COUNTY OF LOS ANGELES

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

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

BOARD OF SUPERVISORS

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DEPARTMENT OF MENTAL HEALTH

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Reply To: (213) 738-4601
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February 12, 2013

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

16 February 19, 2013

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 TWO LEGAL ENTITY AGREEMENTS TO ADD MENTAL HEALTH SERVICES ACT-INNOVATION FUNDING FOR IMPLEMENTING THE INTEGRATED PEER-RUN MODELS FOR FISCAL YEARS 2012-13 THROUGH 2013-14
(SUPERVISORIAL DISTRICTS 1, 2, AND 4)
(3 VOTES)

SUBJECT

Request approval to amend two Legal Entity Agreements to add Mental Health Services Act-Innovation Funding for implementing Integrated Peer-Run Models for Fiscal Years 2012-13 though 2013-14.

IT IS RECOMMENDED THAT THE 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 Mental Health America of Los Angeles (MHALA) and Emotional Health Association dba (SHARE!) the Self-Help and Recovery Exchange. The Amendments will be effective upon your Board's approval through the term of their LE Agreements and will increase the Fiscal Year (FY) 2012-13 Maximum Contract Amounts (MCA) for MHALA in the amount of $707,777, for a revised MCA of $18,043,207 and for SHARE! in the amount of $915,554, for a revised MCA of $1,724,154 (Attachment II). The total amounts to amend these LE Agreements are $1,623,331 for FY 2012-13 and $2,434,998 for FY 2013-14, fully funded by State Mental Health Services Act (MHSA) revenue.

2. 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 fiscal year 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 or extend the term of the Agreements; and 6) the Director notifies your Board and the Chief Executive Officer 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 MHALA, DMH Contract No. MH120918, and SHARE!, DMH Contract No. MH120907, to implement MHSA Innovation Plan (INN) Integrated Peer-Run Models (PRM): Peer-Run Integrated Service Management (PRISM) and Peer-Run Respite Care Homes (PRRCH). Through a competitive solicitation process, DMH selected these contractors to implement three PRISM programs and two PRRCH programs. The two successful bidders are existing service providers; therefore, these new services will be added to their current LE Agreements through these amendments.

The MHSA INN plan is the final MHSA plan to be implemented in Los Angeles County. The State Department of Mental Health (SDMH) guidelines, which remain in effect after the dissolution of SDMH, 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. The results and lessons learned from this INN project will contribute to the transformation of the current mental health system.

As required by State guidelines, DMH's INN Plan was developed through a community 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 PRM. The other models are the Integrated Clinic Model, Integrated Mobile Health Team, and Integrated Service Management Model which have already been implemented throughout the County.

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 role of peer support in achieving integration. With the use of MHSA INN funding, PRISM will be able to provide linkage to health, mental health, substance abuse, and housing services as part of a program designed to empower individuals to sustain their own recovery. PRRCH, on the other hand, will be able to provide guests a short-stay, voluntary living opportunity designed to provide safe and healing environments where people can move through their psychiatric distress in a relatively brief time of 14 days to 30 days. Further support services, such as linkage to substance abuse, physical health, and mental health treatment will be available to guests as desired. By employing peer run approaches delivery of mental health, physical health, and substance abuse disorder service linkage and coordination, the PRM meet 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.

Implementation of PRM will allow the provision of appropriate services to assist individuals with mental illness recover and continue to thrive in community-based settings, offering alternative approaches that seek to decrease the need for involuntary inpatient hospitalization. PRISM and PRRCH service delivery components will include peer-run programs that utilize staff who are engaged in their own successful recovery efforts. Serving as role models and peers for consumers, these staff with lived service recipient experience will assist peer consumers in creating the linkages to allied community mental health, physical health, housing, and substance abuse service resources. The goal of PRM is to assist consumers in resuming their individual recovery efforts within the community, utilizing essential social support systems and preventing the need for costly and intensive inpatient services. Care and linkage assistance supporting ongoing health, mental health, housing, and substance abuse services in the community is essential to sustaining solid community-based recovery for persons with a mental illness.

Implementation of Strategic Plan Goals

The recommended actions support the County's Strategic Plan Goal 1, Operational Effectiveness, and Goal 3, Integrated Services Delivery.

FISCAL IMPACT/FINANCING

The amendment amounts for FY 2012-13 for MHALA and SHARE! are $707,777 and $915,554, respectively, and total $1,623,331. This amount is fully funded by State MHSA revenue and is included in DMH's FY 2012-13 Final Adopted Budget. Funding for future years will be requested through DMH's annual budget request process.

The amendments include one-time funding for expenses associated with starting new MHSA INN programs incurred during the first two months of the program's initiation. The one-time expenses may include non Medi-Cal capital assets and other non Medi-Cal client support expenditures. The one-time funding allocated to MHALA is $176,944 and to SHARE! is $228,888.

There is no net County cost impact associated with these actions.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

The two contractors are located in three Supervisorial Districts and will provide services in three different Service Areas (SAs) of the County. MHALA will implement one PRISM program and one PRRCH program in SA 8. SHARE! will be contracted to implement two PRISM programs, one in SA 4 and another in SA 5, and one PRRCH program in
SA 3. Each contractor will provide PRISM and PRRCH services, staffed by specially trained Peer Specialists

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 Amendment format has been approved as to form by County Counsel. 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 October 5, 2012 (Attachment III), identifying and justifying the need for requesting a percentage increase exceeding 10 percent.

CONTRACTING PROCESS

On March 27, 2012, DMH issued the MHSA INN PRM RFS No. 6 to identify qualified agencies to implement the PRM. 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 April 24, 2012, DMH held a mandatory PRM Proposers' Conference that was attended by 17 agencies. DMH received nine PRISM proposals and four PRRCH proposals by the deadline on May 26, 2012. Agencies that met mandatory minimum requirements were allowed to submit proposals for both PRRCH and PRISM and were required to submit distinct proposals by service model and service area. The submitted proposals were then divided into two groups: proposals submitted to provide PRISM services and proposals to provide PRRCH services. Evaluators were selected to independently review and score either PRISM or PRRCH proposals. Two Evaluation Committees were formed for the review process. The committee reviewing PRISM proposals consisted of three evaluators and a facilitator. The committee reviewing PRRCH proposals consisted of four evaluators and a facilitator. The Evaluation Committees convened between Monday, June 18 and Monday, July 2, 2012. The Evaluation Committees used the PRM RFS No. 6's specific standardized evaluation tools and an informed averaging process to arrive at final scores.

After notification of the RFS results, the unsuccessful proposers were given the opportunity to request a formal debriefing. Consequently, four agencies requested a formal debriefing. Following the debriefing, the agencies were further presented an opportunity to pursue a Proposer Contractor Selection Review. However, the Department did not receive a response from the agencies by the specified deadline.

The Department's Executive Management Team reviewed the Committees' final scores and recommended funding the five highest scoring PRM Proposers (three PRISM program and two PRRCH Programs).

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Upon the contract award, this action will provide funds for two contractors to provide peer support services and linkage to mental health, physical health and substance use disorder services to clients with mental health needs.

Respectfully submitted,

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

MJS:MM:DM:RK:gt

Enclosures

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

Attachment I

CONTRACT NO. _____

AMENDMENT NO. __

THIS AMENDMENT is made and entered into this __ day of _____, 2013, 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 Years (FYs) 2012-13 and 2013-14 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 the Department of Mental Health (DMH) 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, Integrated Mobile Health Team Model, Community Designed Integrated Service Management (ISM) Model, and Integrated Peer-Run Model; and

WHEREAS, Contractor is being selected pursuant to Mental Health Services Act (MHSA) Request for Services – Integrated Peer-Run Models and Contractor has agreed to implement services as stated in the Service Exhibit XX Peer-Run Integrated Services Management **(PRISM)** which is attached hereto; and

WHEREAS, Contractor is being selected pursuant to Mental Health Services Act (MHSA) Request for Services – Integrated Peer-Run Models and Contractor has agreed to implement services as stated in the Service Exhibit XX Peer-Run Respite Care Home **(PRRCH)** 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 (CSS) for MHSA INN Plan Programs" which is attached hereto; and

WHEREAS, County and Contractor intend to amend Agreement to add Service Exhibit XX – "Community Outreach Services (COS)" which is attached hereto; and

WHEREAS, for FYs 2012-13 and 2013-14, County and Contractor intend to amend this Agreement to add MHSA INN Programs (Non Medi-Cal/Non Healthy Families) funds in the amount of $_____, and $ _____, respectively, to provide coordination and delivery of peer-run/self-help

services to the uninsured, homeless, and under-represented ethnic populations (UREP); and

WHEREAS, for FY 2012-13 only, County and Contractor intend to amend this Agreement to **add** One-Time funds in the amount of $_____ for starting a New MHSA INN Program; and (CFA doesn't apply by the time this amendment is executed)

WHEREAS, for FYs 2012-13 and 2013-14 **(if applicable)**, the revised Maximum Contract Amounts will be $ _____, and $ _____, and respectively.

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

1. For FYs 2012-13 and 2013-14, MHSA INN Programs funds are added in the amount of $_____ and $_____, respectively to allow Contractor to provide coordination and delivery of peer-run/self-help services to the uninsured, homeless, and UREP.

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

"C. REIMBURSEMENT FOR INITIAL PERIOD

(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. REIMBURSEMENT IF AGREEMENT IS AUTOMATICALLY RENEWED

(1) Reimbursement For First Automatic Renewal Period: 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.

3. 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."

4. 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."

5. Financial Summary Subprogram Schedule - _ for FY 2012-13, shall be deleted in its entirety and replaced with Financial Summary Subprogram Schedule - _ for FY 2012-13 attached hereto and incorporated herein by reference. All references in Agreement to Financial Summary Subprogram Schedule - _ for FY 2012-13, shall be deemed amended to state "Financial Summary Subprogram Schedule - _ for FY 2012-13."

6. **A Service Exhibit for "MHSA INN-PRISM" services is added to this Agreement and incorporated herein.**

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

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

9. A Service Exhibit for "CSS for MHSA INN Plan Programs" services is added to this Agreement and incorporated herein.

10. A Service Exhibit for "COS" services is added to this Agreement and incorporated herein.

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 sate "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.

/

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

Attachment I-A
Provider No. _____

SERVICE EXHIBIT _____

INTEGRATED PEER RUN MODEL:
PEER RUN INTEGRATED SERVICES MANAGEMENT
Provided Under the Mental Health Services Act (MHSA)
Innovation (INN) Plan

1. GENERAL

Peer-Run Integrated Services Management (PRISM) addresses ways in which peer-run programs can provide effective and cost efficient coordination of health, mental health, housing, and substance abuse service delivery and utilization. The PRISM service model is dedicated to supporting recovery and wellness and includes self-help modalities. PRISM is a peer-operated, member-driven, holistic integrated health/mental health care support modeling and recovery assistance alternative. PRISM links participants to needed physical health, mental health, housing, and substance abuse services as part of a program intended to empower individuals to sustain their own recovery. PRISM is based upon a "whatever it takes" philosophy in a context of personal choice. It addresses delivery of care assistance designed to help members impacted by system fragmentation, while offering learning goals for system transformation and broadening opportunities for the delivery of recovery-based services.

2. STATE DEPARTMENT OF MENTAL HEALTH INN PROGRAM GUIDELINES

PRISM meets SDMH's INN Plan program guidelines through its emphasis on learning about the effectiveness of peer-run services, as they relate to linking clients with a serious mental illness (SMI) to integrated services. PRISM services shall design and deliver cross-agency service networking as a practical model for potential future use. The PRISM service model meets the SDMH INN guidelines through the following:

- Determines whether the model will decrease fragmentation, extend or enhance peer-run service collaborations, or improve the quality and cost-effectiveness of mental health, physical health, housing, and substance abuse services provided to the adult population with SMI.

- Determines whether integrated service management in a peer-support model is effective in: 1) reducing hospital stays, incarceration and other law enforcement interactions; 2) building client empowerment, self-efficacy, hope, and recovery; and 3) advancing clients' personal, vocational, and educational life goals.

- Identifies key peer support and self-help practices that aid clients in developing personal wellness and sustained progress towards individual well-being.

- Determines practical care support guidelines that connect consumers with spiritual or faith-based community organizations.

3. COMMITMENTS

Providers must make the following commitments specific to the PRISM strategy:

- Provide recovery and wellness supports to individuals who meet the priority population criteria;

- Any decision not to provide PRISM services for a potential client referred to PRISM, who meets the priority population criteria, shall be made collaboratively by the Contractor, DMH, the individual, and, where possible and appropriate, the family. Under these circumstances, DMH and the Contractor will commit to supporting the client in receiving appropriate care by transferring or linking the client to the needed service(s);

- Promotion of family member inclusion when appropriate and desired by the client seeking services;

- Partner with consumers and their families to identify their needs and preferences as the foundation to promote the individual's recovery and wellness;

- Development and utilization of community partnerships to facilitate community reintegration for clients of the PRISM programs;

- Hire ethnically and linguistically diverse staff reflective of the community and the clients being served;

- Assist consumers in identifying and applying for all appropriate types of benefits, community, financial, and social supports, through direct supportive assistance and appropriate referral and linkage;

- Collect specific outcome data as required by the conditions of the State and County plans. This includes collecting outcome data to assess the provider's program design and implementation and the commitment to making mid-course corrections as necessary to insure the achievement of positive client and program outcomes.

4. SERVICE POPULATION

The PRISM program is expected to provide recovery support services to at least 300 unique individuals each year, with the goal of serving a minimum of 600 adults (ages 18 and above) over the two-year course of the program. Proposers shall note that this RFS will fund up to 3 PRISM programs. Each PRISM program shall serve at least 100 unique individuals each year.

The target population for PRISM services are mentally ill adults (18 years of age and older) who have one or more co-occurring disorders related to physical health or substance abuse, and who may be uninsured, homeless and/or are of an underserved or underrepresented ethnic population.

5. SERVICES TO BE PROVIDED

Contractor shall implement the PRISM program within 60 days of execution of the RFS contract. Service delivery shall be through the use of trained peers with lived experience. Services provided by PRISM shall meet the Standards of Care, as determined by DMH. Contractor must provide a full array of culturally and linguistically appropriate direct, linkage, or collaborative services which assist with mental health, physical health, co-occurring substance use disorders, housing, and other services as described in this Service Exhibit. PRISM Staff will be responsible for providing the following services:

A. PEER SUPPORT SERVICES

The following Peer Supportive Services detailed below will be provided by PRISM staff members as needed and appropriate:

1. Outreach and Engagement: Outreach and engagement is the process of identifying, and establishing a relationship with, individuals who may receive PRISM services. It includes a process for identifying consumers who meet the target population and who may benefit from PRISM services, informing them of the service, accessing services, and describing the potential benefits of their participation

2. Recovery/Wellness Plan: PRISM staff will collaborate with consumers to develop and complete a personal plan for recovery/wellness, a requirement for ongoing participation in the PRISM program. Shared decision making, an interactive and collaborative process between

individuals and their care providers, shall be integrated into the recovery/wellness planning process.

3. Peer Support: Group and individual services will be led by peers supporting and educating consumers in their movement toward recovery and independent community living. These services shall include Wellness Recovery Action Planning and/or other mental health self-management tools, and will be provided in the designated PRISM site, Peer-Run Respite Care Home, or an accessible community site.

4. Healthy Living Activities: Peer-led individual and group services geared toward health education and maintenance, including culturally-based healing arts and/or one or more of the modified disease self management approaches used to work with consumers to improve health and mental health outcomes will be provided in the designated PRISM site, PRRCH home, or the community.

5. Recovery-Oriented Peer Support Services for Substance Abuse: Trained peer staff will deliver recovery-oriented peer support services to consumers with histories of co-occurring substance use and mental health disorders. This support includes peer-led individual and group services for clients with co-occurring disorders, focusing on wellness tools, relapse prevention, and recovery maintenance.

6. Client Supportive Services (CSS) Funds: Provide ancillary services to enhance outreach, engagement, and ongoing PRISM services. CSS must support individuals in their recovery by providing items necessary for timely resumption of daily community living (e.g. housing, personal/community reintegration and vocational expenses).

B. LINKAGE SERVICES

The following Linkage Services detailed below will be provided by PRISM staff members as needed and appropriate:

1. Linkage to Mental Health Services: Linkage to mental health services and supports, including appropriate linkage to supportive psychiatric medication evaluation and prescription, psychotherapy, and self-help resources.

2. Linkage to Substance Abuse Services: Linkage to community-based substance abuse programs for consumers with co-occurring disorders to assist in reducing drug and alcohol use and improving community functioning.

3. Linkage to Physical Healthcare Services: These services assure practical consumer linkage to area clinics and other primary healthcare providers for treatment and management of acute and chronic physical healthcare needs, including communicable disease prevention and treatment, including HIV, Hepatitis, and Tuberculosis. Screening and assisting consumers to secure allied care for health conditions has become an important part of most mental health programs. It is expected that many individuals receiving ongoing PRISM services will have a medical condition which falls in one or more of the following categories: cardiopulmonary (e.g. hypertension; hyperlipidemia, other cardiovascular conditions, asthma, emphysema, Chronic Obstructive Pulmonary Disease); alcohol or other substance abuse or dependency; type II diabetes and/or obesity; and Sexually Transmitted Diseases.

4. Housing Services: These services assist consumers to find and establish transitional or permanent housing and/or short-term respite care. Services may include, but are not limited to, helping individuals find suitable housing, assisting individuals in negotiating with landlords, helping clients obtain financial aid to cover rental costs and security deposits, and, referring clients to community legal agencies for assistance, if appropriate.

5. Education Opportunities: These services link consumers with opportunities to initiate, resume, or continue their education at whatever educational level is appropriate for and desired by the individual. Linkage services will be tailored to meet the goals of the individual and may include, but are not limited to, assisting individuals navigate the processes required in order to apply for or resume schooling, helping clients obtain financial aid to attend school, and, referring clients to appropriate community resources for assistance, as appropriate

6. Employment Assistance: These services provide consumers with job search assistance and employment support as appropriate and desired by the individual. Employment services will be tailored to meet the goals of the individual and may include, but are not limited to, assisting individuals navigate the process of applying for and interviewing for a job, support individuals to maintain employment, and, referring clients to community employment resources, as appropriate.

7. Transportation Services: These services are for consumers who need assistance in developing resources and skills to independently access transportation services.

8. Community Partnerships: These partnerships may include formal or informal arrangements with an array of community-based organizations and other collaborative agencies regularly promoting clients' well-being including collaborations focused on:

   - Spirituality,
   - Faith-based support
   - Cultural community
   - Recovery programs located in the community including the Peer-Run Respite Care Homes.

6. SERVICE HOURS

PRISM services shall be available a minimum of 48 hours a week during the times clients are most accessible, including no less than four hours on each weekend day.

7. SERVICE LOCATIONS

The PRISM program site(s) shall be situated so as to ensure easy and reliable access to major public transportation routes/hubs and freeways or major thoroughfares. Proximity to other support services and community centers shall be prioritized by the PRISM Contractor.
Services shall be delivered at the service delivery sites listed in the Agreement. Service will be provided by PRISM staff at the program service site(s) and other community settings that may include, but are not limited to, other existing program or service settings such as a PRRCH program, consumer residences, residential mental health contracted facilities, or other public facilities and community settings.

Proposer shall request written approval from DMH, a minimum of 30 days before terminating services at any of the location(s) listed on its Agreement and/or before commencing services at any other location(s) not previously approved in writing. All service delivery sites listed on the Proposer's agreement shall be operational within 60 days of the commencement of the Agreement.

8. STAFFING

A. GENERAL STAFFING REQUIREMENTS

PRISM Contractor shall ensure the following staff and volunteer requirements:

1. Criminal Clearances: Contractor shall ensure that criminal clearances and background checks have been conducted for all Contractor's staff

and volunteers prior to beginning and continuing work under any resulting Contract. The cost of such criminal clearances and background checks is the responsibility of the Contractor whether or not the Contractor's staff passes or fails the background and criminal clearance investigations.

2. Language Ability: Contractor's personnel shall be able to read, write, speak, and understand English in order to conduct business with the County. In addition to having competency in English, Contractor shall ensure there is a sufficient number of bilingual staff to meet the language needs of the communities served.

3. Service Delivery: Contractor shall ensure all staff and volunteers providing services in the PRISM strategy are able to provide services in a manner that effectively responds to differences in cultural beliefs, behaviors and learning, and communication styles within the community the Proposer provides services.

4. Driver's License: Contractor shall maintain copies of current driver's licenses, including current copies of proof of auto insurance of staff providing transportation on an as-needed basis to clients.

5. Driving Record: Contractor shall maintain copies of Department of Motor Vehicles (DMV) printouts for all Contractor's drivers providing service under this Agreement. These reports shall be available to DMH on request. County reserves the option of conducting a DMV check on the Contractor's drivers once a year.

6. Education and Experience: Contractor shall be responsible for securing and maintaining staff that possess sufficient lived experience and expertise required to provide services in this Service Exhibit. When applicable, Contractor shall obtain written verification for staff with foreign degrees, verifying these degrees are recognized as meeting established standards and requirements of an accrediting agency authorized by the U.S. Secretary of Education.

7. Staff Training: Contractor shall provide orientation to all staff, interns, and volunteers providing care support/advocacy or respite care services prior to their beginning service. They shall complete respite care residential preliminary training within thirty (30) business days of their start date. Ongoing training is required for all staff, interns, and volunteers, including, but not limited to: First Aid, HIPAA, safety issues, boundary issues, community resources, team building, and peer support skills. All peer support services staff will have completed a certificated Peer Support, Peer Advocate, or Peer Specialist training.

8. Documentation: Contractor shall maintain documentation in the personnel files of all peer staff, interns, and volunteers of: (1) all training hours and topics; (2) work schedule; and, (3) fax and telephone numbers, and any non-English Los Angeles County threshold-languages spoken by staff

9. Rosters: Contractor shall provide DMH, at the beginning of each Contract term and within 30 days, any staff change(s) and a roster of all staff, including: (1) name and positions; (2) work schedule; and (3) business fax and telephone numbers.

10. Changes in Staffing: Contractor shall advise DMH in writing of any change(s) in the Contractor's key personnel at least twenty-four (24) hours before proposed change(s) occur, including name and qualifications of new personnel. Contractor shall ensure no interruption of services occurs as a result of the change in personnel.

11. Work Stoppages: Proposer shall have a plan for providing sufficient and appropriate multidisciplinary staff to meet the daily mental health, physical health, substance abuse, and housing needs of the target population in the event of a work stoppage.

B. PRISM STAFFING

PRISM staff at all levels, with the only exception of the Director, shall be composed of individuals with lived experience with mental illness. Services shall be delivered by staff possessing similar cultural and linguistic backgrounds to those of the consumer population(s) being served. Service providers must understand and utilize the strengths of consumers' various cultures in service delivery and incorporate the language and culture of their consumers into the services supportive of the most effective outcomes.

Proposer shall identify the number of staff to be hired for PRISM, indicating full-time or part-time employees, in Proposer's budget. Staffing composition may include the following peer professionals:

1. PRISM Director (1.0 FTE or less): The PRISM program shall be overseen by a Director experienced in management and direction of peer-run services. The PRISM Director is designated as the primarily responsible party empowered for the purposes of engaging in negotiating and contracting with DMH. The PRISM Director carries primary responsibility for collecting data necessary to answer the questions posed by this strategy in the Innovations Plan and respond to DMH inquiries and requests. If the PRISM Director does not have

lived experience with mental illness, the Proposer must discuss in the proposal how the integrity of a peer-run program will be maintained.

2. PRISM Site Manager(s): Each PRISM site must have a PRISM Manager, who is essential in providing ongoing coordination of services at PRISM, as well as ongoing supervision of peer specialists and volunteers.

3. Peer Specialists: Trained and certified/certificated Peer Specialists (also called Peer Advocates or Peer Counselors) must comprise the core service staff of PRISM. Peer Specialists provide peer support services, including outreach, engagement, peer group supports, service linkage, self-help, and other personal wellness planning to program consumers. These specialists will also provide 'bridging' services to clients in transition from or to other programs, including community residence, hospitals, etc. Specialists may bear the primarily responsibility for empowering clients and building awareness of and connection to community resources, specifically health, mental health, housing, and substance use services.

4. Family Specialist(s)/Parent Partner(s): Proposer may utilize a Family Specialist or Parent Partner. This position may also be filled by a Peer Specialist, if deemed appropriate. The Family Specialist supports family members directly and through linkage with various family peer support resources. The Parent Partner supports peers who are parents of small children in learning parenting skills and self-advocacy.

5. Administrative and Support: These staff will maintain and conduct adequate business, billing, and maintain documentation records and otherwise provide support to the PRISM project.

9. ADMINISTRATIVE TASKS

Required administrative tasks include the following:

- Record Keeping: Contractor shall keep a record of participants and services provided, as well as the dates, agendas, sign-in sheets, and minutes of all PRRCH meetings, including subcontractor meetings, if applicable.

- Evaluation Tools: Contractor shall provide consumers of the PRISM program and their families, where appropriate, with a tool by which to evaluate the services rendered by PRISM staff. Contractor shall make this information available to DMH upon request. Contractor shall ensure the tool addresses the performance of the Contractor.

- Data Entry: Contractor shall be responsible for collecting and entering any data required by DMH. Contractor shall ensure the data is entered electronically at network sites and downloaded at the DMH centralized web-based Integrated System (IS) database in a timely manner.

- Days/Hours of Operation: PRISM services shall be available 24 hours/7 days per week.

- Computer and Information Technology Requirements: Contractor shall acquire a computer system, within 60 days of commencement of the Agreement, with sufficient hardware and software and an agreement for its on-site maintenance for the entire term of this Agreement, in order to comply with the terms of the contract.

- Cooperation: Contractor shall work cooperatively with DMH Information Technology Services staff and any contracted program evaluator, as applicable. Contractor shall provide data entry staff to process electronic and fully implemented invoices for the IS. Contractor shall be able to electronically invoice the County on a monthly basis.

- Data Collection: The Contractor shall be responsible for collecting, entering, managing, and submitting specific demographic, diagnostic, out-of-home placement and outcome data as directed by DMH to demonstrate client outcomes inclusive of guidelines set forth by DMH and the State. This includes collecting outcome data to assess the PRISM program and make mid-course corrections, as necessary, to ensure the achievement of positive client and program outcomes.

10. QUALITY MANAGEMENT AND DATA COLLECTION

Quality Management

The Contractor shall establish and utilize a comprehensive written Quality Management Program and Plan including Quality Assurance and Quality Improvement processes to ensure the required services are provided at a consistently high level of service throughout the term of the Contract. The Plan shall be submitted to DMH for review and approval prior to the Contract start date. The Plan shall be effective on the Contract start date and shall be updated and re-submitted for DMH approval 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 contract 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 that services meet requirements for timeliness, accuracy, completeness, consistency and conformity as defined in the RFS SOW.

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

- Identifying and preventing deficiencies in the quality of service before the level of performance becomes unacceptable including description of the Quality Improvement strategy and intervention methods.

- 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 was first identified, a clear description of the problem, and the time elapsed between identification and completed corrective action.

- Continuing to provide services to the County in the event of a strike or other labor action of the Proposer's employees.

Data Collection

- The Contractor shall establish and implement a Data Collection Plan to collect, manage, and submit data and reports as directed by the DMH. This will include collecting, managing and submitting the data described in this Service Exhibit.

- The Contractor's Plan shall include a description of specific measures and data analysis methods that are currently in place and/or those to be delivered to ensure the collection and reporting of required data as described in this Service Exhibit.

- The Contractor's Plan shall include 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.

- The Proposer shall 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 mental health, physical health and substance abuse. These meetings shall serve as the basis for learning and for making any mid-course service corrections to the INN service integration models.

11. INFORMATION TECHNOLOGY, PRIVACY & ELECTRONIC SECURITY

Functional Requirements

Contractor must have the capacity for an information system/information technology (IS/IT) compatible with the DMH's IS/IT system. Further Proposer shall have the ability to collect, manage, and submit data as directed by DMH in order to ensure consistently high level of services throughout the term of the contract and demonstrate outcomes inclusive of guidelines set forth by DMH and SDMH.

Contractor shall provide basic demographic, diagnostic, out-of-home placement, outcomes, and PRISM usage and accounting data. Contractor must submit all documentation in an electronic format.

Technology Requirements

- Contractor's IS/IT system shall be required to meet the functional, workflow, and privacy/security requirements listed below under, 9.4 (Privacy and Electronic Security).

- For daily submission of referrals, a dedicated, secure telephone line and facsimile (fax) machine will be required.

- For monthly electronic submission of PRISM information, an Internet connection will be required.

- Contractor is solely responsible to comply with all applicable State and Federal regulations affecting the maintenance and transmittal of electronic information.

Work Flow Requirements

DMH requires Contractor to submit PRISM information to DMH on a monthly and quarterly basis to enhance progress toward learning objectives.

Privacy and Electronic Security

- DMH requires Contractor to comply with Federal and State laws as they apply to protected health information (PHI), individually identifiable health information (IIHI), and electronic information security.

- Any Contractor 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 Contractor that is deemed a "Business Associate" of County under the Health Insurance Portability 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 service 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 status of the students who are 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 the Contractor and the County in case the Contractor may handle information regarding the health status of the students who are consumers of the family members.

12. SUBCONTRACTING

Subcontracting is not encouraged for the provision of services under Service Exhibit. Subcontracts for Non-Medi-Cal Billable services may be allowed in specific circumstances as determined by DMH. Subcontracting between DMH Legal Entities will not be permitted. Shall the Contractor use a subcontractor they must avoid fragmentation of services due to the use of multiple subcontractors.

If the Contractor intends to employ a Subcontractor(s) to perform some of the services described in the Service Exhibit, the transmittal letter shall clearly indicate the other agency (ies) involved and the role of the Subcontractor. A statement from all Subcontractors indicating their willingness to work with the Contractor and the intent to sign a formal agreement between/ among the parties shall be submitted with the signature of the person authorized to bind the subcontracting organization.
A Contractor shall obtain prior written approval from DMH in order to enter into a particular subcontract. All such requests shall be submitted in writing. Contractors shall remain responsible for any and all subcontracted performance required under the Agreement.

13. CONSUMER OUTCOMES

All outcomes targeted for tracking shall be implemented, scored, stored, and transferred in a manner and at intervals prescribed by DMH. Additionally, any and all outcomes, measurement instruments, and procedures may be supplemented, revised, and/or deleted by DMH at any time during the course of funding for this Service Exhibit. The following client outcomes are identified for PRISM:

OUTCOMES	MEASURE OF SUCCESS
Reduced incarcerations	50% reduction of incarcerations, obtained through IS review.
Reduced psychiatric ER visits	50% reduction of psychiatric ER visits, obtained through IS review.
Improved service integration	40% increase in coordinated mental health, physical health and substance abuse services. Methodology to be determined by DMH.
Improved health and mental health status.	70% of clients will have improved health and mental health status. Methodology to be determined by DMH.
Increased consumer self-efficacy, hope for recovery. Reduced client self-stigma.	At least 60% of consumers will increase their self-efficacy and hope for recovery and reduce their self-stigma. Methodology to be determined by DMH.
Consumers will use self-help resources and self-help practices.	At least 80% of consumers will use a self-help resource and self-help practice. Methodology to be determined by DMH.
Increased number of clients obtaining employment, attending school, or participating in community activities.	At least 70% will obtain employment, attend school or participate in community activities. Methodology to be determined by DMH.
Consumer satisfaction with integrated services.	70% of participating consumers will report satisfaction with integrated services. Methodology to be determined by DMH.

14. PERFORMANCE BASED CRITERIA

The Agreement will include five (5) Performance-Based Criteria measuring the Proposer's operational performance, 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 required services and monitor the quality of those services.

Collaboration

The Proposer shall collaborate with DMH to provide processes for systematically evaluating quality and performance indicators and outcomes at the program level. Shall 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.

Scheduled Monitoring

Proposers shall 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 Proposer's adherence to the performance-based criteria will be evaluated.

Performance Based Criteria

PERFORMANCE-BASED CRITERIA	METHOD OF DATA COLLECTION	PERFORMANCE TARGETS
1.PRISM successfully links clients to integrated mental health, housing, physical health, and substance abuse services.	Instrument measuring levels of service integration	100% of clients with co-occurring mental health, physical health, housing, and substance abuse disorders have an integrated care plan.
2.Satisfaction with services.	Client satisfaction survey	80% of clients will be satisfied with PRISM integrated services.
3.PRISM improved utilization of community resources.	Utilization/referral Instrument	80% of homeless clients requesting assistance with housing will obtain housing.
4.PRISM uses a "housing first" approach.	Housing referral records	100% of clients are assisted with finding housing of their choice without prerequisites or conditions for psychiatric treatment or sobriety.

PERFORMANCE-BASED CRITERIA	METHOD OF DATA COLLECTION	PERFORMANCE TARGETS
5.PRISM uses peer support and a client-empowered, recovery-based approach to identify and advance clients' personal physical health, mental health, housing, and substance abuse goals.	Client records and interviews	100%of the services utilize peer recovery approaches and peer support.

The Contractor shall demonstrate in writing how the services impact the performance targets. The Contractor shall maintain, at a minimum, the following documents indicating PRISM performance targets:

- Required reporting to DMH on performance targets related to the Proposer's services.
- Client records/file including, but not limited to, assessments, care/recovery plans, tracking progress notes, and discharge summaries.
- Agency administrative policies and procedures for PRISM.
- Agency budgets and financial records for the PRISM

15. 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.

Attachment I-B
Provider No. _____

SERVICE EXHIBIT _____

INTEGRATED PEER RUN MODEL:
PEER RUN RESPITE CARE HOME
Provided Under the Mental Health Services Act (MHSA)
Innovation (INN) Plan

1. GENERAL

The Innovations Plan Integrated Peer-Run Model provides for the development and implementation of the Peer-Run Respite Care Homes (PRRCH) as an alternative to support people in psychiatric distress who are not a danger to others. The PRRCH Project is intended to provide safe and healing environments where people can move through their psychiatric distress in a relatively brief time (up to 30 days) and then engage in further support services, if desired.

In spite of demonstrated effectiveness of peer-run services, peer-run models and mental health respite care, services are not currently widely implemented in the United States. The innovative combination of these strategies is intended to demonstrate the particular effectiveness of peer-run services for adults experiencing temporary crisis or life adjustment problems, some of whom may be at risk of homelessness or from under-represented ethnic populations. The PRRCH Project addresses system fragmentation, offers learning goals for system transformation, and provides opportunities to deliver innovative recovery-based services to the previously identified populations.

PRRCH encourages community collaboration, seeks integrated service experiences for consumers and their families, focuses on wellness, recovery, and resilience; demonstrates cultural competence, and is driven by consumer-peers trained to support the recovery of people who are at an intense level of need and/or are in transition from an acute care setting. As part of the Innovation Plan, the respite care pilot program must address ways in which peer-run programs can successfully coordinate health, mental health, housing, and substance abuse services, including self-help modalities, while supporting recovery, wellness, and increasing cost effectiveness.

2. STATE DEPARTMENT OF MENTAL HEALTH INN PROGRAM GUIDELINES

The PRRCH Project meets the SDMH INN Plan program guidelines because it contributes to learning about the effectiveness of peer-run services as it relates to utilizing the little-used respite care model for consumers with serious mental illness

and co-occurring problems. State guidelines require all INN programs lead to learning which advance mental health in California in the directions articulated by the MHSA. The PRRCH service model meets the SDMH INN guidelines through the following:

- Identifies innovative peer-run respite care residential service strategies that result in effective coordination of health, mental health, housing, and substance abuse services, while supporting cost-effective recovery and wellness efforts.

- Determines whether successful expansion of peer staffing within respite care residential programs, including administration and supervision by peers, is an effective and economic approach.

- Determines whether peer-run short term respite residential care is a viable alternative to traditional acute intensive care, effectively avoiding and reducing hospital stays, incidents and length of incarcerations and other law enforcement interactions, in building empowerment, self-efficacy and hope for recovery, and in advancing consumers' personal vocational and educational life goals.

- Identifies key peer support and self-help practices aiding consumers to manage their crisis, develop personal wellness strategies, and sustain progress towards their individual physical health and fitness, mental health, housing, and substance abuse recovery goals.

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. 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, DMH will conduct a minimum of quarterly reviews of the Contractor's PRRCH program, including client outcomes and performance-based criteria, throughout the term of the Agreement and at its sole discretion 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 Contractors' Agreement(s).
and organizational supports.

3. PRRCH COMMITMENTS

Providers must make the following commitments specific to the PRRCH strategy:

- Provide trained peer-driven recovery and wellness supports to individuals who meet the priority population criteria.

- Any decision not to provide PRRCH Project services for a potential consumer who has been referred to the PRRCH, and who meets the priority population criteria, shall be made jointly and in collaboration by the Contractor (and/or subcontractors), DMH, the individual, and, where appropriate, with the family. Under these circumstances, DMH and the Contractor will commit to support the client in receiving appropriate supports by transferring or linking the client to the needed services.

- No less than 12 self-help, recovery-oriented program sessions will be available within each local PRRCH program on a weekly basis.

- Provide consumer-driven services and supports promoting inclusion of family members as part of the PRRCH team, when appropriate and desired by the consumer seeking services.

- Partner with consumer peers and their families to identify the needs and preferences of the PRRCH consumer as the foundation for the respite service plan promoting resumption of the individual's recovery and wellness in the community with the support of existing caregivers.

- Develop and utilize community partnerships to facilitate community reintegration for consumers of all PRRCH programs.

- Hire ethnically and linguistically diverse staff, possessing lived mental health experience, reflective of the community to be served.

- Hire staff reflective of the consumers being served.

- Assist consumers in identifying and applying for all appropriate types of community financial, social supports, and benefits.

- Provide supportive recovery care by working collaboratively with the local PRISM program and other community service providers.

- A commitment to collect specific outcome data as required by the conditions of the State and County plans. This includes collecting outcome data to assess the Provider's program design and implementation and the commitment to making mid-course corrections as necessary to insure the achievement of positive client and program outcomes.

4. POPULATION TO BE SERVED

The PRRCH programs are expected to serve adults (18 years and older) who are in psychiatric distress, not a danger to others, who have one or more co-occurring disorders related to physical health or substance abuse and can perform basic daily living skills independently. Individuals who meet Lanterman Petris Short (LPS) criteria for involuntary acute psychiatric hospitalization are not appropriate for PRRCH.

Guests may include persons who are uninsured, are of an underserved or underrepresented ethnic population and/or have been discharged from jail, County or contract hospitals. Guests must have an identified source of housing prior to PRRCH stay. Repeated use of residential services as a means of avoiding utilization of an individual's appropriate benefits resources shall be avoided.

No client may be involuntarily placed or court-ordered to the PRRCH program as part of sentencing or as a portion of the plea agreement. Since PRRCH programs are not secure psychiatric settings, they are not structured to support conditional release or provide services to individuals under any Lanterman Petris Short (LPS) "hold" status. No PRRCH program may apply for or otherwise seek LPS designation.

Each of the two PRRCH programs/homes is expected to serve six to eight individuals at any given time, with the goal of serving no less than 80 clients each year for two subsequent years. Over the course of two years, each PRRCH program/home shall serve no less than 160 guests.

5. SERVICES TO BE PROVIDED

PRRCH Contract Provider shall implement the PRRCH program within 90 days of execution of the RFS agreement. All services shall be provided by trained consumers/peers with lived experience of prior mental illness, mental health services and treatment. Where appropriate, family peer specialists or parent partners may also provide supportive services to family members and PRRCH guests who are parents of small children. All PRRCH services, supports, and linkages shall be fully integrated and culturally and linguistically appropriate. Services provided by PRRCH shall meet the Standards of Care as determined by DMH.

The Contractor shall coordinate care support, assistance services and referrals for those clients to reliable community resources that are capable of addressing the clients' individual needs. For those clients who are not eligible, yet come into contact with, the PRRCH program contract agency will carefully assess the circumstances and appropriately refer those individuals to ongoing services and existing service agencies within their respective communities.

A. RESPITE CARE HOME CORE SERVICES

1. Respite Care Homes: The PRRCH respite program shall provide temporary supportive housing in a comfortable, welcoming home-like residential environment with on-site trained peer support 24 hours per day, 7 days a week, for six to eight individuals, with at least two staff working at all times. Program participation is voluntary. The PRRCH respite care home sites shall include sleeping quarters for up to eight guests, with semi-private room conditions (defined as no more than two individuals per bedroom segregated by gender) and not less than one bathroom with bath/shower per four residents. The PRRCH site shall include a full kitchen for use by staff and consumers for preparing meals, cleaning, and congregate space not less than 800 square feet for community meetings, etc. All PRRCH sites shall meet ADA accessibility requirements for people with physical and sensory disabilities, including at least one bedroom and bathroom which meet ADA residential requirements.

   The PRRCH house will function principally as a self-maintaining home with both staff and guests sharing in basic housekeeping, cooking, and cleaning activities. Daily guest participation in these duties shall be an expectation of consumers, but not a requirement for supportive services of the program. Participation in everyday functional activities is central to the empowering, non-clinical design of the service.

   The initial projected stay by a program participant is up to 15 days. Stays may be extended for an additional 15 days, based on the needs of the participant and the approval from the PRRCH Program Manager. If the adult eligible for respite care is willing to participate as a guest in the PRRCH program, they will sign an agreement to stay as a respite guest, with the understanding that PRRCH is a supportive services setting that assists immediate crisis for no longer than 30 days. The new PRRCH guest will agree to participate in completing household duties, such as helping with community cooking and cleaning activities, in addition to committing to learning about self-help strategies, and health, mental health, housing, and substance abuse resources available in the community in which they live. The essential element of care is the peer relationship established and sustained through peer engagement and peer support.

2. Outreach and Engagement Strategies: These activities are mainly designed to inform the uninsured underserved or underrepresented adult target population, including homeless individuals or persons ready for release from County jails or inpatient hospitals, who may be eligible for the specialized PRRCH services. Outreach and

engagement strategies may be performed by program staff in various care settings, at public events, and through communications media like the Internet.

3. Screening: Adults who meet the criteria for the population to be served will be welcomed by trained Peer Specialists. These Specialists will explain the difference between peer-run respite residential home services and a professional psychiatric facility and the crucial aspects of consumer participation in the PRRCH program, including the expectations of guests to cooperate with staff and volunteer to help with limited household duties. Proper procedures shall be in place to coordinate care for individuals who seek PRRCH services but are found to be a danger to others.

4. Recovery/Wellness Plan: PRRCH staff will collaborate with guests to develop and complete a personal plan for recovery/wellness, although it is not a requirement for consumers becoming a PRRCH guest. Peer Specialists will provide assistance in this orientation to self-care and wellness planning skills, including personal care planning such as self-help and self-advocacy skills. Shared decision making, an interactive and collaborative process between individuals and their care providers, shall be integrated into the recovery/wellness planning process.

5. Client Supportive Services (CSS): Ancillary services will enhance outreach, engagement, and ongoing PRISM services. CSS supports individuals in their recovery by providing items necessary for timely resumption of daily community living (e.g. housing, personal/community reintegration and vocational expenses).

B. PEER SUPPORT SERVICES

1. Peer Supportive Services: Peer Specialists at the PRRCH program will provide peer support and education designed to encourage PRRCH guests to experience the benefits of reciprocal caring relationships. Other wellness-oriented activities or personal skills program sessions may also be provided. These wellness activities may include: self-help recovery practices, meal preparation, relaxation and stress reduction techniques (guided imagery or visualization), exercise and physical wellness, culturally-based healing arts (yoga/meditation, singing, dancing, story-telling), painting/drawing, computer skills, and/or civic engagement. These program offerings shall be guided by the desires and interests of the respite care guests. Attendance/participation in program meetings and events shall be highly encouraged of respite care guests, although no one is forced to participate. No less than 12 self-help, recovery-oriented program

sessions will be available within each local PRRCH program on a weekly basis.

2. Bridging: PRRCH staff will develop relationships with PRRCH guests and continue to work with them through their transition into the community. Staff will work with individuals who are moving forward and living alone. Family Specialists may work with families and established caregivers, and Parent Partners may work with adults seeking to reunite with their children. The focus will be on carrying the learning from the PRRCH into life in the greater surrounding community and linking to needed health, mental health, housing, and/or substance abuse supports.

3. Medication Self-Management Support: PRRCH consumers will be provided a private, locked space to store their medication. No illegal substances shall be permitted in the respite care facility. Peer Specialist team members will support the individual in taking the medication as prescribed, including alerting them to prescribed times, if such assistance is mutually determined upon admission. Taking of prescribed medications according to directions is a decision made by each guest. It is not a staff function or responsibility.

C. COLLABORATIVE LINKAGE SERVICES

1. Referral to Health, Mental Health, Housing, and Substance Abuse Specialty Services: Because the stay in the PRRCH is not of a strict clinically psychiatric nature, Peer Specialists will supply information on specialty services and support to guests seeking such services. This will include referrals to peer services, including PRISM, as well as to professional psychiatric services in the community. In instances where a guest leaves the program and is still awaiting transition to specialized professional care, PRRCH staff shall stay in contact with the respite care guest until the appropriate alternative resources connection has been achieved.

6. SERVICE HOURS

PRRCH core residential support services shall be available to guests 24 hours per day, seven days a week, at the program sites. PRRCH staff, shall provide services including but not limited to outreach, engagement, and care support, as appropriate

7. SERVICE LOCATION

The Peer-Run Respite Care Homes shall be situated so as to ensure easy and reliable access to major public transportation routes/hubs and freeways or major thoroughfares.

All service delivery sites listed on the contract shall be operational within 90 days of the commencement of the Agreement. Services shall be delivered at the service delivery sites listed in the Agreement. Service will be provided by PRRCH staff at the program service site(s).

PRRCH Contract Provider shall request written approval from DMH, a minimum of 30 days before terminating services at any of the location(s) listed on its Agreement and/or before commencing services at any other location(s) not previously approved in writing.

8. STAFFING

A. GENERAL STAFFING REQUIREMENTS

PRRCH Contractor shall ensure the following staff and volunteer requirements:

1. Criminal Clearances: Contractor shall ensure that criminal clearances and background checks have been conducted for all Contractor's staff and volunteers prior to beginning and continuing work under any resulting Contract. The cost of such criminal clearances and background checks is the responsibility of the Contractor whether or not the Contractor's staff passes or fails the background and criminal clearance investigations.

2. Language Ability: Contractor's personnel shall be able to read, write, speak, and understand English in order to conduct business with the County. In addition to having competency in English, Contractor shall ensure there is a sufficient number of bilingual staff to meet the language needs of the communities served.

3. Service Delivery: The Contractor shall ensure all staff and volunteers providing PRRCH services are able to provide services in a manner that effectively responds to differences in cultural beliefs, behaviors and learning, and communication styles within the community the Contractor provides services

4. Driver's License: Contractor shall maintain copies of current driver's licenses, including current copies of proof of auto insurance of staff providing transportation on an as-needed basis to clients.

5. Driving Record: Contractor shall maintain copies of Department of Motor Vehicles (DMV) printouts for all Contractor's drivers providing service under this Agreement. These reports shall be available to DMH on request. County reserves the option of conducting a DMV check on the Contractor's drivers once a year.

6. Education and Experience: Contractor shall be responsible for securing and maintaining staff that possess sufficient lived experience and expertise required to provide services in this Service Exhibit. When applicable, Contractor shall obtain written verification for staff with foreign degrees, verifying these degrees are recognized as meeting established standards and requirements of an accrediting agency authorized by the U.S. Secretary of Education.

7. Staff Training: Contractor shall provide orientation to all staff, interns, and volunteers providing care support/advocacy or respite care services prior to their beginning service. They shall complete respite care residential preliminary training within thirty (30) business days of their start date. Ongoing training is required for all staff, interns, and volunteers, including, but not limited to: First Aid, HIPAA, safety issues, boundary issues, community resources, team building, and peer support skills. All peer support services staff will have completed a certificated Peer Support, Peer Advocate, or Peer Specialist training.

8. Documentation: Contractor shall maintain documentation in the personnel files of all peer staff, interns, and volunteers of: (1) all training hours and topics; (2) work schedule; and, (3) fax and telephone numbers, and any non-English Los Angeles County threshold-languages spoken by staff

9. Rosters: Contractor shall provide DMH, at the beginning of each Contract term and within 30 days, any staff change(s) and a roster of all staff, including: (1) name and positions; (2) work schedule; and (3) business fax and telephone numbers.

10. Changes in Staffing: Contractor shall advise DMH in writing of any change(s) in the Contractor's key personnel at least twenty-four (24) hours before proposed change(s) occur, including name and qualifications of new personnel. Contractor shall ensure no interruption of services occurs as a result of the change in personnel.

11. Work Stoppages: Proposer shall have a plan for providing sufficient and appropriate multidisciplinary staff to meet the daily mental health,

physical health, substance abuse, and housing needs of the target population in the event of a work stoppage.

B. PRRCH STAFFING

PRRCH staff at all levels will be composed of individuals with lived experience of prior mental illness, mental health services and treatment. Services shall be delivered by trained staff possessing similar cultural and linguistic backgrounds to those of the consumer population(s) being served. Where appropriate, Family Peer Specialists or Parent Partners may also provide supportive services to family members and PRRCH guests who are parents of small children. Contract providers must understand and utilize the strengths of consumers various cultures in service delivery and incorporate the language and culture of their consumers into the services supportive of the most effective outcomes. Staffing must be maintained to ensure a minimum of two peer staff members are present in the home at all times.

Staffing composition may include the following peer professionals:

1. Director (1.0 FTE or less): The Program Director shall have at least three years experience directing mental health recovery and peer support services and have knowledge of the existing array of local mental health services. Relevant experience shall include: program and staff development, training, peer support, self-help and bridging supports, recovery-oriented documentation, and community integrated services. If the Director does not have lived experience with a psychiatric disability the integrity of a Peer-Run Program shall be maintained.

2. PRRCH Peer Managers (1.0 FTE at each site): Peer Managers are persons with lived experience of a psychiatric disability, experienced as peer specialists who oversee daily program functions. These managers provide day-to-day oversight of the PRRCH, as well as supervision of Peer Specialists, other staff, and volunteers. PRRCH Managers are ultimately responsible for collecting data necessary to answer the learning questions posed by this strategy in the Innovations Plan.

3. PRRCH Peer Services Staff: The PRRCH team is composed of people with lived experience similar to the people they serve. This may include a variety of Peer Specialists who function as follows:

    a. Peer Specialists: Peer Specialists have appropriate certified training to provide on-site assistance and support to guests. They welcome the guests to the home and introduce them to the available health, mental health, housing, and substance abuse

resources in PRRCH and the surrounding community. They support guests individually, as well as in groups. They may function primarily in the home or in bridging guests to services in the community. Peer Specialists must include bilingual and bicultural individuals to provide support to guests who are from underserved/underrepresented communities.

b. Family Specialists: Family Specialists have lived experience as a family member who works with other family members of guests to provide information and support. The Family Specialist needs to have completed a recognized family advocate training program. At the request of guests, family specialists shall work with peer specialists to facilitate communication between families and service systems.

4. Training Coordinators: Training Coordinators have lived experience of a psychiatric disability as well as a background in training or educational development. This person is responsible for working with PRRCH programs to ensure the quality and timeliness of ongoing specialized training and consultation. Training Coordinators ensure PRRCH team members maintain current care and outcome knowledge essential to the successful operation of the overall program.

9. ADMINISTRATIVE TASKS

Required administrative tasks include the following:

- Record Keeping: Contractor shall keep a record of participants and services provided, as well as the dates, agendas, sign-in sheets, and minutes of all PRRCH meetings, including subcontractor meetings, if applicable.

- Evaluation Tools: Contractor shall provide consumers of the PRRCH program and their families, where appropriate, with a tool by which to evaluate the services rendered by PRRCH staff. Contractor shall make this information available to DMH upon request. Contractor shall ensure the tool addresses the performance of the Contractor.

- Data Entry: Contractor shall be responsible for collecting and entering any data required by DMH. Contractor shall ensure the data is entered electronically at network sites and downloaded at the DMH centralized web-based Integrated System (IS) database in a timely manner.

- Days/Hours of Operation: PRRCH services shall be available 24 hours/7 days per week.

- Computer and Information Technology Requirements: Contractor shall acquire a computer system, within 60 days of commencement of the Agreement, with sufficient hardware and software and an agreement for its on-site maintenance for the entire term of this Agreement, in order to comply with the terms of the contract.

- Cooperation: Contractor shall work cooperatively with DMH Information Technology Services staff and any contracted program evaluator, as applicable. Contractor shall provide data entry staff to process electronic and fully implemented invoices for the IS. Contractor shall be able to electronically invoice the County on a monthly basis.

- Data Collection: The Contractor shall be responsible for collecting, entering, managing, and submitting specific demographic, diagnostic, out-of-home placement and outcome data as directed by DMH to demonstrate client outcomes inclusive of guidelines set forth by DMH and the State. This includes collecting outcome data to assess the PRRCH program and make mid-course corrections, as necessary, to ensure the achievement of positive client and program outcomes.

10. QUALITY MANAGEMENT AND DATA COLLECTION

Quality Management

The Contractor shall establish and utilize a comprehensive written Quality Management Program and Plan including Quality Assurance and Quality Improvement processes to ensure the required services are provided at a consistently high level of service throughout the term of the Contract. The Plan shall be submitted to DMH for review and approval prior to the Contract start date. The Plan shall be effective on the Contract start date and shall be updated and re-submitted for DMH approval 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 contract 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 that services meet requirements for timeliness, accuracy, completeness, consistency and conformity as defined in the Service Exhibit.

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

- Identifying and preventing deficiencies in the quality of service before the level of performance becomes unacceptable including description of the Quality Improvement strategy and intervention methods.

- 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 was first identified, a clear description of the problem, and the time elapsed between identification and completed corrective action.

- Continuing to provide services to the County in the event of a strike or other labor action of the Proposer's employees.

Data Collection

- The Proposer shall establish and implement a Data Collection Plan to collect, manage, and submit data and reports as directed by the DMH. This will include collecting, managing and submitting the data described in this Service Exhibit.

- The Proposer' Plan shall include a description of specific measures and data analysis methods that are currently in place and/or those to be delivered to ensure the collection and reporting of required data as described in this Service Exhibit.

- The Proposer's Plan shall include 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.

- The Proposer shall 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 mental health, physical health and substance abuse. These meetings shall serve as the basis for learning and for making any mid-course service corrections to the INN service integration models.

11. INFORMATION TECHNOLOGY, PRIVACY & ELECTRONIC SECURITY

Functional Requirements

Contractor must have the capacity for an information system/information technology (IS/IT) compatible with the DMH's IS/IT system. Further Proposer shall have the ability to collect, manage, and submit data as directed by DMH in order to ensure consistently high level of services throughout the term of the contract and demonstrate outcomes inclusive of guidelines set forth by DMH and SDMH.

Contractor shall provide basic demographic, diagnostic, out-of-home placement, outcomes, and PRRCH usage and accounting data. Contractor must submit all documentation in an electronic format.

Technology Requirements

- Contractor's IS/IT system shall be required to meet the functional, workflow, and privacy/security requirements listed below under, 9.4 (Privacy and Electronic Security).

- For daily submission of referrals, a dedicated, secure telephone line and facsimile (fax) machine will be required.

- For monthly electronic submission of PRRCH information, an Internet connection will be required.

- Contractor is solely responsible to comply with all applicable State and Federal regulations affecting the maintenance and transmittal of electronic information.

Work Flow Requirements

DMH requires Contractor to submit PRRCH information to DMH on a monthly and quarterly basis to enhance progress toward learning objectives.

Privacy and Electronic Security

- DMH requires Contractor to comply with Federal and State laws as they apply to protected health information (PHI), individually identifiable health information (IIHI), and electronic information security.

- Any Contractor 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 Contractor that is deemed a "Business Associate" of County under the Health Insurance Portability 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 service 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 status of the students who are 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 the Contractor and the County in case the Contractor may handle information regarding the health status of the students who are consumers of the family members.

12. SUBCONTRACTING

Subcontracting is not encouraged for the provision of services under this RFS and does not receive additional points. Subcontracts for Non-Medi-Cal Billable services may be allowed in specific circumstances as determined by DMH. Subcontracting between DMH Legal Entities will not be permitted. Shall the Contractor use a subcontractor they must avoid fragmentation of services due to the use of multiple subcontractors.

If the Contractor intends to employ a Subcontractor(s) to perform some of the services described in the Service Exhbit, the transmittal letter shall clearly indicate the other agency (ies) involved and the role of the Subcontractor. A statement from all Subcontractors indicating their willingness to work with the Contractor and the intent to sign a formal agreement between/ among the parties shall be submitted with the signature of the person authorized to bind the subcontracting organization.

A Contractor shall obtain prior written approval from DMH in order to enter into a particular subcontract. All such requests shall be submitted in writing. Proposers shall remain responsible for any and all subcontracted performance required under the Agreement.

13. CONSUMER OUTCOMES

All outcomes targeted for tracking must be implemented, scored, stored, and transferred in a manner prescribed by DMH at intervals determined by DMH. Additionally, any and all outcomes, measurement instruments, and procedures may be supplemented, revised, or deleted by DMH at any time during the course of funding for this RFS. The following outcomes are identified for PRRCH:

OUTCOMES	METHOD/MEASURE OF SUCCESS
Reduced incarcerations	50% reduction of incarcerations, obtained through IS review.
Reduced psychiatric ER visits	50% reduction of psychiatric ER visits, obtained through IS review.
Improved service integration	40% increase in coordinated mental health, physical health and substance abuse services. Methodology to be determined by DMH.
Improved health and mental health status.	70% of clients will have improved health and mental health status. Methodology to be determined by DMH.
Increased consumer self-efficacy, hope for recovery. Reduced client self-stigma.	At least 60% of consumers will increase their self-efficacy and hope for recovery and reduce their self-stigma. Methodology to be determined by DMH.
Consumers will use self-help resources and self-help practices.	At least 80% of consumers will use a self-help resource and self-help practice. Methodology to be determined by DMH.

14. PERFORMANCE-BASED CRITERIA

The Agreement will include four (4) criteria measuring the Proposer's performance related to operational measures indicative of quality program administration. These Performance-Based Criteria are consistent with the MHSA and the INN Plan learning questions. These measures assess the agency's ability to provide required services and monitor the quality of the services.

Collaboration

The Proposer shall collaborate with DMH to provide processes for systematically evaluating quality and performance indicators and outcomes at the program level. Shall there be a change in federal, State, or County policies/regulations, DMH, at its sole discretion, may amend these Performance-Based Criteria via an amendment to the Agreement.

Scheduled Monitoring

Proposers shall 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 Proposer's adherence to the Performance-Based Criteria will be evaluated.

Performance Based Criteria

PERFORMANCE-BASED CRITERIA	METHOD OF DATA COLLECTION	PERFORMANCE TARGETS
1.PRRCH provides clients with integrated mental health, physical health, housing, and substance abuse service in a respite care setting.	Instrument measuring levels of service integration	100% of clients with co-occurring mental health, physical health, housing, and substance abuse disorders have an integrated care plan.
2. Satisfaction with services.	Client satisfaction survey	80% of clients will be satisfied with PRRCH/PRISM integrated services.
3.PRRCH improved community support for consumers.	Instrument to be identified by DMH	Participation linkage efforts may be made for at least 70% of PRRCH participants voluntarily engaged in a range of existing community support resources.
4.PRRCH uses peer support and a client-empowered, recovery-based approach to identify and advance clients' personal physical health, mental health, housing, and substance abuse recovery goals.	Client interviews and chart reviews	80% of clients indicate a positive response concerning peer support and empowerment.

The Contractor shall demonstrate in writing how the services impact performance targets. The Contractor shall maintain, at a minimum, the following documents and records that indicate the performance targets:

- Required reporting to DMH on performance targets related to the Contractor's services.
- Client medical records/files, including, but is not limited to, assessments, care plans, progress notes, service integration, and discharge summaries.

- Agency administrative policies and procedures for PRRCH.
- Agency budgets and financial records for the PRRCH.

15. 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.

COUNTY OF LOS ANGELES -DEPARTMENT OF MENTAL HEALTH

Mental Health Services Act - INNOVATION
INTEGRATED PEER-RUN MODELS
FISCAL YEARS 2012-13 & 2013-14

Agency	Description of services to be provided	Legal Entity (LE) #	Sup. Dist. Served	Service Area	Innovation Funding FY 2012-13	Revised MCA	Innovation Funding FY 2013-14
PEER- RUN INTEGRATED SERVICE MANAGEMENT (PRISM)							
Emotional Health Association (SHARE!)	Outreach and Engagement, Recovery/Wellness Planning, Individual and Group Peer Support, Healthy Living Activities, Individual and Group Recovery Oriented Peer Support Substance Abuse Services, CSS, Linkage to Mental Health Care Services, Linkage to Substance Abuse Services, Linkage to Physical Health Care Services, Housing Services Assistance and Linkage, Educational Opportunities Assistance and Linkage,Employment Assistance and Linkage,Transportation Assistance and Linkage, Linkage to Services through Community Partnerships	01311	1,3	4	$207,777	*	$311,666
Emotional Health Association (SHARE!)	Outreach and Engagement, Recovery/Wellness Planning, Individual and Group Peer Support, Healthy Living Activities, Individual and Group Recovery Oriented Peer Support Substance Abuse Services, CSS, Linkage to Mental Health Care Services, Linkage to Substance Abuse Services, Linkage to Physical Health Care Services, Housing Services Assistance and Linkage, Educational Opportunities Assistance and Linkage,Employment Assistance and Linkage,Transportation Assistance and Linkage, Linkage to Services through Community Partnerships	01311	2	5	$207,777	*	$311,666
Mental Health America of Los Angeles	Outreach and Engagement, Recovery/Wellness Planning, Individual and Group Peer Support, Healthy Living Activities, Individual and Group Recovery Oriented Peer Support Substance Abuse Services,CSS, Linkage to Mental Health Care Services, Linkage to Substance Abuse Services, Linkage to Physical Health Care Services, Housing Services Assistance and Linkage, Educational Opportunities Assistance and Linkage,Employment Assistance and Linkage,Transportation Assistance and Linkage, Linkage to Services through Community Partnerships	00200	4	8	$207,777	**	$311,666

COUNTY OF LOS ANGELES -DEPARTMENT OF MENTAL HEALTH

Mental Health Services Act - INNOVATION
INTEGRATED PEER-RUN MODELS
FISCAL YEARS 2012-13 & 2013-14

Agency	Description of services to be provided	Legal Entity (LE) #	Sup. Dist. Served	Service Area	Innovation Funding FY 2012-13	Revised MCA FY 2012-13	Innovation Funding FY 2013-14
PEER-RUN RESPITE CARE HOMES (PRRCH)							
Emotional Health Association (SHARE!)	Respite Care Home services that provide temporary supportive housing with on-site trained peer support 24 hours per day, 7 days a week, Outreach and Engagement, Screening, Recovery/Wellness Planning, CSS, Individual and Group Peer Support Services,Bridging Services, Medication Self-Management Support, Linkage to Mental Health Care Services, Linkage to Health Care Services, Linkage to Substance Abuse Services	01311	1	3	$500,000	*	$750,000
Mental Health America of Los Angeles	Respite Care Home services that provide temporary supportive housing with on-site trained peer support 24 hours per day, 7 days a week, Outreach and Engagement, Screening, Recovery/Wellness Planning, CSS, Individual and Group Peer Support Services,Bridging Services, Medication Self-Management Support, Linkage to Mental Health Care Services, Linkage to Health Care Services, Linkage to Substance Abuse Services	00200	4	8	$500,000	**	$750,000
				TOTAL:	**$1,623,331**		**$2,434,998**

***The revised MCA for SHARE! for FY 2012-13 is $1,724,154**

****The revised MCA for MHALA for FY 2012-13 is $18,043,027.**

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
550 S. VERMONT AVE., LOS ANGELES, CA 90020 HTTP://DMH.LACOUNTY.GOV

MARVIN J. SOUTHARD, D.S.W.
Director
ROBIN KAY, Ph.D.
Chief Deputy Director
RODERICK SHANER, M.D.
Medical Director

October 5, 2012

TO: Each Supervisor

Robin Kay for

FROM: Marvin J. Southard, D.S.W.
Director

SUBJECT: **REQUEST TO INCREASE DELEGATED AUTHORITY PERCENTAGE FOR THE MENTAL HEALTH SERVICES ACT INNOVATION INTEGRATED PEER RUN MODELS BOARD LETTER FOR FISCAL YEARS 2012-13 AND 2013-14**

This memorandum is to comply with Board of Supervisors 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 advance 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 (LE) Agreements, Mental Health America of Los Angeles (MHALA) and Emotional Health Association (SHARE!), to implement the Integrated Peer Run Models under the Mental Health Services Act Innovation Plan for Fiscal Years 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

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