County of Los Angeles
Health and Mental Health Services

FESIA A. DAVENPORT
Chief Executive Officer

DATE: Wednesday, April 27, 2022
TIME: 10:30 a.m.

THIS MEETING WILL CONTINUE TO BE CONDUCTED VIRTUALLY TO ENSURE THE SAFETY OF MEMBERS OF THE PUBLIC AND EMPLOYEES AS PERMITTED UNDER STATE LAW.

TO PARTICIPATE IN THE MEETING, PLEASE CALL AS FOLLOWS:
DIAL-IN NUMBER: 1 (323) 776-6996
CONFERENCE ID: 322130288#
MS Teams link (Ctrl+Click to Follow Link)

AGENDA

Members of the Public may address the Health and Mental Health Services Meeting on any agenda item. Two (2) minutes are allowed for each item.

THIS TELECONFERENCE WILL BE MUTED FOR ALL CALLERS. PLEASE DIAL *6 TO UNMUTE YOUR PHONE WHEN IT IS YOUR TIME TO SPEAK.

1:00 P.M. NOTICE OF CLOSED SESSION

CS-1 CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION

Government Code Section 54956.9(a)
Taniela Tuihalamaka v. Jim McDonnell, et al.
Los Angeles Superior Court Case No. BC 706455
Department of Health Services
Sheriff's Department

I. Call to order

II. **Information Item(s)** (Any Information Item is subject to discussion and/or presentation at the request of two or more Board offices)**:**

a. **DHS:** Request Approval of an Amendment to Cerner Agreement to Purchase Transaction Services

III. **Presentation Item(s):**

a. DMH: Approval to Extend the Nine Existing Contracts for Innovation 2 – Developing Trauma Resilient Communities: Community Capacity Building and the Consultant Services Contract with The Regents of the University of California, San Diego on a Sole Source Basis

IV. Items Continued from a Previous Meeting of the Board of Supervisors or from the Previous Agenda Review Meeting

V. Items not on the posted agenda for matters requiring immediate action because of an emergency situation, or where the need to take immediate action came to the attention of the Department subsequent to the posting of the agenda

VI. Public Comment

VII. Adjournment

BOARD LETTER/MEMO
CLUSTER FACT SHEET

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	4/27/2022
BOARD MEETING DATE	5/17/2022
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
DEPARTMENT(S)	Department of Health Services (DHS)
SUBJECT	Approval of delegated authority to the Director of DHS to execute an amendment to Agreement No. H-705407 with Cerner Corporation (Cerner) for the provision of Patient Transaction Services (PTS) for DHS and to address payment stream and price changes for certain items.
PROGRAM	Not Applicable
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No
SOLE SOURCE CONTRACT	☒ Yes ☐ No
	If Yes, please explain why: It is in the best economic interest and operational interest of the County to obtain PTS from Cerner because this module is part of the financial hub product that was included as part of the deployment of DHS's electronic health record, Online Real-time Computerized Healthcare System (ORCHID).
DEADLINES/ TIME CONSTRAINTS	The provision of PTS will be included in the current Agreement with Cerner, (expires on 12/31/2032).
COST & FUNDING	Total cost: The Maximum Agreement Sum of the Agreement will be increased by $22,100,000. Funding source: Funding for the increase to the agreement is included in DHS' Fiscal Year 2021-22 Final Budget and will be requested in future fiscal years as needed.
	TERMS (if applicable): Effective upon execution through December 31, 2032.
	Explanation:
PURPOSE OF REQUEST	Purchase PTS and related implementation, hosting, support and training services from Cerner and increase the Maximum Contract Sum and address payment stream and price changes for certain items.
BACKGROUND (include internal/external issues that may exist including any related motions)	PTS is a suite of new revenue cycle modules that are integrated with DHS' electronic health record system, allowing DHS to use new/enhanced workflows for patient financial clearance, from pre-registration to financial settlement. The modules enable DHS to verify patient eligibility/benefit information real-time and/or in batch through eligibility (270/271) transaction sets from ORCHID, route eligibility/benefits information from the payer back into ORCHID where the electronic data is available for consumption to the patient record, and access healthcare coverage/eligibility information for Medicaid, Medicare, and other commercial insurers/payors. The Board approved the provision of an acuity, scheduling, and time system and related services and leases from Cerner, now named Acuity, Scheduling & Time Employee Resources (ASTER) in November 2020. The first phase was deployed at adult critical care units at LAC+USC Medical Center (LAC+USC MC). Due to extenuating circumstances, design decisions for the "go-live" at LAC+USC MC have been delayed. The next "go-live" will include all inpatient areas/select areas impacted by the coronavirus at LAC+USC MC and Health Services Administration. Therefore, the payment stream may need to be amended to reflect the actual "go-live". Also, certain limited hardware items were included as part of ORCHID when it was approved in 2012. The Board then granted DHS the authority to purchase additional units of the Hardware in 2016. Unfortunately, Cerner will no longer sell additional units at the current price, so DHS needs a new price list, and negotiate/agree to an updated price schedule. Finally, recent federal regulations that apply to Cerner require them to uniformly apply fees for certain services/products related to electronic health information exchange. These regulations were issued in connection with the 21st Century Cures Act of 2016. Therefore, Cerner is not legally permitted to charge fees for certain software/related professional services that differ from the published fees, even if they previously contracted.
EQUITY INDEX OR LENS WAS UTILIZED	☐ Yes ☒ No If Yes, please explain how:
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	☐ Yes ☒ No If Yes, please state which one(s) and explain how:
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: • Kevin Lynch, CIO, (213) 288-8128, KLynch@dhs.lacounty.gov • Christopher Kinney, Contracts Section Manager, (213) 288-8862, CKinney@dhs.lacounty.gov • Lillian Anjargolian, Deputy County Counsel, (213) 288-8124, LAnjargolian@counsel.lacounty.gov

DHS LETTERHEAD

DRAFT

May 17, 2022

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

Dear Supervisors:

APPROVAL TO DELEGATE AUTHORITY TO AMEND AGREEMENT H-705407 WITH CERNER CORPORATION ON A SOLE SOURCE BASIS

(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

CIO RECOMMENDATION: APPROVE [X]

SUBJECT

Approval of delegated authority to the Director of the Department of Health Services to execute amendments to Agreement No. H-705407 with Cerner Corporation for the provision of Patient Transaction Services for the Department of Health Services and to address payment stream and price changes for certain items.

IT IS RECOMMENDED THAT YOUR BOARD:

Delegate authority to the Director of the Department of Health Services (Director), or designee, to: (i) execute an amendment to Agreement H- 705407 (Agreement) with Cerner Corporation (Cerner), effective upon execution through December 31, 2032, if all extensions are exercised, for the provision of patient Transaction services, as described below, on a sole source basis, and increase the Maximum Contract Sum in an amount not to exceed $22,100,000, including for the extension periods if exercised, as follows: (a) $16,400,000 for the provision of a patient transaction services system (Patient Transaction Services), with the option to reallocate any unspent amounts to Pool Dollars; and (b) $5,700,000 in Pool Dollars for Optional Work, with Optional Work to be authorized by the Director, or designee, through the issuance of Amendments or Change Orders, as applicable, and (ii) grant the Director delegated authority to amend the Agreement to address changes to the payment stream for DHS' purchase of the acuity, scheduling and time system, price changes in response to market conditions and product improvements for certain hardware, and price changes required to comply with laws and regulations related to patient information sharing from an electronic health record system.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Patient Transaction Services

Approval of the recommended action will delegate authority to execute an amendment to the Agreement, substantially similar to Exhibit I, to purchase Patient Transaction Services and related implementation, hosting, support and training services from Cerner, and increase the Maximum Contract Sum accordingly.

Patient Transaction Services is a suite of new revenue cycle modules that are integrated with DHS' electronic health record system, referred to as Online Real-time Computerized Healthcare System (ORCHID), allowing DHS to use new and enhanced workflows for patient financial clearance, from pre-registration to financial settlement. The Patient Transaction Services modules enable DHS to, among other features, verify patient eligibility and benefit information real-time and/or in batch through eligibility (270/271) transaction sets from within ORCHID, route eligibility and benefits information from the payer back into ORCHID where the electronic data is available for consumption to the patient record, and access healthcare coverage and eligibility information for Medicaid, Medicare, and other commercial insurers/payors. Healthcare coverage details are then automatically attached to a patient encounter from within ORCHID. In addition, automations (e.g., rules and reports) allow DHS to identify registration inaccuracies, which in turn enable DHS staff to address the issues before the encounter. Finally, Patient Transaction Services provides a tool for researching potential healthcare coverage where staff have been unable to obtain information from the patient.

Over the last several years, DHS has focused heavily on improving the care experience for Los Angeles County patients while working to reduce uncompensated care. A significant part of this effort includes using technology to streamline patient access processes. The purchase and deployment of Patient Transaction Services will enhance the ability of DHS staff to focus on assisting patients directly instead of spending time manually verifying a patient’s healthcare coverage for every outpatient encounter.

Patient Transaction Services consists of a hub, with various transaction services, purchased and used on an as-needed basis, integrated with the registration workflow in ORCHID. While parts of the financial hub were included as part of the deployment of ORCHID , this purchase will increase the Cerner modules available to DHS to include a more complete suite of patient access functionality, utilizing modules provided by Cerner and a Cerner subcontractor.

Further, using the technology available through Patient Transaction Services to streamline and automate financial clearance (i.e., confirming the patient's healthcare coverage is appropriate for DHS) will allow DHS to prioritize resolving discrepancies in health care coverage prior to the patients’ appointments for the bulk of approximately 2 million annual outpatient encounters (pre-COVID 19). In addition to better serving

patients, Patient Transaction Services offers features that will assist DHS in improving the quality of the information on a patient's coverage, thereby facilitating more timely billing and reporting encounter data to health plans, resulting in enhanced revenue recovery.

DHS currently uses manual processes, and multiple smaller systems and software suites to manage its various coverage verification and financial clearance functions. Many of these systems are not connected to each other or to ORCHID, and manual processes to obtain the necessary data are time consuming and subject to human error. For example, while a current contractor also provides eligibility (270/271) information, the information is accessed via a separate request for each patient that must be manually "pulled" for every patient encounter daily. The information received back in the request does not allow DHS staff to electronically "copy" the coverage information, requiring DHS staff to manually note and enter the relevant information in the patient record. Finally, the current contractor has minimal service levels for the provision of these requests.

Patient Transaction Services is integrated with ORCHID and, more importantly, the patient record on a per encounter basis. The integration of these modules within ORCHID is one of the key benefits of Patient Transaction Services. By purchasing an integrated system, users will be able to address patient needs in a single system and record. In addition, Patient Transaction Services are provided in accordance with services levels that account for the importance of the eligibility information in providing services to patients. As of February 2022, an average ORCHID day included 13,831 unique users, 103,483 patient orders, and an average daily inpatient census of 1,121 across all of DHS.

Implementation and deployment activities are projected to take approximately one (1) year. The cost for the purchase of Patient Transaction Services and related services will not exceed $22,100,000, which includes no more than $16,400,000 for the provision of Patient Transaction Services and approximately $5,700,000 in Pool Dollars for Optional Work. The Optional Work includes additional modules which DHS may purchase and deploy later. For example, Pool Dollars may be used to purchase the authorizations module which will facilitate the submission of prior authorization for care and automate the inquiry process for approvals/denials. In addition, Pool Dollars may be used for per transaction fees. The exact cost of each module will be based on the number of transactions. DHS estimated its use of each module, but DHS also expects demand to grow as users realize the benefits and ease of use of the new modules. To account for anticipated growth, DHS is asking for increased Pool Dollars. While DHS used its best efforts to estimate future use, DHS may be required to return to the Board in the future in order to request additional Pool Dollars if use of the modules exceeds estimates.

ASTER Payment Stream Updates and Other Price Changes

In November 2020, the Board approved the provision of an acuity, scheduling, and time system and related services and leases from Cerner, now named Acuity, Scheduling & Time Employee Resources (ASTER). ASTER provides a wide range of functions,

including: (i) patient acuity calculation in accordance with law and using ORCHID data; (ii) staff scheduling using ORCHID data and information about competencies and skills; (iii) system supported scheduling for lunches and breaks; (iv) vacation request tracking and notification of overtime opportunities; (v) a new time system, consisting of new clocks and automatic time entry for a 24/7 workforce; (vi) streamlined timesheet submission to the Auditor-Controller for payroll processing; and (vii) the ability for clinical staff to request shifts/time more efficiently. The first phase of ASTER was deployed at adult critical care units at LAC+USC Medical Center (LAC+USC MC) as planned. Initially, the plan was to deploy ASTER in additional waves, beginning with all of LAC+USC MC and Health Services Administration (HSA). Due to extenuating circumstances, including patient care needs and staffing issues, design decisions for the "go-live" at LAC+USC MC have been delayed, resulting in unavoidable changes to "go-live" plans. The next "go-live" will include all inpatient areas and select areas impacted by the coronavirus (e.g., emergency department) at LAC+USC MC, and HSA. As a result of these changes, the payment stream for ASTER may need to be amended to reflect the actual "go-live". For example, if fewer users will be using the system after this "go-live", the payment schedules will be updated to correctly reflect actual use. DHS does not anticipate an increase in the fees for ASTER as a result of these changes.

When the Board approved the Agreement in 2012, certain limited hardware items were included as part of ORCHID. In 2016, the Board granted DHS the authority to purchase additional units of the Hardware as-needed. For example, the Hardware includes the "Cerner Connectivity Engine" which is hardware that connects medical devices to ORCHID, and related items (e.g., connection cords and docks). While Cerner has been able to maintain the price for the Hardware since 2016, in light of improvements to the features and functions of the Hardware and changes to supply chain and parts costs, Cerner will no longer sell additional units of the Hardware to County at the current price. In the intervening years, the components for the Hardware have been updated, including modernization of the housing and chip updates. Approval of the recommendation will allow DHS to both to amend the Agreement to reflect a new price list for current use, and the ability to negotiate and agree to an updated price schedule for the Term of the Agreement, assuming any future increase results from enhancements to the Hardware.

Finally, recent federal regulations that apply to Cerner require that Cerner uniformly apply fees for certain services and products related to electronic health information (EHI) exchange. The Office of the National Coordinator for Health IT (ONC) issued these regulations in connection with the 21st Century Cures Act of 2016 (Cures Act). Regarding fees that can be charged for EHI-related professional services and certain software, the regulations under the Cures Act say, in part, that the fees charged by an entity such as Cerner for access, exchange, or use of EHI must be based on objective and verifiable criteria uniformly applied across similarly situated classes of persons or entities making requests and must be reasonably allocated among all similarly situated persons or entities to whom the healthcare information technology is provided or for whom the healthcare information technology is supported. As a result of this uniformity requirement, Cerner is not legally permitted to charge fees for certain software and related professional services

that differ from the published fees, even if Cerner had previously contracted with a client such as DHS to provide a particular fee or to provide a discount on certain charges. Therefore, approval of the recommendation will allow DHS to amend certain software and related professional services fees in accordance with law, upon confirmation by County Counsel and outside counsel to comply with laws and regulations related to patient information sharing from an electronic health record system.

Implementation of Strategic Plan Goals

The recommended action supports Strategy III.2, "Embrace Digital Government for the Benefit of Our Internal Customers and Communities," Strategy II.2, "Support the Wellness of Our Communities," and III.3, "Pursue Operational Effectiveness, Fiscal Responsibility and Accountability" of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

The current Contract Sum for the Cerner Agreement is $762,651,850. If approved, the recommended action herein will increase the Contract Sum by $22,100,000 to $784,751,850. Funding for the increase to the agreement is included in DHS' Fiscal Year 2021-22 Final Budget and will be requested in future fiscal years as needed. There will be no net County cost impact.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

The requested action includes amending the Agreement, which was originally awarded as a result of an extensive and unprotested competitive solicitation. In accordance with the Board's policy of engaging outside counsel for certain information technology agreements, County Counsel retained the law firm of Foley & Larder, LLP to assist in all aspects of these negotiations. Accordingly, Foley & Lardner, in conjunction with County Counsel, assisted DHS and drafted and negotiated the recommended Amendment. The amendment for Patient Transaction Services includes certain variances from County standards. These include variances to the County's subcontracting terms to address differences in the contractual relationship between Cerner and its subcontractor, revised service levels and support terms that are more appropriate for Patient Transaction Services, and hosting and information security terms that reflect Cerner's use of a subcontractor. DHS has reviewed these variances and believes it is in the best interest of the County to proceed.

County Counsel has approved Exhibit I as to form. In compliance with Board Policy 6.020 "Chief Information Office Board Letter Approval", the Office of the Chief Information Officer (OCIO) reviewed the information technology (IT) components of this request and recommends approval. The OCIO concurs with the Department's recommendation and that office's analysis is attached (Attachment A).

The Department has evaluated and determined that the Living Wage Program (County Code Chapter 2.201) does not apply to the recommended amendment, and the Agreement, and are exempt from Proposition A (County Code Chapter 2.121).

CONTRACTING PROCESS

On April 5, 2018, DHS notified the Board via Attachment B of its intent to commence negotiations with Cerner for the sole source Amendment with Cerner in accordance with Board Policy No. 5.100. In light of the delays caused by the coronavirus and higher priority projects, the negotiations for Patient Transaction Services were deferred for long periods. DHS recently validated that the statements made in the foregoing sole source notification remain true and accurate. The Sole Source checklist is attached as Attachment C in compliance with the revised Board Policy 5.100, Sole Source Contracts. DHS believes that it is in the best economic interest and operational interest of the County to obtain Patient Transaction Services from Cerner on a sole source basis. Considering the fact that this is module is part of the financial hub product that was included as part of the deployment of ORCHID, there is little opportunity to procure a similar system from another vendor.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommendation will enable DHS to continue to improve patient access to medical experience, achieve efficiency across departmental operations, and increase financial revenue.

Respectfully submitted,

Christina R. Ghaly, M.D.
Director

Reviewed by:

Peter Loo
Acting Chief Information Officer

CRG:az

Enclosures

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

Attachment A

CIO Analysis

Placeholder

Attachment B

LOS ANGELES COUNTY
HEALTH AGENCY

313 N. Figueroa Street, Suite 531A
Los Angeles, CA 90012

Tel: (213) 240-8174
Fax: (213) 482-9760

"The mission of the Los Angeles County Health Agency is to improve health and wellness across Los Angeles County through effective, integrated, comprehensive, culturally appropriate services, programs, and policies that promote healthy people living in healthy communities."

April 5, 2018

TO: Supervisor Sheila Kuehl, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM: Fred Leaf
Interim Director

SUBJECT: **ADVANCE NOTIFICATION OF INTENT TO NEGOTIATE A SOLE SOURCE AMENDMENT TO AGREEMENT NO. H-705407 WITH CERNER CORPORATION**

This is to provide the Board of Supervisors (Board) with advanced notification of the Health Agency's (Agency) intent to amend existing Agreement H-705407 (Agreement) with Cerner Corporation (Cerner) for the provision of an electronic health record (EHR) system, also known as the Online Realtime Centralized Health Information Database (ORCHID), to purchase and implement additional integrated software and services. Board Policy 5.100 requires written notice of a department's intent to enter into sole source negotiations for a Board-approved agreement at least four weeks prior to the initiating sole source negotiations. Although the Cerner Agreement was awarded after a competitive solicitation, the purchase of additional software and services from Cerner is on a sole source basis, and therefore, is subject to the Board's Sole Source Policy.

In addition, this written notice provides the Board with the Agency's proposed format for future sole source notices related to the Agreement and ORCHID.

Background and Sole Source Methodology

With the successful launch of ORCHID, the Agency is consistently reviewing other opportunities to optimize the patient care cycle and deliver the right care to every patient at the right time in the right setting with the right resources by enhancing and building on ORCHID. The Agency considers its options for enhancements to ORCHID first with the goal of improving patient care, next with the goal of providing

suitable resources to provide the care, and finally, with the goal of focusing on efficiencies achievable by standardizing on a fully integrated EHR system. The value of an integrated solution has been recognized by the Board's various motions regarding integrating the County's EHR systems into a single platform - ORCHID. In support of integration, the Agency continues to identify certain products that should be purchased from Cerner on a sole source basis because Cerner is the only vendor able to provide such products as part of ORCHID.

While the ORCHID solicitation was expansive, the Agency has found that certain items were not considered in the 2011 solicitation due to lack of availability or information about particular products. One of the key minimum requirements in the County's solicitation for ORCHID was that it be an integrated solution. The integrated solution was assessed on the basis of several factors, such as is the solution: (i) comprised of several software components designed to work together using a single set of data integrity rules and constraints; (ii) uses a common application infrastructure; and (iii) provides "one single source for truth" for patient information, or (iv) provides computable and meaningful real time decision support of operational and clinical functions regardless of the original care provider and the original source of the data.

Before recommending a new product be purchased from Cerner on a sole source basis due to integration advantages, the Agency will assess the product and its value on the integration factors set forth in the original solicitation and additional similar integration factors that would apply now. This will allow the Agency to conduct a thorough assessment of the advantages of integration and Cerner's role as the sole source of an integrated solution. The Agency acknowledges that this sole source methodology narrows the field of vendors. However, in determining that integration brings immense value to the County and its patients, the County must acknowledge that Cerner, as its EHR vendor, is now also the sole vendor that can meet the County's EHR integration requirements. The Agency believes that this robust and innovative review process will assure a fair process and also result in decisions that are in the best interest of the County.

Sole Source Assessments

Attached are the sole source assessments to support commencing negotiations with Cerner for the purchase of Cerner Clairvia - Clinical Workforce Management, Cerner Time & Attendance and Transaction Services. An integrated set of solutions will enable clinical data to drive outcomes-based patient acuity, with evidence-based staffing and patient flow processes. This in turn will allow the Department of Health Services (DHS) to better track and manage labor costs and support development of cost accounting and other fiscal management processes.

After reviewing the current state at DHS and the proposed solutions with the Chief Information Office and Auditor-Controller, both offices are supportive of our efforts.

The Agency plans to use the same sole source assessment methodology to provide the Board with any future sole source notifications that meet the standards set forth in this notification.

If no objection is received within ten (10) business days upon receipt of this Board notification, the Health Agency plans to begin sole source negotiations with Cerner and anticipates returning to the Board later in 2018 for approval of the agreement amendment(s) for Cerner Clairvia, Cerner Time & Attendance and Transaction Services.

If you have any questions or require additional information, please let me know, or your staff may contact Dr. Christina Ghaly, Acting Director, DHS, at (213) 288-7787.

FL:kh

C: Auditor-Controller
Chief Executive Office
Chief Information Office
County Counsel
Executive Office, Board of Supervisors

CERNER AGREEMENT H-705407
SOLE SOURCE PRE-NEGOTIATION NOTICE

Product – Cerner Clairvia – Clinical Workforce Management

Cerner Clairvia Clinical Workforce Management (Clairvia), consisting of five integrated modules: (i) Staff Manager; (ii) Demand Manager; (iii) Patient Progress Manager; (iv) Assignment Manager; and (v) Outcomes-Driven Acuity. The integrated modules can support enterprise-wide staff scheduling, determine workload/productivity using patient information, assist with care plans by monitoring patient progress against established hospitalization benchmarks, propose appropriate patient assignments to staff and importantly determine patient acuity-levels from clinical documentation – all in real time. Future new and related modules may also be purchased as appropriate.

Statement of Need

The Department of Health Services (DHS) does not have a workforce management solution to accurately capture staff attendance, reconcile attendance against the staff schedules, and adjust staffing levels in real time. With respect to nurse scheduling for patient care and patient acuity, DHS uses multiple stand-alone solutions. Catalyst's EVALYSIS Patient Classification System relies on a set of proprietary forms built in ORCHID that DHS nurses use to classify patient care acuity levels per shift, as is required. The information on the forms is then manually uploaded into McKesson One-Staff to populate patient acuity and accordingly assign patients to nursing staff. The end users/nursing staff offices use the One-Staff data to determine staff scheduling.

Integration Assessment

Clairvia is a Cerner product that is integrated directly with Cerner's Millennium solution, which is the ORCHID platform. Clarvia manages clinical staffing, clinical demand management, patient progress and acuity, presenting evidence-based patient-staff assignments within ORCHID. The ORCHID clinical, demographic, and location data are available within Clairvia through real-time data interfaces. The Clairvia Assignment Manager uses historical patient assignment data to automatically propose appropriate patient assignments that maintain nurse-to-patient continuity of care. These patient assignments then automatically populate ORCHID for the nurses' care delivery to begin on each shift.

Additional Considerations

Implementation of an enterprise-wide solution integrated with ORCHID can help improve the quality and cost of care by providing more automation of predictable tasks, greater visibility, and better responsiveness for workforce tasks. By assigning the right caregivers to the right patients at the right time, DHS can improve patient safety and care quality, achieve superior care outcomes, and reduce workforce costs.

CERNER AGREEMENT H-705407
SOLE SOURCE PRE-NEGOTIATION NOTICE

Product – Cerner Time & Attendance

Cerner Time & Attendance provides automated real time staff time and attendance and labor capture, detailed labor data reporting, integration with Clairvia's Clinical Workforce Management product. Together these provide the capability to send clinical workforce attendance data to the County's eHR CGI time record system for payroll creation and leave reporting.

Statement of Need

DHS does not currently have an automated time and attendance system and instead uses a manual process. Time collection for nursing staff is currently done via punch timecards with time stamps to track shifts, breaks, and shift times. Actual attendance must be verified manually. Attendance information must also be manually entered into the scheduling systems. Hours worked and payroll codes are also manually entered on the timecards and payroll staff manually enter the timecard data into the County's eHR timekeeping system. There is redundant eHR data entry and validation which consumes availability of computer resources and direct care providers. The current manual process is labor intensive, time consuming, lacks real-time accountability, disrupts workflows, and can be prone to errors. Successful implementation to achieve the full benefits of Clairvia requires that the current manual method for time capture be fully automated.

Integration Assessment

Cerner Time & Attendance is integrated with Clairvia by providing computable real time staffing decision support. Cerner Clairvia consumes in near real-time the Cerner Time & Attendance data. This integration provides the ability to view "punch" status of each employee scheduled in Clairvia (i.e. who is scheduled but has not punched in yet, who is punched in by shift, who has floated in from another cost center, etc.). With Cerner Time & Attendance integration, Clairvia provides accurate and near-real-time productivity reporting that aligns with payroll reporting. Additionally, Clairvia sends the schedule to Cerner Time & Attendance for comparing exceptions between scheduled time and worked time.

While this product is provided by a Cerner partner, Workforce Software LLC, purchasing this product from Cerner and implementing it in concert with Clairvia provides additional integration advantages due to the Cerner Time & Attendance rules engine. This will allow a robust use of time-keeping rules that are common and required in the 24/7 staffing of a clinical workforce. Cerner and Workforce Software LLC have a proven track record in implementing the proposed solutions together.

Implementing Clairvia and Cerner Time & Attendance together will provide implementation speed to value that is critically needed. Layering together the Clairvia Staff Manager scheduling with the deployment of the Cerner Time & Attendance

automated time capture, will speed the deployment of a comprehensive workforce management capability that would be difficult to achieve by separate vendors deploying solutions individually. Cerner has a track record of successfully implementing these two capabilities together.

Additional Considerations

DHS manages a large workforce in a 24/7 environment, with complex wage rules based on appointment status and work schedule. Implementation of automated time tracking will eliminate the need for the current costly manual process, while enhancing accuracy and freeing up nursing and payroll staff time. The automated solution will also apply pay and attendance policies in real time, providing DHS with time sensitive insights regarding labor costs and scheduling decisions, and fully integrate with Clairvia.

CERNER AGREEMENT H-705407
SOLE SOURCE PRE-NEGOTIATION NOTICE

Product – Transaction Services

Transaction Services are a suite of products that provide Electronic Data Interchange services in support of DHS' patient access related transactions. The suite of products available from Cerner consists of a financial hub, with various services (e.g., "Address Validation and Verification" and "Eligibility Verification"), purchased on an individual basis as needed.

A list of the currently available transaction services is shown below.

1. Automated Messaging
2. Medical necessity checking (Advance Beneficiary Notice of Noncoverage)
3. Eligibility Checking (X12 270/271)
4. Notice of Admission (X12 278N)
5. Reg (Data) Quality Assurance
6. Propensity to Pay/Payment Advisory
7. Bill Estimation
8. Address Validation & Verification
9. Coverage Discovery
10. Authorization Submission and Reconciliation
11. Claims Scrubbing/Editing/Remits/Claim Submission
12. Contract Management
13. Statements
14. Letters
15. Credit Card Payments (point of service and online bill pay)

Statement of Need

DHS currently uses multiple smaller systems and software suites, as well as manual processes to manage its various patient access functions. Many of these systems are not connected to each other or to ORCHID, and manual processes to obtain the necessary data are time consuming and subject to human error. In many cases, DHS does not currently perform the activity at all. DHS believes that more integrated and automated transactions will streamline processes, improve completeness and accuracy of information in ORCHID, and improve patient experience and the ability to improve financial outcomes. It will also allow DHS to most effectively utilize staff to navigate patients to the appropriate place to obtain care.

Given the high volume of transactions, the ability to perform these functions and upload the data quickly, leveraging technology for innovative practices will be a key success factor in implementing and managing DHS' increasingly sophisticated patient access policies and procedures. Lastly, in light of upcoming planned changes to DHS' financial systems, the accuracy of information at the point of patient scheduling, registration, and care delivery is essential to ensure successful billing.

CERNER AGREEMENT H-705407
SOLE SOURCE PRE-NEGOTIATION NOTICE

Integration Assessment

The integration assessment of Transaction Services demonstrates advantages across several integration factors. The purchase of Transaction Services from Cerner eliminates the need for interfaces and utilizes Cerner's financial hub, allowing single sign-on for users. In addition, there are specific integration advantages for certain modules. For example, with respect to verification tasks such as eligibility, benefits and address validations, these modules are embedded in the ORCHID registration workflow, resulting in "one single source of truth" for patient information.

While certain Transaction Services are provided by Cerner partners such as Experian, purchasing these Transaction Services from Cerner has integration advantages. These include the ability to request and receive all such transactions through a single hub, and to have these data be machine computable and retained over time, as may be needed for later revenue cycle processes.

Additional Considerations

It should be noted that several of the modules for Transaction Services were contemplated in the ORCHID solicitation and included in the Agreement and as such, did not require this sole source notification. However, in the interest of full transparency, and in light of DHS' expanded need for Transaction Services, DHS conducted the integration assessment above and determined that purchase of Transaction Services on a sole source basis as integrated with ORCHID is in the best interest of the County.

Attachment C

SOLE SOURCE CHECKLIST

Department Name: Department of Health Services

☐ New Sole Source Contract

☑ Sole Source Amendment to Existing Contract
Date Existing Contract First Approved: 12/21/2012

Check (✓)	JUSTIFICATION FOR SOLE SOURCE CONTRACTS AND AMENDMENTS **Identify applicable justification and provide documentation for each checked item.**
	➢ Only one bona fide source (monopoly) for the service exists; performance and price competition are not available. A monopoly is an "*Exclusive control of the supply of any service in a given market. If more than one source in a given market exists, a monopoly does not exist*."
	➢ Compliance with applicable statutory and/or regulatory provisions.
	➢ Compliance with State and/or federal programmatic requirements.
	➢ Services provided by other public or County-related entities.
	➢ Services are needed to address an emergent or related time-sensitive need.
	➢ The service provider(s) is required under the provisions of a grant or regulatory requirement.
	➢ Services are needed during the time period required to complete a solicitation for replacement services; provided services are needed for no more than 12 months from the expiration of an existing contract which has no available option periods.
	➢ Maintenance and support services are needed for an existing solution/system during the time to complete a solicitation for a new replacement solution/system; provided the services are needed for no more than 24 months from the expiration of an existing maintenance and support contract which has no available option periods.
	➢ Maintenance service agreements exist on equipment which must be serviced by the original equipment manufacturer or an authorized service representative.
	➢ It is more cost-effective to obtain services by exercising an option under an existing contract.
✔	➢ It is in the best economic interest of the County (e.g., significant costs and time to replace an existing system or infrastructure, administrative cost and time savings and excessive learning curve for a new service provider, etc.). In such cases, departments must demonstrate due diligence in qualifying the cost-savings or cost-avoidance associated with the best economic interest of the County.

Erika Bonilla
Chief Executive Office

4/4/22
Date

BOARD LETTER/MEMO
CLUSTER FACT SHEET

DRAFT

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	4/27/2022
BOARD MEETING DATE	5/17/2022
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
DEPARTMENT(S)	Mental Health
SUBJECT	Request approval to extend the nine existing contracts for Innovation 2 - Developing Trauma Resilient Communities: Community Capacity Building Contracts for the continued provision of Mental Health Services Act Innovation 2 services and the Consultant Services Contract with The Regents of the University of California, San Diego (UC San Diego) in order to continue the evaluation services of the Innovation 2 program on a sole source basis.
PROGRAM	Prevention
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No
SOLE SOURCE CONTRACT	☒ Yes ☐ No If Yes, please explain why: DMH is in the process of developing a new solicitation for the purpose of executing new Community Ambassador Network (CAN) contracts, in the interim it is in the best interest of the communities to continue to fund the existing INN 2 Contracts so that the delivery of services is not disrupted.
DEADLINES/ TIME CONSTRAINTS	05/03/2022
COST & FUNDING	Total cost: $28,550,000 – 9 INN 2 Contractors $1,000,000- UC San Diego for evaluation services $29,550,000 Funding source: 1991 Realignment Revenue and/or State MHSA Revenue TERMS (if applicable): July 1, 2022 through June 30, 2023, with an optional one-year extension Explanation: The MHSA Annual Update is pending board approval and includes the funding for these contracts, if there are any delays with the approval of the MHSA Annual Update, the 1991 Realignment revenue will be used to fund these contracts.
PURPOSE OF REQUEST	The purpose is to extend the existing contracts, to provide continuous, and uninterrupted delivery of INN 2- Community Ambassador Network services and the evaluation of said services while the re-solicitation process is completed.
BACKGROUND (include internal/external issues that may exist including any related motions)	In August and September of 2018, DMH executed nine contracts for the provision of INN 2 services and one Consultant Services Contract with UC San Diego for evaluation services of the INN 2 program. At the onset of the pandemic DMH expanded the INN 2 program by utilizing time-limited Coronavirus Aid, Relief, & Economic Security (CARES) Act funding to support the nine contractors with COVID-19 education and community outreach. This expansion of the INN 2 program established the CAN, which allowed DMH to increase our behavioral health workforce across each Supervisorial District by hiring and training peers to serve as “Community Ambassadors” (CA). Currently, DMH is in the process of developing a new solicitation for the purpose of executing new Community Ambassador Network (CAN) contracts, and in the interim, it is in the best interest

	of the County to continue to fund the existing INN 2 contracts so that the delivery of services under these contracts is not disrupted.
EQUITY INDEX OR LENS WAS UTILIZED	☒ Yes ☐ No If Yes, please explain how: This board letter falls under the Equity Guiding Principle of " Develop and implement strategies that identify, prioritize, and effectively support the most disadvantage geographies and populations," the INN 2-CAN contractors in coordination with community partners, implement capacity building strategies that utilize innovative outreach approaches to communities where there are disproportionate levels of poverty and high concentrations of unserved and underserved individuals, while also addressing issues such as job loss and other stressors brought on by system inequities and the COVID-19 pandemic.
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	☒ Yes ☐ No If Yes, please state which one(s) and explain how: This board letter supports many of the Board priorities specifically: Alliance for Health Integration, Homelessness, and Poverty Alleviation, which are all also the focus of the INN 2- Community Ambassador Network (CAN), The CAN leverage existing networks of community-based providers established under INN 2 and provide outreach and education to the most disadvantaged communities while also making them aware of resources and supports within the community in addition to providing psycho-education on issues such as trauma recovery, positive/healthy parenting skills, homelessness, and recidivism.
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: Robert Byrd, Acting Deputy Director, (424) 369-4018, rbyrd@dmh.lacounty.gov Emily Issa, Deputy County Counsel, (213) 974-1827, eissa@counsel.lacounty.gov

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

JONATHAN E. SHERIN, M.D., Ph.D.
Director

Gregory C. Polk, M.P.A.
Chief Deputy Director

Curley L. Bonds, M.D.
Chief Medical Officer

Lisa H. Wong, Psy.D.
Senior Deputy Director

May 17, 2022

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 EXTEND THE NINE EXISTING CONTRACTS FOR INNOVATION 2 - DEVELOPING TRAUMA RESILIENT COMMUNITIES: COMMUNITY CAPACITY BUILDING AND THE CONSULTANT SERVICES CONTRACT WITH THE REGENTS OF THE UNIVERSITY OF CALIFORNIA, SAN DIEGO ON A SOLE SOURCE BASIS (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Approval to extend the nine existing contracts for Innovation 2 - Developing Trauma Resilient Communities: Community Capacity Building Contracts for the continued provision of Mental Health Services Act Innovation 2 services and the Consultant Services Contract with The Regents of the University of California, San Diego in order to continue the evaluation services of the Innovation 2 program on a sole source basis.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and authorize the Director of Mental Health (Director), or his designee, to prepare, sign, and execute an amendment, substantially similar to Attachment I, to the Innovations 2 (INN 2) contracts with the nine contractors listed in Attachment II, to continue the provision of Mental Health Services Act (MHSA) Innovation services. This extension will be effective July 1, 2022 through June 30, 2023 with one optional extension through July 30, 2024. The Total Contract Amount (TCA) for the nine contract extensions combined are $28,550,000 funded by the 1991 Realignment

and/or MHSA revenue, pending Board approval of the Fiscal Year (FY) 2022-23 MHSA Annual Update, which includes the MHSA funding for these nine contracts.

2. Approve and authorize the Director, or his designee, to prepare, sign, and execute an amendment, substantially similar to Attachment III, to the Consultant Services Contract with The Regents of the University of California, San Diego (UCSD), to continue evaluation services of the INN 2 program. This extension will be effective July 1, 2022 through June 30, 2023 with one optional extension through July 30, 2024, with an annual TCA of $1,000,000 funded by the 1991 Realignment and/or MHSA revenue, pending Board approval of the FY 2022-23 MHSA Annual Update which includes the MHSA funding for this Contract.

3. Delegate authority to the Director, or his designee, to prepare, sign, and execute future amendments to the contracts in Recommendations 1 and 2 to revise the language; revise the TCA, if applicable; add, delete, modify, or replace the Statement of Work (SOW); and/or reflect federal, State, and County regulatory and/or policy changes, provided that: 1) the County's total payment for each fiscal year under the contracts will not exceed an increase of 10 percent of the TCA; 2) sufficient funds are available; and 3) the amendments are subject to prior review and approval as to form by County Counsel, with written notification to your Board and the Chief Executive Officer (CEO).

4. Delegate authority to the Director, or his designee, to terminate the contracts in Recommendations 1 and 2 in accordance with the contracts' termination provisions, including Termination for Convenience. The Director, or his designee, will notify your Board and CEO, in writing, of such termination action.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Board approval of Recommendation 1 will allow Department of Mental Health (DMH) to extend the term of the nine existing INN 2 contracts on a sole source basis. The nine INN 2 contracts listed in Attachment II are due to expire on June 30, 2022. The extension of these contracts is vital for the INN 2 program to continue the seamless delivery of services and supports to marginalized communities.

Board approval of Recommendation 2 will allow DMH to extend the term of the Consultant Services Contract with UCSD for evaluation services of INN 2 programs on a sole source basis. The Contract is due to expire on June 30, 2022. The extension of this Contract is necessary, as it needs to run concurrently with the INN 2 services since the evaluation supports the continued improvement of the INN 2 contractors' delivery of the program.

Board approval of Recommendations 3 and 4 will allow DMH to: 1) amend the contracts expeditiously, as needed, without interruption to services; and 2) terminate the contracts in accordance with the contracts' termination provisions, including Termination for Convenience, in a timely manner, as necessary.

Implementation of Strategic Plan Goals

The recommended actions are consistent with the County's Strategic Plan Goal I, Make Investments that Transform Lives, specifically, Strategies I.1 Increase Our Focus on Prevention Initiatives and I.2 Enhance Our Delivery of Comprehensive Interventions.

FISCAL IMPACT/FINANCING

The total aggregate cost to extend the 10 existing INN 2 contracts, including the Consultant Services Contract with UCSD, is $29,550,000, funded by the 1991 Realignment and/or MHSA revenue.

The FY 2022-23 MHSA Annual Update is pending Board approval and includes funding for these contracts. MHSA is the preferred funding source for these contracts; however, if there are delays with the approval of the MHSA Annual Update, the 1991 Realignment revenue will be used to fund these contracts to ensure the continuation of these services. Funding for these contracts will be included in the FY 2022-23 Final Changes Budget.

Funding for future fiscal years will be requested through DMH's annual budget process.

There is no net County cost impact associated with the recommendation actions.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

In August and September of 2018, DMH executed nine contracts for the provision of INN 2 services and one Consultant Services Contract with UCSD for evaluation services of the INN 2 program, respectively. DMH is in the process of developing a new solicitation for the purpose of executing new Community Ambassador Network (CAN) contracts, and in the interim, it is in the best interest of the County to continue to fund the existing INN 2 contracts so that the delivery of services under these contracts is not disrupted.

The focus of the INN 2 program is to increase awareness and understanding of trauma and providing available supports to strengthen trauma-resiliency within communities. The nine INN 2 contractors, in coordination with community partners, implemented capacity building strategies that utilized innovative outreach approaches while addressing other important issues such as oppression, job loss, and other stressors brought on by system inequities and the COVID-19 pandemic.

At the on-set of the pandemic, DMH expanded the INN 2 program by utilizing time-limited Coronavirus Aid, Relief, & Economic Security (CARES) Act funding to support the nine contractors with COVID-19 education and community outreach. This expansion of the INN 2 program established the CAN, which allowed DMH to increase our behavioral health workforce across each Supervisorial District by hiring and training peers to serve as "Community Ambassadors" (CA). The CAs focused on delivering services in communities where there were disproportionate levels of poverty, and high concentrations of unserved and underserved individuals with poor health and well-being outcomes.

Specifically, the CAN leveraged existing networks of trusted community-based providers established under the INN 2 program to focus primarily on promoting community wellness and increasing awareness of available COVID-19 resources and supports. From the onset of the pandemic until December 2021, the CAN reached almost 560,268 community members by providing 18,000 meals to LA County residents and 14,000 personal protective equipment kits. In addition, 93.4% of all referrals made by CAs were documented as successful linkages for food, education, and/or housing. CAN participants also reported feeling more connected with their communities and feeling more resilient nine months after their participation in the program.

UCSD has been providing INN 2 evaluation services since the inception of the INN 2 program. UCSD not only conducts the program evaluation of each INN 2 contractor, but has also established the methodology for the evaluation. The evaluation is focused on the impact of each contractor's ability to prevent and address trauma, but also to invariably identify geographically-defined community partnerships that are successful and self-sustaining. Currently, UCSD maintains a secure database and a web-based application, Innovation Health Outcomes Management System, that allows the contractors and community-based organizations to enter systems-level and individual-level outcomes data at multiple sites. Automated reports are then generated from the data provided which are then regularly provided to DMH so that DMH can monitor the effectiveness of the INN 2 program. As such, the continuation of the INN 2 program evaluation is imperative to continue providing community-based services and supports to promote healing, recovery, and community empowerment.

On March 24, 2022, DMH notified your Board of its intent to execute Sole Source Contract extensions with the nine contractors (Attachment II) currently providing INN 2 services and the Consultant Services Contract with UCSD, and DMH considers this request approved, as we did not hear otherwise. The required Sole Source Checklist (Attachment V) approved by the CEO is also attached.

As mandated by your Board, the performance of all contractors is evaluated by DMH on an annual basis to ensure that the nine contractors listed in Attachment II, and UCSD as

the Consultant Services Contractor, are in compliance with all contract terms and performance standards.

Attachment I, the amendment to the existing nine INN 2 contracts, has been approved as to form by County Counsel.

Attachment II is the list of the existing nine INN 2 contractors.

Attachment III, the amendment to the existing Consultant Services Contract with UCSD, has been approved as to form by County Counsel.

Attachment IV is the March 24, 2022 – Advance Board Notification.

Attachment V is the Sole Source Checklist.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board approval of the recommended actions will enable DMH to support and expand the CAN program by ensuring marginalized communities receive the following services and linkages: 1) access to emotional support, and 2) psycho-education on issues such as trauma recovery, positive/healthy parenting skills, homelessness, and recidivism.

Respectfully submitted,

JONATHAN E. SHERIN, M.D., Ph.D.
Director

JES:GCP:SK
RLR:ZW:atm

Attachments (5)

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

ATTACHMENT I

CONTRACT NO. MHXXXXXX

AMENDMENT NO. ___

THIS AMENDMENT is made and entered into this ___ day of _____, 2022, by and between the COUNTY OF LOS ANGELES (hereafter "County") and _____ (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled "Mental Health Services Act (MHSA) Innovation (INN) 2 Trauma Resilient Communities: Community Capacity Building Contract", dated August 14, 2018 or September 18, 2018 (only MHALA and Children's Clinic), and further identified as County Contract No. MH _____, and any amendments thereto (hereafter collectively "Contract"); and

WHEREAS, on_____, the County Board of Supervisors authorized the Department of Mental Health (DMH) Director, or designee, to execute amendments to the Contract to extend the term, modify the Statement of Work (SOW), and increase the TCA; and

WHEREAS, County and Contractor intend to amend the Contract to extend the term of the Contract, and revise Exhibit A-4 (SOW - MHSA INN 2 Trauma Resilient Communities: Community Capacity Building), and increase INN 2 Program funds for expansion of the INN 2 Program; and

WHEREAS, as the result of the above changes, the Total Contract Amount (TCA) will increase; and

WHEREAS, said Contract provides that changes may be made in the form of a written amendment which is formally approved and executed by the Parties; and

WHEREAS, Contractor warrants that it continues to possess the competence, expertise, and personnel necessary to provide services consistent with the requirements of this Contract, and consistent with the professional standard of care for these services.

NOW, THEREFORE, County and Contractor agree as follows:

1. The Amendment is effective upon execution for the period beginning July 1, 2022.

2. Paragraph 4.0 (TERM) subsection 4.1 of the Contract is deleted in its entirety and replaced as follows:

"4.1. The term of this Contract shall commence on August 14, 2018 or September 18, 2018 (for MHALA and Children's Clinic), and shall continue in full force and effect through June 30, 2023, unless either party desires to terminate this Contract in accordance with provision 8.42 (Termination for Convenience).

4.1.1 The County shall have the sole option to extend this Contract term for an additional year, for a maximum total Contract term of six years. Such extension option may be exercised at the sole discretion of the Director of Mental Health (Director) or his designee as authorized by the Board of Supervisors.

4.1.2 The County maintains databases that track/monitor contractor performance history. Information entered into such databases may be used for a variety of purposes, including determining whether the County will exercise a contract term extension option".

3. Paragraph 5 (CONTRACT SUM) subsection 5.1 (Total Contract Amount) of the Contract shall be deleted in its entirety and replaced with the following:

"5.1 **Total Contract Sum**

5.1.1 In consideration of the performance by Contractor in a manner satisfactory to County of the services described in Exhibit A (SOW) and Exhibit B (Service Exhibits), Contractor shall be paid in accordance with the guidelines established in Exhibit C (CSS SOW). Total Compensation for all services furnished hereunder shall not exceed the total contract amount (TCA) of _____ **($XXXX)** for the contract term commencing on August 14, 2018 (Or September 18, 2018) through June 30, 2023".

4. For FY 2022-23 only, 1991 Realignment and/or Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funds shall be added in the amount of **$2,855,000 DOLLARS**, pending Board approval of the FY 2022-23 MHSA Annual Update which includes the MHSA funding for this Contract. *(For Westside Infant Family, the amount is $5,710,000)*

5. Exhibit A-5 (SOW), attached hereto and incorporated herein by reference, shall be added to the Contract.

6. Except as provided in this amendment, all other terms and conditions of the Contract shall remain in full force and effect.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be subscribed by the County's Director of Mental Health or 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_____
JONATHAN E. SHERIN, M.D., Ph.D.

_____
CONTRACTOR

By _____

Name _____

Title _____
(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL

By: Emily D. Issa
Deputy County Counsel

EXHIBIT A - 5

STATEMENT OF WORK (SOW)

MHSA INNOVATIONS 2 - COMMUNITY AMBASSADOR NETWORK TRAUMA RESILIENT COMMUNITIES: COMMUNITY CAPACITY BUILDING

TABLE OF CONTENTS

STATEMENT OF WORK (SOW)

1.0 SCOPE OF WORK

1.1 OVERVIEW

The County of Los Angeles (County or LAC) Department of Mental Health (DMH) Innovations 2 (INN 2) - Community Ambassador Network (CAN) Project centers on the creation and implementation of place-based community partnerships within geographically-defined communities (referred to subsequently as communities) as a method to support distinct communities to create the collective will to employ various strategies for people of diverse ages to decrease the risk of or reduce the degree of trauma experienced by community members at risk of or with a potentially serious mental illness or serious emotional disturbance.

The INN 2 – CAN project proposed here is the use of asset-based community capacity building approaches within communities to identify, educate and support members of the community who are at risk of or experiencing trauma and resulting mental illness.

INN 2 - CAN has five (5) key components:

1. It assumes there is a reciprocal inter-connectedness between the community's health and wellbeing and that of individual community members, so it promotes the community's wellness as a way to improve the health and well-being of individual members.

2. It draws upon research on the social determinants of health, which finds that health status is heavily mediated by socioeconomic status so that communities with greater levels of poverty tend to have members who are more disconnected from community supports and services, with fewer health resources and poorer health.

3. It deploys a set of upstream strategies to address the social determinants or root causes of mental illness, namely the trauma experienced by different age groups within a specific community.

4. It actively develops partnerships to engage communities and service systems, building on the learning of Innovation 1 Integrated Care Model outcomes.

5. It builds the community's capacity to take collective ownership and coordinated action to prevent or reduce the incidence of trauma-related mental illness by involving communities, utilizing the INN 2 - CAN in promoting the health and well-being of their members.

1.1.1 COMMITMENTS

Lead agencies must make the following commitments:

- Active participation in the local Service Area Leadership Team (SALT), including providing updates to the SALT and incorporating feedback from the SALT to enhance community capacity building effectiveness.
- Promote community inclusion in all aspects of planning and implementation, including family members, consumers, and key community stakeholders
- Hire ethnically and linguistically diverse staff to function as INN 2 - Community Ambassadors (CA) reflective of the community and the participants being served
- Engage, develop, and empower community leadership and community decision-making
- Build the capacity of the community to sustain leadership and community support for trauma reduction after funding concludes
- Create partnerships that strengthen community knowledge, connectedness, and collective action to reduce trauma and its impact
- Collect specific outcome data as required by the conditions of agreement. This includes collecting outcome data to assess the provider's program design and implementation and the commitment to making mid-course corrections, such as the INN 2 - CAN staffing, as necessary to insure the achievement of positive participant, program, and community level outcomes.

1.1.2 CLAIMING

Claiming for services will be through Mode 60 and Service Function Codes:

<u>Mode 60 - Support Services</u>

- Service Function Code 70- Participant Housing Support Expenditures- funding housing supports including master leases, motel and other temporary housing vouchers, rental security deposits, first and last month's rent and other fiscal housing supports.
- <u>Service Function Code 71</u> – Client Housing Operating Support - the cost of supports to clients, family members and caregivers for credit reports, utilities, cable, internet, etc.

- Service Function Code 72 - Participant Flexible Support Expenditures- the cost of supports to participants, family members and caregivers for daily living, travel, transportation, respite services and other supports.

- Service Function Code 75 - Non-Medi-Cal Assets, including the purchase or lease of vehicles or building rehabilitation for service delivery.

- Service Function Code 78 - Other Non-Medi-Cal Participant Support Expenditures, including the cost of salaries, benefits and related general operating expenditures incurred in providing Non-Medi-Cal supports not otherwise reported in treatment or outreach programs. Units of Service may not be reported for SFC 78.

Funding may be used for the provision of additional specialty mental health services under the following circumstances:

- When capacity does not exist within the agreement of existing DMH-funded Specialty Mental Health providers to serve individuals being referred for Specialty Mental Health Services within the boundaries of the defined proposed community.

- When current DMH-funded Specialty Mental Health Providers do not have capacity to serve an increase in specific cultural or ethnic groups that require Specialty Mental Health Services.
- Should DMH approve a request for the use of funds for mental health services that meets the criteria above, existing Specialty Mental Health contracted providers who receive these funds will not receive any additional Medi-Cal in the form of Federal Financial Participation (FFP) or Early Periodic Screening, Diagnosis and Treatment (EPSDT) by LACDMH.

A Contractor who wishes to fund additional specialty mental health services that meet the above criteria must seek prior approval in writing from DMH.

If it is determined that INN 2 - CAN program is not meeting desirable expected outcome expectations the County may terminate the contract in accordance with the contract's termination provisions. DMH will monitor the program and, at its sole discretion, require changes be made to the program's elements and/or services or terminate the Contract in accordance with Section 8, subparagraph 8.42 Termination for Convenience.

1.2 INN 2 - COMMUNITY AMBASSADOR NETWORK (CAN) OVERVIEW

The INN 2 - CAN is a community outreach and empowerment effort, which would serve to both strengthen communities and create a career path for those community members interested in building their skills, impact, and income as CAs. CAs are people with lived experiences, who are trusted members of the community, trained to serve as lay mental health access agents, navigators, and mobilizers in their neighborhoods. During the COVID-19 pandemic, CAs will serve a special role of outreach into the community to provide support and referrals to services to community members directly impacted by the COVID-19 pandemic.

The INN 2 – CAN will serve the most disadvantaged and marginalized communities in Los Angeles County, including those communities disproportionately impacted by the COVID-19 pandemic. Since community members have more trusted relationships with their peers, such as CAs, they can help respond to community suffering resulting from things like oppression, job loss and other stressors brought on by systemic inequities and the COVID-19 pandemic. INN 2 - CAN CAs can help drive a collective self-help model, using the inherent strengths of the community to promote healing, recovery, and community empowerment.

The INN 2 - CAN will focus on providing services and supports to existing communities and will seek to extend services and supports to communities which have been disproportionately impacted by the COVID-19 pandemic, or that are otherwise marginalized.

2.0 ADDITION AND/OR DELETION OF FACILITIES, SPECIFIC TASKS AND/OR WORK HOURS

2.1 All changes must be made in accordance with sub-paragraph 8.1 Amendments of the Contract.

3.0 QUALITY CONTROL

The Contractor shall establish and utilize a comprehensive Quality Control Plan to assure the County the required services are provided at a consistently high level of service throughout the term of the Agreement.

4.0 QUALITY ASSURANCE PLAN

The County will evaluate the Contractor's performance under this Contract using the quality assurance procedures as defined in this Contract, Paragraph 8, Standard Terms and Conditions, Sub-paragraph 8.15, County's Quality Assurance Plan.

4.1 Mandatory Meetings

All selected lead agencies and representatives from partner agencies will be expected to attend an orientation to the project conducted by DMH at the

beginning of the project and attend mandatory meetings. DMH will provide training on key component areas of the project, as needed, throughout the life of the project.

4.2 County Observations

In addition to departmental contracting staff, other County personnel may observe performance, activities, and review documents relevant to this Contract at any time during normal business hours. However, these personnel may not unreasonably interfere with the Contractor's performance.

5.0 INTENTIONALLY OMITTED

6.0 RESPONSIBILITIES

The County's and the Contractor's responsibilities are as follows:

COUNTY

6.1 Personnel

The County will administer the Contract according to the Contract, Paragraph 6, Administration of Contract - County. Specific duties will include:

6.1.1 Monitoring the Contractor's performance in the daily operation of this Contract.

6.1.2 Providing direction to the Contractor in areas relating to policy, information, and procedural requirements.

6.1.3 Preparing Amendments in accordance with the Contract, Paragraph 8, Standard Terms and Conditions, Sub-paragraph 8.1 Amendments.

CONTRACTOR

6.2 Lead Agency Project Manager

6.2.1 Contractor shall provide a full-time Lead Agency Project Manager or designated alternate. The County must have access to the Lead Agency Project Manager during regular business hours. Contractor shall provide a telephone number where the Lead Agency Project Manager may be reached during normal business hours, Monday through Friday.

6.2.2 Lead Agency Project Manager shall act as a central point of contact with the County.

6.2.3 Lead Agency Project Manager/alternate shall have full authority to act for Contractor on all matters relating to the daily operation of the Contract. Project Manager/alternate shall be able to effectively communicate, in English, both orally and in writing.

6.3 Identification

6.3.1 Contractor shall ensure their employees and employees of partner organizations identify themselves to the public appropriately as set forth in sub-paragraph 7.3 – Contractor's Staff Identification, of the Contract.

6.4 Materials and Equipment

The purchase of all materials/equipment to provide the needed services is the responsibility of the Contractor. Contractor shall use materials and equipment that are safe for the environment and safe for use by the employee.

7.0 INTENTIONALLY OMITTED

8.0 INTENTIONALLY OMITTED

9.0 INTENTIONALLY OMITTED

10.0 SPECIFIC WORK REQUIREMENTS

Contractor must demonstrate the ability to provide, and provide a full array of services described in this SOW. Lead agencies and their partners will be responsible for providing the following services:

10.1 GENERAL LEAD AGENCY EXPECTATIONS

10.1.1 Partnership Development and Coalition Building

10.1.1.1 Contractor will establish a coalition of agencies, groups and/or organizations with identified roles, expectations, and in-kind resources and/or support contributed or provided in-kind that tie to the strategies identified as part of INN 2- CAN and the goals of this project.

10.1.1.2 Contractor will have the social capital or community influence that will create influence and collective will and action in the proposed community in service of the goals of this project.

10.1.1.3 Contractor will have experience leading community change efforts through partnership development and coalition building.

10.1.2 Community empowerment and leadership development

10.1.2.1 Contractor will involve the identified community in the planning, implementation, and decision-making, including establishing an advisory committee to guide decision-making and the INN 2 - CAN implementation.

10.1.2.2 Contractor to establish a connection between or among committees, coalitions and other advisory committees involved in local decision-making, including the mental health SALT.

10.1.2.3 Contractor will ensure community leadership is strengthened so that the capacity of the community to address trauma or trauma risk is sustained beyond the time-limited project.

10.1.3 Outreach, engagement, training, and technical assistance to neighborhoods

10.1.3.1 Contractor will develop a plan, with geographic community input, to create community awareness, action, and support for trauma, including trauma risk factors, and its impact on the development of mental illness and its impact on the community.

10.1.3.2 Contractor will ensure the community residents as well as organizations know how, when, and where to refer an individual for a mental health evaluation

10.1.4 Knowledge, experience and understanding of trauma and its impact

10.1.4.1 Contractor will demonstrate an understanding of trauma, risk factors of trauma, its correlates and potential causes related to the age group(s) proposed to be served.

10.1.5 Cities/geographic area Identified for inclusion

10.1.5.1 The defined geographic area will be identified, along with the rationale for inclusion of each city or boundary-defined geographic area.

10.1.5.2 The geographic area selected will be economically impoverished, including but not limited to a disproportionate level of poverty, poor health and well-being outcomes, high rates of unemployment, poor academic achievement, poor housing quality or higher risk of violence or safety concerns and will have

residents that historically have been under or unserved by the mental health system.

10.1.5.3 The geographic area selected will have a sufficient foundation of support, leadership, and civic engagement to support the development and implementation of INN 2- CAN.

10.1.6 Coordination of work with local health neighborhood and mental health initiatives

10.1.6.1 Contractor will ensure regular reporting of activities to the local SALT.

10.1.6.2 Contractor will ensure community planning and implementation is coordinated with any Best Start, California Endowment, California Community Foundation or other organized health neighborhood initiatives related to mental health.

10.2 SPECIFIC STRATEGIES TO BE EMPLOYED

INN 2 - CAN

10.2.1 INN 2 - CAN was incorporated into each of the seven (7) strategies identified below in Sub-Sections 10.2.2 to 10.2.7.

The role of the INN 2 - CAN is to educate, identify and link individuals to the right care at the right time by the right people. CAs will receive training on coalition building, critical race theory, social determinants of mental health, COVID-19 trauma recovery, COVID-19 testing and contract tracing, and civic participation and advocacy, including voting. The INN 2 - CAN will deliver services and create a career pathway, as illustrated below:

10.2.1.1 Contractor and Subcontractor will hire **a minimum of 20** CA(s), **six** (6) Senior INN 2 - Community Ambassadors (Sr. CA), **three** (3) Supervising INN 2 - Community Ambassadors and **one** (1) Program Manager **and/or** ensure the hiring of CAs.

10.2.1.2 Contractor will ensure that:

1. CA(s) are compensated at rate of $18.00 to $26.00 per hour up to $55,000 annually (including benefits);

2. Sr. CA(s) are compensated at a rate of $26.00 to $31.00 up to $65,000 annually (including benefits);

3. Supervising INN 2 - Community Ambassadors are compensated at a rate of $31.00 to $36.00 per hour, up to $75,000 annually (including benefits);
4. Program Manager is compensated at a rate of $36.00 to $48.00 per hour, up to $100,000 annually (including benefits);
5. CA(s) are individuals with lived experience and reside within the identified community; and
6. CA(s) are culturally representative of their designated areas.

10.2.1.3 Contractor will ensure that CAs are trained on topics including, but not limited to:

1. Community Resiliency Model (CRM):
   a. Coalition building, bringing, and keeping communities together during COVID-19;
   b. The impact of COVID-19 across different communities of color and ethnicities; and
   c. The impact of COVID-19 social determinants of mental health.
2. COVID-19 trauma recovery.
3. COVID-19 testing as well as contact tracing; and
4. Civic participation and advocacy, including voting during COVID-19.
5. Community support services and the process for linking individuals to the appropriate services to address their needs.

10.2.1.4 Contractor will ensure that CAs provide the following support in the designated INN 2 area and surrounding communities through the delivery of:

1. Training and/or support groups on the social determinants of Mental Health;
2. Community and individual support on trauma recovery, specifically as it pertains to COVID-19 and recent incidents of police brutality, and resulting civil unrest;
3. Community psychoeducation and support regarding COVID-19, access to testing and education around contract tracing;

4. Education and empowerment around the importance of civic participation, voting rights and mail in ballot procedures;
5. Based on available funding and community resources, referrals and linkage for rental assistance, utility costs, food, clothing, shelter, and essential needs, etc. Where resources are not available, Contractor will provide concrete supports (i.e., food assistance, household goods, PPE, diapers, and other necessities of life, utility, and rental assistance, etc.) in the above areas. These supports can be made available to individuals experiencing financial hardships due to COVID-19; and
6. Linkage to ongoing needed supports and services, including, but not limited to mental health, health, housing, and employment.

10.2.1.5 Through the introduction and development of the INN 2 - CAN, a non-traditional outreach and engagement practice, Contractor will ensure that the communities demonstrate a(n):

1. Increase in positive social connections by providing supports and services during the COVID-19 pandemic;
2. Increase in the delivery of linkage and utilization of mental health and other services (i.e., health, employment, and housing) for community members exposed to trauma; and
3. Decrease in the overall negative impact of community trauma from COVID-19 after receiving trainings around: (1) COVID-19 virus, (2) social injustice, (3) COVID-19 testing, (4) COVID-19 contact tracing, (5) voting rights and (6) the social determinants of mental health.

10.2.1.6 Contractor will ensure the following outcomes for INN 2 - CAN:

1. Community members served in INN 2 - CAN will be tested pre- and post- assistance to measure their understanding of the impacts of the COVID-19 pandemic.
2. Community members who are educated, trained, and supported by INN 2 - CAN will have a better

understanding of community trauma and will work together to heal and support their communities.

3. Community members will be surveyed to measure whether there was an increase their voting and civic participation.
4. At-risk community members who may have experienced historical and recent trauma (due to COVID-19) will receive the necessary referrals for mental health, health, COVID-19 testing, employment, housing, and/or other supports and services.

10.2.2 STRATEGY 1 - BUILDING TRAUMA-RESILIENT FAMILIES

Age Group(s) of Focus: 0-5 (including activities involving Transition Age Youth (TAY) and Older Adults)

Trauma to be addressed: Complex Childhood and Family Trauma

To provide developmentally appropriate activities designed to reduce the impact of complex trauma (i.e., children exposed to domestic violence, physical abuse, sexual abuse, neglect, traumatic grief and other traumas and adverse childhood experiences including social isolation and disrupted relationships such as removal from a caregiver's care and entering the foster care system) experienced by children and families residing in communities where poverty and other early life stressors and forms of violence negatively impact child development. Building Trauma Resilient Families will target children ages birth to five and their caregivers who have experienced trauma and/or are at risk for trauma. Corresponding activities will be designed to enhance parent/caregiver knowledge of child development and socio-emotional literacy, promote positive social skills in children, and facilitate access to needed natural social support networks and resources. Children and families who are identified as needing more intensive mental health and/or family support services will be referred to affiliated agencies. Families and young children will be assessed for their exposure to Adverse Childhood Experiences (ACES). Community partners (i.e., the Faith-based collaborative network and/or Early Care and Education Network) will be trained on the importance of screening for ACES and how to refer families for Prevention and Early Intervention services and existing birth to five Evidenced Based Practices (EBPs).

The activities will educate the community partners (i.e., the existing faith-based network and/or Early Care and Education members) about the impact and sequelae/consequences of trauma and ways to adapt their settings to be more trauma-informed to enhance the healing process and recovery for families of traumatized young children.

The Building Trauma Resilient Families location will be an existing space in the community donated from a network partner. Examples of network partners include faith-based providers and/or Early Care and Education providers with whom the lead agency has an existing affiliation/collaborative relationship.

Staffing

The key staff who will be designing and/or implementing strategy 1 activities will be qualified child development specialists with appropriate experience and possibly certification in providing play and activity-based parent/caregiver education programs in community-based settings. They will co-facilitate the activities with trained INN 2 - CAN (e.g., parent partners, etc.) who are also community residents and can further provide ongoing INN 2 - CAN support to the participants.

Key Learning Questions:

1. Would increasing positive social connections decrease the negative impacts of trauma for children and their families at risk of developing a serious emotional disturbance?
2. Would increasing positive social connections increase positive coping strategies for children and families to deal with trauma?
3. Would increasing positive social connections by providing non-traditional outreach and engagement practices from the INN 2 - CAN enhance utilization of mental health services for at-risk children and their families who are exposed to trauma?

Intended Outcomes:

1. Children and families served will demonstrate an increased use of positive coping strategies to reduce the impact of trauma.
2. Social isolation reported by parents or caregivers and children will decrease.
3. At-risk children with trauma symptoms who have been underserved will receive referrals to mental health treatment/systems when necessary (improve mental health access for children in underserved at risk communities).

10.2.3 STRATEGY 2 - Trauma-Informed Psychoeducation and Support for School Communities.

Age Group(s) of Focus: 3-15

Trauma to be addressed: Community Violence & Child Abuse (exposure to domestic violence, physical abuse, emotional abuse, and sexual abuse)

In this model, training/workshops on recognizing behaviors and symptoms of stress and trauma in children will be provided to early care/education (EC/E) and school personnel and community mentors who work with children ages 3-15. The workshops will also teach simple trauma-informed coping techniques (attunement skills, self-regulation, affect management, mindfulness, meditation, breathing, etc.) that can be implemented within EC/E and school settings to reduce stress experienced by children.

Key Learning Questions:

1. Would increasing training for EC/E and school personnel and community mentors around trauma needs of children decrease the negative impacts of trauma for children and their families.

2. Would EC/E and school personnel and community mentors modeling and promoting simple coping skills in EC/E and school settings improve children's academic performance?

3. Would trauma-informed training and support for EC/E and school personnel and community mentors enable identification of trauma and mental health needs in previously unserved or underserved children who have experienced trauma?

Intended Outcomes:

- Reduction of stress experienced by children/students served by the participating EC/E programs/agencies and schools as indicated by improved attendance and reduction in suspension and expulsion rates.

- Increased referrals & linkages of identified at-risk students with trauma symptoms and their family members to needed mental health and trauma-informed services.

- Reduction of stress experienced by participating EC/E program/agency and school staff as indicated by decreased sick days and staff turnover and a decrease in compassion fatigue/vicarious trauma scores on corresponding validated measures, administered at both pre & post-intervention.

10.2.4 STRATEGY 3 - Transition Age Youth (TAY) Support Network

Age Group(s) of Focus: Current or formerly homeless TAY (18-25 years old) who are emotionally and physically vulnerable and are at risk of or are experiencing trauma due to the circumstances that led to homelessness and/or the experience of being homeless.

Trauma to be addressed: The TAY developmental period is marked by identity and close relationship formation, which provide the foundation for future adult interactions and behaviors. Many current and formerly homeless TAY lack the protective factor of social connectedness that resulted from their experiencing traumas of: rejection by family, peers, and systems; of being abused; of poverty; of racism; and of stigmatization. Current and formerly homeless TAY who lack the protective factor of social connectedness to effectively manage trauma are at an increased risk of developing or worsening a mental illness as a result of their engaging in maladaptive behaviors (such as substance use, social isolation, and other destructive behaviors) that results in negative outcomes, such as, jeopardizing their current housing placement, continued homelessness due to their maladaptive behaviors preventing them from obtaining housing, and becoming victimized.

Certain populations of TAY are at higher risk of experiencing homelessness such as: TAY from different ethnic/cultural groups who experience racism, poverty, former gang involvement, history of drug and alcohol abuse, or other negative social circumstances; LGBTQ TAY who experience bullying and/or stigmatization as it relates to the coming out process and identifying as LGBTQ; TAY who are physically, verbally, and sexually abused, including victims of Commercial Sex Trafficking; and TAY formerly involved with and now aging out of the dependency/juvenile justice service provider system.

This strategy seeks to implement a TAY INN 2 - CAN that will be convened and led by the lead agency. The lead agency will bring together their community partners, including various housing providers, and employ TAY INN 2 - CAN to: provide settings and opportunities for current and formerly homeless TAY to develop the protective factor of social connectedness; build community capacity to identify and make available housing resources, including rental assistance and housing subsidies; and provide peer relationship-focused outreach and engagement to encourage positive social connectedness with the TAY Support Network and to link them with resources and supports to obtain and/or maintain housing. The TAY INN 2 - CAN will meet monthly within the community to organize and coordinate the resources of

the community partners for current and formerly homeless TAY. In contrast to a traditional fixed-location Youth Drop-In Center, outreach and engagement will be conducted by the TAY INN 2 - CAN and will incorporate non-traditional approaches, such as the utilization of social media and other technological strategies, providing services out in the field, and seeking to connect TAY to the resources of the TAY INN 2 - CAN. The TAY INN 2 - CAN, including the TAY Peers will receive training, such as Mental Health First Aid and other trainings focused on recognizing mental illness, in identifying symptoms related to trauma and mental illness, using safe and appropriate crisis engagement techniques to connect TAY as needed.

Logic Model for Change: Increase and develop the protective factor of social connectedness to identify and provide supportive settings that encourage social connectedness among each other and with community-based organizations and service providers to current and formerly homeless TAY who have experienced the traumas of: rejection by family, peers, and systems; of being abused; of poverty; of racism; and of stigmatization, which has led to homelessness as a consequence of maladaptive coping mechanisms.

Key Learning Questions:

1. Can a community capacity building approach that provides current and formerly homeless TAY who are at risk of or are experiencing trauma due to the circumstances that led to homelessness and/or the experience of being homeless with safe and confidential pathways to connect with other TAY, INN 2 - CAN community services and social supports utilizing non-traditional outreach, engagement practices, and peer support increase positive social connections for those at risk of or with a mental illness?

2. Would increasing positive social connections decrease the negative impact(s) of trauma for emotionally and physically vulnerable TAY?

3. Would increasing positive social connections increase positive coping strategies for current and formerly homeless TAY to deal with trauma?

4. Would increasing positive social connections by providing INN 2 - CAN non-traditional outreach, engagement practices, and INN 2 - CAN support increase utilization of mental health services for SED/SPMI TAY and those emotionally and physically vulnerable TAY who are at high risk of first-break psychosis and developing major mental health issues?

Intended Outcomes:

1. Social isolation/withdrawal and negative social connections will decrease for current and formerly homeless TAY who are at risk of or experiencing trauma and mental illness will decrease over the course of INN 2 - CAN engagement and supports provided.

2. Emotionally and physically vulnerable TAY will demonstrate increased positive coping strategies to reduce the negative impact of trauma which has led to homelessness and/or puts TAY at risk of losing their current housing placement.

3. Through the utilization of positive coping strategies that increase social connectedness (and the decrease of maladaptive strategies), current and former homeless TAY will be able to secure housing and/or maintain their current housing placement.

4. Decreased trauma symptoms for at risk TAY.

5. On average, current and formerly homeless TAY with a mental illness and are at risk of or are experiencing trauma who are referred to the Specialty Mental Health system will have a reduced duration of untreated mental illness, compared to a sample of TAY receiving mental health services from providers not associated with project.

10.2.5 STRATEGY 4 - COORDINATED EMPLOYMENT WITHIN A COMMUNITY

This strategy aims to create a network of businesses within a specific community that will provide employment opportunities to individuals who are mentally ill and homeless/formally homeless. Employment opportunities will be sought out in the competitive employment market and through the development of social enterprises within the neighborhood. A standardized employment assessment tool and a coordinated, systematic approach will be used to match the individuals to the employment opportunities that the network of businesses provides. The current Coordinated Entry System that has been developed across the County to match individuals who are homeless to housing will be leveraged to target those individuals that have obtained permanent housing and to match individuals to employment. Supportive services to help individuals apply for and obtain and retain employment will be provided to each participant and will include INN 2 - CAN led service providers and support groups.

Age Group(s) of Focus: TAY, Adults, Older Adults with employment goals.

Trauma to be addressed: The trauma association with being homeless, including emotional and physical vulnerability, social isolation and stigma that results from being an individual who is mentally ill and homeless/formally homeless. Common traumatic experiences for this population include physical violence, stigma of mental illness and homelessness, victimization, poverty, loss of home, safety, and sense of security, and being unable to meet basic needs of food and shelter.

Key Learning Questions:

1. Can creating a network of businesses within a specific community that provide jobs to individuals who are mentally ill and homeless/formally homeless reduce the social isolation and related trauma they experience by providing them with opportunities to develop relationships with those with whom they work and by utilizing INN 2 - CAN and natural supports within the community and community infrastructure to promote health and well-being?

Intended Outcomes:

An increased sense of well-being and self-sufficiency, increased integration into and connection with the community for individuals employed, increase in individual income and a reduction in poverty and reduction in the use of public resources including SSI and Medi-Cal because of income and health insurance through employment.

10.2.6 STRATEGY 5 - COMMUNITY INTEGRATION FOR INDIVIDUALS WITH A MENTAL ILLNESS WITH RECENT INCARCERATIONS OR WHO WERE DIVERTED FROM THE CRIMINAL JUSTICE SYSTEM

Age Group(s) of Focus: TAY, Adults, Older Adults

Trauma to be Addressed: Individuals with a mental illness and histories of incarcerations often have extensive histories of trauma that are re-activated after release from jail by lack of pro-social community supports, high risk housing and substance use. The trauma correlates addressed in this strategy are social isolation and stigma.

This strategy will capitalize on knowledge and networking of community groups dedicated to community reintegration for incarcerated or diverted individuals. This strategy proposes a

consortium be established, including INN 2 - CAN, to act as a community body to facilitate community reintegration, including providing support for the implementation of this strategy. An existing group may be used if their mission and vision align with the project and meets performance expectations.

Key Learning Questions:

1. Can an established community consortium, with INN 2 - CAN, affect the capacity for a community to welcome individuals with a history of mental illness and incarceration and/or diversion?

2. Will training for judicial team members, mental health providers and law enforcement personnel lead to an improved experience with law enforcement and the court, and improved access to care?

3. Will improved coordination and communication result in increased linkage and improved outcomes for individuals with recent incarceration/diversion and mental illness?

4. Will focused efforts to establish housing for individuals with recent incarceration/diversion and mental illness reduce homelessness?

5. Do targeted self-help support groups reduce re-incarceration?

Intended Outcomes:

This strategy, through smaller focused projects, is designed to:

1. At the community level, reduced stigma in the judicial system, law enforcement, and the community, measured over the course of the project.

2. Increase housing for individuals with a recent history of incarceration and mental illness, measured through the establishment of housing benchmarks.

3. Increase successful linkages from incarceration or diversion to mental health services in the community.

4. Reduce re-incarcerations, sampling participant incarceration rates prior to implementation of this strategy vs. after implementation.

10.2.7 STRATEGY 6 - GERIATRIC EMPOWERMENT MODEL (GEM) PROGRAM

Age Group of Focus: Older Adults (60 years old and above)

Trauma to be addressed: Literature shows that while there is a perception that homelessness is the result of poverty or a lack of benefits and support, traumatic events such as physical, sexual, financial, and emotional abuse are traumatic. Trauma is often the root cause of homelessness and combined with the multitude of losses associated with being homeless, individuals often can lose any semblance of hope. Homelessness itself can then lead to further trauma, particularly among those with severe and persistent mental illness. Being homeless exposes an individual to high-risk situations on an almost constant basis, including physical or sexual assault, either to themselves or as a witness. For those who are older adults, the trauma is further compounded. Their age, combined with multiple medical conditions, reduced mobility, and physical frailty, leaves a homeless older adult at enormous risk for violence and becoming victimized.

Older Adults experiencing the trauma of homelessness are living with a multitude of losses, including isolation and stigma within the larger community. Additionally, there is the daily risk of violence and becoming victimized. Homeless older adults (60+) with mental illness represent one of the most vulnerable populations at risk for harm. This is in part due to advanced age, multiple medical conditions, reduced mobility, and physical frailty. Homeless shelters that do not address the unique needs of older adults are not optimal settings for the homeless older adult. Services and programs in these locations generally have an emphasis on the needs of younger homeless individuals and/or families. The noise and activity level may be overwhelming to an older adult. The physical structure of the setting is not consistent with the mobility needs of the older adult, and staff generally does not have the skillset and knowledge for working with older adults with a mental illness. There's a compelling need for a safe environment for older adults, which would include a place for them to visit daily to rest and shower, eat a meal, wash their clothes, receive screenings to identify immediate health, substance abuse and mental health needs and receive housing support.

On the other end, there are the community concerns from stakeholders such as business owners, homeowners, and other residents as to how to address the problem of individuals sleeping in front of their business or residence. These community members may not be informed of the multiple factors that bring about homelessness and may not understand how to effectively communicate with the homeless older adult or be aware of the community resources that are available to assist, other than to call the police. Community collaboratives can empower the community to address its own homeless needs by creating

innovative strategies such as this proposal, the Geriatric Empowerment Model (GEM) program.

GEM will offer three program components: (1) provide information and education on developing effective communication strategies to community residents and stakeholders on best practices for interacting with homeless older adults; (2) establish a homeless senior center for seniors to access during the day that offers a range of support and mental health services; and (3) linkage to mental health services and supportive services including access to flex funds to address the multiple and complex psychiatric and social needs of the older adult. The agency responsible for administering GEM will be required to work collaboratively with community agencies to improve access to services and to coordinate care and to recruit and hire INN 2 - CAN to outreach, engage, and work with older adults.

Key Learning Questions:

1. Is the SEC program an effective strategy for linking homeless mentally ill Older Adults to mental health treatment and benefits?

2. What are the most effective strategies within the GEM initiative for reducing homelessness?

3. Will providing psycho-social education to community stakeholder's result in an increase of outreach and engagement efforts made by stakeholders?

Intended Outcomes:

1. Improve the likelihood of Older Adults accessing mental health services to better reduce the numbers of homeless mentally ill older adults within the proposed community.

2. Decrease homelessness by GEM participants by 60% or more.

3. Decrease in trauma symptoms after involvement in the GEM.

4. Community stakeholder knowledge and use of resources within the proposed community to engage and assist the homeless mentally ill older adult increases from baseline.

10.2.7 STRATEGY 7 - CULTURALLY COMPETENT NON-TRADITIONAL SELF-HELP ACTIVITIES FOR FAMILIES WITH MULTIPLE GENERATIONS EXPERIENCING TRAUMA

Age Group(s) of Focus: Intergenerational families

Trauma to Be Addressed: Community or societally induced trauma experienced by intergenerational families (nuclear, extended, or as defined by a family).

Community or societally induced trauma can include:

1. Collective trauma (e.g., a school shooting affects everyone in the school community) and/or

2. Historical or cumulative trauma occurring over time (e.g., refugees escaping genocide from their countries of origin).

These self-help activities will be led by INN 2 - CAN, who are well versed in the multi-faceted needs of intergenerational families in each of the targeted geographic communities. The self-help activities listed below, will promote healing and reconnection by identifying and accessing inherent strengths within intergenerational families and communities. As a result, there will be a reduction in maladaptive behaviors, emotional and relational disturbances, and severe psychological symptoms related to collective, historical, or cumulative trauma. This strategy involves the implementation of three (3) distinct phases of work:

1) Culturally Appropriate Outreach, Education and Engagement (OEE)

2) Culturally Appropriate Intergenerational Family Wellness Screening

3) Intergenerational Family Healing Activities

Learning Questions:

1. Can culturally relevant INN 2 - CAN non-traditional self-help activities and groups improve the ability of the neighborhood or community to reduce the impact of trauma on intergenerational families?

2. Will family focused social connections increase positive coping strategies for intergenerational families with trauma-related mental illness or who are at risk of developing trauma-related mental illness?

Intended Outcomes:

1. Increased sense of social connectedness for intergenerational families participating in the culturally relevant INN 2 - CAN non-traditional self-help activities and groups.

2. Increased ability to cope with trauma as reported by intergenerational families.

3. Shame and stigma related to trauma and mental illness will be reduced as reported by intergenerational families.

4. A greater percentage of individuals referred to the Specialty Mental Health system as compared to an ethnically matched sample from a non-program community (increased MH service penetration).

11.0 GREEN INITIATIVES

11.1 Contractor shall use reasonable efforts to initiate "green" practices for environmental and energy conservation benefits.

11.2 Contractor shall notify DMH of Contractor's new green initiatives prior to the contract commencement.

12.0 PERFORMANCE REQUIREMENTS

12.1 CONSUMER OUTCOMES

All participating lead agencies and their community partners will be required to collect and report specific system and participant level 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 Contract. The following general participant outcomes are identified for INN 2-CAN:

OUTCOMES	MEASURE OF SUCCESS
INN-2 community members served by INN 2 - CAN will be tested pre- and post- assistance to measure their understanding of the impact of COVID-19 and community trauma.	Surveys will be administered to participants at the beginning and the end of COVID-19 trainings to measure an increased knowledge around available resources, testing, and understanding of COVID and safety measures with the goal of participants reporting an overall increase in the knowledge of COVID-19.
At-risk community members who may have experienced historical and recent trauma (due to COVID-19) will receive the necessary referrals for mental health, health, COVID-19 testing, employment, housing, and/or other supports and services.	100% of community members will receive the necessary referrals as evidenced by the input entered into the IHOM data system.

OUTCOMES	MEASURE OF SUCCESS
Reduced trauma of program participants	20% or greater reduction in trauma symptoms as measured by an age-appropriate trauma measure prior to and at the end of participation in a service strategy.
Participants, as well as the overall community will have an increased knowledge of the symptoms of trauma as well as when and how to seek mental health services	Survey administered in each community at the beginning of the project and minimally in year 4 of the project. Expect to see increases in knowledge of trauma projected and an increase in knowledge of how and when to seek mental health services projected.
Improved service participant perception of connection to one's community	Survey administered to participants at the beginning of service and at the end of service with success measured as increased connection to one's community. 50% of participants will report increased community connection.
Decreased individual and community stigma of mental illness	Stigma survey administered in each community at the beginning of the project and minimally in year 4 of the project, with an anticipated overall reduction in community stigma of mental illness. Individual or internalized self-stigma will be measured through random sampling of program participants at a frequency to be determined by DMH and the evaluator. Expected overall reduction to individual stigma related to mental illness.
Increased emotional well-being of program participants.	Well-being measure administered at the beginning of program participation and at the end with success deemed as clinically and/or statistically significant improvement well-being
Increased participation in community activities and events	At least 50% of service recipients will report increased participation in one's community. Methodology to be determined by DMH and evaluator with community/stakeholder input.
Reduced social isolation will be reported by service participants	60% of participants report decreased social isolation as a result of program participation.
Participant satisfaction with services	95% of participants will report satisfaction with HN services received.

12.2 PERFORMANCE-BASED CRITERIA

The Agreement will include five (5) Performance-Based Criteria measuring the Contractor's operational performance, indicative of quality program administration. These criteria are consistent with the MHSA Plan learning questions. These measures assess the agency's ability to provide required services and monitor the quality of those services.

12.2.1 COLLABORATION

The Contractor 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 an agreement amendment.

12.2.2 SCHEDULED MONITORING

Contractor 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 Contractor's adherence to the performance-based criteria will be evaluated.

12.2.3 PERFORMANCE-BASED CRITERIA

PERFORMANCE-BASED CRITERIA	METHOD OF DATA COLLECTION	PERFORMANCE TARGETS
1. Successfully establish agency partnerships	Assessment conducted of partnership strength and impact on community, methodology and tools to be determined by DMH and evaluator, with community input.	In each proposed community, 100% of partnerships sustained through life of project
2. Each geographic community is able to identify, serve and support individuals at risk of or experiencing trauma	Each community's partnerships related to each strategy implemented will be assessed for effectiveness in identifying, serving and supporting those at risk of or experiencing trauma. Methodology to be developed by DMH and the evaluator, with community and stakeholder involvement.	Performance targets for each strategy through consultation with the evaluator and informed by a community stakeholder group.
3. Community leadership related to mental health issues within each community has improved	Community capacity and leadership assessment at project implementation, compared to end of each fiscal year. While the specific methodology and instrument will be determined by DMH and evaluator with community and stakeholder input, this will be a qualitative as well as quantitative evaluation.	The qualitative approach will yield a statistically significant improvement in community leadership. Qualitative assessments will yield improved leadership with benchmarks to be co-defined with stakeholder and community input.

PERFORMANCE-BASED CRITERIA	METHOD OF DATA COLLECTION	PERFORMANCE TARGETS
4. At conclusion of project, each community is able to sustain itself without additional funding.	Qualitative review and analysis of each community at the end of each fiscal year.	A plan is developed in each community that continues the gains achieved in preventing or reducing the incidence of trauma.
5. Increased community knowledge of mental illness and trauma symptoms and impact	Telephonic or other survey administered at the beginning of the project and during the last year, with success measured as a mean increase over time.	A statistically significant increase in the number of community members surveyed who have achieved a defined level of knowledge of the signs, symptoms and impact of trauma
6. Services are culturally competent and provided in the preferred language of the participant	Cultural competence measure determined by DMH and the evaluator, with input from community stakeholders from Underrepresented Ethnic Population (UREP) workgroups.	100% of participants surveyed will report that they received services that were culturally competent and relevant and provided in the preferred language of each participant.

13.0 SUBCONTRACTING

13.1 SUBCONTRACTOR STATEMENT

The establishment of community partnerships is required under this project and can be done either through subcontracting relationships or the establishment of operational agreements or Memoranda of Understanding (MOU).

For the purpose of this project all requirements under Paragraph 8, subparagraph 8.40 (Subcontracting) will apply to subcontracts, operational agreements and/or MOU.

Each subcontract, agreement and/or MOU must be signed by the Contractor as well as the partner agency.

INNOVATION 2 - DEVELOPING TRAUMA RESILIENT COMMUNITIES: COMMUNITY CAPACITY BUILDING

STATEMENT OF WORK

FEE SCHEDULE

The total compensation to continue the Innovation 2 (INN 2) - Community Ambassador Network (CAN) services will be **$5,710,000.00 DOLLARS** for the period of July 1, 2022 through June 30, 2023.

1. Claiming for INN 2-CAN services will be through Mode 60 and the following Service Function Codes:

Mode 60 - Support Services

- Service Function Code 70 - Client Housing Support Expenditures- funding housing supports including master leases, motel and other temporary housing vouchers, rental security deposits, first and last month's rent and other fiscal housing supports.
- Service Function Code 71 – Client Housing Operating Support - the cost of supports to clients, family members and caregivers for credit reports, utilities, cable, internet, etc.
- Service Function Code 72 - Client Flexible Support Expenditures- the cost of supports to clients, family members and caregivers for daily living, travel, transportation, respite services and other supports.
- Service Function Code 75 - Non-Medi-Cal Assets, including the purchase or lease of vehicles or building rehabilitation for service delivery.
- Service Function Code 78 - Other Non-Medi-Cal Client Support Expenditures, including the cost of salaries, benefits and related general operating expenditures incurred in providing on-Medi-Cal client supports not otherwise reported in treatment or outreach programs. Units of Service may not be reported for SFC 78.

2. If it is determined that INN 2 - CAN Contractor is not meeting desirable expected outcome expectations the County may terminate the Contract in accordance with the Contract's termination provisions. DMH will monitor the INN 2 - CAN program and, at its sole discretion, require changes be made to the program's elements and/or services or terminate the Contract in accordance with Section 8, subparagraph 8.42 Termination for Convenience.

3. Invoicing parameters and guidelines are contained in Exhibit C "Client Supportive Services (CSS) for Mental Health Services Act (MHSA) Programs" Statement of Work attached to the Contract.

4. Funding may be used for the provision of additional specialty mental health services under the following circumstances:

- When capacity does not exist within the agreement of existing DMH-funded Specialty Mental Health providers to serve individuals being referred for Specialty Mental Health Services within the boundaries of the defined proposed community.
- When current DMH-funded Specialty Mental Health Providers do not have capacity to serve an increase in specific cultural or ethnic groups that require Specialty Mental Health Services.
- Should DMH approve a request for the use of INN 2 - CAN funds for mental health services that meets the criteria above, existing Specialty Mental Health contracted providers who receive these funds will not receive any additional Medi-Cal in the form of Federal Financial Participation (FFP) or Early Periodic Screening, Diagnosis and Treatment (EPSDT) by LACDMH.

5. A contractor who wishes to fund additional specialty mental health services that meet the above criteria must seek prior approval in writing from DMH.

INNOVATION 2- DEVELOPING TRAUMA RESILIENT COMMUNITIES: COMMUNITY CAPACITY BUILDING

STATEMENT OF WORK

FEE SCHEDULE

The total compensation to continue the Innovation 2 (INN 2) - Community Ambassador Network (CAN) services will be **$5,710,000.00 DOLLARS** for the period of July 1, 2022 through June 30, 2023.

1. Claiming

Claiming for INN 2-CAN services will be through Mode 60 and the following Service Function Codes:

Mode 60 - Support Services

- Service Function Code 70 - Client Housing Support Expenditures- funding housing supports including master leases, motel and other temporary housing vouchers, rental security deposits, first and last month's rent and other fiscal housing supports.
- Service Function Code 71 – Client Housing Operating Support - the cost of supports to clients, family members and caregivers for credit reports, utilities, cable, internet, etc.
- Service Function Code 72 - Client Flexible Support Expenditures- the cost of supports to clients, family members and caregivers for daily living, travel, transportation, respite services and other supports.
- Service Function Code 75 - Non-Medi-Cal Assets, including the purchase or lease of vehicles or building rehabilitation for service delivery.
- Service Function Code 78 - Other Non-Medi-Cal Client Support Expenditures, including the cost of salaries, benefits and related general operating expenditures incurred in providing on-Medi-Cal client supports not otherwise reported in treatment or outreach programs. Units of Service may not be reported for SFC 78.

2. If it is determined that INN 2-CAN Contractor is not meeting desirable expected outcome expectations the County may terminate the Contract in accordance with the Contract's termination provisions. DMH will monitor the INN 2- CAN program and, at its sole discretion, require changes be made to the program's elements and/or services or terminate the Contract in accordance with Section 8, subparagraph 8.42 Termination for Convenience.

3. Invoicing parameters and guidelines are contained in Exhibit C "Client Supportive Services (CSS) for Mental Health Services Act (MHSA) Programs" Statement of Work attached to the Contract.

4. Funding may be used for the provision of additional specialty mental health services under the following circumstances:

- When capacity does not exist within the agreement of existing DMH-funded Specialty Mental Health providers to serve individuals being referred for Specialty Mental Health Services within the boundaries of the defined proposed community.
- When current DMH-funded Specialty Mental Health Providers do not have capacity to serve an increase in specific cultural or ethnic groups that require Specialty Mental Health Services.
- Should DMH approve a request for the use of INN 2 - CAN funds for mental health services that meets the criteria above, existing Specialty Mental Health contracted providers who receive these funds will not receive any additional Medi-Cal in the form of Federal Financial Participation (FFP) or Early Periodic Screening, Diagnosis and Treatment (EPSDT) by LACDMH.

5. A contractor who wishes to fund additional specialty mental health services that meet the above criteria must seek prior approval in writing from DMH.

County of Los Angeles-Department of Mental Health-Provider Reimbursement Division
Monthly Claim for Cost Reimbursement

SPECIAL HANDLING REQUIRED

Fiscal Year 2022-23

INVOICE NUMBER: _____

MHSA-Client Supportive Services and One-Time MHSA Expenses

Funding Source Name: 1991 Realignment and/or MHSA PEI **Program:** INN 2 - COMMUNITY AMBASSADOR NETWORK

Lead Agency Name: _____
Lead Agency Mailing Address: _____
Billing Month: _____
Contract Number: _____

1. Expenditures:

1.1	A. SFC 70: Client Housing Support Expenditures		(1.1)
1.2	B. SFC 71: Client Housing Operating Support		(1.2)
1.3	C. SFC 72: Client Flexible Support Expenditures		(1.3)
1.4	D. SFC 75: Non-Medi-Cal Capital Assets (not allowed for PEI funding)		(1.4)
1.5	E. SFC 78: Other Non Medi-Cal CSS General Operating Ependitures		(1.5)
1.6	F. SFC 78: Other Non Medi-Cal CSS Staff Time Detail Expenditures		(1.6)
	Total Expenditures:	**0.00**	

2. One-Time Costs:

2.1	B. SFC 75: Non Medi-Cal Capital Assets		(2.1)
	One-time Assets >$5000 (not allowed for PEI funding)		
2.2	C. SFC 78: Other Non Medi-Cal Client Support Expenditures		(2.2)
	One-time Recruitment, Training, and Equipment <$5000		
	Total One-Time Expenditures:	**0.00**	

3. Total Expenditures **0.00** (3.0)

4. Total Award/Balance _____ (4.0)

5. Award/Balance minus Expenditures **0.00** (5.0)

6. **Current Project Balance** **0.00** (6.0)

Comments: _____

NOTE: ALL ONE-TIME REQUESTS WITHIN THE PARAMETERS OF CLIENT SUPPORTIVE SERVICES, REQUIRE THE DEPUTY AND DIRECTOR'S PRIOR APPROVAL

I hereby certify that all information contained above are services and costs eligible under the terms and conditions for reimbursement under Client Support Services and is true and correct to the best of my knowledge. All supporting documentation will be maintained in a separate file for the period specified under the provisions of the Mental Health Services Agreement - Service Agreement, Exhibit C, MHSA Programs Reimbursement Procedures, Section (3), Sub-Sections (3)(a), (3)(b), (3)(c) and (3)(d).

Signature: _____ Phone No.: _____

Title: _____ Date: _____

LAC-DMH INN 2-CAN Program Approval:

_____ _____
Approved By (signature) Date

_____ _____
Print Name Title

ATTACHMENT II

INN 2 SERVICE PROVIDERS

#	Contractor Name & Headquarter Address	Supervisorial District Service Location	Contract No.	FY 22-23 Funding Increase Amount
1	Alma Family Services 900 Corporate Center Dr., Suite 350 Monterey Park, CA 91754	1	MH250001	$2,855,000
2	Para Los Ninos 5000 Hollywood Boulevard Los Angeles, CA 90027	1	MH250002	$2,855,000
3	Children's Institute Inc. 2121 West Temple St. Los Angeles, CA 90026	1	MH250003	$2,855,000
4	Westside Infant-Family Network 5601 W. Slauson Avenue Suite #220 Los Angeles, CA 90056	2 3	MH250004	$ 2,855,000 $ 2,855,000 $ 5,710,000
5	Safe Place for Youth (fbo Community Partners) 340 Sunset Ave. Venice, CA 90291	3	MH250005	$2,855,000
6	Mental Health America of Los Angeles 200 Pine Ave. Suite 400 Long Beach, CA 90802	4	MH250009	$2,855,000
7	The Children's Clinic "Serving Children & Their Families" 701 E. 28th Street, Suite 200 Long Beach, CA 90806	4	MH250010	$2,855,000
8	City of Pasadena Public Health Dept. 1845 North Fair Oaks Ave. Pasadena, CA 91103	5	MH250006	$2,855,000
9	The Children's Center of the Antelope Valley 45111 Fern Avenue Lancaster, CA 93534	5	MH250007	$2,855,000

ATTACHMENT III

CONTRACT NO. MHXXXXXX

AMENDMENT NO. ___

THIS AMENDMENT is made and entered into this ___ day of _____, 2022, by and between the COUNTY OF LOS ANGELES (hereafter "County") and The Regents of the University of California, San Diego (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled "Evaluation of Innovation (INN) 2 Trauma Resilient Communities: Community Capacity Building Contract", dated August 14, 2018, and further identified as County Contract No. MH250008, and any amendments thereto (hereafter collectively "Contract"); and

WHEREAS, on_____, the County Board of Supervisors authorized the Department of Mental Health (DMH) Director, or designee, to execute amendments to the Contract that include the authority to extend the term and increase the Total Contract Amount (TCA); and

WHEREAS, County and Contractor intend to amend the Contract to extend the term of the Contract and to add funds for the continued evaluation services of the INN 2 program; and

WHEREAS, as the result of this change, the Total Contract Amount (TCA) will increase; and

WHEREAS, said Contract provides that changes may be made in the form of a written amendment which is formally approved and executed by the Parties; and

WHEREAS, Contractor warrants that it continues to possess the competence, expertise, and personnel necessary to provide services consistent with the requirements of this Contract, and consistent with the professional standard of care for these services.

NOW, THEREFORE, County and Contractor agree as follows:

1. The Amendment is effective upon execution for the period beginning July 1, 2022.

2. Paragraph 4.0 (TERM) of the Contract, subsections 4.1 and 4.2 are deleted in their entireties and replaced as follows:

"4.1. The initial period of this Contract shall commence on August 14, 2018 and shall continue in full force and effect through June 30, 2023 unless sooner terminated or extended, in whole or in part, as provided in this Contract.

4.2 The County shall have the sole option to extend this Contract term for an additional year, for a maximum total Contract term of six years. Such extension option may be exercised at the sole discretion of the Director of Mental Health (Director) or his designee as authorized by the Board of Supervisors".

3. For FY 2022-23, 1991 Realignment and/or MHSA funds shall be added in the amount of **$1,000,000 DOLLARS**, and upon Board approval of the FY 2022-23 Mental Health Services Act (MHSA) Annual Update, the funding source will then change to MHSA Prevention and Early Intervention (PEI) funds.

4. The TCA shall be increased by **$1,000,000** from **$4,000,000** to **$ 5,000,000**.

5. Paragraph 5.0 (CONTRACT SUM) subsection 5.1 of the Contract shall be deleted in its entirety and replaced with the following:

"5.1 Total Contract Sum

5.1.1 In consideration of the performance by Contractor in a manner satisfactory to County of the services described in Exhibit A (Statement of Work), Contractor shall be paid in accordance with the Payment Schedule established in Exhibit B (Payment Schedule). The total

compensation for all services furnished hereunder shall not exceed **$5,000,000** for FY 18-19 through FY 2022-23. Contractor will be compensated in the amount of **$1,000,000** for each FY".

6. Exhibit A (Statement of Work) shall be deleted in its entirety and replaced with Exhibit A-3 (Statement of Work) attached hereto and incorporated by this reference. All references to Exhibit A (Statement of Work) shall be deemed amended to state "Exhibit A-3".
7. Exhibit B (Payment Schedule) shall be deleted in its entirety and replaced with Exhibit B-3 (Payment Schedule) attached hereto and incorporated by this reference. All references to Exhibit B (Payment Schedule) shall be deemed amended to state "Exhibit B-3".
8. Except as provided in this amendment, all other terms and conditions of the Contract shall remain in full force and effect.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be subscribed by the County's Director of Mental Health or 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 _____
JONATHAN E. SHERIN, M.D., Ph.D.

The Regents of the University of California, San Diego
CONTRACTOR

By _____

Name _____

Title _____
(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL

By: Emily D. Issa
Deputy County Counsel

EXHIBIT A-3

STATEMENT OF WORK

THE REGENTS OF THE UNIVERSITY CALIFORNIA, SAN DIEGO
EVALUATION OF
INNOVATION 2-COMMUNITY AMBASSADOR NETWORK

DEVELOPING TRAUMA RESILIENT COMMUNITIES:

COMMUNITY CAPACITY BUILDING

TABLE OF CONTENTS

STATEMENT OF WORK

1.0 SCOPE OF WORK

The Contractor shall be required to 1) continue, expand, or implement new methodology for evaluation and 2) conduct the evaluation of Los Angeles County - Department of Mental Health's (LAC-DMH) Prevention and Early Intervention (PEI), Innovation 2 (INN 2)-Community Ambassador Network (CAN) Developing Trauma Resilient Communities through Community Capacity Building project ("Project").

Through this evaluation, the Contractor will evaluate the following:

- Factors that influence trauma and the development of trauma-related mental illness,
- Collect outcome data to assess the provider's program design and implementation and the commitment to making mid-course corrections, such as the INN 2 - CAN staffing, as necessary to insure the achievement of positive participant, program, and community level outcomes,
- Efficacy of Strategies to Strengthen Community Capacity to address trauma; and
- The strength and Sustainability of Community Partnerships to address trauma.

As such, the Contractor will select or develop any necessary instruments needed to measure individual level outcomes for participants of INN 2-CAN service strategies. Contractor will also collect data for each strategy in a web-based application, or comparable electronic format, such that outcome measures specific to the efficacy of the strategy can be developed and analyzed.

Factors that Influence Trauma and the Development of Trauma-Related Mental Illness

Contractor shall manage and update the IHOMS system developed to evaluate the following general activities provided by Contracted Lead Agencies (CLAs) that implement and provide INN 2-CAN services to proposed, geographically-defined communities in the INN 2-CAN Project:

1. Partnership Development and Coalition Building

    a. CLAs will establish a coalition of agencies, groups and/or organizations with identified roles, expectations, and in-kind resources that will be responsible for elements of the work associated to the strategies and the goals of this Project.

    b. CLAs will create synergy within geographically-defined communities to facilitate and sustain the goals of this Project.

2. Community Empowerment and Leadership Development

    a. CLAs will involve stakeholders from the identified geographic areas in the planning, implementation and decision-making, to include establishing an advisory committee to guide decision-making.

    b. CLAs will facilitate sustainable interactions between stakeholders groups, committees, coalition and other advisory bodies involved in local decision-making.

    c. Over the course of the Project, CLAs will ensure community leadership is strengthened so that the capacity of the geographically- defined community to address trauma or trauma risk is sustained beyond the time-limited Project.

3. Outreach, Engagement, Training and Technical Assistance to Communities

    a. CLAs will develop a plan, with community input, to create community awareness, action and support for trauma and its impact on the development of mental illness and its impact on the community.

    b. CLAs will ensure that community participants, as well as organizations, know how, when, and where to refer an individual for a mental health evaluation.

4. Knowledge, Experience and Understanding of Trauma and its Impact

    a. CLAs will demonstrate an understanding of trauma, its correlates and potential causes related to the age group(s) proposed to be served.

5. Cities/Geographic Area(s) Identified for Inclusion and Rationale for Selection

    a. The geographic area selected for this Project will have residents that have been historically underserved or unserved by the mental health system.

    b. The geographic area selected will have a sufficient foundation of support, leadership and civic engagement to support the development and implementation of this Project.

6. Coordination of work with other local, neighborhood health and mental health initiatives, including Best Start initiatives, California Endowment Community Capacity Building Projects and involvement in mental health Service Area Leadership Team (SALT).

7. Contractor shall ensure that the methodologies developed and proposed measures to evaluate the general activities listed above are submitted to LAC-DMH for approval prior to use.

Efficacy of Strategies to Strengthen Community Capacity

Contractor shall also develop/continue the methodology necessary to evaluate one or more of the following strategies implemented by CLAs in proposed geographically-defined areas:

Strategy 1: **Building Trauma-Resilient Families** - This model targets children ages birth to five (5) years and their caregivers who have experienced complex trauma and/or are at risk for complex trauma. Activities include assessing and educating families and young children for exposure to Adverse Childhood Experiences (ACES). The intended outcomes of this strategy are as follows:

1. Children and families served will demonstrate an increased use of positive coping strategies to reduce the impact of trauma.

2. Social isolation reported by parents or caregivers and children will decrease.

3. At-risk children with trauma symptoms who have been underserved will receive referrals to mental health treatment/systems when necessary (improve mental health access for children in underserved at risk communities).

Strategy 2: **Trauma-Informed Psycho-Education And Support For School Communities** - In this model, training/workshops on recognizing behaviors and symptoms of stress and trauma in children will be provided to Early Care/Education (EC/E) and school personnel and community mentors who work with children ages 3-15 years. The workshops would teach simple trauma-informed coping techniques that can be implemented within EC/E and school settings to reduce stress experienced by children. The intended outcomes of this strategy are as follows:

1. Reduction of stress experienced by children/students served by the participating EC/E programs/agencies and schools as indicated by improved attendance and reduction in suspension and expulsion rates.

2. Increased referrals and linkages of identified at-risk students with trauma symptoms and their family members to needed mental health and trauma-informed services.

3. Reduction of stress experienced by participating EC/E program/agency and school staff as indicated by decreased sick days and staff turnover and a decrease in compassion fatigue/vicarious trauma scores on corresponding validated measures, administered at both pre- and post-intervention.

Strategy 3: **Transition Age Youth (TAY) Support Network-** In this model, CLAs convene support networks through outreach and engagement to TAY ages 16-25 years and TAY peer support groups utilized as a universal prevention strategy to engage TAY

who may be socially disconnected and at risk of or experiencing early course mental illness related to trauma due to their circumstances of being currently or formerly homeless. The intended outcomes of this strategy are as follows:

1. Social isolation/withdrawal and negative social connections will decrease.

2. Vulnerable TAY will demonstrate increased positive coping strategies to reduce the impact of trauma over the course of the engagement and support.

3. Through the utilization of positive coping strategies, an increase in social connectedness that leads to the ability of current and former homeless TAY to secure housing and/or maintain their current housing placement.

4. Decreased trauma symptoms for at-risk TAY.

5. On average, a reduced duration of untreated mental illness for TAY who are referred to the specialty mental health system, as compared to a sample of TAY receiving mental health services from providers not associated with INN 2 communities.

Strategy 4: **Coordinated Employment Within a Community** - This model targets TAY, adults, and older adults with employment goals. A network of businesses within a specific community will be created that will provide coordinated job opportunities to individuals who are experiencing trauma associated with being homeless/formerly homeless. Job opportunities will be sought out in the competitive employment market and through the development of social enterprises within the community. In addition to the use of a standardized employment assessment tool, individuals will be matched to the employment opportunities that the network will provide. The intended outcomes of this strategy are as follows:

1. Increased sense of well-being and self-sufficiency.

2. Increased integration into and connection with the community for individuals employed.

3. Increase in individual income and a reduction in poverty.

4. Reduction in the use of public resources including Supplementary Security Income (SSI) and Medi-Cal as a result of income and health insurance received through employment.

Strategy 5: **Community Integration For Individuals With A Mental Illness With Recent Incarcerations Or Who Were Diverted From The Criminal Justice System -** This strategy focuses on TAY (ages 18+ years), adults, and older adults with mental illness and

histories of incarcerations whose trauma is re-activated after release from jail and due to the lack of pro-social community supports, high-risk housing, and substance abuse. This strategy proposes that community consortiums be created to facilitate community reintegration, and to provide training to local law enforcement, courts staff, community agencies and housing supports on the benefits and scope of treatment for those diagnosed with mental illness, and which are designed to reduce re-incarcerations. The intended outcomes of this strategy are as follows:

1. At the community level, reduced stigma in the judicial system, law enforcement, and the community, measured over the course of the INN 2 Project.

2. Increase housing for individuals with a recent history of incarceration and mental illness, measured through the establishment of housing benchmarks.

3. Increase successful linkages from incarceration or diversion to mental health services in the community.

4. Reduce re-incarcerations, as indicated by sampling client incarceration rates prior to implementation of this strategy versus after implementation.

Strategy 6: **Geriatric Empowerment Model (GEM) Program** - This strategy focuses on establishing a Senior Empowerment Center (SEC) that will providing a wide array of supportive services during the day, including food, clothing, shower services, and mental health education, to older adults (aged 60+ years) who are currently homeless and experiencing trauma from being homeless. The CLAs will also provide Community

Stakeholder Education (CSE) to residents and community stakeholders on best practices for communicating and engaging homeless seniors on the issues they face and to help them identify community resources. The intended outcomes of this strategy are as follows:

1. Improve the likelihood of older adults accessing mental health services to better reduce the number of homeless mentally ill older adults within the community.

2. Decrease homelessness of GEM participants by 60% or more.

3. Decrease trauma symptoms in this population.

4. Increase from the baseline level, community knowledge and use of resources to engage and assist the homeless mentally ill older adult.

Strategy 7: **Culturally Competent Non-Traditional Self-Help Activities For Families With Multiple Generations Experiencing Trauma** - This model focuses on addressing community or societally-induced trauma experienced by intergenerational families. The strategy is implemented in three distinct phases of work by the CLAs: (1) Culturally appropriate Outreach, Education and Engagement (OEE); (2) Culturally Appropriate Intergenerational Family Wellness Screenings; and (3) culturally relevant family healing activities, including participation in intergenerational family mentorship services. The intended outcomes of this strategy are as follows:

1. Increased sense of social connectedness for inter-generational families participating in the culturally relevant non-traditional self- help activities and groups.

2. Increased ability to cope with trauma as reported by inter-generational families.

3. Reduction in levels of shame and stigma related to trauma and mental illness as reported by intergenerational families.

4. An increased percent of individuals referred to the specialty mental health system (increased mental health service penetration) as compared to an ethnically-matched sample from a non-INN 2 community mental health.

Contractor shall ensure that the methodologies and proposed measures developed/continue to evaluate each of the seven strategies listed above are submitted to LAC-DMH for approval prior to use.

Sustainability of Community Partnerships in Addressing Trauma

The Contractor shall also be required to conduct an evaluation on all **INN** 2 – CAN community partnerships associated with each geographically-defined partnership across Los Angeles County using a mixed methods quantitative and qualitative approach, that measures the impact of a community capacity approach and the impact of specific strategies at a system (community) level and at an individual participant level over the course of the Project. Through the evaluation, the Contractor should answer the following learning questions:

1. What strategies contribute most significantly to increasing a community's ability and willingness to support its members in ways that reduces the likelihood of the impact of trauma for specific individuals at risk of or with a mental illness? What is the relative impact of selected asset-based culturally competent community capacity-building strategies on reducing trauma and its consequences?

2. Does asset-based, culturally competent community capacity-building within geographically-defined communities result in an increased ability by the community member to seek care and support when it is needed (increased access through formal and informal pathways) and does that approach result in decreased trauma and mental health symptoms for those experiencing symptoms or who are at-risk of experiencing

symptoms?

3. What is the added value of investing in community capacity building, as opposed to investing solely in mental health service delivery directly to the mentally ill client in addressing the correlates of trauma?

2.0 SERVICES TO BE PROVIDED

Contractor shall complete the following tasks:

2.1 Participate in quarterly learning sessions with INN 2 CLAs and partner organizations as specified by LAC-DMH over the course of the Project.

2.2 Engage specific communities in the overall approach to the evaluation, including measures selection and methods to collect data by convening a focus group comprised of key community stakeholders.

2.3 During the Contract Term, conduct evaluations of the following, including identifying and/or developing instruments and an evaluation methodology to measure the following system level outcomes:

2.3.1 The degree to which each INN 2-CAN CLA facilitated/developed community-based networks and leveraged the resources within the geographically-defined community.

2.3.2 The strength of each community partnership.

2.3.3 The impact of the community partnerships in relation to the increased community knowledge of the signs and symptoms of mental illness and trauma.

2.3.4 The impact of the community partnerships in relation to the increase/decrease in community stigma of mental illness and of trauma.

2.3.5 The impact of the community partnerships in relation to community acceptance of mental illness and the experience of trauma.

2.3.6 The degree to which the INN 2 CLAs and their community partners engaged individuals residing in and working in identified communities in the planning, implementation and decision-making related to this work.

2.3.7 The degree to which each community's capacity to identify, serve and support individuals at risk of or experiencing trauma and its mental health consequences increased/decreased over the Contract term.

2.3.8 The degree to which the community partnership impacted the community leadership capacity, and the changes to that capacity in relation to proactive mental health/illness identification and trauma prevention and early intervention.

2.3.9 The degree to which any improvements in community leadership

will be sustained through specifically developed plans and the quality of those plans.

All instruments and evaluation methodologies developed must be approved by LAC-DMH prior to use.

2.4 Conduct an evaluation of the following, including identifying and/or developing/continuing instruments that measure the following individual-level outcomes for participants of INN 2-CAN service strategies:

2.4.1 Changes in trauma risk or symptomatology by age group and by INN 2-CAN community.

2.4.2 Changes in INN 2-CAN participants' knowledge of mental illness and knowledge of trauma symptoms by community.

2.4.3 Changes in the participants' knowledge of how to seek mental health services if needed.

2.4.4 Changes in protective factors, such as changes in social connectedness, parental or caregiver resilience, increased social support/connectedness and increased socio-emotional competency for children.

2.4.5 Changes in positive coping styles for individuals served.

2.4.6 For TAY who are identified as needing formal mental health treatment, measure the duration of untreated mental illness, comparing it to a sample of TAY not engaged through this Project but receiving services in the mental health system.

2.4.7 Changes in access to mental health care earlier in the course of exposure to trauma, including changes in community pathways to mental health care.

2.4.8 Substance (e.g., prescription or illicit drugs, or alcohol) use/abuse patterns prior to and after receiving INN 2-CAN service strategies.

2.4.9 Strategy participant perception of connection to one's community, including the key elements slightly that comprise or operationalize community connection, measured at the beginning of contact and/or service and periodically.

2.4.10 Changes in participation in community activities by individual participants.

2.4.11 Changes in participant emotional well-being and level of self-sufficiency by age group sensitive to ethnicity, culture, and language.

2.4.12 Participant satisfaction with INN 2-CAN services.

2.4.13 All instruments and evaluation methodologies developed must be approved by LAC-DMH prior to use.

2.5 During the Contract Term, identify and/or develop a cultural competency measure that evaluate how well the INN 2-CAN services met the ethnic, cultural and linguistic needs of participants served. Ensure all measures proposed to be used are appropriate to age, culture and ethnicity, and ensure that all participant completed measures are translated into threshold languages pertinent to specific communities involved in this Project. Where translation into these languages is necessary, and where the developer of the outcome measure allows, obtain translation, including back-translation, that is approved by the developer of the measure. All measures and evaluation methodologies developed must be approved by LAC-DMH prior to use.

2.6 Identify and/or develop the following strategy-specific outcomes, measured only for INN 2 communities that choose the strategy:

2.6.1 Building Trauma Resilient Families (Strategy 1).

2.6.1.1 Measure changes in the collective impact of trauma on the family as a system.

2.6.2 Trauma-Informed Psycho-Education And Support For School Communities (Strategy 2).

2.6.2.1 Measure changes in stress level of school/early childhood education personnel, such as changes in sick days, staff turnover, compassion fatigue and vicarious trauma.

2.6.2.2 Measure changes in stress or trauma experienced by children served by the participating early childhood education and schools, including changes in attendance and expulsions/suspensions.

2.6.3 Coordinated Employment Within a Community (Strategy 4).

2.6.3.1 Measure changes in employment rates for participants.

2.6.4 Community Integration For Individuals With A Mental Illness With Recent Incarcerations Or Who Were Diverted From The Criminal Justice System (Strategy 5).

2.6.4.1 Measure change in incarceration rates, sampling client incarceration rates prior to implementation of this strategy versus after implementation within a given geographic area.

2.6.5 Geriatric Empowerment Model (GEM) Program (Strategy 6).

2.6.5.1 Measure the changes in homelessness rates after participation in Strategy 6.

2.6.6 Culturally Competent Non-Traditional Self-Help Activities For Families With Multiple Generations Experiencing Trauma (Strategy 7).

2.6.6.1 Measure changes in the collective impact of trauma on the family as a system.

2.6.6.2 Comparing an ethnically-matched sample from a non-INN 2-CAN community, measure the percent of individuals referred to the specialty mental health service system.

2.7 Continue the use of the tracking instruments/forms developed for INN 2-CAN CLAs and community partners to collect service information required for INN 2-CAN. All tracking instruments/forms developed for INN 2 are approved by LAC-DMH prior to use.

2.8 Obtain all outcome measures, including obtaining any licenses on behalf of LAC- DMH. For measures to be administered by community partners, distribute measures and train INN 2-CAN CLAs and community partners in the use of the measures and in data collection protocols, prioritizing measures and training to those to be administered at the start of services.

2.9 Continue the use of IHOMS for the collection of outcome measures data for each geographically-defined community, and ensure that such data is transmitted electronically in a secure manner to the Contractor, as described in Section 5.0 (Web-based Application System).

2.9.1 Provide both on-site and off-site trainings for INN 2-CAN CLAs on system implementation, data entry, and electronic data transmission, on an as-needed basis.

2.9.2 Provide system help desk support via phone and e-mail to INN 2-CAN CLAs during regular working hours for technical system issues.

2.9.3 During the Contract Term, or earlier as specified by LAC-DMH, and throughout all of the Contract Term, continue to review data entered to ensure that it is accurate and valid.

2.10 During the Contract Term, organize data that will be collected in preparation for data analysis and development of production reports as determined by LAC-DMH. The reports will provide recommendations on successful service strategies, for LAC-DMH to use for programmatic oversight of the evaluation of the INN 2-CAN and for LAC-DMH to report on the status of the INN 2 to local and State entities. Review reports with LAC-DMH, as directed.

2.10.1 Tailor all reports based on feedback from INN 2-CAN CLAs and LAC-DMH.

2.10.2 Complete quarterly outcome measures reports by strategies and by INN 2-CAN CLAs to LAC-DMH.

2.10.3 During the end of the Contract Term, finalize and submit the final report to LAC-DMH in an electronic format on the outcomes for each INN 2-CAN community and strategy, along

with an analysis of the learning questions associated with INN 2-CAN documented in Section 1.0 and final recommendations to LAC-DMH on successful community capacity building approaches and their impact on trauma.

The Contractor shall commence INN 2-CAN Evaluation services within 30 days of the commencement of the awarded contract.

3.0 QUALITY CONTROL

The Contractor shall establish and utilize a comprehensive Quality Control Plan to assure the County a consistently high level of service throughout the term of the Contract. The Plan shall be submitted to the County Contract Project Monitor for review on an annual basis. The plan shall include, but may not be limited to the following:

3.1 Method of monitoring to ensure that Contract requirements are being met; The Quality Improvement Program shall include an identified monitoring system covering all the services listed in this RFS and SOW. To the extent possible, the Quality Improvement Program shall be in keeping with the Department's Quality Improvement Work Plan, and focus on monitoring the agency's service delivery capability.A record of all reviews conducted by the Contractor, any corrective action taken, the time a problem was first identified, a clear description of the problem, and the time elapsed between identification and completed corrective action, shall be provided to the County upon request.

3.2 The Contractor shall establish and utilize a comprehensive Quality Improvement Program, including a Quality Assurance process, to ensure the required evaluation services are provided at a consistently high level of service throughout the term of the Contract. The Plan shall be submitted to LAC-DMH for review and approval. The Plan shall be effective on the Contract start date, and shall be updated and re-submitted for LAC-DMH approval as changes occur.

4.0 QUALITY ASSURANCE PLAN

The County-will evaluate the Contractor's performance under this Contract using the quality assurance procedures as defined in this Contract, Paragraph 8, (Standard Terms and Conditions), sub-paragraph 8.15, (County's Quality Assurance Plan).

4.1 The Contractor shall be required to participate in regular learning session meetings with INN 2-CAN CLAs and LAC-DMH Program Managers where data and progress will be reviewed to determine progress toward achieving the goals of this INN 2-CAN Project. These meetings shall serve as the basis for learning and for making any mid-course service corrections to the INN 2-CAN community approaches.

4.2 **County Observations**

In addition to departmental contracting staff, other County personnel may observe performance, activities, and review documents relevant to this Contract at any time during normal business hours. However,

these personnel may not unreasonably interfere with the Contractor's performance.

5.0 WEB-BASED APPLICATION SYSTEM

Contractor will also be responsible for providing and maintaining an INN 2-CAN program database and web-based application, or comparable system, to collect, track, and report on outcome measures data for each geographically-defined community and report on program outcomes by strategy for each community partnership assembled by CLAs via the INN 2-CAN Project. The system must adhere to the specifications listed in this section.

5.1 Contractor's web-based application must provide the following core user functionality:

5.1.1 User registration management system with self-service password management and a customizable levels system hierarchy that provides unrestricted access to higher-level users and restricts access to lower-level users.

5.1.2 A data collection infrastructure that allows multiple users to collect and enter systems-level and individual-level outcomes data simultaneously from multiple users and across multiple sites, and allows users to edit previously entered data to help ensure data quality.

5.1.3 Data collection forms that capture system-level outcomes and individual-level outcomes, as directed by County's Project Director.

5.1.4 Ability to generate customized reports based on collected data as described in Sections 2.3, 2.4, 2.5, and 2.6 of this SOW on an as needed basis.

5.1.5 Ability to generate customized data quality reports that include data discrepancies to allow users to validate the quality of the system- level and individual level outcomes data entered into the web- application.

5.1.6 User friendly interface/dashboards that provide users a visual way to securely view live data results and reports.

5.2 Contractor's web-based application must provide the following technical functionality:

5.2.1 Support by all major platforms/internet browsers and compatibility with computers, tablets, and mobile devises.

5.2.2 Application Programming Interface (API) that allows integration of backend data to various case management systems and electronic health record systems, to be identified by County's Project Manager, to extract system-level and individual-level data.

5.3 Contractor's web-based application must meet the following security

parameters:

5.3.1 Provide Unique User Identification for all users connecting to Contractor's web-based application.

5.3.2 Information regarding the user's time of access, which pages are accessed, and from what location the connection originated from must be logged and kept for a period of seven (7) years in the system database.

5.3.3 User accounts must have expiration date. Only system administrators shall have the ability to renew or extend an expired account life.

5.3.4 Inactive user accounts must be kept in the system's database and never be deleted. Accounts which are not used and left inactive for a period beyond 90 days must automatically become suspended.

5.3.5 Contractor's web-based application must provide a secure login screen for users and a security system that adheres to HIPAA and FDA CFR Part 11 compliance standards.

5.3.6 Users must be automatically logged out of system after 20 minutes of inactivity and required to log back in to the system before they have access again.

5.3.7 After five (5) consequent failed attempts within five (5) minutes they system must lock the user's account.

5.3.8 A complete history of all changes to all records and fields must be maintained by Contractor's system to prevent past records from being overwritten. When existing records are modified or otherwise changed, the original data must be retained, and the new data must be recorded as a new line of data and tracked with the last mod timestamp field in Contractor's system.

5.3.9 A self-service process that includes several challenges to validate the user's identity is acceptable; otherwise a system administrator must conduct the verification prior unlocking the account.

5.3.10 Stored electronic PHI data must be encrypted utilizing an industry standard AES-256 cypher locally within the drive volume as well as through Microsoft SOL.

5.3.11 Data transmitted over the internet, via Contractor's web-based application, must be encrypted at all times and transmitted via a secure network connection. Contractor's web-based application must utilize SSL technology to ensure a safe and reliable connection. At no point during rest, must electronic PHI data be accessible on Contractor's system.

5.3.12 Emergency access to the Contractor's system must be provided through a mirrored server system in emergency situations where

the Contractor's webserver or database is down.

5.3.13 Database must be backed up in Contractor's server on a regular basis. The backups must be encrypted and stored distant from the actual server.

6.0 INFORMATION TECHNOLOGY, PRIVACY & ELECTRONIC SECURITY

6.1 Technology Requirements

6.1.1 Contractor's information system or information technology system shall meet the functional, workflow, and privacy/security requirements listed below under Section 6.2 (Privacy and Electronic Security).

6.1.2 Contractor is solely responsible for complying with all applicable State and Federal regulations affecting the maintenance and transmittal of electronic information.

6.2 Privacy and Electronic Security

6.2.1 Contractor shall comply with all Federal and State laws as they apply to Protected Health Information (PHI), Individually Identifiable Health Information (IIHI), and Personal Identifying Information (PII), and electronic information security.

6.2.2 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 LAC-DMH or the County of Los Angeles.

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

7.0 RESPONSIBILITIES

The County's and the Contractor's responsibilities are as follows:

COUNTY

7.1 Personnel

The County will administer the Contract according to the Contract, Paragraph 6.0 (Administration of Contract - County). Specific duties will include:

7.1.1 Monitoring the Contractor's performance in the daily operation of this Contract.

7.1.2 Providing direction to the Contractor in areas relating to policy, information and procedural requirements.

7.1.3 Preparing Amendments in accordance with the Contract, Paragraph 8.0 (Standard Terms and Conditions), Sub-paragraph 8.1 (Amendments).

CONTRACTOR

7.2 Personnel/Staffing

7.2.1 Contractor shall assign a sufficient number of employees to perform the required work. At least one employee on site shall be authorized to act for Contractor in every detail and must speak and understand English.

7.2.2 Contractor shall be required to background check their employees as set forth in Paragraph 7 (Administration of Contract-Contractor), sub- paragraph 7.5 (Background and Security Investigations), of the Contract.

7.2.3 Evaluation activities should be led by a qualified individual with appropriate credentials to conduct this scale and type of mixed methods qualitative and quantitative evaluation. The evaluation staffing may include research assistants or interns with appropriate supervision. All staff must have experience and training associated with producing the deliverables of this Project. The organizational chart shall indicate the reporting lines of all staff, including subcontractor staff, if applicable. Staff shall have the ability to provide culturally and linguistically appropriate services related to evaluation. A single evaluation staff shall be appointed as the main evaluation point of contact for each model as referenced in Section 1.0 of this SOW.

7.2.4 Rosters: Contractor shall provide LAC-DMH, at the beginning of each Contract term and within 30 days of any staff change(s), a roster of all staff that includes: (1) name and positions; (2) work schedule; (3) fax and telephone numbers; and (4) any non-English, Los Angeles County threshold-languages spoken by staff.

7.2.5 Changes in Staffing: Contractor shall advise LAC-DMH Program Director in writing of any change(s) in Contractor's key staff at least 24 hours before proposed change(s), including name and qualifications of new staff. Contractor shall ensure that no

interruption of services occurs as a result of the change in staff.

7.2.6 Language/Cultural Ability: Contractor's staff, as well as any Subcontractor staff who are performing services under this Contract, shall be able to read, write, speak, and understand English in order to conduct business with LAC-DMH Program Director Furthermore, the staff must be culturally competent in working with individuals from all communities being served. 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 contractors selected to provide INN 2-CAN services.

7.2.7 Work Stoppages: Contractor shall have a plan for providing sufficient and appropriate multidisciplinary staff to meet the requirements of this SOW.

7.3 Training

7.3.4 Contractor shall provide training programs for all new employees and continuing in-service training for all employees.

7.3.5 Contractor shall provide orientation to all staff, interns, and volunteers providing INN 2-CAN evaluation services prior to their beginning service and shall complete preliminary training within 30 business days of their start date. The program will assure all staff and volunteers will be trained concerning the Health Insurance Portability and Accountability Act (HIPAA) to assure compliance with established regulations. Contractor shall create an infrastructure to support employment staff supervision.

7.3.6 Education and Experience: Contractor shall be responsible for securing and maintaining staff who meet the minimum qualifications below and who possess sufficient experience and expertise required to provide services required in this SOW, including the ability to work effectively with multicultural providers.

Contractor shall obtain written verification for staff with foreign degrees indicating that the degrees are recognized as meeting established standards and requirements of an accrediting agency authorized by the U.S. Secretary of Education, where applicable.

7.3.7 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.

7.4 Administrative Tasks

7.4.1 Record Keeping: Contractor shall document all evaluation services provided for each model and those associated with each deliverable.

7.4.2 Evaluation Instruments: Contractor shall seek approval from LAC- DMH before purchasing and distributing outcome measures associated with this SOW.

7.4.3 Computer and Information Technology Requirements: Within 30 days of commencement of the Contract, Contractor shall acquire a computer system with sufficient hardware and software to meet LAC- DMH requirements and an agreement for its on-site maintenance for the entire term of t is agreement to comply with the terms of the contract.

7.5 Contractor's Office

Contractor shall maintain an office with a telephone in the company's name where Contractor conducts business. The office shall be staffed during the hours of 9:00 a.m. to 5:00 p.m., Monday through Friday, by at least one (1) employee who can respond to inquiries and complaints which may be received about the Contractor's performance of the Contract. When the office is closed, an answering service shall be provided to receive calls. **The Contractor shall answer calls received by the answering service within 24 hours of receipt of the call.**

8.0 SERVICE DELIVERY SITE(S)

Evaluation services shall be delivered primarily at the Contractor's site. The Evaluation staff shall travel to agencies contracted by LAC-DMH and their partner agencies to provide INN 2-CAN evaluation services, including providing training and technical assistance on the use of measures and the web-based outcome system.

9.0 GREEN INITIATIVES

9.1 Contractor shall use reasonable efforts to initiate "green" practices such as recycling and using electronic dissemination approaches rather than using paper for environmental and energy conservation benefits.

9.2 Contractor shall notify County's Project Manager of Contractor's new green initiatives prior to the contract commencement.

10.0 PERFORMANCE REQUIREMENTS SUMMARY

10.1 The Consultant Services Agreement shall include Performance-based Criteria that shall measure the Contractor's performance related to program and operational measures and are indicative of quality services. These criteria are consistent with the MHSA-PEI. These measures assess the agency's ability to provide the mandated services as well to monitor the quality of services.

10.2 Contractor shall provide processes for systematically involving clients and their families, key stakeholders, subject matter experts, and LAC-DMH staff in defining, selecting, and measuring quality indicators at the program and community levels. Contractor shall collaborate with LAC-DMH to provide processes for

systematically evaluating quality and performance indicators and outcomes at the client and program level. Should there be a change in Federal, State and/or County policies/regulations, LAC-DMH, at its sole discretion, may amend these Performance-based Criteria via a contract amendment with a 30 day notice.

10.3 The Performance based Criteria are as follows:

PERFORMANCE BASED CRITERIA	METHOD OF DATA COLLECTION	PERFORMANCE TARGETS
1. Contractor has the capacity to work effectively with multi-ethnic organizations in developing culturally appropriate outcome measures.	Contractor to provide LAC-DMH with an analysis of each proposed measure and literature to suggest its use with specific ethnic populations.	Contractor successfully selects measures that are culturally sensitive and appropriately translated, where appropriate.
2. Contractor has linguistic capability sufficient to meet the needs of multi-ethnic organizations.	Review of staffing list associated with the Project and linguistic capabilities.	Contractor successfully communicates with multi-ethnic organizations and ensures translation of any instruments requiring translation.
3. Contractor successfully identifies, develops or continues all outcome measures listed in Section 1.0 of this SOW.	Deliverable to LAC-DMH, based on deliverables schedule.	100% of all outcomes LAC-DMH requires are identified by the Contractor and approved by LAC-DMH for use.
4. Contractor has successfully obtained all measures and distributed them to the INN 2-CAN contracted lead agencies. Contractor has trained them on their use and on the data collection protocol.	Deliverable to LAC-DMH, based on deliverables schedule.	100% of all measures selected are obtained by the Contractor, distributed to **INN** 2-CAN contracted lead agencies and 100% of **INN 2-CAN** contracted lead agencies have been trained on the data collection protocol.
5. Contractor successfully implements the methodology for data collection and transmission from each INN 2-CAN contracted lead agency to the Contractor.	Deliverable to LAC-DMH, based on deliverables schedule.	100% of all outcome data is successfully transmitted in a secured format by the **INN 2-CAN** contracted lead agencies to the Contractor.
6. Contractor submits quarterly reports to LAC-DMH.	Deliverables to LAC-DMH, based on deliverables schedule.	100% submission at stipulated intervals.

** Note the above performance based criteria table is subject to additional revisions at the discretion of the County.

EVALUATION OF INN 2 - COMMUNITY AMBASSADOR NETWORK (CAN) DEVELOPING TRAUMA RESILIENT COMMUNITIES COMMUNITY CAPACITY BUILDING SERVICES

PAYMENT SCHEDULE

1. FUNDING SOURCES

1991 Realignment and/or Mental Health Services Act (MHSA) - Prevention and Early Intervention (PEI) Funding

The Innovation 2 (INN 2) - Community Ambassador Network (CAN) funding will be extended for Fiscal Year (FY) 2022-23. Contractor will be compensated in the amount of $1,000,000 for the period of July 1, 2022 through June 30, 2023.

2. PAYMENT SCHEDULE

For the INN 2-CAN evaluation services described in the Statement of Work (SOW) LAC-DMH shall pay to Contractor, not to exceed, **$1,000,000.00** for FY 2022-23.

Payment to Contractor shall be based on original invoices, submitted by Contractor. Invoices shall include separate details for administrative and program costs respectively. No payment shall be made for INN 2-CAN evaluation services delivered beyond those services and supports indicated in the SOW without the prior approval of LAC-DMH's County Project Director. The LAC-DMH designated County Project Director will review the invoices and supporting documentation to ensure that the INN 2-CAN evaluation services and supports rendered are in substantial compliance with the requirements described in the SOW.

3. PAYMENT PROCEDURES

Contractor shall submit invoices **(sample below)** for actual cost incurred for services provided under the SOW. Contractor shall retain all relevant supporting documents and make them available to LAC-DMH at any time for audit purposes. Invoices shall be specific as to the type of services being provided. Contractor shall certify that invoices are for services and costs eligible under the terms and conditions for reimbursement.

Upon receipt and approval of original invoices from Contractor, LAC-DMH shall make payment to Contractor within forty-five (45) days of the date the invoice was approved for payment. If any portion of the invoice is disputed by LAC-DMH, LAC-DMH shall reimburse Contractor for the undisputed services contained in the invoice and work diligently with Wendi Tovey, County's Mental Health Clinical Program Manager III, to resolve the disputed portion of the claim in a timely manner.

LAC-DMH shall make reimbursements payable to Contractor. LAC-DMH shall send payments to:

Name of Agency: The Regents of the University of California, San Diego

Address: 9500 Gilman Drive, 0631

City: La Jolla

State: CA

Zip Code: 92093-0631

4. DESIGNATED LAC-DMH CONTACT PERSON

All questions and correspondence should be directed to:

Wendi Tovey, LCSW, Mental Health Clinical Program Manager III at:
County of Los Angeles — Department of Mental Health
510 S. Vermont Avenue, 17th Floor
Los Angeles, CA 90020
(213) 947-6451

All invoices should be directed to:

Provider Reimbursement Section
County of Los Angeles — Department of Mental Health
510 S. Vermont Avenue
Los Angeles, CA 90020

5. CONTRACT TERM

The Evaluation of the INN 2- CAN project is funded by 1991 Realignment and/or MHSA. The project will commence upon execution of the Contract, July 1, 2022 through June 30, 2023. Ongoing funding for this project is contingent on available funding from the State as well as continued approval of Prevention and Early Intervention claims submitted by the County on behalf of the Contractor.

PAYMENT SCHEDULE

FY 2022-2023

TASK		DELIVERY MONTH/QUARTER	PAYMENT AMOUNT	DELIVERABLE
Task 1	Submit quarterly outcome reports by service strategy and lead agency. Continue to review data entered to ensure that it is accurate and valid. (Section 2.9.3 of the SOW) Provide system help desk support via phone and e-mail to CAN CLAs during regular working hours for technical system issues. (Section 2.9.2 of the SOW)	September 2022 December 2022 March 2023 - June 2023	$100,000 each quarter **Total: $400,000**	Submission of reports
Task 2	Participate in LAC-DMH CAN implementation meetings and quarterly learning sessions	September 2022 December 2022 March 2023 June 2023	$100,000 each quarter **Total: $400,000**	Presence noted by County's Project Director
Task 3	Finalize and submit the final report to LAC-DMH in an electronic format on the outcomes for each CAN community and strategy, along with an analysis of the learning questions associated with CAN document in Section 1.0 of the SOW. (Section 2.10.3 of the SOW) Final recommendations to LAC-DMH on successful community capacity building approaches and their impact on trauma. (Section 2.10.3 of the SOW)	June 2022	$200,000	Submission of report Year 5 outcomes measures reports
Total amount billed in FY 2022-2023 shall not exceed $1,000,000.				

County of Los Angeles — Department of Mental Health

MHSA EVALUATION OF INNOVATION 2: Developing Trauma Resilient Communities: Community Capacity Building - Community Ambassador Network

PROJECT INVOICE (SAMPLE)

Send To (Original):

Provider Reimbursement Section
County of Los Angeles — Department of Mental Health
510 S. Vermont Avenue
Los Angeles, CA 90020

Contractor Name: The Regents of the University of California, San Diego

DMH Contract No.: MH250008

LAC-DMH Encumbrance No:_____

Program: Evaluation of Innovation 2 (INN 2): Developing Trauma Resilient Communities: Community Capacity Building- Community Ambassador Network (CAN)

Funding Source: 1991 Realignment and/or MHSA-PEI

Month/Quarter Fiscal Year: _____

DESCRIPTION	AMOUNT
Description of deliverables completed during quarter: 1. Evaluation deliverables and associated cost:	-
2. Administrative Costs (Not to Exceed 15%) (Provide Supporting Documentations)	
I hereby certify that all information contained above are services and costs eligible under the terms and conditions for reimbursement under MHSA Innovation and is true and correct to the best of my knowledge. These services and costs are solely for the Evaluation of INN 2 - Developing Trauma Resilient Communities: Community Capacity Building. All supporting documentations will be maintained in a separate file for the period specified under the provisions of the Consultant Contract.	*$ -*

Signature: _____ Date:

Print Name: _____ Title: Phone: _____

LAC-DMH Program Approval:

Approved by (signature): _____Date: _____

Print Name: _____Title: _____

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

JONATHAN E. SHERIN, M.D., Ph.D.
Director

Gregory C. Polk, M.P.A.
Chief Deputy Director

Curley L. Bonds, M.D.
Chief Medical Officer

Lisa H. Wong, Psy.D.
Senior Deputy Director

March 24, 2022

TO: Supervisor Holly J. Mitchell, Chair
Supervisor Hilda L. Solis
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director

SUBJECT: **NOTICE OF INTENT TO EXTEND THE EXISTING INNOVATION 2 – DEVELOPING TRAUMA RESILIENT COMMUNITIES: COMMUNITY CAPACITY BUILDING CONTRACTS AND THE CONSULTANT SERVICES CONTRACT WITH THE REGENTS OF THE UNIVERSITY OF CALIFORNIA, SAN DIEGO**

In accordance with the Los Angeles County Board of Supervisors' (Board) Policy No. 5.100 (Sole Source Contracts and Amendments), the Department of Mental Health (DMH) is notifying your Board of our Department's intent to extend the term of the ten contracts listed in Attachment I, for the continued provision of Innovation 2 (INN 2) services and the evaluation of the INN 2 program with The Regents of the University of California, San Diego (UCSD).

DMH will request that your Board approve the amendment to extend the term of the contracts listed in Attachment I, on a sole source basis for one fiscal year, effective July 1, 2022 through June 30, 2023, with one optional extension for each contract, as necessary. The total aggregate cost of the amendments will be $29,550,000, funded by Realignment 2011 and/or Mental Health Services Act (MHSA) revenue.

JUSTIFICATION

On August 14, 2018 and September 18, 2018, your Board adopted two Board letters authorizing the Director of Mental Health to execute ten contracts in total, nine contracts to provide INN 2 services throughout all Supervisory Districts in Los Angeles County and

a Consultant services contract with UCSD for the evaluation of the INN 2 program. The purpose of the INN 2 program is to promote interagency or community collaboration to build each community's capacity to prevent trauma or reduce the impact of trauma on residents of that community. At the onset of the pandemic, DMH expanded the INN 2 program and utilized time-limited Coronavirus Aid, Relief & Economic Security (CARES) Act and MHSA funding to support the nine contractors with COVID-19 support, education, and community outreach.

The INN 2 program expansion established the Community Ambassador Network (CAN) to support the most disadvantaged communities in Los Angeles County including those communities disproportionately impacted by the COVID-19 pandemic. The challenges that have surfaced due to the pandemic have positioned DMH to not only ensure delivery of public mental health services, but to pivot and meet emergent demands as well. The Board has identified the following Health Integration/Alliance priorities: Health Integration, Homelessness, and Poverty Alleviation, which are also a primary focus of the CAN. The CAN is a peer-based model that educates, identifies, and links individuals to existing networks of trusted community-based providers and organizations (CBOs) for necessary resources and supports. To date, CAN has reached 560,268 community members with a 93.4% rate of successful linkages for food, basic needs, Personal Protective Equipment, clothing, and community linkage referrals. CAN participants have reported feeling more resilient after nine months of participating in this INN 2 program.

UCSD has been providing evaluation services of the INN 2 program since its inception. UCSD not only conducts the program evaluation of each INN 2 contractor, but has also established the methodology for the evaluation. The evaluation is focused on the impact of each contractor's ability to prevent and address trauma, but also to invariably identify geographically-defined community partnerships that are successful and self-sustaining. Currently, UCSD maintains a secure database and a web-based application, Innovation Health Outcomes Management System, that allows the contractors and CBOs to enter systems-level and individual-level outcomes data at multiple sites. These outcomes generate automated reports that are then regularly provided to DMH so that DMH can monitor the effectiveness of the INN 2 program. As such, the continuation of the INN 2 program evaluation is imperative to support the program's primary goal of improving community-based mental health service delivery through prevention oriented community capacity building.

The existing ten contracts, including the UCSD's consultant services contract, are set to expire on June 30, 2022. DMH will be requesting approval to extend the term of these contracts, as it is essential that DMH continue the INN 2 program and evaluation services, to ensure CAN continues to provide the much needed services and supports to the community.

NOTIFICATION TIMELINE

Pursuant to Board Policy No. 5.100 (Sole Source Contracts and Amendments), DMH is required to notify your Board at least six months prior to the expiration of an existing contract to amend the contracts when departments do not have delegated authority to execute such amendments. DMH is slightly delayed in notifying your Board of its intent to extend the terms of these contracts. The Board letter requesting approval to extend the contract is projected to be presented to your Board in May 2022. If requested by a Board office or the Chief Executive Office, DMH will place this item on the Health and Mental Health Services Cluster Agenda.

Unless otherwise instructed by your Board office within four weeks of this notice, DMH will present your Board a letter for approval to execute a sole source contract extension with the providers listed in Attachment I.

If you have any questions or concerns, please contact me by email at JSherin@dmh.lacounty.gov or at (213) 738-4601, or your staff may contact Stella Krikorian, Division Manager, Contracts Development and Administration Division, at SKrikorian@dmh.lacounty.gov or at (213) 943-9146.

JES:GCP:SK
RLR:ZW:atm

Attachment

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel

ATTACHMENT I

INN 2 SERVICE PROVIDERS

#	Contractor Name & Headquarter Address	Supervisorial District of Service Location	Contract No.
1	Alma Family Services 900 Corporate Center Dr., Suite 350 Monterey Park, CA 91754	1	MH250001
2	Para Los Ninos 5000 Hollywood Boulevard Los Angeles, CA 90027	1	MH250002
3	Children's Institute Inc. 2121 West Temple St. Los Angeles, CA 90026	2	MH250003
4	Westside Infant-Family Network 3701 Stocker Street, Suite 204 Los Angeles, CA 90008	2&3	MH250004
5	Safe Place for Youth (fbo Community Partners) 340 Sunset Ave. Venice, CA 90291	3	MH250005
6	Mental Health America of Los Angeles 200 Pine Ave. Suite 400 Long Beach, CA 90802	4	MH250009
7	The Children's Clinic "Serving Children & Their Families" 701 E. 28th Street, Suite 200 Long Beach, CA 90806	4	MH250010
8	City of Pasadena Public Health Dept. 1845 North Fair Oaks Ave. Pasadena, CA 91103	5	MH250006
9	The Children's Center of the Antelope Valley 45111 Fern Avenue Lancaster, CA 93534	5	MH250007

INN 2 PROGRAM EVALUATOR

#	Contractor Name & Address	Supervisorial District Service Location	Contract No.
10	University of California San Diego 9500 Gilman Drive, 0631 La Jolla, CA 92093	ALL	MH250008