparagraph 20.b below, and CONTRACTOR cannot transport Client due to unforeseen circumstances including, but not limited to, staffing constraints, CONTRACTOR vehicle access within a timely manner or Client's physical condition and/or limitations.

3) CONTRACTOR shall utilize the COUNTY's Ambulance Monthly Rotation Call Log to request transportation services from Ambulance Providers designated for transportation within the city of the CONTRACTOR's facility for each said month as identified on the log.

4) CONTRACTOR shall use its best efforts to contact Ambulance Providers identified on the Monthly Rotation Call Log as those providers who offer van transportation services if and when an ambulance is not required.

5) CONTRACTOR shall be held liable and may be billed by the Ambulance Provider for services requested by CONTRACTOR that are deemed inappropriate for use and not a covered service under this section by the COUNTY.

b. Non-Emergency Transportation – CONTRACTOR shall transport Client to locations that are considered necessary and/or important to the Client's recovery plan including, but not limited to, Social Security Administration offices for Supplemental Security Income benefits and for non-emergency medical or mental health services not identified in Subparagraph 19.a. above, that require treatment at a physician office, urgent care, or emergency room when an ambulance provider is not necessary or required for transportation based on the level of severity and/or services required by the Client.

D. PERFORMANCE OUTCOMES

1. Objective 1: Demonstrate provision of effective withdrawal management services with a client completion rates of at least seventy percent (70%).

2. Objective 2: Completion Rates shall be calculated by using the number of clients who leave with satisfactory progress divided by the total number of clients discharged during the evaluation period.

3. Objective 3: Linkage to the next level of care for Medi-Cal Clients upon discharge; thirty percent (30%) of Clients who have discharged will be linked with a lower level of care within thirty (30) calendar days, as measured by charge data entered into IRIS. Linkage rates for Clients who discharge will include all California Outcome Measurement System (CalOMS) standard discharged dispositions. All CalOMS administrative discharge dispositions will be excluded.

E. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Adult Clinically Managed Withdrawal Management Services Paragraph of this Exhibit A-1 to the Contract.

X. STAFFING

A. CONTRACTOR shall, at a minimum, provide the following staffing pattern expressed in Full-Time Equivalents (FTEs) continuously throughout the term of the Contract. One (1) FTE shall be equal to an average of forty (40) hours work per week.

PROGRAM	FTE
Accountant	1.00
Administrative Assistant	1.00
Admissions & Navigation Supervisor	1.00
Admissions & Navigation Team	1.00
Alumni & Volunteer Coordinator	1.00
Billing & Claims Specialist	1.00

Chief Operations Officer	0.50
Community & Health Equity Liaison	0.50
Clinical Program Monitor	1.00
Director of Quality Improvement	1.00
Executive Director of Operations	1.00
Facilities Coordinator	1.00
Front Desk Staff	3.00
Medical Director	0.25
Payer Relations & Contracting Specialist	0.50
Quality Assurance Specialist	1.00
Strategy & Quality Improvement	0.25
TOTAL FTE	16.00

B. CONTRACTOR shall provide sufficient administrative and program staffing to ensure its delivery of all services specified in this Exhibit A-1 to the Contract.

C. CONTRACTOR shall, at its own expense, provide and maintain licensed practitioners of the healing arts and supportive personnel to provide all necessary and appropriate management services.

D. CONTRACTOR shall attempt in good faith to recruit and retain bilingual, culturally competent staff to meet the diverse needs of the community threshold languages as determined by COUNTY. CONTRACTOR shall also ensure recruitment and retention of staff that have experience in working with diverse populations with specialty needs, including but not limited to, children/adolescents and older adults. When staffing vacancies occur, CONTRACTOR shall attempt to fill with bilingual and bicultural staff. If CONTRACTOR's available candidates require filling those positions with non-bilingual and bicultural staff, CONTRACTOR shall notify ADMINISTRATOR in writing, at least seven (7) calendar days in advance of hiring.

E. CONTRACTOR shall use an interpreter service when a caller speaks a language not spoken by staff, as well as the California Relay Service for hearing impaired Clients.

F. CONTRACTOR shall maintain personnel files for each staff member, both administrative and programmatic, both direct and indirect, which shall include, but not be limited to, an application for employment, qualifications for the position, documentation of bicultural/bilingual capabilities (if applicable), valid licensure verification, if applicable, and pay rate and evaluations justifying pay increases.

G. CONTRACTOR shall notify ADMINISTRATOR, in writing, within seventy-two (72) hours of any non-pooled staffing vacancies that occur during the term of the Contract.

CONTRACTOR's notification shall include at a minimum the following information: employee name(s), position title(s), date(s) of resignation, date(s) of hire, and a description of recruitment activity.

H. CONTRACTOR shall notify ADMINISTRATOR, in writing, at least seven (7) calendar days in advance, of any new non-pooled staffing changes; including promotions, temporary FTE changes and internal or external temporary staffing assignment requests that occur during the term of the Contract.

I. CONTRACTOR shall ensure that all staff are trained based on COUNTY requirements and have a clear understanding of all P&Ps. CONTRACTOR shall provide signature confirmation of the P&P training for each staff member and place it in their personnel files, on forms approved by COUNTY.

J. CONTRACTOR shall ensure that all staff, albeit paid or unpaid, complete necessary training prior to performing duties associated with their titles and any other training necessary to assist CONTRACTOR and COUNTY to be in compliance with prevailing standards of practice as well as State and Federal regulatory requirements. Training information should be tracked on forms mutually agreed upon and approved by COUNTY.

K. CONTRACTOR shall provide ongoing supervision throughout all shifts to all staff, albeit paid or unpaid, direct line staff or supervisors/directors, to enhance service quality and program effectiveness. Supervision methods should include debriefings and consultation as needed, individual supervision or one-on-one support, and team meetings. Supervision should be provided by a supervisor who has extensive knowledge regarding mental health issues.

L. CONTRACTOR shall ensure that designated staff completes COUNTY's Annual Provider Training and Annual Compliance and Cultural Competency Training.

M. TOKENS – ADMINISTRATOR shall provide CONTRACTOR the necessary number of Tokens for appropriate individual staff to access ADMINISTRATOR designated reporting system at no cost to CONTRACTOR.

1. CONTRACTOR recognizes Tokens are assigned to a specific individual staff member with a unique password. Tokens and passwords shall not be shared with anyone.

2. CONTRACTOR shall ensure information obtained by the use of a Token is used for the sole purpose of this Contract and shall not be shared with any other lines of business without the expressed or written consent of the Client.

3. CONTRACTOR shall request and return tokens pursuant to COUNTY Standard Operating Procedure (SOP) for Processing Token Requests.

4. CONTRACTOR shall maintain an inventory of Tokens activated/deactivated for each staff member.

5. CONTRACTOR shall request ADMINISTRATOR deactivate all Tokens under the following conditions:

a. Token of any staff member who no longer supports the Contract;

b. Token of any staff member who no longer requires access to ADMINISTRATOR designated reporting system;

c. Token of any staff member who leaves employment of CONTRACTOR;

d. Token is malfunctioning; or

e. Termination of Contract.

N. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Staffing Paragraph of this Exhibit A-1 to the Contract.

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EXHIBIT B
TO MASTER SERVICES AGREEMENT
FOR PROVISION OF
MENTAL HEALTH AND RECOVERY SERVICES
BETWEEN
COUNTY OF ORANGE
AND
MIND OC
OCTOBER 1, 2022 THROUGH JUNE 30, 2025

MENTAL HEALTH CRISIS SERVICES

I. COMMON TERMS AND DEFINITIONS

A. The Parties agree to the following terms and definitions, and to those terms and definitions which, for convenience, are set forth elsewhere in the Contract.

1. Admission means documentation, by CONTRACTOR, for completion of entry and evaluation services, provided to Clients seen in COUNTY and COUNTY-contracted services, into IRIS.

2. Care Coordination means services that assist a Client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.This definition applies to programs under the DMC-ODS and MHP.

3. CAT means Crisis Assessment Team which provides twenty-four (24) hour mobile response services to anyone who has a psychiatric emergency. This program assists law enforcement, social service agencies, and families in providing crisis intervention services for the mentally ill. CAT is a multi-disciplinary program that conducts risk assessments, initiates involuntary hospitalizations, and provides linkage, follow ups for Clients evaluated. There are separate adult and youth CATs.

4. Client or Individual means a person who is referred or enrolled, for services under the Contract who is living with mental, emotional, or behavioral disorders.

5. Closed-loop referral means the people, processes and technologies that are deployed to coordinate and refer Clients to available community resources (i.e., health care, behavioral health services, and/or other support services) and follow-up to verify if services were rendered.

6. Crisis Stabilization Unit (CSU) means a behavioral health crisis stabilization program that operates 24 hours a day that serves Orange County residents, aged 13 and older,

who are experiencing behavioral health crises that cannot wait until regularly scheduled appointments. Crisis Stabilization services include psychiatric evaluations provided by Doctors of Medicine (MD), Nurse Practitioners (NP), Doctors of Osteopathic Medicine (DO, counseling/therapy provided by Licensed Clinical Social Workers or Marriage Family Therapists or registered/waivered clinicians, nursing assessments, collateral services that include consultations with family, significant others and outpatient providers, client and family education, crisis intervention services, basic medical services, medication services, and referrals and linkages to the appropriate level of continuing care and community services, including Peer Specialist and Peer Mentoring services. As a designated outpatient facility, the CSU may evaluate and treat Clients for no longer than 23 hours and 59 minutes. The primary goal of the CSU is to help stabilize the crises and begin treating Clients in order to refer them to the most appropriate, least restrictive, non-hospital setting when indicated or to facilitate admission to psychiatric inpatient units when the need for this level of care is present. The CSU must meet state and local regulatory requirements.

7. Diagnosis means identifying the nature of a disorder. When formulating a Diagnosis(es), CONTRACTOR shall use the diagnostic codes as specified in the most current edition of the Diagnostic 3 and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association and/or ICD 10. ICD10 diagnoses will be recorded on all IRIS documents, as appropriate.

8. DSH means Direct Service Hours and refers to a measure in minutes that a clinician spends providing Client services. DSH credit is obtained for providing mental health, case management, medication support and a crisis intervention service to any Client open in IRIS, which includes both billable and non-billable services.

9. Engagement means the process where a trusting relationship is developed over a short period of time with the goal to link the Client(s) to appropriate services within the community. Engagement is the objective of a successful outreach.

10. Face-to-Face means an encounter between the client/parent/guardian and provider where they are both physically present. This does not include contact by phone, email, etc., except for Telepsychiatry provided in a manner that meets COUNTY protocols.

11. Head of Service means an individual ultimately responsible for overseeing the program and is required to be licensed as a mental health professional.

12. Integrated Records Information System (IRIS) means COUNTY's database system and refers to a collection of applications and databases that serve the needs of programs within COUNTY and includes functionality such as registration and scheduling, laboratory information system, billing and reporting capabilities, compliance with regulatory requirements, electronic

medical records, and other relevant applications.

13. Lanterman–Petris–Short (LPS) Act (Cal. Welf & Inst. Code, sec. 5000 et seq.) provides guidelines for handling involuntary civil commitment to a mental health institution in the State of California.

14. Licensed Clinical Social Worker (LCSW) means a licensed individual, pursuant to the provisions of Chapter 14 of the California Business and Professions Code, who can provide clinical services to individuals they serve. The license must be current and in force, and has not been suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

15. Licensed Marriage Family Therapist (MFT) means a licensed individual, pursuant to the provisions of Chapter 13 of the California Business and Professions Code, pursuant to the provisions of Chapter 14 of the California Business and Professions Code, who can provide clinical services to individuals they serve. The license must be current and in force, and has not been suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

16. Licensed Professional Clinical Counselor (LPCC) means a licensed individual, pursuant to the provisions of Chapter 13 of the California Business and Professions Code, pursuant to the provisions of Chapter 16 of the California Business and Professions Code, who can provide clinical service to individuals they serve. The license must be current and in force, and has not been suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

17. Licensed Psychiatric Technician (LPT) means a licensed individual, pursuant to the provisions of Chapter 10 of the California Business and Professions Code, who can provide clinical services to individuals they serve. The license must be current and in force, and has not been suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

18. Licensed Psychologist means a licensed individual, pursuant to the provisions of Chapter 6.6 of the California Business and Professions Code, who can provide clinical services to individuals they serve. The license must be current and in force, and has not been suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

19. Licensed Vocational Nurse (LVN) means a licensed individual, pursuant to the provisions of Chapter 6.5 of the California Business and Professions Code, who can provide clinical services to individuals they serve. The license must be current and in force, and has not been suspended or revoked. Also, it is preferred that the individual has at least one (1) year of

experience treating TAY.

20. Linkage means when a Client has attended at least one appointment or made one visit to the identified program or service for which the Client has received a referral or to which they have self-referred.

21. Live Scan means an inkless, electronic fingerprint which is transmitted directly to the Department of Justice (DOJ) for the completion of a criminal record check, typically required of employees who have direct contact with the individuals served.

22. Medi-Cal means the State of California's implementation of the federal Medicaid health care program which pays for a variety of medical services for children and adults who meet eligibility criteria.

23. Medical Necessity means that a service is medically necessary if it is needed in order to address a particular mental health condition. Four parts must be present to meet the criteria for medical necessity: 1) a covered diagnosis per COUNTY's MHP, 2) an impairment as a result of the disorder that affects your ability to function individually or in the community, 3) the intervention needed must be focused on addressing the impairment, and 4) the intervention must meet specialty mental health service criteria (i.e., the condition being treated would be responsive to mental health treatment, but would not be responsive to physical health care based treatment).

24. The Mental Health Services Act (MHSA) means a voter-approved initiative to develop a comprehensive approach to providing community-based mental health services and supports for California residents. It is also known as "Proposition 63."

25. National Provider Identifier (NPI) means the standard unique health identifier that was adopted by the Secretary of HHS Services under HIPAA for health care providers. All HIPAA covered healthcare providers, individuals, and organizations must obtain an NPI for use to identify themselves in HIPAA standard transactions. The NPI is assigned for life.

26. Milestones of Recovery Scale (MORS) refers to a Recovery scale that COUNTY uses in Adult and Older Adult Behavioral Health programs. The scale assigns Clients to their appropriate level of care and replaces diagnostic and acuity of illness-based tools.

27. Notice of Adverse Benefit Determination (NOABD), as outlined in California Code of Regulations Title 9 Chapter 11 Section 1850.210 and Title 22, Section 50179 means to provide formal written notification via hand-delivery or mail to Medi-Cal Beneficiaries and faxed or mailed to ADMINISTRATOR when services are denied, modified, reduced, delayed, suspended or terminated as specified by State standards.

28. Notice of Privacy Practices (NPP) means a document that notifies Clients of uses and disclosures of their PHI. The NPP may be made by, or on behalf of, the health plan or health care provider as set forth in HIPAA.

29. Outreach means linking Clients to appropriate Mental Health Services within the community. Outreach activities will include educating the community about the services offered and requirements for participation in the various mental health programs within the community. Such activities will result in CONTRACTOR developing its own Referral sources for programs being offered within the community.

30. Medi-Cal Peer Recovery Specialist/Counselor means an individual in a paid position who has been through the same or similar Recovery process as those being assisted to attain their Recovery goals in the CSU. A peer Recovery Specialist practice is informed by personal experience.

31. Program Director means an individual who is responsible for all aspects of administration and clinical operations of the behavioral health program, including development and adherence to the annual budget. This individual will also be responsible for the following: hiring, development and performance management of professional and support staff, and ensuring mental health treatment services are provided in concert with COUNTY and state rules and regulations.

32. Protected Health Information (PHI) means individually identifiable health information usually transmitted through electronic media. PHI can be maintained in any medium as defined in the regulations, or for an entity such as a health plan, transmitted or maintained in any other medium. It is created or received by a covered entity and is related to the past, present, or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present, or future payment for health care provided to an individual.

33. Psychiatrist means an individual who meets the minimum professional and licensure requirements set forth in Title 9, CCR, Section 623, and, preferably, has at least one (1) year of experience treating children and TAY.

34. Quality Improvement Committee (QIC) means a committee that meets quarterly to review one percent (1%) of all "high-risk" Medi-Cal recipients in order to monitor and evaluate the quality and appropriateness of services provided. At a minimum, the committee is comprised of one (1) ADMINISTRATOR, one (1) clinician, and one (1) physician who are not involved in the clinical care of the cases.

35. Referral means effectively linking Clients to other services within the community and documenting follow-up provided within five (5) business days to assure that Clients have made contact with the referred service(s).

36. Registered Nurse (RN) means a licensed individual, pursuant to the provisions of Chapter 6 of the California Business and Professions Code, who can provide clinical services to the Clients served. The license must be current and in force, and has not been suspended or

revoked.

37. Residential Counselor means an individual in a paid position who has holds a High School Diploma or General Educational Development Certificate (GED) and two (2) years' experience working in a paid position in the mental health field.

38. Resource Recommendation means the process of providing a Client with one or more suggested resources, without plans and/or an ability to follow up on Linkage status.

39. Self-Referral means when a Client or family member directly contacts a service provider with the goal of receiving services for themselves or a family member, regardless of Linkage status.

40. Seriously Emotionally Disturbed (SED) means children or adolescent minors under the age of eighteen (18) years who have a behavioral health disorder, as identified in the most recent edition of the DSM and/or the ICD 10, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. W&I 5600.3.

41. Serious Persistent Mental Impairment (SPMI) means an adult with a behavioral health disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. W&I 5600.3.

42. Supervisory Review means ongoing clinical case reviews in accordance with procedures developed by ADMINISTRATOR, to determine the appropriateness of Diagnosis and treatment and to monitor compliance to the minimum ADMINISTRATOR and Medi-Cal charting standards. Supervisory review is conducted by the program/clinic director or designee.

43. Soft Token means the security device which allows an individual user to access the COUNTY's computer based IRIS.

44. Uniform Method of Determining Ability to Pay (UMDAP) means the method used for determining an individual's annual liability for Mental Health Services received from the COUNTY mental health system and is set by the State of California. Every Client seen in any COUNTY or COUNTY-contracted program needs an UMDAP regardless of contract payment structure, whether the contract is actual cost based or fee for service.

45. Unit of Service (UOS) means the measurement used to quantify services provided to a client/member; these units can vary depending on type of service in the MHP or DMC_ODS plans. Each one (1) hour block that the Client receives crisis stabilization services shall be claimed. Partial blocks of time shall be rounded up or down to the nearest one (1) hour increment except that services provided during the first hour shall always be rounded up.

46. Wellness Action & Recovery Plan (WRAP) means a self-help technique for monitoring and responding to symptoms to achieve the highest possible levels of wellness, stability, and quality of life.

B. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Common Terms and Definitions Paragraph of this Exhibit B to the Contract.

II. BUDGET

A. COUNTY shall pay CONTRACTOR in accordance with the Payments Paragraph of this Exhibit B to the Contract and the following budget, which is set forth for informational purposes only and may be adjusted by mutual agreement, in writing, by ADMINISTRATOR and CONTRACTOR.

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Crisis Stabilization Unit

	PERIOD THREE	TOTAL
ADMINISTRATIVE COSTS		
Indirect Costs	$ 921,740	$ 921,740
TOTAL ADMINISTRATIVE COSTS	$ 921,740	$ 921,740
PROGRAM COSTS		
Salaries	$ 4,442,553	$ 4,442,553
Benefits	$ 1,337,419	$ 1,337,419
Services and Supplies	$ 687,328	$ 687,328
Subcontractor	$ 2,750,096	$ 2,750,096
TOTAL PROGRAM COSTS	$ 9,217,396	$ 9,217,396
TOTAL AMOUNT NOT TO EXCEED	$ 10,139,136	$ 10,139,136

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Crisis Residential Program

	PERIOD THREE	TOTAL
ADMINISTRATIVE COSTS		
Indirect Costs	$ 261,000	$ 261,000
TOTAL ADMINISTRATIVE COSTS	$ 261,000	$ 261,000
PROGRAM COSTS		
Salaries	$ 1,407,745	$ 1,407,745
Benefits	$ 422,323	$ 422,323
Services and Supplies	$ 606,764	$ 606,764
Subcontractor	$ 150,318	$ 150,318
TOTAL PROGRAM COSTS	$ 2,587,150	$ 2,587,150
TOTAL AMOUNT NOT TO EXCEED	$ 2,848,150	$ 2,848,150

B. CONTRACTOR and ADMINISTRATOR mutually agree that the Amount Not to Exceed identified in Paragraph II.A. of this Exhibit B to the Contract includes Indirect Costs not to exceed ten percent (10%) of Direct Costs, and which may include operating income estimated at two percent (2%). Final settlement paid to CONTRACTOR shall include Indirect Costs and such Indirect Costs may include operating income.

C. BUDGET/STAFFING MODIFICATIONS – CONTRACTOR may request to shift funds between programs, or between budgeted line items within a program, for the purpose of meeting specific program needs or for providing continuity of care to its members, by utilizing a Budget/Staffing Modification Request form provided by ADMINISTRATOR. CONTRACTOR shall submit a properly completed Budget/Staffing Modification Request to ADMINISTRATOR for consideration, in advance, which will include a justification narrative specifying the purpose of the request, the amount of said funds to be shifted, and the sustaining annual impact of the shift as may be applicable to the current contract period and/or future contract periods. CONTRACTOR shall obtain written approval of any Budget/Staffing Modification Request(s) from ADMINISTRATOR prior to implementation by CONTRACTOR. Failure of CONTRACTOR to obtain written approval from ADMINISTRATOR for any proposed Budget/Staffing Modification Request(s) may result in disallowance of those costs.

D. FINANCIAL RECORDS – CONTRACTOR shall prepare and maintain accurate and complete financial records of its cost and operating expenses. Such records will reflect the actual

cost of the type of service for which payment is claimed. Any apportionment of or distribution of costs, including indirect costs, to or between programs or cost centers of CONTRACTOR shall be documented, and will be made in accordance with GAAP, and Medicare regulations. The Client eligibility determination and fee charged to and collected from Clients, together with a record of all billings rendered and revenues received from any source, on behalf of Clients treated pursuant to the Contract, must be reflected in CONTRACTOR's financial records.

E. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Budget Paragraph of this Exhibit B to the Contract.

III. PAYMENTS

A. BASIS FOR PAYMENT: COUNTY shall pay CONTRACTOR monthly, in arrears, the provisional amount of $1,082,273 for Period Three. All payments are interim payments only and are subject to Final Settlement in accordance with the Cost Report Paragraph of the Contract for which CONTRACTOR shall be reimbursed for the actual cost of providing the services in this Exhibit B, which may include Indirect Administrative Costs, as identified in Paragraph II.A. of this Exhibit B to the Contract; provided, however, the total of such payments does not exceed COUNTY's Amount Not to Exceed as specified in the Referenced Contract Provisions of the Contract and, provided further, CONTRACTOR's costs are reimbursable pursuant to COUNTY, State and/or Federal regulations. ADMINISTRATOR may, at its discretion, pay supplemental invoices or make advance payments for any month during the term.

1. In support of the monthly invoices, CONTRACTOR shall submit an Expenditure and Revenue Report as specified in the Reports Paragraph of this Exhibit B to the Contract. ADMINISTRATOR shall use the Expenditure and Revenue Report to determine payment to CONTRACTOR as specified in Subparagraphs A.2. and A.3., below.

2. If, at any time, CONTRACTOR's Expenditure and Revenue Reports indicate that the provisional amount payments exceed the actual cost of providing services, ADMINISTRATOR may reduce COUNTY payments to CONTRACTOR by an amount not to exceed the difference between the year-to-date provisional amount payments to CONTRACTOR and the year-to-date actual cost incurred by CONTRACTOR.

3. If, at any time, CONTRACTOR's Expenditure and Revenue Reports indicate that the provisional amount payments are less than the actual cost of providing services, ADMINISTRATOR may authorize an increase in the provisional amount payment to CONTRACTOR by an amount not to exceed the difference between the year-to-date provisional amount payments to CONTRACTOR and the year-to-date actual cost incurred by CONTRACTOR.

B. CONTRACTOR's invoices shall be on a form approved or supplied by COUNTY and provide such information as is required by ADMINISTRATOR. Invoices are due the twentieth (20th) calendar day of each month. Invoices received after the due date may not be paid within the same month. Payments to CONTRACTOR should be released by COUNTY no later than thirty (30) calendar days after receipt of the correctly completed invoice form.

C. All invoices to COUNTY shall be supported, at CONTRACTOR's facility, by source documentation including, but not limited to, ledgers, journals, time sheets, invoices, bank statements, canceled checks, receipts, receiving records and records of services provided.

D. ADMINISTRATOR may withhold or delay any payment if CONTRACTOR fails to comply with any provision of the Contract.

E. COUNTY shall not reimburse CONTRACTOR for services provided beyond the expiration and/or termination of the Contract, except as may otherwise be provided under the Contract, or specifically agreed upon in a subsequent contract.

F. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Payments Paragraph of this Exhibit B to the Contract.

IV. REPORTS

A. CONTRACTOR is required to comply with all applicable reporting requirements, including the requirements set forth in Division 5 of the California Welfare Institutions Code and Division 1, Title 9 of the California Code of Regulations, as well as any reports required of LPS designated facilities in the County of Orange.

B. CONTRACTOR shall enter demographic information of all Clients served, direct services information, and other appropriate data into COUNTY's data information system (IRIS), including the utilization of the BHS Access Logs and NOABD reporting as required for all programs.

C. PROGRAMMATIC – CONTRACTOR shall submit monthly programmatic reports to ADMINISTRATOR. These reports shall be in a format approved by ADMINISTRATOR and shall include, but not limited to, descriptions of any performance objectives, outcomes, and or interim findings as directed by ADMINISTRATOR. CONTRACTOR shall be prepared to present and discuss the programmatic reports at the monthly meetings with ADMINISTRATOR, to include whether or not CONTRACTOR is progressing satisfactorily and if not, specify what steps are being taken to achieve satisfactory progress. Such reports shall be received by ADMINISTRATOR no later than the twentieth (20th) calendar day following the end of the month being reported.

D. On a monthly basis, CONTRACTOR shall report the following information to

ADMINISTRATOR:

1. Number of admissions, both involuntary vs voluntary;
2. Referral source;
3. Number of admissions by funding (Medi-Cal, Health Plan, unfunded, etc.);
4. Average daily census;
5. Average length of stay (LOS);
6. Number of discharges and inpatient transfers;
7. Type of residence upon discharge;
8. Instances of Restraint and Seclusions/ Initiated and Instances of Seclusions;
9. Percentages of Clients seen for medication by MD/NP within an hour;
10. Percentages Discharged to a lower level of care and higher level of care;
11. Number of stays over twenty-four (24) hours and respective LOS for each;
12. A mutually agreed upon measure of seclusion and restraint utilization;
13. Recidivism, defined as readmissions occurring up to 14 and 60 calendar days post-discharge; and
14. Data regarding recidivating Clients with unmet needs, defined as Clients with four or more admissions in a month.

E. ACCESS LOG – CONTRACTOR shall enter all appropriate services into County BHS Access Log in IRIS.

F. CONTRACTOR shall advise ADMINISTRATOR of any special incidents, conditions, or issue that materially or adversely affect the quality or accessibility of services provided by, or under contract with, COUNTY.

G. CONTRACTOR shall document all adverse incidents affecting the physical and/or emotional welfare of the Clients seen, including, but not limited to, serious physical harm to self or others, serious destruction of property, developments, etc., and which may raise liability issues with COUNTY. CONTRACTOR shall notify COUNTY within twenty-four (24) hours of any such serious adverse incident in the form of a Special Incident Report (SIR).

H. ADDITIONAL REPORTS – Upon ADMINISTRATOR's request, CONTRACTOR shall make such additional reports as required by ADMINISTRATOR concerning CONTRACTOR's activities as they affect the services hereunder. ADMINISTRATOR shall be specific as to the nature of information requested and allow thirty (30) calendar days for CONTRACTOR to respond.

I. CONTRACTOR shall be responsible to inform ADMINISTRATOR of any problems in collecting data, pertinent facts or interim findings, staff changes, status of license(s) and/or certification(s), changes in population served, and reasons for any changes. Additionally, a

statement that CONTRACTOR is or is not progressing satisfactorily in achieving all the terms of the Contract shall be included.

J. CONTRACTOR shall, upon ADMINISTRATOR's request, revise and make changes to all reports as needed.

K. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify this Reports paragraph in Exhibit B.

V. CRISIS STABILIZATION SERVICES

A. FACILITIES

1. CONTRACTOR shall maintain the capability to provide Crisis Stabilization Services to Clients aged thirteen (13) and above at the following facility, which meets the minimum requirements for Medi-Cal eligibility and Designation:

265 South Anita Drive
Orange, CA 92868

2. CONTRACTOR shall provide Crisis Stabilization Services twenty-four (24) hours per day seven (7) days per week, 365 days per year.

3. CONTRACTOR shall commence service delivery thirty (30) calendar days to sixty (60) calendar days from contract start date. A written request for an extension must be submitted in advance to ADMINISTRATOR for approval if CONTRACTOR is not ready to provide services by the target date.

4. The facility shall have access for persons presenting on a drive-up basis, walk-in, via police drop off and ambulance delivery.

5. The facility shall have a minimum of seventy-three hundred (7,300) square feet with the majority of the space dedicated to Clients served and their care. Treatment areas shall be in visible line of sight from the nursing area. Space shall be allocated for: rest; socialization/living room; dining; seclusion and restraint/quiet rooms for agitated persons; private intake/exam space; medication room; and sufficient workspace for staff and conference/meeting rooms. Space shall be designed for the Clients treated and treatment staff to comingle for the majority of the time and shall enable them to work together in an easily accessible fashion. There shall be space dedicated for their families and significant others/support network to receive collateral treatment and areas for family/significant others to participate in program, visit, and stay with the Client being treated as clinically indicated. Nursing stations will be open and easily accessible for staff and Clients to communicate.

6. The facility shall meet the standards of the applicable sections of:

a. Sections 1840.338 and 1840.348 of California Code of Regulations (CCR) Title 9, for Crisis Stabilization Services;

b. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794 et seq., as implemented in 45 CFR 84.1 et seq.);

c. Americans with Disabilities Act of 1990 (42 U.S.C. 12101, et seq.) pertaining to the prohibition of discrimination against qualified persons with disabilities in all programs or activities, as they exist now or may be hereafter amended together with succeeding legislation;

d. All SD/MC requirements as delineated in California Code of Regulations, Title 9, Chapter 11, Medi-Cal Specialty Mental Health Services; and

e. All applicable requirements delineated in Division 5 of the California Welfare & Institutions Code and required by ADMINISTRATOR for LPS designated facilities.

7. CONTRACTOR shall be SD/MC certified prior to the effective date for commencing contracted services. To obtain COUNTY's certification of CONTRACTOR's site, CONTRACTOR shall be responsible for making any necessary changes to meet or maintain Medi-Cal site standards.

8. CONTRACTOR shall be LPS designated prior to the effective date for commencing contracted services for Clients involuntarily detained on Welfare and Institutions Code 5150 or 5585 holds.

9. The facility shall have a capacity to serve twenty-two (22) Clients at one time and twenty-four (24) Clients per day and will include adequate physical space to support the services identified within this Contract.

10. CONTRACTOR's administrative staff holiday schedule shall be consistent with COUNTY's holiday schedule unless otherwise approved in writing by ADMINISTRATOR.

B. CLIENTS TO BE SERVED:

1. Orange County Residents;

2. Experiencing a behavioral health emergency, may have a co-occurring disorder, at risk of hospitalization and cannot wait for a regularly scheduled appointment; and

3. Individuals thirteen (13) years of age or more.

C. SERVICES TO BE PROVIDED

1. CONTRACTOR shall provide psychiatric crisis stabilization services to individuals in behavioral health crisis on a twenty-four (24) hours a day basis to provide a viable option to the default presentation to emergency departments. Crisis Stabilization Services shall be rendered to any individual presenting for services who is in a behavioral health crisis and cannot wait for their regularly scheduled appointment if it is medically safe to do so. Crisis Stabilization services

shall include, but are not limited to: psychiatric assessment, physical screening, collateral history, therapy, crisis intervention, medication services, education, nursing assessment, peer specialist services, coordination of referrals to continuing care and emergency housing, post discharge planning and facilitation of transfer of Clients to inpatient treatment facilities when clinically appropriate and indicated. Services described herein are primarily designed to provide timely and effective crisis intervention and stabilization for persons experiencing behavioral health emergencies. The goals also include: minimize distress for the Client/family resulting from lengthy waits in emergency departments, reduce the wait time for law enforcement presenting Clients for emergency behavioral health treatment; and treating the Client in the least restrictive, most dignified setting as appropriate in lieu of inpatient settings, utilizing alternative, less restrictive treatment options whenever possible and appropriate. Services shall be provided in compliance with Welfare & Institutions Code and consistent with all patients' rights regulations, upholding the dignity and respect of all Clients served and meeting the goals for such services. The services shall also be provided utilizing Trauma Informed and Recovery Model principles that are person-centered, strengths-based, individualized, focused on imparting hope and identifying strengths and resiliency in all persons served. Services shall be tailored to the unique strengths of each Client and will use shared decision-making to encourage the Client to manage their behavioral health treatment, set their own path toward recovery and fulfillment of their hopes and dreams. CONTRACTOR shall have an affiliation with an identified hospital that will be providing the facility with access to medical, laboratory and pharmaceutical support prior to initiating services.

2. CONTRACTOR shall perform clinical and psycho-diagnostic assessment using the most recent DSM and/or ICD10 to include clinical consideration of each fundamental need: physical, psychological, familial, educational, social, environmental and recreational. Additional examinations, tests and evaluations may be conducted as clinically indicated. Findings of the examinations and evaluations shall be documented in the client record and signed by CONTRACTOR's appropriate and responsible staff.

3. CONTRACTOR shall provide psychiatric evaluations by licensed psychiatrist or psychiatric nurse practitioner(s) who shall issue prescriptions and order medications as clinically indicated. Medication support services shall include a system of medication quality review provided by well-trained, experienced psychiatrists knowledgeable in the use of medication to improve functioning.

4. CONTRACTOR shall complete physical health assessments which shall be performed by a physician, doctor of osteopathy, a nurse practitioner or registered nurse. CONTRACTOR shall provide or arrange for laboratory tests as are necessary to adequately

complete the assessment and to support continued psychiatric stabilization of the Client. Non-emergency medical intervention will be provided on-site by qualified and trained and appropriately licensed individuals.

5. CONTRACTOR shall engage both the Client and the Clients' family or other significant support persons whenever possible. Such collateral services may include providing therapy to parents/guardians, adult caregivers or significant others to help the Client in maintaining living arrangements in the community. CONTRACTOR shall refer such caregiver(s) to appropriate community supports, and/or educational services. CONTRACTOR shall document contact with family/support persons or document why such contact is not possible or not advisable.

6. CONTRACTOR shall obtain valid consents from the Clients, parents or courts for treatment as required.

7. CONTRACTOR shall provide a sufficient amount of treatment services at all times to accommodate the Clients served and their supports not able to participate during regular daytime hours.

8. CONTRACTOR shall provide individual sessions for intake, recovery planning, and discharge. Additional individual counseling sessions shall take place as clinically necessary.

9. CONTRACTOR shall use individual therapy, brief intensive services, motivational interviewing, and short-term group therapy modalities including psycho-educational, cognitive behavioral and self-soothing therapy techniques.

10. CONTRACTOR shall promote recovery via individual and/or group sessions. Topics may include, but not be limited to: building a wellness toolbox or resource list, trauma informed principles of self-care, healthy habits, symptom monitoring, triggers and early warning signs of symptoms/relapse, identifying a crisis plan, and WRAP, etc.

11. CONTRACTOR shall provide all medically necessary substance use disorder treatment services for Clients who are living with a co-occurring substance use disorder problem in addition to their behavioral health issues as appropriate and shall make appropriate referrals to the SUD system of care for needs that extend beyond those that co-occur during the course of the mental health crisis stabilization episode.

12. CONTRACTOR shall develop strategies to advance trauma-informed care and to accommodate the vulnerabilities of trauma survivors.

13. Services are to be provided in an environment which is compatible with and supportive of a recovery model. Services shall be delivered in the spirit of recovery and resiliency, tailored to the unique strengths of each Client. The focus will be on personal responsibility for symptom management and independence, which fosters empowerment, hope,

and an expectation of recovery from behavioral health illness. Recovery oriented and trauma informed language and principles shall be evident and incorporated in CONTRACTOR's policies, program design and space, and practice.

14. CONTRACTOR shall sustain a culture that supports and employs Peer Recovery Specialist/Counselors in providing supportive socialization for Clients that will assist in their recovery, self-sufficiency and in seeking meaningful life activities and relationships. Peers shall be encouraged to share their stories of recovery as much as possible to stimulate the milieu with the notion that recovery is possible and to destigmatize behavioral health issues, inspire, and provide guidance.

15. CONTRACTOR shall ensure that Clients leave the facility with a medication supply (seven (7) to fourteen (14) day supply) sufficient to bridge them to their aftercare appointment with a prescribing provider by establishing a contractual agreement with a licensed pharmacy to deliver and supply discharge medications as necessary.

16. CONTRACTOR shall ensure prescribers consider respective formularies as part of their prescribing practices and in accordance with the HCA Behavioral Health Services (BHS) practice guidelines.

17. CONTRACTOR shall have light meals and snacks available as needed. Food will be nutritious and balanced and consist of an array of different foods that consider the special dietary and ethnic and cultural needs/values of the Clients served.

18. CONTRACTOR shall provide linkage and consultation with both more restrictive levels of care and community-based services designed to avoid hospitalization.

19. CONTRACTOR shall develop a written discharge and aftercare plan, including written discharge instructions for each Client that shall be based on the assessment and diagnosis of that Client. The discharge/aftercare plan and discharge instructions shall include all required elements for designated facilities.

20. CONTRACTOR shall adhere to any/all LPS designated facility requirements including providing assessments for involuntary hospitalization when necessary. This service must be available twenty-four (24) hours per day, seven (7) days per week, 365 days per year.

21. CONTRACTOR will make follow up calls to assist Clients in making successful linkage to on-going behavioral health services. Such calls shall be initiated within twenty-four (24) hours during business days and seventy-two (72) hours of discharge during weekend periods and shall be documented in the medical record as a Care Coordination Services as appropriate.

22. As a designated outpatient facility, the facility may evaluate and treat Clients for no longer than twenty-three (23) hours and fifty-nine (59) minutes. CONTRACTOR shall have a process in place for describing actions taken when a person seen at the CSU has an episode that

exceeds the twenty-three (23) hours and fifty-nine (59) minute limitation for a CSU stay. At a minimum, CONTRACTOR will notify COUNTY's Patient Rights Advocate of these instances. CONTRACTOR shall follow designated outpatient requirements as modified by the state for Crisis Stabilization.

23. CONTRACTOR is responsible to provide or arrange for the transport of Clients requiring an inpatient level of care. This may include establishing a system both emergency and non emergency transportation.

D. QUALITY IMPROVEMENT

1. CONTRACTOR shall participate in any clinical case review and implement any recommendations made by COUNTY to improve the care provided to the individuals seen.

2. CONTRACTOR shall conduct Supervisory Review in accordance with procedures developed by ADMINISTRATOR. CONTRACTOR shall ensure that all chart documentation complies with all federal, state, and local guidelines and standards.

3. CONTRACTOR shall ensure that all clinical documentation is completed promptly and is reflected in the individual's chart within seventy-two (72) hours after the completion of services.

4. CONTRACTOR shall agree to adopt and comply with the written ADMINISTRATOR Documentation Manual or its equivalent, and any State requirements, as provided by ADMINISTRATOR, which describes, but is not limited to, the requirements for Medi-Cal and ADMINISTRATOR charting standards. CONTRACTOR shall have a utilization management process in place to internally monitor documentation and billing standards on a routine basis.

5. CONTRACTOR shall demonstrate the capability to maintain a medical records system, including the capability to utilize COUNTY's IRIS system, to enter appropriate data. CONTRACTOR shall regularly review one hundred percent (100%) of their charting for accuracy and clinical appropriateness, IRIS data input and billing systems to ensure compliance with COUNTY and state P&Ps and establish mechanisms to prevent inaccurate claim submissions and follow up on corrections in a timely manner.

6. CONTRACTOR shall maintain on file, at the facility, minutes and records of all quality improvement meetings and processes. Such records and minutes also are subject to regular review by ADMINISTRATOR in the manner specified in the Quality Improvement Implementation Plan and ADMINISTRATOR's P&P.

7. CONTRACTOR shall allow ADMINISTRATOR to attend QIC and medication monitoring meetings and complete all Medication Monitoring reports per COUNTY.

8. CONTRACTOR shall allow COUNTY to periodically review the quantity and quality of services provided pursuant to this Contract. This review will be conducted at

CONTRACTOR's facility(ties) and will consist of a review of medical and other records of Clients provided services pursuant to the Contract.

9. At all times during the term of this Contact, CONTRACTOR shall maintain a compliance program in accordance with COUNTY.

10. CONTRACTOR shall attend meetings as requested by COUNTY including, but not limited to:

a. Case conferences, as requested by ADMINISTRATOR to address any aspect of clinical care and implement any recommendations made by COUNTY to improve individual care;

b. Monthly COUNTY management meetings with ADMINISTRATOR to discuss contractual and other issues related to, but not limited to, whether it is or is not progressing satisfactorily in achieving all the terms of the Contract, and if not, what steps will be taken to achieve satisfactory progress, compliance with P&Ps, review of statistics and clinical services; and

c. Clinical staff and IRIS staff training for individuals conducted by CONTRACTOR and/or ADMINISTRATOR.

11. CONTRACTOR will follow the following guidelines for COUNTY tokens:

a. CONTRACTOR recognizes access Soft Tokens are granted to specific staff members with a unique password. Passwords are not to be shared with anyone.

b. CONTRACTOR shall maintain an inventory of staff members granted access to Soft Tokens.

c. CONTRACTOR shall indicate in the monthly staffing report, the serial number of the Token for each staff member assigned a Token.

d. CONTRACTOR shall notify ADMINISTRATOR when changes have occurred under the following conditions:

1) Each staff member who no longer supports this Contract;
2) Each staff member who no longer requires access to the HCA IRIS;
3) Each staff member who leaves employment of CONTRACTOR;
4) If Soft Token is malfunctioning; or
5) Termination of Contract.

e. CONTRACTOR shall input all IRIS data following COUNTY procedure and practice. All statistical data used to monitor CONTRACTOR shall be compiled using only IRIS reports, if available, and if applicable.

12. CONTRACTOR shall obtain a NPI – The standard unique health identifier adopted by the Secretary of HHS under HIPAA of 1996 for health care providers.

a. All HIPAA covered healthcare providers, individuals and organizations must

obtain a NPI for use to identify themselves in HIPAA standard transactions.

b. CONTRACTOR, including each employee that provides services under the Contract, will obtain a NPI upon commencement of the Contract or prior to providing services under the Contract. CONTRACTOR shall report to ADMINISTRATOR, on a form approved or supplied by ADMINISTRATOR, all NPI as soon as they are available.

13. CONTRACTOR shall provide the NPP for COUNTY, as the MHP, at the time of the first service provided under the Contract to individuals who are covered by Medi-Cal and have not previously received services at a COUNTY operated clinic. CONTRACTOR shall also provide, upon request, the NPP for COUNTY, as the MHP, to any individual who received services under the Contract.

14. CONTRACTOR shall not engage in, or permit any of its employees or subcontractors, to conduct research activity on individuals seen in COUNTY services without obtaining prior written authorization from ADMINISTRATOR.

15. CONTRACTOR shall not conduct any proselytizing activities, regardless of funding sources, with respect to any individual(s) who have been referred to CONTRACTOR by COUNTY under the terms of the Contract. Further, CONTRACTOR agrees that the funds provided hereunder will not be used to promote, directly or indirectly, any religion, religious creed or cult, denomination or sectarian institution, or religious belief.

16. CONTRACTOR shall maintain all requested and required written policies, and provide ADMINISTRATOR for review, input, and approval prior to staff training on said policies. All P&Ps and program guidelines will be reviewed bi-annually at a minimum for updates. Policies will include, but not limited to, the following:

a. Admission Criteria and Admission Procedure;

b. Assessments;

c. Individual and Group Counseling Sessions;

d. Crisis Intervention/Evaluation for Involuntary Holds;

e. Treatment of Non-Compliant Individuals/Unplanned Discharges;

f. Medication Management and Medication Monitoring;

g. Recovery Program Policies and Practices;

h. Community Integration/Case Management/Discharge Planning;

i. Documentation Standards;

j. Quality Management/Performance Outcomes;

k. Individual Rights;

l. Personnel/In service Training;

m. Ensuring Proper Staffing;

n. Unusual Occurrence Reporting;

o. Code of Conduct/Compliance;

p. Mandated Reporting;

q. Seclusion and Restraints;

r. De-escalation Techniques, including use of voluntary and/or emergency medications;

s. Nutritious Snack Services; (if Clients remain in CSU over 24 hours the availability of light meals are addressed above);

t. Transportation Services;

u. Peer Support Services;

v. Chart Review Protocol; and

w. Any/all required LPS Designation Protocols.

17. CONTRACTOR shall provide initial and on-going training and staff development that includes, but is not limited to, the following:

a. Orientation to the programs' goals and P&Ps;

b. Training on subjects as required by state regulations;

c. Orientation to the services in this Paragraph V. of this Exhibit B to the Contract;

d. Recovery philosophy, Trauma Informed Care and individual empowerment;

e. Crisis intervention and de-escalation;

f. Substance use disorder and dependence;

g. Motivational interviewing;

h. Seclusion and Restraints;

i. Crisis Prevention and Crisis Intervention Training;

j. Documentation Training;

k. Assessment and Diagnosis;

l. LPS Involuntary Detention Policies; and

m. Community and Ancillary Resources.

E. PROGRAM DIRECTOR – The Program Director will have ultimate responsibility for the program (s) and will ensure the following:

1. CONTRACTOR shall maintain adequate records on each individual seen in services, which shall include all required forms and evaluations, on-going progress notes, and records of service provided by various personnel in sufficient detail to permit an evaluation of services;

2. CONTRACTOR shall designate a qualified reviewer of records. This reviewer shall complete one hundred percent (100%) review of individual charts regarding clinical documentation, ensuring all charts are in compliance with medical necessity and Medi-

Cal/Medicare chart compliance. CONTRACTOR shall ensure that all chart documentation complies with all federal, state and local guidelines and standards. CONTRACTOR shall ensure that all chart documentation is completed within the appropriate timelines.

3. Provide clinical direction and training to staff on all clinical documentation;

4. Oversee all aspects of the clinical services of the Crisis Stabilization program (s);

5. Coordinate with clinicians, psychiatrists and/or nurses regarding individual treatment issues, professional consultations, or medication evaluations; and

6. Facilitate on-going program development and provide or ensure appropriate and timely supervision and guidance to staff regarding difficult cases and mental health emergencies

F. PERFORMANCE OUTCOMES

1. CONTRACTOR shall be required to achieve, track and report Performance Outcome Objectives, on a quarterly basis as outlined below:

a. Sustain an average daily census of twenty four (24) unduplicated individuals per day;

b. At least sixty percent (60%) of Clients admitted shall be successfully stabilized and returned to the community;

c. At least seventy-five percent (75%) of Clients returned to the community shall successfully link (keep appointment) to on-going behavioral health services within fourteen (14) calendar days of discharge;

d. Provide timely evaluations as measured by completing ninety-five percent (95%) of CSU admissions within one (1) hour of Clients arrival on a monthly basis; and

e. CONTRACTOR shall work towards the ability to track the rate of readmission to any CSU within two days of CONTRACTOR discharge and will remain below two percent (2%) of all admissions.

f. CONTRACTOR and COUNTY shall work towards the ability to track the rate of mobile Crisis Assessment Team (CAT) response within two days of discharge will remain below five percent (5%) of all admissions

G. DATA: On a monthly basis, CONTRACTOR shall report the following information to ADMINISTRATOR:

1. Number of admissions, both involuntary vs voluntary;
2. Referral source;
3. Number of admissions by funding (Medi-Cal, Health Plan, unfunded, etc.);
4. Average daily census;
5. Average length of stay (LOS);
6. Number of discharges and inpatient transfers;

7. Type of residence upon discharge;
8. Summary of Satisfaction Survey Results;
9. Instances of Restraint and Seclusions/ Initiated and Instances of Seclusions;
10. Percentages of Clients seen for medication by MD/NP within an hour;
11. Percentages Discharged to a lower level of care and higher level of care;
12. Number of stays over twenty-four (24) hours and respective LOS for each; and
13. Data regarding recidivating Clients with unmet needs, defined as Clients with four or more admissions in a month.

H. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Crisis Stabilization Services Paragraph of this Exhibit B to the Contract.

VI. CRISIS RESIDENTIAL SERVICES

A. FACILITIES

1. CONTRACTOR shall maintain a facility(ies) for the provision of Adult Crisis Residential Services. The facility(ies) shall include space to support the services identified within the Contract.

2. CONTRACTOR shall meet the standards of the applicable sections of:

a. HSC Code 1520 et.seq;

b. CCR, Title 22. Division 6, Chapter 2, Social Rehabilitation Facilities; Subchapter 1, Article 7;

c. CCR, Title 9, Division 1, Chapter 3, Article 3.5 Standards for the Certification of Social Rehabilitation Programs;

d. WIC Division 5, Part 2, Chapter 2.5, Article 1, section 5670.5;

e. Section 504 of the Rehabilitation Act of 1973 -- (29 U.S.C. 794 et seq., as implemented in 45 CFR 84.1 et seq.);

f. Americans with Disabilities Act of 1990 (42 U.S.C. 12101, et seq.) pertaining to the prohibition of discrimination against qualified persons with disabilities in all programs or activities, as they exist now or may be hereafter amended together with succeeding legislation.

3. The facility shall have a capacity of fifteen (15) beds and include adequate physical space to support the services identified within the Contract.

4. The facility shall be open for regular admissions between the hours of 8:00 a.m. and 8:00 p.m. Monday through Sunday and will also maintain the ability to accept an admission outside of these hours as requested. Services to Clients in this program will be provided on a twenty-four (24) hour, seven (7) day per week, three hundred sixty-five (365) day per year basis.

5. CONTRACTOR's holiday schedule shall be consistent with COUNTY's holiday

schedule unless otherwise approved, in advance and in writing, by ADMINISTRATOR.

B. INDIVIDUALS TO BE SERVED – CONTRACTOR shall provide short-term crisis residential services to individuals evaluated by and referred by COUNTY, COUNTY contractors, and other referring providers as appropriate. CONTRACTOR will serve as the principal source to authorize admissions of individuals who meet the following criteria:

1. Adults between ages eighteen and fifty-nine (18 and 59) and individuals over sixty (60) years of age whose needs are compatible with those of other Clients if they require the same level of care and supervision and all Community Care Licensing requirements can be met;
2. COUNTY Client;
3. Diagnosed with a behavioral health disorder and who may have a co-occurring disorder;
4. In crisis and at the risk of hospitalization and could safely benefit from this level of care; and
5. Willing to participate fully and voluntarily in services.

C. ADULT CRISIS RESIDENTIAL PROGRAM – This program operates twenty-four (24) hours a day, seven (7) days a week, emulates a home-like environment and supports a social rehabilitation model, which is designed to enhance individuals' social connections with family or community so that they can move back into the community and prevent inpatient stays. Short-term crisis residential services will be provided to adults who are in behavioral health crises and may be at risk of psychiatric hospitalization and will involve families and significant others throughout the treatment episodes so that the dynamics of the Clients' circumstances are improved prior to discharge. For individuals who are referred from Adult and Older Adult Behavioral Health Services County or County-contracted behavioral health providers CONTRACTOR shall collaborate with these existing providers to arrange for discharge planning, appropriate housing placements, as needed, in addition to securing linkages to ongoing treatment providers prior to discharge. Crisis residential services provide positive, temporary alternatives for people experiencing acute psychiatric episodes or intense emotional distress who might otherwise face voluntary or involuntary inpatient treatment. CONTRACTOR shall provide crisis intervention, therapy, medication monitoring and evaluation to determine the need for the type and intensity of additional services within a framework of evidence based and trauma-informed approaches to recovery planning, including a rich peer support component. Services shall include treatment for co-occurring disorders based on either harm-reduction or abstinence-based approaches, if clinically appropriate, to wellness and recovery, including providing a safe, smoke free, drug free, accepting environment that nurtures Clients' processes of personal growth and overall wellness. CONTRACTOR must emphasize mastery of daily living skills and

social development using strength-based approaches that support recovery and wellness. The residential settings will create solid links to the continuum of care with heavy emphasis on housing supports and linkages that will ease the transitions into independent living and prevent recidivism. Intensive psychosocial services are provided on an individual and group basis by licensed and licensed-waivered mental health professionals, including therapy, crisis intervention, group education, assistance with self-administration of medications and case management. The focus is on recovery and intensive behavioral health treatment, management and discharge planning, linkage and reintegration into the community. The average length of stay per Client is twenty one (21) calendar days. The program will offer an environment where Clients are supported as they look at their own life experiences, set their own paths toward recovery, and work towards the fulfillment of their hopes and dreams. The Clients are expected to participate fully in all program activities, including all individual sessions, groups, and recovery oriented outings.

1. CONTRACTOR shall operate the program in such a manner that meets or exceeds the following regulations:

a. HSC 1520 et.seq;

b. CCR,Title 22, Division 6, Chapter 2 Social Rehabilitation Facilities;

c. CCR, Title 9, Division 1, Chapter 3, Article 3.5 Standards for the Certification of Social Rehabilitation Programs, Section 531-535; and

d. WIC Division 5, Part 2, Chapter 2.5, Article 1, section 5670, 5670.5 and 5671.

2. CONTRACTOR shall provide short term crisis residential program services as follows:

a. Admission Services:

1) CONTRACTOR shall admit individuals who have been determined to meet admission criteria and will have the Client sign an admission agreement describing the services to be provided, Client rights, and the expectations of the Client regarding house rules and involvement in all aspects of the program, including individual and group therapy sessions.

2) CONTRACTOR shall complete a thorough behavioral health assessment and psychiatric evaluation within twelve (12) hours of admission.

3) During the initial seventy-two (72) hours subsequent to admission, Clients will be expected to remain on site at all times to ensure integration into the program. After this initial period, Client may be eligible for a day pass to an approved activity, usually an MD appointment or an appointment for housing, etc. Prior to the approved activity pass, the Client must be clinically evaluated an hour prior to departure and immediately upon returning to the facility. These clinical evaluations will be clearly documented in the Client's chart.

4) CONTRACTOR shall obtain or complete a medical history within twenty-four (24) hours of admission.

5) CONTRACTOR shall be responsible for Client's TB testing upon admission if Client has not completed the test prior to admission to the program.

6) CONTRACTOR shall not deny referrals for Clients that meet medical necessity if CONTRACTOR has available space and appropriate staffing.

7) CONTRACTOR and Client will together develop a written plan of care specifying goals and objectives, involving Client's family and support persons as appropriate, and as aligned with a recovery focused, person-centered and directed approach within seventy-two (72) hours of admission. CONTRACTOR shall involve the Client's family and support persons, or document attempts to obtain agreement until agreement is obtained or the Client is discharged.

8) Within seventy-two (72) hours of admission, CONTRACTOR shall establish a discharge date in collaboration with the Client and their family/support system. The targeted discharge date will be within twenty-one (21) calendar days after admission.

b. Therapeutic Services:

1) CONTRACTOR shall provide structured day and evening services seven (7) calendar days a week which will include individual, group therapy, and community meetings amongst the Clients and crisis residential staff.

2) CONTRACTOR shall provide group counseling sessions at least four (4) times daily to assist Clients in developing skills that enable them to progress towards self-sufficiency and to reside in less intensive levels of care. Topics may include, but not be limited to: self-advocacy, personal identity, goal setting, developing hope, coping alternatives, processing feelings, conflict resolution, relationship management, proper nutrition, personal hygiene and grooming, household management, personal safety, symptom monitoring, etc. These groups will be clearly documented in the individual's chart. All therapeutic process groups will be facilitated by a licensed clinician or clinically supervised registered/waivered clinicians.

3) CONTRACTOR shall provide individual therapeutic sessions provided by an MD/DO/NP, licensed clinician, or clinically supervised registered/waivered staff at least one time a day to each Client and these sessions will be clearly documented in the chart.

4) CONTRACTOR shall support a culture of "recovery" which focuses on personal responsibility for a Client's behavioral health management and independence, and fosters Client empowerment, hope, and an expectation of recovery from mental illness. Activities and chores shall be encouraged and assigned to each Client on a daily basis to foster responsibility and learning of independent living skills. These chores will be followed up on by residential staff, in the spirit of learning, who will also assist the Client in learning the new skills and completing

the chores as needed.

5) CONTRACTOR's program will be designed to enhance Client motivation to actively participate in the program, provide Clients with intensive assistance in accessing community resources, and assist Clients developing strategies to maintain independent living in the community and improve their overall quality of life. Therapeutic outings (to local museums, art galleries, nature centers, parks, coffee shops) will be provided for all Clients in support of these goals.

6) CONTRACTOR shall assist the Client in developing and working on a WRAP throughout their stay at the program and will promote Client recovery on a daily basis via individual and/or group sessions. This will assist Clients in monitoring and responding to their symptoms in order to achieve the highest possible level of wellness, stability and quality of life. Topics may include but not be limited to: building a wellness toolbox or resource list, symptom monitoring, triggers and early warning signs of symptoms, identifying a crisis plan, etc.

7) CONTRACTOR shall engage both the Client and family/support persons in the program whenever possible. CONTRACTOR shall document contact with family/support persons or document why such contact is not possible or not advisable.

8) CONTRACTOR shall support a Dual Disorders Integrated Treatment Model that is non-confrontational, follows behavioral principles, considers interactions between behavioral health disorders and substance abuse and has gradual expectations of abstinence. CONTRACTOR shall provide, on a regularly scheduled basis, education via individual and/or group sessions to Clients on the effects of alcohol and other drug abuse, triggers, relapse prevention, and community recovery resources. Twelve (12) step groups and Smart Recovery groups will be encouraged at the facility on a regular basis.

9) CONTRACTOR shall support a culture that supports a smoke free environment in the facility and on the campus. CONTRACTOR shall provide educational groups regarding tobacco cessation and provide viable alternatives such as tobacco patches and other approved methods that support tobacco use reduction and cessation.

10) CONTRACTOR shall assist Clients in developing prevocational and vocational plans to achieve gainful employment and/or perform volunteer work if identified as a goal in the service plan.

11) CONTRACTOR shall provide crisis intervention and crisis management services designed to enable the Client to cope with the crisis at hand while maintaining his/her functioning status within the community and to prevent further decompensation or hospitalization.

12) CONTRACTOR shall provide assessments for involuntary hospitalization

when necessary. This service must be available twenty-four (24) hours per day, seven (7) days per week.

13) CONTRACTOR will provide information, support, advocacy education, and assistance with including the Client's natural support system in treatment and services.

14) CONTRACTOR shall sustain a culture that supports Peer Recovery Specialist/Counselors in providing supportive socialization for Clients that will assist Clients in their recovery, self-sufficiency and in seeking meaningful life activities and relationships. Peers shall be encouraged to share their stories of recovery as much as possible to infuse the milieu with the notion that recovery is possible.

15) CONTRACTOR shall provide close supervision and be aware of Clients' whereabouts at all times to ensure the safety of all Clients. Every clinician and Residential Counselor will have an assigned caseload and be responsible for the monitoring of the assigned Clients. CONTRACTOR shall provide routine room checks in the evening and document observations. Rounds are completed by staff on regular intervals.

16) CONTRACTOR will actively explore, research and present ideas for additional evidence-based practices in order to continually improve and refine aspects of the program.

c. Case Management/Discharge Services:

1) CONTRACTOR shall actively engage in discharge planning from the day of admission, instructing and assisting Clients with successful linkage to community resources such as outpatient mental health clinics, substance abuse treatment programs, housing, including providing supportive assistance to the Client in identifying and securing adequate and appropriate follow up living arrangements, physical health care, and government entitlement programs.

2) CONTRACTOR shall collaborate proactively with Client's Mental Health Plan Provider when such is required to link Clients to COUNTY or contracted housing services which may include continued temporary housing, permanent supported housing, interim placement, or other community housing options.

3) CONTRACTOR shall assist Clients in scheduling timely follow-up appointment(s) between Client and their mental health service provider while still a Client or within twenty-four (24) hours following discharge to ensure that appropriate linkage has been successful and if not, relinkage services will be provided. Provide telephone follow up within five (5) days to ensure linkage was successful. Services shall be documented in the Client record. Peer Recovery Specialists and Residential Counselors will be expected to accompany Clients to their follow up linkage appointments as part of their case management duties.

4) CONTRACTOR shall coordinate treatment with physical health providers

as appropriate and assist Clients with accessing medical and dental services and providing transportation and accompaniment to those services as needed.

5) CONTRACTOR shall develop a plan to provide a van/car for each admission as needed accompanied by a Residential Counselor so that a warm hand-off can occur when a Client is in need of transport to the facility. This will also ensure that the engagement and welcoming process commences immediately when a referral is received. Transportation out of the program will also be required to be provided by CONTRACTOR.

6) CONTRACTOR shall obtain concurrent review from ADMINISTRATOR for Clients who are deemed necessary to stay in the program for more than twenty-one (21) calendar days. CONTRACTOR will abide by County Policies from ADMINISTRATOR for Clients who are deemed necessary to stay in the program for more than twenty-one (21) calendar days.

7) Unplanned discharges will be avoided at all costs and only after all other interventions have failed. If, at any time, a Client presents as a serious danger to themselves or others, CONTRACTOR shall assess the safety needs of all concerned and may have the Client assessed for voluntary or involuntary hospitalization utilizing ADMINISTRATOR protocols. If a Client is seriously or repetitively non-compliant with the program, CONTRACTOR may discharge the Client if deemed necessary and only following a multi-disciplinary case conference which will include ADMINISTRATOR. CONTRACTOR shall be in compliance with eviction procedures following the CCR, Title 22, Section 81068.5, and Title 9, Section 532.3, and will provide an unusual occurrence report to ADMINISTRATOR no later than the following business day.

8) In the event a Client leaves the program against clinical advice, CONTRACTOR shall hold Client's bed open for twenty-four (24) hours unless otherwise mutually agreed upon by ADMINISTRATOR and CONTRACTOR.

9) In the event a Client is transferred for crisis stabilization to the COUNTY CSU or to the Emergency Department (ED), CONTRACTOR shall provide a warm hand-off to the CSU or ED receiving staff member and hold a Client's bed open for twenty-four (24) hours unless otherwise mutually agreed upon by ADMINISTRATOR and CONTRACTOR.

d. Medication Support Services:

1) CONTRACTOR shall provide medications, as clinically appropriate, to all Clients regardless of funding.

2) CONTRACTOR shall educate Clients on the role of medication in their recovery plan, and how the Client can take an active role in their own recovery process. CONTRACTOR shall provide education to Clients on medication choices, risks, benefits,

alternatives, side effects and how these can be managed. Client education will be provided on a regularly scheduled basis via individual and group sessions.

3) CONTRACTOR shall obtain signed medication consent forms for each psychotropic medication prescribed.

4) Medications will be dispensed by a physician's order by licensed and qualified staff in accordance with CCR, Title 9, Div. 1, Chapter 3, Article 3.5, Section 532.1, as well as CCL Requirements.

5) Licensed staff authorized to dispense medication will document the Client's response to their medication, as well as any side effects to that medication, in the Client's record.

6) CONTRACTOR shall insure all medications are securely locked in a designated storage area with access limited to only those personnel authorized to prescribe, dispense, or administer medication.

7) CONTRACTOR shall establish written policies and procedures that govern the receipt, storage and dispensing of medication in accordance with state regulations.

8) CONTRACTOR shall not utilize sample medications in the program without first establishing policies and procedures for the use of sample medications consistent with State regulatory requirements.

9) CONTRACTOR shall provide a medication follow-up visit by a psychiatrist at a frequency necessary to manage the acute symptoms to allow the Client to safely stay at the Crisis Residential Program and to prepare the Client to transition to outpatient level of care upon discharge. At a minimum, CONTRACTOR shall provide an initial psychiatric evaluation by a psychiatric prescribing provider within twelve (12) hours after admission and will have a psychiatric prescribing provider available as needed for medication follow-up as needed or at a minimum twice per week thereafter.

10) Upon discharge, CONTRACTOR shall make available a sufficient supply of current psychiatric medications to which the Client has responded, to meet the Client's needs until they can be seen in an outpatient clinic. This may be a combination of new prescriptions, the Client's specific medications remaining at the Crisis Residential Program, and/or additional sample medications with patient labels.

11) CONTRACTOR shall utilize the COUNTY PBM to supply medications for unfunded Clients.

e. Transportation Services:

1) CONTRACTOR shall provide transportation services for program related activities which may include, but not be limited to, transportation to appointments deemed necessary for medical or dental care or activities related to and in support of preparation for

discharge and/or community integration. All other non-crucial appointments will be delayed until after the Client is discharged. CONTRACTOR staff will accompany Clients on these necessary appointments.

f. Food Services:

1) CONTRACTOR shall meet meal service and food supply requirements per Community Care Licensing regulations which shall include, but not be limited to:

a) Meals shall be served in the dining room and tray service provided on emergency need only so as to encourage community food preparation, eating and clean-up activities.

b) CONTRACTOR shall create opportunities for Clients to participate in the planning, preparation and clean-up of food preparation activities.

c) Food Services will meet meal and food supply requirements, including an abundant supply of healthy and fresh food options, including fruits, vegetables and other items that promote healthy choices and wellness.

D. PROGRAM DIRECTOR/QI RESPONSIBILITIES – The Program Director will have ultimate responsibility for the program and will ensure the following:

1. Maintenance of adequate records on each Client which shall include all required forms and evaluations, a written treatment/rehabilitation plan specifying goals, objectives, and responsibilities, on-going progress notes, and records of service provided by various personnel in sufficient detail to permit an evaluation of services.

2. There is a supervisory and administrative structure in place that will ensure high quality, consistent staff are providing high quality and consistent trauma informed services at all hours of operation, including the evenings and nocturnal shifts.

3. The Clinical Supervisor, the Program Administrator/Manager or designated Qualified Staff will complete one hundred percent (100%) review of Client charts regarding clinical documentation, ensuring all charts are in compliance with medical necessity and Medi-Cal and Medicare requirements. Charts will be reviewed within one day of admission to ensure that all initial charting requirements are met and at the time of discharge. CONTRACTOR shall ensure that all chart documentation complies with all federal, state and local guidelines and standards. CONTRACTOR shall ensure that all chart documentation is completed within the appropriate timelines.

4. Provide clinical direction and training to staff on all clinical documentation and treatment plans/problem lists;

5. Retain on staff, at all times, a qualified individual trained by the ADMINISTRATOR's QMS division; ADMINISTRATOR is requesting that Clinical Supervisor

and Program Administrator/Manager positions carry out these duties;

6. Oversee all aspects of the clinical services of the recovery program, know each Client by name and be familiar with details of each of the Clients' cases/situations that brought them to the program;

7. Coordinate with in-house clinicians, psychiatrist and/or nurse regarding Client treatment issues, professional consultations, or medication evaluations;

8. Review and approve all monthly/quarterly/annual logs submitted to ADMINISTRATOR, (e.g. medication monitoring and utilization review); and

9. Facilitate on-going program development and provide or ensure appropriate and timely supervision and guidance to staff regarding difficult cases and behavioral health emergencies.

E. QUALITY IMPROVEMENT

1. CONTRACTOR shall agree to adopt and comply with the written Quality Improvement Implementation Plan and procedures provided by ADMINISTRATOR which describe the requirements for quality improvement, supervisory review and medication monitoring.

2. CONTRACTOR shall agree to adopt and comply with the written ADMINISTRATOR Documentation Manual or its equivalent, and any State requirements, as provided by ADMINISTRATOR, which describes, but is not limited to, the requirements for Medi-Cal, Medicare and ADMINISTRATOR charting standards.

3. CONTRACTOR shall demonstrate the capability to maintain a medical records system, including the capability to utilize COUNTY's IRIS system to enter appropriate data. CONTRACTOR shall regularly review its charting, IRIS data input and billing systems to ensure compliance with COUNTY and State P&Ps and establish mechanisms to prevent inaccurate claim submissions.

4. CONTRACTOR shall maintain on file, at the facility, minutes and records of all quality improvement meetings and processes. Such records and minutes will also be subject to regular review by ADMINISTRATOR in the manner specified in the Quality Improvement Implementation Plan and ADMINISTRATOR's P&P.

5. CONTRACTOR shall allow ADMINISTRATOR to attend QIC and medication monitoring meetings.

6. CONTRACTOR shall allow COUNTY to review the quantity and quality of services provided pursuant to this Contract quarterly or as needed. This review will be conducted at CONTRACTOR's facility and will consist of a review of medical and other records of Clients provided services pursuant to the Contract.

F. CONTRACTOR shall attend meetings, trainings and presentations as requested by COUNTY including but not limited to:

1. Case conferences, as requested by ADMINISTRATOR to address any aspect of clinical care and implement any recommendations made by COUNTY to improve Client care.

2. Monthly COUNTY management meetings with ADMINISTRATOR to discuss contractual and other issues related to, but not limited to whether it is or is not progressing satisfactorily in achieving all the terms of the Contract, and if not, what steps will be taken to achieve satisfactory progress, compliance with P&Ps, review of statistics and clinical services;

3. Any trainings that COUNTY recommends or deems necessary.

4. Any presentations/in-services as requested by COUNTY involving new providers/systems of care so that CONTRACTOR is educated, apprised, up to date, knowledgeable and part of the larger COUNTY system of care.

5. Clinical staff and IRIS staff training for individuals conducted by CONTRACTOR and/or ADMINISTRATOR.

6. CONTRACTOR will follow the following guidelines for COUNTY tokens:

a. CONTRACTOR recognizes Tokens are assigned to a specific individual staff member with a unique password. Tokens and passwords will not be shared with anyone.

b. CONTRACTOR shall maintain an inventory of the Tokens, by serial number and the staff member to whom each is assigned.

c. CONTRACTOR shall request that ADMINISTRATOR deactivate all Tokens under the following conditions:

1) Token of each staff member who no longer supports this Contract;

2) Token of each staff member who no longer requires access to COUNTY IRIS;

3) Token of each staff member who leaves employment of CONTRACTOR;

4) Token is malfunctioning; or

5) Termination of Contract.

d. CONTRACTOR shall input all IRIS data following COUNTY procedure and practice. All statistical data used to monitor CONTRACTOR shall be compiled using IRIS reports, if available, and if applicable.

G. CONTRACTOR shall obtain a NPI – The standard unique health identifier adopted by the Secretary of HHS under HIPAA of 1996 for health care providers.

1. All HIPAA covered healthcare providers, individuals and organizations must obtain a NPI for use to identify themselves in HIPAA standard transactions.

2. CONTRACTOR, including each employee that provides services under the Contract,

will obtain a NPI upon commencement of the Contract or prior to providing services under the Contract. CONTRACTOR shall report to ADMINISTRATOR, on a form approved or supplied by ADMINISTRATOR, all NPI as soon as they are available.

H. CONTRACTOR shall provide the NPP for COUNTY, as the MHP, at the time of the first service provided under the Contract to individuals who are covered by Medi-Cal and have not previously received services at a COUNTY operated clinic. CONTRACTOR shall also provide, upon request, the NPP for COUNTY, as the MHP, to any individual who received services under the Contract.

I. CONTRACTOR shall not engage in, or permit any of its employees or subcontractors, to conduct research activity on Clients without obtaining prior written authorization from ADMINISTRATOR.

J. CONTRACTOR shall not conduct any proselytizing activities, regardless of funding sources, with respect to any individual(s) who have been referred to CONTRACTOR by COUNTY under the terms of the Contract. Further, CONTRACTOR agrees that the funds provided hereunder will not be used to promote, directly or indirectly, any religion, religious creed or cult, denomination or sectarian institution, or religious belief.

K. CONTRACTOR shall maintain all requested and required written policies, and provide to ADMINISTRATOR for review, input, and approval prior to staff training on said policies. All P&Ps and program guidelines will be reviewed bi-annually at a minimum for updates. Policies will include but not limited to the following:

1. Admission Criteria and Admission Procedure;
2. Assessments and Individual Service Plans;
3. Crisis Intervention/Evaluation for Involuntary Holds;
4. Handling Non-Compliant Clients/Unplanned Discharges;
5. Medication Management and Medication Monitoring;
6. Recovery Program/Rehabilitation Program;
7. Community Integration/Case Management/Discharge Planning;
8. Documentation Standards;
9. Quality Management/Performance Outcomes;
10. Client Rights;
11. Personnel/In service Training;
12. Unusual Occurrence Reporting;
13. Code of Conduct/Compliance;
14. Mandated Reporting; and
15. Good Neighbor Policy.

L. CONTRACTOR shall provide initial and on-going training and staff development that includes but is not limited to the following:

1. Orientation to the program's goals and P&Ps;
2. Training on subjects as required by state regulations;
3. Orientation to the services sections outlined in this Section VI. of this Exhibit B to the Contract;
4. Recovery philosophy and individual empowerment;
5. Crisis intervention and de-escalation;
6. Substance abuse and dependence; and
7. Motivational interviewing.

M. PERFORMANCE OUTCOMES

1. CONTRACTOR shall be required to achieve, track and report Performance Outcome Objectives, on a quarterly basis as outlined below:

a. A minimum of seventy-five percent (75%) of Clients shall be discharged to a lower level of care.

b. A minimum of seventy percent (70%) of Clients shall be linked to a continuing care provider.

c. A minimum of ninety-five percent (95%) of Clients shall not be hospitalized within 48 hours of discharge.

d. A minimum of seventy-five percent (75%) of Clients shall not be readmitted within fourteen (14) calendar days of discharge.

e. Average Length of Stay for all Clients shall be tracked and reported.

N. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Crisis Residential Services Paragraph of this Exhibit B to the Contract.

VII. STAFFING

A. CONTRACTOR shall provide adequate staffing to assure that the services outlined above are performed in an efficient manner.

B. Crisis Stablization Services:

1. CONTRACTOR shall provide staffing in conformance with Title 9 regulations for Crisis Stabilization services; shall have as Head of Service a licensed mental health professional in conformance to one of the following staff categories: Psychiatrist, Licensed Psychologist, LCSW, LPCC, Licensed MFT or RN; and shall have one RN on-site at all times.

C. Crisis Residential Services:

1. CONTRACTOR shall ensure that all staff are trained and have a clear understanding

of all Personnel Requirements as stated in CCR Title 22, standards for a Social Rehabilitation Facility as for a Short Term Crisis Residential Division 6, 81065 and that continuing education is provided.

2. Staffing levels and qualifications will meet the requirements as stated in CCR Title 22, Division 6, Chapters 1 and 2; Title 9, Division 1, Chapter 3, Article 3.5; as well as the WIC Division 5, Part 2, Chapter 2.5, Article 1; and the HSC Division 2, Chapter 3, Article 2, and/or other certification standards for a Social Rehabilitation Facility as well as for a Short Term Crisis Residential, as appropriate to the services being provided. A sufficient number of clinical staff will be licensed in order to meet all State requirements. COUNTY shall not reimburse CONTRACTOR for services provided by clinical staff who do not meet these requirements.

3. A limited number of clinical staff will be qualified and designated by COUNTY to perform evaluations pursuant to Section 5150, WIC.

4. WORKLOAD STANDARDS

a. One (1) DSH will be equal to sixty (60) minutes of direct Client service.

b. CONTRACTOR shall provide nine hundred fifty (950) DSHs per year of direct physician time which will include medication support services which are inclusive of both billable and non-billable services.

c. CONTRACTOR shall ensure prescriber services are available a minimum of three (3) hours per day, seven (7) days a week and that each Client is seen at least twice per week or more often as needed.

d. CONTRACTOR shall provide four thousand eight hundred (4,800) Client bed days per year, which are inclusive of both billable and non-billable services.

e. CONTRACTOR shall, during the term of the Contract, provide Client related services, tracking the number of individual counseling sessions and number of therapeutic and educational didactic groups provided with a minimum of four (4) groups, including two therapeutic groups facilitated by licensed clinicians or clinically supervised registered/waivered clinicians and two didactic groups facilitated by non-licensed staff, and one (1) individual session provided by a licensed clinician or clinically supervised registered/waivered clinicians per day .

D. Both Programs:

1. CONTRACTOR shall notify ADMINISTRATOR, in writing, within seventy-two (72) hours, of any staffing vacancies that occur during the term of the Contract. CONTRACTOR's notification shall include at a minimum the following information: employee name(s), position title(s), date(s) of resignation, date(s) of hire, and a description of recruitment activity.

2. CONTRACTOR shall notify ADMINISTRATOR, in writing, at least seven (7) calendar days in advance, of any new staffing changes; including promotions, temporary FTE

changes and internal or external temporary staffing assignment requests that occur during the term of the Contract.

3. CONTRACTOR shall include bilingual/bicultural services to meet the needs of threshold languages as determined by ADMINISTRATOR. Whenever possible, bilingual/bicultural staff should be retained. Any clinical vacancies occurring at a time when bilingual and bicultural composition of the clinical staffing does not meet the above requirement, the vacancies must be filled with bilingual and bicultural staff unless ADMINISTRATOR consents, in advance and in writing, to the filling of those positions with non-bilingual staff. Salary savings resulting from such vacant positions may not be used to cover costs other than salaries and employees benefits unless otherwise authorized, in advance and in writing, by ADMINISTRATOR.

4. CONTRACTOR shall maintain personnel files for each staff person, including management and other administrative positions, both direct and indirect to the Contract, which shall include, but not be limited to, an application for employment, qualifications for the position, applicable licenses, waivers, registrations, documentation of bicultural/bilingual capabilities (if applicable), pay rate and evaluations justifying pay increases.

5. CONTRACTOR shall make its best effort to provide services pursuant to the Contract in a manner that is culturally and linguistically appropriate for the population(s) served. CONTRACTOR shall maintain documents of such efforts which may include; but not be limited to: records of participation in COUNTY-sponsored or other applicable training; recruitment and hiring P&Ps; copies of literature in multiple languages and formats, as appropriate; and descriptions of measures taken to enhance accessibility for, and sensitivity to, Clients who are physically challenged.

6. CONTRACTOR shall recruit, hire, train, and maintain staff that are persons in recovery, and/or family members of persons in recovery. These individuals shall not be currently receiving services directly from CONTRACTOR. Documentation may include, but not be limited to, the following: records attesting to efforts made in recruitment, hiring practices and identification of measures taken to enhance accessibility for potential staff in these categories.

7. CONTRACTOR shall ensure that all staff, paid or unpaid, complete necessary training prior to discharging duties associated with their titles and any other training necessary to assist CONTRACTOR and COUNTY to be in compliance with prevailing standards of practice as well as State and Federal regulatory requirements.

8. CONTRACTOR shall provide ongoing supervision throughout all shifts to all staff, paid or unpaid, direct line staff or supervisors/directors, to enhance service quality and program effectiveness. Supervision methods should include debriefings and consultations as needed,

individual supervision or one-on-one support, and team meetings. Supervision should be provided by a supervisor who has extensive knowledge regarding behavioral health issues.

9. CONTRACTOR may augment the above paid staff with volunteers or interns upon written approval of ADMINISTRATOR. CONTRACTOR shall provide supervision to volunteers or intern as specified in their respective job descriptions or work contracts.

10. CONTRACTOR shall ensure that all staff, including interns and volunteers, are trained and have a clear understanding of all P&Ps. CONTRACTOR shall provide signature confirmation of the P&P training for each staff member and place in their personnel files.

11. CONTRACTOR shall provide detailed job descriptions, including education and experience requirements, all applicable responsibilities, assigned duties, and workflow for each delineated position.

E. CONTRACTOR shall, at a minimum, provide the following staffing pattern expressed in Full-Time Equivalents (FTEs) continuously throughout the term of the Contract. One (1) FTE shall be equal to an average of forty (40) hours work per week.

Crisis Stabilization Unit Staffing

Program	FTE
Program Director	1.00
Program Support Assistant	1.00
Biller	2.00
RN/LVNe	20.69
Mental Health Worker	19.65
Peer Advocate	2.00
Intake Coordinator	1.40
Social Services Coordinator	4.25
Financial Counselor	1.00
Total FTEs	52.99

Crisis Residential Services Staffing

Program	FTE
Program Director	1.00
Program Support Assistant	1.40
Data Specialist	0.50
RN/LVN	4.94
Mental Health Worker	8.56

Care Coordinator	1.00
Intake Coordinator	1.00
Social Services Coordinator II	1.00
Peer Mentor Navigator	1.40
Total FTEs	20.80

F. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Staffing Paragraph of this Exhibit B to the Contract.