COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

BOARD OF SUPERVISORS

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DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.gov

Reply To: (213) 738-4601
Fax: (213) 386-1297

February 14, 2012

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

#21 FEBRUARY 14, 2012

Sachi A. Hamai
SACHI A. HAMAI
EXECUTIVE OFFICER

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

APPROVAL TO AMEND SEVEN LEGAL ENTITY AGREEMENTS TO IMPLEMENT INNOVATION - INTEGRATED CLINIC MODELS AND APPROVAL TO TERMINATE AND AMEND CURRENT AGREEMENTS WITH THE LOS ANGELES FREE CLINIC DBA THE SABAN FREE CLINIC (SUPERVISORIAL DISTRICTS 1, 2, 3, AND 4) (3 VOTES)

SUBJECT

Request approval to amend seven Legal Entity Agreements to add Mental Health Services Act-Innovation funding to implement Integrated Clinic Models and approval to terminate and amend current Agreements with The Los Angeles Free Clinic dba The Saban Free Clinic.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and authorize the Director of Mental Health (Director), or his designee, to prepare, sign, and execute Amendments, substantially similar to Attachment I, to the existing Department of Mental Health (DMH) Legal Entity (LE) Agreements with Exodus Recovery, Inc., The Los Angeles Free Clinic dba The Saban Free Clinic (Saban Free Clinic), Jewish Family Service of Los Angeles, Special Service for Groups, The Los Angeles Gay and Lesbian Community Service Center, JWCH Institute, Inc., and South Central Health and Rehabilitation Program to implement Integrated Clinic Model (ICM) programs. The Amendments will be effective upon your Board's approval through the term of their LE Agreement. The Maximum Contract Amounts (MCA) for each LE will be increased by the amounts listed in Attachment II.

2. Delegate authority to the Director, or his designee, to terminate the 1115 Waiver Demonstration Project Community Partner Agreement (Contract No. MH210015) with Saban Free Clinic and to

reallocate a portion of the funds from the terminated Agreement into their existing LE Agreement (Contract No. MH120813) through an amendment using the delegated authority granted in Board Agenda Item A-4, June 14, 2011 for the provision of Tier 2 mental health services effective upon your Board's approval through June 30, 2012. The MCA for Saban Free Clinic will increase by an additional $250,000 for Fiscal Year (FY) 2011-12, funded by State Mental Health Services Act (MHSA) Revenue.

3. Delegate authority to the Director, or his designee, to prepare, sign, and execute future amendments to these LE Agreements, as necessary, and establish as a new MCA the aggregate of the original Agreement and all amendments, provided that: 1) the County's total payments to each contractor under the Agreements for each FY does not exceed an increase of 20 percent from the applicable Board-approved MCA; 2) any such increase will be used to provide additional services or to reflect program and/or Board policy changes; 3) your Board has appropriated sufficient funds for all changes; 4) approval of County Counsel, or designee, is obtained prior to such amendment; 5) County and Contractors may, by written amendment, mutually agree to reduce programs, services; and 6) the Director notifies your Board and the Chief Executive Officer (CEO) of Agreement changes in writing within 30 days after execution of each amendment.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Board approval of the recommended actions will allow DMH to amend its LE Agreements with Exodus Recovery, Inc., Saban Free Clinic, Jewish Family Service of Los Angeles, Special Service for Groups, The Los Angeles Gay and Lesbian Community Service Center, JWCH Institute, Inc., and South Central Health and Rehabilitation Program to implement MHSA Innovation (INN) Plan ICM programs. Through a competitive solicitation process, DMH selected these contractors to implement these services. Since the seven successful bidders currently have a LE Agreement, amendments will be necessary.

INN is the final MHSA plan to be implemented in Los Angeles County. The State Department of Mental Health (SDMH) guidelines define INN projects as novel, creative and/or ingenious mental health practices/approaches that contribute to learning and that are developed within communities through a process that is inclusive and representative, especially of unserved, underserved, and inappropriately served individuals. SDMH expects that the results and lessons learned from INN projects will contribute to the transformation of the current mental health system.

As required by SDMH, DMH's INN Plan was developed through a Community Program Planning Process. Throughout this process, stakeholders expressed that the mental health, physical health and substance abuse care that is currently provided in Los Angeles County is fragmented and does not fully meet the needs of communities. To address this concern, stakeholders proposed implementation of four integrated models, including the ICM. The other models are Integrated Mobile Health Team, Integrated Service Management Model, and Peer-Run Integrated Service Management Model.

While there are emerging models for the integration of health, mental health, and substance use disorders services that might greatly improve care, relatively little is known about the optimal means to achieve this integration for underrepresented ethnic populations who are uninsured, economically disadvantaged, with high levels of homelessness, and significant mental health challenges. For this reason DMH has proposed to fund ICMs which is a model of service integration that is designed to improve access to quality services for individuals from underrepresented ethnic populations who are

uninsured and homeless with co-occurring mental health and physical health diagnoses by integrating physical health, mental health, and substance abuse disorder services in primary care and mental health sites. The ICM meets the SDMH guidelines for INN projects by exploring novel and creative mental health practices and approaches that contribute to learning, which will guide policy decisions and future resource allocation.

The utilization of existing infrastructure and the leveraging of other programs and funding streams, including Federally Qualified Health Centers, is expected to increase the potential number of individuals served, create an efficient integrated system that promotes interagency collaboration, maximize available resources, and establish sustainable revenue. The contractor's implementation of the ICM will be evaluated for effectiveness relative to degree of integration, access to and quality of care, community improvement, and stakeholder satisfaction and cost.

Saban Free Clinic was awarded an 1115 Waiver Demonstration Project Community Partner Agreement (Contract No. MH210015) based on Board Agenda Item A-4, June 14, 2011. The 1115 Waiver Demonstration Project Community Partner Agreement is based on a one rate per-visit/per-day structure. Saban Free Clinic also has a current LE Agreement (Contract No. MH120813) with DMH for the provision of Community Outreach Services only. With the awarding of MHSA INN funding, Saban Free Clinic will apply for Medi-Cal certification and begin providing outpatient mental health services, which will require the establishment of per-minute rates under its LE Agreement. However, the establishment of per-minute rates for outpatient services creates conflicting rate structures in the two Agreements. As such, Saban Free Clinic cannot continue to have these two separate DMH Agreements. With the approval of Recommendation 2, DMH will have delegated authority to terminate the 1115 Waiver Demonstration Project Community Partner Agreement (Contract No. MH210015) and through Board Agenda Item A-4 (June 14, 2011), DMH will exercise its delegated authority and amend Saban Free Clinic's existing LE Agreement to allow this agency to provide Tier 2 mental health services.

Implementation of Strategic Plan Goals

The recommended actions support the County's Strategic Plan Goal 4, Health and Mental Health.

FISCAL IMPACT/FINANCING

The total cost of amending the LEs for ICM Program is $1,989,799 and is fully funded by State MHSA revenue in the amount of $1,826,337 and Federal Financial Participation (FFP) Medi-Cal in the amount of $163,462. The FY 2011-12 annual MCAs for each LE Agreement, as shown in Attachment II is included in DMH's FY 2011-12 Final Adopted Budget.

In addition, the MCA for Saban Free Clinic will be increased by the amount of $250,000 fully funded by State MHSA Revenue for a revised MCA of $587,016 for FY 2011-12.

Funding for FY 2012-13 and FY 2013-14 will be requested through DMH's annual budget request process.

There is no net County cost impact.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

The seven contractors are located in four Supervisorial Districts and will provide services in three different Service Areas of the County. Each contractor will provide ICM services, staffed with a multi-disciplinary team of professionals, paraprofessionals, and peer counselors with health, mental health, and substance abuse training and experience. Services provided by each ICM will be coordinated by one entity, with one point of supervision, an integrated health record, one set of administrative and operational policies and procedures, at one site.

MHSA INN funds will be used in compliance with Welfare and Institutions Code Section 5891 and California Code of Regulations (CCR), Title 9, Section 3410, Non-Supplant. The draft INN Work Plan was available for stakeholder review and comment from October 20, 2009, through November 19, 2009. A public hearing was held on November 19, 2009, by the Mental Health Commission.

The attached Amendment format has been approved as to form by County Counsel. The CEO has been advised of the recommendations. DMH administrative staff will review and monitor the contractors' adherence to the Agreements and ensure that the Agreements' provisions and departmental policies are being followed.

In accordance with your Board Policy Manual, Section 5.120, Authority to Approve Increases to Board Approved Contract Amounts requirements, DMH notified your Board on December 20, 2011, (Attachment III) identifying and justifying the need for requesting a percentage increase exceeding 10 percent.

CONTRACTING PROCESS

On February 8, 2011, DMH issued the MHSA INN ICM RFS No. 3 to identify qualified agencies to implement an ICM service model. DMH announced the release of the RFS by mailing letters along with a compact disc to agencies on the Department's MHSA Master Agreement List.

On March 1, 2011, DMH held a mandatory ICM Proposers' Conference that was attended by 44 agencies. DMH received 12 proposals by the deadline on March 31, 2011. Due to the design of this model, agencies were required to specify and meet additional minimum mandatory requirements as either a mental health provider (MHP) or a primary care provider (PCP). The submitted proposals were then divided into two groups; proposals submitted by MHPs and proposals submitted by PCPs. Evaluators were selected to independently review and score either MHP or PCP proposals. An Evaluation Committee, comprised of three evaluators and a facilitator, convened on May 16, 17, and 18, 2011, to review proposals received from MHPs. A second Evaluation Committee comprised of four evaluators and a facilitator, convened on May 23, 24, and 31, 2011, to review proposals received from PCPs. The Evaluation Committees used the ICM RFS No. 3's specific standardized evaluation tool and an informed averaging process to arrive at final scores.

The Department's Executive Management Team reviewed the Committees' final scores and recommended funding to the highest scoring ICM Proposers. The following seven agencies will receive INN funding to deliver ICM services:

Mental Health Providers
1. Exodus Recovery, Inc.
2. Special Service for Groups

Primary Care Providers
3. Los Angeles Gay and Lesbian Community Service Center
4. JWCH Institute, Inc.
5. South Central Health and Rehabilitation Program (Partnering)
6. The Los Angeles Free Clinic dba The Saban Free Clinic
7. Jewish Family Service of Los Angeles (Partnering)

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Upon the contract award, this action will provide funds for seven contractors to provide integrated mental health, physical health, and substance use disorders services to uninsured individuals who are homeless and/or members of underrepresented ethnic populations.

Respectfully submitted,

MARVIN J. SOUTHARD, D.S.W.
Director of Mental Health

MJS:RS:NK:RK

Enclosures

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors
Chairperson, Mental Health Commission

ATTACHMENT I

CONTRACT NO. MH120

AMENDMENT NO. __

THIS AMENDMENT is made and entered into this __ day of _____, 2012, by and between the COUNTY OF LOS ANGELES (hereafter "County") and _____ (hereafter "Contractor").

WHEREAS, County and Contractor have entered into a written Agreement, dated _____, identified as County Agreement No. _____, and any subsequent amendments (hereafter collectively "Agreement") **(if applicable)**; and

WHEREAS, for Fiscal Year (FY) 2011-12 and any subsequent fiscal year(s) during the term of this agreement **(if applicable)**, County and Contractor intend to amend Agreement only as described hereunder; and

WHEREAS, on January 30, 2010, State Department Mental Health (SDMH) released the Innovation (INN) guidelines as follows: novel, creative and/or ingenious mental health practices/approaches that contribute to learning, and that are developed within communities through a process that is inclusive and representative, especially of unserved, underserved and inappropriately served individuals; and

WHEREAS, subsequently Department of Mental Health developed the INN Plan in accordance with Stakeholder recommendations; and

WHEREAS, based on community input, DMH developed four INN models that address the needs, priority populations, and special sub-populations selected by the Stakeholders: Integrated Clinic Model (ICM), Integrated Mobile Health Team Model,

Community-Designed Integrated Service Management Model, and Integrated Peer-Run Model; and

WHEREAS, Contractor is being selected pursuant to Mental Health Services Act (MHSA) Request for Services - ICM and Contractor has agreed to implement services as stated in the Service Exhibit XX, ICM Model, which is attached hereto; and

WHEREAS, County and Contractor intend to amend Agreement to add Service Exhibit XX – "One Time Expenses Associated with Starting a New MHSA INN Program" which is attached hereto; and

WHEREAS, County and Contractor intend to amend Agreement to add Service Exhibit XX – "Client Supportive Services for MHSA INN Plan Programs" which is attached hereto; and

WHEREAS, Contractor desires to add Mode XX, Service Function Code XX, (individual services) at a provisional rate of $X.XX to Provider Number XXXX located at _____; **(applicable only to The Los Angeles Free Clinic and LA Gay and Lesbian)** and

WHEREAS, Service Exhibit(s) XX and YY {list the name(s)} shall be added to this agreement; and **(applicable only to The Los Angeles Free Clinic and LA Gay and Lesbian)**

WHEREAS, for Fiscal Years (FYs) 2011-12, 2012-13, and 2013-14 **(if applicable)**, County and Contractor intend to amend this Agreement to add MHSA INN-ICM funds in the amount of $_____, $_____, and $_____, **(if applicable)** respectively, to provide physical health, mental health, and substance abuse services to homeless, economically disadvantaged/uninsured, and/or members of Under Represented Ethnic Populations (UREP); and

WHEREAS, for FYs 2011-12, 2012-13, and 2013-14 **(if applicable)**, the revised Maximum Contract Amount(s) (MCAs) shall be $ _____, $ _____, and $ _____, **(if applicable)** respectively; and

NOW, THEREFORE, County and Contractor agree that Agreement shall be amended only as follows:

1. For FYs 2011-12, 2012-13, and 2013-14 **(if applicable)**, MHSA INN-ICM funds are added in the amount of $_____, $_____, and $_____, **(if applicable)** respectively, to allow Contractor to provide physical health, mental health, and substance abuse services to homeless, economically disadvantaged/uninsured, and/or members of UREP.

2. Financial Exhibit A (FINANCIAL PROVISIONS), Attachment II, Paragraphs C (Reimbursement for Initial Period) shall be deleted in its entirety and the following substituted therefore:

"C. <u>REIMBURSEMENT FOR INITIAL PERIOD</u>

(1) The Maximum Contract Amount for the Initial Period of this Agreement as described in Paragraph 1 (TERM) of the Legal Entity Agreement shall not exceed _____ DOLLARS ($_____) and shall consist of Funded Programs as shown on the Financial Summary.

D. <u>REIMBURSEMENT IF AGREEMENT IS AUTOMATICALLY RENEWED</u>

(1) <u>Reimbursement For First Automatic Renewal Period</u>: The Maximum Contract Amount for the First Automatic Renewal Period of this Agreement as described in Paragraph 1 (TERM) of the DMH Legal Entity Agreement shall not exceed _____

_____ DOLLARS ($_____) and shall consist of Funded Programs as shown on the Financial Summary. **(if applicable)**

(2) Reimbursement For Second Automatic Renewal Period: The Maximum Contract Amount for the Second Automatic Renewal Period of this Agreement as described in Paragraph 1 (TERM) of the DMH Legal Entity Agreement shall not exceed _____ _____ DOLLARS ($_____) and shall consist of Funded Programs as shown on the Financial Summary." **(if applicable)**

3. Financial Summary - _ for FY 2011-12, shall be deleted in its entirety and replaced with Financial Summary - _ for FY 2011-12 attached hereto and incorporated herein by reference. All references in Agreement to Financial Summary - _ for FY 2011-12, shall be deemed amended to state "Financial Summary - _ for FY 2011-12."

4. Financial Summary - _ for FY 2012-13, shall be deleted in its entirety and replaced with Financial Summary - _ for FY 2012-13 attached hereto and incorporated herein by reference. All references in Agreement to Financial Summary - _ for FY 2012-13, shall be deemed amended to state "Financial Summary - _ for FY 2012-13." **(if applicable)**

5. Financial Summary - _ for FY 2013-14, shall be deleted in its entirety and replaced with Financial Summary - _ for FY 2013-14 attached hereto and incorporated herein by reference. All references in Agreement to Financial Summary - _ for FY 2013-14, shall be deemed amended to state "Financial Summary - _ for FY 2013-14." **(if applicable)**

6. Financial Summary Subprogram Schedule - _ for FY 2011-12, shall be deleted in its entirety and replaced with Financial Summary Subprogram Schedule - _ for FY 2011-12 attached hereto and incorporated herein by reference. All references in Agreement to Financial Summary Subprogram Schedule - _ for FY 2011-12, shall be deemed amended to state "Financial Summary Subprogram Schedule - _ for FY 2011-12."

7. A Service Exhibit for "MHSA INN-ICM" is added to this Agreement and incorporated herein.

8. A Service Exhibit for "Client Supportive Services for MHSA INN Plan Programs" is added to this Agreement and incorporated herein.

9. A Service Exhibit for "One Time Expenses Associated with Starting a New MHSA INN Program" services is added to this Agreement and incorporated herein.

10. A Service Exhibit(s) {list the name(s)} is/are added to this Agreement and incorporated herein. **(applicable only to The Los Angeles Free Clinic and LA Gay and Lesbian)**

11. Attachment V, Service Delivery Site Exhibit - _ shall be deleted in its entirety and replaced with Attachment V, Service Delivery Exhibit - _ attached hereto and incorporated herein by reference. All references in Agreement to Service Delivery Site Exhibit - _, shall be deemed amended to sate "Service Delivery Site Exhibit - _."

12. Attachment VI, Service Exhibits - _, shall be deleted in its entirety and replaced with Attachment VI, Service Exhibits - _ attached hereto and incorporated herein

by reference. All references in Agreement to Service Exhibits - _, shall be deemed amended to state "Service Exhibits - _."

13. Contractor shall provide services in accordance with Contractor's FY _____ Negotiation Package for this Agreement and any addenda thereto approved in writing by director.

14. Except as provided in this Amendment, all other terms and conditions of the Agreement shall remain in full force and effect.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be subscribed by County's Director of Mental Health or his designee, and Contractor has caused this Amendment to be subscribed on its behalf by its duly authorized officer, on the day, month, and year first above written.

COUNTY OF LOS ANGELES

By_____
MARVIN J. SOUTHARD, D.S.W.
Director of Mental Health

_____
CONTRACTOR

By _____

Name_____

Title _____
(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL

APPROVED AS TO CONTRACT ADMINISTRATION:

DEPARTMENT OF MENTAL HEALTH

By _____
Chief, Contracts Development
and Administration Division

Provider No. _____

SERVICE EXHIBIT __

INTEGRATED CLINIC MODEL

Provided Under the
Mental Health Services Act
Innovation Plan

1. GENERAL

The Integrated Clinic Model (ICM) is a Mental Health Services Act (MHSA) Innovation (INN) plan service model that is designed to improve access to quality services for individuals with co-occurring mental health and physical health diagnoses by integrating physical health, mental health, and substance use disorders services in primary care and mental health sites.

Increasing the quality of care shall be accomplished by having an ICM multi-disciplinary team of professionals and paraprofessionals provide health, mental health and co-occurring substance use disorders (COD) services that are coordinated by one entity with one point of administrative supervision and integrated administrative and operational policies and procedures. An integrated health record/chart will be created with an expectation of significantly reduced fragmentation of care planning, delivery, and monitoring. The goal is that the integration of physical health and mental heath services will provide more holistic and client-centered care that will yield the best results and be the most acceptable and effective approach to those being served.

The ICM shall be comprised of staff that works for a Prime Contractor and a Federal Qualified Health Center (FQHC) and may include staff from a Partnering Contractor(s). _____ shall serve as the Prime Contractor, _____as the Partnering Contractor and _____ as the FQHC. Prime Contractor shall provide specialty mental health services and serve as the one point of supervision. Prime Contractor shall be responsible for ensuring that the ICM operates under one set of administrative and operational policies and procedures, that the services provided are integrated and coordinated, and an integrated medical record/chart is used. Partnering Contractor(s) shall also provide specialty mental health services. Prime Contractor and Partnering Contractor(s) shall be responsible for a Quality Management Program and Plan, a Data Collection Plan, client outcomes and the Performance-Based criteria.

Contractor is expected to initiate implementation of the ICM service model within thirty days of contract commencement.

ICMs include a full array of mental health, physical health and substance abuse services onsite such as:

- Integrated assessment;
- Treatment for mental health conditions including individual, group, and family psychotherapy and medication support;

- Treatment for physical health conditions including medication and disease management;

- Specialized assessment and treatment interventions for conditions that co-occur with mental illness (i.e., substance abuse and cognitive impairment);

- Single individualized treatment plans that address client's physical health, mental health and substance abuse needs. The treatment plan must incorporate condition-specific healthcare goals and proposed actions for both mental health and medical conditions;

- Referral and linkage to self-help groups, specialty medical services, dental, vision, or other healthcare needs;

- Peer counseling and support which may include:

    - Providing support to vulnerable clients to support wellness and recovery

    - Conducting home visits to strengthen network of relationships and decrease social isolation

    - Providing support to clients who are transitioning from one level of care to another

    - Assisting clients in developing community living skills and utilizing community resources by discussing common experiences

    - Attending treatment team meetings and conveying community and client cultural patterns and attitudes to the multidisciplinary team

- Targeted Case Management, including

    - Housing support

    - Benefits establishment

2. <u>STATE DEPARTMENT OF MENTAL HEALTH INN PROGRAM GUIDELINES</u>

State Department of Mental Health (SDMH) INN guidelines require that all INN programs lead to learning that advances mental health in California in the directions articulated by the MHSA. The ICM service model meets the SDMH INN guidelines to contribute to learning by exploring the following questions:

A. Can Los Angeles County expand and better coordinate services in order to improve health outcomes and better utilize limited public resources?

B. Can the capacity of the public mental health system be expanded to serve uninsured persons with high acuity levels?

C. Can integrated mental health and substance abuse services be provided at primary care settings?

D. Can integrated physical health and substance abuse services be provided at mental health settings?

E. How will persons of differing acuity levels access these integrated mental health and substance abuse services?

F. Will the imbedding of services at primary care settings decrease the stigma of clients receiving mental health services?

G. Will ICM clients achieve positive outcomes? That is:

1) Will ICM clients who receive mental health and substance abuse services in primary care settings achieve positive outcomes?

2) Will ICM clients who receive physical health and substance abuse services in mental health settings achieve positive outcomes?

H. Can these services be delivered in a cost-effective way?

SDMH INN guidelines also state that "it is expected that Innovations will evolve and that some elements of a project might not work as originally envisioned. Such learning and adaptations are likely to be key contributions of the INN project. However, if the County and its stakeholders conclude that an INN project is not meeting design and outcome expectations, to the extent that continuation is not useful and will not add to the learning, the county may terminate the project." To comply with these guidelines, throughout the term of the Agreement, the Department of Mental Health (DMH) will conduct a minimum of quarterly reviews of the ICM program, including client outcomes and performance-based criteria. At its sole discretion, DMH may require changes to the program's elements and/or services or request Board of Supervisor approval to terminate the Prime Contractor's and/or the Partnering Contractor's Agreements.

3. LEVERAGING

SDMH guidelines encourage the leveraging of resources through the formation of collaborative partnerships with organizations and systems outside the mental health system that broaden the scope of current mental health practices and maximize MHSA INN funding. Prime Contractor and Partnering Contractor shall leverage MHSA INN funding with other resources to establish sustainable revenue for the ICM and to increase the ICM's ability to serve the greatest possible number of individuals, including those without medical insurance.

The ability to leverage MHSA INN funding with Federally Qualified Health Center (FQHC) or Public/Private Partnership (PPP) funding is a requirement. Physical health services provided to clients that are reimbursable through any other funding source shall not be submitted to DMH for reimbursement. Contractor shall establish Medi-Cal benefits for eligible individuals by immediately assisting them to obtain Supplemental Security Income (SSI) or Supplemental Security Disability Insurance (SSDI). Other leveraging resources may include, but are not limited to: Patient Assistance Programs, Drug Medi-Cal, Medicare, Substance Abuse and Mental Health Services Administration (SAMHSA) grants, Substance Abuse Prevention and Control (SAPC) funding, community resources

and organizational supports. As a result of increased leveraging, the amount of MHSA INN funding shall decrease each year.

Based on programs that serve a similar population, it is estimated that 20% of the clients receiving ongoing ICM services will establish benefits by the end of the first year. The expectation is that in the second year the percentage of clients with medical insurance will increase to 50% and in the third year the percentage will increase to 80%.

4. VALUES AND PRINCIPLES

The ICM shall adhere to the following ICM values and principles:

- Services that are designed to assist individuals to achieve their wellness and recovery/resiliency goals;
- Services that are voluntary and focus on helping individuals integrate into the community;
- Services that are provided in individuals' preferred language and in a culturally congruent manner;
- Services support doing whatever it takes to improve mental and physical health, and decrease substance use/abuse including, but not limited to:
    - Employment and education
    - Life skills

While the ICM multidisciplinary treatment teams' composition may vary, it is the expectation that the treatment teams will be comprised of certain core members, as proposed:

- Primary care staff (Internal Medicine)
- Psychiatrist
- Licensed, registered or waivered mental health clinician
- Peer Counselor
- Prevention Specialist/Health Promoter
- Homeless and Housing Specialist
- Integrative Care Manager

Additionally, the psychiatrist will serve as a member of the multidisciplinary treatment teams and provide consultation to the primary care staff regarding mental health treatment. The utilization of the ICM team members' expertise shall be based upon the nature of the individual needs of the client. It is essential to the functioning of the multidisciplinary team that special skills of those representing various disciplines are available within the ICM team and that all ICM treatment team members meet on a regular basis to plan, evaluate, and monitor a client's response to treatment.

5. ICM TARGET POPULATION

The Prime Contractor, Partnering Contractor and subcontractor shall provide services to 800 unduplicated adult (age 18 and older) ICM clients, approximately 400 clients during the contract period at each of the ICM sites. These clients must receive both on-going mental health and primary care services, at least one service (mental health or primary care) every 60 days, as well as meet all other criteria of the defined population. Each ICM site must have a minimum of 100 active clients at any given time. ICM clients shall receive at least one service every 60 days.

Prime Contractor and Partnering Contractor shall submit documentation to DMH that all individuals served meet ICM target population criteria. Authorization for services is not required. However, Prime Contractor and Partnering Contractor(s) will be monitored to ensure that clients meet criteria for ICM services. Prime Contractor and Partnering Contractor shall serve the ICM target population, comprised of individuals with at least one health condition (e.g. diabetes, hypertension, cardiovascular disease, asthma or other respiratory illnesses, obesity, cancer, arthritis and chronic pain) who require on-going primary care AND meets Medi-Cal medical necessity criteria for receiving specialty mental health services. In addition, it is agreed that the following minimum percentages will be met for individuals receiving on-going ICM services:

A. 75% must have a medical condition that falls in one or more of the following categories:

   1) Cardiopulmonary, (e.g., hypertension, hyperlipidemia, other cardiovascular conditions, asthma, emphysema, COPD)

   2) Diabetes and/or obesity

   3) Sexually transmittable diseases including HIV/AIDS and hepatitis

B. 50% must meet the criteria for one of the following diagnostic categories based on DSM IV TR: psychotic disorders, bipolar disorders, major depressive disorders, and severe anxiety disorders.

C. Individuals with developmental disabilities or dementia, in the absence of a DSM IV TR Axis I mental health disorder, are not eligible.

D. Individuals served by the ICM program shall have physical health conditions that largely can be treated by primary care providers in outpatient settings. Conditions that would likely resolve quickly, such as upper respiratory illnesses, routine pregnancies, and simple injuries, are excluded as a basis for eligibility.

E. 25% must have at least one co-occurring substance use disorder.

   1) The presence of substance use, abuse or dependence shall not be a reason for exclusion from ICM services.

F. 50% must be new to the clinic site (i.e., have not received any type of services at the clinic site in the last 5 years). Of those 50%, 20% must be referrals from DMH programs, including wellness centers and urgent care programs.

G. At the time of admission to the ICM, all clients must be economically disadvantaged AND uninsured (i.e., with no third party health insurance including Medi-Cal or Medicare).

H. 75% shall be a member of a specified under represented ethnic population (UREP) (African/African American, Native American, Asian/Pacific Islander, Eastern European/Middle Eastern, and Latino).

I. 15% must meet criteria for homelessness at the time of enrollment.

J. Prime Contractor and Partnering Contractor shall only serve individuals who voluntarily consent to receiving on-going ICM mental health services and who sign consent for services form.

6. INITIAL SCREENING, ASSESSMENT, AND TARGET POPULATION VERIFICATION

ICM staff with expertise in mental health, physical health and substance abuse shall complete an integrated assessment for each individual prior to initiating ongoing ICM services. The mental health portion of the integrated assessment shall include a clinical analysis of the history and current status of individuals' mental health, including relevant cultural issues, and a diagnosis based on this information. The physical health portion of the integrated assessment shall include a clinical analysis of an individuals' medical history and current physical status that includes a diagnosis based on this information. The substance abuse portion of the integrated assessment shall include an understanding of individuals' past and current substance use and level of readiness to work toward change. All clients must be initially screened and periodically assessed for substance use issues.

Prime Contractor shall ensure that all new clients are screened and shall submit a DMH INN Target Population Verification form for each individual to document that the individual meets the ICM target population. A copy of which is attached hereto as Attachment 1. For new clients, this may be done during the outreach and engagement process.

In accordance with MHSA funding requirements, individuals must voluntarily consent to mental health services in order to receive ongoing ICM services. The ICM shall provide referrals to community resources that are able to address the needs of individuals who do not meet the ICM target population for ongoing services.

7. CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

Prime Contractor, Partnering Contractor and subcontractor shall ensure that all ICM mental health, physical health and substance abuse services are fully integrated and culturally and linguistically appropriate. Culturally and linguistically appropriate services are respectful of and responsive to a client's cultural and linguistic needs based on their cultural identity. Cultural identity may involve ethnicity, race, language, age, country of origin, level of acculturation, gender, socioeconomic class, disabilities, religious/spiritual beliefs, and/or sexual orientation. Culturally competent services require the importance of a client's culture, an assessment of cross-cultural relations, vigilance of the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs and incorporating into all levels of service

provision. Prime Contractor, Partnering Contractor and subcontractor shall ensure that all staff has the ability to provide culturally and linguistically appropriate services.

8. SERVICE APPROACHES AND STRATEGIES

Prime Contractors and Partnering Contractor shall use the following Evidence-Based Practices (EBPs): Transtheoretical Model of Change, Screening, Brief Intervention, and Referral to Treatment (SBIRT), Illness Management and Recovery, Supportive Employment, Integrated Dual Disorders Treatment (IDDT), Medication Management Approaches in Psychiatry (MedMAP), and Motivational Interviewing. The use of any of the above required service/treatment models shall be reflected in the clients' care/treatment plan interventions and the treatment/progress notes. DMH will monitor Prime Contractor's and Partnering Contractor's fidelity to these EBPs during regular program reviews.

9. SERVICES TO BE PROVIDED

The Prime Contractor and Partnering Contractor shall operate two ICM sites at two separate locations, one in the DMH defined service area 6 (South) and one in service area 7 (East). However, clients should not be denied service if they do not reside in the defined service areas. These clients must receive both on-going mental health and primary care services, at least one service (mental health or primary care) every 60 days, as well as meet all other criteria of the defined population. Each ICM site must have a minimum of 100 active (at least one service every 60 days) clients at any given time. ICMs must assertively pursue benefits establishment for ICM clients.

All mental health and co-occurring substance use disorders services must be provided onsite. Primary healthcare services that cannot be provided onsite must be rapidly and conveniently available when needed. Integrated Team Case Conferencing must include both primary care and mental health providers. Documentation of services provided to the client must be available in an integrated health record/chart, and the care plan must address co-occurring health and mental health issues as well as substance use when present. All services must be readily accessible.

The ICM services to be provided shall be described in Prime Contractor's and Partnering Contractor's Proposal/Negotiation Package for the Legal Entity Agreement, including any addenda thereto, as approved in writing by the Director. The ICM shall determine the ongoing ICM services and the services provided during outreach and engagement based on an individual's stated needs including, but not limited to, mental health, physical health and/or substance abuse issues. The ICM shall base the level and intensity of ongoing services on each client's stated needs.

Prime Contractor and Partnering Contractor shall ensure that services provided by the ICM meet the Standards of Care as determined by DMH and, at a minimum, include the following:

A. Primary Care And Medical Services: These services shall be delivered by providers with the appropriate training, licensure, scope of practice (as specified below Section 12), and must follow community standards of care.

1) Assessment and Diagnosis: Services include physical examination, laboratory and other diagnostic assessment consistent with community standards for such services.

2) Treatment: Services provided to treat mild to moderate, acute or chronic conditions, consistent with community standards for such services in a primary care setting. These services shall include management of chronic illnesses such as diabetes and hypertension and/or prescription and monitoring of medications.

Risk Oriented Preventative Services: These services shall be delivered by providers with the appropriate training, licensure, scope of practice (as specified below Section 12), and must follow community standards of care. These services shall include a range of diagnostic assessments and procedures such as PAP smear and screening pelvic examination, clinical breast examination, referral for mammography, prostate cancer screening, colorectal cancer screening, STD/HIV prevention, testing and counseling; smoking cessation, family planning, nutrition counseling, wellness and health education, that is consistent with community standards for such services.

B. Mental Health And Co-Occurring Substance Use Disorders Services: These services shall be delivered by providers with the appropriate training, licensure, scope of practice (as specified below Section 12), and must follow DMH policies and parameters.

1) Specialty Mental Health Services: Specialty Mental Health Services are defined as those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency. Specialty Mental Health Services include:

a. Assessment and Diagnosis: Clinical analysis of the history and current status of the individual's mental health including relevant cultural issues. This process includes evaluation for psychiatric medication.

b. Treatment: Recovery-oriented evidenced-based therapeutic interventions consistent with the individual's goals.

- These services shall include individual, group, and family psychotherapies.

- Medication Support: Prescribing, administering, dispensing and monitoring of psychiatric medications and medication education.

- Life Skills: Activities that assist with restoring, improving, or maintaining daily independent living.

c. Collateral Support: Contacting family members and/or significant others with the client's authorization to provide them with information about the client and/or discussing how they can assist the client with their treatment goals.

d. Team Conferences/Case Consultations: Using interdisciplinary inter/intra agency conferences and consultation to coordinate client care activities.

e. Targeted Case Management: Service activities include communication, coordination, and referral; monitoring service delivery to ensure the client's access to service and the service delivery system; and monitoring of the client's progress and plan development.

- Benefits Establishment: Assessment of financial status, identification of entitlements (e.g. Medicare and Medi-Cal) and actions taken to ensure that entitlements are established.

- Referral and Linkage: Referring and linking to community resources and supports including self-help groups.

- Housing Activities: Locating housing, negotiating with landlords, completing federal housing subsidy applications, completing requests for rental assistance/eviction prevention intervention, providing referrals to community agencies for tenant rights matters, and related advocacy and support to retain housing.

- Employment and Education Activities: Activities that support education, vocational preparation, and employment.

2) Co-occurring Substance Use Disorders Services for individuals who qualify for specialty mental health services: Co-occurring Substance Use Disorders Services are defined as services designed to establish the presence or absence of co-occurring disorders, determine the client's readiness for change, identify the client's strengths or problem areas that may affect the processes of treatment and recovery, and engage client in the development of an appropriate treatment plan to address problematic substance use. These services shall include:

a. Assessment and Diagnosis: Analysis of the history and current status of the individual's co-occurring mental health and substance use and readiness for change including relevant cultural issues.

b. Treatment: Evidenced-based recovery oriented treatment for co-occurring mental illness and substance abuse.

3) Outreach And Engagement

a. Outreach: Prime Contractor and Partnering Contractor shall develop an outreach strategy aimed at identifying individuals who are coping with both co-occurring mental health and physical health problems and are members of the defined focal population and inform them of the availability of ICM program services.

b. Engagement: Prime Contractor and Partnering Contractor shall train ICM staff on strategies to inform trusting relationships in order to engage clients.

4) Peer Counseling And Self Help: These services shall include advocacy, support, and community linkage provided by individuals who are or have been recipients of specialty mental health services.

5) Client Care Coordination/Treatment Plan Development, Monitoring and Review: Development, monitoring and review of the client's integrated care/treatment plan that includes client-centered long term goals, short term objectives, clinical interventions and outcomes.

6) Prevention and Health Promotion: Individual, group education and activities regarding physical conditions and prevention (e.g. smoking cessation, obesity (nutrition, exercise), STD, and substance abuse). Providing information about physical health conditions and preventative care measures including risk factors that negatively impact health, behaviors that promote good health, and screenings to assess for health conditions and/or infectious diseases and the need for vaccinations. Screenings must include but are not limited to those for diabetes, cardiovascular disease and hypertension.

7) Client Supportive Services (CSS): CSS shall enhance outreach and engagement and on-going ICM services. CSS shall support individuals in their recovery by providing, for example, food, clothing, shelter, bus tokens, school books/supplies, furniture, appliances, on-going rental assistance and other items necessary for daily living and personal and community integration.

8) Transportation: Providing transportation, as needed, to clients by means of bus fare/pass, agency vehicle(s), or private vendor.

Prime Contractor and Partnering Contractor shall be solely liable and responsible for any and all required services, whether provided directly, subcontracted or referred, under this Agreement. Prime Contractor and Partnering Contractor shall indemnify and hold harmless the County from and against any liabilities and costs arising from, connected with, or related to services and treatments rendered under this Agreement by Prime Contractor, Partnering Contractor, subcontractor and/or employees of Prime Contractor, Partnering Contractor or subcontractor.

10. CLIENT CARE COORDINATION PLAN

The ICM services shall be based on the client's stated needs and identify them in an integrated client care/treatment plan that includes client-defined long term goals and short term objectives, clinical interventions and outcomes. The client, their family/significant others, as appropriate, and all of the ICM staff that will provide the services to assist the client to meet their mental health, physical health and substance abuse care/treatment plan goals and objectives shall meet together to develop an initial care/treatment plan and all subsequent plan reviews. Staff that can provide mental health, physical health and substance abuse services shall meet together with the client and review the client's coordination care plan a minimum of every twelve (12) months or as needed to incorporate new client-defined goals and objectives. Prime contractor shall provide to DMH a copy of the form for documenting their ICM integrated care/treatment plan.

11. INTEGRATED MEDICAL CHART/RECORD

Prime Contractor shall maintain all assessments, care/treatment plans, addendums and documentation of all mental health, physical health and substance abuse services provided in an integrated medical chart/record to ensure integrated and coordinated services. DMH Policy and Contract language states that all contractors with DMH must maintain a record of all direct and indirect services rendered to clients. The record must be accessible within 3 business days for inspection, review and/or audit by representatives or designees of LA County DMH or State DMH. Other than this requirement, agencies should consult with their own counsel regarding the integration of the record and issues related to confidentiality, security, and privacy under HIPAA and other State and Federal Laws.

12. DAILY OPERATIONS

Prime Contractor shall ensure that the ICMs adhere to an operational schedule that includes a regularly scheduled meeting. The meeting shall be facilitated by the lead staff person/team leader and staff who can provide mental health, physical health and substance abuse services shall be present. During the meeting, the ICM staff will at a minimum discuss the physical health, mental health and substance use status of each individual served by the ICM and track the contacts with them.

The ICM staff shall communicate with each other throughout the day as needed to ensure that the mental health, physical health and substance abuse needs of clients are met.

13. SERVICE LOCATIONS

Prime Contractor and Partnering Contractor's site from which services are to be provided hereunder is located at the site as identified on the Service Delivery Site Exhibit and in the Contractor's Negotiation Package/Addenda and as identified in each subcontract entered into by Contractor in accordance with the SUBCONTRACTING paragraph of the body of the Agreement. Contractor shall obtain the prior written consent of the DMH Director at least sixty days before terminating services at such location(s) and/or before commencing such services at any other location(s). Contractor shall maintain a Medi-Cal certified site(s) where clients' clinical records will be stored, and from which billing and administrative functions are performed.

Prime Contractor and Partnering Contractor shall maintain a Medi-Cal certified site(s) where clients' clinical records will be stored, and from which billing and administrative functions are performed. This site(s) and any satellite sites where ICM services are provided shall be listed in the Legal Entity Agreement.

14. CLIENT EMERGENCY MEDICAL TREATMENT

Clients who are provided ICM services and who require emergency medical care for physical illness or accident shall be transported to an appropriate medical facility. The cost of such transportation, as well as the cost of any emergency medical care shall not be reimbursable under the Agreement; however, Prime Contractor and Partnering Contractor shall assure that such transportation and emergency medical care are provided. Prime Contractor and Partnering Contractor shall establish and post written procedures describing appropriate action to be taken in the event of a medical emergency. Prime Contractor and Partnering Contractor shall also post and maintain a disaster and mass casualty plan of action in accordance with CCR Title 22, Section 80023. Such plan and

procedures shall be submitted to DMH's Contracts Development and Administration Division at least ten days prior to the commencement of services under the Agreement.

15. NOTIFICATION OF ADVERSE INCIDENTS

Prime Contractor and Partnering Contractor shall comply with the Department of Mental Health Policy No. 202.18, Reporting Clinical Incidents Involving Intentional Injuries, Deaths, Alleged Client Abuse and Possible Malpractice. This policy includes the requirement that the Prime Contractor and Partnering Contractor immediately notify the DMH Medical Director upon becoming aware of the death of any client provided services hereunder. Notice shall be made by Prime Contractor and Partnering Contractor immediately by telephone and in writing upon learning of such a death. The verbal and written notice shall include the name of the deceased, the date of death, a summary of the circumstances thereof, and the name(s) of all Prime Contractor's and Partnering Contractor's staff with knowledge of the circumstances. Prime Contractor and Partnering Contractor must notify ICM DMH representative regarding ay adverse incidents or death of an ICM client.

16. ICM STAFFING REQUIREMENTS

Prime Contractor shall ensure that each ICM site is staffed by a multidisciplinary team that work under one point of supervision and adheres to one set of administrative and operational policies and procedures. Services that can be provided by FQHC allowable staff shall be provided by them. However, the one point of supervision shall be to the Prime Contractor's staff that is directly responsible for overseeing the ICMs. The ICM organizational chart shall clearly delineate the reporting lines of all staff, including Partnering Contractor and subcontractor staff to one point of supervision. Prime Contractor shall inform DMH within twenty-four (24) hours of any changes in the positions included in the organizational chart or changes to the staff reporting lines. Each ICM site shall include the following staff who will provide ICM services, as follows:

A. Licensed physician who is board eligible or certified in internal medicine to provide primary care assessment, treatment, and prevention services with 0.50 full-time equivalent (FTE) .

B. Licensed physician who is board eligible or certified in psychiatry to provide mental health assessment and treatment, prescribe/furnish psychiatric medication, and provide medication monitoring and support with one FTE. In addition, the psychiatrist may act as a consultant to the primary care staff that provides mental health services.

C. Licensed, registered, or waivered mental health clinician, e.g. clinical psychologist, clinical social worker, marriage and family therapist, to provide assessment, psychotherapy, and case management with one FTE.

D. Peer Counselor: An individual who has had current or previous experience as a recipient of mental health services to provide advocacy and support, serve as a role model, and act as a link for clients to connect to the community. Peers may facilitate self-help groups with one FTE.

E. The following are additional minimum staff functions which may be provided by the staff listed above or by other ICM staff who may be employees, independent contractors, or co-located:

1) Integrative Care Manager: Professional staff (e.g. nurse, health educator, or social worker) with healthcare experience to provide education, advocacy and care coordination. Care managers initiate and facilitate linkages to assure access, assess and encourage treatment adherence, participate in treatment planning, and track that all indicated assessments, prevention, treatment, and maintenance services are provided. In addition, the Integrative Care Manager shall use a client tracking system to closely monitor clinical progress and assure that appropriate treatment is provided in a timely manner. Each ICM shall be staffed with two FTEs to function as Integrative Care Managers.

2) Prevention Specialist/Health Promoter: Professional or paraprofessional staff to provide individual and group wellness services such as smoking cessation, nutrition, exercise, weight management, and STD and substance abuse education. Each ICM shall be staffed with one FTE to function as a Prevention Specialist/Health Promoter.

3) Homeless and Housing Specialist: Professional or paraprofessional staff with case management experience to assess and assist with referral, linkages and placement relative to homeless and housing services. Each ICM shall be staffed with one FTE to function as a Homeless and Housing Specialist.

17. SERVICE HOURS

ICM services shall be provided a minimum of 40 hours a week during the hours that clients are most accessible, including early morning hours, evenings and weekends. ICM staff shall be available by phone and/or in person as needed for crisis intervention and other emergency situations 24 hours per day, seven (7) days per week and 365 days a year. Prime Contractor and Partnering Contractor shall notify DMH in writing of any permanent change(s) in the ICM's clinic or field-based service hours at least 24 hours before the change(s).

18. ADMINISTRATIVE HOURS

Prime Contractor's and Partnering Contractor's ICM Manager or County approved alternate shall have full authority to act for Prime Contractor and Partnering Contractor(s) on all matters relating to the daily operation of the Agreement, and shall be available during the County's regular business hours of Monday through Friday, from 9:00 A.M. until 5:00 P.M. to respond to County inquiries and to discuss problem areas.

19. ADMINISTRATIVE TASKS

Required administrative tasks include the following:

- Evaluation Tools: Prime Contractor and Partnering Contractor shall provide clients with a tool as determined by DMH by which to evaluate the services it renders. Prime Contractor and Partnering Contractor shall make this information available to DMH upon request. Prime Contractor and Partnering Contractor

shall administer the tool at various phases of service provision as determined by DMH.

- Unit of Service Claims: Prime Contractor and Partnering Contractor shall ensure unit of service claims are entered electronically at network sites and downloaded to the DMH centralized database (Integrated System).

- Invoicing: Prime Contractor and Partnering Contractor shall submit Client Supportive Services (CSS) invoices monthly as described in the CSS Exhibit G. Prime Contractor and Partnering Contractor(s) shall submit an ICM Cost Reimbursement form monthly for staff time delivering ICM services when the time cannot be reimbursed through another funding source including medical insurance.

- Data Collection: Prime Contractor and Partnering Contractor shall collect, enter, manage, and submit outcome data as directed by DMH to evaluate the INN ICM service model's contribution to learning and adherence to performance-based criteria and to demonstrate client outcomes in accordance with guidelines established by DMH and the State. The Prime Contractor and Partnering Contractor shall work cooperatively with the DMH Contract Liaison and the DMH contracted outcome data evaluator.

20. SUBCONTRACTING

No performance under this Service Exhibit shall be subcontracted by Prime Contractor or Partnering Contractor(s) without the prior written consent of County as provided in Paragraph 29 SUBCONTRACTING of the Legal Entity Agreement.

A. If Prime Contractor or Partnering Contractor(s) desires to subcontract some of the services described in this Service Exhibit, the Prime Contractor or Partnering Contractor(s) must comply with the DMH Agreement Paragraph 29 SUBCONTRACTING terms and conditions.

B. Prime Contractor or Partnering Contractor(s) that has been selected for funding shall obtain prior written approval from DMH in order to enter into a particular subcontract and all requests shall be in writing. Prime Contractor or Partnering Contractor(s) shall remain responsible for any and all performance required of it under the Contract.

C. All Subcontracting Agreements shall be required for review by the County and the official record after award of a contract, if any.

D. The Subcontractor's role in providing ICM services shall be fully described in the Contractor's Negotiation Package/Addenda.

21. INFORMATION TECHNOLOGY REQUIREMENTS

Functional Requirements

Prime Contractor and Partnering Contractor(s) shall have the capacity for an information system/information technology (IS/IT) compatible with DMH's IS/IT system. Prime Contractor and Partnering Contractor(s) shall have the ability to collect, manage, and

submit data as directed by DMH in order to ensure a consistently high level of services throughout the term of the Agreement and demonstrate outcomes inclusive of guidelines set forth by DMH and the State.

Technology Requirements

- Prime Contractor's and Partnering Contractor(s) IS/IT system shall meet the functional, workflow, and privacy/security requirements listed below under Privacy and Electronic Security.

- Prime Contractor and Partnering Contractor(s) shall each be solely responsible for complying with all applicable State and Federal regulations affecting the maintenance and transmittal of electronic information.

Privacy and Electronic Security

- To the extent relevant to deliver the services required by this Service Exhibit, Prime Contractor and Partnering Contractor(s) shall comply with all Federal and State laws as they apply to Protected Health Information (PHI), Individually Identifiable Health Information (IIHI), and electronic information security.

- Any Prime Contractor and/or Partnering Contractor(s) that is deemed a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") shall comply with the HIPAA privacy and security regulations independently of any activities or support of DMH or the County of Los Angeles.

- Any Prime Contractor and Partnering Contractor that is deemed a "Business Associate" of County under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") shall enter into a Business Associate Agreement with the County of Los Angeles to ensure compliance with the privacy standards. For example, if the training is to be designed and delivered by a covered entity such as a Community Mental Health Center and the logistical services providers, vendors, or facilities managers are subcontractors, then a Business Associate Agreement would be required between the covered entity and the logistical services or facility providers in case the subcontractors may handle information regarding the health statues of the students who are consumers or family members. If the training is to be designed and delivered by a non-covered entity, then a Business Associate Agreement will be required between Prime Contractor and Partnering Contractor and the County in case Prime Contractor and Partnering Contractor may handle information regarding the health statues of the students who are consumers or family members.

22. QUALITY MANAGEMENT AND DATA COLLECTION

Quality Management

Prime Contractor and Partnering Contractor shall establish and utilize a comprehensive written Quality Management Program and Plan (Plan) including Quality Assurance and Quality Improvement processes to ensure the organization monitors, documents and reports on the required ICM services provided and that identified measureable performance outcomes are attained. Quality Management activities shall be focused on assuring that the quality of service meets the requirements for timeliness, accuracy,

completeness, consistency and conformity to requirements as set forth in this Service Exhibit. The Plan shall be submitted to DMH and shall be effective upon DMH approval. The Plan shall be updated and re-submitted as changes are needed and/or as changes occur.

The Plan shall include an identified monitoring system covering all the services listed in this Service Exhibit. The system of monitoring to ensure that the Service Exhibit requirements are being met shall include:

- Activities to be monitored, frequency of monitoring, samples of forms to be used in monitoring, title/level and qualifications of personnel performing monitoring functions.

- Ensuring the services, deliverables, and requirements defined in this Service Exhibit are being provided at or above the level of quality agreed upon by the County and the Prime Contractor and Partnering Contractor.

- Ensuring that professional staff rendering services under the Agreement has the necessary prerequisites.

- Identifying and preventing deficiencies in the quality of service before the level of performance becomes unacceptable.

- Taking any corrective action, if needed, including a commitment to provide to the County upon request a record of all inspections, the corrective action taken, the time the problem is first identified, a clear description of the problem, and the time elapsed between identification and completed corrective action.

23. DATA COLLECTION

Prime Contractor and Partnering Contractor shall establish and implement a Data Collection Plan to collect, manage, and submit data and reports as directed by DMH to demonstrate, profile, track, and document the effectiveness of the following: integrating physical health, mental health and substance abuse services delivered, performance outcomes, and quality improvement interventions including pertinent fiscal information related to the leveraging of funds. Prime Contractor's and Partnering Contractor's Data Collection Plan shall include:

- A description of appropriate specific measures and data analysis methods that are currently in place and those to be developed to ensure the collection and reporting of required physical health, mental health and substance abuse treatment data as described in this Service Exhibit.

- A description of how data accuracy problems will be managed and resolved including a description of current data collection, data entry, data analysis, data reporting, and/or other data accuracy problems and actions already taken.

- Prime Contractor, Partnering Contractor and subcontractor agree to participate in regular learning collaborative meetings where data and progress will be reviewed to determine progress toward achieving integration and positive outcomes in the areas of physical health, mental health and substance abuse. These meetings

will serve as the basis for learning and for making any mid-course service corrections to service integration models.

Prime Contractor, Partnering Contractor and subcontractor shall participate in regular learning collaborative meetings where data and progress will be reviewed to determine progress toward achieving integration and positive outcomes in the areas of physical health, mental health and substance abuse. These meetings will serve as the basis for learning and for making any mid-course service corrections to service integration models.

24. OUTCOME DATA REQUIREMENTS

All outcomes targeted for tracking shall be implemented, scored, stored, and transferred in a manner proscribed by DMH at intervals determined by DMH. Additionally, any and all outcomes, measurement instruments, and procedures may be supplemented or revised or deleted by DMH at any time during the course of funding for the ICM.

Monitoring, tracking and reporting of program outcomes by the ICM Prime Contractor, Partnering Contractor and subcontractor are essential for achievement of ICM learning goals. Status reports will be requested and timeliness for submission of such reports will be defined as DMH develops guidelines. Examples of such outcomes may include:

- Improved health and mental health outcomes, e.g. physical and mental health status and functioning.
- Client and provider satisfaction.
- Increased efficiency and better use of limited public resources.
- Decreased frequency of emergency services and
- Hospitalizations.
- Decreased stigma.

25. OWNERSHIP OF DATA

Contractor and DMH hereby agree that any and all outcome data or material collected as part of participation in this program and developed under this Agreement, including but not limited to, client and community satisfaction surveys, evaluation tools, client service utilization data, service cost, diagnostic surveys, tools, and instruments, symptom inventories, stigma measures, integration measures, quality improvement data, measures and reports, and/or program level reports, (hereinafter referred to as "Data"), is the sole property of the County.

Contractor hereby agrees not to use or disclose any such Data and/or not to analyze any portion thereof without the express written consent and/or approval of DMH, except for purposes of evaluating program performance and/or for quality improvement purposes as necessary for compliance with this Agreement, . Use of any such Data for purposes of research and/or publishing is strictly prohibited without the express written consent and/or approval of DMH.

26. PERFORMANCE-BASED CRITERIA

There are six (6) Performance-based Criteria that will measure the Prime Contractor's and Partnering Contractor's performance related to operational measures indicative of quality program administration. These criteria are consistent with the MHSA and the INN Plan learning questions. These measures assess the agency's ability to provide the required services and to monitor the quality of the services. Prime Contractor and Partnering Contractor shall:

- Collaborate with DMH to provide processes for systematically evaluating quality and performance indicators and outcomes at the program level. Should there be a change in Federal, State and/or County policies/regulations, DMH, at its sole discretion, may amend these Performance-based Criteria via a contract amendment.

- Submit required reporting to DMH on performance targets related to the Prime Contractor's, Partnering Contractor and subcontractor services.

- Cooperate with DMH in the regularly scheduled monitoring of the program, including review of agency and program records, site visits, telephonic conferences, correspondence, and attendance at provider meetings where the Prime Contractor's and Partnering Contractor's adherence to the performance-based criteria will be evaluated.

The Performance-based Criteria are as follows:

PERFORMANCE-BASED CRITERIA	METHOD OF DATA COLLECTION	PERFORMANCE TARGETS
1. Integrated care	Record review, provider interview	➢ Integrated care plans created ➢ Services are integrated to a high degree
2. Service levels/access	Existing DMH data measuring service utilization and number of new clients	➢ Service utilization is increased ➢ A significant number of ICM clients are new to the site
3. Quality of care	Existing databases, and tools or surveys measuring quality of care e.g., process measures, stigma measures, satisfaction	➢ Client hospitalizations and emergency services decrease ➢ Clients are satisfied with services provided ➢ Quality of care improves ➢ Stigma related to receiving services decreases ➢ Improved health and mental health outcomes
4. Community improvement	Existing databases, provider interview, tools to evaluate homelessness and access to care especially for UREP groups	➢ Homelessness, incarceration, and emergency service use decreases ➢ More UREP clients are served ➢ Partnering among community organizations increases
5. Stakeholder satisfaction	Provider, client, community survey	➢ Stakeholders surveyed indicate a high level of satisfaction
6. Cost	Documentation and provider survey demonstrating leveraging, billing data	➢ A significant amount of overall funding is leveraged ➢ Costs for high-intensity emergency services decrease

		➢ Numbers of uninsured clients served ➢ Numbers of clients for whom benefits were established by the ICM

Prime Contractor and Partnering Contractor shall maintain, at a minimum, the following that indicate the performance targets:

- Required reporting to DMH on performance targets related to the Contractor's services.
- An Integrated client medical record/chart that include but are not limited to assessments, care/treatment plans, progress notes and discharge summaries.
- Administrative policies and procedures for the ICM.
- Budgets and financial records for the ICM.

27. CONTRACTOR TIMELINES

Prime Contractor shall submit the following to DMH for approval prior to the execution of the Agreement:

- Administrative and organizational policies and procedures for the ICM
- An ICM organizational chart

Prime Contractor and Partnering Contractor shall submit the following to DMH for approval prior to the execution of the Agreement:

- An emergency medical treatment and disaster/mass casualty plan
- A Quality Management Program and Plan
- A Data Collection Plan
- The clinic and field-based service hours
- A list of ICM services that will be provided in the field and those that will be provided in a clinic setting

Prime Contractor and Partner Contractor shall adhere to the following time requirements/timelines within thirty (30) days of the execution of the Agreement:

- Provide orientation training to ICM staff
- Operationalize all sites listed in the Contract
- Implement the ICM service model
- Acquire a computer system with sufficient hardware and software to meet DMH requirements and an agreement for its on-site maintenance for the entire term of this Agreement

Prime Contractor shall adhere to the following time requirements/timelines within thirty (30) days of the execution of the Agreement:

- Provide DMH with a roster of all ICM staff that includes: (1) names and positions; (2) Name of employing agency; (3) work schedules; (4) fax and telephone

numbers; and (5) any non-English, Los Angeles County threshold languages spoken by staff

Agreement No. _____

SERVICE EXHIBIT_____

CLIENT SUPPORTIVE SERVICES FOR MENTAL HEALTH SERVICES ACT INNOVATION PLAN PROGRAMS INTERGATED CLINIC MODEL (ICM)

I. OVERVIEW

The Mental Health Services Act (MHSA), adopted by the California electorate on November 2, 2004, created a new permanent revenue source administered by the California State Department of Mental Health (SDMH) for the transformation and delivery of mental health services provided by State and County agencies. The MHSA requires the development of integrated plans including Prevention and Early Intervention, Innovation, and Community Services and Supports that promote hope, wellness resiliency, and recovery. The Los Angeles County Department of Mental Health's (DMH's) MHSA Community Services and Support and Innovation plans include Client Supportive Services (CSS) funding for ancillary services that support client resiliency, wellness and recovery.

II. ELIGIBILITY/USE OF CLIENT SUPPORTIVE SERVICE FUNDS

Clients of all ages, ethnicities, cultures and conditions who are receiving services through a MHSA Innovation Plan Program are eligible to receive CSS funds. These funds may be expended on clients receiving ongoing mental health services and to engage unserved individuals in the mental health system. CSS expenditures can only be used when the client does not have sufficient financial resources, including Supplemental Security Income (SSI) to pay for a necessary CSS expenditure and these expenditures cannot be obtained or reimbursed through another community and/or funding resource including medical insurance. When these funds are used, the client's chart/record must document how the use of the CSS funding is directly related to the client's care/treatment plan and recovery goals and what other community and/or funding resources have been explored but were unavailable to obtain the necessary item or service. Although the use of CSS funds is client specific, they are allocated as an aggregate pool of funds. The use of CSS funds is not an entitlement.

Items and services purchased with CSS funds including staff time that is not otherwise reimbursed through the Integrated System (IS) or any other leveraging sources must be used in the fiscal year in which they are purchased.

A *Supplemental Information Request Form* (Attachment 2) must be submitted to the INN model District Chief for CSS funds used for any ongoing client

expenses beyond three (3) months. There must be clear documentation indicating how the ongoing expense relates to the client's care/treatment plan and recovery goals and what steps have been to taken to secure alternative sources of funding for the expense.

All CSS expenditures are subject to random audits by DMH and/or the Los Angeles County Office of the Auditor-Controller.

III. CLIENT SUPPORTIVE SERVICES EXPENDITURE CATEGORIES AND SERVICE FUNCTION CODES (SFC)

The following is a list of CSS expenditure categories and Service Function Codes (SFC) that are required for billing purposes. Refer to Attachment 1, Client Supportive Services Expenditure Guidelines, for a complete list of allowable expenditures.

A. Client Housing Support Expenditures, SFC 70

Client Housing Support (CHS) expenditures, SFC 70, apply to the costs associated with providing short-term housing for clients and those needed to help clients maintain their housing. These include payment for rental subsidies, housing vouchers, motels, shelters, security deposits, first and last months rent and rent needed to prevent eviction. The salaries and benefits of staff that provide client housing supports are not included.

B. Client Housing Operating Support Expenditures, SFC 71

Client Housing Operating Support (CHOS) expenditures, SFC 71, apply to the operating costs related to providing housing supports. These include payment for utilities, building repair and maintenance, insurance and credit reporting fees.

C. Client Flexible Support Expenditures, SFC 72

Client Flexible Support (CFS) expenditures, SFC 72, apply to the costs associated with goods and services that are necessary to assist clients with their daily living needs and with achieving their personal/community integration care/treatment goals. CFS expenditures include payment for food, clothing, hygiene products, transportation, tickets/citations (with pre-authorization by DMH) furniture, appliances, housewares, moving expenses, school supplies, tuition and recreational activities.

CFS may also be used for a client's dental and optical care, alternative healing methods such as cupping, acupuncture and curandero services only if these expenses cannot be reimbursed through another funding source including medical insurance.

* Contractor shall be solely liable and responsible for any and all required services, whether provided directly, subcontracted or referred, under this

Agreement. Contractor shall indemnify and hold harmless the County from and against any liabilities and costs arising from, connected with, or related to services and treatments rendered under this Agreement by Contractor, subcontractor, and/or employees of Contractor or subcontractor.

The use of CFS expenditures for gift card purchases is restricted to a limited supply to cover categorical expenditures over a two (2) month time period. Gift cards should not be routinely given to individual clients, but should only be used to supplement a client's resources. Gift card allocations per month per client cannot exceed $150 unless pre-approved by DMH. Items and services purchased with gift cards must be bought/used in the fiscal year in which the gift card was purchased. Clients must be informed of non-allowable purchases when using gift cards. (See Section IV. Non-Allowable Client Supportive Services Expenditures.)

Gift cards must be properly secured and accounted for by maintaining a gift card tracking system that includes the following minimum information:

- Gift card vendor name
- Gift card serial number
- Date gift card was bought
- Name of the client to whom the gift card was given
- Date gift card was given to the client
- Signature of client acknowledging receipt of the gift card
- Gift card balance
- Copies of receipts for gift card purchases
- Name and signature of authorized personnel who give the client the gift card

There must be internal policies and procedures that include, but are not limited to, gift card security, accountability and dispersal, the requirement that gift card purchases must relate to the client's care/treatment plan and how clients will be informed of non-allowable purchases when using gift cards.

The gift card internal policies and procedures and tracking system shall be made available for review by a DMH designee(s) upon request at the agency or by copies sent as requested by a DMH designee.

D. Other Non-Medi-Cal Client Support Expenditures, SFC 78

Other Non-Medi-Cal Client Support Expenditures, SFC, 78 applies to the staff time delivering Innovation plan services only if this time cannot be reimbursed through another funding source including medical insurance.

IV. NON-ALLOWABLE CLIENT SUPPORTIVE SERVICES EXPENDITURES

The following are non-allowable CSS expenditures:

- Alcohol
- Tobacco
- Illegal substances/activities
- Incentives
- Sexually explicit materials
- Costs for staff to accompany clients to venues or events such as sporting events, concerts or amusement parks
- Medi-Cal Share of Cost
- Prescription drugs that are reimbursed by a client's medical insurance, a Prescription Assistance Program or DMH's Indigent Medications Program.
- Expenses related to purchasing land or buildings or the construction/rehabilitation of housing, facilities, buildings or offices
- Costs that are reimbursed by any other funding source including units of services costs reported under Modes 05, 10, 15 or 45
- Program vehicles
- Medications for physical health conditions and laboratory tests.

V. CLIENT SUPPORTIVE SERVICES EXPENSE LIMITS

CSS funds shall be used as reasonably and economically as possible. Purchases should be made from vendors that sell previously used merchandise such as Goodwill, Salvation Army and on-line resources whenever possible. See Attachment 1, Client Supportive Services Expenditure Guidelines for a list of CSS expense limits.

VI. CLIENT PROPERTY PURCHASED WITH CLIENT SUPPORTIVE SERVICES

Items purchased with CSS funds become the property of the client and the client **is not** obligated to return the property if the client no longer receives services though a MHSA Innovation Plan Program. However, there may be situations in which a program provider and a client make an agreement for the client to reimburse the program provider for CSS expenditures, such as rent payments or security deposits made by the program provider on the client's behalf (e.g. upon approval of Social Security Income).

VII. REIMBURSEMENT

The procedures for reimbursement for CSS expenditures are provided in Attachment A.

ATTACHMENT A

CLIENT SUPPORTIVE SERVICE EXPENDITURES REIMBURSEMENT PROCEDURES

The following procedures shall be used for the reimbursement of Client Supportive Client Supportive Services (CSS) expenses:

1. Invoice Submission

A CSS Expense Invoice form, Attachment 1, shall be completed on the last day of each month for the CSS expenses incurred during the month. CSS expenses incurred in different months shall not be combined on the same invoice. The invoice must include the client's name, Integrated System (IS) number, from whom the service was provided or where the item was purchased (vendor/service provider name) a description of the item/service purchased, and the amount claimed by Service Function Code (SFC 70, 71, 72 or 78). If CSS expenditures are used for individuals who are receiving outreach and engagement services, indicate "O & E" instead of an IS number.

Invoices shall be submitted within sixty (60) days from the month in which the CSS expenditure occurred.

The CSS Expense Invoice form(s) shall be submitted to:

County of Los Angeles – Department of Mental Health
550 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90020
ATTN: Provider Reimbursement Unit

2. DMH Invoice Review and Approval

The DMH Provider Reimbursement unit will log the CSS Expense Invoice received and forward the invoice to the designated DMH Innovation manager. The manager will review the invoice to verify the claimed expenditures comply with allowable CSS expenditures and approve the claim. The manager's decision to disallow claims that do not comply with allowable CSS expenditures is final. Invoices that require revisions, edits, and/or additional documentation will be returned to the Contactor for correction. The approved invoices will be forwarded to the Provider Reimbursement unit for payment.

DMH will process all approved CSS Expense Invoices on a monthly basis.

3. Monthly Disbursement Report

Total CSS expenses shall not exceed the total CSS DMH approved amount. The DMH Accounting Division will generate a monthly disbursement report for the Contractor and DMH manager to ensure the expenditures do not exceed the

approved amount. The County shall not be liable for reimbursement of any expenses claimable hereunder in the event that Contractor exceeds its allocation or violates the terms and conditions of this Service Exhibit or the Legal Entity Agreement.

4. Documentation Requirements

The following documents shall be retained in accordance with the Records and Audits paragraph of the Agreement for a period of at least six (6) years:

a. Original receipts to support CSS expense reimbursement claim invoices that identify individual clients and/or bulk purchases. If an original receipt is not obtainable, a copy of the receipt or justification as to why the receipt was not obtained must be retained;

b. Copies of original rental agreements, including the "Return of security and Rental Deposit Agreement" signed by the client/caregiver and the property owner or authorized agent if applicable;

c. Copies of signed checks issued;

d. DMH pre-approved CSS expenditures; and

e. Copies of staff time records identifying the time spent by staff whose time is not billed through the DMH Integrated System (IS) or to any other funding source including medical insurance.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

SUPPLEMENTAL INFORMATION REQUEST FORM

REQUEST / CLIENT INFORMATION

Agency Name: _____ Provider #: _____ Date: _____

Name of case manager requesting CSS funds: _____ Title: _____ Billing Month: _____

Client's Name : _____ IS #: _____

Amount Requested: $ _____ Have CSS funds been requested for this client before? Y _____ N _____

CSS FUND USAGE DETAIL

Description of ongoing expense(s) beyond 3 months: _____

_____

Purpose of expense(s): _____

_____

How does/do the expense(s) support and contribute to client's treatment goals? (attach CCCP) _____

_____

List alternative resources explored to cover expense(s):

_____

_____

VERIFICATION

I hereby certify that all of the information contained above is true and accurate to the best of my knowledge.

Case Manager's Name	Case Manager's Signature	Date
Approving DMH Manager's Name	Approving DMH Manager's Signature	Date

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
CSS EXPENSE INVOICE

CLIENT SUPPORTIVE SERVICE EXPENDITURES REIMBURSEMENT PROCEDURES

The following procedures shall be used for the reimbursement of Client Supportive Client Supportive Services (CSS) expenses:

5. Invoice Submission

A ***CSS Expense Invoice*** form, shall be completed on the last day of each month for the CSS expenses incurred during the month. CSS expenses incurred in different months shall not be combined on the same invoice. The invoice must include the client's name, Integrated System (IS) number, from whom the service was provided or where the item was purchased (vendor/service provider name) a description of the item/service purchased, and the amount claimed by Service Function Code (SFC 70, 71, 72 or 78). If CSS expenditures are used for individuals who are receiving outreach and engagement services, indicate "O & E" instead of an IS number.

Invoices shall be submitted within sixty (60) days from the month in which the CSS expenditure occurred.

The CSS Expense Invoice form(s) shall be submitted to:

County of Los Angeles – Department of Mental Health
550 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90020
ATTN: Provider Reimbursement Unit

6. DMH Invoice Review and Approval

The DMH Provider Reimbursement unit will log the CSS Expense Invoice received and forward the invoice to the designated DMH Innovation manager. The manager will review the invoice to verify the claimed expenditures comply with allowable CSS expenditures and approve the claim. The manager's decision to disallow claims that do not comply with allowable CSS expenditures is final. Invoices that require revisions, edits, and/or additional documentation will be returned to the Contactor for correction. The approved invoices will be forwarded to the Provider Reimbursement unit for payment.

DMH will process all approved CSS Expense Invoices on a monthly basis.

7. Monthly Disbursement Report

Total CSS expenses shall not exceed the total CSS DMH approved amount. The DMH Accounting Division will generate a monthly disbursement report for the Contractor and DMH manager to ensure the expenditures do not exceed the

approved amount. The County shall not be liable for reimbursement of any expenses claimable hereunder in the event that Contractor exceeds its allocation or violates the terms and conditions of this Service Exhibit or the Legal Entity Agreement.

8. Documentation Requirements

The following documents shall be retained in accordance with the Records and Audits paragraph of the Agreement for a period of at least six (6) years:

a. Original receipts to support CSS expense reimbursement claim invoices that identify individual clients and/or bulk purchases. If an original receipt is not obtainable, a copy of the receipt or justification as to why the receipt was not obtained must be retained;

b. Copies of original rental agreements, including the "Return of security and Rental Deposit Agreement" signed by the client/caregiver and the property owner or authorized agent if applicable;

c. Copies of signed checks issued;

d. DMH pre-approved CSS expenditures; and

e. Copies of staff time records identifying the time spent by staff whose time is not billed through the DMH Integrated System (IS) or to any other funding source including medical insurance.

INNOVATION FUNDS

Fiscal Year: _____

Legal Entity Number : _____

Billing Month: _____

Legal Entity Name: _____

Provider Number: _____

*See attached table for common Service Function Codings

IS #	Client Name	Vendor/Service Provider Name	Description of Item/Service Purchased	*SFC 70	*SFC 71	*SFC 72	*SFC 78
			Totals:				

TOTAL EXPENSE CLAIM:

Agency Verification

I hereby certify that all information contained above are services and costs eligible under the terms and conditions for reimbursement under Client Support Services and is true and correct to the best of my knowledge. All supporting documentation will be maintained in a separate file for te period specified under the provisions of the Mental Health Services Agreement - Legal Entity, Paragraph 13, Subparagraph A, Section (1), Sub-sections (1)(a) and (1)(b), Section (2), Section (3), and Section (4).

Signature _____ Date _____

Print Name _____ Title _____

DMH APPROVAL

Date _____ Signature _____

Print Name _____ Title _____

Provider No. **TBA**

SERVICE EXHIBIT ____

ONE-TIME EXPENSES
ASSOCIATED WITH STARTING A NEW
MENTAL HEALTH SERVICES ACT INNOVATION PROGRAM

I. OVERVIEW

In response to the implementation requirements of the Mental Health Services Act, Los Angeles County Department of Mental Health (DMH) has designed and implemented contracts, policies, procedures and payment processes that support the implementation of new programs.

DMH has developed this Service Exhibit to facilitate reimbursement of one-time expenses associated with starting new MHSA Innovation programs. These include non-Medi-Cal capital assets and other non-Medi-Cal client support expenditures. These expenses will only be allowed during the first two months of the program's initiation unless prior approval is obtained from the program's lead DMH District Chief.

II. ALLOWABLE ONE-TIME EXPENSES

A. Service Function Code (SFC) 75: Non-Medi-Cal Capital Assets

SFC 75 applies to the one-time capital asset expenses dedicated solely to non-Medi-Cal activities. These expenses shall be $5,000 or greater; they may be claimed in the year purchased. Expenses that should be reported under SFC 75, provided such expenses are dedicated solely to non Medi-Cal activities, include:

- Vehicles
- Other capital assets dedicated solely to non-Medi-Cal activities.

Units of Service shall not be reported for SFC 75.

All Capital Assets purchased within the parameters of this exhibit require the DMH's Director's or the Director's designee's prior approval.

B. Service Function Code (SFC) 78: Other Non-Medi-Cal Client Support Expenditures

SFC 78 applies to one-time expenses other than SFC 75 expenses that are associated with starting a new MHSA Innovation program. These expenses include general operating expenditures incurred in providing non-Medi-Cal

client supports not otherwise reported in treatment or outreach programs (Mode 05, 10, 15 or 55). Allowable expenses include extraordinary costs associated with leases and utilities (e.g. deposits), recruitment, staff orientation/training, staff time dedicated to program development and equipment. Equipment expenses must be less than $5,000. Lease costs, utilities, staff orientation/training and staff time dedicated to program development shall only be claimed prior to the provision of service delivery.

III. REIMBURSEMENT

The procedures for reimbursement for One-Time Expenses Associated with Starting a New MHSA Innovation Program are provided in Attachment A.

ONE-TIME EXPENSES ASSOCIATED WITH STARTING A NEW MENTAL HEALTH SERVICES ACT INNOVATION PROGRAM REIMBURSEMENT PROCEDURES

The following procedures shall be used for reimbursement of One-Time MHSA Innovation program expenditures:

1. ONE-TIME EXPENSES ELIGIBLE FOR REIMBURSEMENT

A. Service Function Code 75: One-Time Non-Medi-Cal Capital Assets >$5,000
B. Service Function Code 78: One-Time Non-Medi-Cal Client Support Expenditures <$5,000

2. REIMBURSEMENT GUIDELINES

The funds allocated for one-time expenses shall be used only when no other non-Medi-Cal funds are available.

3. DOCUMENTATION REQUIREMENTS FOR REIMBURSEMENT

The following supportive documentation shall be maintained on file in accordance with the Records and Audits paragraph of the Agreement:

a. Original receipts to support payment invoices. If an original receipt is not obtainable, a copy of the receipt or justification as to why the receipt was not obtained should be retained;

b. Copies of Real Estate Contracts/Agreements/Leases;

c. Copies of signed checks issued; and

d. Documentation of costs for recruitment or orientation/training of staff.

4. SUBMISSION OF MONTHLY INVOICES

Contractor shall, on the last day of each month, complete a Monthly Claim for Cost Reimbursement Client Supportive Services and One-time MHSA Expenses form indicating the funding source categories of expenses (SFC 75 or 78) and the amount spent, including staff salaries. All claims shall be submitted by Contractor to DMH within sixty (60) days from the month in which the expenditure occurred.

The Monthly Claim for Cost Reimbursement Client Supportive Services and One-time MHSA Expenses form(s) (Attachment B) shall be submitted to:

Department of Mental Health
Provider Reimbursement Unit
550 S. Vermont Ave., 8th Floor
Los Angeles, CA 90020

5. **DMH REVIEW AND APPROVAL OF INVOICES**

DMH's Provider Reimbursement Unit will record receipt of the Monthly Claim for Cost Reimbursement Client Supportive Services and One-time MHSA Expenses form(s) and then submit them to the program's lead DMH Program Manager who will review the monthly invoices and sign to affirm that expenditures meet established procedures for One-time Expenses Associated with Starting a New MHSA Innovation Program. Approved invoices will be forwarded to the DMH Provider Reimbursement Unit for payment.

DMH shall process all completed requests for reimbursement on a monthly basis. DMH's decision as to the allowability of any expenditure shall be final.

6. **MONTHLY RECONCILIATION REPORT**

The amount of funds allocated for one-time MHSA expenditures associated with starting a new Innovation program must have been approved by the DMH prior to the expenditures. Monthly disbursements reports will be generated by the DMH Accounting Division for the contractors and program staff to ensure expenditures do not exceed the allocation. The County shall not be liable for reimbursement of any expenses claimable hereunder in the event that Contractor exceeds its allocation or violates the terms and conditions of these procedures or the Legal Entity Agreement.

ATTACHMENT II

COUNTY OF LOS ANGELES -DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE MEDICAL DIRECTOR

Mental Health Services Act Integrated Clinic Model

CONTRACT FOR FY 2011-12, 2012-13, 2013-14

Agency	Legal Entity (LE)	Sup. Dist. (HQ)	SA	Innovation Funding	Revised MCA	Innovation Funding	Estimated MCA	Innovation Funding	Estimated MCA
				FY 2011-12		FY 2012-13		FY 2013-14	
PRIME CONTRACTOR 1									
Exodus Recovery, Inc.	00527	1	4	$ 397,572	$ 15,075,047	$ 1,164,419	*	$ 1,195,771	**
PRIME CONTRACTOR 2									
Special Service for Groups	00214	2 & 4	6	$ 368,964	$ 31,627,715	$ 1,078,983	*	$ 1,226,584	**
PRIME CONTRACTOR 3									
The Los Angelees Free Clinic dba The Saban Free Clinic	00323	4	4	$ 313,716	$ 587,016	$ 908,916	*	$ 1,003,246	**
PARTNERING CONTRACTOR 3A									
Jewish Family Service of Los Angeles	01521	4	4	$ 49,258	$ 1,309,725	$ 132,993	$ 1,442,718	$ 147,768	$ 1,590,486
PRIME CONTRACTOR 4									
JWCH Institute, Inc.	01563	1,2 & 4	6 & 7	$ 228,391	$ 943,444	$ 598,321	$ 1,541,765	$ 693,137	**
PARTNERING CONTRACTOR 4A									
South Central Health and Rehabilitation Program (SCHARP)	00506	1,2 & 4	6 & 7	$ 219,525	$ 8,763,810	$ 615,013	$ 9,378,823	$ 762,863	**
PRIME CONTRACTOR 5									
The Los Angeles Gay and Lesbian Community Service Center	00304	1 & 3	4	$ 412,373	$ 524,770	$ 1,045,071	*	$ 1,077,023	**
			TOTAL:	$ 1,989,799	$ 58,831,527	$ 5,543,716	$ 12,363,306	$ 6,106,392	$ 1,590,486

*Contract will be renewed on July 1, 2012

**Contract will be renewed on July 1, 2013

ATTACHMENT III

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

BOARD OF SUPERVISORS
GLORIA MOLINA
MARK RIDLEY-THOMAS
ZEV YAROSLAVSKY
DON KNABE
MICHAEL D. ANTONOVICH

DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.info

Reply To: (213) 738-4601
Fax: (213) 386-1297

December 20, 2011

TO: Each Supervisor

FROM: Robin Kay for
Marvin J. Southard, D.S.W.
Director

SUBJECT: **REQUEST TO INCREASE DELEGATED AUTHORITY PERCENTAGE FOR THE MENTAL HEALTH SERVICES ACT INNOVATION INTEGRATED CLINIC MODEL BOARD LETTER FOR FISCAL YEARS 2011-12, 2012-13, and 2013-14**

This memorandum is to comply with Board Policy Manual, Section 5.120, Authority to Approve Increases to Board Approved Contract Amounts. The Policy mandates that any department requesting a percentage increase exceeding ten percent of the total contract amount must provide a detailed justification and advanced written notice to your Board, with a copy to the Chief Executive Officer, at least two weeks prior to the Board Meeting at which the proposed contract is to be presented.

The Department of Mental Health (DMH) requests an additional ten percent for a total of twenty percent delegated authority to amend the existing DMH Legal Entity Agreements with Exodus Recovery, Inc., The Los Angeles Free Clinic dba The Saban Free Clinic, Jewish Family Service of Los Angeles, Special Service for Groups, The Los Angeles Gay and Lesbian Community Service Center, JWCH Institute, Inc., and South Central Health and Rehabilitation Program to implement an Integrated Clinic Model under the Mental Health Services Act Innovation Plan, for Fiscal Years 2011-12, 2012-13, and 2013-14. This authority will allow DMH greater capacity to amend contracts for new funding streams and programs/services and implement such programs/services in a timely and expeditious manner. Therefore, in most instances where speed and response time are of key importance, the objectives to maximize, prioritize, and increase access to services will more effectively meet the County's mission "To Enrich Lives through Effective and Caring Service."

Should there be a need to exceed the twenty percent delegated authority, DMH will return to your Board with a request for authority to amend the Agreements accordingly.

If you have any questions or concerns, please contact me, or your staff may contact Richard Kushi, Chief, Contracts Development and Administration Division, at (213) 738-4684.

MJS:RK:RS:NSK

c: Executive Officer, Board of Supervisors
Chief Executive Officer
County Counsel
Robin Kay
Margo Morales
Roderick Shaner
Deputy Directors
District Chiefs
Kimberly Nall
Richard Kushi