Chief Executive Office.

COUNTY OF LOS ANGELES
CHIEF EXECUTIVE OFFICER
Fesia A. Davenport

HEALTH AND MENTAL HEALTH CLUSTER AGENDA REVIEW MEETING

DATE: Wednesday, May 24, 2023
TIME: 11:30 A.M.

THIS MEETING WILL CONTINUE TO BE CONDUCTED VIRTUALLY AS PERMITTED UNDER THE BOARD OF SUPERVISORS' FEBRUARY 7, 2023, ORDER SUSPENDING THE APPLICATION OF BOARD POLICY 3.055 UNTIL JUNE 30, 2023

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.

11:00 A.M. NOTICE OF CLOSED SESSION
CS-1 CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Government Code Section 54956.9(d)
Significant exposure to Litigation
Department of Health Services

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. DPH: Approval to Amend Three Black Infant Health Services Contracts as Sole Source to Extend the Contract Term (#06904)

b. DPH: Approval to Execute Amendment to the Memorandum of Understanding with the Los Angeles County Children and Families First -

Proposition 10 Commission to Support African American Infant and Maternal Mortality Prevention Initiative Activities (#06907)

c. DPH: Authorization to Amend Two Sole Source Contracts for School Novel Coronavirus 2019 Prevention Partnership Services to Extend the Term Effective July 1, 2023, through June 30, 2024 (#06938)

d. DPH: Approval to Execute an Amendment to the Master Agreement Work Order with Rescue Agency Public Benefit, LLC for the Provision of Substance Use/Misuse Prevention and Treatment Media Services (#06917)

e. DHS: Authorize the Sole Source Acquisition of a Human Patient Simulator for the Los Angeles General Medical Center

f. DHS: Request Approval of Amendment No. 11 To Extend the Sole Source Agreement with Insight Corp. For The Continued Provision of Magnetic Resonance Imaging Services

g. DHS: Request Approval of Funding Methodology and Allocation of Funding to Non- County Trauma Centers for FY 2022-23

h. DMH: Approval to Amend Existing Legal Entity and 24-Hour Residential Treatment Contracts to Increase Their Maximum Contract Amounts for Fiscal Years 2022-23 and 2023-24 for the Continued Provision of Specialty Mental Health Services

i. DMH: Approval to Extend the Existing Contract with Southern California Grantmakers for the Veteran Peer Access Network Program on a Sole Source Basis

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

a. DPH: Authorization to Accept and Sign a Forthcoming Agreement and Future Agreements and/or Amendments from the California Department of Public Health to Support the Youth Suicide Prevention Reporting and Crisis Response Pilot Program (#06915)

b. DPH: Approval to Execute Four Contracts for Trauma Prevention Initiative: Hospital Violence Intervention Program Services (#06852)

c. DMH: Approval to Amend an Existing Contract with CBRE Managed Services, Inc. to Increase the Total Contract Sum for 2023 and 2024 for the Continued Provision of Facilities Management Services

d. DMH: Adopt the Department of Mental Health's Mental Health Services Act Annual Update for Fiscal Year 2023-24

e. DHS: Approval of Ordinance Amendment to the County Code, Title 7 – Business Licenses, Chapter 7.16, Ambulances

f. DHS: Approve Acceptance of an Award from the California Department of State Hospitals and Approve Related Actions and Appropriation Adjustments to Further Implement the Felony Incompetent to Stand Trial Community-based Restoration Program and the Pre-trial Felony Mental Health Diversion Program

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

DRAFT

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/24/2023
BOARD MEETING DATE	6/6/2023
SUPERVISORIAL DISTRICT AFFECTED	☐ All ☐ 1st ☒ 2nd ☐ 3rd ☒ 4th ☒ 5th
DEPARTMENT(S)	Public Health
SUBJECT	Approval to amend three black infant health services contracts as sole source contracts to extend the contract term
PROGRAM	Maternal, Child, and Adolescent Health Division (MCAH)
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No
SOLE SOURCE CONTRACT	☒ Yes ☐ No
	If Yes, please explain why: Current BIH contracts are scheduled to end on June 30, 2023, with additional funding to be effective July 1, 2023. Extension of these contracts will allow agencies to continue the provision of BIH services as Public Health explores program expansion plans that align with forthcoming revised California Department of Public Health (CDPH) BIH program mandates and conduct a solicitation.
DEADLINES/ TIME CONSTRAINTS	Current BIH contracts are scheduled to end on June 30, 2023.
COST & FUNDING	Total cost: $3,~~0~~65~~5~~16,~~389~~000 | Funding source: State General Funds (SGF), Federal Title V – Assistance Listing Number (ALN) 93.994, and Title XIX – Medical Assistance Program, ALN #93.778, awarded by CDPH
	TERMS (if applicable): 7/01/23 through 6/30/24, with an additional year through 6/30/25
	Explanation: Funding amounts for the service contracts are subject to CDPH funding availability.
PURPOSE OF REQUEST	Authorize Public Health to amend the three BIH services contracts as sole source to extend the contract term.
BACKGROUND (include internal/external issues that may exist including any related motions)	The BIH program aims to improve health among African American mothers and babies and to reduce Black-White disparities by empowering pregnant and parenting African American women and connecting them to important social support programs. These program support mothers to make healthy choices for themselves, their families, and their communities. Since 1993, Public Health has contracted with community-based organizations to provide BIH services in Los Angeles County.
EQUITY INDEX OR LENS WAS UTILIZED	☒ Yes ☐ No If Yes, please explain how: BIH program aims to improve health among African American mothers and babies and to reduce Black-White disparities by empowering pregnant and parenting African American women and connecting them to important social support programs. and toddlers.
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	☒ Yes ☐ No If Yes, please state which one(s) and explain how: The recommended actions support Strategy I.1 – Increase Our Focus on Prevention Initiatives, of the County's Strategic Plan.

DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: Joshua Bobrowsky, Public Health Director Government Affairs, (213) 288-7871, jbobrowsky@ph.lacounty.gov Melissa Franklin, Director, MCAH, (213) 639-6400 MFranklin@ph.lacounty.gov Craig L. Kirkwood, Jr., Deputy County Counsel, (213) 974-1751 CKirkwood@counsel.lacounty.gov

COUNTY OF LOS ANGELES
Public Health

DRAFT

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June 6, 2023

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

Dear Supervisors:

APPROVAL TO AMEND THREE BLACK INFANT HEALTH SERVICES CONTRACTS AS SOLE SOURCE CONTRACTS TO EXTEND THE CONTRACT TERM (SUPERVISORIAL DISTRICTS 2, 4 and 5) (3 VOTES)

SUBJECT

Request approval to execute amendments to three Black Infant Health services contracts as sole source contracts to extend the term effective July 1, 2023, through June 30, 2024, and delegate authority to execute future amendments and change notices, as appropriate, as well as to extend the term, reflect funding adjustments, and other related changes; and suspend and/or terminate the contracts, as necessary.

IT IS RECOMMENDED THAT THE BOARD:

1. Approve and instruct the Director of the Department of Public Health (Public Health), or designee, to execute contract amendments, substantially similar to Exhibit I, to three contracts as sole source contracts for the continued provision of Black Infant Health (BIH) services, effective July 1, 2023, through June 30, 2024, at the following amounts: a) Contract Number PH-003175 with The Children's Collective, Inc. (TCC) for $1,808,000, b) Contract Number PH-003173 with Children's Bureau of Southern California (CBS) for $904,000, and, c) Contract Number PH-002924 with City of Pasadena (COP) for $904,000; fully offset by State General Funds, Federal Title V, Assistance Listing Number (ALN) 93.994 and Federal Title XIX, ALN 93.778, awarded by the California Department of Public Health (CDPH).

2. Delegate authority to the Director of Public Health, or designee, to execute amendments to the BIH contracts that: a) extend the term for one additional year through June 30, 2025, at amounts to be determined by the Director of Public Health based on funding availability; b) allow a no-cost adjustment to the term of the contracts for up to six months; c) provide an increase or decrease in funding up to 10 percent above or below each term's annual base maximum obligation, and/or, d) reflect other necessary modifications to the contract to meet Public Health, County, and/or, CDPH requirements, effective upon amendment execution or at the beginning of the applicable contract term, and make corresponding service adjustments, as necessary, subject to review and approval by County Counsel, and notification to your Board and the Chief Executive Office (CEO).

3. Delegate authority to the Director of Public Health, or designee, to execute change notices to the BIH contracts that authorize budget modifications, and corresponding service adjustments, as necessary; changes to hours of operation and/or service locations; and/or corrections of errors in the contract's terms and conditions.

4. Delegate authority to the Director of Public Health, or designee, to immediately suspend any contract upon issuing a written notice to contractors who fail to fully comply with program requirements; to terminate contracts for convenience by providing a 30-calendar day advance written notice to contractors; and to accept voluntary contract termination notices from contractors.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Public Health's BIH program utilizes the CDPH BIH Program Model to provide services to African American women who are 18 years of age and older and less than 30 weeks pregnant. The program is a 20-session group intervention (10 sessions prenatally and 10 sessions postpartum) with complementary case management designed to be culturally relevant and to help women develop life skills, learn strategies for reducing stress, and build social support. The BIH program aims to improve health among African American mothers and babies and to reduce Black-White health inequities by empowering pregnant and parenting African American women and connecting them to important social support programs. This program supports mothers to make healthy choices for themselves, their families, and their communities.

Public Health currently has three contracts to provide BIH services in high priority areas as follows: a) CBS for services in Los Angeles County (LAC) Service Planning Area (SPA) 1; b) TCC for services in SPAs 6 and 8; and c) COP for services in SPA 3.

Approval of Recommendation 1 will allow Public Health to extend the term of three BIH contracts as sole source contracts to continue the provision of program services to address the problem of poor birth outcomes and health disparities that affect African American women and their babies.

Approval of Recommendation 2 will allow Public Health to execute amendments to the contracts to extend and/or adjust the term of the contracts, rollover unspent funds, and/or increase or decrease funding up to 10 percent above or below each term's annual base maximum obligation, and/or reflect other necessary modifications to the contract to meet Public Health, County, and/or, CDPH requirements effective upon amendment execution, or at the beginning of the applicable contract term, and make corresponding service adjustments, as necessary. This recommended action will also enable Public Health to amend the contracts to adjust the term for a period of up to one year beyond the anticipated expiration date. Such amendments will only be executed if and when there is an unanticipated extension of the term of the applicable grant funding. This authority is being requested to enhance Public Health's efforts to expeditiously maximize grant revenue, consistent with Board Policy 4.070: Full Utilization of Grant Funds.

CDPH conducted a beta test related to the BIH group services curriculum. Results from this test will be used by CDPH to determine how the State BIH program model and expansion will be implemented in the next three-year program cycle (2023-2026). It is anticipated that Public Health will need to make modifications to the contracts to meet revised CDPH requirements during next fiscal year's extension.

Approval of Recommendation 3 will allow Public Health to execute change notices to the contracts that authorize budget modifications and corresponding service adjustments, and as necessary, changes to hours of operation and/or service locations; as well corrections of errors in the contracts' terms and conditions, when needed

Approval of Recommendation 4 will allow Public Health to immediately suspend contracts with contractors who fail to perform and/or fully comply with program requirements, to terminate contracts for convenience by providing 30-calendar days' advance written termination notice to contractors, and to accept notices from contractors who voluntarily request to terminate their contract(s).

Implementation of Strategic Plan Goals

The recommended actions support Strategy I.1, Increase Our Focus on Prevention Initiative, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

The total estimated cost for the three recommended contract extensions for the period effective July 1, 2023, through June 30, 2024, is $3,616,000, fully offset by State General Funds, Federal Title V, and Federal Title XIX, awarded by CDPH.

There is no net County cost associated with this action.

Funding is included in Public Health's Recommended Budget for fiscal year (FY) 2023-24 and will be included in future FYs, as necessary.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

The state-wide BIH program began in 1989 to address the alarming number of black infant deaths. Even now, health disparities are prevalent in African American communities in LAC. Since 1993, Public Health has contracted with community-based organizations to provide BIH services using the CDPH BIH Program model. Data compiled by the Public Health Maternal, Child and Adolescent Health Division in 2012 demonstrates that the infant mortality rate for African American babies in LAC is twice as high as the overall County rate and that of white babies. Based on an analysis of selected perinatal indicators, high-need priority areas were identified as SPA 1, 6, and 8.

In 2014, CDPH notified all local health jurisdictions that the distribution of BIH funding for the state-wide program would be recalculated to reflect the latest data on African American deaths. As a result, CDPH determined that COP was no longer eligible to directly receive State BIH funds. It was also determined that LAC should include COP as a County contractor to allow for the continued provision of BIH services in Pasadena and the surrounding areas in SPA 3.

On October 31, 2022, CDPH announced the BIH 2022 Expansion Plan and Allocation for Local Health Jurisdictions that demonstrated the ability to reach 80% of their FY 2021-22 commitment for BIH program participation. The Expansion Plan and Allocation includes State General Fund funding that supports capacity building for expansion of the existing BIH program model and includes planning and preparing for expansion and successful implementation.

In the months of November and December of 2022, CDPH conducted a beta test related to the BIH group services curriculum. Results from this test will be used by CDPH to determine how the State BIH program model and expansion will be implemented in the next three-year program cycle (2023-2026). Once CDPH provides the program requirements, Public Health intends to release a solicitation for BIH services in LAC.

As required by Board Policy 5.100, your Board was notified on March 9, 2023, of Public Health's intent to request approval to extend the term of three BIH services contracts as sole source contracts.

County Counsel has reviewed and approved Exhibit I as to use. Attachment A is the Sole Source Checklist signed by the CEO.

CONTRACTING PROCESS

On March 8, 2016, Public Health released an Invitation for Bids (IFB) to solicit BIH services. On August 23, 2016, your Board approved contracts for BIH services in Service Planning Area (SPA) 1, 6 and 8.

For several years, your Board has approved contracting with various entities to provide BIH services in high priority areas in Los Angeles County (LAC).

Currently, Public Health contracts with three entities to provide BIH services in high priority areas: a) CBS under Contract Number PH-003173 for services in LAC SPA 1; b) TCC under Contract Number PH-003175 for services in SPAs 6 and 8; and c) COP under Contract Number PH-002924 for services in SPA 3. These contracts are scheduled to end on June 30, 2023.

Extension of the three BIH contracts will allow these agencies to continue to provide the needed services as Public Health explores program expansion plans that align with the forthcoming revised CDPH mandates for the BIH program and conduct a new solicitation. Furthermore, CDPH's allocation for subsequent FYs will be determined by Public Health's ability to reach this underserved population.

IMPACT ON CURRENT SERVICES

Approval of the recommended actions will allow Public Health to continue the provision of BIH program services in LAC to address the problem of poor birth outcomes and health disparities that affect African American women and their babies.

Respectfully submitted,

Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

BF:mk
#06904

Enclosures

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

BIH Scope of Work Description

The Scope of Work (SOW) is a very important document because it contains the deliverables of the contract for which the Contractor is responsible. The SOW functions as a master plan for the program. Contractors should become intensely familiar with the SOW to establish, maintain, and implement a thriving BIH Program. Contractors are encouraged to be creative in the development of their program, which may result in the creation of additional goals and objectives not described herein.

The SOW contains broad statements that describe the objectives of the program, activities that will lead to achieving the objectives, a timeline for accomplishing activities, and methods of evaluation that determine and measure a Contractor's success in establishing a BIH Program. The SOW is organized with the goals at the top, the measurable objectives in the first column, the implementation activities in the second column, the timeline in the third column, and the methods of evaluation in the fourth column. The implementation activities, timeline, and methods of evaluation all support the measurable objective.

- **Goals** – A description of the desired outcomes of the program.
- **Measurable Objectives** – The process and outcome activities (stated in measurable terms) by which the goals will be accomplished.
- **Implementation Activities** – The essential actions/steps needed to achieve the objectives.
- **Timeline** – The due date(s) to accomplish each implementation activity.
- **Method(s) of Evaluation** – A description of how the objective will be documented to determine successful achievement of the objective.

The BIH staff and subcontractor(s)/consultant(s) implementing program services are instrumental in managing the SOW objectives and are responsible for the performance of the implementation activities. The SOW is a part of the final contract with the Department of Public Health and will be monitored for compliance.

The term 'Program Fidelity' is used within the document, and it refers to how well an intervention is implemented in comparison with the original program design. Fidelity criteria are necessary to maintain the original program design, and to ensure the program services being implemented are the same across sites. Consequently, the Contractor must ensure all staff and subcontractor(s)/consultant(s) performing BIH services receive a copy of the SOW and become thoroughly familiar with its content.

Exhibit B-11

Black Infant Health Program (BIH) Program Services
Scope of Work
July 1, 2023 through June 30, 2024

The Contractor must work toward achieving the following measurable objectives. The objectives shall be achieved by following the work plan that is comprised of implementation activities, a timeline and methods of evaluation. Implementation activities are to be completed according to the timeline and are to be documented/evaluated as specified.

Goals

- Empower African American women, build resilience and reduce stress
- Promote healthy behaviors to support health, wellness and relationships
- Promote healthy relationships and enhance bonding and parenting skills
- Connect women with medical, social, economic and mental health services
- Engage African American communities to raise awareness and mobilize community action to support BIH efforts and improve conditions for African American women and their families

MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
1.1 The Contractor will maintain qualified staff to conduct a community-based Black Infant Health (BIH) Program that is relevant to African American women, culturally competent and honors the unique history/traditions of people of African American descent. ***BIH Fidelity Core Element*** ➢ *Are efforts made to continually ensure quality staffing of the BIH program?* ***A working definition of cultural competence is…*** *"Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities."*	**1.1a** Maintain culturally competent staff to perform program services. The staff must possess knowledge, understanding and respect for the values and beliefs of the African American community, and support the BIH governing concepts of: culturally relevant; participant-centered; strength-based; cognitive skill-building. **Staff REQUIRED to perform BIH services:** **Mental Health Specialist (MHS) (1.0 Full Time Equivalent (FTE)) –** This staff person is responsible for the participant enrollment activities which includes, but is not limited to: program orientation; obtaining consent; initiating the first prenatal and first postpartum assessments; distributing the Group Intervention Schedule; conducting the EPDS; participating in group sessions as needed; conducting case conferences. The MHS will also identify relevant mental health resources. **Group Facilitator (GF) (2.0 FTE)** – Two (2) staff are responsible for the group intervention activities which includes and is not limited to: creating the GIS; co-	07/01/23 – 06/30/24 Hire within 3 months of vacancy Hire within 3 months of vacancy	**1.1a** Maintain on file for each position: current job description; recruitment ad/bulletin/flyer(s): employment applications; documentation of the position minimum requirements and supporting credentials (e.g., I9 Employment Eligibility; diploma/certification/official transcript; a valid CA driver license and auto insurance that remains current while performing program tasks/activities etc.). **Position Minimum Requirements** **MHS** – Minimum of a Master's Degree in one of the following fields: a) social work, b) counseling, or, c) psychology with an emphasis on the family and/or women/children; three (3) years of experience providing direct services to the target population; socio-cultural experience(s) compatible for the target population; excellent oral and written communications; interpersonal skills; critical thinking and problem-solving skills. **GF –** Minimum of a Bachelor's Degree in one of the following fields: a) women/maternal, child/infant health, b) social work, c) health education, or d) African American Studies; three (3) years of experience

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MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
	facilitating the Prenatal and Postpartum Groups; documenting participants' engagement in group sessions; participating in case conference activities.		providing direct services to the target population; socio-cultural experience(s) compatible for the target population; excellent oral and written communications; interpersonal skills; critical thinking and problem-solving skills.
	Family Health Advocate (FHA) (3.0 FTE) - Three (3) staff are responsible for the case management services which includes, but is not limited to: ensuring participants complete the Character Strengths Survey; participating in case conference activities; assisting participants to create goals and develop their Life Plan; initiating follow-up assessments; maintaining consistent contact with participants; promoting tobacco cessation; making appropriate referrals; providing support for group sessions.	Hire within 3 months of vacancy	**FHA** – Minimum of a Bachelor's Degree or enrollment in a college/university in one of the following fields: a) women/maternal, child/infant health, b) social work, c) health education, or d) human services; three (3) years of experience providing direct services to the target population; socio-cultural experience(s) compatible for the target population; excellent oral and written communications; interpersonal skills; critical thinking and problem-solving skills. For FHAs currently enrolled in college, the Bachelor's Degree must be completed within six (6) years from the hire date.
	Community Outreach Liaison (COL) (1.0 FTE) – This staff is responsible for the program recruitment activities which includes and is not limited to: developing and implementing the RP; making formal presentations about BIH services to create referral networks; cultivating and maintaining working relationships with collaborative partners to maintain networks for recruiting/referring participants.	Hire within 3 months of vacancy	**COL –** Minimum of a Bachelor's Degree or enrollment in a college/university in one of the following fields: a) public relations, b) marketing, or c) communications; three (3) years of experience providing information/making presentations to the target population/community; excellent oral and written communications; interpersonal skills; critical thinking and problem-solving skills. For COLs currently enrolled in college, the Bachelor Degree must be completed within six (6) years from the hire date.
	Data Entry Assistant (DEA) (1.0 FTE) – This staff is responsible for the data management activities and the office administrative/clerical duties.	Hire within 3 months of vacancy	**DEA –** Minimum of an Associate of Arts degree or enrollment in a certification program in one of the following fields: a) information systems, b) database management, or c) office technology; three (3) years of experience performing data entry/retrieval tasks; three

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The Contractor must work toward achieving the following measurable objectives. The objectives shall be achieved by following the work plan that is comprised of implementation activities, a timeline and methods of evaluation. Implementation activities are to be completed according to the timeline and are to be documented/evaluated as specified.

MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
			(3) years of experience performing general office duties including word processing, answering phones, and maintaining filing systems; excellent communication and interpersonal skills; critical thinking and problem solving skills. For DEAs currently enrolled in a certification program or college, an Associate Degree must be completed within three years from the hire date, or a Bachelor Degree must be completed within six (6) years from the hire date.
	OPTIONAL additional staff position(s): ***Program Supervisor (PS)*** *– This staff person will supervise the implementation of the State BIH Program Group Intervention(s), Case Management Services, and the Efforts to Outcome (ETO) data system. Serve as the BIH liaison for Public Health, assign new participants to a FHA, manage tobacco education activities, as well as participate in recruitment activities.* *<u>If a PS position is not included in the program budget</u>, the PS duties and position minimum requirements must be assumed within the MHS position.*	Hire within 3 months of vacancy	***PS –*** *Minimum of a Bachelor's Degree in one of the following fields: a) women/maternal, child/infant health, b) public/business administration, or c) a closely related health/social science field; five (5) years management experience including the supervision of 6 or more employees; socio-cultural experience(s) compatible for the target population; excellent oral and written communications; interpersonal skills; critical thinking and problem-solving skills.*

Exhibit B-11

Black Infant Health Program (BIH) Program Services
Scope of Work
July 1, 2023 through June 30, 2024

The Contractor must work toward achieving the following measurable objectives. The objectives shall be achieved by following the work plan that is comprised of implementation activities, a timeline and methods of evaluation. Implementation activities are to be completed according to the timeline and are to be documented/evaluated as specified.

MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
2.1 The Contractor will ensure the Fiscal Manager (FM) and all BIH staff and subcontractor(s) performing program implementation activities are trained on the State-mandated Federal Financial Participation (FFP) Program and the Public Health Automated Time Study procedures.	**2.1a** The staff/subcontractor(s)/FM will attend the State FFP Program / Public Health Automated Time Study training(s).	As scheduled	**2.1a** Maintain training certificate/documentation in staff/subcontractor(s) personnel files.
	2.1b Contractor will use the State and Public Health training materials to train new staff/subcontractor(s)/FM about the FFP Program and Automated Time Study procedures within the first two (2) weeks of their employment.	As needed	**2.1b** Maintain on file current copies of the State and Public Health training materials. Maintain training certificate/documentation in staff/subcontractor(s) personnel files.
	2.1c As required by Public Health, staff/subcontractor(s) will complete quarterly time study forms for July and October of 2023, and January and April of 2024. Original (signed in blue ink) forms and a staffing roster will be delivered (overnight mail or hand delivery) to Public Health no later than the 5th work day of the following month.	08/05/23 11/07/23 02/07/24 05/05/24	**2.1c** Maintain on file copies of mail/delivery receipts.
	2.1d Public Health will review original Time Study forms and return forms to the Contractor for correction. Staff/subcontractor(s) will correct and resubmit forms to Public Health no later than seven (7) calendar days from receipt.	08/27/23 – 06/30/24	**2.1d** Maintain on file copies of corrected quarterly time studies and delivery receipts.

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Black Infant Health Program (BIH) Program Services
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The Contractor must work toward achieving the following measurable objectives. The objectives shall be achieved by following the work plan that is comprised of implementation activities, a timeline and methods of evaluation. Implementation activities are to be completed according to the timeline and are to be documented/evaluated as specified.

MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
2.2 The Contractor will ensure all BIH staff/subcontractor(s) performing program implementation activities are trained on the State-mandated Recruitment Procedures, Group Interventions, Case Management Services and BIH ETO System. *Public Health will coordinate core intervention training with the State BIH Program Office.*	**2.2a** Staff/subcontractor(s) will attend State BIH recruitment, group interventions, case Management and BIH ETO trainings.	As scheduled	**2.2a** Maintain training certificate/documentation in staff/subcontractor(s) personnel files.
	2.2b Contractor will use the State BIH recruitment strategy, group curriculums, case management protocol and ETO guidelines to train new staff/subcontractor(s) to implement a recruitment strategy, facilitate the group interventions, perform case management services and use the BIH ETO System. The PS will develop a training schedule for each new hire within the first two (2) weeks of employment to ensure staff/subcontractor(s) are consistently acclimated to BIH Program services/job duties and responsibilities. The PS will submit the training schedule to Public Health for review and complete training with new staff/subcontractor(s) within the first sixty (60) days of their employment.	As needed	**2.2b** Maintain on file current copies of the State BIH group curriculums, case management protocol, ETO guidelines, recruitment procedures and Public Health Acknowledgment of Receipt. Maintain training certificate/documentation in staff/subcontractor(s) personnel files.

Exhibit B-11

Black Infant Health Program (BIH) Program Services
Scope of Work
July 1, 2023 through June 30, 2024

The Contractor must work toward achieving the following measurable objectives. The objectives shall be achieved by following the work plan that is comprised of implementation activities, a timeline and methods of evaluation. Implementation activities are to be completed according to the timeline and are to be documented/evaluated as specified.

MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
2.3 The Contractor will ensure all BIH staff/subcontractor(s) performing program implementation activities attend or receive appropriate staff development/training. *Public Health will coordinate SIDS and Safe Sleep for Infants Training and Immunizations Training.*	**2.3a** Contractor will ensure staff/subcontractor(s) receive on-going training on perinatal health subjects (e.g., stages of pregnancy; effects of drugs, alcohol and tobacco on pregnancy; postpartum depression; family planning; child safety; nutrition and physical activity; etc.) and other topics (e.g., time management; self-care; intimate partner violence; active listening; basic counseling skills; etc.) that will improve their knowledge, skills and ability to perform program services competently with participants.	As scheduled	**2.3a** Maintain training certificate/documentation in staff/subcontractor(s) personnel files.
	2.3b Staff/subcontractor(s) will attend the Public Health SIDS and Safe Sleep Training.	As scheduled	**2.3b** Maintain on file current Public Health SIDS and Safe Sleep training materials. Maintain training certificate/documentation in staff/subcontractor(s) personnel files.
	2.3c The PS will review the SIDS and Safe Sleep Education Form to ensure the form is suitable for documenting one-on-one health education with participants and that FHAs are adept at using the form. Submit form to Public Health for review and approval.	08/01/23	**2.3c** Maintain Public Health approval on file.
	2.3d During case management, FHAs will educate participants about SIDS and Safe Sleep at the following intervals: during a home visit within two (2) weeks of the infant's birth; when the infant is 8 months old.	07/01/23 – 06/30/24	**2.3d** Maintain an up-to-date/completed SIDS and Safe Sleep Education Form in the participant's file. During the Annual Program Review participant records will be reviewed for compliance.

Exhibit B-11

Black Infant Health Program (BIH) Program Services
Scope of Work
July 1, 2023 through June 30, 2024

The Contractor must work toward achieving the following measurable objectives. The objectives shall be achieved by following the work plan that is comprised of implementation activities, a timeline and methods of evaluation. Implementation activities are to be completed according to the timeline and are to be documented/evaluated as specified.

MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
	At each interval, a FHA will observe the infant's sleeping area and sleeping position to provide the mother/parents/other caregivers appropriate feedback to reinforce SIDS and Safe Sleep messages, and will document the observations on the participant's SIDS and Safe Sleep Education Form.		
	2.3e Contractor will use the Public Health SIDS and Safe Sleep training materials to train new staff/subcontractor(s). Contractor will complete training within the first sixty (60) days of their employment.	As needed	**2.3e** Maintain training certificate/documentation in staff/subcontractor(s) personnel files.
	2.3f Staff/subcontractor(s) will attend the Public Health Immunizations Training.	As scheduled	**2.3f** Maintain on file a current Public Health Immunization Manual (training binder). Maintain training certificate/documentation in staff/subcontractor(s) personnel files.
	2.3g Contractor will use the Public Health Immunization Manual to train new staff/subcontractor(s) about the importance of immunizations. Contractor will complete training within the first sixty (60) days of their employment.	As needed	**2.3g** Maintain training certificate/documentation in staff/subcontractor(s) personnel files.
	2.3h Staff/subcontractor(s) will attend Public Health Tobacco Education Training to gain knowledge about the impact of tobacco use/exposure during the perinatal period.	As scheduled	**2.3h** Maintain training certificate/documentation in staff/subcontractor(s) personnel files.
	2.3i Staff will attend other State and Public Health required/sponsored training.	As scheduled	**2.3i** Maintain training certificate/documentation in staff/subcontractor(s) personnel files.

Exhibit B-11

Black Infant Health Program (BIH) Program Services
Scope of Work
July 1, 2023 through June 30, 2024

The Contractor must work toward achieving the following measurable objectives. The objectives shall be achieved by following the work plan that is comprised of implementation activities, a timeline and methods of evaluation. Implementation activities are to be completed according to the timeline and are to be documented/evaluated as specified.

MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
	2.3j The FHAs will use the BIH Case Management FHA Self-Assessment Tool for one (1) workweek each quarter to evaluate their case management skills.	By 09/15/23 By 12/15/23 By 03/15/24 By 06/15/24	**2.3j** Maintain on file completed FHA Case Management Self-Assessment Tools for each FHA.
	2.3k In conjunction with the FHA completing the FHA Self-Assessment Tool, the PS will complete the BIH Case Management FHA Supervision Tool to support staff development.	By 09/30/23 By 12/30/23 By 03/30/24 By 06/30/24	**2.3k** Maintain on file completed Supervision Tools that correlate with completed FHA Case Management Self-Assessment Tools.

Exhibit B-11

Black Infant Health Program (BIH) Program Services
Scope of Work
July 1, 2023 through June 30, 2024

The Contractor must work toward achieving the following measurable objectives. The objectives shall be achieved by following the work plan that is comprised of implementation activities, a timeline and methods of evaluation. Implementation activities are to be completed according to the timeline and are to be documented/evaluated as specified.

MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
3.1 The Contractor will increase awareness about African American birth outcomes and BIH Program services by conducting community engagement activities in the target areas. **TARGETED SERVICE PLANNING AREA** **SPA 1** *All flyers/educational materials purchased with BIH funding must have the State BIH logo and include a funding tag line that reads: "Funded by the California Department of Public Health and the Los Angeles County Department of Public Health."* ***BIH Fidelity Core Element*** ➢ *Are efforts made to establish and maintain community linkages?*	**3.1a** The PS and COL will review the Recruitment Plan (RP) to ensure it is sufficient for establishing linkages and engagement with African American communities in SPA 1. Submit a RP bi-annually to Public Health for review and approval. At a minimum include in the RP: *1)* a description of the way community engagement will be conducted within the target areas including guidelines for staff to conduct street/provider/media outreach to recruit eligible women into groups; *2)* an elevator speech that contains standardized messages about adverse health outcomes for African American women and babies, a narrative about BIH's emphasis to empower black women and a program description that will attract women to enroll; *3)* a policy to follow-up referrals within 48 hours, and making three attempts to contact; *4)* a policy to distribute culturally appropriate program brochures, flyers and educational materials; *6)* a policy to develop and maintain an up-to-date resource directory/file for staff use; *7)* a policy to use the BIH Recruitment Form and the Recruitment Form for Referring Partners.	08/01/23 02/01/24	**3.1a** Maintain on file a Recruitment Plan Binder that contains the Recruitment Plan and Public Health approval.
	3.1b The COL will implement the RP, enroll African American women in the BIH Recruitment Program and create a participant record (paper/electronic).	07/01/23 – 06/30/24	**3.1b** Maintain on file participant records (paper/electronic). At the Annual Program Review, participant records will be reviewed to ensure Recruitment Program standards are progressing/achieved.

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Black Infant Health Program (BIH) Program Services
Scope of Work
July 1, 2023 through June 30, 2024

The Contractor must work toward achieving the following measurable objectives. The objectives shall be achieved by following the work plan that is comprised of implementation activities, a timeline and methods of evaluation. Implementation activities are to be completed according to the timeline and are to be documented/evaluated as specified.

MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
	3.1c Contractor will ensure/solicit a cross-section of 9-12 community members to serve as BIH Community Council (BCC) members. (BIH staff cannot be included in this count.)	07/01/23 – 06/30/24	**3.1c** Maintain in the Recruitment Plan Binder, a current BCC roster with contact information (name, organizational affiliation, title, address, phone number) for each council member.
	3.1d Conduct quarterly (minimum) BCC meetings to obtain input and support for program activities, and to work collaboratively to improve African American birth outcomes and family health in the target areas.	07/01/23 – 06/30/24	**3.1d** Maintain in the Recruitment Plan Binder, BCC meeting notices, agendas and minutes.
	3.1e Contractor will create informal and formal partnerships with other programs, agencies and entities to support BIH participants/program services.	07/01/23 – 06/30/24	**3.1e** Maintain on file in the Recruitment Plan Binder, descriptions of informal partnerships and current (within the past two fiscal years) Memorandums of Agreement for formal partnerships.
	3.1f Schedule and participate in community engagement activities (e.g., collaborative meetings; community events; etc.) that benefit the target areas. Document the staff/subcontractor(s) participating in the activity, the address where the activity takes place and if appropriate, record community participation via sign-in/attendance sheets by obtaining original signatures with contact information (phone number *or* email address *or* work/home address including zip code).	07/01/23 – 06/30/24	**3.1f** Maintain on file in the Recruitment Plan Binder (by month/year), a description of the community engagement activity/event including required documentation.

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Black Infant Health Program (BIH) Program Services
Scope of Work
July 1, 2023 through June 30, 2024

The Contractor must work toward achieving the following measurable objectives. The objectives shall be achieved by following the work plan that is comprised of implementation activities, a timeline and methods of evaluation. Implementation activities are to be completed according to the timeline and are to be documented/evaluated as specified.

MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
4.1 The Contractor will conduct Prenatal and Postpartum Groups and serve 100 participants in group-case management services.	**4.1a** The MHS will review the written standardized In-take Procedure and make necessary updates to program/services information. Submit the In-take Procedure to Public Health for review.	08/01/23	**4.1a** Maintain on file an up-to-date In-take Procedure and Public Health Acknowledgment of Receipt.
BIH Fidelity Core Elements ➢ *Do participants meet eligibility requirements?* ➢ *Does staff follow enrollment guidelines?* ➢ *Do participants participate in the full intervention?* ➢ *Do group sessions meet structural standards?* ➢ *Do group sessions meet quality of delivery standards?* ➢ *Are efforts made to continue working on quality assurance?*	**4.1b** The GFs will create a Group Intervention Schedule (GIS), submit it bi-annually to Public Health and provide the rationale used to determine the schedule (frequency/timing).	08/01/23 02/01/24	**4.1b** Maintain on file the Group Intervention Schedule and Public Health Acknowledgment of Receipt.
	4.1c The DEA will enroll eligible African American women into the BIH Services Program. Participant records (paper/electronic) must be arranged/maintained in identical order, contain completed required forms, and clearly show regular and consistent interaction with participants. The Contractor must use record-keeping systems that maintain participant information/data <u>confidentially and securely</u>.	07/01/23 – 06/30/24	**4.1c** Maintain on file up-to-date participant records (paper/electronic). At the Annual Program Review, participant records will be reviewed to ensure the established Services Program Standards are achieved.
	4.1d GFs will implement the group series following the standards set forth in the BIH Group Curriculums, Program Standards, ETO Data Book and Public Health Scope of Work. Staff/subcontractor(s) will encourage participants to attend and participate fully in group sessions.	07/01/23 – 06/30/24	**4.1d** Maintain on file up-to-date participant records, current copies of the BIH Group Curriculums, BIH Program Standards, BIH ETO Data Book and Public Health Scope of Work. At the Annual Program Review, participant and program records will be reviewed to ensure compliance.

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Black Infant Health Program (BIH) Program Services
Scope of Work
July 1, 2023 through June 30, 2024

The Contractor must work toward achieving the following measurable objectives. The objectives shall be achieved by following the work plan that is comprised of implementation activities, a timeline and methods of evaluation. Implementation activities are to be completed according to the timeline and are to be documented/evaluated as specified.

MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
	4.1e Contractor will participate in the Public Health Group Observation Visits. Public Health will observe two (2) prenatal group sessions and one (1) postpartum group session and provide the Contractor feedback to support BIH fidelity efforts.	As scheduled	**4.1e** Maintain on file by month/year Public Health Group Observation Feedback Forms.
	4.1f With guidance from the State BIH Program Office, Contractor will develop Performance Enhancement Plans (PEP) and participate in PEP conference calls with the BIH County Coordinator and the State.	As required	**4.1f** Maintain on file completed PEPs, Public Health feedback, and Public Health Acknowledgement of Receipt.
	Additionally, Contractor will conduct a mid-year *Participant Satisfaction Survey* to obtain feedback about their experiences receiving BIH Program services. Contractor will develop an action plan to implement new strategies that address participants' expectations and concerns. Submit the action plan to Public Health for review.	02/01/24	

Exhibit B-11

Black Infant Health Program (BIH) Program Services
Scope of Work
July 1, 2023 through June 30, 2024

The Contractor must work toward achieving the following measurable objectives. The objectives shall be achieved by following the work plan that is comprised of implementation activities, a timeline and methods of evaluation. Implementation activities are to be completed according to the timeline and are to be documented/evaluated as specified.

MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
4.2 The Contractor will provide case management services for participants enrolled in a group series. ***BIH Fidelity Core Elements*** ➢ *Does case management meet structural standards?* ➢ *Does case management meet quality of delivery standards?*	**4.2a** The MHS will conduct an initial assessment with all new participants and complete required forms. The purpose of the assessment is used to identify the participant's strengths and their needs. In collaboration with the PS, the new participant will be assigned to a FHA.	07/01/23 – 06/30/22	**4.2a** Maintain on file participant records (paper/electronic). At the Annual Program Review, participant records will be reviewed to ensure established Program Standards are achieved.
	4.2b The FHAs will work collaboratively with participants to assist them to create a Life Plan. The intent of the Life Plan is to help the participant create personal goals that include specific activities/steps for reaching their goals.	07/01/23 – 06/30/24	**4.2b** Maintain on file participant records (paper/electronic). At the Annual Program Review, participant records will be reviewed to ensure established Program Standards are achieved.
	4.2c FHAs will coordinate case management services with the GFs to reinforce the weekly group session. Case management services include, but are not limited to: ensuring participants have prenatal care; distributing health education literature; conducting one-on-one tobacco education and providing support and referrals to participants that smoke; making sure participants have health insurance; developing and updating the Life Plan; writing progress notes; conducting home visits; participating in case conferences; completing ETO forms; distributing support materials; coaching participants in-home to complete a safety checklist; assisting participants to create their Birth Plan and Life Plan.	07/01/23 – 06/30/24	**4.2c** Maintain on file participant records (paper/electronic) that document the delivery of case management services. At the Annual Program Review, participant records will be reviewed to ensure established Program Standards are achieved.

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Black Infant Health Program (BIH) Program Services
Scope of Work
July 1, 2023 through June 30, 2024

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MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
	4.2d Staff/subcontractor(s) will provide participants with appropriate referrals that help expand and strengthen the participant's support system. Document the referrals and follow-up with participants to determine if services are accessed.	07/01/23 – 06/30/24	**4.2d** Maintain on file participant records (paper/electronic) that document the referrals given to each participant. At the Annual Program Review, participant records will be reviewed.
	4.2e Staff/subcontractor(s) will refer the BIH participant's husband/partner to resources for fathers, including tobacco cessation resources. As applicable, document the father's referral(s) in the participant's file. Staff/subcontractor(s) will document the fathers' referral(s) in the same location in all participant files.	07/01/23 – 06/30/24	**4.2e** Maintain on file participant records (paper/electronic) that document the father's referral(s). At the Annual Program Review, participant records will be reviewed.
	4.2f Staff/subcontractor(s) will refer participants who use illicit drugs, alcohol and/or tobacco products to appropriate treatment programs. FHAs will monitor the participant's effort to eliminate/reduce the risky behavior, provide positive reinforcement to encourage the participant and supply the participant with appropriate health education literature. Document the referrals and follow-up with participants to determine if services are accessed.	07/01/23 – 06/30/24	**4.2f** Maintain on file participant records (paper/electronic) that document the referral(s) given to affected participants. At the Annual Program Review, participant records will be reviewed.

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Black Infant Health Program (BIH) Program Services
Scope of Work
July 1, 2023 through June 30, 2024

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MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
	4.2g Contractor will conduct quarterly participant-centered program activities (e.g., workshop; event; etc.) that address one of the following subjects: a) personal development; b) family-strengthening; c) mental health; d) physical health. Contractor will submit an activity plan (including activity costs) to Public Health for review 45 days (minimum) prior to the event.	By 08/15/23 By 11/15/23 By 02/15/24 By 05/15/24	**4.2g** Maintain on file by month/year Public Health Acknowledgement of Receipt, activity plans and documentation that identifies the staff that participated in the activity, the address where the activity was held, an activity flyer, pictures of the activity and participant sign-in sheets.

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Black Infant Health Program (BIH) Program Services
Scope of Work
July 1, 2023 through June 30, 2024

The Contractor must work toward achieving the following measurable objectives. The objectives shall be achieved by following the work plan that is comprised of implementation activities, a timeline and methods of evaluation. Implementation activities are to be completed according to the timeline and are to be documented/evaluated as specified.

MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
4.3 The Contractor will conduct Case Management Only (CMO) services with 55 participants (pregnant and postpartum up to 6 months.) ***BIH Fidelity Core Elements*** ➢ *Do participants meet eligibility requirements?* ➢ *Does staff follow enrollment guidelines?* ➢ *Do participants participate in the full intervention?* ➢ *Are efforts made to continue working on quality assurance?*	**4.3a** The MHS will review the written standardized In-take Procedure and make necessary updates to program/services information. Submit the In-take Procedure to Public Health for review.	As needed	**4.3a** Maintain on file an up-to-date In-take Procedure and Public Health Acknowledgment of Receipt.
	4.3b The DEA will enroll eligible African American women into the BIH Services Program. Participant records (paper/electronic) must be arranged/maintained in identical order, contain completed required forms and clearly show regular and consistent interaction with participants. The Contractor must use record-keeping systems that maintain participant information/data confidentially and securely.	07/01/23 – 06/30/24	**4.3b** Maintain on file up-to-date participant records (paper/electronic). At the Annual Program Review, participant records will be reviewed to ensure the established Services Program Standards are achieved.
	4.3c With guidance from the State BIH Program Office, Contractor will develop Performance Enhancement Plans (PEP) and participate in PEP conference calls with the BIH County Coordinator and the State.	As required	**4.3c** Maintain on file completed PEPs, Public Health feedback, and Public Health Acknowledgement of Receipt.
	Additionally, Contractor will conduct a mid-year *Participant Satisfaction Survey* to obtain feedback about their experiences receiving BIH Program services. Contractor will develop an action plan to implement new strategies that address participants' expectations and concerns. Submit the action plan to Public Health for review.	02/01/23	

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Black Infant Health Program (BIH) Program Services
Scope of Work
July 1, 2023 through June 30, 2024

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MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
4.4 The Contractor will provide CMO services for participants that are not enrolled in Group Model/Life Planning. ***BIH Fidelity Core Elements*** ➢ *Does case management meet structural standards?* ➢ *Does case management meet quality of delivery standards?*	**4.4a** The MHS will conduct an initial assessment with all new participants and complete required forms. The purpose of the assessment is used to identify the participant's strengths and their needs. In collaboration with the PS, the new participant will be assigned to a FHA.	07/01/23 – 06/30/24	**4.4a** Maintain on file participant records (paper/electronic). At the Annual Program Review, participant records will be reviewed to ensure established Program Standards are achieved. .
	4.4b The FHAs will work collaboratively with participants to assist them to create a Life Plan. The intent of the Life Plan is to help the participants create personal goals that include specific activities/steps for reaching their goals.	07/01/23 – 06/30/24	**4.4b** Maintain on file participant records (paper/electronic). At the Annual Program Review, participant records will be reviewed to ensure established Program Standards are achieved. .
	4.4c FHAs will conduct case management services with participants. Case management services include but are not limited to: ensuring participants have prenatal care; distributing health education literature; conducting one-on-one tobacco education and providing support and referrals to participants that smoke; making sure participants have health insurance; developing and updating the Life Plan; writing progress notes; conducting home visits; participating in case conferences; completing ETO forms; distributing support materials; coaching participants in-home to complete a safety checklist; assisting participants to create their Birth Plan and Life Plan.	07/01/23 – 06/30/24	**4.4c** Maintain on file participant records (paper/electronic) that document the delivery of case management services. At the Annual Program Review, participant records will be reviewed to ensure established Program Standards are achieved. .
	4.4d Staff/subcontractor(s) will provide participants with appropriate referrals that help expand and strengthen the participant's support system.	07/01/23 – 06/30/24	**4.4d** Maintain on file participant records (paper/electronic) that document the referrals given to each participant. At the Annual Program

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Black Infant Health Program (BIH) Program Services
Scope of Work
July 1, 2023 through June 30, 2024

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MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
	Document the referrals and follow-up with participants to determine if services are accessed.		Review, participant records will be reviewed.
	4.4e Staff/subcontractor(s) will refer the BIH participant's husband/partner to resources for fathers, including tobacco cessation resources. As applicable, document the father's referral(s) in the participant's file. Staff/subcontractor(s) will document the fathers' referral(s) in the same location in all participant files.	07/01/23 – 06/30/24	**4.4e** Maintain on file participant records (paper/electronic) that document the father's referral(s). At the Annual Program Review, participant records will be reviewed.
	4.4f Staff/subcontractor(s) will refer participants who use illicit drugs, alcohol and/or tobacco products to appropriate treatment programs. FHAs will monitor the participant's effort to eliminate/reduce the risky behavior, provide positive reinforcement to encourage the participant and supply the participant with appropriate health education literature. Document the referrals and follow-up with participants to determine if services are accessed.	07/01/23 – 06/30/24	**4.4f** Maintain on file participant records (paper/electronic) that document the referral(s) given to affected participants. At the Annual Program Review, participant records will be reviewed.
	4.4g Contractor will conduct quarterly participant-centered program activities (e.g., workshop; event; etc.) that address one of the following subjects: a) personal development; b) family-strengthening; c) mental health; d) physical health.	By 02/15/23 By 05/15/23	**4.4g** Maintain on file by month/year Public Health Acknowledgement of Receipt, activity plans and documentation that identifies the staff that participated in the activity, the address where the activity was held, an activity flyer, pictures of the activity and participant sign-in sheets.

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Black Infant Health Program (BIH) Program Services
Scope of Work
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MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
	Contractor will submit an activity plan (including activity costs) to Public Health for review 45 days (minimum) prior to the event.		
4.5 The Contractor will ensure BIH participants have access to mental health resources.	**4.5a** The MHS will assess the participants' EPDS and make an appropriate mental health service recommendation/referral.	07/01/23 – 06/30/24	**4.5a** Maintain on file participant records (paper/electronic) that document the mental health referral(s) given to affected participants. At the Annual Program Review, participant records will be reviewed.
	4.5b The MHS will conduct short-term basic counseling services and document the participant's file for participants who report/present MILD cases of: non-coping responses to life events; persistent family discord; continual experiences of loss.	07/01/23 – 06/30/24	**4.5b** Maintain on file participant records (paper/electronic) that document the mental health basic counseling services provided to affected participants. At the Annual Program Review, participant records will be reviewed.
5.1 The Contractor will use the BIH ETO System and enter all participant data for evaluation purposes.	**5.1a** Contractor will install all necessary computer equipment and software to meet State BIH specifications.	As needed	**5.1a** At the BIH Program site, computer equipment and software is installed and meet the required State specifications.
Public Health will provide a format for the monthly Invoice and Program Narrative/Data Report. The Contractor is responsible for submitting program information in the format required by Public Health.	**5.1b** The DEA/other staff/subcontractor(s) will enter, update and maintain participant data in the BIH ETO System.	07/01/23 – 06/30/24	**5.1b** At the Annual Program Review, data entered in BIH ETO will be reviewed and compared to data collected from the participant (paper record) to ensure accuracy and completeness.
	5.1c As specified by Public Health, no later than the 15th of the month Contractor will submit the monthly Program Narrative/Data Report and monthly Invoice (Reimbursement Claim).	07/01/23 – 06/30/24	**5.1c** At the time of the Annual Program Review, the Public Health BIH Contractor's Quarterly Invoice Log and Quarterly Program Narrative/Data Report Log will be reviewed.

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Black Infant Health Program (BIH) Program Services
Scope of Work
July 1, 2023 through June 30, 2024

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MEASURABLE OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATION
6.1 Throughout the term of this agreement, maintain excellent communication and program coordination with Public Health, the State BIH Program Office and other stakeholders to maximize program effectiveness and to ensure fidelity in the BIH Program.	**6.1a** Attend the monthly Public Health BIH Team Meeting and host a meeting in rotation.	07/01/23 – 06/30/24	**6.1a** Meeting sign-in sheets.
	6.1b Attend and participate in Public Health and State BIH meetings (State BIH Annual Meeting; role specific conference calls; role specific training; focus groups; etc.).	07/01/23 – 06/30/24	**6.1b** Meeting sign-in sheets, roll call, documentation of travel.

BUDGET

CONTRACTOR

BLACK INFANT HEALTH SERVICES

	Budget Period July 1, 2023 through June 30, 2024
Full-Time Salaries	$
Employee Benefits @ %	$
Total Full-Time Salaries and Employee Benefits	$
Part-Time Salaries	$
Employee Benefits @ %	$
Total Part-Time Salaries and Employee Benefits	$
Total Salaries and Employee Benefits	**$**
Operating Expenses	$
Other	$
Indirect Cost @ % of Salaries	$
TOTAL PROGRAM BUDGET	**$**

Contract No. PH-00####

DEPARTMENT OF PUBLIC HEALTH
BLACK INFANT HEALTH SERVICES CONTRACT

Amendment No. ___

THIS AMENDMENT is made and entered into on _____.

by and between	COUNTY OF LOS ANGELES (hereafter "County"),
and	CONTRACTOR NAME (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled "BLACK INFANT HEALTH SERVICES CONTRACT," dated_____, and further identified as Contract No. PH-00####, and any Amendments thereto (all hereafter "Contract"); and

WHEREAS, on Month XX, 2023, the Board of Supervisors authorized the Director of Public Health, or designee, to execute amendments to the Contract; and

WHEREAS, it is the intent of the parties to amend Contract to extend the term of the Contract for one additional year, increase the maximum obligation of the County, and make other hereafter designated changes; 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 possesses the competence, expertise, and personnel necessary to provide services consistent with the requirements of this Contract; and

WHEREAS, this Contract is funded by State General Funds; Title V Maternal and Child Health Services Block Grant, Catalog of Federal Domestic Assistance (CFDA)

Number 93.994, and Title XIX Medical Assistance Program Funds, CFDA #93.778.

NOW, THEREFORE, the parties hereto agree as follows:

1. This Amendment is hereby incorporated into the original Contract, and all of its terms and conditions, including capitalized terms defined therein, is given full force and effect as if fully set forth herein.

2. This Amendment will be effective July 1, 2023.

3. Exhibit B-11, Scope of Work, attached hereto and incorporated herein by reference is added to the Contract.

4. Exhibit C-X Budget, attached hereto and incorporated herein by reference is added to the Contract.

5. Exhibit K-1, Notice of Federal Subaward Information, attached hereto and incorporated herein by reference is added to the Contract.

6. Paragraph 3, DESCRIPTION OF SERVICES, Subparagraph A, is deleted in its entirety and replaced as follows:

> "A. Contractor shall provide services in the manner described in Exhibit A (Statement of Work) and Exhibits B-1, B-2, B-3, B-4, B-5, B-6, B-7, B-8, B-9, B-10, and B-11 (Scopes of Work); attached hereto and incorporated herein by reference."

7. Paragraph 3, DESCRIPTION OF SERVICES, Subparagraph D, is deleted in its entirety and replaced as follows:

> "D. Federal Award Information for this Contract is detailed in Exhibits K and K-1, Notice of Federal Subaward Information, attached hereto and incorporated herein by reference."

8. Paragraph 4, TERM OF CONTRACT, is deleted in its entirety and replaced as follows:

"4. TERM OF CONTRACT:

The term of this contract shall be effective September 1, 2016, and will continue in full force and effect through June 30, 2024, unless sooner terminated or extended, in whole or in part, as provided in this Contract.

The Contractor shall notify Maternal, Child and Adolescent Health (MCAH) when this Contract is within six months from the expiration of the term as provided for hereinabove. Upon occurrence of this event, the Contractor shall send written notification to MCAH at the address herein provided in the NOTICES Paragraph."

9. Paragraph 5, MAXIMUM OBLIGATION OF COUNTY, Subparagraph K, is deleted in its entirety and replaced to read as follows:

"K. For the period of July 1, 2023, through June 30, 2024, the maximum obligation of County for all services provided hereunder shall not exceed AMOUNT ($), as set forth in Exhibit C-11, attached hereto and incorporated herein by reference."

10. Paragraph 58, PUBLIC RECORDS ACT, is deleted in its entirety and replaced to read as follows:

"33. PUBLIC RECORDS ACT:

A. Any documents submitted by Contractor; all information obtained in connection with the County's right to audit and inspect the Contractor's documents, books, and accounting records pursuant to the

RECORD RETENTION AND AUDITS Paragraph of this Contract; as well as those documents which were required to be submitted in response to the solicitation process for this Contract, become the exclusive property of the County. All such documents become a matter of public record and will be regarded as public records. Exceptions will be those elements in the California Government Code Section 7921.000 et seq. (Public Records Act) and which are marked "trade secret," "confidential," or "proprietary." The County will not in any way be liable or responsible for the disclosure of any such records including, without limitation, those so marked, if disclosure is required by law, or by an order issued by a court of competent jurisdiction.

B. In the event the County is required to defend an action on a Public Records Act request for any of the aforementioned documents, information, books, records, and/or contents of a proposal marked "trade secret," "confidential," or "proprietary," Contractor agrees to defend and indemnify the County from all costs and expenses, including reasonable attorney's fees, in action or liability arising under the Public Records Act."

11. Except for the changes set forth hereinabove, Contract shall not be changed in any other respect by this Amendment.

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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 its Director of Public Health, or designee, and Contractor has caused this Amendment to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____
Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

_____
Contractor

By _____
Signature

_____
Printed Name

Title_____

APPROVED AS TO FORM
BY THE OFFICE OF THE COUNTY COUNSEL
DAWYN R. HARRISON
County Counsel

APPROVED AS TO CONTRACT
ADMINISTRATION:

Department of Public Health

By _____
Contracts and Grants Division Management

#06904:mk

County of Los Angeles

Notice of Federal Subaward Information

Recipient Information (i)

1. **Recipient Name**

2. **Vendor Customer Code (VCC)**

3. **Employer Identification Number (EIN)**

4. **Recipient's Unique Entity Identifier** (ii)
   Data Universal Numbering System (DUNS)
   (www.SAM.gov)

5. **Award Project Title**

6. **Project Director or Principal Investigator**
   Name:
   Title:
   Address:

   E-mail:

7. **Authorized Official**
   Name:
   Title:
   Address:

   E-mail:

County Department Information (xi)

8. **County Department Contact Information**
   Name:
   Title:
   Address:

   E-mail:

9. **Program Official Contact Information**
   Name:
   Title:
   Address:

   E-mail:

Federal Award Information (www.usaspending.gov)

10. **Federal Award Number** (1)

11. **Federal Award Date** (iv)

12. **Unique Federal Award Identification Number (FAIN)** (iii)

13. **Name of Federal Awarding Agency** (xi)

14. **Federal Award Project Title** (x)

15. **Assistance Listing Number** (xii)

16. **Assistance Listing Program Title** (xii)

17. **Is this Award R&D?** (xiii)

Summary Federal Subaward Financial Information

18. **Budget Period Start Date** (vi): **End Date:**

19. **Total Amount of Federal Funds Obligated by this Action** (vii) $
    20a. Direct Cost Amount $
    20b. Indirect Cost Amount (xiv) $

20. **Authorized Carryover** $

21. **Offset** $

22. **Total Amount of Federal Funds Obligated this Budget Period** (viii) $

23. **Total Approved Cost Sharing or Matching, where applicable** $

24. **Total Federal and Non-Federal Approved this Budget Period** (ix) $

25. **Projected Performance Period Start Date** (v): **End Date:**

26. Total Amount of the Federal Award including Approved Cost Sharing or Matching this Project Period $

27. **Authorized Treatment of Program Income**

28. **County Program Officer Signature**

    Name:
    Title:

    Signature/Date

29. **Remarks**

BOARD LETTER/MEMO
CLUSTER FACT SHEET

DRAFT

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/24/2023	
BOARD MEETING DATE	6/6/2023	
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th	
DEPARTMENT(S)	Public Health	
SUBJECT	Approval to execute amendment to the Memorandum of Understanding (MOU) with Los Angeles County Children and Families First – Proposition 10 Commission (First 5 LA) to support African American Infant and Maternal Mortality Prevention Initiative (AAIMM Initiative) activities	
PROGRAM	Maternal, Child, and Adolescent Health Division (MCAH)	
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No	
SOLE SOURCE CONTRACT	☐ Yes ☒ No	
	If Yes, please explain why:	
DEADLINES/ TIME CONSTRAINTS	Current MOU with First 5 LA is scheduled to end on June 30, 2023.	
COST & FUNDING	Total cost: Estimated $360,000	Funding source: California Department of Public Health (CDPH) California Perinatal Health Initiative (PEI), California Home Visiting Program (CHVP) State General Fund Innovative home visiting project (Innovation), and the Pritzker Children's Initiative Community Innovation Grant (Pritzker) There is no net County cost associated with this action.
	TERMS (if applicable): 7/01/23 through 6/30/24	
	Explanation:	
PURPOSE OF REQUEST	Public Health is requesting approval to extend the MOU Number PH-004187 with First 5 LA to continue the utilization and expansion of current communication strategies for the AAIMM Initiative in promoting awareness of infant and maternal mortality disparities and their solutions, including the value of doulas, fathers, health system and village support for both Black women and their babies. Communications activities include focus groups, advertising, creation and distribution of digital and print collateral, social media engagement, and collaborative events.	
BACKGROUND (include internal/external issues that may exist including any related motions)	The AAIMM Initiative is a joint project of Public Health and First 5 LA to reduce disparities in infant mortality in Los Angeles County (LAC). The AAIMM Initiative also includes countywide and regional community engagement, provider training, research, public awareness, and multiple clinical and community interventions, including a direct service doula program. Public Health uses PEI, CHVP Innovation and Pritzker grants to fund the AAIMM Initiative. Each of Public Health's grant applications were inclusive of First 5 LA's commitment, staff time and in-kind resources.	
EQUITY INDEX OR LENS WAS UTILIZED	☒ Yes ☐ No If Yes, please explain how: AAIMM Initiative services aim to reduce racial disparities in life outcomes, implement strategies that identify, prioritize and effectively support the most disadvantage populations, and intervene early and emphasize long-term prevention.	

SUPPORTS ONE OF THE NINE BOARD PRIORITIES	☒ Yes ☐ No If Yes, please state which one(s) and explain how: Board Priority #2 Alliance for Health Integration (AHI) – In accordance with AHI's focus on reducing health inequities, the AAIMM Initiative seeks to establish a coordinated, equitable, high quality system of perinatal care for African American women to reduce disparities in infant mortality and birth outcomes.
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: Joshua Bobrowsky, Public Health Director Government Affairs, (213) 288-7871 jbobrowsky@ph.lacounty.gov Melissa Franklin, Director, MCAH 213-639-6400, mfranklin@ph.lacounty.gov Craig L. Kirkwood, Jr., Deputy County Counsel, (213) 974-1751, CKirkwood@counsel.lacounty.gov

COUNTY OF LOS ANGELES
Public Health

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

MEGAN McCLAIRE, M.S.P.H.
Chief Deputy Director

313 North Figueroa Street, Room 806
Los Angeles, California 90012
TEL (213) 288-8117 • FAX (213) 975-1273

www.publichealth.lacounty.gov

DRAFT

June 6, 2023

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 EXECUTE AMENDMENT TO THE MEMORANDUM OF UNDERSTANDING WITH THE LOS ANGELES COUNTY CHILDREN AND FAMILIES FIRST – PROPOSITION 10 COMMISSION TO SUPPORT AFRICAN AMERICAN INFANT AND MATERNAL MORTALITY PREVENTION INITIATIVE ACTIVITIES
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request approval to amend the Memorandum of Understanding between the Department of Public Health and the Los Angeles County Children and Families First – Proposition 10 Commission to support African American Infant and Maternal Mortality Prevention Initiative activities.

IT IS RECOMMENDED THAT THE BOARD:

1. Approve and instruct the Director of the Department of Public Health (Public Health), or designee, to execute an amendment to the Memorandum of Understanding (MOU) PH- 004187, substantially similar to Exhibit I, with the Los Angeles County Children and Families First – Proposition 10 (First 5 LA) for the continued development and implementation of standardized communication efforts to support the African American Infant and Maternal Mortality Prevention Initiative (AAIMM Initiative) activities, effective upon date of execution for the term of July 1, 2023, through June 30, 2024, in the total amount of $360,000, fully offset by California Department of Public Health (CDPH) California Perinatal Health Initiative (CPHI), California Home Visiting Program (CHVP) State General Fund Innovative home visiting project (Innovation), and the Pritzker Children's Initiative Community Innovation Grant (Pritzker).

2. Delegate authority to the Director of Public Health, or designee, to execute amendments to the MOU that extend the term through June 30, 2026, and/or provide an increase or decrease in funding at amounts to be determined by the funders; and reflect other necessary modifications, subject to review and approval by County Counsel.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Approval of Recommendation 1 will allow Public Health to execute an amendment to the MOU with First 5 LA to continue the utilization and expansion of current communication strategies for the AAIMM Initiative.

In partnership with First 5 LA, Public Health has implemented the AAIMM Initiative to reduce disparities in infant mortality in Los Angeles County (LAC). The AAIMM Initiative includes countywide and regional community engagement, provider training, research, public awareness, and multiple clinical and community interventions, including a direct service doula program. Public Health uses Perinatal Equity Initiative (PEI), CHVP and Pritzker grants to fund the AAIMM Initiative. Each of Public Health's grant applications were inclusive of First 5 LA's commitment, staff time, and in-kind resources.

First 5 LA currently utilizes and expands current communication strategies to develop and implement communication efforts to promote awareness of infant and maternal mortality disparities and their solutions, including the value of doulas, fathers, health system, and village support for both Black women and their babies. Communication activities include focus groups, advertising, creation, and distribution of digital and print collateral, social media engagement, and collaborative events. Content is developed in consultation with the LAC AAIMM Initiative Steering Committee, as well as Service Planning Area-level Community Action Teams, to develop and refine core messaging, calls to action, and an approach to ensure materials are culturally affirming. Under the recommended amendment, First 5 LA would continue to develop and update, as well as distribute AAIMM campaign messaging and engage diverse stakeholders.

Approval of Recommendation 2 will allow Public Health to execute amendments to this MOU that extend the term and/or increase or decrease funding and reflect other necessary modifications.

Implementation of Strategic Plan Goals

The recommended actions support Strategy I.1, Increase Our Focus on Prevention Initiatives and Strategy II.2, Support the Wellness of Our Communities, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

The total cost for this MOU for the term effective July 1, 2023, through June 30, 2024, is $360,000, consisting of $340,000 from CDPH's Grant Award Number 21-10059, $10,000 from CHVP Innovation, and $10,000 from Pritzker.

There is no net County cost associated with this action.

Funding has been included in Public Health's fiscal year (FY) 2023-24 Recommended Budget and will be included in future FYs as necessary.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On August 31, 2021, your Board authorized Public Health to accept CPHI Grant Agreement Number 21-10059 for the period of July 1, 2021, through June 30, 2023, from CDPH's CPHI to support the continuation of the PEI project. Funding was awarded in lump sum payments that allows for rollover into subsequent fiscal years.

On November 19, 2021, Public Health utilized delegated authority to accept Pritzker funding for the period of October 15, 2021, through October 14, 2024, to support the AAIMM Initiative and early childhood interventions in LAC.

On February 15, 2023, CDPH released the Notice of Preliminary Intent to award for CHVP State General Fund Innovation Project, Fiscal Years 2023-24 through 2025-26. The purpose of this funding is to provide continued support for doula home visiting services for African American families.

Exhibit I has been reviewed and approved by County Counsel as to form.

CONTRACTING PROCESS

On January 7, 2020, your Board authorized the execution of MOU PH-004187 between Public Health and First 5 LA, effective March 26, 2020, through June 30, 2021, with delegated authority to extend the term through June 30, 2023. Public Health has since exercised this delegated authority and extended the MOU through June 30, 2023.

IMPACT ON CURRENT SERVICES

Approval of the recommended actions will allow Public Health to further the partnership with First 5 LA on the AAIMM Initiative and develop and implement standardized communication efforts.

Respectfully submitted,

Megan McClaire, M.S.P.H.
Chief Deputy Director

MM:im
#06907

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

Exhibit I

MOU NO. PH-004187

MEMORANDUM OF UNDERSTANDING

BETWEEN

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH

AND

LOS ANGELES COUNTY CHILDREN AND FAMILIES FIRST – PROPOSITION 10 COMMISSION

TO SUPPORT

WHOLE PERSON CARE, CALIFORNIA PERINATAL EQUITY INITIATIVE, AND AFRICAN AMERICAN INFANT AND MATERNAL MORTALITY PREVENTION INITIATIVE ACTIVITIES

MOU Number: PH-004187

MEMORANDUM OF UNDERSTANDING

BETWEEN

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH

AND

LOS ANGELES COUNTY CHILDREN AND FAMILIES FIRST – PROPOSITION 10 COMMISSION

TO SUPPORT

WHOLE PERSON CARE, CALIFORNIA PERINATAL EQUITY INITIATIVE, AND AFRICAN AMERICAN INFANT AND MATERNAL MORTALITY PREVENTION INITIATIVE ACTIVITIES

AMENDMENT NUMBER FIVE

THIS AMENDMENT is made and entered into on _____.

Reference is made to Memorandum of Understanding ("MOU") Number PH-004187 by and between County of Los Angeles Department of Public Health ("Public Health") and Los Angeles County Children and Families First – Proposition 10 Commission ("First 5 LA"), dated March 26, 2020, any subsequent Amendments thereto, hereinafter all referred to as "MOU."

WHEREAS, on January 7, 2020, the County Board of Supervisors ("County Board") authorized the Director of Public Health, or designee, to execute MOUs that allow for collaboration on public health activities; and

WHEREAS, on June XX, 2023, County Board authorized the Director of Public Health, or designee, to execute amendments to this MOU.

WHEREAS, it is the intent of the parties to amend the MOU to continue the activities to support African American Infant and Maternal Mortality Prevention Initiative (AAIMM) services; and

WHEREAS, the MOU provides that changes may be made in the form of a written Amendment which is formally approved and executed by the parties.

NOW, THEREFORE, the parties agree as follows:

1. This Amendment is hereby incorporated into the original MOU, and all of its terms

and conditions, including capitalized terms defined therein, shall be given full force and effect as fully set forth herein.

2. This Amendment shall be effective upon date of execution for the period July 1, 2023, through June 30, 2024.

3. Exhibit A-3, Scope of Work, attached hereto and incorporated herein by reference is added to the MOU.

4. Exhibit B-3, Budget, attached hereto and incorporated herein by reference is added to the MOU.

5. Section II, **TERM OF MOU**, is deleted in its entirety an replaced to read as:

   "This MOU is effective March 26, 2020, and will continue through June 30, 2024, unless terminated by either party, in accordance with Section III. TERMINATION OF MOU."

6. Section VI**, FIRST 5 LA RESPONSIBILITIES**, is deleted in its entirety an replaced to read as:

   "First 5 LA will, in the performance of this MOU:

   A. Provide services in the manner described in Exhibits A.1, A-1, A-2 and A-3 – Scopes of Work, attached hereto and incorporated herein by reference; and

   B. Designate a representative for the term of this MOU to serve as the contact for information related to program services. First 5 LA's representative is: Tara Ficek at: tficek@first5la.org."

7. Section VII, **PUBLIC HEALTH RESPONSIBILITIES**, is deleted in its entirety an replaced to read as:

   "**VII. PUBLIC HEALTH RESPONSIBILITIES**

   Public Health will, in the performance of this MOU:

   A. Review all messaging and collateral to ensure alignment with AAIMM initiative activities and coordinate media approvals with Public Health Communications;

   B. Acknowledge First 5 LA's participation in the projects described in this MOU in any published material arising out of the projects and shall provide First 5 LA with a copy of the published material(s). Neither party shall use the other party's name, trademark(s), or service mark(s) without the other

party's prior written consent, which consent shall not be unreasonably withheld; and

C. Coordinate monthly meetings of the AAIMM Management Team.

D. Designate a representative for the term of this MOU to serve as the contact for information related to program services. Public Health's representative is: Helen O'Connor at: hoconnor@ph.lacounty.gov."

8. Section VII, **FUNDING**, is deleted in its entirety and replaced to read as:

"VII. **FUNDING**

A.1 For the period March 26, 2020, through October 21, 2021, the maximum funding authorized by Public Health for services rendered by First 5 LA pursuant to this MOU to support Whole Person Care (WPC), and California Perinatal Equity Initiative (CPEI) activities shall not exceed three hundred fifty thousand dollars ($350,000) as indicated in Exhibit B.1, Budget, attached hereto and incorporated herein by reference.

Funding is comprised of two hundred fifty thousand dollars ($250,000) from WPC, and one hundred thousand dollars ($100,000) from CPEI. Funding provided by California Department of Public Health (CDPH), and federal funds, Assistance Listing Number 93.778, passed through California Department of Health Care Service.

A.2 For the period November 1, 2021, through June 30, 2023, the maximum funding authorized by Public Health for services rendered by First 5 LA pursuant to this MOU to support California Home Visiting Program (CHVP), and CPEI activities shall not exceed six hundred twenty-three thousand, two hundred fifty dollars as ($623,250) as indicated in Exhibit B-2, Budget, attached hereto and incorporated herein by reference.

Funding is comprised of five hundred thirteen thousand, two hundred fifty dollars ($513,250) from CPEI, twenty thousand dollars ($20,000) from CHVP, and ninety thousand dollars ($90,000) from Pritzker Innovation.

A.3 For the period July 1, 2023, through June 30, 2024, maximum funding authorized by Public Health for services rendered by First 5 LA pursuant to this MOU to support AAIMM Initiative activities shall not exceed three hundred sixty thousand dollars ($360,000) as indicated in Exhibit B-3, Budget, attached hereto and incorporated herein by reference.

Funding is comprised of three hundred forty thousand dollars ($340,000) from the CDPH CPEI, ten thousand dollars ($10,000) from the CHVP State General Fund Innovative home visiting project, and ten

thousand dollars ($10,000) from the Pritzker Children's Initiative Community Innovation Grant."

B. First 5 LA must submit invoices that comply with Public Health guidelines. Public Health shall pay First 5 LA all undisputed invoice amounts within thirty (30) calendar days of Public Health's receipt of a submitted invoice.

C. Invoices with supporting documentation must be submitted to:

Helen O'Connor, Health Program Analyst
County of Los Angeles Department of Public Health
Division of Maternal, Child and Adolescent Health
600 South Commonwealth Avenue, Suite 800
Los Angeles, CA 90005
hoconnor@ph.lacounty.gov

9. All other terms and conditions remain in full force and effect.

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IN WITNESS HEREOF, the parties hereto have executed this MOU on the day, month, and year indicated on page 1 of this MOU.

COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC HEALTH

_____
Megan McClaire
Chief Deputy Director

LOS ANGELES COUNTY CHILDREN AND FAMILIES
FIRST – PROPOSITION 10 COMMISSION

_____
Karla Pleitéz Howell
Executive Director

BL#06907:at

EXHIBIT A-3 – SCOPE OF WORK

MEMORANDUM OF UNDERSTANDING
BETWEEN LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH
AND LOS ANGELES COUNTY CHILDREN AND FAMILIES FIRST – PROPOSITION 10 COMMISSION
AFRICAN AMERICAN INFANT AND MATERNAL MORTALITY (AAIMM) PREVENTION INITIATIVE

TERM: July 1, 2023 – June 30, 2024

Project Description: Strategic communications efforts to foster awareness about the disparity in African American infant and maternal mortality (AAIMM), and the interventions being improved, expanded, or created to address them within Los Angeles County.

Activities	Subtasks/Deliverables	Timeline
1. Develop digital and print collateral, as well as outdoor advertising (e.g., flyers, postcards, web banner ads, social media ads, outdoor ads, social media video posts, banner ads, blogs, etc.). This will include broad awareness messaging, (i.e., "Grow the Village" campaign), as well as materials specific to father engagement, breastfeeding, preconception health, doulas, community action, and others, as determined by AAIMM Management Team.	A. Develop digital media advertising schedule and plan B. Develop digital media creative elements (visuals and copy) C. Develop print collateral schedule and plan D. Update existing collateral and develop new collateral E. Distribute collateral	A. July – August 2023 B. Sept. 2023 – June 2024 C. July – August 2023 D. August 2023 – March 2024 E. Sept. 2023 – June 2024
2. Engage key stakeholders to promote "Grow the Village" campaign and Perinatal Equity Initiative (PEI)-funded and doula programs.	A. Develop outreach strategies to engage diverse stakeholders, with feedback from AAIMM Management Team B. Implement outreach strategies	A. July – Nov. 2023 B. Oct. 2023 – June 2024
3. Compile quarterly reports of communications activities, reach and impact.	A. Compile report of communications activities within grant period B. Present report at PEI statewide public awareness campaign meetings	A. July 2023-June 2024 B. Quarterly beginning Oct. 2023
4. Lead the Community Advisory Board Annual Planning.	A. Engage consultant to conduct ongoing strategic and structural planning meetings with AAIMM Community Action Teams and Steering Committee B. Implement structural and strategic plans, with ongoing assessment to identify areas of weakness or challenge	A. July – Sept. 2023 B. Sept. 2023 – June 2024

EXHIBIT A-3 – SCOPE OF WORK

Activities	Subtasks/Deliverables	Timeline
5. Participate in monthly meetings with AAIMM Management Team.	A. Meeting agendas and notes created and submitted monthly	A. July 2023 – June 2024
6. Participate in regular meetings with AAIMM Evaluation Team.	A. Participate in the evaluation of the AAIMM Communications strategies and provide evaluator with qualitative and quantitative data, as necessary.	A. July 2023 – June 2024

EXHIBIT B-3

MEMORANDUM OF UNDERSTANDING
BETWEEN
LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH
AND
LOS ANGELES COUNTY CHILDREN AND FAMILIES FIRST – PROPOSITION 10 COMMISSION
TO SUPPORT
AFRICAN AMERICAN INFANT AND MATERNAL MORTALITY (AAIMM) PREVENTION INITIATIVE

BUDGET

TERM: July 1, 2023 - June 30, 2024

BUDGET SUMMARY	
CATEGORY	AMOUNT
Personnel	$ -
Contracted Services (Excluding Evaluation)	$ 340,000
Equipment	$ -
Travel and Training	$ -
Supplies	$ -
Other Expenses	$ -
Indirect Costs - Administration	$ 20,000
TOTAL COST	$ 360,000

BOARD LETTER/MEMO
CLUSTER FACT SHEET

DRAFT

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/24/2023
BOARD MEETING DATE	6/6/2023
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
DEPARTMENT(S)	Department of Public Health
SUBJECT	AUTHORIZATION TO AMEND TWO SOLE SOURCE CONTRACTS FOR SCHOOL NOVEL CORONAVIRUS 2019 PREVENTION PARTNERSHIP SERVICES TO EXTEND THE TERM EFFECTIVE JULY 1, 2023 THROUGH JUNE 30, 2024 (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)
PROGRAM	Executive Office
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No
SOLE SOURCE CONTRACT	☒ Yes ☐ No
	If Yes, please explain why: These sole source contracts need to continue to complete activities in accordance with the grant requirements.
DEADLINES/ TIME CONSTRAINTS	Contracts expire June 30, 2023.
COST & FUNDING	Total cost: LACOE $ 959,029.00 HELUNA $ 6,875,495.00 — Funding source: Centers for Disease Control and Prevention- CoAg
	TERMS (if applicable): Extend the term at no cost for the period July 1, 2023 through June 30, 2024.
	Explanation: No Cost Extension
PURPOSE OF REQUEST	To extend the term of the sole source Contracts: Number PH-004715 with Los Angeles County Office of Education (LACOE) and Contract Number PH-004755 with Public Health Foundation Enterprises, Inc. dba Heluna Health (Heluna) to continue Schools Covid-19 Prevention Partnership (SCPP) programs to assure that the County of Los Angeles continues to actively respond to the adverse impacts of the COVID-19 pandemic, effective July 1, 2023 through June 30, 2024.
BACKGROUND (include internal/external issues that may exist including any related motions)	Public Health received funding from the Centers for Disease Control and Prevention (CDC), and engaged LACOE as the educational partner to assist with program coordination to ensure that youth and families in LAC K-12 sector are educated, informed, and connected to vital resources that supported the prevention and mitigation of the COVID-19 virus. As the landscape of the COVID-19 pandemic has evolved over the years, the SCPP program has also pivoted to broaden the scope of integral support and resources necessary to improve the health, mental health, academic and social emotional learning outcomes among LAC youth adversely impacted by the COVID-19 pandemic. Public Health recognizes the need to continue the ongoing collaboration and partnership with

	LACOE to aid K-12 schools across LAC to address the pandemic-related challenges particularly among underserved communities, and likewise remain vigilant to ensure that the K-12 sector is equipped to respond swiftly and appropriately to future threats of COVID-19 outbreaks and/or other vaccine-preventable diseases. Heluna is a fiscal sponsor who administers this program.
EQUITY INDEX OR LENS WAS UTILIZED	☒ Yes ☐ No f Yes, please explain how: Children have faced trauma due to illness or death of loved ones, disruption in learning, and interrupted routine health care. These experiences contribute to adverse health effects most notably among children who reside in marginalized communities – often an intersection of communities of color, low socioeconomic status, and decreased access to health/mental health services – and further substantiates the need for ongoing pandemic recovery and resiliency programs and services that address the health, mental health, and academic achievement gaps that have been both created and/or exacerbated by the COVID-19 pandemic.
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	☒ Yes ☐ No If Yes, please state which one(s) and explain how: Priority 1: Child Protection Priority 2: Health Integration The extension of this agreement will provide the resources needed to for Public Health to continue COVID-19 pandemic recovery and resiliency work important to closing health and wellness, and learning gaps exacerbated by existing social inequities as well as address emerging threats of increased youth mental health and substance abuse disorders
DEPARTMENTAL CONTACTS	Noel Barakat NBarakat@ph.lacounty.gov Rachel Bonkovsky RBonkovsky@ph.lacounty.gov

COUNTY OF LOS ANGELES
Public Health

DRAFT

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

MEGAN McCLAIRE, M.S.P.H.
Chief Deputy Director

313 North Figueroa Street, Room 806
Los Angeles, California 90012
TEL (213) 288-8117 • FAX (213) 975-1273

www.publichealth.lacounty.gov

June 6, 2023

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:

AUTHORIZATION TO AMEND TWO SOLE SOURCE CONTRACTS FOR SCHOOL NOVEL CORONAVIRUS 2019 PREVENTION PARTNERSHIP SERVICES TO EXTEND THE TERM EFFECTIVE JULY 1, 2023 THROUGH JUNE 30, 2024 (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Request approval to execute amendments to two sole source contracts for School Novel Coronavirus 2019 Prevention Partnership services to extend the term effective July 1, 2023 through June 30, 2024, and delegated authority to amend these contracts for other various actions.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Authorize and instruct the Director of Department of Public Health (Public Health), or designee, to execute amendments to two sole source contracts for School COVID-19 Prevention Partnership (SCPP) services, substantially similar to Exhibit I, with Los Angeles County Education Office (LACOE) and Public Health Foundation Enterprises, Inc. dba Heluna Health (Heluna), to extend the term for the period of July 1, 2023 through June 30, 2024, at no additional cost, and make changes to the Statement of Work for the Heluna contract, 100 percent offset by Center for Disease Control and Prevention (CDC) Cooperative Agreement for Emergency Response: Public Health Crisis Response, Assistance Listing Number 93.354.

2. Delegate authority to the Director of Public Health, or designee, to execute future amendments to the contracts that: 1) allow for extending the term through December 31, 2024, at amounts determined by the Director of Public Health; 2) make changes to

the Statement of Work; 3) allow for the rollover of unspent funds; and/or 4) provide an increase or decrease in funding up to 10 percent above or below each term's annual base maximum obligation, as necessary, effective upon amendment execution and make corresponding service adjustments, as necessary, all subject to review and approval by County Counsel, and notification to your Board and the CEO.

3. Delegated authority to the Director of Public Health, or designee, to execute change notices to these sole source contracts that authorize modifications to or within budget categories within each budget, and corresponding service adjustments, as necessary; changes to hours of operation and/or service locations; and/or make changes corrections to the contract's terms and conditions.

4. Delegate authority to the Director of Public Health, or designee, to immediately suspend the contracts upon issuing a written notice to contractors who fail to perform and/or fully comply with program requirements; to terminate the contracts for convenience by providing a 30-calendar day advance written notice to the contractors; and to accept voluntary contract termination notices from contractors.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

On March 4, 2020, the Board declared a local and public health emergency in response to the increased spread of COVID-19 across the country. Public Health continues to oversee engagement initiatives to reach communities throughout Los Angeles County (LAC) that have been most impacted by COVID-19 and ensure that they receive culturally and linguistically appropriate outreach. Public Health has expanded outreach efforts by implementing a spectrum of services designed to address urgent COVID-19 needs and creating infrastructure for post-pandemic recovery in communities hardest hit by COVID-19.

Approval of Recommendation 1 will allow Public Health to execute amendments to the SCPP sole source contracts with LACOE and Heluna, at no cost through June 30, 2024. Since school's reopened, from closures due to COVID-19, children in LAC have faced trauma due to illness or death of loved ones and likewise experienced unprecedented academic and social/emotional learning challenges due to the lengthy period of isolation during school closures/remote learning, struggling with chronic absenteeism and lagging in grade-level achievements. These experiences contribute to adverse health effects most notably among children who reside in marginalized communities with the highest infection rates and lowest COVID-19 vaccination rates – often an intersection of communities of color, low socioeconomic status, and decreased access to health/mental health services – and further substantiates the need for ongoing pandemic recovery and resiliency programs and services that address the health, mental health, and academic achievement gaps that have been both created and/or exacerbated by the COVID-19 pandemic. The SCPP program addresses the negative impacts of COVID-19 on students' health by collaborating and partnering with K-12 schools across LAC to address the health, academic, and mental

health gaps and challenges both created and exacerbated by the COVID-19 pandemic, particularly among underserved communities.

Approval of Recommendation 2 will allow Public Health to amend the two sole source contracts to: 1) extend the term through December 31, 2024 at amounts determined by the Director of Public Health; 2) make revisions to the Statement of Work; 3) allow the rollover of unspent funds; and/or 4) provide an increase or decrease in funding up to 10 percent above or below each term's annual base maximum obligation, as necessary, effective upon amendment execution or at the beginning of the applicable agreement term and make corresponding service adjustments, as necessary, provided that sufficient funding is available in the existing grant funds.

Approval of Recommendation 3 will allow Public Health to execute change notices to contracts that authorize modifications to or within budget categories within each budget, and corresponding service adjustments, as necessary; changes to hours of operation and/or service locations; and/or make corrections to contract's terms and conditions.

Approval of Recommendation 4 will allow Public Health to immediately suspend contracts with contractors who fail to perform and/or to fully comply with program requirements, to terminate contracts for convenience by providing a 30-calendar day advance written termination notice to contractors, and to accept a voluntarily requests to terminate their contracts.

Implementation of Strategic Plan Goals

The recommended actions support two of the strategic plan goals contained in the County of Los Angeles Strategic Plan - Goal I, Make Investments that Transform Lives; Goal II, Foster Vibrant and Resilient Communities.

FISCAL IMPACT/FINANCING

Funding for these contracts may include but is not limited to: CDC Cooperative Agreement for Emergency Response: Public Health Crisis Response, Assistance Listing Number 93.354. There is no net County cost associated with this action.

Funding is included in Public Health's Recommended Budget fiscal year (FY) 2023-24 and will be included in future FYs, as necessary.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On January 30, 2020, the World Health Organization (WHO) declared the COVID-19 outbreak a public health emergency of international concern.

On March 4, 2020, the Board declared a local and public health emergency in response to the increased spread of COVID-19 across the country.

On October 13, 2020, the Board of Supervisors delegated authority to the Acting CEO, or designee(s) which includes departments, in consultation with County Counsel, to enter into, execute, amend, and if necessary, terminate contracts, including sole source, necessary to support the County's continued efforts to assist and address the health, safety, and welfare of County residents during the COVID-19 pandemic and in compliance with requirements of the federal or state funding source for such contract.

As required under Board Policy 5.100, on May 8, 2023, your Board received advance notice of Public Health's intent to execute a sole source contract with the agencies in Attachment A for the term July 1, 2023 through June 30, 2024.

Attachment A is the Sole Source Checklists signed by the CEO.

County Counsel has reviewed and approved Exhibit I as to form.

CONTRACTING PROCESS

The execution of these sole source contracts was completed under the October 13, 2020 CEO delegated authority to support the County's continued efforts to assist and address the health, safety, and welfare of County residents during the COVID-19 pandemic and to comply with the requirements of the federal or state funding sources supporting each contract.

On September 27, 2022, the Board of Supervisors delegated authority to execute amendments to the COVID-19 SCPP sole source service contracts to extend the term to December 31, 2023, however, the CDC has approved a no cost extension to complete activities through June 30, 2024. Therefore, we are returning to your Board to request delegated authority for a no-cost extension through June 30, 2024.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

The extension of these contracts will allow Public Health to continue collaboration and partnership with K-12 schools across LAC to address the health, academic, and mental health gaps and challenges both created and exacerbated by the COVID-19 pandemic, particularly among underserved communities.

Respectfully submitted,

Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

BF:js
#06938

Enclosure

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

Attachment A

SOLE SOURCE CHECKLIST

Department Name: Department of Public Health (DPH)

☐ New Sole Source Contract — Heluna Health for Schools COVID-19 Prevention Partnerhsip

☑ Existing Sole Source Contract — Date Sole Source Contract Approved: _____

Check (√)	JUSTIFICATION FOR SOLE SOURCE CONTRACTS Identify applicable justification and provide documentation for each checked item.
	➢ Only one bona fide source (monopoly) for the service exists; performance and prices 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.
✓	➢ Additional services are needed to complete an ongoing task and it would be prohibitively costly in time and money to seek a new service provider.
	➢ 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 with 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 options periods.
	➢ Maintenance and 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 to replace an existing system or infrastructure, administrative cost 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

5/5/23
Date

Attachment A

SOLE SOURCE CHECKLIST

Department Name: Department of Public Health (DPH)

☐ New Sole Source Contract — Heluna Health for Schools COVID-19 Prevention Partnerhsip

☑ Existing Sole Source Contract — Date Sole Source Contract Approved: _____

Check (√)	JUSTIFICATION FOR SOLE SOURCE CONTRACTS Identify applicable justification and provide documentation for each checked item.
☐	➢ Only one bona fide source (monopoly) for the service exists; performance and prices 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.
✓	➢ Additional services are needed to complete an ongoing task and it would be prohibitively costly in time and money to seek a new service provider.
☐	➢ 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 with 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 options periods.
☐	➢ Maintenance and 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 to replace an existing system or infrastructure, administrative cost 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

5/5/23
Date

EXHIBIT I

Contract No. PH-004715

COUNTY OF LOS ANGELES / DEPARTMENT OF PUBLIC HEALTH

CONTRACT

FOR

SCHOOL COVID-19 PREVENTION PARTNERSHIP

Amendment Number 3

THIS AMENDMENT is made and entered into on _____

by and between	COUNTY OF LOS ANGELES (hereafter "County"),
and	LOS ANGELES COUNTY OFFICE OF EDUCATION (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled “School COVID-19 Prevention Partnership”, dated April 19, 2022, and further identified as Contract No. PH-004715, and any Amendments thereto (all hereafter referred to as “Contract”) between County and Contractor; and

WHEREAS, on March 4, 2020, the Board and Public Health declared a local and public health emergency in response to the increased spread of the novel coronavirus (COVID-19) across the country; and

WHEREAS, on October 13, 2020, the Board delegated authority to the Acting CEO, or her designee(s) which includes departments, in consultation with County Counsel, to enter into, execute, amend, and if necessary, terminate agreements, including sole source, necessary to support of the County’s continued efforts to assist and address the health, safety, and welfare of County residents during the COVID-19

pandemic and in compliance with requirements of the federal or state funding source for such agreement; and

WHEREAS, on February 19, 2013, the Board of Supervisors authorized the Director of the Department of Public Health, to execute amendments to this contract that revise or incorporate provisions consistent with all applicable State and/or federal laws and regulations, county Ordinances, and Board policy; and

WHEREAS, it is the intent of the parties hereto to amend the Contract to extend the term of the Contract through June 30, 2024 and make other designated changes as set forth herein; and

WHEREAS, said Agreement provides that changes may be made in the form of a written Amendment which is formally approved and executed by the parties.

NOW, THEREFORE, the parties agree as follows:

1. This Amendment is hereby incorporated into the original Contract, and all of its terms and conditions, including capitalized terms defined herein, will be given full force and effect as if fully set forth therein.

2. The Amendment is effective upon execution through June 30, 2024.

3. Effective on the date of this Amendment, "Exhibit C-1 Budget, shall be deleted in its entirety and replaced with Exhibit C-2, Budget, attached hereto and incorporated herein by reference. Any reference Exhibit C-1 shall be deemed amended to state Exhibit C-2. Exhibit J County's Administration and Exhibit K Contractor's Administration both shall be deleted in its entirety and replaced with the attached Exhibit J-1 and Exhibit K-1."

4. Paragraph 3 **DESCRIPTION OF SERVICES** subparagraph C. and subparagraph D. will be added to read as follows:

"C. If Contractor provides any tasks, deliverables, goods, services, or other work, other than as specified in this Contract, the same shall be deemed to be a gratuitous effort on the part of the Contractor, and the Contractor shall have no claim whatsoever against the County.

D. Federal Award Information for this Contract is detailed in Exhibit M, Notice of Federal Subaward Information, attached hereto and incorporated herein by reference.

5. Paragraph 4 **TERM OF CONTRACT**, is deleted in its entirety and replaced as follows:

"Paragraph 4 **TERM OF THE CONTRACT**, the term of this Contract shall be effective April 19, 2022 and shall continue in full force and effect through June 30, 2024, unless sooner terminated or extended, in whole or in part, as provided in this Contract.

The Contractor shall notify (Program Office) when this Contract is within six (6) months from the expiration of the term as provided for hereinabove. Upon occurrence of this event, the Contractor shall send written notification to (Program Office) at the address herein provided in Exhibit J."

6. Paragraph 18 **CONSTRUCTION** is deleted in its entirety.

7. Paragraph 29. **COMPLIANCE WITH CIVIL RIGHTS LAW,** sections 1, 2, 3, and 4 will be added to read as follows:

"Additionally, Contractor certifies to the County:

1. That Contractor has a written policy statement prohibiting discrimination in all phases of employment.

2. That Contractor periodically conducts a self-analysis or utilization analysis of its work force.

3. That Contractor has a system for determining if its employment practices are discriminatory against protected groups.

Where problem areas are identified in employment practices, Contractor has a system for taking reasonable corrective action, to include establishment of goals or timetables.

4. Where problem areas are identified in employment practices, Contractor has a system for taking reasonable corrective action, to include establishment of goals or timetables. Contractor shall comply with Exhibit D – Contractor's EEO Certification."

8. Paragraph 35. **CONSIDERATION OF HIRING GAIN/GROW PARTICPANTS** subparagraph C. will be deleted in its entirety.

9. Paragraph 39. **COUNTY'S QUALITY ASSURANCE PLAN** will be deleted and replaced in its entirety to read as follows:

"County or its agent(s) will monitor Contractor's performance under this Contract on not less than an annual basis. Such monitoring will include assessing Contractor's compliance with all Contract terms and performance standards. Contractor deficiencies which County determines are significant, or continuing, and that may place performance of the Contract in jeopardy if not corrected, will be reported to the Board of Supervisors and listed in the appropriate contractor performance database. The report to the Board

will include improvement/corrective action measures taken by County and Contractor. If improvement does not occur consistent with the corrective action measures, the County may terminate this Contract or impose other penalties as specified in this Contract."

10. Paragraph 44. **DATA ENCRYPTION** is deleted in its entirety.

11. Paragraph 54. **NON DISCRIMINATION IN SERVICES** is deleted in its entirety and replaced as follows:

"NON DISCRIMINATION AND AFFIRMATIVE ACTION

A. "Contractor certifies and agrees that all persons employed by it, its affiliates, subsidiaries, or holding companies are and will be treated equally without regard to or because of race, color, religion, ancestry, national origin, sex, age, physical or mental disability, marital status, or political affiliation, in compliance with all applicable federal and State anti-discrimination laws and regulations.

B. Contractor certifies to the County each of the following:

1. Contractor has a written policy statement prohibiting discrimination in all phases of employment.

2. That Contractor periodically conducts a self-analysis or utilization analysis of its work force.

3. That Contractor has a system for determining if its employment practices are discriminatory against protected groups.

4. Where problem areas are identified in employment practices, the Contractor has a system for taking reasonable corrective action, to include establishment of goals or timetables.

C. Contractor must take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to race, color, religion, ancestry, national origin, sex, age, physical or mental disability, marital status, or political affiliation, in compliance with all applicable federal and State anti-discrimination laws and regulations. Such action must include, but is not limited to: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.

D. Contractor certifies and agrees that it will deal with its subcontractors, bidders, or vendors without regard to or because of race, color, religion, ancestry, national origin, sex, age, physical or mental disability, marital status, or political affiliation.

E. Contractor certifies and agrees that it, its affiliates, subsidiaries, or holding companies will comply with all applicable federal and State laws and regulations to the end that no person will, on the grounds of race, color, religion, ancestry, national origin, sex, age, physical or mental disability, marital status, or political affiliation, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Contract or under any project, program, or activity supported by this Contract.

F. Contractor will allow County representatives access to Contractor's employment records during regular business hours to verify compliance with the provisions of this Paragraph (Nondiscrimination and Affirmative Action) when so requested by the County.

G. If the County finds that any provisions of this Paragraph (Nondiscrimination and Affirmative Action) have been violated, such violation will constitute a material breach of this Contract upon which the County may terminate or suspend this Contract. While the County reserves the right to determine independently that the anti-discrimination provisions of this Contract have been violated, in addition, a determination by the California Fair Employment and Housing Commission or the Federal Equal Employment Opportunity Commission that the contractor has violated Federal or State anti-discrimination laws or regulations will constitute a finding by the County that the contractor has violated the anti-discrimination provisions of this Contract.

The parties agree that in the event Contractor violates any of the anti-discrimination provisions of this Contract, the County will, at its sole option, be entitled to the sum of five hundred dollars ($500) for each such violation pursuant to California Civil Code Section 1671 as liquidated damages in lieu of terminating or suspending this Contract."

12. Paragraph 55 **NONDISCRIMINATION IN EMPLOYMENT** is deleted in its entirety.

13. Paragraph 63 **PUBLIC RECORDS ACT** is deleted and replaced in its entirety and replaced as follows: "

"A. Any documents submitted by Contractor; all information obtained in connection with the County's right to audit and inspect the Contractor's documents, books, and accounting records pursuant to the RECORD RETENTION AND AUDITS Paragraph of this Contract; as well as those

documents which were required to be submitted in response to the solicitation process for this Contract, become the exclusive property of the County. All such documents become a matter of public record and will be regarded as public records. Exceptions will be those elements in the California Government Code Section 7921.000 et seq. (Public Records Act) and which are marked "trade secret," "confidential," or "proprietary." The County will not in any way be liable or responsible for the disclosure of any such records including, without limitation, those so marked, if disclosure is required by law, or by an order issued by a court of competent jurisdiction.

B. In the event the County is required to defend an action on a Public Records Act request for any of the aforementioned documents, information, books, records, and/or contents of a proposal marked "trade secret," "confidential," or "proprietary," Contractor agrees to defend and indemnify the County from all costs and expenses, including reasonable attorney's fees, in action or liability arising under the Public Records Act."

14. Paragraph 68 **SOLICITATION OF BIDS OR PROPOSALS** is deleted in its entirety and replaced as follows:

"**PROHIBITION FROM PARTICIPATION IN FUTURE SOLICITATION(S):**

A Proposer, or a Contractor or its subsidiary or Subcontractor ("Proposer/Contractor"), is prohibited from submitting a bid or proposal in a County solicitation if the Proposer/Contractor has provided advice or consultation for the solicitation. A Proposer/Contractor is also prohibited from submitting a bid or proposal in a County solicitation if the Proposer/Contractor has developed or

prepared any of the solicitation materials on behalf of the County. A violation of this provision will result in the disqualification of the Contractor/Proposer from participation in the County solicitation or the termination or cancellation of any resultant County contract. This provision will survive the expiration, or other termination of this Agreement."

15. Paragraph 74. **TERMINATION FOR GRATUITIES AND/OR IMPROPER CONSIDERATION** is deleted in its entirety and replaced as follows:

TERMINATION FOR IMPROPER CONSIDERATION: "County may, by written notice to Contractor, immediately terminate Contractor's right to proceed under this Contract, if it is found that consideration, in any form, was offered or given by Contractor, either directly or through an intermediary, to any County officer, employee, or agent, with the intent of securing this Contract or securing favorable treatment with respect to the award, amendment, or extension this Contract, or making of any determinations with respect to the Contractor's performance pursuant to this Contract. In the event of such termination, the County will be entitled to pursue the same remedies against Contractor as it could pursue in the event of default by Contractor.

Contractor must immediately report any attempt by a County officer or employee to solicit such improper consideration. The report must be made either to the County manager charged with the supervision of the employee or to the County Auditor-Controller's Employee Fraud Hotline at (800) 544-6861. Among other items, such improper considerations may take the form of cash,

discounts, services, the provision of travel or entertainment, or other tangible gifts."

16. Paragraph 79 **UNLAWFUL SOLICITATION** is deleted in its entirety.

Except for the changes set forth herein above, Contract shall not be changed in any other respect by this Amendment.

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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 its Director of the Department of Public Health and Contractor has caused this Amendment to be subscribed in its behalf by its duly authorized officer, the day, month and year first above written.

COUNTY OF LOS ANGELES

By _____
Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

Los Angeles County Office of Education
Contractor

By _____
Signature

_____
Printed Name

Title _____

APPROVED AS TO FORM
BY THE OFFICE OF THE COUNTY COUNSEL
DAWYN R. HARRISON
Acting County Counsel

APPROVED AS TO CONTRACT ADMINISTRATION:

Department of Public Health

By _____
Contracts and Grants Division Management

#6938:js

SCHOOL COVID PREVENTION PARTNERSHIP (SCPP) LOS ANGELES COUNTY OFFICE OF EDUCATION (LACOE)

Budget Period
April 19, 2022
Through
June 30, 2024

Description **Year 1 (April 1, 2022 - June 30, 2023)**	**Amount**
Salaries • 1 FTE Coordinator III • 1 FTE Admin Assistant	 $ 11,703 $ 0
Employee Benefits	$ 5,343
Subtotal - Salaries & Employee Benefits	**$ 17,046**
Instructional Materials & Supplies	$ 0
Subcontracts	$ 0
Subtotal - Direct Costs	**$ 17,046**
Indirect Cost*/Administrative Costs	$ 1,555
Total - Year 1	**$ 18,601**
Year 2 (July 1st 2023- June 30, 2024)	
Salaries • 1 Coordinator III 100% • Admin Assistant 60% • 1 Sr. Division Secretary	 $120,540 $ 26,196 $ 26,536
Employee Benefits	$ 96,808
Subtotal - Salaries & Employee Benefits	**$270,080**
Supplies	$ 74,700
Office Space	$ 12,643
Mileage	$ 10,000
Facilities Services	$ 6,000
Reprographics	$ 10,000
Mailing Services	$ 5,000
Communications Support	$288,000
Copier	$ 4,000
Telephone	$ 3,900
Other Contract Services/Consultants	$150,000
GPM Fiscal Support	$ 53,256
Subtotal – Direct Costs	**$887,579**
Indirect Cost*/Administrative Costs	$ 71,450
Total - Year 2	**$959,029**
Year 1 and Year 2 – Direct Costs	**$904,625**
Indirect Cost*/Administrative Costs @9.1769%	$ 73,005
TOTAL (Year 1 and Year 2) Overall Budget	**$977,630**

During the term of this Contract, any variation to the above budget must be executed through a written Change Notice, executed by the Public Health Project Director and the Contractor. Invoices and cost reports must be submitted in accordance with approved line-item detailed budgets.

COUNTY'S ADMINISTRATION

CONTRACTOR'S NAME: Los Angeles County Office of Education

CONTRACT NO.: PH-004715

COUNTY PROJECT DIRECTOR:

Name: Rachel Bonkovsky, M.Ed
Title: Director of Education Partnerships and Programs, Office of Planning, Integration, and Engagement
Address: 313 N. Figueroa St.
Los Angeles, CA 90012

Telephone: (323) 695-4077
E-Mail Address: RBonkovsky@ph.lacounty.gov

COUNTY PROJECT MANAGER:

Name: Kara Karibian
Title: HPA III, Office of Planning, Integration, and Engagement
Address: 313 N. Figueroa St.
Los Angeles, CA 90012

Phone: (323) 236-9380
E-mail: kkaribian@ph.lacounty.gov

COUNTY CONTRACT PROJECT MONITOR:

Name: Sandra Hernandez, Office of Planning, Integration, and Engagement
Title: HPA II
Address: 313 N. Figueroa St.
Los Angeles, CA 90012

Phone: (213) 502-7545
E-mail: shernandez@ph.lacounty.gov

CONTRACTOR'S ADMINISTRATION

CONTRACTOR'S NAME: Los Angeles County Office of Education

CONTRACT NO.: PH-004715

CONTRACTOR'S PROJECT MANAGER:

Name: Gregory Jackson
Title: Coordinator III, Special Projects
Address: 9300 Imperial Highway
Downey, CA 90242

Telephone: (323) 559-4159 (c) / (562) 922-6239
E-Mail Address: Jackson_Gregory@lacoe.edu

CONTRACTOR'S AUTHORIZED OFFICIALS:

Name: Karen Kimmel
Title: Chief Financial Officer
Address: Interim Coordinator III, Public Affairs, Equity and Innovation
9300 Imperial Highway
Downey, CA 90242
Phone: (562) 922-6124
E-mail: Karen_Kimmel@lacoe.edu

Name:
Title:
Address:

Phone:
E-mail:

Notices to Contractor shall be sent to the following:

Name: Los Angeles Office of Education, EC 113
Title: Office of the Superintendent
Address: 9300 Imperial Highway
Downey, CA 90242

Phone: (562) 922-6127(562) 922-6492
E-mail:

EXHIBIT I

County of Los Angeles **Notice of Federal Subaward Information**

Public Health - School COVID-19 Prevention Partnership (SCPP)

Recipient Information (i)

1. **Recipient Name**
   Los Angeles County of Education
2. **Vendor Customer Code (VCC)**
3. **Employer Identification Number (EIN)**
   95-6000942
4. **Recipient's Unique Entity Identifier** (ii)
   Data Universal Numbering System (DUNS)
   (www.SAM.gov)
5. **Award Project Title**
   School COVID-19 Prevention Partners
6. **Project Director or Principal Investigator**
   Name: Gregory Jackson
   Title: Coordinator III, Special Projects
   Address: 9300 Imperial Highway
   Downey, CA 90242
   E-mail: Jackson_Gregory@lacoe.edu
7. **Authorized Official**
   Name: Karen Kimmel
   Title: Cheif Financial Officer
   Address: 9300 Imperial Highway
   Downey, CA 90242
   E-mail: Kimmel_Karen@lacoe.edu

County Department Information (xi)

Office of Planning, Integration and Eng

8. **County Department Contact Information**
   Name: Kara Karibian
   Title: Health Program Analyst III
   Address: 313 N. Figueroa St.
   Los Angeles, CA 90012
   E-mail: KKaribian@ph.lacounty.gov
9. **Program Official Contact Information**
   Name: Rachel Bonkovsky, M.Ed
   Title: Director of Education Partnerships, OPIE
   Address: 313 N. Figueroa St.
   Los Angeles, CA 90012
   E-mail: Rbonkovsky@ph.lacounty.gov

Federal Award Information (www.usaspending.gov)

10. **Federal Award Number** (1)
    1 NU90TP922183-01
11. **Federal Award Date** (iv)
    03-09-2023
12. **Unique Federal Award Identification Number (FAIN)** (iii)
    NU90TP922183
13. **Name of Federal Awarding Agency** (xi)
    Centers for Disease Control and Prevention
14. **Federal Award Project Title** (x)
    Cooperative Agreement for Emergency Response: PH Crisis Response: 2018
15. **Assistance Listing Number** (xii)
    93.354
16. **Assistance Listing Program Title** (xii)
    PH Emergency Response: CoAg for Emergency Response: PH Crisis Resp
17. **Is this Award R&D?** (xiii)
    No

Summary Federal Subaward Financial Information

18. **Budget Period Start Date** (vi): 07/01/2023	**End Date:** 06/30/2024	
19. **Total Amount of Federal Funds Obligated by this Action** (vii)		$ 977,630
20a. Direct Cost Amount		$ 895,455
20b. Indirect Cost Amount (xiv)		$ 82,175
20. **Authorized Carryover**		$
21. **Offset**		$
22. **Total Amount of Federal Funds Obligated this Budget Period** (viii)		$ 977,630
23. **Total Approved Cost Sharing or Matching, where applicable**		$
24. **Total Federal and Non-Federal Approved this Budget Period** (ix)		$ 977,630
25. **Projected Performance Period Start Date** (v): 07/01/2023	**End Date:** 06/30/2024	
26. Total Amount of the Federal Award including Approved Cost Sharing or Matching this Project Period		$ 977,630

27. **Authorized Treatment of Program Income**

28. **County Program Officer Signature**

AO for

Name: Rachel Bonkovsky, M.Ed
Title: Director of Education Partnerships,OPIE

Signature/Date

29. **Remarks**

Contract Number: PH-004715

EXHIBIT I

Contract No. PH-004755

COUNTY OF LOS ANGELES / DEPARTMENT OF PUBLIC HEALTH

CONTRACT

FOR

SCHOOL COVID-19 PREVENTION PARTNERSHIP

Amendment Number 2

THIS AMENDMENT is made and entered into on _____

by and between	COUNTY OF LOS ANGELES (hereafter "County"),
and	PUBLIC HEALTH FOUNDATION ENTERPRISES, INC. dba HELUNA HEALTH (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled “School COVID-19 Prevention Partnership”, dated April 19, 2022, and further identified as Contract No. PH-004755, and any Amendments thereto (all hereafter referred to as “Contract”) between County and Contractor; and

WHEREAS, on March 4, 2020, the Board and Public Health declared a local and public health emergency in response to the increased spread of the novel coronavirus (COVID-19) across the country; and

WHEREAS, on October 13, 2020, the Board delegated authority to the Acting CEO, or her designee(s) which includes departments, in consultation with County Counsel, to enter into, execute, amend, and if necessary, terminate agreements, including sole source, necessary to support of the County’s continued efforts to assist and address the health, safety, and welfare of County residents during the COVID-19

pandemic and in compliance with requirements of the federal or state funding source for such agreement; and

WHEREAS, it is the intent of the parties hereto to amend the Contract to 1) extend the term of the Contract through June 30, 2024; 2) revise the Statement of Work; and make other designated changes, as set forth herein; and

WHEREAS, said Agreement provides that changes may be made in the form of a written Amendment which is formally approved and executed by the parties.

NOW, THEREFORE, the parties agree as follows:

1. This Amendment is hereby incorporated into the original Contract, and all of its terms and conditions, including capitalized terms defined herein, will be given full force and effect as if fully set forth therein.

2. The Amendment is effective upon execution through June 30, 2024.

3. Effective on the date of this Amendment, "Exhibit A-1 Statement of Work shall be deleted in its entirety and replaced with Exhibit A-2, Statement of Work, attached hereto and incorporated herein by reference. Any reference to Exhibit A-1 will be deemed amended to state Exhibit A-2.

Exhibit C-1 Budget, shall be deleted in its entirety and replaced with Exhibit C-2, Budget, attached hereto and incorporated herein by reference. Any reference Exhibit C-1 shall be deemed amended to state Exhibit C-2.

Exhibit J County's Administration is deleted in its entirety and replaced with the attached Exhibit J-1."

4. Paragraph 3 **DESCRIPTION OF SERVICES** subparagraph C. and subparagraph D. will be added to read as follows:

"C. If Contractor provides any tasks, deliverables, goods, services, or other work, other than as specified in this Contract, the same shall be deemed to be a gratuitous effort on the part of the Contractor, and the Contractor shall have no claim whatsoever against the County.

D. Federal Award Information for this Contract is detailed in Exhibit M, Notice of Federal Subaward Information, attached hereto and incorporated herein by reference."

5. Paragraph 4 **TERM OF CONTRACT**, is deleted in its entirety and replaced as follows:

"Paragraph 4 **TERM OF THE CONTRACT**, the term of this Contract shall be effective April 20, 2022 and shall continue in full force and effect through June 30, 2024, unless sooner terminated or extended, in whole or in part, as provided in this Contract.

The Contractor shall notify (Program Office) when this Contract is within six (6) months from the expiration of the term as provided for hereinabove. Upon occurrence of this event, the Contractor shall send written notification to (Program Office) at the address herein provided in Exhibit J."

6. Paragraph 18 **CONSTRUCTION** is deleted in its entirety.

7. Paragraph 29. **COMPLIANCE WITH CIVIL RIGHTS LAW,** sections 1, 2, 3, and 4 will be added to read as follows:

"Additionally, Contractor certifies to the County:

1. That Contractor has a written policy statement prohibiting discrimination in all phases of employment.

2. That Contractor periodically conducts a self-analysis or utilization analysis of its work force.

3. That Contractor has a system for determining if its employment practices are discriminatory against protected groups.

Where problem areas are identified in employment practices, Contractor has a system for taking reasonable corrective action, to include establishment of goals or timetables.

4. Where problem areas are identified in employment practices, Contractor has a system for taking reasonable corrective action, to include establishment of goals or timetables. Contractor shall comply with Exhibit D – Contractor's EEO Certification."

8. Paragraph 35. **CONSIDERATION OF HIRING GAIN/GROW PARTICPANTS** subparagraph C. will be deleted in its entirety.

9. Paragraph 39. **COUNTY'S QUALITY ASSURANCE PLAN** will be deleted and replaced in its entirety to read as follows:

"County or its agent(s) will monitor Contractor's performance under this Contract on not less than an annual basis. Such monitoring will include assessing Contractor's compliance with all Contract terms and performance standards. Contractor deficiencies which County determines are significant, or continuing, and that may place performance of the Contract in jeopardy if not corrected, will be reported to the Board of Supervisors and listed in the appropriate contractor performance database. The report to the Board will include improvement/corrective action measures taken by County and Contractor. If

improvement does not occur consistent with the corrective action measures, the County may terminate this Contract or impose other penalties as specified in this Contract."

10. Paragraph 44 **DATA ENCRYPTION** is deleted in its entirety.

11. Paragraph 54. **NON DISCRIMINATION IN SERVICES** is deleted in its entirety and replaced as follows:

"NON DISCRIMINATION AND AFFIRMATIVE ACTION

A. "Contractor certifies and agrees that all persons employed by it, its affiliates, subsidiaries, or holding companies are and will be treated equally without regard to or because of race, color, religion, ancestry, national origin, sex, age, physical or mental disability, marital status, or political affiliation, in compliance with all applicable federal and State anti-discrimination laws and regulations.

B. Contractor certifies to the County each of the following:

1. Contractor has a written policy statement prohibiting discrimination in all phases of employment.

2. That Contractor periodically conducts a self-analysis or utilization analysis of its work force.

3. That Contractor has a system for determining if its employment practices are discriminatory against protected groups.

4. Where problem areas are identified in employment practices, the Contractor has a system for taking reasonable corrective action, to include establishment of goals or timetables.

C. Contractor must take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to race, color, religion, ancestry, national origin, sex, age, physical or mental disability, marital status, or political affiliation, in compliance with all applicable federal and State anti-discrimination laws and regulations. Such action must include, but is not limited to: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.

D. Contractor certifies and agrees that it will deal with its subcontractors, bidders, or vendors without regard to or because of race, color, religion, ancestry, national origin, sex, age, physical or mental disability, marital status, or political affiliation.

E. Contractor certifies and agrees that it, its affiliates, subsidiaries, or holding companies will comply with all applicable federal and State laws and regulations to the end that no person will, on the grounds of race, color, religion, ancestry, national origin, sex, age, physical or mental disability, marital status, or political affiliation, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Contract or under any project, program, or activity supported by this Contract.

F. Contractor will allow County representatives access to Contractor's employment records during regular business hours to verify compliance with the provisions of this Paragraph (Nondiscrimination and Affirmative Action) when so requested by the County.

G. If the County finds that any provisions of this Paragraph (Nondiscrimination and Affirmative Action) have been violated, such violation will constitute a material breach of this Contract upon which the County may terminate or suspend this Contract. While the County reserves the right to determine independently that the anti-discrimination provisions of this Contract have been violated, in addition, a determination by the California Fair Employment and Housing Commission or the Federal Equal Employment Opportunity Commission that the contractor has violated Federal or State anti-discrimination laws or regulations will constitute a finding by the County that the contractor has violated the anti-discrimination provisions of this Contract.

The parties agree that in the event Contractor violates any of the anti-discrimination provisions of this Contract, the County will, at its sole option, be entitled to the sum of five hundred dollars ($500) for each such violation pursuant to California Civil Code Section 1671 as liquidated damages in lieu of terminating or suspending this Contract."

12. Paragraph 55 **NONDISCRIMINATION IN EMPLOYMENT** is deleted in its entirety.

13. Paragraph 63 **PUBLIC RECORDS ACT** is deleted and replaced in its entirety and replaced as follows: "

"A. Any documents submitted by Contractor; all information obtained in connection with the County's right to audit and inspect the Contractor's documents, books, and accounting records pursuant to the RECORD RETENTION AND AUDITS Paragraph of this Contract; as well as those

documents which were required to be submitted in response to the solicitation process for this Contract, become the exclusive property of the County. All such documents become a matter of public record and will be regarded as public records. Exceptions will be those elements in the California Government Code Section 7921.000 et seq. (Public Records Act) and which are marked "trade secret," "confidential," or "proprietary." The County will not in any way be liable or responsible for the disclosure of any such records including, without limitation, those so marked, if disclosure is required by law, or by an order issued by a court of competent jurisdiction.

B. In the event the County is required to defend an action on a Public Records Act request for any of the aforementioned documents, information, books, records, and/or contents of a proposal marked "trade secret," "confidential," or "proprietary," Contractor agrees to defend and indemnify the County from all costs and expenses, including reasonable attorney's fees, in action or liability arising under the Public Records Act."

14. Paragraph 68 **SOLICITATION OF BIDS OR PROPOSALS** is deleted in its entirety and replaced as follows:

"**PROHIBITION FROM PARTICIPATION IN FUTURE SOLICITATION(S):**

A Proposer, or a Contractor or its subsidiary or Subcontractor ("Proposer/Contractor"), is prohibited from submitting a bid or proposal in a County solicitation if the Proposer/Contractor has provided advice or consultation for the solicitation. A Proposer/Contractor is also prohibited from submitting a bid or proposal in a County solicitation if the Proposer/Contractor has developed or

prepared any of the solicitation materials on behalf of the County. A violation of this provision will result in the disqualification of the Contractor/Proposer from participation in the County solicitation or the termination or cancellation of any resultant County contract. This provision will survive the expiration, or other termination of this Agreement."

15. Paragraph 74. **TERMINATION FOR GATUITIES AND/OR IMPROPER CONSIDERATION** is deleted in its entirety and replaced as follows:

TERMINATION FOR IMPROPER CONSIDERATION: "County may, by written notice to Contractor, immediately terminate Contractor's right to proceed under this Contract, if it is found that consideration, in any form, was offered or given by Contractor, either directly or through an intermediary, to any County officer, employee, or agent, with the intent of securing this Contract or securing favorable treatment with respect to the award, amendment, or extension this Contract, or making of any determinations with respect to the Contractor's performance pursuant to this Contract. In the event of such termination, the County will be entitled to pursue the same remedies against Contractor as it could pursue in the event of default by Contractor.

Contractor must immediately report any attempt by a County officer or employee to solicit such improper consideration. The report must be made either to the County manager charged with the supervision of the employee or to the County Auditor-Controller's Employee Fraud Hotline at (800) 544-6861. Among other items, such improper considerations may take the form of cash,

discounts, services, the provision of travel or entertainment, or other tangible gifts."

16. Paragraph 79 **UNLAWFUL SOLICITATION** is deleted in its entirety.

Except for the changes set forth herein above, Contract shall not be changed in any other respect by this Amendment.

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EXHIBIT I

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be subscribed by its Director of the Department of Public Health and Contractor has caused this Amendment to be subscribed in its behalf by its duly authorized officer, the day, month and year first above written.

COUNTY OF LOS ANGELES

By _____
Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

PUBLIC HEALTH FOUNDATION ENTERPRISES, INC. dba HELUNA HEALTH
Contractor

By _____
Signature

_____
Printed Name

Title_____

APPROVED AS TO FORM
BY THE OFFICE OF THE COUNTY COUNSEL
DAWYN R. HARRISON
County Counsel

APPROVED AS TO CONTRACT ADMINISTRATION:

Department of Public Health

By_____
Contracts and Grants Division Management

#6938:js

EXHIBIT I
EXHIBIT C-2

SCHOOL COVID PREVENTION PARTNERSHIP (SCPP) LOS ANGELES COUNTY OFFICE OF EDUCATION (LACOE)

Budget Period
April 19, 2022
Through
June 30, 2024

Description **Year 1 (April 1, 2022 - June 30, 2023)**	**Amount**
Salaries • 1 FTE Coordinator III • 1 FTE Admin Assistant	 $ 11,703 $ 0
Employee Benefits	$ 5,343
Subtotal - Salaries & Employee Benefits	**$ 17,046**
Instructional Materials & Supplies	$ 0
Subcontracts	$ 0
Subtotal - Direct Costs	**$ 17,046**
Indirect Cost*/Administrative Costs	$ 1,555
Total - Year 1	**$ 18,601**
Year 2 (July 1st 2023- June 30, 2024)	
Salaries • 1 Coordinator III 100% • Admin Assistant 60% • 1 Sr. Division Secretary	 $120,540 $ 26,196 $ 26,536
Employee Benefits	$ 96,808
Subtotal - Salaries & Employee Benefits	**$270,080**
Supplies	$ 74,700
Office Space	$ 12,643
Mileage	$ 10,000
Facilities Services	$ 6,000
Reprographics	$ 10,000
Mailing Services	$ 5,000
Communications Support	$288,000
Copier	$ 4,000
Telephone	$ 3,900
Other Contract Services/Consultants	$150,000
GPM Fiscal Support	$ 53,256
Subtotal – Direct Costs	**$887,579**
Indirect Cost*/Administrative Costs	$ 71,450
Total - Year 2	**$959,029**
Year 1 and Year 2 – Direct Costs	**$904,625**
Indirect Cost*/Administrative Costs @9.1769%	$ 73,005
TOTAL (Year 1 and Year 2) Overall Budget	**$977,630**

During the term of this Contract, any variation to the above budget must be executed through a written Change Notice, executed by the Public Health Project Director and the Contractor. Invoices and cost reports must be submitted in accordance with approved line-item detailed budgets.

COUNTY'S ADMINISTRATION

CONTRACTOR'S NAME: Los Angeles County Office of Education

CONTRACT NO.: PH-004715

COUNTY PROJECT DIRECTOR:

Name: Rachel Bonkovsky, M.Ed
Title: Director of Education Partnerships and Programs, Office of Planning, Integration, and Engagement
Address: 313 N. Figueroa St.
Los Angeles, CA 90012

Telephone: (323) 695-4077
E-Mail Address: RBonkovsky@ph.lacounty.gov

COUNTY PROJECT MANAGER:

Name: Kara Karibian
Title: HPA III, Office of Planning, Integration, and Engagement
Address: 313 N. Figueroa St.
Los Angeles, CA 90012

Phone: (323) 236-9380
E-mail: kkaribian@ph.lacounty.gov

COUNTY CONTRACT PROJECT MONITOR:

Name: Sandra Hernandez, Office of Planning, Integration, and Engagement
Title: HPA II
Address: 313 N. Figueroa St.
Los Angeles, CA 90012

Phone: (213) 502-7545
E-mail: shernandez@ph.lacounty.gov

CONTRACTOR'S ADMINISTRATION

CONTRACTOR'S NAME: Los Angeles County Office of Education

CONTRACT NO.: PH-004715

CONTRACTOR'S PROJECT MANAGER:

Name: Gregory Jackson
Title: Coordinator III, Special Projects
Address: 9300 Imperial Highway
Downey, CA 90242

Telephone: (323) 559-4159 (c) / (562) 922-6239
E-Mail Address: Jackson_Gregory@lacoe.edu

CONTRACTOR'S AUTHORIZED OFFICIALS:

Name: Karen Kimmel
Title: Chief Financial Officer
Address: Interim Coordinator III, Public Affairs, Equity and Innovation
9300 Imperial Highway
Downey, CA 90242
Phone: (562) 922-6124
E-mail: Karen_Kimmel@lacoe.edu

Name:
Title:
Address:

Phone:
E-mail:

Notices to Contractor shall be sent to the following:

Name: Los Angeles Office of Education, EC 113
Title: Office of the Superintendent
Address: 9300 Imperial Highway
Downey, CA 90242

Phone: (562) 922-6127(562) 922-6492
E-mail:

EXHIBIT I

County of Los Angeles **Notice of Federal Subaward Information**

Public Health - School COVID-19 Prevention Partnership (SCPP)

Recipient Information (i)

1. **Recipient Name**
   Los Angeles County of Education
2. **Vendor Customer Code (VCC)**
3. **Employer Identification Number (EIN)**
   95-6000942
4. **Recipient's Unique Entity Identifier** (ii)
   Data Universal Numbering System (DUNS)
   (www.SAM.gov)
5. **Award Project Title**
   School COVID-19 Prevention Partners
6. **Project Director or Principal Investigator**
   Name: Gregory Jackson
   Title: Coordinator III, Special Projects
   Address: 9300 Imperial Highway
   Downey, CA 90242
   E-mail: Jackson_Gregory@lacoe.edu
7. **Authorized Official**
   Name: Karen Kimmel
   Title: Cheif Financial Officer
   Address: 9300 Imperial Highway
   Downey, CA 90242
   E-mail: Kimmel_Karen@lacoe.edu

County Department Information (xi)

Office of Planning, Integration and Eng

8. **County Department Contact Information**
   Name: Kara Karibian
   Title: Health Program Analyst III
   Address: 313 N. Figueroa St.
   Los Angeles, CA 90012
   E-mail: KKaribian@ph.lacounty.gov
9. **Program Official Contact Information**
   Name: Rachel Bonkovsky, M.Ed
   Title: Director of Education Partnerships, OPIE
   Address: 313 N. Figueroa St.
   Los Angeles, CA 90012
   E-mail: Rbonkovsky@ph.lacounty.gov

Federal Award Information (www.usaspending.gov)

10. **Federal Award Number** (1)
    1 NU90TP922183-01
11. **Federal Award Date** (iv)
    03-09-2023
12. **Unique Federal Award Identification Number (FAIN)** (iii)
    NU90TP922183
13. **Name of Federal Awarding Agency** (xi)
    Centers for Disease Control and Prevention
14. **Federal Award Project Title** (x)
    Cooperative Agreement for Emergency Response: PH Crisis Response: 2018
15. **Assistance Listing Number** (xii)
    93.354
16. **Assistance Listing Program Title** (xii)
    PH Emergency Response: CoAg for Emergency Response: PH Crisis Resp
17. **Is this Award R&D?** (xiii)
    No

Summary Federal Subaward Financial Information

18. **Budget Period Start Date** (vi): 07/01/2023	**End Date:** 06/30/2024	
19. **Total Amount of Federal Funds Obligated by this Action** (vii)		$ 977,630
20a. Direct Cost Amount		$ 895,455
20b. Indirect Cost Amount (xiv)		$ 82,175
20. **Authorized Carryover**		$
21. **Offset**		$
22. **Total Amount of Federal Funds Obligated this Budget Period** (viii)		$ 977,630
23. **Total Approved Cost Sharing or Matching, where applicable**		$
24. **Total Federal and Non-Federal Approved this Budget Period** (ix)		$ 977,630
25. **Projected Performance Period Start Date** (v): 07/01/2023	**End Date:** 06/30/2024	
26. Total Amount of the Federal Award including Approved Cost Sharing or Matching this Project Period		$ 977,630

27. **Authorized Treatment of Program Income**

28. **County Program Officer Signature**

AO for

Name: Rachel Bonkovsky, M.Ed
Title: Director of Education Partnerships,OPIE

Signature/Date

29. **Remarks**

Contract Number: PH-004715

BOARD LETTER/MEMO
CLUSTER FACT SHEET

DRAFT

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/24/2023
BOARD MEETING DATE	6/6/2023
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
DEPARTMENT(S)	Department of Public Health (Public Health)
SUBJECT	APPROVAL TO EXECUTE AN AMENDMENT TO THE MASTER AGREEMENT WORK ORDER WITH RESCUE AGENCY PUBLIC BENEFIT, LLC FOR THE PROVISION OF SUBSTANCE USE/MISUSE PREVENTION AND TREATMENT MEDIA SERVICES (3 VOTES)
PROGRAM	Substance Abuse Prevention and Control (SAPC)
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No
SOLE SOURCE CONTRACT	☐ Yes ☒ No
	If yes, please explain why:
DEADLINES/ TIME CONSTRAINTS	Current Media Master Agreement Work Order (MAWO) expires June 30, 2023
COST & FUNDING	Total cost: $6,000,000 (for extension) / Funding source: Substance Abuse Prevention and Treatment Block Grant (SABG) funds
	TERMS (if applicable): July 1, 2023, through June 30, 2025
	Explanation: The current funding of this MAWO is $5,418,927; additional funding for the extended term is $6,000,000 for a total maximum obligation of the MAWO of $11,418,927. There is no net County cost associated with this action. Funding has been included in Public Health's fiscal year (FY) 2023-24 Adopted Budget and will be included in future FYs as necessary.
PURPOSE OF REQUEST	To execute an amendment to the Master Agreement Work Order with Rescue Agency Public Benefit, LLC to extend the term of the MAWO for the provision of additional Substance Use/Misuse Prevention and Treatment Media Services, including fentanyl and overdose prevention.
BACKGROUND (Include internal/external issues that may exist including any related motions)	The threat of fentanyl overdose is currently affecting people of all ages, race/ethnicities~~,~~ and socio-economic status in Los Angeles County (LAC). Many residents are unaware or under informed about the dangers of overdose and~~,~~ lack information or resources available to protect themselves and their loved ones. According to a recent ~~F~~fentanyl overdose special report for the County of Los Angeles conducted by the ~~Department of~~ Public Health, accidental fentanyl overdose deaths increased 1,280% from 109 in 2016 to 1,504 in 2021. From 2016 to 2020, fentanyl overdose Emergency Department (ED) visits increased 308% from 133 to 542, and fentanyl overdose hospitalizations increased 98% from 102 to 202 cases. Adults aged 26-39 years had the highest rates of fentanyl overdose deaths (30.0) and ED visits (13.1) per 100,000 population, while young adults aged 18-25 years had the highest hospitalization rate (4.5) in the most recent available data year in ~~Los Angeles County~~LAC.

	In 2021, there were 224 fentanyl-related overdose deaths among teens, ages 15–19 years old~~,~~ in California according to data from the California Department of Public Health~~. Fentanyl and Overdose Prevention~~. The Los Angeles Times reported in September 2022 that at least seven teenagers residing in Los Angeles overdosed after taking pills possibly laced with fentanyl within the month of September 2022.
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: Sustainability: Public Health continues to expand its efforts designing and implementing a large-scale fentanyl and overdose prevention campaign to respond and mitigate the overdose epidemic in Los Angeles County. Amending the contract with Rescue Agency Public Benefit, LLC will allow this to happen. The threat of fentanyl overdose is currently affecting people of all ages, race/ethnicities, and socio-economic status in Los Angeles County. Many residents are unaware or underinformed about the dangers of overdose, lack of information or resources available to protect themselves and their loved ones.
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: Joshua Bobrowsky, Public Health Director Government Affairs, (213) 288-7871 jbobrowsky@ph.lacounty.gov Emily Issa, Senior Deputy County Counsel (213) 974-1827 eissa@counsel.lacounty.gov Gary Tsai, Public Health Substance Abuse Prevention and Control (626) 299-3504 GTsai@ph.lacounty.gov

COUNTY OF LOS ANGELES
Public Health

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

MEGAN McCLAIRE, M.S.P.H.
Chief Deputy Director

313 North Figueroa Street, Suite 806
Los Angeles, CA 90012
TEL (213) 288-8117 • FAX (213) 975-1273

www.publichealth.lacounty.gov

DRAFT

June 6, 2023

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
5000 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

APPROVAL TO EXECUTE AN AMENDMENT TO THE MASTER AGREEMENT WORK ORDER WITH RESCUE AGENCY PUBLIC BENEFIT, LLC FOR THE PROVISION OF SUBSTANCE USE/MISUSE PREVENTION AND TREATMENT MEDIA SERVICES
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request approval to execute an amendment to the Master Agreement Work Order with Rescue Agency Public Benefit, LLC to extend the term and increase the maximum obligation effective July 1, 2023, through June 30, 2025.

IT IS RECOMMENDED THAT THE BOARD:

1. Approve and instruct the Director of the Department of Public Health (Public Health), or designee, to execute an amendment, substantially similar to Exhibit I, to Master Agreement Work Order (MAWO) Number PH-003527-W1 with Rescue Agency Public Benefit, LLC (Rescue Agency) for the provision of Substance Use/Misuse Prevention and Treatment Media Services, to extend the term through June 30, 2025, at a maximum annual obligation of $3,312,830 for the period of July 1, 2023, through June 30, 2024, and $2,687,170 for the period of July 1, 2024, through June 30, 2025, 100 percent offset by Substance Abuse Prevention and Treatment Block Grant (SABG) funds, Assistance Listing Number 93.959.

2. Delegate authority to the Director of Public Health, or designee, to execute future MAWO amendments with Rescue Agency that; a) extend the term for an additional one year period through June 30, 2026; b) allow the rollover of unspent MAWO funds; and c) provide an increase or decrease in funding up to 50 percent above or below each periods annual base maximum obligation, effective upon amendment execution or at the beginning of the applicable MAWO period, which may include corresponding revisions to the Scope of Work, as necessary, subject to review and approval by County Counsel, and notification to your Board and the Chief Executive Office (CEO).

PURPOSE/JUSTIFICATION OF RECOMMEND ACTIONS

The threat of fentanyl overdose is currently affecting people of all ages, race/ethnicities and socio-economic status in Los Angeles County (LAC). Many residents are unaware or under informed about the dangers of overdose and lack information or resources that would help them protect themselves and their loved ones.

According to a recent fentanyl overdose special report for the County of Los Angeles conducted by Public Health, accidental fentanyl overdose deaths increased 1,280% from 109 in 2016 to 1,504 in 2021. From 2016 to 2020, fentanyl overdose Emergency Department (ED) visits increased 308% from 133 to 542, and fentanyl overdose hospitalizations increased 98% from 102 to 202 cases[1]. Adults aged 26-39 years had the highest rates of fentanyl overdose deaths (30.0) and ED visits (13.1) per 100,000 population, while young adults aged 18-25 years had the highest hospitalization rate (4.5) in the most recent data year in LAC.

In 2021, there were 224 fentanyl-related overdose deaths among teens ages 15–19 years old in California, according to data from the California Department of Public Health[2]. The Los Angeles Times reported in September 2022 that at least seven teenagers residing in Los Angeles overdosed after taking pills possibly laced with fentanyl within the month of September 2022.

Public Health continues to expand its efforts designing and implementing a large-scale fentanyl and overdose prevention campaign to respond and mitigate the overdose epidemic in LAC. Rescue Agency will design and implement a broad-based, large scale media campaign to effectively increase knowledge of the risks of fentanyl, educate about fentanyl laced counterfeit pills and other illicit drugs, and promote harm reduction resources such as naloxone (nasal spray). This campaign will include a robust evaluation component including measurable outcomes that reflect increased knowledge around the risk associated with fentanyl and behavior change.

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[1] Fentanyl Overdoses in Los Angeles County: Special Report Los Angeles County Department of Public Health http://publichealth.lacounty.gov/sapc/MDU/SpecialReport/FentanylOverdosesInLosAngelesCounty.pdf.
[2] https://www.cdph.ca.gov/Programs/OPA/Pages/Communications-Toolkits/Fentanyl-Overdose-Prevention.aspx

Approval of Recommendation 1 will allow Public Health to amend MAWO Number PH-003527-W1 with Rescue Agency to extend the term through June 30, 2025, to provide additional Substance Use/Misuse Prevention and Treatment Media Services.

Approval of Recommendation 2 will allow Public Health to execute future amendments to the MAWO that: a) extend the term for an additional one-year period; b) allow the rollover of unspent MAWO funds; and c) provide an increase or decrease in funding up to 50 percent above or below each period's annual base maximum obligation.

Implementation of Strategic Plan Goals

The recommended actions support Strategy II.2 – Support Wellness of our Communities; Objective II.2.4 – Promote Active and Healthy Lifestyles, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

The total cost of the MAWO amendment for the period of July 1, 2023, through June 30, 2025, is $6,000,000; 100 percent offset by federal SABG funds.

There is no net County cost associated with this action. Funding for this action has been included in Public Health's fiscal year (FY) 2023-24 Adopted Budget and will be included in future FYs as necessary.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

As required under Board Policy 5.120, your Board was notified on March 31, 2023, of Public Health's request to increase or decrease funding up to 50 percent above or below each period's annual base maximum obligation. This will allow Public Health to address the emergent need to increase and expand community awareness and knowledge around the risks associated with fentanyl and behavior change if additional funding is identified.

County Counsel has reviewed and approved Exhibit I as to form.

CONTRACTING PROCESS

On May 5, 2020, Public Health released a work order solicitation to identify a vendor to manage and implement various media campaigns around substance use, including fentanyl and overdose prevention. Rescue Agency was awarded the MAWO for the initial three-year term, and the MAWO was executed on August 14, 2020.

On May 3, 2022, your Board authorized Public Health to amend the MAWO with Rescue Agency to increase funding to expand existing media campaign efforts around stigma reduction, alcohol prevention targeting young adults who attend college, and

social marketing approaches that target high-risk geographic areas, incorporating new technologies and other novel public health approaches to disease prevention efforts.

Since then, Public Health has exercised its delegated authority to amend the MAWO and has made funding and service adjustments.

Public Health intends to expand the existing scope of work to include a more broad-based campaign extending into FY 2023-24 and FY 2024-25. Rescue Agency has already been engaged to develop the fentanyl campaign and is uniquely positioned to complete this effort.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommended actions will allow Public Health to expand media service campaigns in support of Substance Use/Misuse Prevention and Treatment Services.

Respectfully submitted,

Barbara Ferrer, PhD, MPH, MEd
Director

BF:jt
#06917

Enclosures

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisor

EXHIBIT I

Work Order Number: PH-003527-W1

Amendment Number 7

COUNTY OF LOS ANGELES / DEPARTMENT OF PUBLIC HEALTH
MASTER AGREEMENT WORK ORDER
FOR
SUBSTANCE USE/MISUSE PREVENTION AND TREATMENT
MEDIA SERVICES

RESCUE AGENCY PUBLIC BENEFIT, LLC

THIS AMENDMENT is made and entered into on _____,

by and between	COUNTY OF LOS ANGELES (hereafter "County")
and	RESCUE AGENCY PUBLIC BENEFIT, LLC (hereafter "Contractor").

WHEREAS, on July 3, 2018, County and Contractor entered into Master Agreement Number PH-003527 to provide media services for the Department of Public Health (Public Health); and

WHEREAS, reference is made to Master Agreement Number PH-003527 and any amendments thereto (all referred to as “Master Agreement”) between County and Contractor; and

WHEREAS, on August 14, 2020, County and Contractor entered into Master Agreement Work Order (MAWO) Number PH-003527-W1 to provide Substance Use/Misuse Prevention and Treatment media services; and

WHEREAS, on June 6, 2023, the County Board of Supervisors approved delegated authority to the Director of Public Health, or designee, to execute amendments to MAWO PH-003527-W1; and

WHEREAS, it is the intent of the parties hereto to amend MAWO to extend the term of the MAWO through June 30, 2025, for the provision of additional Substance Use/Misuse Prevention and Treatment media services, and make certain modifications to the MAWO; and

WHEREAS, Master Agreement provides that changes in accordance to Paragraph 8.1, Amendments, 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 possesses the competence, expertise, and personnel necessary to provide services consistent with the requirements of the MAWO.

NOW, THEREFORE, the parties hereto agree as follows:

1. This amendment is effective July 1, 2023.

2. Attachment A-1, Statement of Work, Attachments B-1 and B-2, Scopes of Work, and Attachments C-4 and C-5, Budgets, attached hereto and incorporated herein by reference, are added to the MAWO.

3. Paragraph 3.0, TERM OF MASTER AGREEMENT WORK ORDER, is deleted in its entirety and replaced as follows:

"**3.0 TERM OF MASTER AGREEMENT WORK ORDER**

The term of this MAWO is effective upon execution through and including June 30, 2025, unless sooner terminated or extended, in whole or in part, as provided in this MAWO."

4. Paragraph 4.0, CONTRACT BUDGET, is deleted in its entirety and replaced as follows:

"**4.0 CONTRACT BUDGET**

Contractor will provide media services at the specified rates in Attachments C-1.2, C-2.5, C-3.5, C-4, and C-5, Budgets. Contractor will not add or replace services or personnel without the prior written permission of the County Project Director or designee."

5. Paragraph 7.0, MAXIMUM TOTAL COST AND PAYMENT, Subparagraphs 7.4, 7.5 and 7.8 are revised, and Subparagraphs 7.9 and 7.10 are added to read as follows:

"7.4 County agrees to compensate Contractor in accordance with the payment structure set forth in Attachments C-1.2, C-2.5, C-3.5, C-4, and C-5, Budgets, attached hereto and incorporated herein by reference."

"7.5 Contractor shall satisfactorily perform and complete all required services in accordance with Attachment A.1, Statement of Work, and Attachments B, B-1 and B-2, Scopes of Work, notwithstanding the fact that total payment from County will not exceed the Maximum Total Cost amount. Performance of services as used in this Paragraph includes time spent performing any of the service activities designated

in the Attachment(s) including, but not limited to, any time spent on the preparation for such activities."

"7.8 Contractor may request the Director of Public Health, or designee, to execute Change Notices to the MAWO that authorize modifications to or within budget categories within the budget, as reflected in Attachments C-1.2, C-2.5, C-3.5, C-4, and C-5, Budgets, and corresponding service adjustments, as necessary; changes to hour of operation and/or services locations; and/or corrections of errors in the MAWO's terms and conditions."

"7.9 Effective July 1, 2023, through June 30, 2024, the Maximum Total Amount that County will pay Contractor for all Services to be provided under this MAWO for media services will not exceed three million, three hundred twelve thousand, eight hundred thirty dollars ($3,312,830), as set forth in Attachment C-4, Budget, attached hereto and incorporated herein."

"7.10 Effective July 1, 2024, through June 30, 2025, the Maximum Total Amount that County will pay Contractor for all Services to be provided under this MAWO for media services will not exceed two million, six hundred eighty-seven thousand, one hundred seventy dollars ($2,687,170), as set forth in Attachment C-5, Budget, attached hereto and incorporated herein."

6. Paragraph 8.0, INVOICE AND PAYMENTS, is deleted in its entirety and replaced as follows:

"**8.0 INVOICE AND PAYMENTS**

Contractor will invoice the County in arrears only for providing the tasks, deliverables, services, and other work specified in this MAWO. Contractor will invoice County on a Cost Reimbursement basis as reflected in Attachments C-1.2, C-2.5, C-3.5, C-4, and C-5, Budgets.

Invoices under this MAWO will be submitted to the address(es) set forth in Attachment F."

7. Except for the changes set forth hereinabove, the MAWO will not be changed in any other respect by this amendment.

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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 its Director of Public Health, or designee, and Contractor has caused this amendment to be subscribed in its behalf by its duly authorized officer, the day, month and year first above written.

COUNTY OF LOS ANGELES

By _____
Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

RESCUE AGENCY PUBLIC BENEFIT, LLC
Contractor

By _____
Signature

_____
Printed Name

Title _____

APPROVED AS TO FORM
BY THE OFFICE OF THE COUNTY COUNSEL
DAWYN R. HARRISON
County Counsel

APPROVED AS TO CONTRACT
ADMINISTRATION:

Department of Public Health

By_____
Contracts and Grants Division Management

#06917:jt

STATEMENT OF WORK
SUBSTANCE USE/MISUSE PREVENTION AND TREATMENT MEDIA SERVICES
RESCUE AGENCY PUBLIC BENEFIT, LLC

1.0 INTRODUCTION

The County of Los Angeles Department of Public Health (DPH) Substance Abuse Prevention and Control (SAPC) program administers the County's Drug Medi-Cal Organized Delivery System (DMC-ODS), which is the SUD treatment program for Medi-Cal, California's Health Coverage Program for low-income people.

In recent years, SAPC has launched three media campaigns educating youth, young adults, and parents/guardians regarding the harms of substance use in the categories of marijuana, prescription opioids and heroin, and synthetic drugs. The marijuana campaign highlighted public health concerns of smoking and ingesting marijuana, its impact on adolescent and young adult brain development, and potential individual and community impact from increased use and availability. The campaign on prescription opioid misuse and heroin use brought awareness of the harms and risks associated with this public health epidemic through creative prevention messaging. The synthetic drug use campaign informed and educated youth and young adults about the dangers and risks associated with using synthetic drugs through social marketing approaches and targeted placement in high-risk geographic areas.

The three media campaigns launched were:

1. The Bigger Choices

   Teen Marijuana Use Prevention Campaign featured videos, messages and posts on social media, including Teen Roundtable Videos, Kesh Weed Rap Video, Animated Fact Video, 10-second Snapchat videos, Instagram and Facebook. This campaign also featured radio contest promotions at middle schools, broadcasts on iHeart Radio, Pandora, Hulu, and digital display banner ads. The Bigger Choices campaign ran from May through December 2018, and again from April through May 2019.

2. The Take Back Day Campaign

   This local media campaign included 10/15-second ads across traffic radio in Los Angeles, as well as paid Facebook social advertisement posts, that were targeted to the zip codes where Take Back Day events were held. This campaign ran from April 15, 2019, through April 27, 2019.

3. The Opioid Awareness Media Campaign

This campaign launched a far-reaching multi-media public education campaign including informational tools to foster dialogues between doctors and their patients on safe pain management, and to educate the public on how to get treatment for addiction using billboards, television advertisements, radio spots, and social media. This campaign ran from July through November 2019.

In an ongoing effort to inform and prevent substance use, misuse, and/or abuse among the County's youth, young adults, and active users and/or parents/guardians, SAPC intends to develop, create, implement, and place media buys for new and existing public education campaigns. These campaigns will focus on prevention and increase awareness of two anticipated issues: 1) methamphetamine prevention, and, 2) alcohol misuse/abuse prevention.

2.0 PROJECT TERM

The term of the Substance Use/Misuse Prevention and Treatment Media Services is effective through June 30, 2025.

3.0 SERVICE SITE(S) AND DAYS / HOURS OF OPERATION

Contractor must maintain a physical office in Los Angeles County with a telephone in the company's name where Contractor conducts business. The office must be staffed Monday through Friday by at least one employee who can respond to inquiries and complaints which may be received about Contractor's performance of the MAWO. When the office is closed, an answering service or machine shall be provided to receive calls and take messages. Contractor shall answer calls within 24 hours of receipt of the call.

4.0 QUALITY CONTROL

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 MAWO. Contractor must submit the Plan to the County MAWO Project Monitor for review. The Plan must include, but may not be limited to the following:

4.1 Method of monitoring to ensure that MAWO requirements are being met.

4.1.1 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.

5.0 QUALITY ASSURANCE PLAN

The County will evaluate Contractor's performance under the MAWO using the quality assurance procedures as defined in the Master Agreement, Sub-paragraph 8.14, County's Quality Assurance Plan.

5.1 Meetings

Contractor shall attend meetings as required by DPH.

5.2 Contract Discrepancy Report

Verbal notification of a Contract discrepancy will be made to the Contractor's Project Manager as soon as possible whenever a Contract discrepancy is identified. The problem shall be resolved within a time period mutually agreed upon by the County and the Contractor's Project Manager.

The County will determine whether a Contract Discrepancy Report will be issued. Upon receipt of this document, Contractor must respond in writing to the County within five workdays, acknowledging the reported discrepancies or presenting contrary evidence. A plan for correction of all deficiencies identified in the Contract Discrepancy Report shall be submitted to the County within 15 workdays.

5.3 County Observations

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

6.0 DEFINITIONS

Throughout this SOW, references are made to certain persons, groups, or departments/agencies, as identified below. Additional definitions can be found in the Master Agreement.

A. Threshold languages – Prevalent languages, defined by the Medi-Cal Eligibility System, are indicated by having 3,000 beneficiaries or five percent of the eligible beneficiary population (whichever is lower) in the Managed Care Plan's service area, which for this contract includes the following languages: Arabic, Armenian, Cantonese, other Chinese, Farsi, Khmer (Cambodian), Korean, Mandarin, Russian, Spanish, Tagalog, and Vietnamese.

B. Priority Populations – The priority populations of the media campaigns are youth (ages 12-17), young adults (ages 18-25), at-risk pregnant women, active users, and/or parents/guardians. Priority populations for the awareness videos include

those who have historically been marginalized from substance use related public health messaging and engagement. These communities include, but are not limited to, homeless, non-English monolingual, and LGBTQ. Priority populations may include English and non-English speaking people. To ensure the content messaging for campaigns is culturally and linguistically relevant to the priority communities, campaign materials may need to be provided in English, Spanish, and/or other languages as appropriate for the community selected.

7.0 CONTRACTOR PERSONNEL

Contractor must have a sufficient number of staff to meet MAWO requirements and must hire personnel as needed to complete project deliverables and implementation activities, including at minimum the below:

A. Project Manager(s) is responsible for the overall MAWO administration, oversee account team(s) for each project, trouble-shooting, and big picture content to make sure Scope of Work deliverables and timelines are being met. This person will oversee overall strategies, identify efficiencies, direct strategy, and act as agency lead over media initiatives. Project Manager(s) must have a minimum of five years' experience within the last seven years managing multiple accounts simultaneously and must be able to effectively communicate in English, both orally and in writing, and be based in a Los Angeles County office.

B. Creative Director is responsible for presenting the design process and design concepts to SAPC, managing design teams, and working with the staff to ensure creative/design is within the timeline and budget for both media initiatives. The Creative Director must have experience in managing and overseeing the work of the creative team(s) and developing content.

C. Media Director is responsible for planning and developing campaign advertising programs. The Media Director/Manager must have experience in purchasing and placing advertising in the Los Angeles Designated Market Area.

8.0 SPECIFIC WORK REQUIREMENTS

Contractor must implement countywide public health education and awareness media campaigns focused on Priority Populations. Contractor will provide media support for additional countywide project activities in all five of the media categories outlined below. In addition to the specific work requirements listed herein, Attachment B, Scope of Work, provides the specific project tasks, objectives, activities, and timeline, and will also serve as a guide in monitoring Contractor's performance under the MAWO.

8.1 Designing and Creating: Plan, design, create, implement, and evaluate media advertisement and public education campaigns that may include the need to translate into one or more of the County’s Threshold Languages, and provide multiple creative executions for maximum impact on positive behavior change. Activities may include but are not limited to the following:

A. Plan, recruit, conduct, and evaluate audience responses through marketing research tools such as, but not limited to, testing campaign creative messaging for each media and public education campaign; and as part of the evaluation, submit a summary report on research finding.

B. Develop creative educational and/or promotional materials to support the call to action, desired behavioral change for each media and public education campaign. Creative material includes but is not limited to: videos, outreach/promotional materials (e.g., infographics), fact sheets, posters, stickers, postcards, brochures, interactive online tools, mobile and digital content, social media graphics, website content, and graphical designs for promotional items (e.g., t-shirts, reusable bags). Purchase of promotional items requires prior approval from SAPC.

C. Develop and produce materials for press events to support the media and public education campaigns (e.g., press information packets), news releases, coordinating or creating visuals and/or props, and campaign promotional materials such as brochures, stickers, campaign toolkits, etc.

D. Develop webinar presentation(s) and coordinate webinar services to coincide with campaign launches for stakeholders and partners, manage registration for webinars, and support SAPC staff during the webinar.

E. Plan and develop educational and/or storytelling videos to promote campaign messaging surrounding substance use disorder for digital or social media platforms. Manage all areas of filming and producing videos including pre-production, production and postproduction of videos, such as secure film location, casting, licenses for talent and music, editing and translation of videos. Provide SAPC staff with high definition quality videos including video files and assets (e.g., images and other elements used in the video production).

8.2 Formative Research: Consult with SAPC to update and submit a formative research plan to inform the development of the media campaign that may include but not limited to needs assessment based on existing countywide and national data, data collection and analysis. Conduct informational session(s) with SAPC leadership and contracted provider organization staff and other entities.

8.3 Media Planning and Buying: Plan, develop, and execute advertising buy plans in consultation with and approved by SAPC that may include but are not limited to the following:

A. Research media landscape and provide advertising recommendations based on current program needs.

B. Negotiate and secure advertising including but not limited to: out-of-home (e.g., billboards), transit shelters, bus/rail cards, television, radio, print, digital, social media, and other advertising spaces such as

health care clinics, doctor offices, pharmacies, gas station, public serving areas, airports, closed circuit, coffee shops, gyms etc.

C. Provide detailed campaign reports for earned and paid media including ad placement metrics and tracking to DPH. Save one to two media clips for historical records for each campaign.

8.4 Social Media: Develop and produce content for DPH's social media platforms, including:

A. Create or provide updated content to appear on existing social media profiles: Facebook, Twitter, YouTube, Instagram, Snapchat, Pinterest, Tumblr.

B. If required, purchase and/or renew website hosting, security certificates, and URL names.

C. Create and develop mobile and digital content and graphics for electronic devices such as smartphones and tablets, interactive online tools, and digital media elements for radio/video.

D. Complementary campaign-created materials, such as microsites, banner ads, online graphics, social media promotion, and community outreach opportunities.

8.5 Public Relations: Conduct public relations and coordinate press events to support the launch of the media and public education campaigns which may include but are not limited to the following:

A. Develop media materials such as writing and distributing media advisories and press releases, creating press information packets, writing campaign program toolkit materials e.g., template press release, template e-newsletter article, template social media messages that community partners can utilize.

B. Lead campaign press events by conducting media pitches; securing and purchasing photos and/or videos from event and capturing photo/video b-roll for media distribution; creating visuals and/or props; planning, implementing, and managing all logistics for day-of the event including renting audio/visual equipment, easels or canopies, securing media venue, writing talking points for press event speakers, coordinating media interviews, and monitoring and collecting all earned media coverage pre- and post-campaign launch.

8.6 Community Outreach: Plan, coordinate, promote, and manage outreach to engage communities during specific local, State, and federally recognized events; as well as engage and encourage primary care clinics, public health facilities, and relevant community-based organizations in various areas throughout the County to disseminate messages and show public awareness videos.

8.7 Evaluation:

Develop, pre and post survey instrument in coordination with DPH/SAPC to be conducted with campaign target population(s). Submit plan, survey instrument, and other necessary documentation to the LAC-DPH Institutional Review Board (IRB) for approval. Upon completion of campaign, analyze survey data and prepare report on survey findings.

SCOPE OF WORK
SUBSTANCE USE/MISUSE PREVENTION AND TREATMENT MEDIA SERVICES
RESCUE AGENCY PUBLIC BENEFIT, LLC
PERIOD: July 1, 2023 – June 30, 2024

OBJECTIVES	IMPLEMENTATION	TIMELINE	DELIVERABLES	EVALUATION AND DOCUMENTATION
1. Provide strategic consultation for all communication and media activities related to the Substance Use/Misuse Prevention and Treatment campaigns.	1.1 Contractor will provide organizational chart and description of each staff member's role in development of fentanyl awareness campaign.	1.1 July 1, 2023, through June 30, 2024.	1.1 Copy of organizational chart.	1.1 Organizational chart kept on file and available for SAPC upon request.
	1.2 Assign a Project Manager to act as central point of contact with SAPC and oversee the day-to-day project deliverables.	1.2 July 1, 2023, and as frequently as required by SAPC.	1.2 Provide contact information on Project Manager.	1.2 Contact information willl be kept on file and available for SAPC upon request.
	1.3 Provide an up-to-date contact roster for all contract staff including name title, phone number, and email address. Notify SAPC within five workdays and in writing of any changes in staff assignments.	1.3 July 1, 2023, and ongoing through June 30, 2024.	1.3 Roster for all project staff assigned to work under the Master Agreement Work Order (MAWO).	1.3 Roster submitted and on file as required, and available for SAPC review upon request.
	1.4 Contractor will provide a SAPC-approved written Communications Plan to address all components of the Statement of Work (SOW). Contractor to work closely with SAPC to achieve approved plan within 30 days of MAWO amendment execution.	1.4 (a) First draft due within 10 business days of MAWO amendment execution (b) Final draft due within 30 business days of execution	1.4 Final Communication Plan.	1.4 SAPC approved written Communication Plan will be kept on file.
	1.5 Facilitate weekly scheduled conference calls and/or meetings with SAPC staff to discuss status updates including, but not limited to progress and action items on Scope of Work deliverables and activities.	1.5 July 1, 2023, and at least monthly through June 30, 2024.	1.5 Meeting agendas, minutes, and other documents five (5) workdays after each occurrence.	1.5 Meeting agendas, minutes, e-mail, other related documents will be kept on file and available for SAPC review upon request.
	1.6 Contractor will participate and cooperate in the Department of Health Care Services (DHCS) data reporting system on a monthly basis.	1.6 From date of execution of MAWO amendment and monthly on an ongoing basis.	1.6 Service data for each SOW objective implementation activity/effort as allowed per reporting requirements will be entered into the DHCS system.	1.6 Monthly report submitted to SAPC and, SAPC Manager will review DHCS system to ensure compliance monthly with data entry requirements.
2. Plan and implement one countywide media and public awareness campaign targeting the priority	2.1 Complete production of multiple creative concepts for one multi-media and public education/awareness campaign, as outlined in each creative brief approved by SAPC (inclusive of social media, educational fact sheet, flyer, etc.) to be	2.1a Initial run must be launched by July 2023 2.1b. Videos to be completed within three	2.1 To include but not limited to four fully rendered videos based on approved	2.1 Approved produced concepts submitted in requested formats and Kick-off strategy

SCOPE OF WORK
SUBSTANCE USE/MISUSE PREVENTION AND TREATMENT MEDIA SERVICES
RESCUE AGENCY PUBLIC BENEFIT, LLC
PERIOD: July 1, 2023 – June 30, 2024

OBJECTIVES	IMPLEMENTATION	TIMELINE	DELIVERABLES	EVALUATION AND DOCUMENTATION
populations listed in the Statement of Work or as determined by SAPC throughout the period. <u>Campaign includes two Market Runs:</u> 1.Phase 1: July-December 2023 2.Phase 2: January-June 2024 Messaging includes but is not limited to: a. Fentanyl Education b. Counterfeit Pills c. Overdose Prevention/Harm Reduction	conducted within SAPC identified cities/regions, at minimum in each of the five Supervisorial Districts (SD) and eight Services Planning Areas (SPA). Ensure content messaging for all campaigns are culturally and linguistically relevant to the target communities and created in English, Spanish, and other languages as appropriate to the campaign and target populations.	months of MAWO amendment execution.	creative concepts.	meeting notes and action items for campaign kept on file.
	2.2 Place, maintain and update social media messaging, and online content for posting on Facebook, Twitter, Instagram, SnapChat, LinkedIn, Tik Tok, YouTube and all other relevant digital outlets. Social media messages/contents to include, but not limited to, the following: a) Mobile friendly content (designed for smart phones, tablets, etc.) b) Interactive online tools c) Digital media elements (audio and video) d) Graphics e) Photographs	2.2 No later than July 2023 and ongoing for market run.	2.2 Social Media placement, general distribution lists, education material, community feedback, media clips, audio files and paid media report.	2.2 As applicable, general distribution lists, education material, community feedback, media clips, audio files and paid media reports will be kept on file and made available to SAPC upon request.
	2.3 Execute/launch press event to earn press coverage of the campaign in consultation with SAPC. This includes coordinating all logistics to include but not limited to securing event venue, AV equipment rental, canopies, easels, etc., providing strategic counsel, press kit development, and managing media relations.	2.3 Timeline determined with SAPC to occur one month after MAWO amendment execution (no later than August 2023).	2.3 Receipt of Purchase, agreements, etc. are submitted with monthly invoice to SAPC for approval by end of each campaign launch event.	2.3 Receipt of Purchases and approved monthly invoices kept on file.
	2.4 Perform media relations that includes developing media pitches, pitching the event to the media, and on-hands management of media requests and interviews. Media firm to purchase 1-2 media clips for presentation and historical records.	2.4 Upon execution of the media launch for campaign.	2.4 Purchased news clips submitted to SAPC.	2.4 Purchased news clips will be kept on file.
	2.5 Develop campaign program toolkit to include but not limited to template social media messages, template press materials, web assets, graphics support and social media graphics creation, videos, promotional materials, and website/e-newsletter/blog content.	2.5 By launch date – July 31st.	2.5 Submit completed campaign toolkit assets.	2.5 Program toolkit kept on file.

SCOPE OF WORK
SUBSTANCE USE/MISUSE PREVENTION AND TREATMENT MEDIA SERVICES
RESCUE AGENCY PUBLIC BENEFIT, LLC
PERIOD: July 1, 2023 – June 30, 2024

OBJECTIVES	IMPLEMENTATION	TIMELINE	DELIVERABLES	EVALUATION AND DOCUMENTATION
	2.6 In consultation with SAPC, conduct campaign webinar and toolkit rollout to drive support from stakeholders and funded partners to promote the campaign. Media firm will arrange webinar service, toll-free conference call line, and support staff to send out registration information, manage RSVPs, and coordinate the day-of webinar presentation. Develop the webinar presentation.	2.6 No more than one month after launch of campaign event – Augusts 31st.	2.6 Webinar presentation, materials, and registration will be submitted to SAPC. Kept on file.	2.6 Webinar presentation, materials, and registration kept on file.
3. Evaluate Phase 1 Run of countywide media and public awareness campaign	3.1 Provide campaign performance metrics/earned media report for all three target populations, including social media activity and other information needed for reporting including, but not limited to: analytics, reach, impressions, Targeted Rating Points (TRP), video completion rates, Click Through Rate (CTR). Include other data such as: calls to the Substance Abuse Services Helpline, ad images/photos, social media interactions, earned media, and other analytical components that will help demonstrate the return on investment and value of the paid media activity.	3.1 Submit reports by 30 days post media buy placement and when final run numbers & figures arrive from media companies.	3.1 Final report including analytics, reach, impressions, video completion rates, TRPs and other data, images/ photos, and any other materials.	3.1 Final report kept on file.
	3.2 Provide a post-evaluation report, inclusive of summary of respondent demographics, research goals and objectives, limitations, process indicators (i.e., impressions, campaign reach) and outcome metrics (i.e., awareness, perceived effectiveness, knowledge, attitudes, behavioral change, and other relevant outcomes through regression analyses, etc. and final takeaways.	3.2 Within 30 days of the campaign conclusion.	3.2 Three hard copies of the Campaign Wrap-up report and/or program binder, and one digital copy.	3.2 Campaign wrap-up report in requested format.
	3.3 Provide an executive summary of 3-5 pages including an overview of the campaign, description of objective, strategy, target audiences, messaging, creative examples, media plan (earned and paid). Also, to be included are highlights of the performance metrics, achieved outcome objectives and evaluation.	3.3 Within 60 days of campaign conclusion. December 2024	3.3 Digital copy of executive summary.	3.3 Executive summary kept on file.

SCOPE OF WORK
SUBSTANCE USE/MISUSE PREVENTION AND TREATMENT MEDIA SERVICES
RESCUE AGENCY PUBLIC BENEFIT, LLC
PERIOD: July 1, 2024 – June 30, 2025

OBJECTIVES	IMPLEMENTATION	TIMELINE	DELIVERABLES	EVALUATION AND DOCUMENTATION
1. Provide strategic consultation for all communication and media activities related to the Substance Use/Misuse Prevention and Treatment campaigns	1.1 Contractor will provide organizational chart and description of each staff member's role in development of fentanyl awareness campaign.	1.1 July 1, 2024 through June 30, 2025.	1.1 Copy of organizational chart.	1.1 Organizational chart kept on file and available for SAPC upon request.
	1.2 Assign a Project Manager to act as central point of contact with SAPC and oversee the day-to-day project deliverables.	1.2 July 1, 2024 and frequently as required by SAPC.	1.2 Provide contact information on Project Manager.	1.2 Contact information will be kept on file and available for SAPC upon request.
	1.3 Provide an up-to-date contact roster for all contract staff including name title, phone number, and email address. Notify SAPC within five workdays and in writing of any changes in staff assignments.	1.3 July 1, 2024 and ongoing through June 30, 2025.	1.3 Roster for all project staff assigned to work under the Master Agreement Work Order (MAWO).	1.3 Roster submitted and on file as required, and available for SAPC review upon request.
	1.4 Facilitate weekly scheduled conference calls and/or meetings with SAPC staff to discuss status updates including, but not limited to progress and action items on Scope of Work deliverables and activities	1.4 July 1, 2024 and at least monthly through June 30, 2025.	1.4 Meeting agendas, minutes, and other documents five workdays after each occurrence	1.4 Meeting agendas, minutes, e mail, other related documents will be kept on file and available for SAPC review upon request
	1.5 Contractor shall participate and cooperate in the Department of Health Care Services (DHCS) data reporting system on a monthly basis by reporting all related prevention media activities and services to Health Outcomes and Data Analytics.	1.5 July 1, 2024 and at least monthly through June 30, 2025	1.5 Service data for each SOW objective implementation activity/effort as allowed per reporting requirements will be entered into the DHCS system.	1.5 Monthly report submitted to SAPC and, SAPC Manager will review DHCS system to ensure compliance monthly with data entry requirements.
	1.6 Provide campaign performance metrics/earned media report including social media activity and other information needed for reporting and evaluation including, but not limited to: analytics, reach, impressions, Targeted Rating Points (TRP), video completion rates, Click Through Rate (CTR). Include other data such as: calls to the Substance Abuse Services Helpline, ad images/photos, social media interactions, earned media, and other analytical components that will help demonstrate the ROI and value of the paid media activity.	1.6 Complete Phase 2 report 30 days post media buy placement and when final numbers & figures arrive from media companies and SAPC.	1.6 Report to include analytics, reach, impressions, video completion rates, TRPs and other data, images/ photos, and any other materials.	1.6 Final report kept on file.

SCOPE OF WORK
SUBSTANCE USE/MISUSE PREVENTION AND TREATMENT MEDIA SERVICES
RESCUE AGENCY PUBLIC BENEFIT, LLC
PERIOD: July 1, 2024 – June 30, 2025

OBJECTIVES	IMPLEMENTATION	TIMELINE	DELIVERABLES	EVALUATION AND DOCUMENTATION
2. Evaluate one countywide media and public awareness campaign targeting the priority populations listed in the Statement of Work, or as determined by SAPC throughout the period for phase 2 market run from Jul. 2024 – Dec. 2024)	2.1 Provide a post-evaluation report containing the combined information from phase 1 and phase 2 runs, inclusive of summary of respondent demographics, research goals and objectives, limitations, process indicators (i.e., impressions, campaign reach) and outcome metrics (i.e., awareness, perceived effectiveness, knowledge, attitudes, behavioral change, and other relevant outcomes through regression analyses, etc. and final takeaways.	2.1 Within 30 days of the campaign conclusion.	2.1 Three hard copies of the Campaign Wrap-up report and/or program binder, and one digital copy.	2.1 Campaign wrap-up report in requested format.
	2.2 Provide an executive summary of 3-5 pages including an overview of the campaign, description of objective, strategy, target audiences, messaging, creative examples, media plan (earned and paid). Also, to be included are highlights of the performance metrics, achieved outcome objectives and evaluation.	2.2 Within 60 days of campaign conclusion. March-April 2025	2.2 Digital copy (in MS Word) of executive summary.	2.2 Executive summary kept on file.
	2.3 Develop at least one abstract and/or presentation submission for conference, meeting, or other related event.	2.3 Within 30 days of request	2.3 Digital copy (in Word) of abstract.	2.3 Conference application on file

EXHIBIT I
Attachment C-4
Budget - Period 4

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE USE/MISUSE PREVENTION AND TREATMENT MEDIA SERVICES

RESCUE AGENCY PUBLIC BENEFIT, LLC

Period 4: July 1, 2023 through June 30, 2024

BUDGET SUMMARY (Schedule of Projected Costs)			
COST CATEGORY	AMOUNT	CRRSAA AMOUNT	TOTAL AMOUNT
Budget Category I. - Strategic Counsel	$ 788,467	$ -	$ 788,467
Budget Category II. - Research & Evaluation	$ 180,000	$ -	$ 180,000
Budget Category III. - Creative Development	$ 856,675	$ -	$ 856,675
Budget Category IV. - FY23 Campaign Implementation	$ 1,487,688	$ -	$ 1,487,688
Budget Category V	$ -	$ -	$ -
Budget Category VI	$ -	$ -	$ -
TOTAL COST TO MEET THE REQUIREMENTS OF THE WORK	**$ 3,312,830**	**$ -**	**$ 3,312,830**

EXHIBIT I
Attachment C-5
Budget - Period 5

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE USE/MISUSE PREVENTION AND TREATMENT MEDIA SERVICES

RESCUE AGENCY PUBLIC BENEFIT, LLC

Period 5: July 1, 2024 through June 30, 2025

BUDGET SUMMARY (Schedule of Projected Costs)			
COST CATEGORY	AMOUNT	CRRSAA AMOUNT	TOTAL AMOUNT
Budget Category I. - Strategic Counsel	$ 792,170	$ -	$ 792,170
Budget Category II. - Research & Evaluation	$ 180,000	$ -	$ 180,000
Budget Category III. - Creative Development	$ -	$ -	$ -
Budget Category IV. - FY23 Campaign Implementation	$ 1,715,000	$ -	$ 1,715,000
Budget Category V	$ -	$ -	$ -
Budget Category VI	$ -	$ -	$ -
TOTAL COST TO MEET THE REQUIREMENTS OF THE WORK	**$ 2,687,170**	**$ -**	**$ 2,687,170**

BOARD LETTER/MEMO
CLUSTER FACT SHEET

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/24/2023	
BOARD MEETING DATE	6/6/2023	
SUPERVISORIAL DISTRICT AFFECTED	☐ All ☒ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th	
DEPARTMENT(S)	Health Services	
SUBJECT	Authorize the Sole Source Acquisition of a Human Patient Simulator for LAC+USC Medical Center	
PROGRAM	N/A	
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☐ Yes ☒ No	
SOLE SOURCE CONTRACT	☐ Yes ☒ No	
	If Yes, please explain why:	
DEADLINES/ TIME CONSTRAINTS	N/A	
COST & FUNDING	Total cost: $241,000	Funding source: DHS FY 2022-23 Final Budget
	TERMS (if applicable): N/A	
	Explanation:	
PURPOSE OF REQUEST	Authorize the Director of Internal Services Department, as the County's Purchasing Agent, to proceed with the sole source acquisition of a Human Patient Simulator (HPS) from CAE Healthcare, Inc. for LAC+USC Medical Center (LAC+USC MC), with a total value of approximately $319,000. An offsetting trade-in credit of $78,000 can be applied to this equipment purchase, resulting in a net cost of $241,000.	
BACKGROUND (include internal/external issues that may exist including any related motions)	This acquisition will allow LAC+USC MC to replace the existing non-functional and end-of-life HPS simulator. The HPS will allow clinicians to continue using patient simulation to educate and train anesthesia providers and hospital personnel, related to real airway management, administration of anesthesia medications and gases in preparation for safe patient care.	
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: Board Priority #2: Health Integration/ Alliance for Health Integration – The acquisition of this system will ensure patients that receive services through this alliance, receive high-quality health care services.
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: DHS - Jason Ginsberg, Chief of Supply Chain Operations, (323) 914-7926, jginsberg@dhs.lacounty.gov; DHS – Daniel Amaya, (323) 409-4066, damaya@dhs.lacounty.gov; County Counsel- Kelly Hassel, khassel@counsel.lacounty.gov, (213) 974-1803

June 6, 2023

DRAFT
DHS Letterhead

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:

AUTHORIZE THE SOLE SOURCE ACQUISITION OF A HUMAN PATIENT SIMULATOR FOR LOS ANGELES GENERAL MEDICAL CENTER (SUPERVISORIAL DISTRICTS 1) FISCAL YEAR 2022-23 (3 VOTES)

SUBJECT

Authorize the Internal Services Department (ISD), as the Los Angeles County (LA County) Purchasing Agent, to proceed with the sole source acquisition of a Human Patient Simulator (HPS) for the Department of Health Services' (DHS) Los Angeles General Medical Center (LA General MC).

IT IS RECOMMENDED THAT THE BOARD:

Authorize the Director of ISD, as the LA County's Purchasing Agent, to proceed with the sole source acquisition of a HPS from CAE Healthcare, Inc. (CAE) for LA General MC, with a total value of approximately $319,000. An offsetting trade-in credit of $78,000 can be applied to this equipment purchase, resulting in a net cost of $241,000.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Approval of this action will authorize ISD, as the LA County's Purchasing Agent to proceed with the sole source acquisition of a HPS with an estimated total value of $319,000, with an offsetting trade-in credit of $78,000, resulting in a net cost of $241,000.

This acquisition will allow LA General MC to replace the existing non-functional and end-of-life HPS simulator. The HPS will allow clinicians to continue using patient simulation to educate and train anesthesia providers and hospital personnel, related to real airway management, administration of anesthesia medications, and gases in preparation for safe patient care.

DHS is requesting that the acquisition be acquired from a sole source vendor, CAE. The HPS is a life-like anatomically correct simulator with anesthesia specific physiologic responses that mimic real patients undergoing anesthesia and provides real-time human like responses to airway management. The HPS interfaces with a real anesthesia machine with a ventilator which can provide anesthetic and airway gases, including oxygen. In addition, medications and fluids can be administered to the HPS. All these capabilities provide an expected human response for which patient care provider actions can be evaluated prior to real-time patient care. The HPS, including all software, learning modules, and accessories, which are manufactured, sold, and distributed exclusively by CAE. There are no like items or products available for purchase that would offer the same functionality and capabilities as the HPS and CAE technology. The interface is installed and is currently being used at LA General MC .

Implementation of Strategic Plan Goals

This recommendation supports the County Strategic Plan: Strategy II.2, “Support the Wellness of Our Communities” and III.3, “Pursue Operational Effectiveness, Fiscal Responsibility and Accountability”.

FISCAL IMPACT/FINANCING

The total purchase cost for the equipment is approximately $319,000. The estimated acquisition cost includes HPS, delivery system, accessory kit, training, one-year warranty, tax, and shipping. An offsetting trade-in credit of $78,000 can be applied to this equipment purchase, resulting in a net cost of $241,000. Funding is included in the Fiscal Year 2022-23 Final Budget.

Operating Budget Impact

DHS will request and fund the associated ongoing annual maintenance, as needed, with departmental resources in future budget phases. There is no net County cost impact associated with the recommendation.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On October 16, 2001, the Board of Supervisors (Board) approved the classification categories for fixed assets and new requirements for major fixed asset (now referred to as capital asset) acquisitions requiring LA County departments to obtain Board approval to acquire or finance equipment with a unit cost of $250,000 or greater prior to submitting their requisition to ISD.

CONTRACTING PROCESS

The acquisition of equipment falls under the statutory authority of the LA County Purchasing Agent and will be accomplished in accordance with LA County's purchasing policies and procedures for sole source purchases.

IMPACT ON CURRENT SERVICES

Approval of the recommendation will allow LA General MC to continue to provide high-fidelity, human patient simulated training and in-services to anesthesia providers, as well as inter-departmental providers of patient care. These clinical education activities include, but are not limited to, airway management, provisions of anesthesia, advanced life support, and operating room in-services. All of which will help to strengthen provider competence and patient safety throughout the medical center.

Respectfully submitted,

Christina R. Ghaly, M.D.
Director

CRG:jc

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
Internal Services Department

BOARD LETTER/MEMO
CLUSTER FACT SHEET

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/24/2023
BOARD MEETING DATE	6/6/2023
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
DEPARTMENT(S)	Department of Health Services
SUBJECT	**APPROVAL OF SOLE SOURCE AMENDMENT TO AGREEMENT WITH INSIGHT HEALTH CORPORATION FOR MAGNETIC RESONANCE IMAGING SERVICES**
PROGRAM	Radiology Program
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No
SOLE SOURCE CONTRACT	☒ Yes ☐ No If Yes, please explain why: Department utilized all delegated authority
DEADLINES/ TIME CONSTRAINTS	Agreement expires June 30, 2023, if not extended.
COST & FUNDING	Total cost: $10,997,773 | Funding source: DHS Fiscal Year (FY) 2023-24 Recommended Budget, and will be requested in future fiscal years as needed. TERMS (if applicable): Not Applicable Explanation:
PURPOSE OF REQUEST	Requesting delegated authority to execute sole source amendment to extend agreement and expend funds for the continued provision of Magnetic Resonance Imagining (MRI) services for various DHS facilities.
BACKGROUND (include internal/external issues that may exist including any related motions)	This Agreement enables DHS facilities to provide MRI services and was approved by the Board June 24, 2008 with an initial per scan rate of $546.10. Under this Agreement Insight constructed modular buildings, installed MRI equipment and systems at these DHS Facilities: Olive View-UCLA Medical Center (OV-UCLA MC), Los Angeles General Medical Center (LA General), Rancho Los Amigos National Rehabilitation Center (RLANRC) and Martin Luther King Jr. Outpatient Center (MLK OC) and remodeled an existing building at Harbor-UCLA Medical Center (H-UCLA MC) for the provision of MRI services. On June 19, 2018, the Board approved the extension of the Agreement through June 30, 2023, with a per scan rate of $369.00 to enable DHS to continue its enterprise-wide assessment of service needs. During this extension, DHS effectively removed RLANRC from the Agreement. DHS' assessment of its MRI service needs timeline was greatly impacted by multiple major construction projects such as the OV-UCLA MC fire alarm system replacement, the nurse call project, and the County's Local Health Emergency for Novel Coronavirus making any an in-house migration of contracted services operationally prohibitive.

	On October 18, 2022, DHS notified the Board of its intention to negotiate an Amendment to the Sole Source Agreement with Insight for the continued provision of MRI Services at the remaining DHS Facilities, H-UCLA MC, OV-UCLA MC and MLK OC. It is anticipated H-UCLA MC will be removed as a service site during the recommended extension period once construction of the new H-UCLA outpatient center and replacement hospital are completed.
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: supports Sustainability by providing MRI services to promote the physical health of the County's population.
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: DHS - John Brunner, DHS Director of Radiology, (213) 240-7819, JBrunner2@dhs.lacounty.gov County Counsel – Victoria Mansourian, Principal Deputy County Counsel, (213) 974-6681, VMansorian@counse.lacounty.gov

DRAFT

June 6, 2023

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 OF SOLE SOURCE AMENDMENT TO AGREEMENT WITH INSIGHT HEALTH CORPORATION FOR MAGNETIC RESONANCE IMAGING SERVICES (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Request approval for the delegated authority to execute a sole source Amendment to extend the term of the Agreement H-703334 (Agreement) with Insight Health Corporation (Insight) for the continued provision of Magnetic Resonance Imaging (MRI) services for the Department of Health Services (DHS) and to take other actions with respect to the Agreement, including amending and terminating, as described below.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Authorize the Director of Health Services (Director), or designee, to execute Amendment No. 11 to Agreement with Insight, effective upon execution, to extend the term of the Agreement for five years through June 30, 2028, with the option to extend the term for up to five additional one-year periods, for the continued provision of MRI services for multiple DHS facilities, with an estimated approximate Los Angeles County (LA County) obligation of $11 million for the first year of the extension.

2. Delegate authority to the Director, or designee, to further amend the Agreement to: (i) incorporate and/or revise certain non-substantive terms and conditions; (ii) make changes to the Agreement, including the statement of work, and, if needed, rates to reflect those changes, for operational efficiencies, meeting service requirements and/or changes to the needs of the serviced facilities and/or technology, and for addressing emergencies; (iii) to restate the Agreement in its entirety consistent with the current DHS contracting format and standards; (iv) comply with revisions to Federal and/or State reimbursement directives for Medicare and/or Medi-Cal programs and any National Medical Society recommendations such as American Medical Association; and (v) adjust compensation for services to remain competitive with prevailing market rates, with all amendments subject to review and approval as to form by County Counsel and, regarding (ii) and (v), notification to the Board of Supervisors (Board) and Chief Executive Office (CEO).

3. Delegate authority to the Director, or designee, to: (i) terminate for convenience the MRI services provided for any of the DHS facilities upon 180-day written notice; (ii) terminate the Agreement in accordance with other termination provisions specified in the Agreement; and (iii) upon Agreement termination, purchase any MRI equipment from Insight at fair-market value of such equipment, as agreed to by the parties, if DHS determines it is in the best interest of LA County to do so, and execute all necessary documents to effectuate such purchase(s), with all actions subject to review and approval by County Counsel and notice to the Board and CEO.

4. Delegate authority to the Director, or designee, to execute amendments to Ground Leases H-703367, H-703368, and H-703369, and Building Lease H-703370 with Insight to extend the term of each Lease to be co-terminus with the provision of MRI services at each DHS facility pursuant to Agreement H-703334 with Insight and to revise Lease terms to accommodate fluctuations in the needs of serviced facilities, with all amendments subject to review and approval as to form by County Counsel.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Background

The current Agreement with Insight was originally solicited for and approved by the Board on June 24, 2008, for the term of July 1, 2008 through June 30, 2018, for the provision of MRI services at Harbor-UCLA Medical Center (H-UCLA MC), Olive View-UCLA Medical Center (OV-UCLA MC), Los Angeles General Medical Center (LAGMC), Rancho Los Amigos National Rehabilitation Center (RLANRC), and Martin Luther King Jr. Outpatient Center (MLK OC). Under this Agreement, Insight facilitated the construction of modular buildings to house MRI scanning equipment to provide MRI services at OV-UCLA MC, RLANRC, and MLK OC; remodeled an existing building at H-UCLA MC to house two new MRI scanners, at the negotiated all-inclusive rate of $546.10 per MRI scan. That negotiated fixed rate was based on the cost of services and amortization of the construction and equipment acquisition costs over the initial 10-year term of the Agreement.

Following the Board's approval, the Agreement was subsequently amended to extend through June 30, 2023, for the continued provision of MRI services for multiple DHS facilities, at a negotiated per-scan rate of $369 for the five-year extension term, to enable DHS to continue its enterprise-wide assessment to identify the equipment, staffing and construction needs for the eventual migration of MRI services in-house for provision of MRI services by each DHS facility. Since the inception of the Agreement, two of the DHS facilities, LAGMC and RLANRC, have assumed provision of MRI services and been effectively removed from the Agreement.

However, the assessment process was greatly impacted by multiple major construction projects such as the OV-UCLA MC fire alarm system replacement and the nurse call project, as well as by DHS's need to divert its facility personnel to address LA County's healthcare needs resulting from the Coronavirus Disease 2019 (COVID-19) during the COVID-19 pandemic, all of which made insourcing of MRI services operationally prohibitive. By approving the recommendations in this letter, the Board will be providing DHS the additional time needed to reassess its MRI service needs following the Board's lifting of the COVID-19 local and public health emergency and to re-evaluate its insourcing strategy.

On October 18, 2022, DHS notified the Board (see Attachment 1) of its intention to negotiate a sole source Amendment to the Agreement with Insight for the continued provision of MRI Services at the remaining DHS facilities, H-UCLA MC, OV-UCLA MC, and MLK OC. It is anticipated that H-UCLA MC will be removed as a service site during the recommended extension period once construction of the H-UCLA MC replacement hospital is completed.

Pursuant to the Agreement, Insight's services include MRI studies provided with the use of MRI scanners in Insight's constructed modular buildings at OV-UCLA MC and MLK OC and in a LA County owned building at H-UCLA MC, MRI studies provided via mobile MRI units, and subcontracted open MRI studies for obese patients. The DHS facilities will continue to provide physician radiologists who will read the MRI studies and perform MRI guided procedures, provide procedure supplies, and provide nursing and/or non-MRI as-needed tech support for studies or procedures for the MRI services. The modular buildings at OV-UCLA MC and MLK OC are owned by Insight and leased at no cost to LA County through June 30, 2023, and on a month-to-month basis thereafter, until MRI services at those facilities are terminated or otherwise through the end of the term of the Agreement. The building at H-UCLA MC is owned by LA County and leased at no cost to Insight through June 30, 2023, and on a month-to-month thereafter, until MRI services at H-UCLA MC are terminated or otherwise through the end of the term of the Agreement.

Insight has not had a rate increase since the Agreement was extended in 2018. The recommended Amendment provides for a 14.9% increase in the per-MRI scan rate from the current rate of $369 to $424 to reflect prevailing market rates for MRI services and to account for scheduled new equipment acquisition and equipment upgrade costs during the initial five-year extension period.

Recommendations

Approval of the first recommendation will authorize the Director, or designee, to execute an Amendment, substantially similar to Exhibit I, which will ensure the continued provision of MRI services for at least five years for patients at H-UCLA MC, OV-UCLA MC, and MLK OC and as-needed open MRI studies, which are conducted off-site, for these three facilities, as well as RLANRC and LAGMC. The first recommendation will also authorize

the Director, or designee, to exercise up to five one-year term extension options. The current MRI services Agreement is slated to expire on June 30, 2023.

Approval of the second recommendation will allow the Director, or designee, to execute Amendments to the Agreement, including for improving operational efficiencies, maintaining compliance with regulatory standards to meet service needs at the facilities, and addressing emergencies. This recommendation will also enable the Director, or designee to adjust compensation for MRI services to remain competitive with prevailing market rates.

Approval of the third recommendation will delegate authority to the Director, or designee, to terminate the Agreement in whole, or in part, in accordance with the applicable termination provisions.

Approval of the fourth recommendation will delegate authority to the Director, or designee, to amend each of the Lease Agreements to make them coterminous with the provision of MRI Services for each DHS facility under the Agreement for MRI services. Additionally, DHS will be able to revise Lease terms to accommodate fluctuations in service needs of the facilities.

DHS is exercising due diligence by continuing to assess DHS facilities' service needs, while not hastily rushing into implementation decisions that will have large scale fiscal ramifications. In the interim, DHS requires Insight to continue providing MRI services to LA County patients without service interruption.

DHS intends to use the extension period to reassess its post-pandemic MRI service needs with the intent of insourcing MRI services at H-UCLA MC following the completion of the new outpatient center in 2026 and a hospital in 2028. Thereafter, it is DHS' intent to insource MRI services at OV-UCLA MC and MLK OC, which will require a sizable financial investment and a significant amount of time to accomplish. If DHS determines that insourcing MRI services at OV-UCLA MC and MLK OC is not prudent or in its best interest, DHS will use the recommended extension and/or options to complete a solicitation and return to the Board with recommendation of a successor MRI services agreement.

Over the term of this Agreement, Insight constructed modular buildings on the OV-UCLA MC and MLK OC campuses, which it will quit claim to LA County when the Agreement expires or is otherwise terminated. If DHS does not want the buildings, Insight will remove them at its own cost. Insight has and will continue to have in place maintenance agreements for servicing building systems, such as the Heating, Ventilation, and Air Conditioning Systems (HVAC). LA County will continue to be responsible for paying for any capital expenditures associated with extending the life of the modular buildings, such as HVAC or roof replacement, since these modular buildings will revert to LA County. The typical useful life of a modular building is 20 years; the modular building at OV-UCLA

MC is approximately 15 years old, and the modular building at MLK OC is approximately two years old.

Implementation of Strategic Plan Goals

The recommended actions support "Goal III, Realize Tomorrow's Government Today, Strategy III.3, Pursue Operational Effectiveness, Fiscal Responsibility, and Accountability."

FISCAL IMPACT/FINANCING

The estimated annual cost of MRI services for the first year of the requested term extension is $11 million, with the breakdown by facility as follows: H-UCLA MC - $4,939,600; LAGMC - $260,000; OV-UCLA MC - $4,377,173; and MLK OC - $1,421,000. The service fees are subject to an annual 2.5% increase after the first year of the extension. Funding is included in the DHS Fiscal Year (FY) 2023-24 Recommended Budget and will be requested in future FYs as needed.

DHS will request and fund any associated modular building capital expenditures, as needed, with departmental resources for the respective facility in future budget phases.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

The Agreement with Insight was approved by the Board for the period July 1, 2008 through June 30, 2018, for MRI services at H-UCLA MC, OV-UCLA MC, LAGMC, RLANRC, and MLK OC. Under this Agreement, Insight facilitated the construction of modular buildings at OV-UCLA MC, RLANRC, and MLK OC and remodeling of an existing building at H-UCLA MC, as well as installed new MRI scanners, as necessary, including the installation and programming of software, at the negotiated all-inclusive rate of $546.10 per MRI scan fixed for the initial 10-year term of the Agreement. The rate was based on the cost of services and amortization of the construction and equipment acquisition costs over the ten-year term.

Over time, Amendments to the Agreement revised pricing terms; implemented background and security investigation requirements for Contractor staff providing services under the Agreement; incorporated MRI guided breast biopsy procedures and functional MRI for measuring brain wave activity; updated Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements; implemented a software interface for the Online Real-time Centralized Health Information Database (ORCHID); and revised the billing and collection of payments terms for professional services.

The Agreement may be terminated by LA County for convenience in whole or in part upon a 180-day advance written notice.

The Agreement has been, and will continue to be, amended to include the latest Board mandated provisions. County Counsel has approved Exhibit I as to form.

CONTRACTING PROCESS

This Amendment is to an existing Agreement with Insight that was originally awarded following a Request for Proposals for MRI services.

Attachment A provides the sole source checklist in compliance with Board Policy 5.100.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board approval of the recommendations will ensure the uninterrupted provision of critical MRI services to the patients served by DHS facilities until the transition of the services to the facilities.

Respectfully submitted,

Christina R. Ghaly, M.D.
Director

CRG:se

Enclosures

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

SOLE SOURCE CHECKLIST

Department Name: Department of Health Services

☐ New Sole Source Contract

☑ Sole Source Amendment to Existing Contract
Date Existing Contract First Approved: June 24, 2008

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

4/24/23
Date

BOARD LETTER/MEMO
CLUSTER FACT SHEET

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/24/2023
BOARD MEETING DATE	6/6/2023
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
DEPARTMENT(S)	Department of Health Services
SUBJECT	Request the approval of funding methodology and allocation of funding to non-County trauma centers for Fiscal Year 2022-23, and delegation of authority to the Director of Health Services, or designee, to extend the term of the Trauma Center Provisions for Reimbursement (TCPR) Memorandum of Agreement through June 30, 2024, which will contain the reimbursement provision for Fiscal Year 2022-2023, and approval of an allocation of funds to County hospitals.
PROGRAM	Emergency Medical Services
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No
SOLE SOURCE CONTRACT	☐ Yes ☒ No
	If Yes, please explain why:
DEADLINES/ TIME CONSTRAINTS	Dept. of Health Care Services (DHCS) requires County to complete Intergovernmental Transfer by July 29, 2023. The Trauma Center Provisions for Reimbursement (TCPR) Memorandum of Agreements (MOA) expire June 30, 2023.
COST & FUNDING	Total cost: $58.564 million / Funding source: Measure B Maddy Fund, Richie's Fund and federal (Ca. Dept. of Health Care Services) matching dollars for supplemental Medi-Cal payments to eligible non-County trauma centers.
	TERMS (if applicable): The amendment will extend the term of the TCPR MOAs for the period July 1, 2023 through June 30, 2024.
	Explanation: The total maximum payment for the above-recommended actions under the MOAs for FY 2022-23 is approximately $100.047 million, including $58.615 million of County funds (Measure B: $55.827 million; Maddy Fund: $2.035 million, and Richie's Fund: $0.753 million, which includes $0.051 million in funds for the two County pediatric trauma hospitals) and $41.432 million of federal matching funds, which was calculated based on a federal matching rate of 50%. Funding for the County responsible portion of the TCPR MOAs is included in DHS' FY 2022-23 Final Budget. The MOAs are fully funded by the Measure B, Maddy funds, and Richie's funds. There is no net County cost impact associated with the recommendations.
PURPOSE OF REQUEST	Approval of the Recommendations will ratify the funding methodology and delegate authority to the Director, or designee, to execute the amendments to the TCPR MOAs, to include financial terms for FY 2022-23, extend the term of the MOAs for an additional one (1) year period, process payments for FY 2022-23, and submit an IGT to draw down federal matching funds for those portions of the payments that are to be made as Medi-Cal supplements. These amendments permit the continued provision of Measure B funding to trauma centers which help to secure emergency care access for Medi-Cal beneficiaries, stabilize the

	trauma care system in Los Angeles County, and allow sufficient time for the development of a funding methodology for FY 2023-24.
BACKGROUND (include internal/external issues that may exist including any related motions)	Measure B, passed by the voters on November 5, 2002, authorized the County to levy a tax on structural improvements within the County, in part, to provide funding to strengthen the Los Angeles County trauma network, particularly those trauma centers operated by the County, and expand it if possible; and to fund emergency medical services and bioterrorism preparedness. Subsequent to Measure B's passage, the Board approved multiple proposals to allocate Measure B funds among the non-County trauma centers. The Board also approved payments to reimburse trauma centers for costs associated with serving as a base hospital in the Emergency Medical Services system. The County receives funds derived from penalties assessed on fines and bail forfeitures that the Superior Court collects for certain criminal offenses and motor vehicle violations. As permitted by California Government Code Section 76000.5 and H&S Code Section 1797.98a, these funds are placed in the County's Maddy Fund and used by DHS for trauma and emergency services. A portion of the Maddy Fund is designated by statute for support of pediatric trauma programs and is segregated as the Richie's Fund. The remaining Maddy Fund dollars are available to support trauma and emergency services provided by hospitals and physicians.
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: Manal Dudar, Chief, Financial Management (626) 525-6426 Mdudar@dhs.lacounty.gov Richard Tadeo, Emergency Medical Services, Director (562) 378-1610 Rtadeo@dhs.lacounty.gov

June 6, 2023

DRAFT
DHS Letterhead

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 OF FUNDING METHODOLOGY AND AMENDMENTS TO THE MEMORANDUM OF AGREEMENTS FOR NON-COUNTY TRAUMA CENTER PROVISIONS FOR REIMBURSEMENT (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Request the approval of a funding methodology and allocation of funding to non-Los Angeles County (LA County) trauma centers for Fiscal Year (FY) 2022-23, and for delegation of authority to the Director of Health Services (Director), or designee, to extend the term of the Trauma Center Provisions for Reimbursement (TCPR) Memorandum of Agreement (MOA) through June 30, 2024, which will contain the reimbursement provision for FY 2022-2023 and approval of an allocation of funds to LA County hospitals.

IT IS RECOMMENDED THAT THE BOARD:

1. Approve the funding methodology and allocation of the TCPR for FY 2022-23, and authorize the Director, or designee, to execute amendments to the TCPR MOA, substantially similar to Exhibit I, with 13 non-LA County trauma centers to extend the term for the period July 1, 2023 through June 30, 2024, and include the funding terms for the period July 1, 2022 through June 30, 2023, for a total LA County obligation of approximately $58.564 million which is comprised of $55.827 million from the Measure B funds, $2.035 million from the Maddy Emergency Medical Services Fund (Maddy Fund), and $0.702 million from the Richie's Fund, as set forth in Attachment A and described below.

2. Approve and authorize the Director, or designee, to allocate up to a maximum of $41.432 million of the Measure B funds to be used as an

Intergovernmental Transfer (IGT) to the California Department of Health Care Services to draw down Federal matching dollars for supplemental Medi-Cal payments to eligible non-LA County trauma centers.

3. Approve and authorize the Director, or designee, to allocate the amount of $0.051 million from the Richie's Fund to the two LA County Pediatric Trauma Centers listed in Attachment A.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Funding Methodology Background

Prior to the implementation of the Affordable Care Act (ACA) in January 2014, the methodology used to distribute trauma funding to non-LA County trauma centers was largely based on trauma claims for the uninsured population. After the ACA was implemented and its impact became more widespread, there was a significant reduction in the volume of uninsured trauma claims. Beginning in FY 2014-15, the number of uninsured trauma claims was too minimal to allow the full allocation of Measure B funds. In light of the significant and continuing decrease in the number of uninsured, the non-LA County trauma centers expressed concerns and wanted to ensure they would continue to receive the same level of trauma funding as in years prior to the ACA. Therefore, on May 3, 2016, the Board of Supervisors (Board) approved an amendment to the Trauma Centers Agreements for FY 2014-15 which continued trauma funding to the non-LA County trauma centers for the same funding amounts received by the trauma centers in FY 2013-14.

Given the significant and continuing impact of the ACA, and to ensure that prior funding levels would be maintained, the non- LA County trauma centers deemed it necessary to develop a new basis for distributing trauma funds. Pursuant to discussions between the non-LA County trauma centers and the Department of Health Services (DHS), a new funding methodology for FY 2015-16 was developed that incorporated new categories for reimbursement, and which was approved by the Board on November 1, 2016.

During FY 2016-17, the non-LA County trauma centers advised that funding levels should be maintained at levels similar to prior FYs, despite the severe decline in uninsured trauma patients. As such, the funding methodology that was approved for the FY was based on the following: the level of indigent services, the provision of base station services, and a flat amount to support infrastructure. In addition, and recognizing the continuing ACA impact, the non-LA County trauma centers identified other add-on factors to be used as a basis for the distribution of the FY 2016-17 trauma funds at levels similar to prior years. The add-ons selected by the non-LA County trauma centers and approved by DHS were as follows: 1) an adjustment for the volume of trauma patients; 2) an adjustment for the level of acuity of trauma patients; and 3) an adjustment for the number of Medi-Cal days and visits,

which serves as a proxy for the underinsured population. Lastly, to address concerns that the application of the proposed FY 2016-17 formula would impact each trauma center to a greater or lesser degree, a parity adjustment was made in proportion to the degree of positive or negative impact to assure that no trauma center would be affected disproportionately. The FY 2016-17 methodology was approved by the Board on May 16, 2017.

For FY 2017-18, in conjunction with all 13 non-LA County trauma centers, DHS reached a consensus for utilizing the basic methodology components from FY 2016-17, but with the following modifications: 1) including a parity adjustment to reduce the decrease in funding received by a trauma center in comparison to the prior fiscal year; 2) information about services was included with the Medi-Cal information given to patients who were brought in by law enforcement to determine the component related to underinsured populations; and 3) the allocation of pediatric trauma payments to each pediatric trauma center from Richie's Funds for pediatric trauma services was based on the facility type. Since Northridge Hospital Medical Center is the only pediatric trauma center in LA County operating as a community hospital, it was given a larger allocation than the remaining pediatric trauma centers, which are tertiary trauma centers.

DHS and all 13 non-County trauma centers reached a consensus for utilizing the same components used in the FY 2017-18 methodology for FY 2018-19. FY 2018-19 funding also included a one-time allocation of unspent Measure B funds from FY 2017-18 for the trauma centers as recommended by the Measure B Advisory Board (MBAB), which was presented by the Chief Executive Office (CEO) to the Board on March 12, 2019.

For FY 2019-20, DHS again reached a consensus with the 13 non-LA County trauma centers to use the funding methodology used in the previous FYs, including a recommendation by the MBAB for a one-time allocation of unspent Measure B funds from FY 2018-19, which was presented by the CEO to the Board on February 11, 2020.

For FY 2020-21, DHS again reached a consensus with the 13 non-LA County trauma centers to use the funding methodology used in the previous FYs, but without the one-time allocation of unspent and unallocated Measure B funds, as recommended by the MBAB.

For FY 2021-22, DHS again reached a consensus with the 13 non-LA County trauma centers to use the funding methodology used in the previous FYs, including a recommendation by the MBAB for a one-time allocation of unspent Measure B funds from FY 2020-21, which was presented by the CEO to the Board on February 7, 2022.

FY 2022-23 Distribution Methodology

DHS and all 13 non-County trauma centers have reached a consensus for utilizing the same components used in the FY 2021-22 methodology for FY 2022-23 with the following modification: (1) this does not include a parity adjustment to mitigate the change in funding received by a trauma center in comparison to the prior FYs and the one-time allocation of unspent and unallocated Measure B funds, per recommendation by the MBAB; (2) FY 2022-23 funding includes an annual on-going Measure B Funding of $8.957 million, per the Measure B property assessment rate increase, which the Board approved on September 13, 2022. Of this amount, $5.957 million is allocated to all 13 non-LA County trauma centers to support ongoing investments to maintain and/or expand the regional trauma care system, while $3.000 million is allocated to six pediatric trauma hospitals to support ongoing investments in pediatric trauma care.

The proposed FY 2022-23 payments to each non-LA County trauma center are summarized in Attachment A.

Trauma Center Provisions for Reimbursement (TCPR) Memorandum of Agreement (MOA) Background

Prior to June 30, 2021, the trauma center designation process requirements, and provisions for reimbursement were covered under a Trauma Center Services Agreement as a means to provide supplemental funding to offset operating expenses related to trauma center operations. On June 22, 2021, DHS split the two actions and executed TCPR MOAs for the continued implementation of reimbursement provisions for designated trauma centers. The trauma center designation for each hospital was added, by way of an amendment, and under delegated authority by the Board, to the Specialty Care Center Designations Master Agreement, which was approved by the Board on June 11, 2019.

Summary of Recommendations

Approval of the Recommendations will ratify the funding methodology and delegate authority to the Director, or designee, to execute the amendments to the TCPR MOAs, substantially similar to Exhibit I, to include financial terms for FY 2022-23, extend the term of the MOAs for an additional one year period, process payments for FY 2022-23, and submit an IGT to draw down Federal matching funds for those portions of the payments that are to be made as Medi-Cal supplements. These amendments permit the continued provision of Measure B funding to trauma centers which help to secure emergency care access for Medi-Cal beneficiaries, stabilize the trauma care system in LA County, and allow sufficient time for the development of a funding methodology for FY 2023-24.

Implementation of Strategic Plan Goals

The recommended actions support Strategy III.3, "Pursue Operational Effectiveness, Fiscal Responsibility, and Accountability", of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

The total maximum payment for the above-recommended actions under the MOAs for FY 2022-23 is approximately $100.047 million, including $58.615 million of LA County funds (Measure B: $55.827 million; Maddy Fund: $2.035 million, and Richie's Fund: $0.753 million, which includes $0.051 million in funds for the two LA County pediatric trauma hospitals) and $41.432 million of Federal matching funds, which was calculated based on a Federal matching rate of 50%. Funding for the LA County responsible portion of the TCPR MOAs is included in DHS' FY 2022-23 Final Budget. The MOAs are fully funded by the Measure B, Maddy funds, and Richie's funds. There is no net County cost impact associated with the recommendations.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Pursuant to the authority under California Health and Safety (H&S) Code Section 1798.160, LA County maintains trauma facilities as part of the regional trauma care system for the treatment of potentially seriously injured persons. Division 2.5 of the H&S Code authorizes the local Emergency Medical Services Agency to designate trauma centers as part of the regional trauma care system. Since March 1, 2017, there have been 13 non-LA County and two LA County-operated trauma centers.

The TCPR MOAs are designed to provide supplemental funding to offset the significant expenses related to maintaining trauma designation and treating trauma patients. The FY 2022-23 TCPR MOAs are funded by the Measure B, Maddy Fund, and Richie's funds and contemplate the State making IGT-funded supplemental Medi-Cal payments to non-public trauma centers in LA County.

Measure B Funds

Measure B, passed by the voters on November 5, 2002, authorized LA County to levy a tax on structural improvements within LA County, in part to provide funding to strengthen the LA County trauma network, particularly those trauma centers operated by LA County, expand the trauma network if possible, and to fund emergency medical services and bioterrorism preparedness. Subsequent to Measure B's passage, the Board approved multiple proposals to allocate Measure B funds among the non-LA County trauma centers. The Board also approved payments to reimburse trauma centers for costs associated with serving as a base hospital in the Emergency Medical Services system.

The Maddy and Richie's Funds

LA County receives funds collected from penalties assessed on fines and bail forfeitures that the Superior Court collects for certain criminal offenses and motor vehicle violations. As permitted by California Government Code Section 76000.5 and H&S Code Section 1797.98a, these funds are placed in LA County's Maddy Fund and used by DHS for trauma and emergency services. A portion of the Maddy Fund is designated by statute for support of pediatric trauma programs and is segregated as the Richie's Fund. The remaining Maddy Fund dollars are available to support trauma and emergency services provided by hospitals and physicians.

Medi-Cal Payments

The California State Plan, starting at page 51 of Attachment 4.19B, permits the California Department of Health Care Services to make supplemental Medi-Cal payments to non-public trauma centers in LA County. LA County makes recommendations regarding the amount of the supplemental payments and provides the funding for the non-federal share of such payments through an IGT.

County Counsel has reviewed and approved Exhibit I as to form.

CONTRACTING PROCESS

N/A.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommendations will assure continued participation of non-LA County trauma centers in LA County's trauma network and provide trauma funding for FY 2023-24.

Respectfully submitted,

Christina R. Ghaly, M.D.
Director

CRG:jr:md

Enclosures

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

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
LOS ANGELES COUNTY TRAUMA CARE SYSTEM

PROPOSED PAYMENTS TO NON-COUNTY TRUAMA HOSPITALS
FISCAL YEAR 2022-23

Attachment A

	Patient-Based	Pediatric	Designation Support		Add-Ons			Additional Funding (Measure B Rate Increase)		Total Payments (1) thru (9)
	(1) UNINSURED (Volume)	(2) PEDIATRIC (Fixed Rate)	(3) BASE STATION (Fixed Rate)	(4) INFRASTRUCTURE (Fixed Rate)	(5) TRAUMA (Volume)	(6) ACUITY (Adjustment)	(7) UNDERINSURED (Adjustment)	(8) TRAUMA HOSPITALS (Adjustment)	(9) PEDIATIC HOSPITAL (Adjustment)	
Non-County Hospitals										
Antelope Valley Hospital	$ 569,770	$ -	$ 700,000	$ 1,200,000	$ 1,483,226	$ 635,619	$ 2,553,326	$ 1,018,068	$ -	$ 8,160,009
California Hospital Medical Center	3,106,217	-	700,000	1,200,000	1,679,751	729,578	3,778,025	1,309,094	-	12,502,665
Cedars-Sinai Medical Center	153,974	25,455	700,000	1,200,000	1,541,890	817,781	2,214,168	775,126	318,360	7,746,754
Children's Hospital Los Angeles	-	25,455	-	1,200,000	764,590	180,223	790,952	343,340	3,454,148	6,758,708
Henry Mayo Newhall Memorial	56,217	-	700,000	1,200,000	709,837	251,784	634,131	415,404	-	3,967,373
Huntington Memorial Hospital	34,442	-	700,000	1,200,000	1,327,767	531,834	1,316,802	597,716	-	5,708,561
Long Beach Memorial Medical Center	150,933	25,455	700,000	1,200,000	1,257,369	583,796	1,915,461	679,196	760,516	7,272,726
Northridge Hospital Medical Center	1,054,164	600,000	700,000	1,200,000	1,283,768	533,685	1,927,285	783,440	697,422	8,779,764
Pomona Valley Hospital Medical Center	178,958	-	700,000	1,200,000	1,762,859	806,033	2,931,066	886,358	-	8,465,274
Providence Holy Cross Medical Center	1,812,768	-	700,000	1,200,000	1,141,018	510,630	2,180,564	882,388	-	8,427,368
Ronald Reagan UCLA Medical Center	86,106	25,455	700,000	1,200,000	1,364,920	559,080	1,671,517	795,649	384,777	6,787,504
St. Francis Medical Center	119,532	-	700,000	1,200,000	1,623,043	699,145	3,922,401	966,492	-	9,230,613
St. Mary Medical Center	864,877	-	700,000	1,200,000	820,321	394,345	1,561,368	648,012	-	6,188,923
Subtotal Non-County Hospitals	$ 8,187,958	$ 701,820	$ 8,400,000	$ 15,600,000	$ 16,760,359	$ 7,233,533	$ 27,397,066	$ 10,100,283	$ 5,615,223	$ 99,996,242
County Hospitals										
LAC + USC Medical Center		$ 25,455								$ 25,455
Harbor-UCLA Medical Center		25,455								25,455
Subtotal (County Hospitals)	$ -	$ 50,910	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 50,910
Grand Total:	**$ 8,187,958**	**$ 752,730**	**$ 8,400,000**	**$ 15,600,000**	**$ 16,760,359**	**$ 7,233,533**	**$ 27,397,066**	**$ 10,100,283**	**$ 5,615,223**	**$ 100,047,152**

Col (1) - Payment is based on each hospital's share in the total value of the FY 21-22 indigent claims submitted by non-County trauma hospitals to the County (net of FY 20-21 disallowed claims), multiplied by the total funding allocated for this category.

Col (2) - Payment is based on facility type. Northridge Hospital Medical Center receives a larger allocation due to its State-designated status as a Pediatric Community Hospital.

Col (3) - Fixed payment for each hospital that provides base hospital service meeting the requirement of County's Emergency Medical Services Agency.

Col (4) - Infrastructure is a fixed payment for each trauma hospital to defray the trauma call panel, specialist physicians and trauma program costs.

Col (5) - Trauma payment is based on each hospital's percentage in the total trauma patient volume of non-County trauma hospitals (reported by County's TEMIS for CY 2021) multiplied by the total funding allocated for this category.

Col (6) - Acuity payment is based on each hospital's percentage in the total patient days of non-County trauma hospitals (reported by County's TEMIS for CY 2021) that are adjusted for severity factors, multiplied by the total funding allocated for this category.

Col (7) - Under-insured payment is based on each hospital's percentage in the total Medi-Cal and In-Custody patient days of non-County trauma hospitals (reported by County's TEMIS for CY 2021), multiplied by the total funding allocated for this category.

Col (8) - Payment is based on each hospital's percentage of the grand total from columns 1 – 7 (except column 2) for each hospital, multiplied by $5.957 million, then double the payments for the two public hospitals (Antelope Valley Hospital and Ronald Reagan UCLA Medical Center) that are not eligible to receive the State matching. After that, recalculate 11 private hospitals' percentages to account for the two public hospitals' half of the payments and add the same calculated amounts for the State matching.

Col (9) - Payment is based on similar calculation with columns 5, 6 and 7, but using only pediatric data.

EXHIBIT I

Agreement No.: _____

MEMORANDUM OF AGREEMENT
FOR
NON-COUNTY TRAUMA CENTER PROVISIONS FOR REIMBURSEMENT

Amendment No. 2

THIS AMENDMENT is made and entered into this _____ day of June, 2023,

By and between — COUNTY OF LOS ANGELES (hereinafter "County"),

And — ABC HOSPITAL (hereinafter "Hospital").

Business Address:

xx
xx

WHEREAS, reference is made to that certain document entitled " MEMORANDUM OF AGREEMENT FOR NON-COUNTY TRAUMA CENTER PROVISIONS FOR REIMBURSEMENT" dated on _____and further identified as Agreement No.:_____, including any amendments and any other modifications thereto (cumulatively hereafter referred to as "MOA"); and

WHEREAS, the Board of Supervisors approved reimbursement to the Non-County Trauma Hospitals using funding provided by Measure B, the EMS Maddy Fund, and Richie's Fund.

WHEREAS, on _____2023 the County's Board of Supervisors delegated authority to the Director of Health Services, or authorized designee, to, among other delegations, to execute amendments to the MOA to extend the term of the MOA for the period July 1, 2023 through June 30, 2024, to provide for funding allocation for Fiscal Year 2022-23, for a total County obligation of approximately $58.564 million comprised of various amounts from Measure B, the EMS Maddy Fund, and Richie's Fund.

NOW THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

1. This Amendment shall be effective upon execution.

2. The MOA is hereby incorporated by reference, and all of its terms and conditions, including capitalized terms defined herein, shall be given full force and effect as if fully set forth herein.

3. The MOA, Paragraph 1.0 – SCOPE is deleted in its entirety and replaced to read as follows:

"1.0 SCOPE

1.1 This MOA addresses funding through the fiscal year ending June 30, 2023 (the "Contract Period") for non-County trauma hospitals in Los Angeles County having trauma centers ("Non-County Trauma Hospitals"). Non-County Trauma Hospitals are hospitals that are not owned nor operated by County of Los Angeles (the "County"). The County's funding to Non-County Trauma Hospitals for this contract period assures the continuance of emergency care access for Medi-Cal beneficiaries and stabilizes the provision of trauma care services in Los Angeles County.

1.2 The funding identified in this MOA for Non-County Trauma Hospitals, described in Exhibit A, Provisions For Reimbursement, covers the following four components:

1.2.1. Patient/Hospital-Based Payments
This component includes uninsured trauma claims and pediatric trauma services, as described in Exhibit A, Sections I and II.

1.2.2 Designation Support Payments
This component includes payments for Non-County Trauma Hospitals that serve as base stations and funding for trauma hospitals' infrastructure, as described in Exhibit A, Section III A.

1.2.3 Add-On Payments
This component includes payments for: a) trauma patient volume; b) patient acuity; c) the volume of underinsured patients (i.e., Medi-Cal and In-Custody patients); and d) a parity adjustment to mitigate the negative financial impact among various hospitals as described in Exhibit A, Section IV.

1.2.4 Measure B Advisory Board Funding (if available)
This component includes one-time payments, as applicable, if funding is available and recommended by the Measure B Advisory Board (MBAB), and approved by the County Board of Supervisors, to distribute prior year unspent and unallocated Measure B funds as described in Exhibit A, Section V.

1.3 The County intends to provide funding to Hospital for one or more of the four components described in Section 1.2 from the following fund sources under this MOA: Measure B, The EMS Maddy Fund, and Richie's Fund. In addition, the County will utilize Measure B funds, to the extent possible, to make an inter-governmental transfer (IGT) of funds to the California Department of Health Care Services (CDHCS) to draw down Federal matching dollars for enhanced Medi-Cal payments to Eligible Trauma Hospitals, pursuant to California's Medicaid State Plan (Title XIX), Attachment 4.19B (Enhanced Payments to Private Trauma Hospitals), pp. 51-51c (TN-03-032, app. Mar. 31, 2005; eff. Jul. 1, 2003), attached hereto as Attachment A.

1.4 The Non-County Trauma Hospitals entering into this MOA acknowledge that Attachment A, was approved by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. Attachment A enables private trauma hospitals in Los Angeles County to receive additional Medi-Cal payments, under Section 14087.3 of the Welfare and Institutions Code. Pursuant to Medicaid State Plan and a related interagency agreement between the County and the CDHCS, these additional Medi-Cal payments are distributed to the County-designated private trauma hospitals, in a lump-sum amount to ensure continued access by Medi-Cal beneficiaries to trauma and emergency room care in the County."

4. The MOA, Paragraph 2.0 – TERM is deleted in its entirety and replaced to read as follows:

"2.0 TERM

2.1 The term of this MOA is effective upon the date of execution by the Director of Health Services (Director), or designee. This MOA shall expire on June 30, 2024 unless sooner extended or terminated, in whole or in part, as provided herein.

2.2 In any event, this MOA may be terminated for any reason at any time by either party by giving at least thirty (30) calendar days advance written notice to the other party."

5. The MOA, Paragraph 3.0 – PAYMENT AND INVOICES is deleted in its entirety and replaced to read as follows:

"3.0 PAYMENT AND INVOICES

3.1 County's maximum reimbursement amount to the Non-County Trauma Hospitals for the delivery of trauma services for fiscal years 2020-21, 2021-22 and 2022-23 shall not exceed the amounts identified in Exhibit A."

6. The MOA, Exhibit A- Provisions For Reimbursement is modified to add Exhibit A-2, attached hereto and incorporated herein by reference, to the existing Exhibits A and A-1. Any reference to Exhibit A in the MOA shall include Exhibit A-2.

7. Except for the changes set forth hereinabove, the MOA shall not be changed in any respect by this Amendment.

/

/

/

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

COUNTY OF LOS ANGELES

By: _____
Christina R. Ghaly, M.D.
Director of Health Services

HOSPITAL

_____

By_____
Signature

_____
Printed Name

_____
Title

APPROVED AS TO FORM:

DAWYN R. HARRISON
County Counsel

By: _____
Brian T. Chu
Principal Deputy County Counsel

EXHIBIT I

MEMORANDUM OF AGREEMENT (MOA) EXHIBIT A-2
PROVISIONS FOR REIMBURSEMENT

TABLE OF CONTENTS

LISTING OF ATTACHMENTS

ATTACHMENT	ATTACHMENT NAME
1	PATIENT INCLUSION IN THE TRAUMA CENTER DATA SYSTEM
2	HOSPITAL SIGNAGE – NOTICE OF REDUCED COST CARE - ENGLISH
3	HOSPITAL SIGNAGE – NOTICE OF REDUCED COST CARE - SPANISH
4	TRAUMA SERVICES COUNTY ELIGIBILITY
5	HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE
6	INSTRUCTIONS FOR SUBMISSION OF CLAIMS AND DATA COLLECTION
7	TRAUMA CENTER PAYMENT SURRENDER

TRAUMA CENTER PROVISIONS FOR REIMBURSEMENT

I. ELIGIBLE PATIENT-BASED FUNDING

A. BUDGET ALLOCATION

1. Patient-Based Allocation Amounts

This Section I is applicable to the Non-County Trauma Hospitals with the exception of Children's Hospital Los Angeles. For the Contract Period, the County has established a budget allocation (the "Budget Allocation") for each such Non-County Trauma Hospital providing medical care to Eligible Patients (as defined below) during the Contract Period. The budget allocations are as follows:

Antelope Valley Hospital	$ 569,770
California Hospital Medical Center	$3,106,217
Cedars-Sinai Medical Center	$ 153,974
Henry Mayo Newhall Memorial Med. Ctr.	$ 56,217
Huntington Memorial Hospital	$ 34,442
Long Beach Memorial Medical Center	$ 150,933
Northridge Hospital Medical Center	$1,054,164
Pomona Valley Hospital Medical Center	$ 178,958
Providence Holy Cross Medical Center	$1,812,768
Ronald Reagan UCLA Medical Center	$ 86,106
St. Francis Medical Center	$ 119,532
St. Mary Medical Center	$ 864,877
Total Patient Based Funding	**$8,187,958**

The above amounts for each hospital were determined based on each Non-County Trauma Hospital's share of the total value of the Fiscal Year (FY) 2021-22 indigent claims submitted by all the Non-County Trauma Hospitals to the County, net of any FY 2020-21 disallowed claims, multiplied by the total funding allocated for this category (which include Measure B, Maddy,

and Federal matching funds). The value of the indigent claims was computed by applying the emergency department (ED) visit or per diem rates described in the paragraph below. The final value of all the claims was adjusted upwards by an escalation factor of 34.02%, in order to fully distribute the entire funding available for this category. Payments to Non-County Trauma Hospitals listed in this section will be made directly by the County (inclusive of the Maddy Fund as defined below) and/or by the California Department of Health Care Services (CDHCS) as enhanced Medi-Cal payments to eligible private hospitals as set forth in this Exhibit.

$ 6,425	per emergency department visit and assessment. (No such fee will be paid if the patient is admitted to the hospital as an inpatient from the emergency department.)
$12,471	for the first inpatient day; and
$ 5,417	for the second inpatient day; and
$ 4,283	for the third inpatient day; and
$ 4,283	for the fourth inpatient day; and
$ 3,023	for each day thereafter.

Accordingly, the Patient-Based Allocations will be taken into account in the amounts that the County recommends be paid by CDHS as enhanced Medi-Cal payments taking into account direct payments the County has made or will make to the hospitals for such allocations.

2. Maddy Fund

Certain funding known as “Maddy Emergency Medical Services Fund” (Maddy Fund) is available for hospital care rendered to Eligible Patients (as defined in I.B below) by the Non-County Trauma Hospitals. As described in I.D of this Exhibit, Contractor is required to submit a claim (an "Eligible Claim") to the County for the hospital care rendered to Eligible Patients within the Contract Period. Based on claims for patient visits and days from July 1, 2021, to June 30, 2022, County will determine the Maddy Fund

payment amount for ED visits, and inpatient stays up to three (3) days, using the rates below plus an escalation adjustment factor of 34.02%, due to each hospital for this Contract Period. The amount of Maddy Fund payments are included in determining the total funding for the Patient/Hospital-Based Allocation amount.

$ 6,425	per emergency department visit and assessment. (No such fee will be paid if the patient is admitted to the hospital as an inpatient from the emergency department.)
$12,471	for the first inpatient day; and
$ 5,417	for the second inpatient day; and
$ 4,283	for the third inpatient day

B. GENERAL CONDITIONS

Contractor shall provide Trauma Services, as defined below, to Eligible Patients. For purposes of this Exhibit, an “Eligible Patient” is a patient receiving Trauma Services from Contractor meeting the following criteria: (1) the Contractor believes that the patient is unable to pay for the Trauma Services so provided; (2) the patient has no third-party coverage, in part or in whole for the Trauma Services provided by Contractor and (3) the patient’s annual income places the patient at or below 200% of the current year Federal Poverty Level (FPL).

For purposes of this Exhibit, “third-party coverage” or “third-party payers” includes but is not limited to commercial insurance or any program funded in whole or in part by local, state, or federal government. “Trauma Services” refers to all hospital services furnished by the Contractor to a patient who presents to the Contractor or is classified subsequently during the patient’s stay as a Trauma Patient from the time the patient presents at or is admitted to the Contractor’s hospital until the patient is discharged. The term “Trauma Patient” for purposes of this Contract is defined in the Specialty Care Center Designation Master Agreement Exhibit A, Sub Exhibit - TC Trauma Center, Attachment 5, *Patient Inclusion in the Trauma Data System* and incorporated in this Exhibit as Attachment 1.

A claim (a “Patient-Based Claim”) shall not be submitted to the County hereunder for an Eligible Patient if: (a) the patient has the ability to pay for the service but refuses or fails to pay for the service; or (b) Contractor has failed to submit to any known third-party payer(s) for the patient, an accurate, complete, and timely billing, and for that reason has been denied payment by such payer(s); or (c) for any Trauma Services which is covered in, or the subject of reimbursement in, any other contract between Contractor and County. Subject to the County’s review and verification, Contractor will determine and document persons who are Eligible Patients as described in Section I.C below.

County claim is accepted from Non-County Trauma Hospitals for patient care provided to Trauma Patients who do not have the ability to pay for the services under the following conditions: (1) Contractor has made a reasonable, good faith effort to determine if there is a responsible private or public third-party source of payment, in accordance with Section I.C below; (2) Contractor either determines that there is no source of payment; or there is a potential source of payment, but the Contractor is unable to obtain payment after making reasonable efforts to pursue such revenue and (3) the patient’s annual income places the patient at or below 200% of the current year Federal Poverty Level (FPL).

During the term of this Agreement, as required by Section 16818 of the Welfare and Institutions Code (W&IC), Contractor shall continue to provide, at the time treatment is sought by a patient at its facility, an individual notice of the availability of reduced cost hospital care. Additionally, Contractor shall post, in conspicuous places in its emergency department and patient waiting rooms, notices of the procedures for applying for reduced-cost hospital care. The approved "Notice" language is reflected in English in Attachment 2 and in Spanish in Attachment 3.

C. PATIENT ELIGIBILITY

For a patient to be an Eligible Patient, Contractor must document that the person cannot afford to pay for the services provided by the Contractor. Contractor must

also document that payment for the services will not be covered by third-party coverage, including any program funded in whole or in part by the federal government, and that Contractor has not received payment for any portion of the amount billed.

The documentation that the person cannot afford to pay must show that the patient's annual income places the patient at or below 200% of the current year's Federal Poverty Level (FPL).

Contractor shall utilize Attachment 4, *Trauma Service County Eligibility* ("TSCE") *Agreement* form as the sole means for determining whether the patient is at or below the 200% of the current year FPL and therefore meets patient's eligibility criteria for trauma care claiming during the term of this Agreement. The TSCE Agreement form must be completed and signed by the patient or the patient's responsible relative(s) at the time it is determined there is not a responsible private or public third-party source of payment and that the patient meets the eligibility requirements. The completed form must be signed and dated by the hospital representative who obtained the information, verifying that the information was obtained from the patient or the patient's responsible relative(s).

If a TSCE Agreement form cannot be secured because the patient's condition prevents the patient from providing the necessary financial information, and there is no responsible relative(s) available, then Attachment 5, *Hospital Certification of Inability to Cooperate* form must be completed. A hospital representative will complete the form, sign and date it, and a second hospital representative will verify the information by also signing and dating the form. The original (or electronic scan) of either the *TSCE* or *Inability to Cooperate* form must be maintained by Contractor as part of its financial records. Contractor shall submit a copy of the application form to the County Emergency Medical Services (EMS) Agency when submitting a claim to be included in the patient-based claims total as stated in Attachment 6, *Instructions for Submission of Claims and Data Collection*.

Contractor must document that it has made reasonable efforts to secure payment from the patient by billing upon discharge and two (2) subsequent billings at least a month apart with a minimum of three (3) billings. Financial notes must clearly indicate that the patient was billed at least three (3) times.

Documentation to establish that Contractor has complied with the aforementioned patient eligibility requirements must be maintained by Contractor and made available upon request to authorized County or State representatives for inspection, audit, and photocopying.

D. CLAIMS SUBMISSION:

Contractor shall submit all Patient-based Claims to the County for Trauma Services to Eligible Patients for the Contract Period. These claims, subject to the following conditions and subsequent agreements of the parties, will be used to determine the amount of the patient-based Budget Allocation for Contractor. Claims from the prior fiscal year will be used to determine the patient-based funding for the contract period.

1. A valid claim shall include a completed Trauma Patient Summary ("TPS") form for each Eligible Patient receiving Trauma Services.
2. In addition to the TPS form, Contractor shall submit the required claim form (UB04) as well as all required reports as set forth in Attachment 6, *Instructions for Submission of Claims and Data Collection*, attached hereto and incorporated herein by reference, to County's Emergency Medical Services Agency, 10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, California 90670, for Trauma Services provided to Eligible Patients under the terms of this Agreement. This information shall be used in determining the next (and possibly subsequent) year's Budget Allocation.
3. Claims submitted to the County shall be limited to the hospital component of Trauma Services provided to Eligible Patients during the term of this Agreement. Inclusion of the claims in the determination of a Contractor's Budget Allocation or funding under

this Agreement shall be limited to the claims for which all required data has been included in the Trauma and Emergency Medicine Information System (TEMIS) and which has been submitted as required by reporting procedures reflected in Attachment 6.

4. Claims shall be submitted to County's EMS Agency on an ongoing basis once all eligibility requirements have been met and the Contractor has determined that no other source of funding is likely to be available. All Contractor claims for services provided during a County Fiscal Year (FY) (July 1 – June 30) must be received by County no later than the last working day of the first December following the close of the FY. Only claims for which the Contractor has ascertained that no payment will be received should be submitted.

5. To the extent permitted by law, upon submission of claim by Contractor to County for a trauma patient's care, and unless and until the claim is rejected by the County, Contractor assigns and subrogates to County any and all rights to collection as set forth herein, and Contractor shall cease all current and waive all future collection efforts, by itself and by its contractors/agents, to obtain any payment from the patient. At its sole discretion, County and/or County's Contractor may proceed independently against any parties responsible for payment for the Trauma Services to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement up to the full amount of usual and customary fees (including, for example, billed charges) for patient care and services regardless of any amount the Contractor has received under the TCPR, but only to the extent permitted by law. In the event Contractor is contacted by a third party's representative (e.g., insurance claim adjuster) or a patient's attorney regarding pending litigation concerning a claim that has been assigned to the County hereunder, Contractor shall indicate that the claim is assigned and subrogated to the County and refer

such representative to the designated County contact. Contractor shall reasonably cooperate with County in its collection efforts.

6. Contractor shall notify the County, and update the financial status of the patient in TEMIS, if Contractor becomes aware of any third-party coverage such as Medi-Cal, Medicare, other government programs**,** or other health insurance for any claim that the Contractor submitted to be included for purposes of calculating the Budget Allocation. The County has all rights to work with the identified third-party payers to receive any payment due with respect to claims that Contractor has assigned to County, but only to the extent permitted by law.

7. Any and all payments received by Contractor from a Trauma Patient or from third-party payers, including a legal settlement, for a claim previously submitted to and not rejected by the County, must be immediately reported to the County, and the payment amount shall be surrendered and remitted to the County since Contractor assigned and subrogated its rights to said claim. Contractor must remit to the County the payment that was received within sixty (60) days of receipt of such payment and must complete and submit Attachment 7, TRAUMA CENTER PAYMENT SURRENDER FORM, with each surrendered payment.

8. For Trauma Patients admitted to Contractor's facility prior to or on the last day during the term of this Agreement and remaining in the hospital after that date, reports and claim submission to County shall be made only after the patient has been discharged; the Contractor shall not submit partial or interim billings.

9. All reports and claims shall be completed in such detail and with such attachments as are in accordance with procedures prescribed in writing in Attachment 6. Contractor hereby acknowledges receipt of such forms, attachments, and procedures. Contractor and County agree that County may revise such forms, and such procedures and instructions without using a formal amendment to this Agreement. Such revised forms, procedures and instructions shall be effective at

least fifteen (15) calendar days after written notice to Contractor. In the event Contractor submits a timely written objection, Contractor and County will promptly meet and confer in good faith in an effort to resolve their differences. In the event the parties are not able to resolve their differences, Contractor may send a written notice to County within (30) days of the meet and confer session terminating this Agreement. This Agreement shall terminate fifteen (15) days after the date of the written notice, on such other days as the parties shall agree in writing.

E. AUDITING OF RECORDS

Contractor shall maintain and, upon request, make available to State or County representatives, records containing the financial information referenced in this Section, including records of patient and third-party payer payments, all in accordance with Section I B. General Conditions of this Exhibit.

1. County may periodically conduct an audit of the Contractor's records pertaining to the Patient-Based Claims for Eligible Patients that are required under this Exhibit. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a statistically random sample of submitted claims for a fiscal year, provided the sampling methodology is statistically valid. The scope of the audit shall include an examination of patient medical and financial records, patient and/or insurance billing records, and collection agency reports associated with the sampled claims.
2. Audited claims that do not comply with requirements in this Agreement shall result in a reduction in the total value of patient-based claims that will be used to determine each trauma hospital's patient-based Budget Allocation for the next fiscal year.

For example, if two patient-based claims for the prior fiscal year with a total value of $12,850 were audited and determined not to be in compliance with the program requirements and the Contractor's total value of submitted claims for that prior fiscal year was $150,000, $12,850 would be subtracted from the total value, reducing it to $137,150 which would then be the amount used to determine the Contractor's patient-based Budget Allocation for the next fiscal year. The County will notify Contractor of any audit findings. Audit results may be appealed to the EMS Agency Director, or his/her designee.

II. FUNDING FOR PEDIATRIC TRAUMA CENTERS

The parties acknowledge that Chapter 841 of the Statutes of 2006, authorized the County Board of Supervisors (Board), until December 31, 2008, to elect to levy an additional penalty in the amount of two dollars ($2) for every ten dollars ($10), upon fines, penalties, and forfeitures collected for specific criminal offenses. This authority was subsequently extended to December 31, 2013 by Chapter 288 of the Statutes of 2008. New legislation (SB 191) was chaptered October 5, 2013 and Section 76000.5 of the Government Code was amended extending these provisions through January 1, 2017. In 2016, legislation (SB 867) was again passed amending Section 76000.5 of the Government Code, extending these provisions through January 1, 2027.

The legislation further authorized the Board to utilize fifteen percent (15%) of the funds collected pursuant to the provisions of Health and Safety Code section 1797.98a, subdivision (e) (known as Richie's Fund) to provide funding to enhance pediatric trauma services by both publicly and privately owned and operated Pediatric Trauma Centers (PTCs) throughout the County.

The FY 2021-22 Richie's Fund collections available for FY 2022-2023 allocation to the non-County PTCs and County PTCs are $752,730. This amount is allocated to PTCs for the expansion of pediatric trauma care services as follows:

Cedars-Sinai Medical Center	$ 25,455
Children's Hospital Los Angeles	$ 25,455
Long Beach Memorial Medical Center	$ 25,455
Northridge Hospital Medical Center	$ 600,000
Ronald Reagan UCLA Medical Center	$ 25,455
Total	**$ 701,820**

III. DESIGNATION SUPPORT FUNDING

The funding described in this Section III is in addition to the funding described in Section I and II of this Exhibit.

A. BASE HOSPITAL SERVICES AND INFRASTRUCTURE

To account for the special costs incurred for those private trauma hospitals providing base and trauma hospital services and to ensure the continued access by Medi-Cal beneficiaries to emergency rooms and emergency room care in the County by maintaining efficient prehospital transport of all patients to the most appropriate emergency room, the County will recommend to the State that it make an aggregate supplemental payment in the amount of $700,000 for base station and $1,200,000 for infrastructure to each private Non-County Trauma Hospital pursuant to the Trauma SPA, with the exception of Children's Hospital Los Angeles. Children's Hospital Los Angeles will receive a supplemental infrastructure payment in the amount of $1,200,000 but will not receive a supplemental base station payment because it does not provide base hospital services.

As public hospitals, Ronald Reagan UCLA Medical Center ("UCLA") and Antelope Valley Hospital ("Antelope") may not receive these supplemental Medi-Cal payments under the State Plan. Accordingly, the County will directly pay each of those hospitals the amount of $700,000 for base station support and $1,200,000 for infrastructure support at or about the same time as County makes its IGT payment to the State. In the event the County makes its IGT payment to the State in multiple installments, the County will

make the base station and infrastructure supplemental payments to UCLA and Antelope in the same number of installments.

IV. ADD-ONS PAYMENTS

The funding described in this Section IV is in addition to the funding described in Sections I, II and III of this Exhibit. The total payment amounts below were designed to reflect the following: a) trauma patient volume; b) trauma patient acuity; and c) the levels of underinsured trauma patients treated.

Antelope Valley Hospital	$ 4,672,171
California Hospital Medical Center	$ 6,187,354
Cedars-Sinai Medical Center	$ 4,573,839
Children's Hospital Los Angeles	$ 1,735,765
Henry Mayo Newhall Mem. Med. Ctr.	$ 1,595,752
Huntington Memorial Hospital	$ 3,176,403
Long Beach Memorial Medical Center	$ 3,756,626
Northridge Hospital Medical Center	$ 3,744,738
Pomona Valley Hospital Medical Center	$ 5,499,958
Providence Holy Cross Medical Center	$ 3,832,212
Ronald Reagan UCLA Medical Center	$ 3,595,517
St. Francis Medical Center	$ 6,244,589
St. Mary Medical Center	$ 2,776,034
Total	**$51,390,958**

Except for UCLA and Antelope, it is the intent of the County to send an IGT to CDHCS so it can draw down federal matching dollars for enhanced Medi-Cal payments to the above hospitals in the amounts set forth above. The County will issue the above payments directly to UCLA and Antelope as grants to support their provision of trauma services.

V. ADDITIONAL FUNDING FROM MEASURE B TAX RATE INCREASE

The funding described in this Section IV is in addition to the funding described in Sections I, II, III and IV of this Exhibit. On September 13, 2022, the Board of Supervisors approved an increase to the Measure B Trauma, Emergency, and Bioterrorism Response property assessment rate of $0.0076 per improved square foot, for a total assessment of $0.0500 per improved square foot, effective July 1, 2022. The additional revenue from the Measure B tax rate increase is projected to generate approximately $50.18 million annually. Of this revenue, the Board approved $5.96 million per year to thirteen (13) non-County Trauma Hospitals to support staffing, technology, and capital improvement investments to maintain or expand the regional trauma care system; as well as $3.00 million per year to five (5) non-County Pediatric Trauma Hospitals for investments in staffing, technology, and capital improvements to boost pediatric trauma care.

1. The additional payments to the thirteen (13) Non-County Trauma Hospitals are as follows:

Additional Funding To Support Trauma Care System	
Antelope Valley Hospital	$ 1,018,068
California Hospital Medical Center	$ 1,309,094
Cedars-Sinai Medical Center	$ 775,126
Children's Hospital Los Angeles	$ 343,340
Henry Mayo Newhall Mem. Med. Ctr.	$ 415,404
Huntington Memorial Hospital	$ 597,716
Long Beach Memorial Medical Center	$ 679,196
Northridge Hospital Medical Center	$ 783,440
Pomona Valley Hospital Medical Center	$ 886,358
Providence Holy Cross Medical Center	$ 882,388
Ronald Reagan UCLA Medical Center	$ 795,649
St. Francis Medical Center	$ 966,492
St. Mary Medical Center	$ 648,012
Total	**$ 10,100,283**

The above total payment amount of $10.10 million includes Measure B funding and federal matching. Except for Antelope and UCLA, the County intends to send an IGT to CDHCS so it can draw down federal matching dollars for enhanced Medi-Cal payments to the above hospitals in the amounts set forth above. The County will issue the above payments directly to Antelope and UCLA.

2. The payments to the five (5) non-County Pediatric Trauma Hospitals are as follows:

Additional Funding To Support Pediatric Trauma Care		
Cedars-Sinai Medical Center	$	318,360
Children's Hospital Los Angeles	$	3,454,148
Long Beach Memorial Medical Center	$	760,516
Northridge Hospital Medical Center	$	697,422
Ronald Reagan UCLA Medical Center	$	384,777
Total	**$**	**5,615,223**

The above total payment amount of $5.61 million includes Measure B funding and federal matching. Except for UCLA, the County intends to send an IGT to CDHCS so it can draw down federal matching dollars for enhanced Medi-Cal payments to the above hospitals in the amounts set forth above. The County will issue the above payments directly to UCLA.

VI. PAYMENT LIMIT

Contractor acknowledges that the amounts payable under Attachment A ("the Trauma SPA") are limited to the uncompensated costs of providing outpatient hospital services of all eligible private trauma hospitals in Los Angeles County and are also limited by the State's upper payment limit, as established in 42 C.F.R. Section 447.321. To the extent that either or both limits preclude the State from

paying all the aggregate amounts set forth below, the amount to be recommended by the County for each private trauma hospital shall be reduced by the same percentage as the percentage of total allowable supplemental payments under the Trauma SPA is to total recommended supplemental Medi-Cal payments under the Trauma SPA to all private trauma hospitals.

VII. POTENTIAL IGT FOR FEDERAL MATCHING FUNDS

As discussed in Section III, the County intends that the Designation Support payments, Add-On Payments, a portion of the Patient-Based payments and any Additional Payments Due to Measure B Rate Increase, should they be allocated, to the private Non-County Trauma Hospitals be made as additional Medi-Cal payments in accordance with the Trauma SPA. Unless CDHCS rejects this payment approach, the County will transfer the non-federal share of such funds to CDHCS in one or more IGTs. The amount of the additional Medi-Cal payments to the private Non-County Trauma Hospitals will be included in the amounts set forth in Sections IA.1, III, IV and V above.

The parties acknowledge and agree that some or all of the IGT, which the County intends to make to effectuate the provisions of this Agreement may not be capable of drawing down federal matching funds under the Trauma SPA. To the extent that is true, the parties agree that the County shall have no obligation to make an IGT of such amounts and shall instead provide such IGT funds directly to the private Non-County Trauma Hospitals in proportion to the payments that would have been made to each hospital relating to such IGT funds if the funds had been accepted as a permissible IGT for which federal matching funds would be available under the Trauma SPA. To the extent that Non-County Trauma Hospitals receive the full amounts set forth in Section VIII, County has no obligation to make further direct payments, even if not all of the funds set aside for use as an IGT are ultimately used for that purpose.

The total amount of the IGT the County intends to make shall be $41.43 million.

VIII. TOTAL MAXIMUM PAYMENTS

The total maximum payments that each Non-County Trauma Hospital may receive, either directly from the County, or from the State of California, as additional Medi-Cal payments under the Trauma SPA (which includes the amounts of IGTs made by the County and federal matching funds), and subject to the limitations and conditions as described in this Agreement, shall be as follows:

Antelope Valley Hospital	$ 8,160,009
California Hospital Medical Center	$ 12,502,665
Cedars-Sinai Medical Center	$ 7,746,754
Children's Hospital Los Angeles	$ 6,758,708
Henry Mayo Newhall Memorial Med. Ctr.	$ 3,967,373
Huntington Memorial Medical Center	$ 5,708,561
Long Beach Memorial Medical Center	$ 7,272,726
Northridge Hospital Medical Center	$ 8,779,764
Pomona Valley Hospital Medical Center	$ 8,465,274
Providence Holy Cross Medical Center	$ 8,427,368
Ronald Reagan UCLA Medical Center	$ 6,787,504
St. Francis Medical Center	$ 9,230,613
St. Mary Medical Center	$ 6,188,923
Total	**$ 99,996,242**

Each non-County Trauma Hospital will be paid the above amounts through a combination of direct payments by the County or additional Medi-Cal payments under the Trauma SPA, except for UCLA and Antelope, which shall receive only funds from the County. Payments may be reduced to the extent that the amounts anticipated to be paid as Medi-Cal funds through the Trauma SPA cannot be paid in that manner, in which case the County will make direct payments of the non-federal share of such payments, up to, but not exceeding the amount of the IGT set forth above, less the amount used to fund the Medi-Cal payments which were actually made.

IX. EFFECTIVE DATES

The provisions of this Exhibit shall only apply to trauma services provided on or after July 1, 2022 and before July 1, 2023.

TRAUMA CENTER SERVICE AGREEMENT

PATIENT INCLUSION IN THE TRAUMA DATA SYSTEM

EXCLUSIONS:

Patients with the following injuries are to be EXCLUDED from the registry, unless an additional injury that meets criteria/guidelines exists:

GROUND LEVEL FALLS:

resulting in isolated closed hip fractures in patients > 50 years of age; or

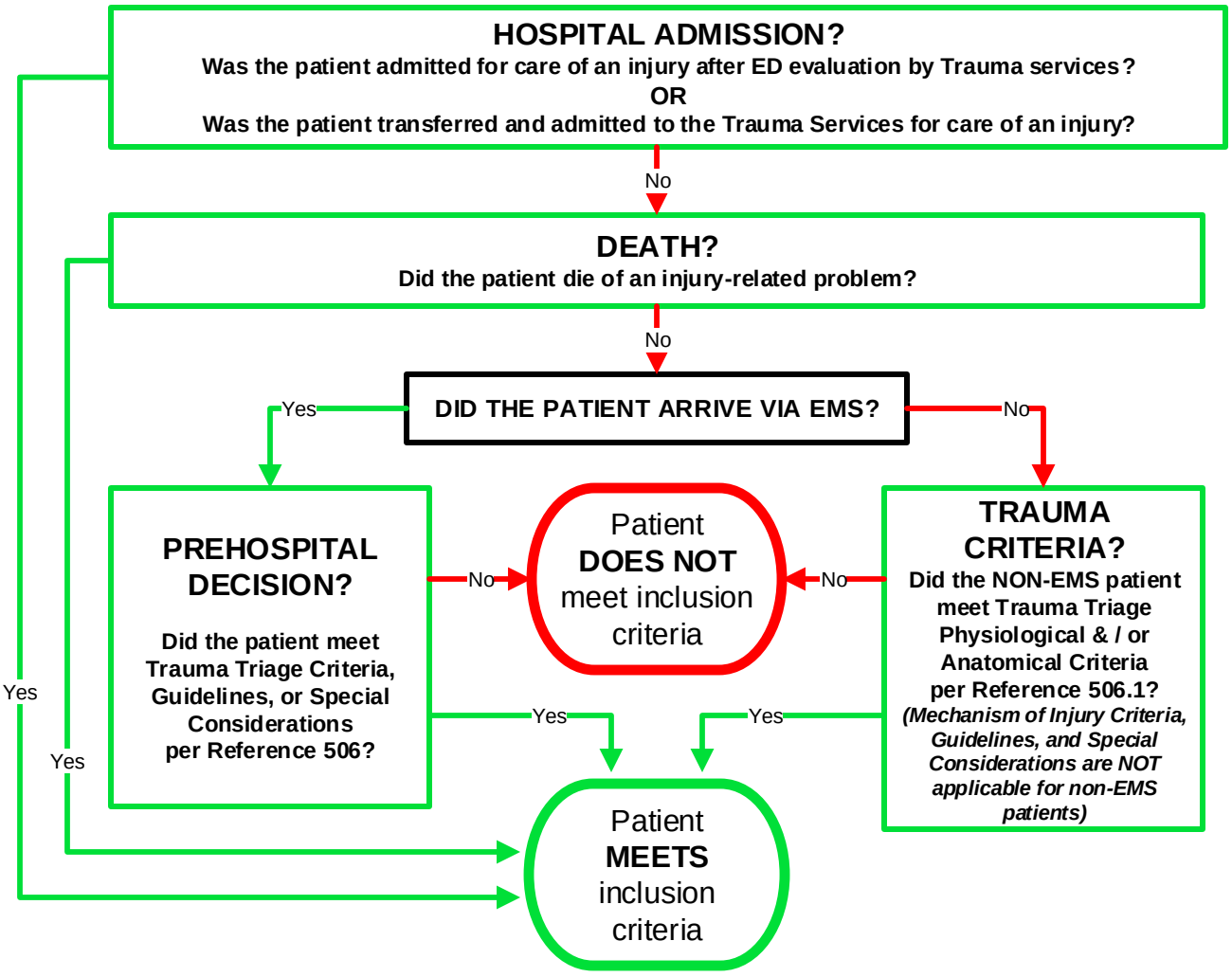
ALL injuries of or distal to the knee or elbow in patients of any age

OR

drownings; hangings; poisonings; late effect of injuries; foreign bodies; superficial injuries (S00, S10, S20, S30, S40, S50, S60, S70, S80, & S90); insect bites; and isolated injuries to fingers and/or toes.

INCLUSIONS:

Does the patient have at least one ICD-10 injury diagnostic code within the range of S00 - S99; T20-T28; T30-T32; & T79.A1 - T79.A9?



CASES ENTERED INTO THE REGISTRY THAT DO NOT MEET THE INCLUSION CRITERIA MUST BE IDENTIFIED AS "DHS=NO", AND HAVE THE TPS RATIONALE OF "DHS=NO" INDICATED.

January 1, 2020 (Implemented)
Valid until amended by the EMS Agency
(Replaces Exhibit C dated July 1, 2019)

NOTICE

MEDICAL CARE FOR THOSE WHO CANNOT AFFORD TO PAY

THIS HEALTH CARE FACILITY PROVIDES SERVICES FREE OF CHARGE OR AT A REDUCED CHARGE TO PERSONS WHO CANNOT AFFORD TO PAY FOR MEDICAL CARE.

IF YOU ARE UNABLE TO PAY FOR ALL OR PART OF THE CARE YOU NEED, YOU MAY CONTACT THE ADMISSIONS OR BUSINESS OFFICE OF THIS FACILITY AND ASK ABOUT THE AVAILABILITY OF SUCH CARE. IF YOU WOULD LIKE FURTHER INFORMATION, YOU MAY CALL THE COUNTY OF LOS ANGELES, PRIVATE SECTOR COORDINATOR'S OFFICE AT (562) 378-1590.

NOTICIA

SERVICIO MEDICO PARA QUIENES NO PUEDEN AFRONTAR PAGARLO

ESTE HOSPITAL PROVEE SERVICIOS GRATIS O A COSTO REDUCIDO A PERSONAS QUE NO PUEDEN PAGAR POR SERVICIOS MEDICOS.

SI USTED NO PUEDE PAGAR POR TODO O PARTE DEL CUIDADO QUE NECESITA, USTED DEBE COMUNICARSE CON LA OFICINA DE ADMISIONES O NEGOCIOS DE ESTE HOSPITAL Y PREGUNTAR ACERCA DE ESTE PROGRAMA. SI DESEA MAS INFORMACION, PUEDE LLAMAR AL CONDADO DE LOS ANGELES, OFICINA DEL COORDINADOR DEL SECTOR PRIVADO, AL (562) 378-1590.

ATTACHMENT 4

TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE) AGREEMENT

_____ _____ _____/_____/_____
Trauma Service Hospital/Physician Medical Record Number Date(s) of Service

NOTE: Patients unwilling or refusing to cooperate DO NOT qualify for the Trauma Services for Indigents Program.

PATIENT INFORMATION:

_____
Last First Middle

_____
Street City State Zip

_____ - _____ - _____ ( ) _____ - _____ _____/_____/_____
Social Security Number Telephone Number Birth Date

_____
Patient's Responsible Relative(s) Name(s) Addresses(s)

Does patient have third party coverage (i.e., private insurance) which may partially or fully cover the cost of health services on the above date(s)?

YES ☐ (IF YES, PATIENT IS NOT ELIGIBLE) NO ☐

TSCE COMPUTATION: (Taken from 2023 Federal Poverty Level 4/1/23)

CIRCLE ONE IN EACH COLUMN BELOW: Figure Family Size based on the number of persons in the patient's household. Figure the income of the patient and the patient's responsible relative(s) before taxes and deductions.

Family Size	Monthly Income	Yearly Income
1	$2,430	$29,160
2	3,288	39,456
3	4,144	49,728
4	5,000	60,000
5	5,858	70,296
6	6,714	80,568
7	7,570	90,840
8	8,428	101,136
9	9,284	111,408
10	10,140	121,680
11	10,998	131,976
12	$11,854	$142,248

(For family units with more than 12 members, add $858 monthly and $10,926 yearly for each additional member.)
My/our Monthly Income and Yearly Income are less than or equal to the amount circled above.

TSCE CERTIFICATION:

I/we understand that in order to be eligible for TSCE for the health services received on the above date(s), my/our Monthly Income and Yearly Income must be less than or equal to the amounts corresponding to my/our Family Size. I/we will not be liable for these health services.

I/we understand and agree that this Agreement shall be governed by the terms and conditions set forth in the TSCE, which has been made available to me/us for review, and that I/we shall fully cooperate with the County and Trauma Service Hospital in accordance with the TSCE.

I/WE, PATIENT OR RESPONSIBLE RELATIVE(S), CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE(S) THAT THE INFORMATION I/WE HAVE GIVEN TO DETERMINE MY/OUR TRAUMA SERVICE COUNTY ELIGIBILITY AS CIRCLED ABOVE FOR HEALTH SERVICES ON THE ABOVE DATE(S) IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE ALSO CERTIFY THAT I/WE HAVE DISCLOSED ALL MY/OUR THIRD PARTY COVERAGE WHICH MAY PAY FOR ANY OF THE COST OF HEALTH SERVICES RECEIVED. I/WE UNDERSTAND THAT IF I/WE HAVE A THIRD OR FIRST PARTY CLAIM OR LAWSUIT, LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES, SHALL HAVE THE RIGHT TO RECOVER ALL REASONABLE HOSPITAL AND PHYSICIAN CHARGES INCURRED DURING THE ABOVE REFERENCED DATE OF SERVICE AND OTHER MEDICAL SERVICES RELATED HERETO AS PERMITTED BY STATE LAW. THIS INCLUDES THE FULL BILLED CHARGES OF THE HOSPITAL.

_____ _____/_____/_____
Patient's Signature Date

_____ _____/_____/_____
Responsible Relative(s) Signature (State relationship to patient) Date
If patient unable to sign

_____ _____/_____/_____
TSCE Hospital Reviewer (Required to verify above information and signature) Date

THIS FORM OR A U-2 MUST BE ON FILE IN THE PATIENT(S) FINANCIAL CHART

TSCE 040792 Revised 3/1/23jd

ATTACHMENT 5

HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE (U-2) AGREEMENT

_____ _____ _____
Trauma Service Hospital/Physician Medical Record Number Date(s) of Service

NOTE: Patients **unwilling or refusing to cooperate** DO NOT qualify for the Trauma Services for Indigents Program.

PATIENT INFORMATION:

_____
Last First Middle

_____
Street City State Zip

_____
Patient's Responsible Relative(s) Name(s) Addresses(s)

_____-_____-_____ ( ) _____-_____ _____/_____/_____
Social Security Number Telephone Number Birth date

WE CERTIFY UNDER PENALTY OF PERJURY BY OUR SIGNATURES THAT WE HAVE USED ALL REASONABLE MEANS TO DETERMINE THE PATIENT'S ELIGIBILITY IN ACCORDANCE WITH THE TSCE AGREEMENT. SPECIFICALLY, WE HAVE USED ALL REASONABLE MEANS TO:

1) Obtain the names and addresses of the patient and the patient's responsible relatives,

2) Obtain acceptable address verification, and

3) Obtain all information needed to complete the TSCE Agreement, including information regarding the income and family size of the patient and patient's responsible relatives, and the patient's third-party coverage.

The patient and/or patient's responsible relatives, if any, were UNABLE to cooperate fully because:

_____

and TO THE BEST OF OUR KNOWLEDGE AND BELIEF, THE PATIENT OR PATIENT'S RESPONSIBLE RELATIVES ARE UNABLE TO PAY FOR THE COST OF HEALTH SERVICES PROVIDED AND THEPATIENT OR PATIENT'S RESPONSIBLE RELATIVES HAVE NO THIRD-PARTY COVERAGE FOR THESE HEALTH SERVICES. THE INFORMATION SET FORTH ABOVE IS ALL OF THE INFORMATION WEWERE ABLE TO OBTAIN WITH RESPECT TO THIS PATIENT.

_____ _____/_____/_____
Hospital Reviewer #1 Date

_____ _____/_____/_____
Hospital Reviewer #2 Date

THIS FORM MUST BE SIGNED BY TWO HOSPITAL STAFF VERIFYING THE REASON THE PATIENT AND/OR THE PATIENT'S RESPOPNSIBLE RELATIVES, IF ANY, WERE UNABLE TO COOPERATE AND SHOULD BE COMPLETED AT THE TIME OF REGISTRATION AND FINANCIAL INFORMATION IS COLLECTED FOR THIS ACCOUNT.

THIS FORM OR A TSCE MUST BE ON FILE IN THE PATIENT'S FINANCIAL CHART

Instructions for Submission of Claims and Data Collection

1. Completion of UB-04 Claims
2. Completion of Excel Electronic File of the UB 04 Data
   - INPATIENT LISTING
   - OUTPATIENT LISTING
3. Trauma Patient Summary (TPS) Print-Out
4. Completion of the Trauma Service County Eligibility TSCE (U1) Agreement Form
5. Completion of the Hospital Certification of Inability to Cooperate (U2) Agreement Form

BOARD LETTER/MEMO
CLUSTER FACT SHEET

DRAFT

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/24/2023
BOARD MEETING DATE	6/6/2023
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
DEPARTMENT(S)	Mental Health (DMH)
SUBJECT	Approval to Amend Existing Legal Entity (LE) Contracts and 24-Hour Residential Treatment Contracts to Increase Their Maximum Contract Amounts for Fiscal Years (FYs) 2022-23 and 2023-24 for The Continued Provision of Specialty Mental Health Services
PROGRAM	Legal Entity and 24-Hour Residential Treatment Contracts
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No
SOLE SOURCE CONTRACT	☐ Yes ☒ No If Yes, please explain why:
DEADLINES/ TIME CONSTRAINTS	N/A
COST & FUNDING	Total aggregate increase: FY 2022-23 - $9,246,867 FY 2023-24 - $7,904,795 Funding source: Federal and State Medi-Cal, and State Mental Health Services Act (MHSA) revenues TERMS (if applicable): FYs 2022-23 and 2023-24 Explanation: Increase Maximum Contract Amounts for FYs 2022-23 and 2023-24.
PURPOSE OF REQUEST	Request approval to amend nine existing DMH LE and four 24-Hour Residential Treatment Contracts to increase their Maximum Contract Amounts for the continued provision of specialty mental health services for FYs 2022-23 and 2023-24.
BACKGROUND (include internal/external issues that may exist including any related motions)	On June 8, 2021, the Board authorized DMH to execute Legal Entity Contracts for three years, through June 30, 2024, for the provision of specialty mental health services, including Delegated Authority (DA) up to 25 percent of the contracted amount. On May 3, 2022, the Board authorized DMH to execute 24-Hour Residential Treatment Contracts for four years, through June 30, 2026, for the provision of specialty mental health services at its crisis residential treatment program, including DA up to 25 percent of the contracted amount. Nine LE Contractors listed in Attachment I and four 24-Hour Residential Treatment Contracts listed in Attachment II have reached their previously Board-approved 25 percent DA for FYs 2022-23 and 2023-24. This Board action will allow DMH to amend their contracts to increase the MCAs, specifically for the provisions of DMH Mental Health Services, MHSA Alternative Crisis Services, MHSA Full Service Partnership, MHSA Outpatient Care Services, MHSA Prevention & Early Intervention, Specialized Foster Care (SFC) Department of Children and Family Services, and SFC Multidisciplinary Assessment Team, thereby ensuring the continuation of these services throughout the contract term.
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: This Board Letter supports Board Priority No. 2 "Alliance for Health Integration" and will allow DMH to meet the County's shortage of psychiatric beds and improve the efficiency of placing high-need clients in this intensive crisis residential treatment program.
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: DMH: Amanda Ruiz, Deputy Director (213) 943-8745, AmaRuiz@dmh.lacounty.gov DMH: Terri Boykins, LCSW, Deputy Director, (213) 943-8890, TBoykins@dmh.lacounty.gov Deputy County Counsel: Craig Kirkwood, Jr., (213) 974-1751, CKirkwood@counsel.lacounty.gov

DEPARTMENT OF MENTAL HEALTH

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LISA H. WONG, Psy.D.
Director

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

Connie D. Draxler, M.P.A.
Acting Chief Deputy Director

June 6, 2023

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 AMEND EXISTING LEGAL ENTITY AND 24-HOUR RESIDENTIAL TREATMENT CONTRACTS TO INCREASE THEIR MAXIMUM CONTRACT AMOUNTS FOR FISCAL YEARS 2022-23 AND 2023-24 FOR THE CONTINUED PROVISION OF SPECIALTY MENTAL HEALTH SERVICES (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Request approval to amend nine existing Department of Mental Health Legal Entity and four 24-Hour Residential Treatment Contracts to increase their Maximum Contract Amounts for the continued provision of specialty mental health services for Fiscal Years 2022-23 and 2023-24.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and authorize the Director of Mental Health (Director), or her designee, to prepare, sign, and execute amendments to nine existing Department of Mental Health (DMH) Legal Entity (LE) Contracts as identified on Attachment I, to increase the Maximum Contract Amounts (MCA) for Fiscal Year (FY) 2022-23 and FY 2023-24. The amendment will be effective upon Board approval; the total aggregate increase for these LE Contracts is $5,796,136 for FY 2022-23 and $4,174,246 for FY 2023-24, fully funded by Federal Financial Participation (FFP) and State Aid Mental Health Medi-Cal; and State Mental Health Services Act (MHSA) revenues.

2. Approve and authorize the Director, or her designee, to prepare, sign, and execute amendments to four existing DMH 24-Hour Residential Treatment Contracts as identified on Attachment II, to increase the MCA for FY 2022-23 and FY 2023-24. The amendment will be effective upon Board approval; the total aggregate increase for these 24-Hour Residential Treatment Contracts is $3,450,731 for FY 2022-23 and $3,730,549 for FY 2023-24, fully funded by FFP and State Aid Mental Health Medi-Cal, and MHSA revenues.

3. Delegate authority to the Director, or her designee, to prepare, sign, and execute future amendments to the Contracts in Recommendations 1 and 2 in order to revise the language; revise the annual MCAs; add, delete, modify, or replace the Service Exhibit(s) and/or Statement(s) of Work; and/or reflect federal, State, and County regulatory and/or policy changes provided that: 1) the County's total payment will not exceed 25 percent of the Board-approved MCA in Recommendation 1 and 2; and 2) sufficient funds are available. These amendments will be subject to prior review and approval as to form by County Counsel, with written notice to the Board and Chief Executive Office (CEO).

4. Delegate authority to the Director, or her designee, to terminate the Contracts described in Recommendation 1 and 2 in accordance with the termination provisions, including Termination for Convenience. The Director, or her designee, will provide written notification to your Board and CEO of such termination action.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Board approval of Recommendation 1 will allow DMH to amend nine existing LE Contracts in order to increase their MCAs for the continued provision of Specialty Mental Health Services (SMHS) since the LE Contracts have reached their previously Board-approved 25 percent delegated authority for FYs 2022-23 and 2023-24. Additional funding will support the LE Contractors listed in Attachment I to support their capacity in expanding services to new and existing beneficiaries.

Board approval of Recommendation 2 will allow DMH to amend four existing 24-Hour Residential Treatment Contracts in order to increase their MCAs for the continuous delivery of sub-acute psychiatric residential services for Medi-Cal beneficiaries and/or uninsured clients since the Contracts has reached their previously Board-approved 25 percent delegated authority for FYs 2022-23 and 2023-24. Additional funding will support the 24-Hour Residential Treatment Contractors listed in Attachment II allowing DMH to decompress the number of clients in psychiatric emergency and inpatient units by supporting ongoing efforts to discharge clients from acute hospital settings to outpatient residential programs.

Board approval of Recommendation 3 will allow DMH to amend the Contracts in Recommendation 1 and 2 in a timely manner, as necessary, for the continued provision and expansion of SMHS without interruption to clients in need of these services.

Board approval of Recommendation 4 will allow DMH to terminate the Contracts in accordance with the Contract's termination provisions, including Termination for Convenience, in a timely manner, as necessary.

Implementation of Strategic Plan Goals

The recommended action is consistent with the County's Strategic Plan Goal I, Make Investments that Transform Lives, specifically Strategy I.1- Increase Our Focus on Prevention Initiatives, and Strategy I.2- Enhance Our Delivery of Comprehensive Interventions, and County's Strategic Plan Goal III, Realize Tomorrow's Government Today, specifically Strategy III.3 – Pursue Operational Effectiveness, Fiscal Responsibility, and Accountability.

FISCAL IMPACT/FINANCING

The total aggregate increase for the LE Contracts is $5,796,136, fully funded by FFP and State Aid Mental Health Medi-Cal; and State MHSA revenues, and the total aggregate increase for the 24-Hour Residential Treatment Contracts is $3,450,731, fully funded by FFP, State Aid Mental Health Medi-Cal, and State MHSA revenues.

Sufficient appropriation is included in DMH's FY 2022-23 Final Adopted 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 recommended action.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On June 8, 2021, your Board authorized the Director to enter into 131 LE Contracts, which included the nine contractors listed on Attachment I. DMH is seeking your Board's approval to amend these nine LE Contracts in order to increase their MCAs. These Contractors have reached the 25 percent delegated authority for FYs 2022-23 and 2023-24. DMH previously amended these LE Contracts up to delegated authority and is returning to your Board for authority to amend the LE Contracts to increase funds for FYs 2022-23 and 2023-24. The increase of funds is for the provisions of DMH Mental Health Services, MHSA Alternative Crisis Services, MHSA Full Service Partnership, MHSA Outpatient Care Services, MHSA Prevention & Early Intervention, Specialized Foster Care (SFC) Department of Children and Family Services, and SFC Multidisciplinary

Assessment Team. The LE Contractors listed on Attachment I provide a variety of SMHS in Supervisorial Districts 1, 2, 3, and 5.

On May 3, 2022, your Board authorized the Director to execute 24-Hour Residential Treatment Contracts, which included the four contractors listed on Attachment II. DMH is seeking your Board's approval to amend these four 24-Hour Residential Treatment Contracts in order to increase their MCAs. These Contractors have reached the 25 percent delegated authority for FYs 2022-23 and 2023-24. DMH previously amended these 24-Hour Residential Treatment Contracts up to delegated authority and is returning to your Board for authority to amend the 24-Hour Residential Treatment Contracts to increase funds for FYs 2022-23 and 2023-24. The increase of funds is for the provision of DMH Mental Health Services and MHSA Alternative Crisis Services. The 24-Hour Residential Treatment Contractors listed on Attachment II provide a variety of SMHS at its crisis residential treatment program in Supervisorial Districts 1, 2, 3, 4, and 5.

Under Board Policy No. 5.100 (Sole Source Contracts and Amendments), DMH is required to notify your Board six months in advance of amendments to existing contracts when DMH does not have delegated authority to increase the maximum amount of the current contract. On February 28, 2023, your Board Adopted a Board letter which exempts DMH Contracts providing Specialty Mental Health Services from Board Policy No. 5.100 as these contracts provide federal entitlement services to beneficiaries. In addition, an exemption to Board Policy No. 5.100 allows DMH to meet the federal requirements to ensure an adequate network of providers and services are available throughout the County.

The amendment format has been approved as to form by County Counsel. Attachment I lists the LE Contractors and Attachment II lists the 24-Hour Residential Treatment Contractors, along with their headquarter addresses, Supervisorial District(s), Service Area(s), and MCA.

As mandated by your Board, the performance of all contractors is evaluated by DMH on an annual basis to ensure compliance with all contract terms and performance standards.

IMPACT ON CURRENT SERVICES OR PROJECTS

Board approval of the recommended actions will allow the LE and 24-Hour Residential Treatment Contractors to provide ongoing Specialty Mental Health Services and allow DMH the ability to make revisions/updates to the work provided by the Contractors in a timely manner.

Respectfully submitted,

Lisa H. Wong, Psy.D.
Director

LHW:CDD:KN
SK:BJA:atm

Attachments (2)

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

LOS ANGELES COUNTY
Department of Mental Health

Legal Entity Contracts
Increase of Maximum Contract Amounts for FY 2022-23 for the Continued Provision of Specialty Mental Health Services

	Legal Entity Contractor Name	Headquarters Address	Service Provider Supervisorial District(s)	Service Provider Service Area(s)	FY 22-23 Current MCA	Total Increase for FY 22-23
1	Alcott Center for Mental Health Services	1433 S. Robertson Blvd. Los Angeles, CA 90035	2	5	$4,387,523	$475,000
2	BRIDGES Community Treatment Services, Inc.	279 East Arrow Highway, Ste. 102 San Dimas, CA 91773-3338	1, 3	2, 3	$4,867,785	$130,536
3	El Centro de Amistad	566 South Brand Blvd. San Fernando, CA 91340	3	2	$5,498,988	$99,000
4	Five Acres - The Boys' & Girls' Aid Society of Los Angeles County	760 W. Mountain View St. Altadena, CA 91001	5	3	$26,628,332	$3,114,000
5	McKinley Children's Center, Inc. dba McKinley	762 Cypress St. San Dimas, CA 91773	1,5	3	$10,117,436	$534,462
6	The People Concern	1453 16th St. Santa Monica, CA 90404-2715	1,3,5	1,4,5	$12,171,443	$900,000
7	Tobinworld	912 E. Broadway Glendale, CA 91025	5	2	$2,028,568	$254,286
8	Topanga-Roscoe Corporation dba Topanga West Guest Home	22115 Roscoe Blvd. Canoga Park, CA 91304	5	2	$1,055,742	$288,852
	TOTAL AGGREGATED AMOUNT AMENDED FOR FY 2022-23					**$5,796,136**

Legal Entity Contracts
Increase of Maximum Contract Amounts for FY 2023-24 for the Continued Provision of Specialty Mental Health Services

	Legal Entity Contractor Name	Headquarters Address	Service Provider Supervisorial District(s)	Service Provider Service Area(s)	FY 23-24 Current MCA	Total Increase for FY 23-24
1	Alcott Center for Mental Health Services	1433 S. Robertson Blvd. Los Angeles, CA 90035	2	5	$4,397,523	$475,000
2	The People Concern	1453 16th St. Santa Monica, CA 90404-2715	1,3,5	1,4,5	$11,349,443	$900,000
3	The Regents of the University of California, Los Angeles	10889 Wilshire Blvd., Suite 700 Los Angeles, CA 90095	3	5	$2,347,541	$2,256,108
4	Tobinworld	912 E. Broadway Glendale, CA 91205	5	2	$2,028,568	$254,286
5	Topanga-Roscoe Corporation dba Topanga West Guest Home	22115 Roscoe Blvd. Canoga Park, CA 91304	5	2	$1,055,742	$288,852
	TOTAL AGGREGATED AMOUNT AMENDED FOR FY 2023-24					**$4,174,246**

LOS ANGELES COUNTY
Department of Mental Health

24-Hour Residential Treatment Contracts
Increase of Maximum Contract Amounts for FY 2022-23 for the Continued Provision of Specialty Mental Health Services

	24-Hour Residential Treatment Contractor Name	Headquarters Address	Service Provider Supervisorial District(s)	Service Provider Service Area(s)	FY 22-23 Current MCA	Total Increase for FY 22-23
1	Didi Hirsch Psychiatric Service	4760 Sepulveda Blvd. Culver City, CA 90230	2, 3	5, 8	$3,081,423	$775,000
2	Gateways Hospital and Mental Health Center	1891 Effie St. Los Angeles, CA 90026	1	4,7	$8,786,989	$2,301,636
3	Homes for Life Foundation	8939 S. Sepulveda Blvd. #460 Los Angeles, CA 90045	2,4,5	3,5,7,8	$648,729	$42,583
4	Special Service for Groups, Inc.	905 E. 8th St. Los Angeles, CA 90021	1	4	$8,370,853	$331,512
	TOTAL AGGREGATED AMOUNT AMENDED FOR FY 2022-23					**$3,450,731**

24-Hour Residential Treatment Contracts
Increase of Maximum Contract Amounts for FY 2023-24 for the Continued Provision of Specialty Mental Health Services

	24-Hour Residential Treatment Contractor Name	Headquarters Address	Service Provider Supervisorial District(s)	Service Provider Service Area(s)	FY 23-24 Current MCA	Total Increase for FY 23-24
1	Gateways Hospital and Mental Health Center	1891 Effie St. Los Angeles, CA 90026	1	4,7	$8,786,989	$2,757,886
2	Homes for Life Foundation	8939 S. Sepulveda Blvd. #460 Los Angeles, CA 90045	2,4,5	3,5,7,8	$648,729	$127,750
3	Special Service for Groups, Inc.	905 E. 8th St. Los Angeles, CA 90021	1	4	$8,370,853	$844,913
	TOTAL AGGREGATED AMOUNT AMENDED FOR FY 2023-24					**$3,730,549**

BOARD LETTER/MEMO
CLUSTER FACT SHEET

DRAFT

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/24/2023
BOARD MEETING DATE	6/6/2023
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
DEPARTMENT(S)	Mental Health
SUBJECT	Approval to Extend the Existing Contract with Southern California Grantmakers for the Veteran Peer Access Network Program on a Sole Source Basis
PROGRAM	Veteran Peer Access Network
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No
SOLE SOURCE CONTRACT	☒ Yes ☐ No If Yes, please explain why: On November 19, 2019, the Board approved a Board motion titled "Countywide Mental Health Services for Veterans." The Board motion instructed DMH to execute a contract with Southern California Grantmakers (SCG) to create a public-private partnership focused on implementing services to veterans using a peer-to-peer model to form the Veteran Peer Access Network (VPAN) in Los Angeles County. As the existing contract is set to expire on June 30, 2023, DMH notified the Board on December 15, 2022, in accordance with Board Policy No. 5.100 (Sole Source Contracts and Amendments) of its intent to extend the term of the existing contract with SCG to continue the VPAN program as it is more cost-effective to continue partnership with SCG on a sole source basis.
DEADLINES/ TIME CONSTRAINTS	6/30/2023
COST & FUNDING	Total cost: $5,786,000 each Fiscal Year | Funding source: State Mental Health Services Act TERMS (if applicable): July 1, 2023 through June 30, 2024, with two automatic one-year extensions through June 30, 2026.
PURPOSE OF REQUEST	Request approval to extend the term of the existing contract with SCG to continue the VPAN program in Los Angeles County on a sole source basis.
BACKGROUND (include internal/external issues that may exist including any related motions)	The "Countywide Mental Health Services for Veterans" Board motion dated November 19, 2019 authorized DMH to collaborate with SCG to implement the VPAN program to achieve the following goals: 1) increase protective factors such as financial stability, resiliency, socio-emotional skill building, and social connectedness, and 2) reduce risk factors such as suicidality, homelessness, and under/unemployment. Through this contract, SCG has set up Rally Points in each of the five Supervisorial Districts for veterans and military family members to obtain resources, trained and certified veteran peers, and launched a technology platform to facilitate the coordination of resources and access for veterans and their families. Board approval of this contract extension will allow DMH to continue and expand the County's efforts to connect veterans and their families to essential resources as SCG has proven to be a valuable partner in VPAN's success in Los Angeles County.
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: La Tina Jackson, Deputy Director, (818) 610-6717, ltjackson@dmh.lacounty.gov Margaret Ambrose, Principal Deputy County Counsel, (213) 974-0941, mabrose@counsel.lacounty.gov

DEPARTMENT OF MENTAL HEALTH

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LISA H. WONG, Psy.D.
Director

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

Connie D. Draxler, M.P.A.
Acting Chief Deputy Director

June 6, 2023

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 EXISTING CONTRACT WITH SOUTHERN CALIFORNIA GRANTMAKERS FOR THE VETERAN PEER ACCESS NETWORK PROGRAM ON A SOLE SOURCE BASIS (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Request approval to extend the term of the existing contract with Southern California Grantmakers to continue the Veteran Peer Access Network program in Los Angeles County on a sole source basis.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and authorize the Director of Mental Health (Director), or designee to sign and execute an amendment (Attachment I) to the existing contract with Southern California Grantmakers (SCG) to continue the Veteran Peer Access Network (VPAN) program on a sole source basis for three fiscal years, effective July 1, 2023 through June 30, 2024, with two automatic one-year extensions through June 30, 2026. The funding amount per fiscal year is $5,786,000, for a Total Compensation Amount (TCA) of $17,358,000, fully funded by State Mental Health Services Act (MHSA) revenue.

2. Delegate authority to the Director, or designee, to prepare, sign, and execute future amendments or modifications to revise the contract language; add, delete, modify, or replace the Statement of Work; and/or reflect federal, State, and County regulatory and/or policy changes; shift unspent funds from one fiscal year to other(s) during the term of the contract; and increase the TCA provided that: 1) the County's total payment

does not exceed an increase of 10 percent from the applicable TCA in Recommendation 1; and 2) sufficient funds are available. These amendments will be subject to the prior review and approval as to form by County Counsel, with written notice to the Board and Chief Executive Officer (CEO).

3. Delegate authority to the Director, or designee, to terminate the contract in accordance with the termination provisions, including Termination for Convenience. The Director, or designee, will notify the Board and CEO, in writing, of such termination action.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

On November 19, 2019, your Board approved a Board motion titled "Countywide Mental Health Services for Veterans." The Board motion instructed DMH to execute a contract with SCG to create a public-private partnership focused on implementing services to veterans using a peer-to-peer model to form VPAN in Los Angeles County.

Board approval of Recommendation 1 will allow DMH to amend SCG's contract to extend the term on a sole source basis for three fiscal years, effective July 1, 2023 through June 30, 2024, with two automatic one-year extensions through June 30, 2026.

Board approval of Recommendation 2 will allow DMH to amend the contract to revise the contract language as needed; add, delete, modify, or replace the Statement of Work; reflect federal, State, and County regulatory and/or policy changes; including a shift of unspent funds and/or modify the TCA.

Board approval of Recommendation 3 will allow DMH to terminate the contract in accordance with the Contract's termination provisions, including Termination for Convenience, in a timely manner, as necessary.

Implementation of Strategic Plan Goals

These recommended actions are consistent with the County's Strategic Plan Goal I, Make Investments that Transform Lives, specifically Strategy I.1 – Increase Our Focus on Prevention Initiatives; Strategic Plan Goal II, Foster Vibrant and Resilient Communities via Strategy II.1 – Drive Economic and Workforce Development in the County and Strategy II.2 – Support the Wellness of our Communities.

FISCAL IMPACT/FINANCING

The total funding amount is $5,786,000, fully funded by State MHSA revenue. Appropriation and funding will be included in DMH's FY 2023-24 Recommended Budget.

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

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

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

The Countywide Mental Health Services for Veterans Board Motion dated November 19, 2019, authorized DMH to execute a contract with SCG to create a public-private partnership focused on implementing services to veterans using a peer-to-peer model to form VPAN in Los Angeles County. VPAN is designed to achieve the following goals: 1) increase protective factors such as financial stability, resiliency, socio-emotional skill building, and social connectedness, and 2) reduce risk factors such as suicidality, homelessness, and under/unemployment.

Through this contract, Rally Points were set up within each of the five Supervisorial Districts. The Rally Points are community access points for veterans and military family members to obtain resources to a wide range of services that include but are not limited to the following services: mental health, housing, workforce development/employment, healthcare, education, legal services, and numerous other reintegration resources for veterans and military families.

A key component of the VPAN program is the delivery of peer support services to veterans and their families. SCG has trained and certified veteran peers and collaborated with DMH to provide additional certified trainings as follows: trauma-informed services, peer navigator, peer boundaries and ethics, risk management and mitigation, and veteran suicide fatality review training.

In addition, a technology platform with Unite Us was launched in January 2021 to facilitate the coordination of resources and access for veterans and their families. Over 9,000 service referrals have been sent from Unite Us to DMH's VPAN teams and CBOs peer teams resulting in over 5,700 individuals served.

DMH's existing contract with SCG expires on June 30, 2023. Board approval of this contract extension will allow DMH to continue and expand the County's efforts to connect veterans and their families to essential resources as SCG has proven to be a valuable partner in VPAN's success in Los Angeles County.

The attached amendment format (Attachment I) has been approved as to form by County Counsel.

In accordance with Board Policy No. 5.100 (Sole Source Contracts and Amendments), DMH notified your Board on December 15, 2022 (Attachment II) of its intent to extend the term of the existing contract with SCG to continue the VPAN program as it is more cost-effective to continue partnership with SCG on a sole source basis. The required Sole Source Checklist (Attachment III) identifying and justifying the need for a sole source has been approved by CEO.

As mandated by your Board, the performance of the Contractor is evaluated by DMH on an annual basis to ensure the Contractor's compliance with all contract terms and performance standards.

IMPACT ON CURRENT SERVICES OR PROJECTS

Board approval will continue the partnership with SCG to accomplish the County's efforts to connect veterans and their families to essential VPAN resources through its continued collaboration with DMH and CBOs.

Respectfully submitted,

LISA H. WONG, Psy.D.
Director

LHW:CDD:KN
SK:RLR:sc

Attachments

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

AGREEMENT NO. MH440001

AMENDMENT NO. 5

THIS AMENDMENT is made and entered into this 1st day of July, 2023, by and between the COUNTY OF LOS ANGELES (hereafter "County") and Southern California Grantmakers (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled "Department of Mental Health Veteran Peer Access Networks Contract," dated July 1, 2020, and further identified as County Contract No. MH440001, and any amendments thereto (hereafter collectively "Contract"); and

WHEREAS, on June 6, 2023, the County Board of Supervisors delegated authority to the Director of Mental Health, or designee, to execute amendments to extend the Contract on a sole source basis for three Fiscal Years (FYs), effective July 1, 2023 through June 30, 2024, with two automatic one-year extensions through June 30, 2026, and make other designated changes; 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, for FYs 2023-26, County and Contractor intent to amend Contract to revise the Fee Schedule (Exhibit B) to update funding allocations; and

WHEREAS, for FYs 2023-26, as a result of the updated funding allocations, the Total Contract Amount (TCA) will increase; and

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

NOW, THEREFORE, County and Contractor agree as follows:

1. This Amendment is hereby incorporated into the original Contract, and all its terms and conditions, including capitalized terms defined therein, shall give full force and effect as is fully set forth herein.
2. This amendment is effective upon execution.
3. For FYs 2023-26, Contractor shall be paid a TCA not to exceed SEVENTEEN MILLION, THREE HUNDRED FIFTY-EIGHT THOUSAND DOLLARS ($17,358,000) over the terms of the Contract as defined in Exhibit B - 5 Fee Schedule.
4. Fee Schedule (Exhibit B) - 3 is deleted in its entirety and replaced with Fee Schedule (Exhibit B) – 5 attached hereto and incorporated by reference. All references in Contract to Fee Schedule (Exhibit B) - 3 will be deemed amended to state “Fee Schedule (Exhibit B) – 5.”
5. 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 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_____
LISA H. WONG, Psy.D.
Director County of Los Angeles
Department of Mental Health

Southern California Grantmakers
CONTRACTOR

By_____

Name Christine Essel

Title President/CEO
(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL

By: Margaret Ambrose
Principal Deputy County Counsel

AGREEMENT NO. MH440001

EXHIBIT B - 5

FISCAL INTERMEDIARY SERVICES FOR VETERAN PEER ACCESS NETWORK CONTRACT

FEE SCHEDULE

1. TOTAL CONTRACT AMOUNT

The Los Angeles County Department of Mental Health (DMH) will pay to Southern California Grantmakers (SCG) a maximum of **$17,358,000** for services rendered during the three Fiscal Year (FY) Term of the Contract, as shown in Table 1.

2. PAYMENT SCHEDULE

For services rendered in accordance with Exhibit A (Statement of Work (SOW), County will pay Contractor the annual amounts as detailed in Table 1: ANNUAL MAXIMUM EXPENDITURE PER FISCAL YEAR.

Payment to SCG is based on original invoices, submitted monthly in arrears by Contractor. Monthly invoices shall include separate details for administrative and program costs respectively. No payment is made for services delivered beyond those services indicated in Exhibit A (SOW) without the prior approval of the DMH Lead Manager. The DMH designated staff will review the invoices and supporting documentation to ensure that services rendered are in substantial compliance with the requirements described in Exhibit A (SOW).

Table 1: ANNUAL MAXIMUM EXPENDITURE PER FISCAL YEAR

Table 1				
CATEGORY	**FY 2023-24**	**FY 2024-25**	**FY 2025-26**	**Allocation for three FYs**
1. CBO Services	$4,625,000	$4,625,000	$4,625,000	$13,875,000
2. LAVC	$64,200	$64,200	$64,200	$192,600
3. VPAN Technology Platform	$152,500	$152,500	$152,500	457,500
4. Training	$70,000	$70,000	$70,000	210,000
5. VPAN Space	$137,545	$137,545	$137,545	$412,635
Development/Administrative 15% Indirect Costs • Overhead • Salary (i.e. benefits) • Services and Supplies	$736,755	$736,755	$736,755	$2,210,265
Total Contract Amount:	**$5,786,000**	**$5,786,000**	**$5,786,000**	**$17,358,000**

***Indirect Administrative/Overhead costs may not exceed 15% of the total allocation per fiscal year as indicated in Table 1 - ANNUAL MAXIMUM EXPENDITURE PER FISCAL YEAR.

3. PAYMENT PROCEDURES

SCG will submit monthly invoices (Attachment I) for actual cost incurred for services provided under Exhibit A (SOW). SCG must submit supporting documentation and receipts, if applicable, for the confirmation and verification of services and invoice approval. Invoices must be specific as to the type of services being delivered.
SCG will submit the monthly invoices to DMH by the 30th calendar day of the month following the month of the completed service.

Upon receipt and approval of original invoices from SCG, DMH will make payment within 60 days of the date the invoice was approved for payment. If any portion of the invoice is disputed by DMH, DMH will reimburse SCG for the undisputed services contained on the invoice and work diligently with SCG to resolve the disputed portion of the claim in a timely manner.

DMH shall make reimbursements payable to SCG. DMH shall send payments to:

Name of Agency: Southern California Grantmakers

Address of Agency: 1000 N. Alameda Street, Suite 230

City, State, Zip: Los Angeles, CA 90012

4. DESIGNATED DMH CONTACT PERSON

All questions and correspondence should be directed to:

Anh Tran, LCSW, DMH Lead Manager:
County of Los Angeles – Department of Mental Health
Countywide Engagement Division
1816 S. Figueroa St, 6th Floor
Los Angeles, CA 90015
Atran@dmh.lacounty.gov

All invoices should be submitted electronically to:

sayrapetyan@dmh.lacounty.gov,
Attention: Sona Ayrapetyan, VPAN Health Program Analyst II

Date Submitted:
Invoice Number:

To: **Los Angeles County Department of Mental Health**
c/o Sona Ayrapetyan; Sayrapetyan@dmh.lacounty.gov,

Submitted By: **Southern California Grantmakers**
1000 N. Alameda Street, Suite 230
Los Angeles, CA 90012

Description	Cost
TOTAL	**$**

Name & Title SCG Staff

Signature

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Interim Director

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

Connie D. Draxler, M.P.A.
Acting Chief Deputy Director

December 15, 2022

TO: Supervisor Janice Hahn, Chair
Supervisor Hilda L. Solis
Supervisor Holly J. Mitchell
Supervisor Lindsey P. Horvath
Supervisor Kathryn Barger

FROM: Lisa H. Wong, Psy.D.
Interim Director
Connie D. Draxler for

SUBJECT: **NOTICE OF INTENT TO EXTEND THE EXISTING CONTRACT WITH SOUTHERN CALIFORNIA GRANTMAKERS FOR THE VETERAN PEER ACCESS NETWORK PROGRAM ON A SOLE SOURCE BASIS**

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 contract with Southern California Grantmakers (SCG) to continue the Veteran Peer Access Network (VPAN) program.

DMH will request that your Board approve an amendment to extend the term of the contract with SCG on a sole source basis for three fiscal years, effective July 1, 2023 through June 30, 2024, with two automatic one-year extensions through June 30, 2026. The amount per each fiscal year is $5,786,000, for a total of $17,358,000 funded by State Mental Health Services Act revenue.

JUSTIFICATION

On November 19, 2019, your Board approved a Board motion titled "Countywide Mental Health Services for Veterans." The Board motion instructed DMH under Directive #3 to execute an agreement with SCG to create a public-private partnership focused on implementing services to veterans using a peer-to-peer model to form VPAN in Los Angeles County.

Through an open and competitive process, SCG released a Request for Proposals in the Fall of 2020 and identified Community-Based Organizations (CBOs) to develop a Veteran Service Team in each of the five Supervisorial Districts to provide peer support and resource navigation to veterans.

The Board motion directed SCG to train and certify 100 veteran peers. As some peers came with the training already completed, SCG has trained and certified 62 veteran peers to date. SCG also collaborated with DMH to provide additional certified trainings as follows: trauma-informed services, peer navigator, peer boundaries and ethics, risk management and mitigation, and veteran suicide fatality review training.

In addition, SCG identified and secured a technology platform with Unite Us that launched in January 2021 to facilitate the coordination of resources and access for veterans and their families. Over 9,000 service referrals have been sent from Unite Us to DMH's VPAN teams and CBOs peer teams resulting in over 5,700 individuals served.

Within each of the five Supervisorial Districts, SCG has identified and secured space to serve as Rally Points for veterans and their families to provide resources and outreach services in collaboration with DMH. The Rally Points are community access points for veterans and military family members to obtain resources for the following VPAN programs: mental health, housing, workforce development/employment, healthcare, education, legal services, and numerous other reintegration resources for veterans and military families.

SCG has proven to be a valuable partner in VPAN's successes in Los Angeles County. As DMH's existing contract with SCG expires on June 30, 2023, DMH will request approval to extend the contract term as it is more cost-effective to continue its partnership with SCG on a sole source basis.

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 when departments do not have delegated authority to extend the term of the contract beyond its original term. 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 amendment with SCG to continue the VPAN program in Los Angeles County.

If you have any questions, or require additional information, please contact me by email at LWong@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.

LHW:CDD:SK
RLR:SC:atm

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

Attachment III

SOLE SOURCE CHECKLIST

Department Name: Department of Health Services

☐ New Sole Source Contract

☑ Sole Source Amendment to Existing Contract
Date Existing Contract First Approved: June 24, 2008

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

Date

BOARD LETTER/MEMO
CLUSTER FACT SHEET

DRAFT

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/24/2023
BOARD MEETING DATE	6/6/2023
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
DEPARTMENT(S)	Public Health
SUBJECT	Authorization to accept and sign a forthcoming agreement and future agreements and/or amendments from the California Department of Public Health (CDPH) to support the Youth Suicide Prevention Reporting and Crisis Response Pilot Program
PROGRAM	Office of Violence Prevention (OVP)
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No
SOLE SOURCE CONTRACT	☐ Yes ☒ No
	If Yes, please explain why:
DEADLINES/ TIME CONSTRAINTS	Agreement (award) from CDPH must be executed before fiscal year end of 22-23.
COST & FUNDING	Total cost: $5,185,185 (estimated amount) / Funding source: California Department of Public Health
	TERMS (if applicable): Effective upon execution through June 30, 2025.
	Explanation:
PURPOSE OF REQUEST	Delegate authority to acceptance of a forthcoming CDPH Injury and Violence Prevention Branch agreement to allow Public Health to participate in the Youth Suicide Prevention Reporting and Crisis Response Pilot Program.
BACKGROUND (include internal/external issues that may exist including any related motions)	CDPH Injury and Violence Prevention Branch established an Office of Suicide Prevention (OSP) in 2021 through Assembly Bill (AB) 2112 to elevate suicide as a public health concern in California. The mission of the OSP is to address the root causes of suicide and self-harm injuries through strong partnerships, dissemination of data, and promotion of evidence-informed public health prevention strategies that create safe and healthy communities across California. In addition, the OSP was allocated funding in the Governor's 2022-2023 Budget to implement the Youth Suicide Reporting and Crisis Response Pilot Program (Program). The Program's funded Pilot Projects (carried out at the local level) will develop and test models for making youth suicide and attempted suicide reportable events that initiate rapid and comprehensive responding (i.e., crisis response) to reported youth suicide deaths and attempted suicides.
EQUITY INDEX OR LENS WAS UTILIZED	☐ Yes ☒ No If Yes, please explain how: N/A
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	☒ Yes ☐ No If Yes, please state which one(s) and explain how: This agreement will support Board Priority 1, Child Protection, which will allow OVP to develop and test models for rapid

	reporting and comprehensive crisis response at the local level related to youth suicide and suicide attempts in youth 25 and under.
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: Joshua Bobrowsky, Public Health Director Government Affairs, (213) 288-7871 jbobrowsky@ph.lacounty.gov Andrea Welsing, MPH Director, Office of Violence Prevention (626) 293-2998 / (213) 550-6407 cell, awelsing@ph.lacounty.gov Craig L. Kirkwood, Jr., Deputy County Counsel, (213) 974-1751 CKirkwood@counsel.lacounty.gov

COUNTY OF LOS ANGELES
Public Health

DRAFT

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

MEGAN McCLAIRE, M.S.P.H.
Chief Deputy Director

313 North Figueroa Street, Room 806
Los Angeles, California 90012
TEL (213) 240-8117 • FAX (213) 975-1273

June 6, 2023

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:

AUTHORIZATION TO ACCEPT AND SIGN A FORTHCOMING AGREEMENT AND FUTURE AGREEMENTS AND/OR AMENDMENTS FROM THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH TO SUPPORT THE YOUTH SUICIDE PREVENTION REPORTING AND CRISIS RESPONSE PILOT PROGRAM (ALL SUPERVISORIAL DISTRICT) (3 VOTES)

SUBJECT

Provide authorization to accept and sign a forthcoming agreement and future agreements and/or amendments from the California Department of Public Health to support the Youth Suicide Prevention Reporting and Crisis Response Pilot Program.

IT IS RECOMMENDED THAT THE BOARD:

1. Delegate authority to the Director of the Department of Public Health (Public Health), or designee, to accept and sign a forthcoming agreement from the California Department of Public Health (CDPH), to support the Youth Suicide Prevention Reporting and Crisis Response Pilot Program (Pilot Program), effective upon execution, through June 30, 2025, in an amount estimated not to exceed $5,185,185, subject to review and approval by County Counsel, and notification to your Board and the Chief Executive Office (CEO).

2. Delegate authority to the Director of Public Health, or designee, to accept future agreement(s) and/or amendment(s) that are consistent with the requirements of the forthcoming agreement, that extend the funding periods, at amounts to be determined by CDPH; reflect revisions to the agreement's terms and conditions to include, but not be limited to, the rollover of unspent funds, redirection of funds, and/or increase or decreases in funding, subject to review and approval by County Counsel and notification to your Board and the CEO.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Approval of Recommendation 1 will allow Public Health to accept a forthcoming CDPH Injury and Violence Prevention Branch agreement to participate in the Youth Suicide Prevention Reporting and Crisis Response Pilot Program which aims to develop and test models for rapid reporting and comprehensive crisis response at the local level related to youth suicide and suicide attempts in youth 25 and under.

The funding will allow Public Health to: 1) participate in training and technical assistance activities focused on strengthening of rapid reporting and crisis response; 2) participate in evaluation activities that focus on the overarching/statewide evaluation of the Pilot Program; 3) participate in existing or new advisory and/or coalition efforts to support prevention of youth suicide at the local level; 4) provide funding via memoranda of understanding to County departments that support/expand/sustain suicide prevention planning and coordination; and 5) provide funding to local Community-Based Organizations and/or other relevant partners to engage in planning/coordination and/or implementation and/or evaluation of activities.

Approval of Recommendation 2 will allow Public Health to accept future agreements and/or amendments that extend the funding periods at amounts determined by CDPH and reflect revisions to the agreement's terms and conditions to include but not be limited to the rollover of unspent funds, redirection of funds, and/or increase or decrease in funding. This authority is being requested to enhance Public Health's efforts to expeditiously maximize grant revenue, consistent with Board Policy 4.070: Full Utilization of Grant Funds.

Implementation of Strategic Plan Goals

The recommended actions support Strategy II.2, Support the Wellness of Our Communities; Objective II.2.1, Reduce Violence in Communities, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

Public Health will accept a forthcoming award from the CDPH effective upon execution, through June 30, 2025, in the estimated annual amount of $5,185,185. Final funding amounts are subject to CDPH approval. Funds will support expenditures associated

with personnel, operating expenses, and contractual costs.

Funding will be included in Public Health's Final Adopted Budget for fiscal year (FY) 2022-23, as well as in future FYs, as necessary.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On March 1, 2023, CDPH issued an invitation to participate in the Youth Suicide Prevention Crisis Response Pilot Program.

Public Health accepted the invitation and emailed our acceptance to participate in the Pilot Program by the deadline of March 8, 2023.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommended actions will allow Public Health to accept funds from CDPH and participate in the Pilot Program that aims to rapidly report and provide comprehensive crisis response at the local level related to youth suicide and suicide attempts.

Respectfully submitted,

Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

BF:mk
#06915

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

BOARD LETTER/MEMO
CLUSTER FACT SHEET

DRAFT

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/24/2023	
BOARD MEETING DATE	6/6/2023	
SUPERVISORIAL DISTRICT AFFECTED	☐ All ☒ 1st ☒ 2nd ☐ 3rd ☐ 4th ☐ 5th	
DEPARTMENT(S)	Public Health	
SUBJECT	Approval to execute four contracts for Trauma Prevention Initiative (TPI): Hospital Violence Intervention Program (HVIP) services.	
PROGRAM	Office of Violence Prevention (OVP)	
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No	
SOLE SOURCE CONTRACT	☐ Yes ☒ No	
	If Yes, please explain why:	
DEADLINES/ TIME CONSTRAINTS	The current contracts are set to expire on June 30, 2023.	
COST & FUNDING	Total cost: $3,150,000	Funding source: Measure B, Proposition AB109 funds, and net County cost
	TERMS (if applicable): 7/1/2023 through 6/30/2026	
	Explanation:	
PURPOSE OF REQUEST	Public Health is requesting approval to execute four contracts for the provision of TPI: HVIP services in Los Angeles County at designated Level I or Level II trauma hospital sites that serves specific TPI communities. The identified trauma hospital sites are: 1) St. Francis Medical Center, 2) Harbor UCLA Medical Center, 3) LAC+USC Medical Center and 4) Pomona Valley Hospital. Public Health is also requesting delegated authority to execute future amendments and change notices as appropriate, to reflect funding adjustments, and non-material and/or ministerial revisions; suspend or terminate and/or accept a voluntary contract termination notice from contractors; as well as authority to extend or adjust the term.	
BACKGROUND (include internal/external issues that may exist including any related motions)	No issue expected. In 2015, Public Health began implementing TPI to reduce the disproportionate impact of violence and trauma among Black and Latinx communities of South Los Angeles. Recognizing the need to invest in prevention, and to reduce the burden on the County's trauma hospital system, the County Board of Supervisors and Emergency Medical Services Agency allocated ongoing Measure B funding to Public Health to implement TPI. Measure B dollars are collected through a county parcel tax and provide funding for the County's trauma hospital system. The goal of TPI is to reduce trauma visits and deaths due to assault, and reduce serious and violent crimes throughout LAC.	

	OVP has funded HVIP services since 2017 at St. Francis Medical Center via a contract with a Community-Based Organization, Southern California Crossroads. In 2021, the County Board of Supervisors approved funding to expand TPI to additional communities, including East LA, Puente Valley, Pomona, Hawaiian Gardens/Norwalk, and Antelope Valley. OVP has identified an additional 3 hospital sites to prioritize for HVIP funding as part of the expansion: Harbor UCLA Medical Center, LAC+USC Medical Center, and Pomona Valley Hospital. OVP began funding HVIP services in these new hospital sites beginning in 2022. Each identified hospital is a designated Level I or Level II trauma center that serves specific TPI communities.
EQUITY INDEX OR LENS WAS UTILIZED	☒ Yes ☐ No If Yes, please explain how: OVP conducted a criteria-based data assessment to identify communities most impacted by violence for prioritizing TPI communities and the hospitals that serve them. TPI invests in community-driven public safety by investing in community-based organizations that hire local community members with lived experience.
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	☒ Yes ☐ No If Yes, please state which one(s) and explain how: HVIP supports Board Priority 3, Care First Jails Last, which includes OVP's public health approach to preventing violence and promoting healing, including TPI.
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: Kelly Fischer, MA Deputy Director, Office of Violence Prevention (626) 293-2918 / (323) 236-6858 cell kfischer@ph.lacounty.gov Joshua Bobrowsky, Public Health Director Government Affairs, (213) 288-7871 jbobrowsky@ph.lacounty.gov Craig L. Kirkwood, Jr., Deputy County Counsel, (213) 974-1751, CKirkwood@counsel.lacounty.gov

COUNTY OF LOS ANGELES
Public Health

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

MEGAN McCLAIRE, M.S.P.H.
Chief Deputy Director

313 North Figueroa Street, Room 806
Los Angeles, California 90012
TEL (213) 288-8117 • FAX (213) 975-1273
www.publichealth.lacounty.gov

DRAFT

June 6, 2023

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 EXECUTE FOUR CONTRACTS FOR TRAUMA PREVENTION INITIATIVE: HOSPITAL VIOLENCE INTERVENTION PROGRAM SERVICES (SUPERVISORIAL DISTRICTS 1 AND 2) (3 VOTES)

SUBJECT

Request approval to execute four contracts for the provision of Trauma Prevention Initiative: Hospital Violence Intervention Program services in Los Angeles County, effective for the term of July 1, 2023, through June 30, 2026; with delegated authority to execute future amendments and change notices as appropriate, to reflect funding adjustments, and non-material and/or ministerial revisions; suspend or terminate and/or accept a voluntary contract termination notice from contractors; as well as authority to extend or adjust the term through December 31, 2028.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and instruct the Director of the Department of Public Health (Public Health), or designee, to execute four new contracts, substantially similar to Exhibit I, with Southern California Crossroads and Soledad Enrichment Action, Inc., selected under a competitive solicitation process for the provision of Trauma Prevention Initiative (TPI): Hospital Violence Intervention Program (HVIP) services, effective July 1, 2023, through June 30, 2026, for an annual maximum obligation of $1,050,000, as detailed in

Attachment A, with a total maximum obligation of $3,150,000, 100 percent offset by Measure B, Proposition AB109 funds, and net County cost.

2. Delegate authority to the Director of Public Health, or designee, to execute future amendments to the contracts that extend the term for up to two additional one-year periods through June 30, 2028, at amounts to be determined by the Director of Public Health; allow a no-cost adjustment to the term through December 31, 2028; allow the rollover of unspent contract funds; and/or provide an increase or decrease in funding up to 10 percent above or below the term's annual base maximum obligation, effective upon amendment execution, or at the beginning of the applicable contract term, and make corresponding service adjustments, as necessary, subject to review and approval by County Counsel, and notification to your Board and the Chief Executive Office (CEO).

3. Delegate authority to the Director of Public Health, or her designee, to execute change notices to the contracts that authorize modifications to or within budget categories, and corresponding service adjustments, as necessary; changes to hours of operation and/or service locations; and/or corrections of errors in the contract's terms and conditions.

4. Delegate authority to the Director of DPH, or designee, to immediately suspend any contract upon issuing a written notice to contractors who fail to fully comply with program requirements; to terminate contracts for convenience by providing a 30-calendar day advance written notice to contractors; and to accept voluntary contract termination notices from contractors.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Public Health's Office of Violence Prevention (OVP) implements the TPI, which is a comprehensive, place-based violence prevention and intervention strategy. TPI includes several key strategies, including community engagement, capacity building for community stakeholders and grassroots organizations, and peer violence intervention strategies, including Street Outreach and Community Violence Intervention Services, and HVIP services. TPI began in unincorporated communities of South Los Angeles, including Westmont West Athens, Willowbrook, Florence Firestone, and unincorporated Compton.

HVIP services is an intervention used throughout the nation to reduce community violence and decrease repeat visits to trauma centers for violence-related injuries. The overall objective of HVIP is to provide an intervention for victims of violence at a critical point – when they present at the hospital site with assault-related injuries. Contractor will provide trained case managers for case management services which includes, but will not be limited to engaging and developing rapport with patients at bedside in the trauma center, and linking patients to community resources and services, based on individualized assessments. Case managers will provide the victims with support and assistance in the trauma center and during the critical months following the patient's discharge. An example of case management services is providing access to resources such as mental health services, tattoo removal, general education development programs, employment, court advocacy, substance use assistance, and housing. The strategy is designed to quickly stem the flow

of violence in the community while building a network of prevention and intervention support for the victim.

Approval of Recommendation 1 will enable Public Health to execute four contracts with qualified agencies, effective July 1, 2023, through June 30, 2026, for the provision of TPI: HVIP services in Los Angeles County (LAC) at designated Level I or Level II trauma hospital sites that serve specific TPI communities. The identified trauma hospital sites are: 1) St. Francis Medical Center, 2) Harbor UCLA Medical Center, 3) LAC+USC Medical Center and 4) Pomona Valley Hospital.

Approval of Recommendation 2 will allow Public Health to execute amendments to extend the term of the contracts for two additional one-year periods through June 30, 2028, at amounts to be determined by the Director of Public Health, contingent upon the availability of funding and contractor performance; rollover unspent funds; provide an increase or decrease in funding up to 10 percent above or below the annual base maximum obligation, effective upon amendment execution, or at the beginning of the applicable contract term, and/or make corresponding service adjustments, as necessary. This recommended action will enable Public Health to amend the contract to adjust the term for a period of up to six (6) months beyond the expiration date. Such amendments will only be executed if and when there is an unanticipated extension of the term of the applicable grant funding to allow additional time to complete services and utilize grant funding. This authority is being requested to enhance DPH's efforts to expeditiously maximize revenue, consistent with Board Policy 4.070: Full Utilization of Grant funds.

Approval of Recommendation 3 will allow Public Health to execute change notices to the contracts that authorize modifications to or within budget categories, and corresponding service adjustments, as necessary; changes to hours of operation and/or service locations; and/or corrections of errors in the contract's terms and conditions.

Approval of Recommendation 4 will allow Public Health to immediately suspend contracts with contractors who fail to perform and/or fully comply with program requirements, to terminate contracts for convenience by providing 30-calendar days' advance written termination notice to contractors, and to accept notices from contractors who voluntarily request to terminate their contract(s).

Implementation of Strategic Plan Goals

The recommended actions support Strategy II.2, Support the Wellness of Our Communities; Objective II.2.1, Reduce Violence in Communities, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

The total County maximum obligation for four recommended contracts is $3,150,000; for the term of July 1, 2023, through June 30, 2026; 100 percent offset by Measure B, Proposition AB109 funds, and net County cost.

Funding for these contracts is included in Public Health's Recommended Budget for fiscal year (FY) 2023-24 and will be included in future FYs, as necessary.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

In 2015, Public Health began implementing TPI to reduce the disproportionate impact of violence and trauma among Black and Latinx communities of South Los Angeles. Recognizing the need to invest in prevention, and to reduce the burden on the County's trauma hospital system, the County Board of Supervisors and Emergency Medical Services Agency allocated ongoing Measure B funding to Public Health to implement TPI. Measure B dollars are collected through a county parcel tax and provides funding for the County's trauma hospital system.

The goal of TPI is to reduce trauma visits and deaths due to assault, and reduce serious and violent crime throughout LAC, with an initial focus on reducing the high rate of violence in South Los Angeles.

On May 2, 2017, your Board approved the annual allocation of Measure B funds to support TPI in selected priority communities that have a high level of violence. In July of 2021, your Board approved and instructed the CEO to allocate additional funding from Measure B Special Revenue Fund to support expansion of TPI services. In November of 2021, your Board approved one-time Measure B funds for additional TPI expansion. In October of 2022, during supplemental budget, the CEO identified ongoing funding to support TPI Expansion using Measure B, AB109 funds, and net County cost.

As required under revised Board Policy 5.120, your Board was notified on May xx, 2023 of DPH's request to increase or decrease funding up to 50 percent above or below each term's annual base maximum obligation.

Exhibit I is the contract template approved by County Counsel.

Attachment A is the Trauma Site Annual Total Amount Allocation that indicates the list of recommended contractors, as well as the annual maximum obligation for each trauma site. Attachment B is the contracting opportunity announcement posted on the County website. Attachment C is the Community Business Enterprise Information Summary for the recommended contractors.

CONTRACTING PROCESS

On February 1, 2023, Public Health released Request for Applications (RFA #2023-001) to solicit applications from qualified community-based organizations (CBO) to provide TPI: HVIP services in South Los Angeles. The contracting opportunity announcement was posted on the County of Los Angeles website (Attachment B) as well as Public Health's website and sent by electronic mail to six prospective agencies listed in Public Health's internal list of vendors for HVIP services.

Public Health received four applications by the deadline of March 1, 2023, from two agencies. The four applications were reviewed by a committee that consisted of representatives within Public Health and evaluated in accordance with the Evaluation Methodology for Proposals – Policy 5.054 approved by the Los Angeles County Board of Supervisors on March 31, 2009, and the RFA solicitation process. As a result, SCC and SEA's applications were deemed responsive applicants.

On May 1, 2023, notifications of the RFA results were sent to the selected Applicants.

Community Business Enterprise Program information as reported by the recommended Applicants are identified in Attachment C. Applicants were selected without regard to gender, race, creed, color, or national origin for award of contracts.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommended actions will allow Public Health to continue and expand the implementation of TPI: HVIP services to reduce community violence and decrease repeat visits to trauma hospital sites for violence-related injuries.

Respectfully submitted,

Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

BF:sp
#06852

Enclosures

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

d Enrichment Action, Inc.	LAC+USC Medical Center	1200 N. State Street, Los Angeles, CA 90033	$250,000
rn California Crossroad	Saint Francis Medical Center	3630 E. Imperial Hwy, Lynwood, CA 90262	$400,000
rn California Crossroad	Harbor UCLA Medical Center	1000 W. Carson St, Torrance, CA 90502	$250,000
rn California Crossroad	Pomona Valley Hospital	1798 N. Garey Ave, Pomona, CA 91767	$150,000
		TOTAL RECOMMENDED AWARD:	**$1,050,000**

CONTRACTING OPPORTUNITY*

BID NUMBER: 2023-001
BID TITLE: Request for Applications for Trauma Prevention Initiative: Hospital Violence Intervention Program

RELEASE/OPEN DATE: February 01, 2023
CLOSING/DUE DATE: March 01, 2023

***Visit websites indicated below for additional information and updates.**

The County of Los Angeles Department of Public Health (Public Health) is pleased to announce the release of a Request for Applications (RFA) to solicit applications from interested qualified community-based organizations to provide Hospital Violence Intervention Program (HVIP) services in select hospital sites in Los Angeles County.

HVIP is an evidenced-based model that is implemented by community-based organizations, in partnership with selected trauma hospitals, to provide peer outreach and case management to victims of violence in the hospital setting.

Minimum Mandatory Requirements

Interested agencies/vendors that meet the Minimum Mandatory Requirements are invited to respond to this RFA by submitting an application by the closing/due date. Please click the Public Health link below to review the Minimum Mandatory Requirements identified in Section 1.4 of the RFA.

Next Steps for Interested Agencies/Vendors

- ✓ Register at http://camisvr.co.la.ca.us/webven, if not already registered.
- ✓ Review the RFA solicitation document for additional information, requirements, submission information, and updates at:

  - http://camisvr.co.la.ca.us/lacobids/BidLookUp/BidOpenStart.asp
  - http://publichealth.lacounty.gov/cg/index.htm

TRAUMA PREVENTION INITIATIVE: HOSPITAL VIOLENCE INTERVENTION COMMUNITY BUSINESS ENTERPRISE (CBE) INFORMATION SUMMARY

Firm/Organization Information	Soledad Enrichment Action, Inc.	Southern California Crossroads
Total Number of Employees in Firm	138	81
Total Number of Employees (including owners)	138	81
Owners/Partner/Associate Partners		
Black/African American	28	
Hispanic/Latino	99	
Asian or Pacific Islander	2	
American Indian	6	
Filipino	1	
White	2	
Total	138	
Female (should be included in counts above and also reported here separately).	79	
Percentage of how ownership of the firm is distributed		
Black/African American		
Hispanic/Latin American		
Asian or Pacific Islander		
American Indian		
Filipino		
White		
Female (should be included in counts above and also reported here separately).		
Current Certification as Minority, Women, Disadvantaged, and Disabled Veteran Business		
Minority		
Women		
Disadvantaged		
Disabled Veteran		
LGBTQQ		

Figures are based on information provided by Vendors in their Applications.

EXHIBIT I

Contract No. PH-00XXXX

CONTRACT

BY AND BETWEEN

COUNTY OF LOS ANGELES

DEPARTMENT OF PUBLIC HEALTH

AND

CONTRACTOR NAME

FOR

TRAUMA PREVENTION INITIATIVE: HOSPITAL VIOLENCE INTERVENTION PROGRAM SERVICES

DEPARTMENT OF PUBLIC HEALTH
TRAUMA PREVENTION INITIATIVE:
HOSPITAL VIOLENCE INTERVENTION PROGRAM SERVICES CONTRACT

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CONTRACT BODY (CB)

UNIQUE TERMS AND CONDITIONS

ADDITIONAL PROVISIONS (AP)

STANDARD EXHIBITS

UNIQUE EXHIBITS

Contract No. PH-_____

DEPARTMENT OF PUBLIC HEALTH
TRAUMA PREVENTION INITIATIVE:
HOSPITAL VIOLENCE INTERVENTION PROGRAM
SERVICES CONTRACT

THIS CONTRACT "Contract" is made and entered into on _____,

by and between COUNTY OF LOS ANGELES (hereafter "County")

and _____ (hereafter "Contractor").

WHEREAS, California Health and Safety Code Section 101025 places upon County's Board of Supervisors ("Board"), the duty to preserve and protect the public's health; and

WHEREAS, on (enter date of DA Memo or authorization document), the Board delegated authority for the County's Director of the Department of Public Health (Public Health), or duly authorized designee (hereafter jointly referred to as "Director") to execute contracts for (give title of services) to preserve and protect the public's health; and

WHEREAS, the County is authorized by Government Code Section 31000 to contract for these services; and

WHEREAS, Contractor warrants that it possesses the competence, expertise, and personnel necessary to provide services consistent with the requirements of this Agreement and consistent with the professional standard of care for these services; and

WHEREAS, Contractor is willing and able to provide the services described herein, in consideration of the payments under this Contract and under the terms and conditions hereafter set forth; and

WHEREAS, it is the intent of the parties hereto to enter into this Contract to provide Trauma Prevention Initiative (TPI):Hospital Violence Intervention Program (HVIP) services for compensation, as set forth herein; and

WHEREAS, Contractor is willing and able to provide the services described herein, in consideration of the payments under this Contract and under the terms and conditions hereafter set forth; and

NOW THEREFORE, in consideration of the mutual covenants contained herein, and for good and valuable consideration, the parties agree to the following:

1. APPLICABLE DOCUMENTS:

Exhibits A, B, C, D, E, F, G, and H are attached to and form a part of this Contract. In the event of any conflict or inconsistency in the definition or interpretation of any word, responsibility, budget, or the contents or description of any task, deliverable, goods, service, or other work, or otherwise between the base Contract and the Exhibits, or between Exhibits, such conflict or inconsistency shall be resolved by giving precedence first to the terms and conditions of the Contract and then to the Exhibits as listed below:

Standard Exhibits

Exhibit A – Statement of Work
Exhibit B – Scope of Work
Exhibit C – Budget(s)
Exhibit D – Contractor's EEO Certification
Exhibit E – Contractor Acknowledgement and Confidentiality Agreement
Exhibit F – Health Insurance Portability and Accountability Act (HIPAA)
Exhibit G – Safely Surrendered Baby Law

Unique Exhibits

Exhibit H – Charitable Contributions Certification

2. DEFINITIONS:

A. Contract: This agreement executed between County and Contractor. It sets forth the terms and conditions for the issuance and performance of all tasks, deliverables, services and other work including the Statement of Work, Exhibit A and the Scope of Work, Exhibit B.

B. Contractor: The sole proprietor, partnership, corporation or other person or entity that has entered into this Contract with the County.

3. DESCRIPTION OF SERVICES:

A. Contractor shall provide services in the manner described in Exhibit A (Statement of Work) and Exhibit B (Scopes of Work), attached hereto and incorporated herein by reference.

B. Contractor acknowledges that the quality of service(s) provided under this Contract shall be at least equivalent to that which Contractor provides to all other clients it serves.

C. If Contractor provides any tasks, deliverables, goods, services, or other work, other than as specified in this Contract, the same shall be deemed to

be a gratuitous effort on the part of the Contractor, and the Contractor shall have no claim whatsoever against the County.

4. TERM OF CONTRACT:

The term of this Contract shall be effective July 1, 2023, and shall continue in full force and effect through June 30, 2026, unless sooner terminated or extended, in whole or in part, as provided in this Contract.

The County will have the sole option to extend this Contract term up to two additional one-year periods for a maximum total Contract term of five years. Each such extension option may be exercised at the sole discretion of the Director through written notification from the Director to the Contractor prior to the end of the Contract term.

Contractor must notify (Program Office) when this Contract is within six months from the expiration of the term as provided for hereinabove. Upon occurrence of this event, Contractor must send written notification to (Program Office) at the address herein provided under the NOTICES paragraph.

5. MAXIMUM OBLIGATION OF COUNTY:

A.1 For the period of July 1, 2023, through June 30, 2024, the maximum obligation of County for all services provided hereunder shall not exceed _____ ($_____), as set forth in Exhibit C-1, attached hereto and incorporated herein by reference.

A.2 For the period of July 1, 2024, through June 30, 2025, the maximum obligation of County for all services provided hereunder shall

not exceed _____ ($_____), as set forth in Exhibit C-2, attached hereto and incorporated herein by reference.

A.3 For the period of July 1, 2025, through June 30, 2026, the maximum obligation of County for all services provided hereunder shall not exceed _____ ($_____), as set forth in Exhibit C-3, attached hereto and incorporated herein by reference.

B. Contractor will not be entitled to payment or reimbursement for any tasks or services performed, nor for any incidental or administrative expenses whatsoever incurred in or incidental to performance hereunder, except as specified herein. Assumption or takeover of any of Contractor's duties, responsibilities, or obligations, or performance of same by person or entity other than Contractor, whether through assignment, subcontract, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason whatsoever, must not occur except with the County's express prior written approval.

C. Contractor must maintain a system of record keeping that will allow it to determine when it has incurred seventy-five percent (75%) of the total maximum obligation under this Contract. Upon occurrence of this event, Contractor must send written notification to the Department at the address herein provided under the NOTICES Paragraph.

D. No Payment for Services Provided Following Expiration/ Termination of Contract: Contractor will have no claim against County for payment of any money or reimbursement, of any kind whatsoever, for any

service provided by Contractor after the expiration or other termination of this Contract. Should Contractor receive any such payment it must immediately notify County and must immediately repay all such funds to County. Payment by County for services rendered after expiration/termination of this Contract will not constitute a waiver of County's right to recover such payment from Contractor. This provision will survive the expiration or other termination of this Contract.

6. INVOICES AND PAYMENT:

A. Contractor must invoice the County only for providing the tasks, deliverables, goods, services, and other work specified in Exhibit A and/or Exhibit B and in accordance with Exhibit C attached hereto and incorporated herein by reference.

B. Contractor shall invoice the County monthly in arrears. All invoices shall include a financial invoice and all required reports and/or data. All invoices shall clearly reflect all required information as specified on forms provided by the County regarding the services for which claims are to be made and any and all payments made to Contractor.

C. Invoices must be submitted to County within 30 calendar days after the close of each calendar month. County will make a reasonable effort to make payment within 30 days following receipt of a complete and correct monthly invoice and will make payment in accordance to the Budget(s) attached hereto and incorporated herein by reference.

D. Invoices must be submitted directly to the Division of Office of Violence Prevention at the address herein provided under Paragraph, NOTICES.

E. For each term, or portion thereof, that this Contract is in effect, Contractor shall provide an annual cost report within 30 calendar days following the close of the Contract period. Such cost report shall be prepared in accordance with generally accepted accounting principles and clearly reflect all required information as specified in instructions and forms provided by the County.

If this Contract is terminated prior to the close of the Contract period, the cost report shall be for that Contract period which ends on the termination date. The report shall be submitted within 30 calendar days after such termination date.

The primary objective of the annual cost report shall be to provide the County with actual expenditure data for the Contract period that shall serve as the basis for determining final amounts due to/from Contractor.

If the annual cost report is not delivered by Contractor to County within the specified time, Director may withhold all payments to Contractor under all service agreements between County and Contractor until such report is delivered to County and/or, at the Director's sole discretion, a final determination of amounts due to/from Contractor is determined on the basis of the last monthly invoice received.

Failure to provide the annual cost report may constitute a material breach of this Contract, in the sole discretion of the County, upon which the County may suspend or terminate this Contract.

F. Upon expiration or prior termination of this Contract, Contractor shall submit, within 30 calendar days, any outstanding and/or final invoice(s) for processing and payment. Contractor's failure to submit any outstanding and/or final invoice(s) within the specified period shall constitute Contractor's waiver to receive payment for any outstanding and/or final invoice(s).

G. Withholding Payment:

(1) Subject to the reporting and data requirements of this Contract and the Exhibit(s) attached hereto, Director may withhold any payment to Contractor if any report or data is not delivered by Contractor to County within the time limits of submission as set forth in this Contract, or if such report or data is incomplete in accordance with requirements set forth in this Contract. This withholding may be invoked for the current month and any succeeding month(s) for reports or data not delivered in a complete and correct form.

(2) Subject to the Record Retention and Audits provision of this Contract, Director may withhold any claim for payment by Contractor if Contractor has been given at least 30 calendar days' notice of deficiency(ies) in compliance with the terms of this Contract and has failed to correct such deficiency(ies). This withholding may be invoked for any month(s) for deficiency(ies) not corrected.

(3) Upon acceptance by County of all report(s) and data previously not accepted under this provision and/or upon correction of the

deficiency(ies) noted above, Director will reimburse all withheld payments on the next regular monthly claim for payment by Contractor.

(4) Subject to the provisions of this Contract and its Exhibit(s), if the services are not completed by Contractor within the specified time, Director may withhold all payments to Contractor under this Contract until proof of such service(s) is/are delivered to County.

(5) In addition to Sub-paragraphs (1) through (4) immediately above, Director may withhold payments due to Contractor for amounts due to County as determined by any cost report settlement, audit report, audit report settlement, or financial evaluation report, resulting from this or any current year's Contract(s) or any prior year's Contract(s) between the County and Contractor. The withheld payments will be used to pay all amounts due to the County. Any remaining withheld payment will be paid to the Contractor accordingly.

(6) Director may withhold any payment to Contractor if Contractor, in the judgment of the County, is in material breach of this Contract or has failed to fulfill its obligations under this Contract, until Contractor has cured said breaches and/or failures. Director will provide written notice of its intention to withhold payment specifying said breaches and/or failure to Contractor.

H. Fiscal Viability: Contractor must be able to carry the costs of its program without reimbursement under this Contract for at least 60 days at any point during the term of this Contract.

I. Local Small Business Enterprises – Prompt Payment Program

Certified Local Small Business Enterprises (LSBEs) will receive prompt payment for services they provide to County departments. Prompt payment is defined as 15 calendar days after receipt of an undisputed invoice.

7. FUNDING/SERVICES ADJUSTMENTS AND REALLOCATIONS:

A. Upon Director's specific written approval, as authorized by the County's Board of Supervisors, County may: 1) increase or decrease funding up to fifty percent (50%) above or below each term's annual base maximum obligation; 2) reallocate funds between budgets within this Contract where such funds can be more effectively used by Contractor up to fifty percent (50%) of the term's annual base maximum obligation; and 3) make modifications to or within budget categories within each budget, as reflected in Exhibit C and make corresponding service adjustments, as necessary. Such adjustments may be made based on the following: (a) if additional monies are available from federal, State, or County funding sources; (b) if a reduction of monies occurs from federal, State, or County funding sources; and/or (c) if County determines from reviewing Contractor's records of service delivery and invoices to County that an underutilization of funds provided under this Contract will occur over its term.

All funding adjustments and reallocation as allowed under this Paragraph may be effective upon amendment execution or at the beginning of the applicable contract term, to the extent allowed by the funding source and as authorized by the County's Board of Supervisors. Adjustments and reallocations of funds in excess of the aforementioned amount shall require separate approval

by County's Board of Supervisors. Any change to the County maximum obligation or reallocation of funds between budgets in this Contract shall be effectuated by an amendment to this Contract pursuant to the ALTERATION OF TERMS/AMENDMENTS Paragraph of this Contract. Any modification to or within budget categories within each budget, as reflected in Exhibit C, shall be effectuated by a change notice that shall be incorporated into and become part of this Contract pursuant to the ALTERATION OF TERMS/AMENDMENTS Paragraph of this Contract.

B. County and Contractor shall review Contractor's expenditures and commitments to utilize any funds which are specified in this Contract for the services hereunder and which are subject to time limitations as determined by Director, midway through each County fiscal year during the term of this Contract, midway through the applicable time limitation period for such funds if such period is less than a County fiscal year, and/or at any other time or times during each County fiscal year as determined by Director. At least 15 calendar days prior to each such review, Contractor shall provide Director with a current update of all of Contractor's expenditures and commitments of such funds during such fiscal year or other applicable time period.

8. ALTERATION OF TERMS/AMENDMENTS:

A. The body of this Contract and any Exhibit(s) or Attachments attached hereto, fully expresses all understandings of the parties concerning all matters covered and shall constitute the total Contract. No addition to, or alteration of, the terms of this Contract, whether by written or verbal

understanding of the parties, their officers, employees or agents, shall be valid and effective unless made in the form of a written amendment to this Contract which is formally approved and executed by the parties in the same manner as this Contract.

B. The County's Board of Supervisors, the Chief Executive Officer or designee, or applicable State and/or federal entities, laws, or regulations may require the addition and/or change of certain terms and conditions in the Contract during the term of this Contract to comply with changes in law or County policy. The County reserves the right to add and/or change such provisions as required by the County's Board of Supervisors, Chief Executive Officer, or State or federal entity, law or regulation. To implement such changes, an Amendment to the Contract shall be prepared by Director and executed by the Contractor and Director, as authorized by the County's Board of Supervisors.

C. Notwithstanding Paragraph 8.A., in instances where the County's Board of Supervisors has delegated authority to the Director to amend this Contract to permit extensions or adjustments of the Contract term, the rollover of unspent Contract funds, and/or an internal reallocation of funds between budgets and/or an increase or decrease in funding up to fifty percent (50%) above or below each term's annual base maximum obligation, effective upon amendment execution or at the beginning of the applicable Contract term, and make corresponding service adjustments, as necessary, an Amendment shall be prepared by Director and executed by the Contractor and Director, as authorized

by the County's Board of Supervisors, and shall be incorporated into and become part of this Contract.

D. Notwithstanding Paragraph 8.A., in instances where the County's Board of Supervisors has delegated authority to the Director to amend this Contract to permit modifications to or within budget categories within each budget, as reflected in Exhibit C, and corresponding adjustment of the scope of work tasks and/or activities and/or allow for changes to hours of operation, changes to service locations, and/or correction of errors in the Contract's terms and conditions, a written Change Notice shall be signed by the Director and Contractor, as authorized by the County's Board of Supervisors. The executed Change Notice shall be incorporated into and become part of this Contract.

9. CONFIDENTIALITY:

A. Contractor must maintain the confidentiality of all records and information in accordance with all applicable federal, State and local laws, rules, regulations, ordinances, directives, guidelines, policies and procedures relating to confidentiality, including, without limitation, County policies concerning information technology security and the protection of confidential records and information.

B. Contractor must indemnify, defend, and hold harmless County, its officers, employees, and agents, from and against any and all claims, demands, damages, liabilities, losses, costs and expenses, including, without limitation, defense costs and legal, accounting and other expert, consulting, or professional fees, arising from, connected with, or related to any failure by Contractor, its

officers, employees, agents, or Subcontractors, to comply with this CONFIDENTIALITY Paragraph, as determined by County in its sole judgment. Any legal defense pursuant to Contractor's indemnification obligations under this CONFIDENTIALITY Paragraph will be conducted by Contractor and performed by counsel selected by Contractor and approved by County. Notwithstanding the preceding sentence, County will have the right to participate in any such defense at its sole costs and expense, except that in the event Contractor fails to provide County with a full and adequate defense, as determined by County in its sole judgment, County will be entitled to retain its own counsel, including, without limitation, County Counsel, and to reimbursement from Contractor for all such costs and expenses incurred by County in doing so. Contractor will not have the right to enter into any settlement, agree to any injunction, or make any admission, in each case, on behalf of County without County's prior written approval.

C. Contractor must inform all of its officers, employees, agents and Subcontractors providing services hereunder of the confidentiality provisions of this Contract.

D. Contractor must sign and adhere to the provisions of Exhibit E, Contractor Acknowledgement and Confidentiality Agreement.

10. CONSIDERATION OF HIRING COUNTY EMPLOYEES TARGETED FOR LAYOFFS OR ON A COUNTY RE-EMPLOYMENT LIST: Should Contractor require additional or replacement personnel after the effective date of this Contract to perform the services set forth herein, Contractor will give first consideration for such

employment openings to qualified, permanent County employees who are targeted for layoff, or qualified, former County employees who are on a re-employment list, during the life of this Contract.

11. INDEMNIFICATION: The Contractor must indemnify, defend, and hold harmless the County, its Special Districts, elected and appointed officers, employees, agents and volunteers (County Indemnitees) from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, and expenses (including attorney and expert witness fees), arising from and/or relating to this Contract, except for such loss or damage arising from the sole negligence or willful misconduct of the County Indemnitees.

12. GENERAL PROVISIONS FOR ALL INSURANCE COVERAGES: Without limiting Contractor's indemnification of County, and in the performance of this Contract and until all of its obligations pursuant to this Contract have been met, Contractor must provide and maintain at its own expense, insurance coverage satisfying the requirements specified in this Paragraph and in the INSURANCE COVERAGE REQUIREMENTS Paragraph of this Contract. These minimum insurance coverage terms, types and limits (the “Required Insurance”) also are in addition to and separate from any other contractual obligation imposed upon Contractor pursuant to this Contract. The County in no way warrants that the Required Insurance is sufficient to protect the Contractor for liabilities which may arise from or relate to this Contract.

A. Evidence of Coverage and Notice to County: Certificate(s) of insurance coverage (Certificate) satisfactory to County, and a copy of an Additional Insured endorsement confirming the County and its Agents have been

given Insured status under the Contractor's General Liability policy, must be delivered to the County at the address shown below and provided prior to commencing services under this Contract.

Renewal Certificates must be provided to County not less than 10 calendar days prior to Contractor's policy expiration dates. The County reserves the right to obtain complete, certified copies of any required Contractor and/or Subcontractor insurance policies at any time.

Certificates must identify all Required Insurance coverage types and limits specified herein, reference this Contract by name or number, and be signed by an authorized representative of the insurer(s). The Insured Party named on the Certificate must match the name of the Contractor identified as the contracting party in this Contract. Certificates must provide the full name of each insurer providing coverage, its NAIC (National Association of Insurance Commissioners) identification number, its financial rating, the amounts of any policy deductibles or self-insured retentions exceeding fifty thousand dollars ($50,000), and list any County required endorsement forms.

Neither the County's failure to obtain, nor the County's receipt of, or failure to object to a non-complying insurance certificate or endorsement, or any other insurance documentation or information provided by the Contractor, its insurance broker(s) and/or insurer(s), will be construed as a waiver of any of the Required Insurance provisions.

Certificates and copies of any required endorsements must be sent to:

County of Los Angeles
Department of Public Health - Contract Monitoring Section

5555 Ferguson Drive, 3rd Floor, Suite 3031
Commerce, California 90022
Attention: Manager Contract Monitoring Section

Contractor must promptly report to County any injury or property damage accident or incident, including any injury to a Contractor employee occurring on County property, and any loss, disappearance, destruction, misuse, or theft of County property, monies, or securities entrusted to Contractor. Contractor also must promptly notify County of any third party claim or suit filed against Contractor or any of its Subcontractors which arises from or relates to this Contract, and could result in the filing of a claim or lawsuit against Contractor and/or County.

B. Additional Insured Status and Scope of Coverage: The County of Los Angeles, its Special Districts, Elected Officials, Officers, Agents, employees and volunteers (collectively County and its Agents) must be provided additional insured status under Contractor's General Liability policy, with respect to liability arising out of Contractor's ongoing and completed operations performed on behalf of the County. County and its Agents' additional insured status must apply with respect to liability and defense of suits arising out of the Contractor's acts or omissions, whether such liability is attributable to Contractor or to the County. The full policy limits and scope of protection also must apply to the County and its Agents as an additional insured, even if they exceed the County's minimum Required Insurance specifications herein. Use of an automatic additional insured endorsement form is acceptable providing it satisfies the Required Provisions herein.

C. Cancellation of or Changes in Insurance: Contractor must provide County with, or Contractor's insurance policies must contain a provision that County will receive, written notice of cancellation or any change in Required Insurance, including name of insurer, limits of coverage, term of coverage or policy period. The written notice must be provided to County at least 10 days in advance of cancellation for non-payment of premium and 30 days in advance for any other cancellation or policy change. Failure to provide written notice of cancellation or any change in Required Insurance may constitute a material breach of this Contract, in the sole discretion of the County, upon which the County may suspend or terminate this Contract.

D. Failure to Maintain Insurance: Contractor's failure to maintain or to provide acceptable evidence that it maintains the Required Insurance will constitute a material breach of this Contract, upon which County immediately may withhold payments due to Contractor, and/or suspend or terminate this Contract. County, at its sole discretion, may obtain damages from Contractor resulting from said breach. Alternatively, the County may purchase the Required Insurance, and without further notice to Contractor, deduct the premium cost from sums due to Contractor or pursue Contractor reimbursement.

E. Insurer Financial Ratings: Coverage must be placed with insurers acceptable to the County with an A.M. Best ratings of not less than A:VII unless otherwise approved by County.

F. Contractor's Insurance Must Be Primary: Contractor's insurance policies, with respect to any claims related to this Contract, must be primary with

respect to all other sources of coverage available to Contractor. Any County maintained insurance or self-insurance coverage must be in excess of and not contribute to any Contractor coverage.

G. Waivers of Subrogation: To the fullest extent permitted by law, the Contractor hereby waives its rights and its insurer(s)' rights of recovery against County under all the Required Insurance for any loss arising from or relating to this Contract. Contractor must require its insurers to execute any waiver of subrogation endorsements which may be necessary to effect such waiver.

H. Compensation for County Costs: In the event that Contractor fails to comply with any of the indemnification or insurance requirements of this Contract, and such failure to comply results in any costs to County, Contractor shall pay full compensation for all costs incurred by County.

I. Subcontractor Insurance Coverage Requirements: Contractor must include all Subcontractors as insureds under Contractor's own policies, or must provide County with each Subcontractor's separate evidence of insurance coverage. Contractor will be responsible for verifying each Subcontractor complies with the Required Insurance provisions herein, and must require that each Subcontractor name the County and Contractor as additional insureds on the Subcontractor's General Liability policy. Contractor must obtain County's prior review and approval of any Subcontractor request for modification of the Required Insurance.

J. Deductibles and Self-Insured Retentions (SIRs): Contractor's policies will not obligate the County to pay any portion of any Contractor deductible or SIR. The County retains the right to require Contractor to reduce or eliminate policy deductibles and SIRs as respects to the County, or to provide a bond guaranteeing Contractor's payment of all deductibles and SIRs, including all related claims investigation, administration and defense expenses. Such bond must be executed by a corporate surety licensed to transact business in the State of California.

K. Claims Made Coverage: If any part of the Required Insurance is written on a claims made basis, any policy retroactive date will precede the effective date of this Contract. Contractor understands and agrees it will maintain such coverage for a period of not less than three years following Contract expiration, termination or cancellation.

L. Application of Excess Liability Coverage: Contractor may use a combination of primary, and excess insurance policies which provide coverage as broad as the underlying primary policies, to satisfy the Required Insurance provisions.

M. Separation of Insureds: All liability policies must provide cross-liability coverage as would be afforded by the standard ISO (Insurance Services Office, Inc.) separation of insureds provision, with no insured versus insured exclusions or limitations.

N. Alternative Risk Financing Programs: The County reserves the right to review, and then approve, Contractor's use of self-insurance, risk

retention groups, risk purchasing groups, pooling arrangements and captive insurance to satisfy the Required Insurance provisions. The County and its Agents must be designated as an Additional Covered Party under any approved program.

O. County Review and Approval of Insurance Requirements: The County reserves the right to review and adjust the Required Insurance provisions, conditioned upon County's determination of changes in risk exposures.

13. INSURANCE COVERAGE REQUIREMENTS:

A. Commercial General Liability insurance (providing scope of coverage equivalent to ISO policy form "CG 00 01"), naming County and its Agents as an additional insured, with limits of not less than the following:

General Aggregate:	$2 Million
Products/Completed Operations Aggregate:	$1 Million
Personal and Advertising Injury:	$1 Million
Each Occurrence:	$1 Million

B. Automobile Liability insurance (providing scope of coverage equivalent to ISO policy form CA 00 01) with limits of not less than $1 Million for bodily injury and property damage, in combined or equivalent split limits, for each single accident. Insurance must cover liability arising out of Contractor's use of autos pursuant to this Contract, including "owned," "leased," "hired," and/or non-owned autos, as each may be applicable.

C. Workers Compensation and Employers' Liability: Contractor will maintain insurance, or qualified self-insurance, satisfying statutory requirements, including Employers' Liability coverage with limits of not less than $1 Million per accident. If Contractor will provide leased employees, or, is: (1) an employee leasing temporary staffing firm; or, (2) a professional employer organization (PEO), coverage also shall include an Alternate Employer Endorsement (providing scope of coverage equivalent to ISO policy form WC 00 03 01 A) naming the County as the Alternate Employer. Written notice must be provided to the County at least 10 days in advance of cancellation for non-payment of premium and 30 days in advance for any other cancellation or policy change. If applicable to Contractor's operations, coverage shall be arranged to satisfy the requirements of any federal workers or workmen's compensation law or any federal occupational disease law.

D. Sexual Misconduct Liability: Insurance covering actual or alleged claims for sexual misconduct and/or molestation with limits of not less than $2 Million per claim and $2 Million aggregate, and claims for negligent employment, investigation, supervision, training or retention of, or failure to report to proper authorities, a person(s) who is alleged to have committed any act of abuse, molestation, harassment, mistreatment or maltreatment of a sexual nature.

14. OWNERSHIP OF MATERIALS, SOFTWARE AND COPYRIGHT:

A. Contractor agrees that all public announcements, literature, audiovisuals, and printed material developed or acquired by Contractor or

otherwise, in whole or in part, under this Contract, and all works based thereon, incorporated therein, or derived therefrom, shall be the sole property of County.

B. Contractor hereby assigns and transfers to County in perpetuity for all purposes all Contractors' rights, title, and interest in and to all such items including, but not limited to, all unrestricted and exclusive copyrights and all renewals and extensions thereof.

C. With respect to any such items which come into existence after the commencement date of this Contract, Contractor shall assign and transfer to County in perpetuity for all purposes, without any additional consideration, all Contractor's rights, title, and interest in and to all items, including, but not limited to, all unrestricted and exclusive copyrights and all renewals and extensions thereof.

D. During the term of this Contract and for seven years thereafter, the Contractor shall maintain and provide security for all of the Contractor's working papers prepared under this Contract. County shall have the right to inspect, copy, and use at any time during and subsequent to the term of this Contract, any and all such working papers and all information contained therein.

E. Any and all materials, software and tools which are developed or were originally acquired by Contractor outside the scope of this Contract, which Contractor desires to use hereunder, and which Contractor considers to be proprietary or confidential, must be specifically identified by Contractor to the County's Project Manager as proprietary or confidential, and shall be plainly and

prominently marked by Contractor as "Proprietary" or "Confidential" on each appropriate page of any document containing such material.

F. If directed to do so by County, Contractor will place the County name, its department names and/or its marks and logos on all items developed under this Contract. If also directed to do so by County, Contractor shall affix the following notice to all items developed under this Contract: "© Copyright 20XX (or such other appropriate date of first publication), County of Los Angeles. All Rights Reserved." Contractor agrees that it shall not use the County name, its department names, its program names, and/or its marks and logos on any materials, documents, advertising, or promotional pieces, whether associated with work performed under this Contract or for unrelated purposes, without first obtaining the express written consent of County.

For the purposes of this Contract, all such items shall include, but not be limited to, written materials (e.g., curricula, text for vignettes, press releases, advertisements, text for public service announcements for any and all media types, pamphlets, brochures, fliers), software, audiovisual materials (e.g., films, videotapes, websites), and pictorials (e.g., posters and similar promotional and educational materials using photographs, slides, drawings, or paintings).

15. PUBLICITY: Contractor agrees that all materials, public announcements, literature, audiovisuals, and printed materials utilized in association with this Contract, shall have prior written approval from the Director or designee prior to its publication, printing, duplication, and implementation with this Contract. All such materials, public announcements, literature, audiovisuals, and printed material shall include an

acknowledgement that funding for such public announcements, literature, audiovisuals, and printed materials was made possible by the County of Los Angeles, Department of Public Health and other applicable funding sources.

For the purposes of this Contract, all such items shall include, but not be limited to, written materials (e.g., curricula, text for vignettes, text for public service announcements for any and all media types, pamphlets, brochures, fliers), audiovisual materials (e.g., films, videotapes), and pictorials (e.g., posters and similar promotional and educational materials using photographs, slides, drawings, or paintings).

16. RECORD RETENTION AND AUDITS:

A. Service Records: Contractor shall maintain all service records related to this contract for a minimum period of seven years following the expiration or prior termination of this Contract. Contractor shall provide upon request by County, accurate and complete records of its activities and operations as they relate to the provision of services, hereunder. Records shall be accessible as detailed in the subsequent sub-paragraph.

B. Financial Records: Contractor shall prepare and maintain on a current basis, complete financial records in accordance with generally accepted accounting principles; written guidelines, standards, and procedures which may from time to time be promulgated by Director; and requirements set forth in the Los Angeles County Auditor-Controller's Contract Accounting and Administration Handbook. The handbook is available on the internet at:

AC Contract Accounting and Administration Handbook - June 2021 (lacounty.gov)

Such records shall clearly reflect the actual cost of the type of service for which payment is claimed and shall include, but not be limited to:

(1) Books of original entry which identifies all designated donations, grants, and other revenues, including County, federal, and State revenues and all costs by type of service.

(2) A General Ledger.

(3) A written cost allocation plan which shall include reports, studies, statistical surveys, and all other information Contractor used to identify and allocate indirect costs among Contractor's various services. Indirect Costs shall mean those costs incurred for a common or joint objective which cannot be identified specifically with a particular project or program.

(4) Personnel records which show the percentage of time worked providing service claimed under this Contract. Such records shall be corroborated by payroll timekeeping records, signed by the employee and approved by the employee's supervisor, which show time distribution by programs and the accounting for total work time on a daily basis. This requirement applies to all program personnel, including the person functioning as the executive director of the program, if such executive director provides services claimed under this Contract.

(5) Personnel records which account for the total work time of personnel identified as indirect costs in the approved contract budget. Such records shall be corroborated by payroll timekeeping records signed

by the employee and approved by the employee's supervisor. This requirement applies to all such personnel, including the executive director of the program, if such executive director provides services claimed under this Contract.

The entries in all of the aforementioned accounting and statistical records must be readily traceable to applicable source documentation (e.g., employee timecards, remittance advice, vendor invoices, appointment logs, client/patient ledgers). The client/patient eligibility determination and fees charged to, and collected from, clients/patients must also be reflected therein. All financial records shall be retained by Contractor at a location within Los Angeles County during the term of this Contract and for a minimum period of seven years following expiration or earlier termination of this Contract, or until federal, State and/or County audit findings are resolved, whichever is later. During such retention period, all such records shall be made available during normal business hours within 10 calendar days, to authorized representatives of federal, State, or County governments for purposes of inspection and audit. In the event records are located outside Los Angeles County and Contractor is unable to move such records to Los Angeles County, Contractor shall permit such inspection or audit to take place at an agreed to outside location, and Contractor shall pay County for all travel, per diem, and other costs incurred by County for any inspection and audit at such other location. Contractor further agrees to provide such records, when

possible, immediately to County by facsimile/FAX, or through the Internet (i.e. electronic mail ["e-mail"]), upon Director's request. Director's request shall include appropriate County facsimile/FAX number(s) and/or e-mail address(es) for Contractor to provide such records to County. In any event, Contractor agrees to make available the original documents of such FAX and e-mail records when requested by Director for review as described hereinabove.

C. Preservation of Records: If, following termination of this Contract, Contractor's facility is closed or if ownership of Contractor changes, within 48 hours thereafter, the Director is to be notified thereof by Contractor in writing and arrangements are to be made by Contractor for preservation of the client/patient and financial records referred to hereinabove.

D. Audit Reports: In the event that an audit of any or all aspects of this Contract is conducted by any federal or State auditor, or by any auditor or accountant employed by Contractor or otherwise, Contractor shall file a copy of each such audit report(s) with the Chief of the Public Health Contract Monitoring Division, and with County's Auditor-Controller (Auditor-Controller's Audit Branch) within 30 calendar days of Contractor's receipt thereof, unless otherwise provided for under this Contract, or under applicable federal or State regulations. To the extent permitted by law, County shall maintain the confidentiality of such audit report(s).

E. Independent Audit: Contractor's financial records shall be audited by an independent auditor in compliance with 2 CFR 200.501. The audit shall be

made by an independent auditor in accordance with Governmental Financial Auditing Standards developed by the Comptroller General of the United States, and any other applicable federal, State, or County statutes, policies, or guidelines. Contractor shall complete and file such audit report(s) with the County's Public Health Contract Monitoring Division no later than the earlier of 30 days after receipt of the auditor's report(s) or nine months after the end of the audit period.

If the audit report(s) is not delivered by Contractor to County within the specified time, Director may withhold all payments to Contractor under all service agreements between County and Contractor until such report(s) is/are delivered to County.

The independent auditor's work papers shall be retained for a minimum of three years from the date of the report, unless the auditor is notified in writing by County to extend the retention period. Audit work papers shall be made available for review by federal, State, or County representative upon request.

F. Federal Access to Records: If, and to the extent that, Section 1861 (v) (1) (I) of the Social Security Act [42 United States Code ("U.S.C.") Section 1395x(v) (1) (I)] is applicable, Contractor agrees that for a period of seven years following the furnishing of services under this Contract, Contractor shall maintain and make available, upon written request, to the Secretary of the United States Department of Health and Human Services or the Comptroller General of the United States, or to any of their duly authorized representatives, the contracts, books, documents, and records of Contractor which are necessary to verify the

nature and extent of the cost of services provided hereunder. Furthermore, if Contractor carries out any of the services provided hereunder through any subcontract with a value or cost of ten thousand dollars ($10,000) or more over a 12-month period with a related organization (as that term is defined under federal law), Contractor agrees that each such subcontract shall provide for such access to the subcontract, books, documents, and records of the Subcontractor.

G. Program and Audit/Compliance Review: In the event County representatives conduct a program review and/or an audit/compliance review of Contractor, Contractor shall fully cooperate with County's representatives. Contractor shall allow County representatives access to all records of services rendered and all financial records and reports pertaining to this Contract and shall allow photocopies to be made of these documents utilizing Contractor's photocopier, for which County shall reimburse Contractor its customary charge for record copying services, if requested. Director will provide Contractor with at least 10 working days' prior written notice of any audit/compliance review, unless otherwise waived by Contractor.

County may conduct a statistical sample audit/compliance review of all claims paid by County during a specified period. The sample will be determined in accordance with generally accepted auditing standards. An exit conference will be held following the performance of such audit/compliance review at which time the result shall be discussed with Contractor. Contractor will be provided with a copy of any written evaluation reports.

Contractor will have the opportunity to review County's findings on Contractor, and Contractor will have 30 calendar days after receipt of County's audit/compliance review results to provide documentation to County representatives to resolve the audit exceptions. If, at the end of the 30 calendar day period, there remains audit exceptions which have not been resolved to the satisfaction of County's representatives, then the exception rate found in the audit, or sample, shall be applied to the total County payment made to Contractor for all claims paid during the audit/compliance review period to determine Contractor's liability to County. County may withhold any claim for payment by Contractor for any month(s) for any deficiency(ies) not corrected.

H. Audit Settlements:

(1) If an audit conducted by federal, State, and/or County representatives finds that units of service, actual reimbursable net costs for any services and/or combinations thereof furnished hereunder are lower than units of service and/or reimbursement for stated actual net costs for any services for which payments were made to Contractor by County, then payment for the unsubstantiated units of service and/or unsubstantiated reimbursement of stated actual net costs for any services shall be repaid by Contractor to County. For the purpose of this paragraph an "unsubstantiated unit of service" shall mean a unit of service for which Contractor is unable to adduce proof of performance of that unit of service and "unsubstantiated reimbursement of stated actual net costs" shall mean stated actual net costs for which Contractor is unable to

adduce proof of performance and/or receipt of the actual net cost for any service.

(2) If an audit conducted by federal, State, and/or County representatives finds that actual allowable and documented costs for a unit of service provided hereunder are less than the County's payment for those units of service, the Contractor shall repay County the difference immediately upon request, or County has the right to withhold and/or offset that repayment obligation against future payments.

(3) If within 30 calendar days of termination of this Contract, such audit finds that the units of service, allowable costs of services and/or any combination thereof furnished hereunder are higher than the units of service, allowable costs of services and/or payments made by County, then the difference may be paid to Contractor, not to exceed the County maximum contract obligation.

(4) In no event shall County be required to pay Contractor for units of services that are not supported by actual allowable and documented costs.

(5) In the event that Contractor's actual allowable and documented cost for a unit of service are less than fee-for-service rate(s) set out in the budget(s), the Contractor will only be reimbursed for its actual allowable and documented costs.

I. Failure to Comply: Failure of Contractor to comply with the terms of this Paragraph shall constitute a material breach of contract upon which Director may suspend or County may immediately terminate this Contract.

17. TERMINATION FOR NON-ADHERENCE OF COUNTY LOBBYIST ORDINANCE OR RESTRICTIONS ON LOBBYING:

The Contractor, and each County Lobbyist or County Lobbying firm as defined in County Code Section 2.160.010 retained by Contractor, must fully comply with the County's Lobbyist Ordinance, County Code Chapter 2.160. Failure on the part of Contractor or any County Lobbyist or County Lobbying firm retained by the Contractor to fully comply with the County's Lobbyist Ordinance will constitute a material breach of this Contract, upon which the County may, in its sole discretion, immediately terminate or suspend this Contract.

18A. CONTRACTOR'S CHARITABLE ACTIVITIES COMPLIANCE: The Supervision of Trustees and Fundraisers for Charitable Purposes Act regulates entities receiving or raising charitable contributions. The "Nonprofit Integrity Act of 2004" increased Charitable Purposes Act requirements. By requiring Contractor to complete the Charitable Contributions Certification, Exhibit H, the County seeks to ensure that all County contractors which receive or raise charitable contributions comply with California law in order to protect the County and its taxpayers. A contractor which receives or raises charitable contributions without complying with its obligations under California law commits a material breach subjecting it to either contract termination or debarment proceedings or both. (County Code Chapter 2.202)

18B. COMPLIANCE WITH COUNTY'S CHILD WELLNESS POLICY: This Contract is subject to Los Angeles County Board of Supervisors Policy Manual, Chapter 3, Administration and Government, 3.116 Los Angeles County Child Wellness Policy (Child Wellness). As required by the Child Wellness policy Contractor shall make every effort to provide current nutrition and physical activity information to parents, caregivers, and staff as recommended by the Centers for Disease Control and Prevention, and the American Academy of Pediatrics; ensure that age appropriate nutritional and physical activity guidelines for children both in out-of-home care and in child care settings are promoted and adhered to; and provide opportunities for public education and training.

18C. DATA DESTRUCTION:

A. If Contractor maintains, processes or stores the County of Los Angeles' ("County") data and/or information, implied or expressed, Contractor has the sole responsibility to certify that the data and information have been appropriately destroyed consistent with the National Institute of Standards and Technology (NIST) Special Publication SP 800-88 titled Guidelines for Media Sanitization (Available at: http://csrc.nist.gov/publications/PubsDrafts.html#SP-800-88-Rev.%201).

B. The data and/or information may be stored on purchased, leased, or rented electronic storage equipment (e.g., printers, hard drives) and electronic devices (e.g., servers, workstations) that are geographically located within the County, or external to the County's boundaries. The County must receive within 10 business days, a signed document from Contractor that certifies and validates

the data and information were placed in one or more of the following stored states: unusable, unreadable, and indecipherable.

C. Contractor must certify that any County data stored on purchased, leased, or rented electronic storage equipment and electronic devices, including, but not limited to printers, hard drives, servers, and/or workstations are destroyed consistent with the current NIST Special Publication SP-800-88, *Guidelines for Media Sanitization.* Contractor must provide County with written certification, within 10 business days of removal of any electronic storage equipment and devices that validates that any and all County data was destroyed and is unusable, unreadable, and/or undecipherable.

18D. CHILD/ELDER ABUSE/FRAUD REPORT

A. Contractor's mandated reporting staff working on this Contract that are subject to California Penal Code (PC) Section 11164 et seq. shall comply with the reporting requirements described in PC Section 11164 et seq. and shall report all known or suspected instances of child abuse to an appropriate child protective agency, as mandated by the aforementioned Code sections. Contractor's mandated reporting staff working on this Contract shall make the report on such abuse, and shall submit all required information, in accordance with PC Sections 11166 and 11167.

B. Child abuse reports shall be made by telephone to the Department of Children and Family Services hotline at: (800) 540-4000, within 24 hours of suspicion of instances of child abuse.

C. Contractor's mandated reporting staff working on this Contract that are subject to California Welfare and Institutions Code (WIC), Section 15600 et seq. shall comply with the reporting requirements described in WIC Section 15600 et seq., and shall report all known or suspected instances of physical abuse of elders and dependent adults either to an appropriate County adult protective services agency or to a local law enforcement agency, as mandated by these code sections. Contractor's mandated reporting staff working on this Contract shall make the report on such abuse, and shall submit all required information, in accordance with WIC Sections 15630, 15633 and 15633.5.

D. Elder abuse reports shall be made by telephone to the Department of Workforce Development, Aging, and Community Services hotline at: (800) 992-1660 within one business day from the date Contractor became aware of the suspected instance of elder abuse.

E. Contractor staff working on this Contract shall also immediately report all suspected fraud situations to County within three business days to DPSS Central Fraud Reporting Line at: (800) 349-9970, unless otherwise restricted by law from disclosing such information.

19. CONFLICT OF TERMS: To the extent that there exists any conflict or inconsistency between the language of this Contract and that of any Exhibit(s), Attachment(s), and any documents incorporated herein by reference, the language found within this Contract shall govern and prevail.

20. CONTRACTOR'S OFFICES: Contractor's office is located at _____. Contractor's business telephone number is (____) _____, facsimile (FAX) number is (____) _____, and electronic Mail (e-mail) address is _____. Contractor shall notify County, in writing, of any changes made to their business address, business telephone number, FAX number and/or e-mail address as listed herein, or any other business address, business telephone number, FAX number and/or e-mail address used in the provision of services herein, at least 10 calendar days prior to the effective date(s) thereof.

21. NOTICES: Notices hereunder shall be in writing and may either be delivered personally or sent by registered or certified mail, return receipt requested, postage prepaid, attention to the parties at the addresses listed below. Director is authorized to execute all notices or demands which are required or permitted by County under this Contract. Addresses and parties to be notified may be changed by providing at least 10 working days' prior written notice to the other party.

A. Notices to County shall be addressed as follows:

(1) Department of Public Health
Office of Violence Prevention Division
1000 South Fremont Avenue, Unit 61
Building A-9 East, 5th Floor South
Alhambra, California 91803

Attention: Project Director

(2) Department of Public Health
Contracts and Grants Division
5555 Ferguson Drive, Suite 210
Commerce, California 90022

Attention: Division Chief

B. Notices to Contractor shall be addressed as follows:

(1) _____
_____
_____

Attention: _____

22. ADMINISTRATION OF CONTRACT:

A. County's Director of Public Health or authorized designee(s) (hereafter collectively "Director") shall have the authority to administer this Contract on behalf of County. Contractor agrees to extend to Director the right to review and monitor Contractor's programs, policies, procedures, and financial and/or other records, and to inspect its facilities for contractual compliance at any reasonable time.

B. Approval of Contractor's Staff: County has the absolute right to approve or disapprove all of Contractor's staff performing work hereunder and any proposed changes in Contractor's staff, including, but not limited to, Contractor's Project Manager.

C. Contractor's Staff Identification: All of Contractor's employees assigned to County facilities are required to have a County Identification (ID) badge on their person and visible at all times. Contractor bears all expense related to the badges.

D. Background and Security Investigations: Each of Contractor's staff and Subcontractors performing services under this Contract, who is in a designated sensitive position, as determined by County in County's sole discretion, must undergo and pass a background investigation to the satisfaction

of County as a condition of beginning and continuing to perform services under this Contract. Such background investigation must be obtained through fingerprints submitted to the California Department of Justice to include State, local, and federal-level review, which may include, but will not be limited to, criminal conviction information. The fees associated with the background investigation will be at the expense of the Contractor, regardless of whether the member of Contractor's staff passes or fails the background investigation.

If a member of Contractor's staff who is in a designated sensitive position does not obtain work clearance through the criminal history background review, they may not perform services under this Contract, or be placed and/or assigned within the Department of Public Health. During the term of this Contract, the Department may receive subsequent criminal information. If this subsequent information constitutes a job nexus, the Contractor shall immediately remove staff from performing services under this Contract and replace such staff within 15 days of removal, or within an agreed upon time with the County. Pursuant to an agreement with the Federal Department of Justice, the County will not provide to Contractor, nor to Contractor's staff, any information obtained through the criminal history review.

Disqualification of any member of Contractor's staff pursuant to this section will not relieve Contractor of its obligation to complete all work in accordance with the terms and conditions of this Contract.

23. ASSIGNMENT AND DELEGATION/MERGERS OR ACQUISITIONS:

A. Contractor must notify the County of any pending acquisitions/mergers of its company unless otherwise legally prohibited from doing so. If Contractor is restricted from legally notifying the County of pending acquisitions/mergers, then it should notify the County of the actual acquisitions/mergers as soon as the law allows and provide to the County the legal framework that restricted it from notifying the County prior to the actual acquisitions/mergers.

B. Contractor must not assign, exchange, transfer, or delegate its rights or duties under this Contract, whether in whole or in part, without the prior written consent of County, in its discretion, and any attempted assignment, delegation, or otherwise transfer of its rights or duties, without such consent shall be null and void. For purposes of this paragraph, County consent requires a written Amendment to this Contract, which is formally approved and executed by the parties. Any payments by the County to any approved delegate or assignee on any claim under this Contract will be deductible, at County's sole discretion, against the claims, which Contractor may have against the County.

C. Any assumption, assignment, delegation, or takeover of any of Contractor's duties, responsibilities, obligations, or performance of same by any person or entity other than Contractor, whether through assignment, subcontract, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason whatsoever without County's express prior written approval, will be a material breach of this Contract which may result in the termination of this Contract. In the event of such termination, County will be

entitled to pursue the same remedies against Contractor as it could pursue in the event of default by Contractor.

24. AUTHORIZATION WARRANTY: The Contractor represents and warrants that the person executing this Contract for Contractor is an authorized agent who has actual authority to bind Contractor to each and every term, condition, and obligation of this Contract and that all requirements of Contractor have been fulfilled to provide such actual authority.

25. BUDGET REDUCTION: In the event that the Board adopts, in any fiscal year, a County Budget which provides for reductions in the salaries and benefits paid to the majority of County employees, and imposes similar reductions with respect to County contracts, the County reserves the right to reduce its payment obligation under this Contract correspondingly for that fiscal year and any subsequent fiscal year during the term of this Contract (including any extensions), and the services to be provided by the Contractor under this Contract will also be reduced correspondingly. The County's notice to Contractor regarding said reduction in payment obligation will be provided within 30 calendar days of the Board's approval of such actions. Except as set forth in the preceding sentence, Contractor shall continue to provide all of the services set forth in this Contract.

26. CONTRACTOR BUDGET AND EXPENDITURES REDUCTION FLEXIBILITY: In order for County to maintain flexibility regarding budget and expenditure reductions, Contractor agrees that Director may cancel this Contract, without cause, upon the giving of 10 calendar days' written notice to Contractor. In the alternative to cancellation, Director may, consistent with federal, State, and/or County

budget reductions, renegotiate the scope/description of work, maximum obligation, and budget of this Contract via a written amendment to this Contract.

27. COMPLAINTS: Contractor must develop, maintain, and operate procedures for receiving, investigating, and responding to complaints.

A. Within 30 business days after the Contract effective date, Contractor must provide the County with Contractor's policy for receiving, investigating, and responding to user complaints.

B. The policy shall include, but not be limited to, when and how new clients, as well as current and recurring clients, are to be informed of the procedures to file a complaint.

C. The client and/or his/her authorized representative shall receive a copy of the procedure.

D. The County will review Contractor's policy and provide Contractor with approval of said plan or with requested changes.

E. If the County requests changes in Contractor's policy, Contractor must make such changes and resubmit the plan within 30 business days for County approval.

F. If, at any time, Contractor wishes to change its policy, Contractor must submit proposed changes to the County for approval before implementation.

G. Contractor must preliminarily investigate all complaints and notify the County's Project Manager of the status of the investigation within 15 business days of receiving the complaint.

H. When complaints cannot be resolved informally, a system of follow-through shall be instituted which adheres to formal plans for specific actions and strict time deadlines.

I. Copies of all written responses must be sent to the County's Project Manager within three business days of mailing to the complainant.

28. COMPLIANCE WITH APPLICABLE LAW:

A. In the performance of this Contract, Contractor must comply with all applicable federal, State and local laws, rules, regulations, ordinances, directives, guidelines, policies and procedures, and all provisions required thereby to be included in this Contract are hereby incorporated herein by reference.

B. Contractor must indemnify, defend and hold harmless County, its officers, employees, and agents, from and against any and all claims, demands, damages, liabilities, losses, costs, and expenses, including, without limitation, defense costs and legal, accounting and other expert, consulting or professional fees, arising from, connected with, or related to any failure by Contractor, its officers, employees, agents, to comply with any such laws, rules, regulations, ordinances, directives, guidelines, policies, or procedures, as determined by County in its sole judgment. Any legal defense pursuant to Contractor's indemnification obligations under this Paragraph will be conducted by Contractor and performed by counsel selected by Contractor and approved by County. Notwithstanding the preceding sentence, County will have the right to participate in any such defense at its sole costs and expense, except that in the event Contractor fails to provide County with a full and adequate defense, as

determined by County in its sole judgment, County will be entitled to retain its own counsel, including without limitation, County Counsel, and to reimbursement from Contractor for all such costs and expenses incurred by County in doing so. Contractor will not have the right to enter into settlement, agree to any injunction or other equitable relief, or make any admission, in each case, on behalf of County without County's prior written approval.

29. COMPLIANCE WITH CIVIL RIGHTS LAW: Contractor hereby assures that it will comply with Subchapter VI of the Civil Rights Act of 1964, 42 USC Sections 2000 (e) (1) through 2000 (e) (17), to the end that no person will, on the grounds of race, creed, color, sex, religion, ancestry, age, condition of physical handicap, marital status, political affiliation, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Contract or under any project, program, or activity supported by this Contract.

Additionally, Contractor certifies to the County:

1. That Contractor has a written policy statement prohibiting discrimination in all phases of employment.

2. That Contractor periodically conducts a self-analysis or utilization analysis of its work force.

3. That Contractor has a system for determining if its employment practices are discriminatory against protected groups.

4. Where problem areas are identified in employment practices, Contractor has a system for taking reasonable corrective action, to include

establishment of goals or timetables. Contractor shall comply with Exhibit D – Contractor's EEO Certification.

30. COMPLIANCE WITH THE COUNTY'S JURY SERVICE PROGRAM:

A. Jury Service Program: This Contract is subject to the provisions of the County's ordinance entitled Contractor Employee Jury Service ("Jury Service Program") as codified in Sections 2.203.010 through 2.203.090 of the Los Angeles County Code.

B. Written Employee Jury Service Policy:

(1) Unless Contractor has demonstrated to the County's satisfaction either that Contractor is not a "Contractor" as defined under the Jury Service Program (Section 2.203.020 of the County Code) or that the Contractor qualifies for an exception to the Jury Service Program (Section 2.203.070 of the County Code), Contractor must have and adhere to a written policy that provides that its Employees will receive from Contractor, on an annual basis, no less than five days of regular pay for actual jury service. The policy may provide that Employees deposit any fees received for such jury service with Contractor or that Contractor deduct from the Employee's regular pay the fees received for jury service.

(2) For purposes of this sub-paragraph, "Contractor" means a person, partnership, corporation or other entity which has a contract with the County or a subcontract with a County Contractor and has received or will receive an aggregate sum of fifty thousand dollars ($50,000) or more in any 12-month period under one or more County contracts or

subcontracts. "Employee" means any California resident who is a full-time employee of the Contractor. "Full-time" means 40 hours or more worked per week, or a lesser number of hours if: 1) the lesser number is a recognized industry standard as determined by the County, or, 2) Contractor has a long-standing practice that defines the lesser number of hours as full-time. Full-time employees providing short-term, temporary services of 90 days or less within a 12-month period are not considered full-time for purposes of the Jury Service Program. If Contractor uses any Subcontractor to perform services for the County under this Contract, the Subcontractor shall also be subject to the provisions of this sub-paragraph. The provisions of this sub-paragraph must be inserted into any such subcontract agreement and a copy of the Jury Service Program must be attached to that contract.

(3) If Contractor is not required to comply with the Jury Service Program when this Contract commences, Contractor will have a continuing obligation to review the applicability of its "exception status" from the Jury Service Program, and Contractor must immediately notify the County if Contractor at any time either comes within the Jury Service Program's definition of "Contractor" or if Contractor no longer qualifies for an exception to the Jury Service Program. In either event, Contractor must immediately implement a written policy consistent with the Jury Service Program. The County may also require, at any time during this Contract and at its sole discretion, that Contractor demonstrate, to the

County's satisfaction that Contractor either continues to remain outside of the Jury Service Program's definition of "Contractor" and/or that Contractor continues to qualify for an exception to the Program.

(4) Contractor's violation of this sub-paragraph of this Contract may constitute a material breach of this Contract. In the event of such material breach, County may, at its sole discretion, terminate this Contract and/or bar Contractor from the award of future County contracts for a period of time consistent with the seriousness of the breach.

31. COMPLIANCE WITH COUNTY'S ZERO TOLERANCE POLICY ON HUMAN TRAFFICKING:

A. Contractor acknowledges that the County has established a Zero Tolerance Human Trafficking Policy prohibiting contractors from engaging in human trafficking.

B. If Contractor or a member of Contractor's staff is convicted of a human trafficking offense, the County will require that Contractor or member of Contractor's staff be removed immediately from performing services under this Contract. County will not be under any obligation to disclose confidential information regarding the offenses other than those required by law.

C. Disqualification of any member of Contractor's staff pursuant to this Paragraph will not relieve Contractor of its obligation to complete all work in accordance with the terms and conditions of this Contract.

32. COMPLIANCE WITH FAIR CHANCE EMPLOYMENT PRACTICES: Contractor, and any subcontractors, must comply with fair chance employment hiring

practices set forth in California Government Code Section 12952. Contractor's violation of this Paragraph of this Contract may constitute a material breach of this Contract. In the event of such material breach, County may, in its sole discretion, terminate this Contract.

33. COMPLIANCE WITH THE COUNTY'S POLICY OF EQUITY: Contractor acknowledges that the County takes its commitment to preserving the dignity and professionalism of the workplace very seriously, as set forth in the County Policy of Equity (CPOE): (https://ceop.lacounty.gov/). Contractor further acknowledges that the County strives to provide a workplace free from discrimination, harassment, retaliation and inappropriate conduct based on a protected characteristic, and which may violate the CPOE. Contractor, its employees and Subcontractors acknowledge and certify receipt and understanding of the CPOE. Failure of Contractor, its employees or its Subcontractors to uphold the County's expectations of a workplace free from harassment and discrimination, including inappropriate conduct based on a protected characteristic, may subject Contractor to termination of contractual agreements as well as civil liability.

34. CONFLICT OF INTEREST:

A. No County employee whose position with the County enables such employee to influence the award of this Contract or any competing contract, and no spouse or economic dependent of such employee, may be employed in any capacity by Contractor or have any other direct or indirect financial interest in this Contract. No officer or employee of Contractor who may financially benefit from the performance of work hereunder will in any way participate in the County's

approval, or ongoing evaluation, of such work, or in any way attempt to unlawfully influence the County's approval or ongoing evaluation of such work.

B. Contractor must comply with all conflict of interest laws, ordinances, and regulations now in effect or hereafter to be enacted during the term of this Contract. Contractor warrants that it is not now aware of any facts that create a conflict of interest. If Contractor hereafter becomes aware of any facts that might reasonably be expected to create a conflict of interest, it must immediately make full written disclosure of such facts to the County. Full written disclosure must include, but is not limited to, identification of all persons implicated and a complete description of all relevant circumstances. Failure to comply with the provisions of this sub-paragraph will be a material breach of this Contract.

35. CONSIDERATION OF HIRING GAIN/GROW PARTICIPANTS:

A. Should Contractor require additional or replacement personnel after the effective date of this Contract, Contractor will give consideration for any such employment openings to participants in the County's Department of Public Social Services Greater Avenues for Independence (GAIN) Program or General Relief Opportunity for Work (GROW) Program who meet Contractor's minimum qualifications for the open position(s). For this purpose, consideration means that Contractor will interview qualified candidates. The County will refer GAIN/GROW participants by job category to Contractor. Contractor must report all job openings with job requirements to: GAINGROW@DPSS.LACOUNTY.GOV and BSERVICES@WDACS.LACOUNTY.GOV; and DPSS will refer qualified GAIN/GROW job candidates.

B. In the event that both laid-off County employees and GAIN/GROW participants are available for hiring, County employees must be given first priority.

36. CONTRACTOR RESPONSIBILITY AND DEBARMENT:

A. Responsible Contractor: A responsible contractor is a contractor who has demonstrated the attribute of trustworthiness, as well as quality, fitness, capacity and experience to satisfactorily perform the contract. It is the County's policy to conduct business only with responsible contractors.

B. Chapter 2.202 of the County Code: Contractor is hereby notified that, in accordance with Chapter 2.202 of the County Code, if the County acquires information concerning the performance of Contractor on this or other contracts which indicates that Contractor is not responsible, the County may, in addition to other remedies provided in this Contract, debar Contractor from bidding or proposing on, or being awarded, and/or performing work on County contracts for a specified period of time, which generally will not exceed five years but may exceed five years or be permanent if warranted by the circumstances, and terminate any or all existing contracts Contractor may have with the County.

C. Non-Responsible Contractor: The County may debar a contractor if the Board of Supervisors finds, in its discretion, that the contractor has done any of the following: (1) violated a term of a contract with the County or a nonprofit corporation created by the County, (2) committed an act or omission which negatively reflects on the contractor's quality, fitness or capacity to perform a contract with the County, any other public entity, or a nonprofit corporation created by the County, or engaged in a pattern or practice which negatively

reflects on same, (3) committed an act or offense which indicates a lack of business integrity or business honesty, or (4) made or submitted a false claim against the County or any other public entity.

D. Contractor Hearing Board: If there is evidence that Contractor may be subject to debarment, the Department will notify Contractor in writing of the evidence which is the basis for the proposed debarment and will advise Contractor of the scheduled date for a debarment hearing before the Contractor Hearing Board.

E. The Contractor Hearing Board will conduct a hearing where evidence on the proposed debarment is presented. Contractor and/or Contractor's representative will be given an opportunity to submit evidence at that hearing. After the hearing, the Contractor Hearing Board will prepare a tentative/proposed decision, which will contain a recommendation regarding whether Contractor should be debarred, and, if so, the appropriate length of time of the debarment. Contractor and the Department will be provided an opportunity to object to the tentative proposed decision prior to its presentation to the Board of Supervisors.

F. After consideration of any objections, or if no objections are submitted, a record of the hearing, the proposed decision, and any other recommendation of the Contractor Hearing Board will be presented to the Board of Supervisors. The Board of Supervisors will have the right to modify, deny, or adopt the proposed decision and recommendation of the Contractor Hearing Board.

G. If a contractor has been debarred for a period longer than five years, that contractor may after the debarment has been in effect for at least five years, submit a written request for review of the debarment determination to reduce the period of debarment or terminate the debarment. The County may, in its discretion, reduce the period of debarment or terminate the debarment if it finds that the contractor has adequately demonstrated one or more of the following: (1) elimination of the grounds for which the debarment was imposed; (2) a bona fide change in ownership or management; (3) material evidence discovered after debarment was imposed; or (4) any other reason that is in the best interest of the County.

H. The Contractor Hearing Board will consider a request for review of a debarment determination only where (1) the contractor has been debarred for a period longer than five years; (2) the debarment has been in effect for at least five years; and (3) the request is in writing, states one or more of the grounds for reduction of the debarment period or termination of the debarment, and includes supporting documentation. Upon receiving an appropriate request, the Contractor Hearing Board will provide notice of the hearing on the request. At the hearing, the Contractor Hearing Board will conduct a hearing where evidence on the proposed reduction of debarment period or termination of debarment is presented. This hearing will be conducted and the request for review decided by the Contractor Hearing Board pursuant to the same procedures as for a debarment hearing.

I. The Contractor Hearing Board's proposed decision will contain a recommendation on the request to reduce the period of debarment or terminate the debarment. The Contractor Hearing Board will present its proposed decision and recommendation to the Board of Supervisors. The Board of Supervisors will have the right to modify, deny, or adopt the proposed decision and recommendation of the Contractor Hearing Board.

J. Subcontractors of Contractors: These terms will also apply to Subcontractors of County contractors.

37. CONTRACTOR'S ACKNOWLEDGEMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW: Contractor acknowledges that the County places a high priority on the implementation of the Safely Surrendered Baby Law. Contractor understands that it is the County's policy to encourage all County contractors to voluntarily post the County's "Safely Surrendered Baby Law" poster in a prominent position at a contractor's place of business. Contractor will also encourage its Subcontractors, if any, to post this poster in a prominent position in the Subcontractor's place of business. Information and posters for printing are available at: https://lacounty.gov/residents/family-services/child-safety/safe-surrender/

38. CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM:

A. Contractor acknowledges that the County has established a goal of ensuring that all individuals who benefit financially from the County through contracts are in compliance with their court-ordered child, family and spousal

support obligations in order to mitigate the economic burden otherwise imposed upon the County and its taxpayers.

B. As required by the County's Child Support Compliance Program (County Code Chapter 2.200) and without limiting Contractor's duty under this Contract to comply with all applicable provisions of law, Contractor warrants that it is now in compliance and will during the term of this Contract, maintain compliance with employment and wage reporting requirements as required by the Federal Social Security Act (42 USC Section 653a) and California Unemployment Insurance Code Section 1088.5, and will implement all lawfully served Wage and Earnings Withholding Orders or Child Support Services Department Notices of Wage and Earnings Assignment for Child, Family or Spousal Support, pursuant to Code of Civil Procedure Section 706.031 and Family Code Section 5246(b).

39. COUNTY'S QUALITY ASSURANCE PLAN: County or its agent(s) will monitor Contractor's performance under this Contract on not less than an annual basis. Such monitoring will include assessing Contractor's compliance with all Contract terms and performance standards. Contractor deficiencies which County determines are significant, or continuing, and that may place performance of the Contract in jeopardy if not corrected, will be reported to the Board of Supervisors and listed in the appropriate contractor performance database. The report to the Board will include improvement/corrective action measures taken by County and Contractor. If improvement does not occur consistent with the corrective action measures, the County may terminate this Contract or impose other penalties as specified in this Contract.

40. SERVICE DELIVERY SITE - MAINTENANCE STANDARDS: Contractor shall assure that the locations where services are provided under provisions of this Contract are operated at all times in accordance with County community standards with regard to property maintenance and repair, graffiti abatement, refuse removal, fire safety, landscaping, and in full compliance with all applicable local laws, ordinances, and regulations relating to the property. County's periodic monitoring visits to Contractor's facilities shall include a review of compliance with the provisions of this Paragraph.

41. RULES AND REGULATIONS: During the time that Contractor's personnel are at County Facilities such persons shall be subject to the rules and regulations of such County Facility. It is the responsibility of Contractor to acquaint persons who are to provide services hereunder with such rules and regulations. Contractor shall immediately and permanently withdraw any of its personnel from the provision of services hereunder upon receipt of oral or written notice from Director, that: (1) such person has violated said rules or regulations, or, (2) such person's actions, while on County premises, indicate that such person may do harm to County patients, staff, or other individuals.

42. DAMAGE TO COUNTY FACILITIES, BUILDINGS OR GROUNDS:

A. Contractor will repair, or cause to be repaired, at its own cost, any and all damage to County facilities, buildings, or grounds caused by Contractor or Contractor's employees or agents. Such repairs must be made immediately after Contractor has become aware of such damage, but in no event later than 30 days after the occurrence.

B. If Contractor fails to make timely repairs, County may make any necessary repairs. All costs incurred by County, as determined by County, for such repairs must be repaid by Contractor by cash payment upon demand.

43. EMPLOYMENT ELIGIBILITY VERIFICATION:

A. Contractor warrants that it fully complies with all federal and State statutes and regulations regarding the employment of aliens and others and that all its employees performing work under this Contract meet the citizenship or alien status requirements set forth in federal and State statutes and regulations. Contractor must obtain from all employees performing work hereunder, all verification and other documentation of employment eligibility status required by federal and State statutes and regulations including, but not limited to, the Immigration Reform and Control Act of 1986, (P.L. 99-603), as they currently exist or as they may be hereafter amended. Contractor must retain all such documentation for all covered employees for the period prescribed by law.

B. Contractor must indemnify, defend, and hold harmless, the County, its agents, officers, and employees from employer sanctions and any other liability which may be assessed against Contractor or the County or both in connection with any alleged violation of any federal or State statutes or regulations pertaining to the eligibility for employment of any persons performing work under this Contract.

44. DEFAULT METHOD OF PAYMENT: DIRECT DEPOSIT OR ELECTRONIC FUNDS TRANSFER:

The County, at its sole discretion, has determined that the most efficient and secure default form of payment for goods and/or services provided under an

agreement/contract with the County will be Electronic Funds Transfer (EFT) or direct deposit, unless an alternative method of payment is deemed appropriate by the Auditor-Controller (A-C). Contractor must submit a direct deposit authorization request via the website https://directdeposit.lacounty.gov with banking and vendor information, and any other information that the A-C determines is reasonably necessary to process the payment and comply with all accounting, record keeping, and tax reporting requirements. Any provision of law, grant, or funding agreement requiring a specific form or method of payment other than EFT or direct deposit will supersede this requirement with respect to those payments.

At any time during this Contract, Contractor may submit a written request for an exemption to this requirement. Such request must be based on specific legal, business or operational needs and explain why the payment method designated by the A-C is not feasible and an alternative is necessary. The A-C, in consultation with Public Health, will decide whether to approve exemption requests.

45. COUNTERPARTS AND ELECTRONIC SIGNATURES AND REPRESENTATIONS: This Contract may be executed in two or more counterparts, each of which will be deemed an original, but all of which together will constitute one and the same Contract. The facsimile, email or electronic signature of the Parties will be deemed to constitute original signatures, and facsimile or electronic copies hereof shall be deemed to constitute duplicate originals. The County and Contractor hereby agree to regard electronic representations of original signatures of authorized officers of each party, when appearing in appropriate places on the Amendments prepared pursuant to ALTERATIONS OF TERMS/AMENDMENTS Paragraph and received via

communications facilities, (e.g., facsimile, email or electronic signature), as legally sufficient evidence that such legally binding signatures have been affixed to Amendments to this Contract.

46. FAIR LABOR STANDARDS: Contractor must comply with all applicable provisions of the Federal Fair Labor Standards Act and must indemnify, defend, and hold harmless the County and its agents, officers, and employees from any and all liability, including, but not limited to, wages, overtime pay, liquidated damages, penalties, court costs, and attorneys' fees arising under any wage and hour law, including, but not limited to, the Federal Fair Labor Standards Act, for work performed by Contractor's employees for which the County may be found jointly or solely liable.

47. FISCAL DISCLOSURE: Contractor shall prepare and submit to Director, within 10 calendar days following execution of this Contract, a statement executed by Contractor's duly constituted officers, containing the following information: a detailed statement listing all sources of funding to Contractor including private contributions, nature of the funding, services to be provided, total dollar amount, and period of time of such funding.

If during the term of this Contract, the source(s) of Contractor's funding changes, Contractor shall promptly notify Director in writing, detailing such changes.

48. FORCE MAJEURE:

A. Neither party will be liable for such party's failure to perform its obligations under and in accordance with this Contract, if such failure arises out of fires, floods, epidemics, quarantine restrictions, other natural occurrences, strikes, lockouts (other than a lockout by such party or any of such party's

subcontractors), freight embargoes, or other similar events to those described above, but in every such case the failure to perform must be totally beyond the control and without any fault or negligence of such party (such events are referred to in this paragraph as "force majeure events").

B. Notwithstanding the foregoing, a default by a subcontractor of contractor will not constitute a force majeure event, unless such default arises out of causes beyond the control of both Contractor and such subcontractor, and without any fault or negligence of either of them. In such case, Contractor will not be liable for failure to perform, unless the goods or services to be furnished by the subcontractor were obtainable from other sources in sufficient time to permit contractor to meet the required performance schedule. As used in this subparagraph, the term “subcontractor” and “subcontractors” mean subcontractors at any tier.

C. In the event Contractor's failure to perform arises out of a force majeure event, Contractor agrees to use commercially reasonable best efforts to obtain goods or services from other sources, if applicable, and to otherwise mitigate the damages and reduce the delay caused by such force majeure event.

49. GOVERNING LAW, JURISDICTION, AND VENUE: This Contract will be governed by, and construed in accordance with, the laws of the State of California. Contractor agrees and consents to the exclusive jurisdiction of the courts of the State of California for all purposes regarding this Contract and further agrees and consents that venue of any action brought hereunder will be exclusively in the County of Los Angeles.

50. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA): The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations. The County and Contractor therefore agree to the terms of Exhibit F.

51. INDEPENDENT CONTRACTOR STATUS:

A. This Contract is by and between the County and Contractor and is not intended, and must not be construed, to create the relationship of agent, servant, employee, partnership, joint venture, or association, as between the County and Contractor. The employees and agents of one party must not be, or be construed to be, the employees or agents of the other party for any purpose whatsoever.

B. Contractor will be solely liable and responsible for providing to, or on behalf of, all persons performing work pursuant to this Contract all compensation and benefits. The County will have no liability or responsibility for the payment of any salaries, wages, unemployment benefits, disability benefits, federal, State, or local taxes, or other compensation, benefits, or taxes for any personnel provided by or on behalf of Contractor.

C. Contractor understands and agrees that all persons performing work pursuant to this Contract are, for purposes of Workers' Compensation liability, solely employees of Contractor and not employees of the County. Contractor will be solely liable and responsible for furnishing any and all Workers' Compensation benefits to any person as a result of any injuries arising from or connected with any work performed by or on behalf of Contractor pursuant to this Contract.

D. Contractor must adhere to the provisions stated in the CONFIDENTIALITY Paragraph of this Contract.

52. LICENSES, PERMITS, REGISTRATIONS, ACCREDITATIONS, AND CERTIFICATES: Contractor will obtain and maintain during the term of this Contract, all appropriate licenses, permits, registrations, accreditations, and certificates required by federal, State, and local law for the operation of its business and for the provision of services hereunder. Contractor will ensure that all of its officers, employees, and agents who perform services hereunder obtain and maintain in effect during the term of this Contract, all licenses, permits, registrations, accreditations, and certificates required by federal, State, and local law which are applicable to their performance hereunder. Contractor will provide a copy of each license, permit, registration, accreditation, and certificate upon request of Public Health at any time during the term of this Contract.

53. NONDISCRIMINATION AND AFFIRMATIVE ACTION:

A. Contractor certifies and agrees that all persons employed by it, its affiliates, subsidiaries, or holding companies are and will be treated equally without regard to or because of race, color, religion, ancestry, national origin, sex, age, physical or mental disability, marital status, or political affiliation, in compliance with all applicable federal and State anti-discrimination laws and regulations.

B. Contractor certifies to the County each of the following:

1. Contractor has a written policy statement prohibiting discrimination in all phases of employment.

2. That Contractor periodically conducts a self-analysis or utilization analysis of its work force.

3. That Contractor has a system for determining if its employment practices are discriminatory against protected groups.

4. Where problem areas are identified in employment practices, the Contractor has a system for taking reasonable corrective action, to include establishment of goals or timetables.

C. Contractor must take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to race, color, religion, ancestry, national origin, sex, age, physical or mental disability, marital status, or political affiliation, in compliance with all applicable federal and State anti-discrimination laws and regulations. Such action must include, but is not limited to: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.

D. Contractor certifies and agrees that it will deal with its subcontractors, bidders, or vendors without regard to or because of race, color, religion, ancestry, national origin, sex, age, physical or mental disability, marital status, or political affiliation.

E. Contractor certifies and agrees that it, its affiliates, subsidiaries, or holding companies will comply with all applicable federal and State laws and regulations to the end that no person will, on the grounds of race, color,

religion, ancestry, national origin, sex, age, physical or mental disability, marital status, or political affiliation, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Contract or under any project, program, or activity supported by this Contract.

F. Contractor will allow County representatives access to Contractor's employment records during regular business hours to verify compliance with the provisions of this Paragraph (Nondiscrimination and Affirmative Action) when so requested by the County.

G. If the County finds that any provisions of this Paragraph (Nondiscrimination and Affirmative Action) have been violated, such violation will constitute a material breach of this Contract upon which the County may terminate or suspend this Contract. While the County reserves the right to determine independently that the anti-discrimination provisions of this Contract have been violated, in addition, a determination by the California Fair Employment and Housing Commission or the Federal Equal Employment Opportunity Commission that the contractor has violated Federal or State anti-discrimination laws or regulations will constitute a finding by the County that the contractor has violated the anti-discrimination provisions of this Contract.

H. The parties agree that in the event Contractor violates any of the anti-discrimination provisions of this Contract, the County will, at its sole option, be entitled to the sum of five hundred dollars ($500) for each such violation pursuant to California Civil Code Section 1671 as liquidated damages in lieu of terminating or suspending this Contract.

54. NON-EXCLUSIVITY: Nothing herein is intended nor will be construed as creating any exclusive arrangement with Contractor. This Contract will not restrict the County from acquiring similar, equal, or like goods and/or services from other entities or sources.

55. NOTICE OF DELAYS: Except as otherwise provided under this Contract, when either party has knowledge that any actual or potential situation is delaying or threatens to delay the timely performance of this Contract, that party shall, within one business day, give notice thereof, including all relevant information with respect thereto, to the other party.

56. NOTICE OF DISPUTES: Contractor must bring to the attention of the County's Project Manager and/or County's Project Director any dispute between the County and Contractor regarding the performance of services as stated in this Contract. If the County's Project Manager or County's Project Director is not able to resolve the dispute, the Director will resolve it.

57. NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT: Contractor must notify its employees, and will require each Subcontractor to notify its employees, that they may be eligible for the Federal Earned Income Credit under the federal income tax laws. Such notice must be provided in accordance with the requirements set forth in Internal Revenue Service Notice No. 1015.

58. NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW: Contractor must notify and provide to its employees, and will require each Subcontractor to notify and provide to its employees, information regarding the Safely

Surrendered Baby Law, its implementation in Los Angeles County, and where and how to safely surrender a baby. Additional information is available at: https://lacounty.gov/residents/family-services/child-safety/safe-surrender/.

59. PROHIBITION AGAINST INDUCEMENT OR PERSUASION: Notwithstanding the above, Contractor and the County agree that, during the term of this Contract and for a period of one year thereafter, neither party will in any way intentionally induce or persuade any employee of one party to become an employee or agent of the other party. No bar exists against any hiring action initiated through a public announcement.

60. PROHIBITION AGAINST PERFORMANCE OF SERVICES WHILE UNDER THE INFLUENCE: Contractor will ensure that no employee or physician performs services while under the influence of any alcoholic beverage, medication, narcotic, or other substance that might impair his/her physical or mental performance.

61. PUBLIC RECORDS ACT:

A. Any documents submitted by Contractor; all information obtained in connection with the County's right to audit and inspect the Contractor's documents, books, and accounting records pursuant to the RECORD RETENTION AND AUDITS Paragraph of this Contract; as well as those documents which were required to be submitted in response to the solicitation process for this Contract, become the exclusive property of the County. All such documents become a matter of public record and will be regarded as public records. Exceptions will be those elements in the California Government Code Section 7921.000 et seq. (Public Records Act) and which are marked "trade secret," "confidential," or

"proprietary." The County will not in any way be liable or responsible for the disclosure of any such records including, without limitation, those so marked, if disclosure is required by law, or by an order issued by a court of competent jurisdiction.

B. In the event the County is required to defend an action on a Public Records Act request for any of the aforementioned documents, information, books, records, and/or contents of a proposal marked "trade secret," "confidential," or "proprietary," Contractor agrees to defend and indemnify the County from all costs and expenses, including reasonable attorney's fees, in action or liability arising under the Public Records Act.

62. PURCHASES:

A. Purchase Practices: Contractor shall fully comply with all federal, State, and County laws, ordinances, rules, regulations, manuals, guidelines, and directives, in acquiring all furniture, fixtures, equipment, materials, and supplies. Such items shall be acquired at the lowest possible price or cost if funding is provided for such purposes hereunder.

B. Proprietary Interest of County: In accordance with all applicable federal, State, and County laws, ordinances, rules, regulations, manuals, guidelines, and directives, County shall retain all proprietary interest, except for use during the term of this Contract, in all furniture, fixtures, equipment, materials, and supplies, purchased or obtained by Contractor using any Contract funds designated for such purpose. Upon the expiration or earlier termination of this Contract, the discontinuance of the business of Contractor, the failure of

Contractor to comply with any of the provisions of this Contract, the bankruptcy of Contractor or its giving an assignment for the benefit of creditors, or the failure of Contractor to satisfy any judgment against it within 30 calendar days of filing, County shall have the right to take immediate possession of all such furniture, removable fixtures, equipment, materials, and supplies, without any claim for reimbursement whatsoever on the Contractor's part. Contractor, in conjunction with County, shall attach identifying labels on all such property indicating the proprietary interest of County.

C. Inventory Records, Controls, and Reports: Contractor shall maintain accurate and complete inventory records and controls for all furniture, fixtures, equipment, materials, and supplies, purchased or obtained using any contract funds designated for such purpose. Annually, Contractor shall provide Director with an accurate and complete inventory report of all furniture, fixtures, equipment, materials, and supplies, purchased or obtained using any County funds designated for such purpose.

D. Protection of Property in Contractor's Custody: Contractor must maintain vigilance and take all reasonable precautions, to protect all furniture, fixtures, equipment, materials, and supplies, purchased or obtained using any Contract funds designated for such purpose, against any damage or loss by fire, burglary, theft, disappearance, vandalism, or misuse. Contractor must contact Director for instructions for disposition of any such property which is worn out or unusable.

E. Disposition of Property in Contractor's Custody: Upon the termination of the funding of any program covered by this Contract, or upon the expiration or early termination of this Contract, or at any other time that County may request, Contractor shall: (1) provide access to and render all necessary assistance for physical removal by Director or authorized representatives, of any or all furniture, fixtures, equipment, materials, and supplies, purchased or obtained using any County funds designated for such purpose, in the same condition as such property was received by Contractor, reasonable wear and tear expected; or, (2) at Director's option, deliver any or all items of such property to a location designated by Director. Any disposition, settlement, or adjustment connected with such property shall be in accordance with all applicable federal, State, and County laws, ordinances, rules, regulations, manuals, guidelines, and directives.

63. REAL PROPERTY AND BUSINESS OWNERSHIP DISCLOSURE:

A. Real Property Disclosure: If Contractor is renting, leasing, or subleasing, or is planning to rent, lease, or sublease, any real property where persons are to receive services hereunder, Contractor shall prepare and submit to Director within 10 calendar days following execution of this Contract, an affidavit sworn to and executed by Contractor's duly constituted officers, containing the following information:

(1) The location by street address and city of any such real property.

(2) The fair market value of any such real property as such value is reflected on the most recently issued County Tax Collector's tax bill.

(3) A detailed description of all existing and pending rental agreements, leases, and subleases with respect to any such real property, such description to include: the term (duration) of such rental agreement, lease or sublease; the amount of monetary consideration to be paid to the lessor or sublessor over the term of the rental agreement, lease or sublease; the type and dollar value of any other consideration to be paid to the lessor or sublessor over the term of the rental agreement, lease, or sublease; the full names and addresses of all parties who stand in the position of lessor or sublessor; if the lessor or sublessor is a private corporation and its shares are not publicly traded (on a stock exchange or over-the-counter), a listing by full names of all officers, directors, and stockholders thereof; and if the lessor or sublessor is a partnership, a listing by full names of all general and limited partners thereof.

(4) A listing by full names of all Contractor's officers, directors, members of its advisory boards, members of its staff and consultants, who have any family relationships by marriage or blood with a lessor or sublessor referred to in sub-paragraph (3) immediately above, or who have any financial interest in such lessor's or sublessor's business, or both. If such lessor or sublessor is a corporation or partnership, such listing shall also include the full names of all Contractor's officers,

members of its advisory boards, members of its staff and consultants, who have any family relationship, by marriage or blood, to an officer, director, or stockholder of the corporation, or to any partner of the partnership. In preparing the latter listing, Contractor shall also indicate the names(s) of the officer(s), director(s), stockholder(s), or partner(s), as appropriate, and the family relationship which exists between such person(s) and Contractor's representatives listed.

(5) If a facility of Contractor is rented or leased from a parent organization or individual who is a common owner, (as defined by Federal Health Insurance Manual 15, Chapter 10, Paragraph 1002.2), Contractor shall only charge the program for costs of ownership. Costs of ownership shall include depreciation, interest, and applicable taxes.

True and correct copies of all written rental agreements, leases, and subleases with respect to any such real property shall be appended to such affidavit and made a part thereof.

B. Business Ownership Disclosure: Contractor shall prepare and submit to Director, upon request, a detailed statement, executed by Contractor's duly constituted officers, indicating whether Contractor totally or partially owns any other business organization that will be providing services, supplies, materials, or equipment to Contractor or in any manner does business with Contractor under this Contract. If, during the term of this Contract, the Contractor's ownership of other businesses dealing with Contractor under this

Contract changes, Contractor shall notify Director in writing of such changes within 30 calendar days prior to the effective date thereof.

64. REPORTS: Contractor shall make reports as required by County concerning Contractor's activities and operations as they relate to this Contract and the provision of services hereunder. However, in no event may County require such reports unless Director has provided Contractor with at least 30 calendar days' prior written notification thereof. Director's notification shall provide Contractor with a written explanation of the procedures for reporting the information required.

65. RECYCLED CONTENT BOND PAPER: Consistent with the Board of Supervisors' policy to reduce the amount of solid waste deposited at County landfills, Contractor agrees to use recycled-content bond paper to the maximum extent possible in connection with services to be performed by Contractor under this Contract.

66. PROHIBITION FROM PARTICIPATION IN FUTURE SOLICITATION(S): A Proposer, or a Contractor or its subsidiary or Subcontractor ("Proposer/Contractor"), is prohibited from submitting a bid or proposal in a County solicitation if the Proposer/Contractor has provided advice or consultation for the solicitation. A Proposer/Contractor is also prohibited from submitting a bid or proposal in a County solicitation if the Proposer/Contractor has developed or prepared any of the solicitation materials on behalf of the County. A violation of this provision will result in the disqualification of the Contractor/Proposer from participation in the County solicitation or the termination or cancellation of any resultant County contract. This provision will survive the expiration, or other termination of this Agreement.

67. STAFFING AND TRAINING/STAFF DEVELOPMENT: Contractor shall operate continuously throughout the term of this Contract with at least the minimum number of staff required by County. Such personnel shall be qualified in accordance with standards established by County. In addition, Contractor shall comply with any additional staffing requirements which may be included in the Exhibits attached hereto.

During the term of this Contract, Contractor shall have available and shall provide upon request to authorized representatives of County, a list of persons by name, title, professional degree, salary, and experience who are providing services hereunder. Contractor also shall indicate on such list which persons are appropriately qualified to perform services hereunder. If an executive director, program director, or supervisorial position becomes vacant during the term of this Contract, Contractor must, prior to filling said vacancy, notify County's Director. Contractor must provide the above set forth required information to County's Director regarding any candidate prior to any appointment. Contractor must institute and maintain appropriate supervision of all persons providing services pursuant to this Contract.

Contractor must institute and maintain a training/staff development program pertaining to those services described in the Exhibit(s) attached hereto. Appropriate training/staff development shall be provided for treatment, administrative, and support personnel. Participation of treatment and support personnel in training/staff development should include in-service activities. Such activities must be planned and scheduled in advance, and conducted on a continuing basis. Contractor must develop and institute a plan for an annual evaluation of such training/staff development program.

68. SUBCONTRACTING:

A. For purposes of this Contract, subcontracts must be approved in advance in writing by Director or authorized designee(s). Contractor's request to Director for approval of a subcontract shall include:

(1) Identification of the proposed Subcontractor, (who shall be licensed as appropriate for provision of subcontract services), and an explanation of why and how the proposed Subcontractor was selected, including the degree of competition involved.

(2) A detailed description of the services to be provided by the subcontract.

(3) The proposed subcontract amount and manner of compensation, if any, together with Contractor's cost or price analysis thereof.

(4) A copy of the proposed subcontract. (Any later modification of such subcontract shall take the form of a formally written subcontract amendment which also must be approved in writing by the Director in the same manner as described above, before such amendment is effective.)

(5) Any other information and/or certification(s) requested by Director.

B. Director will review Contractor's request to subcontract and determine, in his/her sole discretion, whether or not to consent to such a request on a case-by-case basis.

C. Subcontracts must be made in the name of Contractor and may not bind nor purport to bind County. The making of subcontracts hereunder does not relieve Contractor of any requirement under this Contract, including, but not limited to, the duty to properly supervise and coordinate the work of Subcontractors. Further, Director's approval of any subcontract must also not be construed to limit in any way, any of County's rights or remedies contained in this Contract.

D. In the event that Director consents to any subcontracting, Contractor is solely liable and responsible for any and all payments or other compensation to all Subcontractors, and their officers, employees, and agents.

E. In the event that Director consents to any subcontracting, such consent is provisional, and shall not waive the County's right to later withdraw that consent when such action is deemed by County to be in its best interest. County is not liable or responsible in any way to Contractor, or any Subcontractor, for any liability, damages, costs, or expenses, arising from or related to County's exercising of such a right.

F. The County's consent to subcontract does not waive the County's right to prior and continuing approval of any and all personnel, including Subcontractor employees, providing services under this Contract. The Contractor must notify its Subcontractors of this County right.

G. Subcontracts must contain the following provision: "This contract is a subcontract under the terms of a prime contract with the County of Los Angeles and is subject to all of the provisions of such prime contract." Further, Contractor

shall also reflect as Subcontractor requirements in the subcontract form all of the requirements of the INDEMNIFICATION, GENERAL PROVISIONS FOR ALL INSURANCE COVERAGES, INSURANCE COVERAGE REQUIREMENTS, COMPLIANCE WITH APPLICABLE LAW, CONFLICT OF TERMS and ALTERATION OF TERMS Paragraphs and all of the provisions of this Contract.

Contractor must deliver to Director a fully executed copy of each subcontract entered into by Contractor, as it pertains to the provision of services under this Contract, on or immediately after the effective date of the subcontract, but in no event, later than the date any services are to be performed under the subcontract.

H. Contractor shall obtain certificates of insurance which establish that the Subcontractor maintains all the programs of insurance required by the County from each approved Subcontractor.

I. Director is hereby authorized to act for and on behalf of County pursuant to this Paragraph, including but not limited to, consenting to any subcontracting.

J. Contractor will indemnify, defend, and hold the County harmless with respect to the activities of each and every Subcontractor in the same manner and to the same degree as if such Subcontractor(s) were Contractor employees.

K. Contractor shall remain fully responsible for all performances required of it under this Contract, including those that Contractor has determined to subcontract, notwithstanding the County's approval of Contractor's proposed subcontract.

69. TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM: Contractor's failure to maintain compliance with the requirements set forth in the Paragraph entitled CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM, herein, will constitute default under this Contract. Without limiting the rights and remedies available to the County under any other provision of this Contract, Contractor's failure to cure such default within 90 calendar days of written notice will be grounds upon which the County may terminate this Contract pursuant to the Paragraph entitled TERMINATION FOR DEFAULT, herein, and pursue debarment of the Contractor, pursuant to County Code Chapter 2.202.

70. TERMINATION FOR CONVENIENCE: This Contract may be terminated, in whole or in part, from time to time, when such action is deemed by County, in its sole discretion, to be in its best interest. Termination of services hereunder will be effected by Notice of Termination to Contractor specifying the extent to which performance of work is terminated and the date upon which such termination becomes effective. The date upon which such termination becomes effective will be no less than 30 days after the notice is sent.

After receipt of a Notice of Termination and except as otherwise directed by County, Contractor must:

A. Stop work under this Contract on the date and to the extent specified in such Notice of Termination; and

B. Complete performance of such part of the work as would not have been terminated by such Notice of Termination.

Further, after receipt of a Notice of Termination, Contractor shall submit to County, in the form and with the certifications as may be prescribed by County, its termination claim and invoice. Such claim and invoice shall be submitted promptly, but not later than 60 calendar days from the effective date of termination. Upon failure of Contractor to submit its termination claim and invoice within the time allowed, County may determine on the basis of information available to County, the amount, if any, due to Contractor in respect to the termination, and such determination shall be final. After such determination is made, County shall pay Contractor the amount so determined.

Contractor, for a period of seven years after final settlement under this Contract, in accordance with the Paragraph entitled RECORD RETENTION AND AUDITS, herein, shall retain and make available all its books, documents, records, or other evidence, bearing on the costs and expenses of Contractor under this Contract in respect to the termination of services hereunder. All such books, records, documents, or other evidence shall be retained by Contractor at a location in Los Angeles County and shall be made available within 10 calendar days of prior written notice during County's normal business hours to representatives of County for purposes of inspection or audit.

71. TERMINATION FOR DEFAULT: The County may, by written notice to Contractor, terminate the whole or any part of this Contract, if, in the judgement of County's Project Director:

A. Contractor has materially breached this Contract; or

B. Contractor fails to timely provide and/or satisfactorily perform any task, deliverable, service, or other work required either under this Contract; or

C. Contractor fails to demonstrate a high probability of timely fulfillment of performance requirements under this Contract, or of any obligations of this Contract and in either case, fails to demonstrate convincing progress toward a cure within five working days (or such longer period as the County may authorize in writing) after receipt of written notice from the County specifying such failure.

In the event that the County terminates this Contract in whole or in part as provided hereinabove, the County may procure, upon such terms and in such manner as the County may deem appropriate, goods and services similar to those so terminated. Contractor will be liable to the County, for such similar goods and services. Contractor will continue the performance of this Contract to the extent not terminated under the provisions of this paragraph.

Except with respect to defaults of any subcontractor, Contractor will not be liable for any such excess costs of the type identified in the Paragraph hereinabove if its failure to perform this Contract arises out of causes beyond the control and without the fault or negligence of Contractor. Such causes may include, but are not limited to: acts of God or of the public enemy, acts of the County in either its sovereign or contractual capacity, acts of federal or State governments in their sovereign capacities, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, and unusually severe weather; but in every case, the failure to perform must be beyond the control and without the

fault or negligence of the contractor. If the failure to perform is caused by the default of a subcontractor, and if such default arises out of causes beyond the control of both Contractor and any subcontractor, and without the fault or negligence of either of them, the contractor will not be liable for any such excess costs for failure to perform, unless the goods or services to be furnished by the subcontractor were obtainable from other sources in sufficient time to permit Contractor to meet the required performance schedule. As used in this paragraph, the term "subcontractor(s)" means subcontractor(s) at any tier.

If, after the County has given notice of termination under the provisions of this paragraph, it is determined by the County that Contractor was not in default under the provisions of this paragraph or that the default was excusable under the provisions hereinabove, the rights and obligations of the parties will be the same as if the notice of termination had been issued pursuant to the Paragraph entitled TERMINATION FOR CONVENIENCE, herein.

The rights and remedies of County provided in this Paragraph will not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

72. TERMINATION FOR IMPROPER CONSIDERATION: County may, by written notice to Contractor, immediately terminate Contractor's right to proceed under this Contract, if it is found that consideration, in any form, was offered or given by Contractor, either directly or through an intermediary, to any County officer, employee, or agent, with the intent of securing this Contract or securing favorable treatment with respect to the award, amendment, or extension this Contract, or making of any

determinations with respect to the Contractor's performance pursuant to this Contract. In the event of such termination, the County will be entitled to pursue the same remedies against Contractor as it could pursue in the event of default by Contractor.

Contractor must immediately report any attempt by a County officer or employee to solicit such improper consideration. The report must be made either to the County manager charged with the supervision of the employee or to the County Auditor-Controller's Employee Fraud Hotline at (800) 544-6861.

Among other items, such improper considerations may take the form of cash, discounts, services, the provision of travel or entertainment, or other tangible gifts.

73. TERMINATION FOR INSOLVENCY: The County may terminate this Contract forthwith in the event of the occurrence of any of the following:

A. Insolvency of Contractor. Contractor will be deemed to be insolvent if it has ceased to pay its debts at least 60 days in the ordinary course of business or cannot pay its debts as they become due, whether or not a petition has been filed under the Federal Bankruptcy Code and whether or not Contractor is insolvent within the meaning of the Federal Bankruptcy Code;

B. The filing of a voluntary or involuntary petition regarding Contractor under the federal Bankruptcy Code;

C. The appointment of a Receiver or Trustee for Contractor;

D. The execution by Contractor of a general assignment for the benefit of creditors.

The rights and remedies of the County provided in this Paragraph will not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

74. TERMINATION FOR NON-APPROPRIATION OF FUNDS: Notwithstanding any other provision of this Contract, the County will not be obligated for Contractor's performance hereunder, or by any provision of this Contract during any of the County's future fiscal years, unless and until the County's Board of Supervisors appropriates funds for this Contract in the County's Budget for each such future fiscal year. In the event that funds are not appropriated for this Contract, then this Contract shall terminate as of June 30th, of the last fiscal year for which funds were appropriated. The County will notify Contractor in writing of any such non-allocation of funds at the earliest possible date.

75. NO INTENT TO CREATE A THIRD PARTY BENEFICIARY CONTRACT: Notwithstanding any other provision of this Contract, the parties do not in any way intend that any person shall acquire any rights as a third party beneficiary under this Contract.

76. TIME OFF FOR VOTING: Contractor must notify its employees, and must require each Subcontractor to notify and provide to its employees, information regarding the time off for voting law (Elections Code Section 14000). Not less than 10 days before every Statewide election, Contractor and any Subcontractors must keep posted conspicuously at the place of work, if practicable, or elsewhere where it can be seen as employees come or go to their place of work, a notice setting forth the provisions of Elections Code Section 14000.

77. VALIDITY: If any provision of this Contract or the application thereof to any person or circumstance is held invalid, the remainder of this Contract and the application of such provision to other persons or circumstances will not be affected thereby.

78. WAIVER: No waiver by the County of any breach of any provision of this Contract will constitute a waiver of any other breach or of such provision. Failure of the County to enforce at any time, or from time to time, any provision of this Contract will not be construed as a waiver thereof. The rights and remedies set forth in this Paragraph will not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

79. WARRANTY AGAINST CONTINGENT FEES:

A. Contractor warrants that no person or selling agency has been employed or retained to solicit or secure this Contract upon any Contract or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by Contractor for the purpose of securing business.

B. For breach of this warranty, the County will have the right to terminate this Contract and, at its sole discretion, deduct from the Contract price or consideration, or otherwise recover, the full amount of such commission, percentage, brokerage, or contingent fee.

80. WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM:

Contractor acknowledges that County has established a goal of ensuring that all individuals and businesses that benefit financially from County through contract are current in paying their property tax obligations (secured and unsecured roll) in order to mitigate the economic burden otherwise imposed upon County and its taxpayers.

Unless Contractor qualifies for an exemption or exclusion, Contractor warrants and certifies that to the best of its knowledge it is now in compliance, and during the term of this Contract will maintain compliance, with Los Angeles County Code Chapter 2.206.

81. TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM: Failure of Contractor to maintain compliance with the requirements set forth in the Paragraph entitled WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM, herein, will constitute default under this Contract. Without limiting the rights and remedies available to County under any other provision of this Contract, failure of Contractor to cure such default within 10 days of notice shall be grounds upon which County may terminate this Contract and/or pursue debarment of Contractor, pursuant to County Code Chapter 2.202.

82. INJURY AND ILLNESS PREVENTION PROGRAM:

Contractor will be required to comply with the State of California's Cal OSHA's regulations. California Code of Regulations Title 8 Section 3203 requires all California employers to have a written, effective Injury and Illness Prevention

Program (IIPP) that addresses hazards pertaining to the particular workplace covered by the program.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Contract to be subscribed by its Director of Public Health, and Contractor has caused this Contract to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____
Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

_____
Contractor

By _____
Signature

_____
Printed Name

Title_____

APPROVED AS TO FORM
BY THE OFFICE OF THE COUNTY COUNSEL
DAWYN R. HARRISON
County Counsel

APPROVED AS TO CONTRACT
ADMINISTRATION:

Department of Public Health

By_____
Contracts and Grants Division Management

Revised 10-2022 – Approved by Counsel

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
TRAUMA PREVENTION INITIATVIE:
HOSPITAL VIOLENCE INTERVENTION PROGRAM SERVICES

STATEMENT OF WORK

INTRODUCTION

The Office of Violence Prevention (OVP) was established by the County of Los Angeles (County) Board of Supervisors within the Department of Public Health (Public Health) in February 2019 to: 1) strengthen the coordination, capacity and partnerships in addressing the root causes of violence, 2) advance policies and practices that are grounded in race equity, 3) prevent all forms of violence, and 4) promote healing across all communities in Los Angeles County (LAC). The services described in herein are part of the Trauma Prevention Initiative (TPI), a priority of OVP's Strategic Plan.

In 2015, Public Health began implementing TPI to reduce the disproportionate impact of violence and trauma among Black and Latinx communities of South Los Angeles. Recognizing the need to invest in prevention, and to reduce the burden on the County's trauma hospital system, the County Board of Supervisors and Emergency Medical Services Agency allocated ongoing Measure B funding to Public Health to implement TPI. Measure B dollars are collected through a county parcel tax and provides funding for the County's trauma hospital system. TPI has developed a comprehensive, place-based violence prevention and intervention strategy, that aligns with County services and initiatives to support community-driven safety solutions. The goal of TPI is to reduce trauma visits and deaths due to assault, and reduce serious and violent crimes throughout LAC, with an initial focus on reducing the high rates of violence in South Los Angeles by investing in three key areas:

1) Intervention, by using a peer approach to break the cycle of violence in hospital and community settings.

2) Prevention infrastructure, by leveraging parks and other community hubs for innovative programming, facilitating community dialogue and decision making, and funding community identified strategies; and

3) Capacity building, by providing technical assistance for grassroots organizations and multidisciplinary training opportunities.

By empowering communities and working with County partners to advance systems change, TPI is building a transformative approach to public safety that is equitable and healing informed. TPI strategies are providing a strong foundation for building a countywide crisis response system tailored to the unique needs of communities. TPI includes a mix of funded strategies and strategies implemented by County departments

and other partners that are leveraged to meet the needs of communities. TPI includes the following components:

- **Hospital Violence Intervention Program (HVIP)** employs credible messengers to engage victims of violence during a teachable moment in the trauma center and provides follow-up case management (CM) upon release. Public Health participates in Hospital Violence Intervention Consortium with community-based organizations, Department of Health Services, and private trauma centers to improve coordination across hospitals and partners. OVP has contracted for HVIP services with St. Francis Medical Center, and Harbor UCLA Medical Center since July 2017.

- **Street Outreach and Community Violence Intervention (SOCVI)** agencies employ credible messengers to: 1) respond to violent incidents, 2) conduct rumor control and maintain peace across neighborhoods, 3) conduct safe passages to and from schools and parks, and 4) link gang-impacted and affiliated community members to resources and services. Through TPI, OVP has established protocols for unincorporated communities, with clear roles, and guidelines for collaboration with the Department of Parks and Recreation for safe passages, and with the Sheriff's Department for incident response. OVP has contracted for SOCVI services in four South Los Angeles communities (Westmont West Athens, Willowbrook, Florence Firestone, and unincorporated Compton) since July 2018.

- **Community Engagement** supports community residents and stakeholders or existing coalitions, to empower leadership, promote positive community identity, provide opportunities for shared decision making to inform implementation, and create collaborative support networks. TPI will be linked to the OVP Regional Violence Prevention Coalitions, which will serve as regional coordination hubs. OVP has established Community Action for Peace (CAP) networks in Westmont West Athens since 2017 and in Willowbrook since 2018.

- **Peer-to-Peer Violence Prevention Learning Academy** (P2P), which is in its planning phase, will implement cross-training cohorts of peer support specialists, such as community intervention workers, *promotores*, and others, in violence prevention and trauma and healing informed practice, and connects peers to collaborate on system navigation. OVP contracted with consultants to develop a P2P landscape analysis, curriculum and workplan from 2018-2019, and piloted P2P training during 2020-2021 as part of the COVID-19 Community Health Worker Outreach Initiative.

- **Capacity Building Training and Technical Assistance** project supports grassroots violence prevention and intervention agencies, in the areas of organizational development, funding, marketing, and evaluation. Originally implemented in TPI communities in 2017-2018, the Probation Department funded an expansion of this service countywide to provide short-term technical assistance during the COVID-19 pandemic period from 2019-2022.

1.0 DEFINITIONS

1.1 AB109: California Assembly Bill AB109 which established the Public Safety Realignment Act of 2011 designed to reduce state prison populations by shifting responsibility for non-violent, non-serious, and non-sex offenders to be supervised at the local county level. It also provides local funding for initiatives that support these populations.

1.2 Board: County of Los Angeles Board of Supervisors. The governing body of the County serving as both the executive and legislative head of the County.

1.3 Case Management (CM): a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for services to meet an individual's and family's multiple health needs.

1.4 Hospital Violence Intervention Program (HVIP): An approach that employs peer outreach works and combines brief in-hospital intervention with intensive community-based CM and provides targeted services to high-risk populations to reduce risk factors for re-injury and retaliation while cultivating protective factors.

1.5 Street Outreach and Community Violence Intervention (SOCVI) Services: Intervention services, inclusive of Safe Passage, designed to provide specialized, street-based mediation and mitigation efforts to stop or prevent violence between gang members and gang neighborhoods, and the concurrent redirection of individual gang members and their families in ways that bring progress to themselves and their communities.

2.0 SERVICES TO BE PROVIDED:

HVIP services is an intervention used throughout the nation to reduce community violence and decrease repeat visits to trauma centers for violence-related injuries. The overall objective of HVIP is to provide an intervention for victims of violence at a critical point – when they present at the trauma hospital site with assault-related injuries. Contractor will provide trained case managers for CM services which includes but will not be limited to engaging and developing rapport with patients at bedside in the trauma center, and linking patients to community resources and services, based on individualized assessments. Case managers will provide the victims with support and assistance in the trauma center and during the critical months following the patient's discharge. An example of CM services is providing access to resources such as mental health services, tattoo removal, general education development programs, employment, court advocacy, substance use assistance, and housing. The strategy is designed to quickly stem the flow of violence in a given community while building a network of prevention and intervention support for the victim.

2.1 HVIP Services include: establishing a Memorandum of Understanding (MOU) between the trauma hospital site and community-based organization that will provide the HVIP services, establishing a 24/7 response protocol with the trauma hospital site to refer and engage patients, intake and assessment for clients who consent to services, individualized service plan, CM services and referrals and follow-up.

2.2 Contractor must provide HVIP services to patients who are being treated for violence-related injuries, including community and gang violence, or domestic violence, with a focus on patients who reside or were injured in TPI communities.

2.3 Contractor must provide individualized service plan and CM for clients who consent to services, provide peer support, mentoring and system navigation, and linking to services that meet client goals, including but not limited to: victim assistance, education, job development and employment services, mental health and substance abuse services, housing and basic needs. The type and duration of services is based upon the needs of a client as documented in the service plan, with a recommended minimum of 6 months follow-up post hospital discharge.

2.4 Contractor must coordinate with OVP TPI staff regarding the provision of HVIP services to ensure coordination and standardized protocols across sites, including participation in meetings and evaluation activities.

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

All changes must be made in accordance with the Contract Paragraph 8. Alteration of Terms/Amendments.

4.0 QUALITY CONTROL

The Contractor must 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 must be submitted to the County Contract Project Monitor for review. The plan must include, but may not be limited to the following:

4.1 Method of monitoring to ensure that Contract requirements are being met;

4.2 A record of all inspections 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, must be provided to the County upon request.

5.0 QUALITY ASSURANCE PLAN

The County will evaluate the Contractor's performance under this Contract using the quality assurance procedures as defined in Paragraph 40, County's Quality

Assurance Plan of the Contract.

5.1 **Monthly Meetings**

Contractor is required to attend a scheduled monthly meeting.

5.2 **Contract Discrepancy Report**

Verbal notification of a Contract discrepancy will be made to the Contract Project Monitor as soon as possible whenever a Contract discrepancy is identified. The problem must be resolved within a time period mutually agreed upon by the County and the Contractor.

The County Contract Project Monitor will determine whether a formal Contract Discrepancy Report must be issued. Upon receipt of this document, the Contractor is required to respond in writing to the County Contract Project Monitor within fifteen (15) workdays, acknowledging the reported discrepancies or presenting contrary evidence. A plan for correction of all deficiencies identified in the Contract Discrepancy Report must be submitted to the County Contract Project Monitor within thirty (30) workdays.

5.3 **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.

6.0 RESPONSIBLITIES

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 23, Administration of Contract. 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, Alteration of Terms/Amendments.

6.2 **Furnished Items**

The County will provide the Contractor with previous HVIP tools and evaluation reports, a Case Management Database and evaluation support via a contracted evaluation agency.

CONTRACTOR

6.3 **Project Manager and Case Manager**

6.3.1 Contractor must provide a part-time Project Manager equivalent (FTE) or designated alternate, who will supervise and oversee all staff and services provided. Contractor must provide a telephone number where the Project Manager and where calls received by the answering service must be returned by the Project Lead within twenty-four (24) hours of receipt of the call.

6.3.2 Project Manager must act as a central point of contact with the County.

6.3.3 Project Manager must have a minimum of five years of experience in the last seven years overseeing programs providing direct services to community members, with preference for community or hospital based violence intervention.

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

6.3.5 Contractor must also provide a full-time equivalent (FTE) Case Manager, who will provide services directly to participants, and is physically based at Contractor's program office site(s).

6.3.6 The Contractor's Project Manager or designated alternate staff and a Case Manager must respond to any calls during business hours, between 9 am and 5 pm, Monday through Friday.

6.4 Personnel

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

6.4.2 Contractor must be required to conduct a background check of their employees as set forth in in the Contract, Paragraph 22, sub-paragraph D – Background and Security Investigations.

6.5 Uniforms/Identification Badges

6.5.1 Contractor employees assigned to HVIP are required to wear badges and/or shirts that clearly designate their role and their agency name. All uniforms, as required and approved by the Director or designee, will be provided by at Contractor's expense.

6.5.2 Contractor must ensure their employees are appropriately identified as set forth in Paragraph 22, sub-paragraph C – Contractor's Staff Identification, of the Contract.

6.6 Materials and Equipment

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

6.7 Training

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

6.8 Contractor's Office

Contractor must maintain an office with a telephone in the company's name where Contractor conducts business. The office must be staffed during the hours of 9:00 a.m. to 5:00 p.m., Monday through Friday, by at least one 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 must be provided to receive calls. **The Contractor must answer calls received by the answering service within twenty-four (24) hours of receipt of the call.**

6.9 Service Site

Contractor must coordinate with the hospital to provide engagement services on site, and also provide services to clients upon hospital discharge at a site within the surrounding community. Contractor should continuously manage and operate the community-based site(s) for provision of post-discharge services set forth in Exhibit B, Scope of Work.

For the community-based service site, Contractor must obtain required inspection certificates (health, fire, etc.) and written consent of the Director of Public Health or authorized designee before modifying or terminating services, revising hours of service delivered at such location(s), and/or before commencing such services at any other location.

Contractor must maintain the building and surrounding areas in a manner consistent with applicable local, State, and federal occupational safety and

sanitation regulations. The premises must be free of any accumulation of garbage, rubbish, stagnant water, and/or filthy or offensive matter of any kind to ensure that the premises are maintained in a clean and wholesome condition.

7.0 HOURS/DAY OF WORK

The Contractor must conduct routine services/activities during their proposed hours of operation. The Contactor must be required to submit days and hours of operation to Public Health. Upon funding, Contactor will be required to comply with days and hours of operation and notify Public Health of all observed holidays (i.e., office closure dates).

Contractor's site must be open and available to provide the required services to participants Monday through Friday at the service site within the catchment areas of the hospital where Case Management services are provided.

Contractor must ensure that staff responds to any calls and inquiries received between agency's operating hours of 9:00 am and 5:00 pm. In addition, Contractor must make good faith efforts to provide services on weekends and evenings, as needed, in cases where it will increase accessibility to program services and enhance the likelihood of a participant achieving his/her goals.

8.0 WORK SCHEDULES

8.1 Contractor must submit for review and approval a work schedule for each facility to the County Project Director within seven days prior to starting work. Said work schedules must be set on an annual calendar identifying all the required on-going maintenance tasks and task frequencies. The schedules must list the time frames by day of the week, morning, and afternoon the tasks will be performed.

8.2 Contractor must submit revised schedules when actual performance differs substantially from planned performance. Said revisions must be submitted to the County Project Manager for review and approval within two working days prior to revised scheduled time for work.

9.0 UNSCHEDULED WORK

9.1 The County Project Manager or designee may authorize the Contractor to perform unscheduled work, including, but not limited to, repairs and replacements when the need for such work arises out of extraordinary incidents such as vandalism, acts of God, and third party negligence; or to add to, modify or refurbish existing facilities.

9.2 Prior to performing any unscheduled work, the Contractor must prepare and submit a written description of the work with an estimate cost of labor and materials. If the unscheduled work exceeds the Contractor's estimated cost, the County Project Director or designee must approve the excess cost. In any

case, no unscheduled work must commence without written authorization.

9.3 When a condition exists wherein there is imminent danger of injury to the public or damage to property, Contractor must contact County's Project Director for approval before beginning the work. A written estimated cost must be sent within twenty-four (24) hours for approval. Contractor must submit an invoice to County's Project Director within five (5) working days after completion of the work.

9.4 All unscheduled work must commence on the established specified date. Contractor must proceed diligently to complete said work within the time allotted.

9.5 The County reserves the right to perform unscheduled work itself or assign the work to another Contractor.

10.0 SPECIFIC WORK REQUIREMENTS – (Refer to Exhibit B, Scope of Work)

10.1 ORGANIZATIONAL STRUCTURE AND MEETINGS

Contractor must provide Project Manager to oversee the day-to-day project deliverables and the Contract. Work closely with Public Health's finance staff to ensure timely delivery of monthly invoices and other administrative paperwork. The Project Manager must be available to lead and participate in scheduled conference calls and/or meetings with Public Health staff to discuss status updates, including but not limited to: progress & action items on Scope of Work deliverables, and activities developed by Public Health to achieve the objectives of the Scope of Work, as well as Administrative action items. Contractor shall assign other team staff as needed to complete project deliverables and implementation activities in a timely matter.

10.2 PROTOCOLS AND AGREEMENTS

Contractor must develop protocols and agreements to supports the implementation of HVIP services, including establishing an MOU with the trauma hospital site, establishing an oversight committee, and developing a collaboration plan.

10.3 24/7 RESPONSE AND REFERRALS

Contractor must develop 24/7 response protocol that includes procedures to communicate with trauma hospital staff to identify eligible patients, how patients and families will be engaged, and engage a minimum of 100 referred patients per year.

- Pomona Valley Hospital: 100 referred patients
  (To be customized specific to each trauma hospital prior to contract award)

- Harbor UCLA: 200 referred patients
  (To be customized specific to each trauma hospital prior to contract award)

- LAC+USC: 200 referred patients
  (To be customized specific to each trauma hospital prior to contract award)

- St. Francis: 320 referred patients
  (To be customized specific to each trauma hospital prior to contract award)

10.4 INTAKE

Contractor must conduct an interview and complete a Client Intake form and obtain Client Consent Form from all participants who consent to services to obtain information and determine participant's immediate needs.

10.5 ASSESSMENT

Contractor must conduct a comprehensive risk assessment of every new client, using the tool provided by Public Health, to obtain the information needed to develop an Individualized Service Plan. Assessment must be completed within 15 days of intake, and at 3-month interval post engagement, and at exit, at minimum.

10.6 INDIVIDUALIZED SERVICE PLAN

An Individualized Service Plan must be created to empower the participant to engage in services to accomplish desired goals and serve as a guiding document for provision of CM that will be updated to track progress made.

10.7 CASE MANAGEMENT SERVICES

Contractor must provide tailored CM services to a minimum number of clients as identified below per hospital, per year via an Individualized Service Plan. Case Managers should maintain a caseload not to exceed 30 clients.

- Pomona Valley Hospital: 50 clients
  (To be customized specific to each trauma hospital prior to contract award)

- Harbor UCLA: 100 clients
  (To be customized specific to each trauma hospital prior to contract award)

- and LAC+USC: 100 clients

(To be customized specific to each trauma hospital prior to contract award)

- St. Francis: 160 clients
  (To be customized specific to each trauma hospital prior to contract award)

10.8 TRAINING AND STAFF SELF-CARE

Develop a training and staff self-care support plan for Case Managers and other direct services staff. Contractor must allocate a portion of their budget at minimum of $5,000 annually to support training and self-care needs identified by staff. Contractors may also identify other sources of funding to support staff training and self-care.

10.9 HOSPITAL STAFF

Contractor must have an MOU with trauma hospital as referenced in subparagraph 2.1 of this Statement of Work. Contractor will work with the trauma hospital to identify and designate key staff to support HVIP services:

10.9.1 Administrative lead who will provide oversight for HVIP services and is empowered to make decisions on behalf of the trauma hospital.

10.9.2 Trauma Director or designee, who will coordinate day to day operations, including notifications to Contractor and facilitate engagement of patients.

10.9.3 If applicable, Social Workers at the trauma hospital site who can coordinate with HVIP Case Managers to support client needs.

10.10 CLIENT RECORDS

10.10.1 Contractor must maintain a current and comprehensive case file for each client interviewed. The client's case file, at minimum, must contain the following documents/information, which must be entered into a CM database that must be approved by Public Health:

1. Client Intake form (created by the Contractor in collaboration with OVP),

2. Risk Assessment at intake, 3-months and exit, at minimum (created by OVP),

3. Individualized Service Plan (created by the Contractor in collaboration with OVP),

4. Client Consent Form (created by the Contractor in collaboration with OVP),

5. Progress notes with service delivery dates,

6. Key dates for services, including date of hospitalization, initial engagements, consent and intake completed, assessment completed, service plan developed, patient discharge, engagements post discharge including 3-month follow-up, dates of referrals to services, and date CM closed,

7. Case summary post closure, including reason for closure, and narrative assessment of success/goals met, and

8. Client satisfaction survey (created by Public Health).

10.10.2 In addition to other confidentiality requirements set forth in the Contract, Contractor must maintain client's case file in either a locked file cabinet or in a secure room, or encrypted database, to ensure confidentiality. Contractor must ensure confidentiality and provide secure storage, access, and disposal of participant records for seven years after the contact has terminated as set forth in the Contract, Paragraph 16, Record Retention and Audits.

10.11 REQUIRED MEETINGS

Contractor must participate in all required meetings in providing HVIP services.

10.12 REPORTING

Contractor must submit the following:

10.12.1 Monthly Invoice and Progress Report

10.12.2 Mid-year and Year-end Reports

10.12.3 Other Reports

11.0 OTHER REQUIREMENTS

Public Statements and Program Materials

Contractor must indicate in any and all program materials/brochures, press release(s) and any statement to the public related to the Program the following statement:

"This project is funded, in whole or in part, by Los Angeles County, Department of Public Health, Office of Violence Prevention, Trauma Prevention Initiative."

Contractor must share program materials/brochures with OVP for review/approval prior to distribution. All job announcements must indicate that Contractor is, an " Equal Employment Opportunity Employer".

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
SCOPE OF WORK
[COMMUNITY BASED ORGANIZATION]
Trauma Prevention Initiative:
Hospital Violence Intervention Program – (Name of Hospital Site)
July 1, 2023 – June 30, 2026

DELIVERABLES	ACTIVITIES	COMPLETED BY	DOCUMENTATION/TRACKING MEASURES TO BE KEPT ON FILE
1. Organizational Structure and Meetings	1.1 Contractor shall provide organizational chart for the Hospital Violence Intervention Program (HVIP) team and description of each staff member's role and qualifications.	Upon Contract execution	1.1 Organizational chart for the HVIP team, description of each staff member's role and qualifications submitted to the Public Health and kept on file.
	1.2 Contractor shall provide an up-to-date contact sheet for all HVIP staff assigned to work under this Contract including name, title, address, phone number, and email address. Contractor shall notify the Department of Public Health (Public Health) in writing within 5 business days of any changes in staff assignments under this Contract.	Upon Contract execution and ongoing	1.2 Up-to-date contact sheet for all project staff assigned to work under this Contract to be kept on file.
	1.3 Assigned Project Manager shall oversee the day-to-day project deliverables and the Contract. Work closely with Public Health's finance staff to ensure timely delivery of monthly invoices and other administrative paperwork. The Project Manager must be available to lead and participate in scheduled conference calls and/or meetings with Public Health staff to discuss status updates, including but not limited to: progress & action items on Scope of Work deliverables, and activities developed by Public Health to achieve the objectives of the Scope of Work, as well as Administrative action items. Contractor shall assign other team staff as needed to complete project deliverables and implementation activities in a timely matter.	Upon Contract execution and ongoing	1.3 Meeting agendas, minutes, and email correspondence to be kept on file.

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
SCOPE OF WORK
[COMMUNITY BASED ORGANIZATION]
Trauma Prevention Initiative:
Hospital Violence Intervention Program – (Name of Hospital Site)
July 1, 2023 – June 30, 2026

DELIVERABLES	ACTIVITIES	COMPLETED BY	DOCUMENTATION/TRACKING MEASURES TO BE KEPT ON FILE
2. Protocols and Agreements	2.1 Establish a Memorandum of Understanding (MOU) between the Contractor and trauma hospital site to guide the provision of HVIP services; identify key staff, clear roles, and responsibilities for the hospital contractor; establish needed protocols, and infrastructure to support the work; and establish goals and track achievement of contracted deliverables, as well as processes for troubleshooting challenges and identifying lessons learned.	By August 1, 2023	2.1 Memorandum of understanding including list of key staff, roles, and protocols
	2.2 Establish an oversight committee that meets quarterly. The oversight committee must consist of at least 6 individuals, including at least 2 trauma center personnel, (including physicians, nurses, social workers, and administrative staff), and 2 community violence intervention experts or community leaders.	August 1, 2023; quarterly thereafter	2.2 Oversight committee names and titles and meeting records.
	2.3 Develop and submit, (on a semi-annual basis), a collaboration plan that includes strategies for working with partners, and resources to support client outcomes and HVIP successes, including key service providers, community coalitions and leaders, Street Outreach and Community Violence Intervention (SOCVI) contractors, adjacent Gang Reductions and Youth Development (GRYD) zones or other local violence intervention initiatives, where applicable, and law enforcement agencies. This collaboration plan must be developed in coordination with Public Health.	September 20, 2023; every 6 months thereafter	2.3 Semi-annual collaboration plan

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
SCOPE OF WORK
[COMMUNITY BASED ORGANIZATION]
Trauma Prevention Initiative:
Hospital Violence Intervention Program – (Name of Hospital Site)
July 1, 2023 – June 30, 2026

DELIVERABLES	ACTIVITIES	COMPLETED BY	DOCUMENTATION/TRACKING MEASURES TO BE KEPT ON FILE
3. 24/7 Response and Referrals	3.1 Develop and submit 24/7 response protocol, to be approved by Public Health. The response protocol must include an outline of the procedures used to communicate and consult with the hospital trauma surgeon and/or other Emergency Department/trauma center personnel to determine eligibility of trauma patient for HVIP services. The protocol must also include how patients and families will be engaged, including pairing of Case Managers with peer Street Outreach workers to build trust and direct communication.	August 1, 2023, and ongoing	3.1 24/7 response protocol
	3.2 Engage in a minimum of 100 (*vary per trauma hospital site*) referred patients per year at the designated trauma hospital site. An engagement is an initial contact and interaction with a patient/client who has experienced violence related injuries. Although dose (frequency and length of encounter) may vary, patient encounter must be substantive. o Pomona Valley Hospital: 100 referred patients o Harbor UCLA: 200 referred patients o LAC+USC: 200 referred patients o St. Francis: 320 referred patients	June 30, 2024; annually thereafter	3.2 Client records of a minimum of 100 (vary per hospital site) referred patients per year.
4. Intake	4.1 Intake form must be approved by Public Health and include at a minimum: consent language to participate in services, date of initial engagement, date of consent to services, demographic information, (e.g., age, race/ethnicity, gender, zip code of residence), hospital name, injury, immediate needs (e.g., victim's services, basic needs).	August 1, 2023	4.1 Draft intake form and client consent form keep on file; provided to Public Health upon request.

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
SCOPE OF WORK
[COMMUNITY BASED ORGANIZATION]
Trauma Prevention Initiative:
Hospital Violence Intervention Program – (Name of Hospital Site)
July 1, 2023 – June 30, 2026

DELIVERABLES	ACTIVITIES	COMPLETED BY	DOCUMENTATION/TRACKING MEASURES TO BE KEPT ON FILE
	4.2 Contractor shall conduct an interview and complete a Client Intake form for all participants, who consent to services to obtain information and determine participant's immediate needs.	Ongoing	4.2 Client Intake form records (as specified by Public Health requirements) per participant.
5. Assessment	5.1 Risk assessment tool to be provided by Public Health to assess: levels of need, based on a tiered system of risk and protective factors, circumstances of injury, criminal history, gang affiliation, mental health and substance use history, client's support system; and other factors.	February 1, 2023	5.1 Draft assessment tool
	5.2 Contractor shall conduct a comprehensive risk assessment of every new client, using the provided tool, within 15 days of intake to obtain the information needed to develop an Individualized Service Plan (ISP).	Ongoing	5.2 Client assessment records (as specified by Public Health requirements) per new client, to be completed within 15 days of intake.
	5.3 Assessment must be completed within 15 days of intake, and a post assessment completed at 6-month intervals post engagement, and at exit, at minimum.	Ongoing	5.3 Assessment records completed within 15 days, every 6-months, and at exit for each client.
6. Individualized Service Plan (ISP)	6.1 ISP shall be created to empower the participant to engage in services to accomplish desired goals and serve as a guiding document for provision of Case Management (CM) that will be updated to track progress made. Client ISP should be reviewed on a monthly basis and revised as needed to adjust client goals.	Ongoing	6.1 Individualized Service Plan records per participant (as specified by Public Health requirements)

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
SCOPE OF WORK
[COMMUNITY BASED ORGANIZATION]
Trauma Prevention Initiative:
Hospital Violence Intervention Program – (Name of Hospital Site)
July 1, 2023 – June 30, 2026

DELIVERABLES	ACTIVITIES	COMPLETED BY	DOCUMENTATION/TRACKING MEASURES TO BE KEPT ON FILE
	6.2 Narrative summary of client goals and objectives for CM, recommended services and referrals, and schedule of follow-up check-ins with client to assess progress. • Safety Plan to address concerns of client returning to community post discharge, including potential threats of retaliation, coordination with local Street Outreach providers as available to support client safety, and identification of safe support system and safe places; • Referral to Victim Services; • COVID-19 vaccination and testing resources; • Where applicable and with assistance from Public Health, coordinate cross-referrals with county partner initiatives to provide supportive services to clients, including but not limited to Department of Youth Development, Law Enforcement Assisted Diversion, and Office of Diversion and Reentry for employment programs and services; • Other service referrals provided to meet identified goals including but not limited to counseling, domestic violence prevention, housing and basic needs, substance use treatment, tattoo removal, education, employment services, legal services, peer mentoring, etc.; • Documentation of the types and duration of services provided, and linked referrals made and completed;	Ongoing	6.2 Thorough narrative summary (as specified by Public Health requirements)

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
SCOPE OF WORK
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Trauma Prevention Initiative:
Hospital Violence Intervention Program – (Name of Hospital Site)
July 1, 2023 – June 30, 2026

DELIVERABLES	ACTIVITIES	COMPLETED BY	DOCUMENTATION/TRACKING MEASURES TO BE KEPT ON FILE
	• Documentation of client goals met, successes, and challenges.		
7. Case Management (CM) Services	7.1 Case Managers will be required to collect data through an Access database and/or web-based data collection and CM platform provided by Public Health's evaluation team, that documents intake, assessment, Service Plans, and case management progress and follow-up. Public Health will advise on required data points to track;	August 31, 2023	7.1 CM database (as specified by Public Health requirements)
	7.2 Develop and maintain a list of service providers and partners to support client goals and HVIP success, including but not limited to: counseling, domestic violence, housing and basic needs, substance use treatment, tattoo removal, education, employment services, legal services, peer mentoring, etc. Provide updated list to Public Health semi-annually (every 6 months);	August 1, 2023; every 6-months thereafter	7.2 List of service providers and partners
	7.3 Provide tailored CM services to a minimum of 50 clients (*vary per hospital site*) per year via ISP. Case Managers should maintain a caseload not to exceed 30 clients per case manager, some requiring intensive case management and others classified as maintenance. Clients should be engaged monthly, (at a minimum), for case management services. Duration of case management may vary depending on client goals and commitment, and will include follow-ups at 3 months, post intake, at a minimum.	Ongoing	7.3 CM records for each client, including meeting dates, safety plans, referrals

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
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[COMMUNITY BASED ORGANIZATION]
Trauma Prevention Initiative:
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July 1, 2023 – June 30, 2026

DELIVERABLES	ACTIVITIES	COMPLETED BY	DOCUMENTATION/TRACKING MEASURES TO BE KEPT ON FILE
	o Pomona Valley Hospital: 50 clients o Harbor UCLA: 100 clients o LAC+USC: 100 clients o St. Francis: 160 clients Case management to include: • Provide peer support and service navigation for clients, regular contact with clients to track progress, ensure that services are adequate in order to achieve goals, and address challenges and barriers experienced by client; • Coordinate development of client Safety Plans, with SOCVI agencies to ensure client returns safely to community upon hospital discharge; • Evaluate whether services are consistent with the needs enumerated in the service plan, determine if any changes to ISP goals are necessary, and ensure that referrals are linked, and services are obtained in a timely, coordinated manner.		
8. Training and Staff Self-Care	8.1 Develop a training and staff self-care support plan that must include: • Identification of required trainings and certifications for Case Managers and other direct services staff (e.g., intervention, trauma informed practice, motivational interviewing), and a process for ensuring that staff are up to date;	August 1, 2023; quarterly thereafter	8.1 Written training and staff self-care support plan (as specified by Public Health requirements); provide quarterly report on types of self-care and training provided for staff

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
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Trauma Prevention Initiative:
Hospital Violence Intervention Program – (Name of Hospital Site)
July 1, 2023 – June 30, 2026

DELIVERABLES	ACTIVITIES	COMPLETED BY	DOCUMENTATION/TRACKING MEASURES TO BE KEPT ON FILE
	• Providing weekly staff "check-in" meetings to discuss experiences and support teamwork and self-care; • Encouraging staff to participate in trainings sessions provided by Public Health and other partners relative to gender based violence, trauma informed practice, and other topics;		
9. Hospital Staff	Contractor must work with the trauma hospital via MOU to identify and designate key staff to support HVIP services as follows: • Administrative lead who will provide oversight for HVIP services and is empowered to make decisions on behalf of the trauma hospital. • Trauma Director or designee, who will coordinate day to day operations, including notifications to Contractor and facilitate engagement of patients. • If applicable, Social Workers at the trauma hospital site who can coordinate with HVIP Case Managers to support client needs.	August 1, 2023 and ongoing	A fully executed MOU between the Contractor and Hospital, and up-to-date contact sheet of all hospital staff assigned to work under this Contract to be kept on file
10. Client Records	Contractor must maintain a current and comprehensive case file for each client interviewed. The client's case file, at minimum, must contain the following documents/information, which must be entered into a CM database that must be approved by Public Health: • Client Intake form (created by the Contractor in collaboration with OVP), • Risk Assessment at intake, 3-months and exit, at minimum (created by OVP),	Ongoing	Up-to-date contact sheet of all hospital staff assigned to work under this Contract, and case file to be kept on file.

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
SCOPE OF WORK
[COMMUNITY BASED ORGANIZATION]
Trauma Prevention Initiative:
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July 1, 2023 – June 30, 2026

DELIVERABLES	ACTIVITIES	COMPLETED BY	DOCUMENTATION/TRACKING MEASURES TO BE KEPT ON FILE
	• Individualized Service Plan (created by the Contractor in collaboration with Office of Violence Prevention (OVP), • Client Consent Form (created by the Contractor in collaboration with OVP), • Progress notes with service delivery dates, • Key dates for services, including date of hospitalization, initial engagements, consent and intake completed, assessment completed, service plan developed, patient discharge, engagements post discharge including 3-month follow-up, dates of referrals to services, and date CM closed, • Case summary post closure, including reason for closure, and narrative assessment of success/goals met, and • Client satisfaction survey (created by Public Health).		
11. Required Meetings	11.1 Contractor will participate in monthly contract management meetings with Public Health to discuss progress, successes, and challenges.	Monthly	11.1 Documented attendance at Monthly contract meetings
	11.2 Contractor will participate in quarterly Trauma Prevention Initiative (TPI) Advisory Committee meetings to discuss progress and connect with County services and other contracted agencies	Quarterly	11.2 Documented attendance at Quarterly TPI Advisory Committee meetings
	11.3 Contractor will participate, at a minimum, in quarterly Hospital Violence Intervention Consortium meetings to support collaboration,	Quarterly	11.3 Documented attendance at Quarterly Hospital Violence Intervention Consortium meetings

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
SCOPE OF WORK
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Trauma Prevention Initiative:
Hospital Violence Intervention Program – (Name of Hospital Site)
July 1, 2023 – June 30, 2026

DELIVERABLES	ACTIVITIES	COMPLETED BY	DOCUMENTATION/TRACKING MEASURES TO BE KEPT ON FILE
	peer learning, and data sharing across trauma hospital sites		
	11.4 Contractor's staff will participate in at least one capacity building training opportunity annually, hosted by Public Health or partner agencies	June 30, 2024	11.4 Documented attendance at capacity building training
12. Reporting and Invoicing	12.1 Monthly Invoice and Progress Report - Contractor shall submit to Public Health a Monthly Progress Report, with their billing invoice no later than 15 days after the month services were rendered. Invoices received without the Monthly Report will not be paid.	Monthly	12.1 Monthly Invoice and Progress Report
	12.2 Year-end Reports – Contractor will submit mid-year and year-end reports using a template provided by Public Health, including updates on progress meeting each deliverable, a data summary of clients served, types of service provided, client anecdotes, and overall successes and challenges.	June 2024; and annually thereafter	12.2 Year-end reports (as specified by Public Health requirements)
	12.3 Other Reports - County may request data or other information from Contractor on an ad-hoc basis, as needed by Public Health, County agencies, or entities for budgetary or other purposes. Contractor shall provide the requested data to County in a mutually agreeable time period.	Ongoing	12.3 Ad-hoc reports, as requested
13. Case Management (CM)	13.1 Ensure that 90% of new clients have an ISP based on their unique needs and circumstances.	Monthly	13.1 Individual Clients File

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
SCOPE OF WORK
[COMMUNITY BASED ORGANIZATION]
Trauma Prevention Initiative:
Hospital Violence Intervention Program – (Name of Hospital Site)
July 1, 2023 – June 30, 2026

DELIVERABLES	ACTIVITIES	COMPLETED BY	DOCUMENTATION/TRACKING MEASURES TO BE KEPT ON FILE
Performance Outcomes	Review new clients on CM database and check for ISP during the month. **Denominator** = All new clients enrolled in CM database during the month. **Numerator** = Clients that received ISP in the same month. [Public Health will take the annual average]		
	13.2 Ensure that 90% of new clients complete a baseline risk assessment within 15 days of enrollment. Review all new enrolled clients and check if they completed an assessment during the month. **Denominator** = All new enrolled clients during the month. **Numerator** = Clients who completed an assessment in the same month. [Public Health will take the annual average	Monthly	13.2 All Clients file
	13.3 Ensure that 75% of clients complete a post assessment at 3 months post enrollment. Review continuing clients and check if they completed a post assessment 3 months after enrollment. **Denominator** = All continuing enrolled clients who have been enrolled in the program for 3 months. **Numerator** = Clients who completed a post assessment in the same month. [Public Health will take the annual average]	Monthly	13.3 All Clients file

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
SCOPE OF WORK
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Trauma Prevention Initiative:
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July 1, 2023 – June 30, 2026

DELIVERABLES	ACTIVITIES	COMPLETED BY	DOCUMENTATION/TRACKING MEASURES TO BE KEPT ON FILE
	13.4 Ensure that 80% of clients receive risk-reduction resources in the community. Review continuing clients and check if they have been referred to at least one service in the community as identified by their ISP. **Denominator** = All continuing enrolled clients. **Numerator** = Clients who have received at least one referral for each need identified in their ISP. [Public Health will take the annual average]	Monthly	13.4 All Clients file.
	13.5 Ensure that 80% of clients are engaged at minimum once a month during the duration of their enrollment, and at 3-months post intake. Review continuing clients and check if they have been successfully engaged at least once a month during their enrollment. **Denominator** = All continuing enrolled clients. **Numerator** = Clients who have received at least one successful engagement a month for the duration of their enrollment, and at 3-months and 6-months post intake. [Public Health will take the annual average]	Monthly	13.5 All Clients file.
	13.6 Ensure that 75% of continuing clients that are receiving CM will receive a comprehensive reassessment of ISP at minimum every 180 days (six months). Review continuing clients who have been enrolled for at least 180 days (six months) and check if they have an updated individual service plan.	Monthly	13.6 All Clients file.

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
SCOPE OF WORK
[COMMUNITY BASED ORGANIZATION]
Trauma Prevention Initiative:
Hospital Violence Intervention Program – (Name of Hospital Site)
July 1, 2023 – June 30, 2026

DELIVERABLES	ACTIVITIES	COMPLETED BY	DOCUMENTATION/TRACKING MEASURES TO BE KEPT ON FILE
	Denominator = All clients who have been enrolled for at least 180 days (six months). **Numerator** = Clients who have completed an updated individual service plan during the month. [Public Health will take the annual average]		
	13.7 Ensure that 90% of clients in need of victim services are notified of the availability of victim services and receive a referral. Review continuing clients who have been enrolled for at least 180 days (six months) and check if they have an updated safety plan. **Denominator** = All clients who have been enrolled for at least 180 days (six months). **Numerator** = Clients who have completed an updated safety plan during the month. [Public Health will take the annual average]	Monthly	13.7 All Clients file.
	13.8 Ensure that 90% of clients are offered information about COVID-19 safety and assistance obtaining appointment to get vaccinated Review continuing clients and check if they have received information about COVID-19 safety and vaccine appointments. **Denominator** = All continuing clients. **Numerator** = Clients who have received a COVID-19 safety information and assistance obtaining an appointment to get vaccinated. [Public Health will take the annual average]	Monthly	13.8 All Clients file.

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
SCOPE OF WORK
[COMMUNITY BASED ORGANIZATION]
Trauma Prevention Initiative:
Hospital Violence Intervention Program – (Name of Hospital Site)
July 1, 2023 – June 30, 2026

DELIVERABLES	ACTIVITIES	COMPLETED BY	DOCUMENTATION/TRACKING MEASURES TO BE KEPT ON FILE
14. Evaluation	14.1 Contractor must coordinate with Public Health and Public Health's contracted evaluator to ensure that data are entered within the approved CM database, monitored for quality, and provided to the evaluator on a monthly basis.	Ongoing	14.1 Review monthly CM database
	14.2 Contractor will support other evaluation needs, including but not limited to coordinating distribution of client satisfaction surveys, participating in focus groups or interviews about HVIP services, or providing as needed reports on work completed and clients served.	Ongoing	14.2 Client Satisfaction Survey, Sign-in sheet, and reports as needed.
	14.3 Contractor must ensure data quality and compliance with all data submission requirements.	Ongoing	14.3 Quality control procedure on file.

EXHIBIT C-1

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

TRAUMA PREVENTION INITIATIVE: HOSPITAL VIOLENCE INTERVENTION PROGRAM

ANNUAL BUDGET

Trauma Hospital Site: _____

Contractor Name: _____

Period 1: July 1, 2023 - June 30, 2024

BUDGET

		Monthly Salary	Percent of Time	No. of Months	Totals
A.	**SALARIES**				
	Full Time Salaries				
	Case Manager - TBD	$0.00	100%	12	$ -
	Total Full Time Salaries				$ -
	Part Time Salaries				
	Project Manager - TBD	$0.00	50%	12	$ -
	Total Part Time Salaries				$ -
	Total Salary Costs				$ -
B.	**EMPLOYEE BENEFITS @ 26.75%**				
	Employee Benefits for Full Time Employees				$ -
	Employee Benefits for Part Time Employees				$ -
	Total Employee Benefit Costs				$ -
	Total Salaries & Employee Benefits				$ -
C.	**OPERATING EXPENSES**				
	Telecommunications				$ -
	Utilities				$ -
	Rent/Lease				$ -
	Office Supplies				$ -
	Postage				$ -
	Audit and Insurance Fees				$ -
	Total Operating Expenses Costs				$ -
D.	**PROGRAM SUPPLIES**				
	Office Supplies				$ -
	Promotional Materials				$ -
	Incentives				$ -
	Printing and Duplication				$ -
	Total Opetating Expenses Costs				$ -
E.	**TRAVEL & MILEAGE**				
	Travel				$ -
	Mileage				$ -
	Total Travel & Mileage Costs				$ -
F.	**TRAINING & STAFF SELF-CARE**				
	Self-Care & Training				$ 5,000
					$ -
	Total Training & Staff Self-Care Costs				$ 5,000
G.	**OTHER COSTS**				
	IT Equipment				$ -
	Event Costs				$ -
	Training Costs				$ -
	Translation Services				$ -
	Total Other Costs				$ -
H.	**INDIRECT COST* (Cannot exceed 10% of personnel cost excluding Fringe Benefits)**				
	TOTAL PROGRAM BUDGET				$ 5,000.00

EXHIBIT C-2

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
TRAUMA PREVENTION INITIATIVE: HOSPITAL VIOLENCE INTERVENTION PROGRAM
ANNUAL BUDGET
Trauma Hospital Site: _____
Contractor Name: _____
Period 2: July 1, 2024 - June 30, 2025
BUDGET

		Monthly Salary	Percent of Time	No. of Months	Totals
A.	**SALARIES**				
	Full Time Salaries				
	Case Manager - TBD	$0.00	100%	12	$ -
	Total Full Time Salaries				$ -
	Part Time Salaries				
	Project Manager - TBD	$0.00	50%	12	$ -
	Total Part Time Salaries				$ -
	Total Salary Costs				$ -
B.	**EMPLOYEE BENEFITS @ 26.75%**				
	Employee Benefits for Full Time Employees				$ -
	Employee Benefits for Part Time Employees				$ -
	Total Employee Benefit Costs				$ -
	Total Salaries & Employee Benefits				$ -
C.	**OPERATING EXPENSES**				
	Telecommunications				$ -
	Utilities				$ -
	Rent/Lease				$ -
	Office Supplies				$ -
	Postage				$ -
	Audit and Insurance Fees				$ -
	Total Operating Expenses Costs				$ -
D.	**PROGRAM SUPPLIES**				
	Office Supplies				$ -
	Promotional Materials				$ -
	Incentives				$ -
	Printing and Duplication				$ -
	Total Opetating Expenses Costs				$ -
E.	**TRAVEL & MILEAGE**				
	Travel				$ -
	Mileage				$ -
	Total Travel & Mileage Costs				$ -
F.	**TRAINING & STAFF SELF-CARE**				
	Self-Care & Training				$ 5,000
					$ -
	Total Training & Staff Self-Care Costs				$ 5,000
G.	**OTHER COSTS**				
	IT Equipment				$ -
	Event Costs				$ -
	Training Costs				$ -
	Translation Services				$ -
	Total Other Costs				$ -
H.	**INDIRECT COST* (Cannot exceed 10% of personnel cost excluding Fringe Benefits)**				
	TOTAL PROGRAM BUDGET				$ 5,000.00

EXHIBIT C-3

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
TRAUMA PREVENTION INITIATIVE: HOSPITAL VIOLENCE INTERVENTION PROGRAM
ANNUAL BUDGET
Trauma Hospital Site: _____
Contractor Name: _____
Period 3: July 1, 2025 - June 30, 2026
BUDGET

		Monthly Salary	Percent of Time	No. of Months		Totals
A.	**SALARIES**					
	Full Time Salaries					
	Case Manager - TBD	$0.00	100%	12	$	-
	Total Full Time Salaries				$	-
	Part Time Salaries					
	Project Manager - TBD	$0.00	50%	12	$	-
	Total Part Time Salaries				$	-
	Total Salary Costs				$	-
B.	**EMPLOYEE BENEFITS @ 26.75%**					
	Employee Benefits for Full Time Employees				$	-
	Employee Benefits for Part Time Employees				$	-
	Total Employee Benefit Costs				$	-
	Total Salaries & Employee Benefits				$	-
C.	**OPERATING EXPENSES**					
	Telecommunications				$	-
	Utilities				$	-
	Rent/Lease				$	-
	Office Supplies				$	-
	Postage				$	-
	Audit and Insurance Fees				$	-
	Total Operating Expenses Costs				$	-
D.	**PROGRAM SUPPLIES**					
	Office Supplies				$	-
	Promotional Materials				$	-
	Incentives				$	-
	Printing and Duplication				$	-
	Total Opetating Expenses Costs				$	-
E.	**TRAVEL & MILEAGE**					
	Travel				$	-
	Mileage				$	-
	Total Travel & Mileage Costs				$	-
F.	**TRAINING & STAFF SELF-CARE**					
	Self-Care & Training				$	5,000
					$	-
	Total Training & Staff Self-Care Costs				$	5,000
G.	**OTHER COSTS**					
	IT Equipment				$	-
	Event Costs				$	-
	Training Costs				$	-
	Translation Services				$	-
	Total Other Costs				$	-
H.	**INDIRECT COST* (Cannot exceed 10% of personnel cost excluding Fringe Benefits)**					
	TOTAL PROGRAM BUDGET				$	5,000.00

EXHIBIT D

CONTRACTOR'S EEO CERTIFICATION

Contractor Name

Address

Internal Revenue Service Employer Identification Number

GENERAL CERTIFICATION

In accordance with Section 4.32.010 of the Code of the County of Los Angeles, the contractor, supplier, or vendor certifies and agrees that all persons employed by such firm, its affiliates, subsidiaries, or holding companies are and will be treated equally by the firm without regard to or because of race, religion, ancestry, national origin, or sex and in compliance with all anti-discrimination laws of the United States of America and the State of California.

CONTRACTOR'S SPECIFIC CERTIFICATIONS

1.	The Contractor has a written policy statement prohibiting discrimination in all phases of employment.	Yes ☐	No ☐
2.	The Contractor periodically conducts a self analysis or utilization analysis of its work force.	Yes ☐	No ☐
3.	The Contractor has a system for determining if its employment practices are discriminatory against protected groups.	Yes ☐	No ☐
4.	Where problem areas are identified in employment practices, the Contractor has a system for taking reasonable corrective action, to include establishment of goals or timetables.	Yes ☐	No ☐

Authorized Official's Printed Name and Title

Authorized Official's Signature

Date

EXHIBIT E

CONTRACTOR ACKNOWLEDGEMENT AND CONFIDENTIALITY AGREEMENT

CONTRACTOR NAME _____ Contract No._____

GENERAL INFORMATION:

The Contractor referenced above has entered into a contract with the County of Los Angeles to provide certain services to the County. The County requires the Corporation to sign this Contractor Acknowledgement and Confidentiality Agreement.

CONTRACTOR ACKNOWLEDGEMENT:

Contractor understands and agrees that the Contractor employees, consultants, Outsourced Vendors and independent contractors (Contractor's Staff) that will provide services in the above referenced agreement are Contractor's sole responsibility. Contractor understands and agrees that Contractor's Staff must rely exclusively upon Contractor for payment of salary and any and all other benefits payable by virtue of Contractor's Staff's performance of work under the above-referenced contract.

Contractor understands and agrees that Contractor's Staff are not employees of the County of Los Angeles for any purpose whatsoever and that Contractor's Staff do not have and will not acquire any rights or benefits of any kind from the County of Los Angeles by virtue of my performance of work under the above-referenced contract. Contractor understands and agrees that Contractor's Staff will not acquire any rights or benefits from the County of Los Angeles pursuant to any agreement between any person or entity and the County of Los Angeles.

CONFIDENTIALITY AGREEMENT:

Contractor and Contractor's Staff may be involved with work pertaining to services provided by the County of Los Angeles and, if so, Contractor and Contractor's Staff may have access to confidential data and information pertaining to persons and/or entities receiving services from the County. In addition, Contractor and Contractor's Staff may also have access to proprietary information supplied by other vendors doing business with the County of Los Angeles. The County has a legal obligation to protect all such confidential data and information in its possession, especially data and information concerning health, criminal, and welfare recipient records. Contractor and Contractor's Staff understand that if they are involved in County work, the County must ensure that Contractor and Contractor's Staff will protect the confidentiality of such data and information. Consequently, Contractor must sign this Confidentiality Agreement as a condition of work to be provided by Contractor's Staff for the County.

Contractor and Contractor's Staff hereby agrees that they will not divulge to any unauthorized person any data or information obtained while performing work pursuant to the above-referenced contract between Contractor and the County of Los Angeles. Contractor and Contractor's Staff agree to forward all requests for the release of any data or information received to County's Project Manager.

Contractor and Contractor's Staff agree to keep confidential all health, criminal, and welfare recipient records and all data and information pertaining to persons and/or entities receiving services from the County, design concepts, algorithms, programs, formats, documentation, Contractor proprietary information and all other original materials produced, created, or provided to Contractor and Contractor's Staff under the above-referenced contract. Contractor and Contractor's Staff agree to protect these confidential materials against disclosure to other than Contractor or County employees who have a need to know the information. Contractor and Contractor's Staff agree that if proprietary information supplied by other County vendors is provided to me during this employment, Contractor and Contractor's Staff shall keep such information confidential.

Contractor and Contractor's Staff agree to report any and all violations of this agreement by Contractor and Contractor's Staff and/or by any other person of whom Contractor and Contractor's Staff become aware.

Contractor and Contractor's Staff acknowledge that violation of this agreement may subject Contractor and Contractor's Staff to civil and/or criminal action and that the County of Los Angeles may seek all possible legal redress.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

POSITION: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

BUSINESS ASSOCIATE AGREEMENT UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

County is a Covered Entity as defined by, and subject to the requirements and prohibitions of, the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), and regulations promulgated thereunder, including the Privacy, Security, Breach Notification, and Enforcement Rules at 45 Code of Federal Regulation (C.F.R.) Parts 160 and 164 (collectively, the "HIPAA Rules").

Contractor performs or provides functions, activities or services to County that require Contractor in order to provide such functions, activities or services to create, access, receive, maintain, and/or transmit information that includes or that may include Protected Health Information as defined by the HIPAA Rules. As such, Contractor is a Business Associate, as defined by the HIPAA Rules, and is therefore subject to those provisions of the HIPAA Rules that are applicable to Business Associates.

The HIPAA Rules require a written agreement ("Business Associate Agreement") between County and Contractor in order to mandate certain protections for the privacy and security of Protected Health Information, and these HIPAA Rules prohibit the disclosure to or use of Protected Health Information by Contractor if such an agreement is not in place.

This Business Associate Agreement and its provisions are intended to protect the privacy and provide for the security of Protected Health Information disclosed to or used by Contractor in compliance with the HIPAA Rules.

Therefore, the parties agree as follows:

1. DEFINITIONS

1.1 "Breach" has the same meaning as the term “breach" at 45 C.F.R. § 164.402.

1.2 “Business Associate” has the same meaning as the term “business associate” at C.F.R § 160.103. For the convenience of the parties, a “business associate” is a person or entity, other than a member of the workforce of covered entity, who performs functions or activities on behalf of, or provides certain services to a covered entity that involve access by the business associate to Protected Health Information. A “business associate” also is a subcontractor that creates, receives, maintains or transmits Protected Health Information on behalf of another business associate. And in reference to the party to this Business Associate Agreement “Business Associate” shall mean Contractor.

1.3 “Covered Entity” has the same meaning as the term “covered entity" at 45 CFR § 160.103, and in reference to the party to this Business Associate Agreement, “Covered Entity” shall mean County.

1.4 “Data Aggregation” has the same meaning as the term “data aggregation” at 45 C.F.R. § 164.501.

1.5 “De-identification” refers to the de-identification standard at 45 C.F.R. 164.514.

1.6 “Designated Record Set” has the same meaning as the term “designated record set” at 45 C.F.R. § 164.501.

1.7 “Disclose” and “Disclosure” mean, with respect to Protected Health Information the release, transfer, provision of access to, or divulging in any other manner of Protected Health Information outside Business Associate’s internal operations or to other than its workforce. (See 45 C.F.R. § 160.103.)

1.8 "Electronic Health Record" means an electronic record of health-related information on and individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff. (See 42 U.S.C. § 17921.)

1.9 "Electronic Media" has the same meaning as the term "electronic media" at 45 C.F.R. § 160.103. For the convenience of the parties, electronic media means (1) Electronic storage material on which data is or may be recorded electronically, including, for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; (2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the Internet, extranet or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media if the information being exchanged did not exist in electronic form immediately before the transmission.

1.10 Electronic Protected Health Information" has the same meaning as the term "electronic protected health information" at 45 C.F.R. § 160.103, limited to Protected Health Information created or received by Business Associate from or on behalf of Covered Entity. For the convenience of the parties, Electronic Protected Health Information means Protected Health Information that is (i) transmitted by electronic media; (ii) maintained in electronic media.

1.11 "Health Care Operations" has the meaning as the term "health care operations" at 45 C.F.R. § 164.501.

1.12 "Individual" has the same meaning as the term “individual” at 45 C.F.R. § 160.103. For the convenience of the parties, Individual means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R § 164.502 (g).

1.13 “Law Enforcement Official” has the same meaning as the term “law enforcement official” at 45 C.F.R. § 164.103.

1.14 “Minimum Necessary" refers to the minimum necessary standard at 45 C.F.R. § 164.502 (b).

1.15 “Protected Health Information” has the same meaning as the term “protected health information” at 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity. For the convenience of the parties, Protected Health Information includes information that (i) relates to the past, present or future physical or mental health or condition of an Individual; the provision of health care to an Individual, or the past, present or future payment for the provision of health care to an Individual; (ii) identifies the Individual (or for which there is a reasonable basis for believing that the information can be used to identify the Individual); and (iii) is created, maintained, or transmitted by Business Associate from or on behalf of Covered Entity, and includes Protected Health Information that is made accessible to Business Associate by Covered Entity. “Protected Health Information” includes Electronic Protected Health Information.

1.16 “Required By Law” has the same meaning as the term “required by law” at 45 C.F.R. § 164.103.

1.17 “Secretary” has the same meaning as the term “secretary” at 45 C.F.R. § 160.103.

1.18 “Security Incident” has the same meaning as the term “security incident” at 45 C.F.R. § 164.304.

1.19 “Services” means, unless otherwise specified, those functions, activities, or services in the applicable underlying Agreement, Contract, Master Agreement, Work Order, or Purchase Order or other service arrangement, with or without payment, that gives rise to Contractor’s status as a Business Associate.

1.20 “Subcontractor” has the same meaning as the term “subcontractor” at 45 C.F.R. § 160.103.

1.21 "Unsecured Protected Health Information" has the same meaning as the term “unsecured protected health information" at 45 C.F.R. § 164.402.

1.22 “Use” or “Uses” means, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Information within Business Associate’s internal operations. (See 45 C.F.R. § 164.103.)

1.23 Terms used, but not otherwise defined in this Business Associate Agreement, have the same meaning as those terms in the HIPAA Rules.

2. PERMITTED AND REQUIRED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

2.1 Business Associate may only Use and/or Disclose Protected Health Information as necessary to perform Services, and/or as necessary to comply with the obligations of this Business Associate Agreement.

2.2 Business Associate may Use Protected Health Information for de-identification of the information if de-identification of the information is required to provide Services.

2.3 Business Associate may Use or Disclose Protected Health Information as Required by Law.

2.4 Business Associate shall make Uses and Disclosures and requests for Protected Health Information consistent with the applicable Covered Entity's Minimum Necessary policies and procedures.

2.5 Business Associate may Use Protected Health Information as necessary for the proper management and administration of its business or to carry out its legal responsibilities.

2.6 Business Associate may Disclose Protected Health Information as necessary for the proper management and administration of its business or to carry out its legal responsibilities, provided the Disclosure is Required by Law or Business Associate obtains reasonable assurances from the person to whom the Protected Health Information is disclosed (i.e. the recipient) that it will be held confidentially and Used or further Disclosed only as Required by Law or for the purposes for which it was disclosed to the recipient and the recipient notifies Business Associate of any instances of which it is aware in which the confidentiality of the Protected Health Information has been breached.

2.7 Business Associate may provide Data Aggregation services relating to Covered Entity's Health Care Operations if such Data Aggregation services are necessary in order to provide Services.

3. PROHIBITED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

3.1 Business Associate shall not Use or Disclose Protected Health Information other than as permitted or required by this Business Associate Agreement or as Required by Law.

3.2 Business Associate shall not Use or Disclose Protected Health Information in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by Covered Entity, except for the specific Uses and Disclosures set forth in Sub-Paragraph 2.5 and 2.6 above.

3.3 Business Associate shall not Use or Disclose Protected Health Information for de-identification of the information except as set forth in Sub-Paragraph 2.2 above.

4. OBLIGATIONS TO SAFEGUARD PROTECTED HEALTH INFORMATION

4.1 Business Associate shall implement, use, and maintain appropriate safeguards to prevent the Use or Disclosure of Protected Health Information other than as provided for by this Business Associate Agreement.

4.2 Business Associate shall comply with Subpart C of 45 C.F.R. Part 164 with respect to Electronic Protected Health Information, to prevent the Use or Disclosure of such information other than as provided for by this Business Associate Agreement.

5. REPORTING NON-PERMITTED USES OR DISCLOSURES, SECURITY INCIDENTS, AND BREACHES OF UNSECURED PROTECTED HEALTH INFORMATION

5.1 Business Associate shall report to Covered Entity any Use or Disclosure of Protected Health Information not permitted by this Business Associate Agreement, any Security Incident, and/ or any Breach of Unsecured Protected Health Information as further described in Sub-Paragraph 5.1.1, 5.1.2 and 5.1.3 below.

5.1.1 Business Associate shall report to Covered Entity any Use or Disclosure of Protected Health Information by Business Associate, its

employees, representatives, agents or Subcontractors not provided for by this Agreement of which Business Associate becomes aware.

5.1.2 Business Associate shall report to Covered Entity any Security Incident of which Business Associate becomes aware.

5.1.3 Business Associate shall report to Covered Entity any Breach by Business Associate, its employees, representatives, agents, workforce members, or Subcontractors of Unsecured Protected Health Information that is known to Business Associate or, by exercising reasonable diligence, would have been known to Business Associate. Business Associate shall be deemed to have knowledge of a Breach of Unsecured Protected Health Information if the Breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is an employee, officer, or other agent of Business Associate, including a Subcontractor, as determined in accordance with the federal common law of agency.

5.2 Except as provided in Sub-Paragraph 5.3, for any reporting required by Sub-Paragraph 5.1, Business Associate shall provide, to the extent available, all information required by, and within the time frames specified in, Sub-Paragraphs 5.2.1 and 5.2.2.

5.2.1 Business Associate shall make an <u>immediate telephonic report</u> upon discovery of the non-permitted Use or Disclosure of Protected Health Information, Security Incident or Breach of Unsecured Protected Health Information to **(562) 940-3335** that minimally includes:

(a) A brief description of what happened, including the date of the non-permitted Use or Disclosure, Security Incident, or Breach and

the date of Discovery of the non-permitted Use or Disclosure, Security Incident, or Breach, if known;

(b) The number of Individuals whose Protected Health Information is involved;

(c) A description of the specific type of Protected Health Information involved in the non-permitted Use or Disclosure, Security Incident, or Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code or other types of information were involved);

(d) The name and contact information for a person highly knowledge of the facts and circumstances of the non-permitted Use or Disclosure of PHI, Security Incident, or Breach.

5.2.2. Business Associate shall make a written report without unreasonable delay and in no event later than three (3) business days from the date of discovery by Business Associate of the non-permitted Use or Disclosure of Protected Health Information, Security Incident, or Breach of Unsecured Protected Health Information and to the **HIPAA Compliance Officer at: Hall of Records, County of Los Angeles, Chief Executive Office, Risk Management Branch-Office of Privacy, 320 W. Temple Street, 7th Floor, Los Angeles, California 90012, PRIVACY@ceo.lacounty.gov,** that includes, to the extent possible:

(a) A brief description of what happened, including the date of the non-permitted Use or Disclosure, Security Incident, or Breach and the date of Discovery of the non-permitted Use or Disclosure, Security Incident, or Breach, if known;

(b) The number of Individuals whose Protected Health Information is involved;

(c) A description of the specific type of Protected Health Information involved in the non-permitted Use or Disclosure, Security Incident, or Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code or other types of information were involved);

(d) The identification of each Individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been, accessed, acquired, Used, or Disclosed;

(e) Any other information necessary to conduct an assessment of whether notification to the Individual(s) under 45 C.F.R. § 164.404 is required;

(f) Any steps Business Associate believes that the Individual(s) could take to protect him or herself from potential harm from the non-permitted Use or Disclosure, Security Incident, or Breach;

(g) A brief description of what Business Associate is doing to investigate, to mitigate harm to the Individual(s), and to protect against any further similar occurrences; and

(h) The name and contact information for a person highly knowledgeable of the facts and circumstances of the non-permitted Use or Disclosure of PHI, Security Incident, or Breach.

5.2.3 If Business Associate is not able to provide the information specified in Sub-paragraphs 5.2.1 or 5.2.2 at the time of the required report,

Business Associate shall provide such information promptly thereafter as such information becomes available.

5.3 Business Associate may delay the notification required by Sub-paragraph 5.1.3, if a law enforcement official states to Business Associate that notification would impede a criminal investigation or cause damage to national security.

5.3.1 If the law enforcement official's statement is in writing and specifies the time for which a delay is required, Business Associate shall delay its reporting and/or notification obligation(s) for the time period specified by the official.

5.3.2 If the statement is made orally, Business Associate shall document the statement, including the identity of the official making the statement, and delay its reporting and/or notification obligation(s) temporarily and no longer than 30 days from the date of the oral statement, unless a written statement as described in Sub-paragraph 5.3.1 is submitted during that time.

6. WRITTEN ASSURANCES OF SUBCONTRACTORS

6.1 In accordance with 45 C.F.R. § 164.502 (e)(1)(ii) and § 164.308 (b)(2), if applicable, Business Associate shall ensure that any Subcontractor that creates, receives, maintains, or transmits Protected Health Information on behalf of Business Associate is made aware of its status as a Business Associate with respect to such information and that Subcontractor agrees in writing to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such information.

6.2 Business Associate shall take reasonable steps to cure any material breach or violation by Subcontractor of the agreement required by Sub-paragraph 6.1.

6.3 If the steps required by Sub-paragraph 6.2 do not cure the breach or end the violation, Contractor shall terminate, if feasible, any arrangement with Subcontractor by which Subcontractor creates, receives, maintains, or transmits Protected Health Information on behalf of Business Associate.

6.4 If neither cure nor termination as set forth in Sub-paragraphs 6.2 and 6.3 is feasible, Business Associate shall immediately notify County.

6.5 Without limiting the requirements of Sub-paragraph 6.1, the agreement required by Sub-paragraph 6.1 (Subcontractor Business Associate Agreement) shall require Subcontractor to contemporaneously notify Covered Entity in the event of a Breach of Unsecured Protected Health Information.

6.6 Without limiting the requirements of Sub-paragraph 6.1, agreement required by Sub-paragraph 6.1 (Subcontractor Business Associate Agreement) shall include a provision requiring Subcontractor to destroy, or in the alternative to return to Business Associate, any Protected Health Information created, received, maintained, or transmitted by Subcontractor on behalf of Business Associate so as to enable Business Associate to comply with the provisions of Sub-paragraph 18.4.

6.7 Business Associate shall provide to Covered Entity, at Covered Entity's request, a copy of any and all Subcontractor Business Associate Agreements required by Sub-paragraph 6.1.

6.8 Sub-paragraphs 6.1 and 6.7 are not intended by the parties to limit in any way the scope of Business Associate's obligations related to Subcontracts or Subcontracting in the applicable underlying Agreement, Contract, Master

Agreement, Work Order, Purchase Order, or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

7. ACCESS TO PROTECTED HEALTH INFORMATION

7.1 To the extent Covered Entity determines that Protected Health Information is maintained by Business Associate or its agents or Subcontractors in a Designated Record Set, Business Associate shall, within two (2) business days after receipt of a request from Covered Entity, make the Protected Health Information specified by Covered Entity available to the Individual(s) identified by Covered Entity as being entitled to access and shall provide such Individuals(s) or other person(s) designated by Covered Entity with a copy the specified Protected Health Information, in order for Covered Entity to meet the requirements of 45 C.F.R. § 164.524.

7.2 If any Individual requests access to Protected Health Information directly from Business Associate or its agents or Subcontractors, Business Associate shall notify Covered Entity in writing within two (2) days of the receipt of the request. Whether access shall be provided or denied shall be determined by Covered Entity.

7.3 To the extent that Business Associate maintains Protected Health Information that is subject to access as set forth above in one or more Designated Record Sets electronically and if the Individual requests an electronic copy of such information, Business Associate shall provide the Individual with access to the Protected Health Information in the electronic form and format requested by the Individual, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed to by Covered Entity and the Individual.

8. AMENDED OF PROTECTED HEALTH INFORMATION

8.1 To the extent Covered Entity determines that any Protected Health Information is maintained by Business Associate or its agents or Subcontractors in a Designated Record Set, Business Associate shall, within ten (10) business days after receipt of a written request from Covered Entity, make any amendments to such Protected Health Information that are requested by Covered Entity, in order for Covered Entity to meet the requirements of 45 C.F.R. § 164.526.

8.2 If any Individual requests an amendment to Protected Health Information directly from Business Associate or its agents or Subcontractors, Business Associate shall notify Covered Entity in writing within five (5) days of the receipt of the request. Whether an amendment shall be granted or denied shall be determined by Covered Entity.

9. ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

9.1 Business Associate shall maintain an accounting of each Disclosure of Protected Health Information made by Business Associate or its employees, agents, representatives or Subcontractors, as is determined by Covered Entity to be necessary in order to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

9.1.1 Any accounting of disclosures provided by Business Associate under Sub-paragraph 9.1 shall include:

(a) The date of the Disclosure;

(b) The name, and address if known, of the entity or person who received the Protected Health Information;

(c) A brief description of the Protected Health Information Disclosed; and

(d) A brief statement of the purpose of the Disclosure.

9.1.2 For each Disclosure that could require an accounting under Sub-paragraph 9.1, Business Associate shall document the information specified in Sub-paragraph 9.1.1, and shall maintain the information for six (6) years from the date of the Disclosure.

9.2 Business Associate shall provide to Covered Entity, within ten (10) business days after receipt of a written request from Covered Entity, information collected in accordance with Sub-paragraph 9.1.1 to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

9.3 If any Individual requests an accounting of disclosures directly from Business Associate or its agents or Subcontractors, Business Associate shall notify Covered Entity in writing within five (5) days of the receipt of the request, and shall provide the requested accounting of disclosures to the Individual(s) within 30 days. The information provided in the accounting shall be in accordance with 45 C.F.R. § 164.528.

10. COMPLIANCE WITH APPLICABLE HIPAA RULES

10.1 To the extent Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 C.F.R. Part 164, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity's performance of such obligation(s).

10.2 Business Associate shall comply with all HIPAA Rules applicable to Business Associate in the performance of Services.

11. AVAILABILITY OF RECORDS

11.1 Business Associate shall make its internal practices, books, and records relating to the Use and Disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity available to the Secretary for purposes of determining Covered Entity's compliance with the Privacy and Security Regulations.

11.2 Unless prohibited by the Secretary, Business Associate shall immediately notify Covered Entity of any requests made by the Secretary and provide Covered Entity with copies of any documents produced in response to such request.

12. MITIGATION OF HARMFUL EFFECTS

Business Associate shall mitigate, to the extent practicable, any harmful effect of a Use or Disclosure of Protected Health Information by Business Associate in violation of the requirements of this Business Associate Agreement that is known to Business Associate.

13. BREACH NOTIFICATION TO INDIVIDUALS

13.1 Business Associate shall, to the extent Covered Entity determines that there has been a Breach of Unsecured Protected Health Information by Business Associate, its employees, representatives, agents or Subcontractors, provide breach notification to the Individual in a manner that permits Covered Entity to comply with its obligations under 45 C.F.R. § 164.404.

13.1.1 Business Associate shall notify, subject to the review and approval of Covered Entity, each Individual whose Unsecured Protected Health Information has been, or is reasonably believed to have been, accessed, acquired, Used, or Disclosed as a result of any such Breach.

13.1.2 The notification provided by Business Associate shall be written in plain language, shall be subject to review and approval by Covered Entity, and shall include, to the extent possible:

(a) A brief description of what happened, including the date of the Breach and the date of the Discovery of the Breach, if known;

(b) A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

(c) Any steps the Individual should take to protect him or herself from potential harm resulting from the Breach;

(d) A brief description of what Business Associate is doing to investigate the Breach, to mitigate harm to Individual(s), and to protect against any further Breaches; and

(e) Contact procedures for Individual(s) to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address.

13.2 Covered Entity, in its sole discretion, may elect to provide the notification required by Sub-paragraph 13.1 and/or to establish the contact procedures described in Sub-paragraph 13.1.2.

13.3 Business Associate shall reimburse Covered Entity any and all costs incurred by Covered Entity, in complying with Subpart D of 45 C.F.R. Part 164, including but not limited to costs of notification, internet posting, or media publication, as a result of Business Associate's Breach of Unsecured Protected

Health Information; Covered Entity shall not be responsible for any costs incurred by Business Associate in providing the notification required by Sub-paragraph 13.1 or in establishing the contact procedures required by Sub-paragraph 13.1.2.

14. INDEMNIFICATION

14.1 Business Associate shall indemnify, defend, and hold harmless Covered Entity, its Special Districts, elected and appointed officers, employees, and agents from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, expenses (including attorney and expert witness fees), and penalties and/or fines (including regulatory penalties and/or fines), arising from or connected with Business Associate's acts and/or omissions arising from and/or relating to this Business Associate Agreement, including, but not limited to, compliance and/or enforcement actions and/or activities, whether formal or informal, by the Secretary or by the Attorney General of the State of California.

14.2 Sub-paragraph 14.1 is not intended by the parties to limit in any way the scope of Business Associate's obligations related to Insurance and/or Indemnification in the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order, or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

15. OBLIGATIONS OF A COVERED ENTITY

15.1 Covered Entity shall notify Business Associate of any current or future restrictions or limitations on the Use or Disclosure of Protected Health Information that would affect Business Associate’s performance of the Services, and Business Associate shall thereafter restrict or limit its own Uses and Disclosures accordingly.

15.2 Covered Entity shall not request Business Associate to Use or Disclose Protected Health Information in any manner that would not be permissible under

Subpart E of 45 C.F.R. Part 164 if done by Covered Entity, except to the extent that Business Associate may Use or Disclose Protected Health Information as provided in Sub-paragraphs 2.3, 2.5, and 2.6.

16. TERM

16.1 Unless sooner terminated as set forth in Sub-paragraph 17, the term of this Business Associate Agreement shall be the same as the term of the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order, or other service arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

16.2 Notwithstanding Sub-paragraph 16.1, Business Associate's obligations under Sub-paragraphs 4.1, 4.2, 5.1, 5.2, 6.1, and 9.1, 10.1, 11.1, 11.2, and 18.1 to 18.4 shall survive the termination or expiration of this Business Associate Agreement.

17. TERMINATION FOR CAUSE

17.1 In addition to and notwithstanding the termination provisions set forth in the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order, or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate, if either party determines that the other party has violated a material term of this Business Associate Agreement, and the breaching party has not cured the breach or ended the violation within the time specified by the non-breaching party, which shall be reasonable given the nature of the breach and/or violation, the non-breaching party may terminate this Business Associate Agreement.

17.2 In addition to and notwithstanding the termination provisions set forth in the applicable underlying Agreement, Contract, Master Agreement, Work Order,

Purchase Order, or services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate, if either party determines that the other party has violated a material term of this Business Associate Agreement, and cure is not feasible, the non-breaching party may terminate this Business Associate Agreement immediately.

18. DEPOSITION OF PROTECTED HEALTH INFORMATION UPON TERMINATION OR EXPIRATION

18.1 Except as provided in Sub-paragraph 18.3, upon termination for any reason or expiration of this Business Associate Agreement, Business Associate shall return or, if agreed to by Covered entity, shall destroy as provided for in sub-paragraph 18.2, all Protected Health Information received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, that Business Associate, including any Subcontractor, still maintains in any form. Business Associate shall retain no copies of the Protected Health Information.

18.2 Destruction for purposes of sub-paragraph 18.2 and sub-paragraph 6.1.2 shall mean that media on which the Protected Health Information is stored or recorded has been destroyed and/or electronic media have been cleared, purged, or destroyed in accordance with the use of a technology or methodology specified by the Secretary in guidance for rendering Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals.

18.3 Notwithstanding Sub-paragraph 18.1, in the event return or destruction of Protected Health Information is not feasible or Business Associate determines that any such Protected Health Information is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities, Business Associate may retain that Protected Health

Information for which destruction or return is feasible or that Protected Health Information which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities and shall return or destroy all other Protected Health Information.

18.3.1 Business Associate shall extend the protections of this Business Associate Agreement to such Protected Health Information, including continuing to use appropriate safeguards and continuing to comply with Subpart C of 45 C.F.R Part 164 with respect to Electronic Protected Health Information, to prevent the Use or Disclosure of such information other than as provided for in Sub-paragraphs 2.5 and 2.6 for so long as such Protected Health Information is retained, and Business Associate shall not Use or Disclose such Protected Health Information other than for the purposes for which such Protected Health Information was retained.

18.3.2 Business Associate shall return or, if agreed to by Covered entity, destroy the Protected Health Information retained by Business Associate when it is no longer needed by Business Associate for Business Associate's proper management and administration or to carry out its legal responsibilities.

18.4 Business Associate shall ensure that all Protected Health Information created, maintained, or received by Subcontractors is returned or, if agreed to by Covered entity, destroyed as provided for in Sub-paragraph 18.2.

19. AUDIT, INSPECTION, AND EXAMINATION

19.1 Covered Entity reserves the right to conduct a reasonable inspection of the facilities, systems, information systems, books, records, agreements, and policies and procedures relating to the Use or Disclosure of Protected Health

Information for the purpose determining whether Business Associate is in compliance with the terms of this Business Associate Agreement and any non-compliance may be a basis for termination of this Business Associate Agreement and the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate, as provided for in Paragraph 17.

19.2 Covered Entity and Business Associate shall mutually agree in advance upon the scope, timing, and location of any such inspection.

19.3 At Business Associate's request, and to the extent permitted by law, Covered Entity shall execute a nondisclosure agreement, upon terms and conditions mutually agreed to by the parties.

19.4 That Covered Entity inspects, fails to inspect, or has the right to inspect as provided for in Sub-paragraph 19.1 does not relieve Business Associate of its responsibility to comply with this Business Associate Agreement and/or the HIPAA Rules or impose on Covered Entity any responsibility for Business Associate's compliance with any applicable HIPAA Rules.

19.5 Covered Entity's failure to detect, its detection but failure to notify Business Associate, or its detection but failure to require remediation by Business Associate of an unsatisfactory practice by Business Associate, shall not constitute acceptance of such practice or a waiver of Covered Entity's enforcement rights under this Business Associate Agreement or the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

19.6 Sub-paragraph 19.1 is not intended by the parties to limit in any way the scope of Business Associate's obligations related to Inspection and/or Audit and/or similar review in the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order, or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

20. MISCELLANEOUS PROVISIONS

20.1 Disclaimer. Covered Entity makes no warranty or representation that compliance by Business Associate with the terms and conditions of this Business Associate Agreement will be adequate or satisfactory to meet the business needs or legal obligations of Business Associate.

20.2 HIPAA Requirements. The Parties agree that the provisions under HIPAA Rules that are required by law to be incorporated into this Amendment are hereby incorporated into this Agreement.

20.3 No Third Party Beneficiaries. Nothing in this Business Associate Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

20.4 Construction. In the event that a provision of this Business Associate Agreement is contrary to a provision of the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order, or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate, the provision of this Business Associate Agreement shall control. Otherwise, this Business Associate Agreement shall be construed under, and in accordance with, the terms of the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order or other services arrangement,

with or without payment, that gives rise to Contractor's status as a Business Associate.

20.5 Regulatory References. A reference in this Business Associate Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

20.6 Interpretation. Any ambiguity in this Business Associate Agreement shall be resolved in favor of a meaning that permits the parties to comply with the HIPAA Rules.

20.7 Amendment. The parties agree to take such action as is necessary to amend this Business Associate Agreement from time to time as is necessary for Covered Entity or Business Associate to comply with the requirements of the HIPAA Rules and any other privacy laws governing Protected Health Information.


THERE'S A BETTER CHOICE.
SAFELY SURRENDER YOUR BABY.
Any fire station. Any hospital. Any time.
1.877.222.9723
BabySafeLA.org
No shame | No blame | No names
21
FIRE STATION

Some parents of newborns can find themselves in difficult circumstances. Sadly, babies are sometimes harmed or abandoned by parents who feel that they're not ready or able to raise a child. Many of these mothers or fathers are afraid and don't know where to turn for help.

This is why California has a Safely Surrendered Baby Law, which gives parents the choice to legally leave their baby at any hospital or fire station in Los Angeles County.

FIVE THINGS YOU NEED TO KNOW ABOUT BABY SAFE SURRENDER

1. Your newborn can be surrendered at any hospital or fire station in Los Angeles County up to 72 hours after birth.
2. You must leave your newborn with a fire station or hospital employee.
3. You don't have to provide your name.
4. You will only be asked to voluntarily provide a medical history.
5. You have 14 days to change your mind; a matching bracelet (parent) and anklet (baby) are provided to assist you if you change your mind.

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BabySafeLA.org

ABOUT THE BABY SAFE SURRENDER PROGRAM

In 2002, a task force was created under the guidance of the Children's Planning Council to address newborn abandonment and to develop a strategic plan to prevent this tragedy.

Los Angeles County has worked hard to ensure that the Safely Surrendered Baby Law prevents babies from being abandoned. We're happy to report that this law is doing exactly what it was designed to do: save the lives of innocent babies. Visit BabySafeLA.org to learn more.

No shame | No blame | No names

ANY FIRE STATION.
ANY HOSPITAL.
ANY TIME.

1.877.222.9723
BabySafeLA.org

THERE'S A BETTER CHOICE.
SAFELY SURRENDER YOUR BABY.

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FROM SURRENDER TO ADOPTION: ONE BABY'S STORY

Los Angeles County firefighter Ted and his wife Becki were already parents to two boys. But when they got the call asking if they would be willing to care for a premature baby girl who'd been safely surrendered at a local hospital, they didn't hesitate.

Baby Jenna was tiny, but Ted and Becki felt lucky to be able to take her home. "We had always wanted to adopt," Ted says, "but taking home a vulnerable safely surrendered baby was even better. She had no one, but now she had us. And, more importantly, we had her."

Baby Jenna has filled the longing Ted and Becki had for a daughter—and a sister for their boys. Because her birth parent safely surrendered her when she was born, Jenna is a thriving young girl growing up in a stable and loving family.

ANSWERS TO YOUR QUESTIONS

Who is legally allowed to surrender the baby?
Anyone with lawful custody can drop off a newborn within the first 72 hours of birth.

Do you need to call ahead before surrendering a baby?
No. A newborn can be surrendered anytime, 24 hours a day, 7 days a week, as long as the parent or guardian surrenders the child to an employee of the hospital or fire station.

What information needs to be provided?
The surrendering adult will be asked to fill out a medical history form, which is useful in caring for the child. The form can be returned later and includes a stamped return envelope. No names are required.

What happens to the baby?
After a complete medical exam, the baby will be released and placed in a safe and loving home, and the adoption process will begin.

What happens to the parent or surrendering adult?
Nothing. They may leave at any time after surrendering the baby.

How can a parent get a baby back?
Parents who change their minds can begin the process of reclaiming their baby within 14 days by calling the Los Angeles County Department of Children and Family Services at (800) 540-4000.

If you're unsure of what to do:
You can call the hotline 24 hours a day, 7 days a week and anonymously speak with a counselor about your options or have your questions answered.

1.877.222.9723 or BabySafeLA.org
English, Spanish and 140 other languages spoken.

EXHIBIT H

CHARITABLE CONTRIBUTIONS CERTIFICATION

_____
Company Name

_____
Address

_____
Internal Revenue Service Employer Identification Number

_____
California Registry of Charitable Trusts "CT" number (if applicable)

The Nonprofit Integrity Act (SB 1262, Chapter 919) added requirements to California's Supervision of Trustees and Fundraisers for Charitable Purposes Act which regulates those receiving and raising charitable contributions.

Check the Certification below that is applicable to your company.

☐ Proposer or Contractor has examined its activities and determined that it does not now receive or raise charitable contributions regulated under California's Supervision of Trustees and Fundraisers for Charitable Purposes Act. If Proposer engages in activities subjecting it to those laws during the term of a County contract, it will timely comply with them and provide County a copy of its initial registration with the California State Attorney General's Registry of Charitable Trusts when filed.

OR

☐ Proposer or Contractor is registered with the California Registry of Charitable Trusts under the CT number listed above and is in compliance with its registration and reporting requirements under California law. Attached is a copy of its most recent filing with the Registry of Charitable Trusts as required by Title 11 California Code of Regulations, sections 300-301 and Government Code sections 12585-12586.

_____ _____
Signature Date

_____
Name and Title of Signer (please print)

BOARD LETTER/MEMO
CLUSTER FACT SHEET

DRAFT

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/24/2023
BOARD MEETING DATE	6/6/2023
SUPERVISORIAL DISTRICT AFFECTED	☐ All ☐ 1st ☒ 2nd ☐ 3rd ☐ 4th ☐ 5th
DEPARTMENT(S)	Mental Health
SUBJECT	Approval to Amend an Existing Contract with CBRE Managed Services, Inc. to Increase the Total Contract Sum for 2023 and 2024
PROGRAM	N/A
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No
SOLE SOURCE CONTRACT	☐ Yes ☒ No If Yes, please explain why:
DEADLINES/ TIME CONSTRAINTS	6/6/2023
COST & FUNDING	$1,041,930: 2023: $446,643 2024: $595,287 Funding source: Realignment 2011 and Intrafund Transfers from DHS and DPH TERMS (if applicable): Jan 10, 2022- December 31, 2024 Explanation:
PURPOSE OF REQUEST	This Board Letter will allow DMH to amend the existing Facilities Management Services contract with CBRE Managed Services, Inc. to increase the total contract sum for 2023 and 2024.
BACKGROUND (include internal/external issues that may exist including any related motions)	This contract was initially executed under a Board Motion entitled: "*Crisis Residential Treatment Program Provider, Building Manager Contracts and Data for the Behavioral Health Center (BHC) on the MLK Medical Campus*," Contract No. MH540001 was executed with CBRE Managed Services, Inc for the provision of FMS. The Board motion, however, did not provide authority to amend the contract. Therefore, DMH is now seeking Board authority to amend the existing Contract with CBRE to increase the TCS for 2023 and 2024. The increase of funds will allow for the continued provision of full-service facility management services necessary to maintain the building and grounds of the BHC and to add 24-hour custodial services. The continued maintenance of the building and grounds allows for a reduction in operating costs, improving compliance with building codes, mitigating the risk of damage to the building, and maintaining overall building safety allowing for a positive experience for both staff and clients who utilize the facility.
EQUITY INDEX OR LENS WAS UTILIZED	☐ Yes ☒ No If Yes, please state which one(s) and 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: Damien Parker, (Admin. Svcs. Div. Mgr.) (213) 943-8579 dparker@dmh.lacounty.gov Margaret Ambrose, Senior Deputy County Counsel, (213) 974-0971,mambrose@counsel.lacounty.gov

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Director

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

Connie D. Draxler, M.P.A.
Acting Chief Deputy Director

June 6, 2023

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

Dear Supervisors:

APPROVAL TO AMEND AN EXISTING CONTRACT WITH CBRE MANAGED SERVICES, INC., TO INCREASE THE TOTAL CONTRACT SUM FOR 2023 AND 2024 FOR THE CONTINUED PROVISION OF FACILITIES MANAGEMENT SERVICES (SUPERVISORIAL DISTRICT 2) (3 VOTES)

SUBJECT

Request approval to amend the existing Facilities Management contract with CBRE Managed Services, Inc., to increase the total contract sum for 2023 and 2024.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and authorize the Director of Mental Health (Director), or her designee, to prepare, sign, and execute an amendment (Attachment I) to the existing Department of Mental Health (DMH) Facilities Management Services (FMS) contract with CBRE Managed Services, Inc. (CBRE), to increase the Total Contract Sum (TCS) by $446,643, upon Board approval until December 31, 2023, and for the period of January 1, 2024 to December 31, 2024, by $595,287, fully funded by 2011 Realignment funds and Intrafund Transfers from Department of Public Health (DPH) and Department of Health Services (DHS).

2. Delegate authority to the Director, or her designee, to prepare, sign, and execute future amendments to the Contract in Recommendation 1 to revise the boilerplate language; revise the annual TCS; rollover unspent funds to future years; add, delete, modify, or replace the Statements of Work; and/or reflect federal, State, and County regulatory and/or policy changes provided that: 1) the County's total payment will not exceed 10 percent of the Board-approved TCS in Recommendation 1; and 2) sufficient funds are

available. This amendment will be subject to prior review and approval as to form by County Counsel, with written notice to the Board and the Chief Executive Office (CEO).

3. Delegate authority to the Director, or her designee, to terminate the Contract described in Recommendation 1 in accordance with the termination provisions, including Termination for Convenience. The Director, or her designee, will provide written notification to your Board and CEO of such termination action.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Board approval of Recommendation 1 will allow DMH to amend the existing Contract with CBRE for the continued provision of FMS and to include 24-Hour custodial services to maintain the building and grounds of the Behavioral Health Center on the Martin Luther King, Jr. (MLK) Medical Campus.

Board approval of Recommendation 2 will allow DMH to amend the Contract in Recommendation 1 in a timely manner, as necessary, for the continued provision of FMS without interruption to these services.

Board approval of Recommendation 3 will allow DMH to terminate the Contract in accordance with the Contract's termination provisions, including Termination for Convenience, in a timely manner, as necessary.

Implementation of Strategic Plan Goals

The recommended action is consistent with the County's Strategic Plan Goal III, Realize Tomorrow's Government Today, specifically Strategy III.3.4- Complete Business Continuity Planning.

FISCAL IMPACT/FINANCING

The TCS increase of $446,643 for the remainder of calendar year 2023 will be fully funded by 2011 Realignment and Intrafund Transfers from DPH and DHS. Sufficient funding is included in DMH's Final Adopted Budget for Fiscal Year 2022-23 for this action.

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

There is no net County cost impact associated with the recommended action.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On January 20, 2021, DMH posted a Request for Proposals (RFP) for a facilities management company to provide overall management of the Behavioral Health Center.

As a result of the RFP, CBRE's proposal was recommended for a contract award. Subsequently, on November 16, 2021, Board Motion titled "*Crisis Residential Treatment Program Provider, Building Manager Contracts and Data for the Behavioral Health Center (BHC) on the MLK Medical Campus*," Contract No. MH540001 was executed with CBRE Managed Services, Inc., for the provision of FMS. The said Board Motion, however, did not provide authority to amend the contract.

Therefore, DMH is now seeking your Board's authority to amend the existing Contract with CBRE to increase the TCS for 2023 and 2024. The increase of funds will allow for the continued provision of full-service facility management services necessary to maintain the building and grounds of the BHC and to add 24-Hour custodial services. The continued maintenance of the building and grounds allows for a reduction in operating costs, improving compliance with building codes, mitigating the risk of damage to the building, and maintaining overall building safety allowing for a positive experience for both staff and clients who utilize the facility.

Attachment I, the amendment to the existing contract, has been approved as to form by County Counsel.

As mandated by your Board, the performance of all contractors is evaluated by DMH on an annual basis to ensure the contractor's compliance with all contract terms and performance standards.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board approval of the recommended actions will allow CBRE to continue its maintenance of the building and grounds of BHC.

Respectfully submitted,

LISA H. WONG, Psy.D.
Director

LHW:CDD:SK
RLR:ZW:atm

Attachment

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

Chairperson, Mental Health Commission

CONTRACT NO. MH540001

AMENDMENT NO. 1

THIS AMENDMENT is made and entered into this ___ day of June, 2023, by and between the COUNTY OF LOS ANGELES (hereafter "County") and CBRE Managed Services, Inc. (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled "Department of Mental Health Facilities Management Services", dated January 10, 2022, and further identified as County Contract No. MH540001, and any amendments thereto (hereafter collectively "Contract"); and

WHEREAS, on June 6, 2023, the County Board of Supervisors delegated authority to the Director of Mental Health, or designee, to execute amendments to the Contract that amend the annual Total Contract Sum (TCS), to modify the Contract language, and make other designated changes; 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, County and Contractor intend to amend the Contract to revise the Statement of Work (Exhibit A), the Fee Schedule (Exhibit B), and increase the Total Contract Sum (TCS) for Contractor to continue to provide facilities management services;

WHEREAS, as the result of the above changes, the TCS will increase for the remainder of the term; and

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

NOW, THEREFORE, County and Contractor agree as follows:

1. This amendment is effective upon execution.

2. For 2023 the TCS for all deliverables in Exhibit B-1, Fee-Schedule, is increased by $ 446,643 from $ 3,745,389 to $ 4,192,032 fully funded by 2011 Realignment and Intrafund Transfers from the Department of Public Health (DPH) and the Department of Health Services (DHS).

3. For 2024 the TCS for all deliverables in Exhibit B-1, Fee-Schedule, is increased by $ 595, 287 from $ 3,745,389 to $ 4,340,676 fully funded by 2011 Realignment and Intrafund Transfers from DPH and DHS.

4. Paragraph 5 (Contract Sum) subsection 5.1 (Total Contract Sum) of the contract shall be deleted in its entirety and replaced with the following:

"5.1 Total Contract Sum

5.1.1 The funding for this contract shall be available as follows:

Years	Amount
Year One (2022)	$ 3,745,389
Year Two (2023)	$ 4,192,032
Year Three (2024)	$ 4,340.676

Payment rates for Facilities Management services are described in Exhibit B-1 Fee Schedule and shall remain stable and fixed for the term of the Contract, including any optional extension periods, unless a written

Contract amendment is approved by the County and executed by County and Contractor."

5. Exhibit A – 1 SOW attached hereto and incorporated herein by reference, shall be added to the Contract.
6. Exhibit B –1 Fee Schedule, attached hereto and incorporated herein by reference, shall be added to the Contract.
7. 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 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 _____
LISA H. WONG, Psy.D.
Director of Mental Health

CBRE MANAGED SERVICES, INC.
CONTRACTOR

By _____

Name _____

Title _____
(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL

By: Margaret Ambrose
Senior Deputy County Counsel

BM_Amendment Format_ TCS

EXHIBIT A-1

STATEMENT OF WORK

FACILITIES MANAGEMENT SERVICES

BEHAVIORAL HEALTH CENTER

TABLE OF CONTENTS

STATEMENT OF WORK (SOW)

FACILITIES MANAGEMENT SERVICES

BEHAVIORAL HEALTH CENTER

1.0 SCOPE OF WORK

Behavioral Health Center

The Los Angeles County (LAC or County) Behavioral Health Center (BHC) located on the Martin Luther King (MLK) Jr. hospital campus, is one of the first facilities of its kind. Located in the Willowbrook area of LAC, this facility integrates inpatient, outpatient and supportive services for some of the most vulnerable and underserved populations, including those living with mental illness, substance use disorders, and homelessness.

The BHC is the first facility in the County to bring together many different but related services. It houses staff from the LAC Department of Mental Health (DMH or Mental Health), Department of Health Services (DHS or Health Services), Department of Public Health (DPH or Public Health), Probation Department (Probation), and Workforce Development, Aging and Community Services (WDACS). County-contracted agencies are also co-located at the BHC and provide essential services in partnership with County departments.

BHC Facilities Management

The Contractor shall provide and coordinate the integrated facility management services for the BHC located at 12021 Wilmington Ave. Los Angeles, CA 90059. Contractor shall provide full-service facility management services necessary to maintain the building and grounds of the BHC, excluding linen services, security, and food services. Contractor shall run the day-to-day facility, operations, and property to reduce operating costs, improve compliance with all building codes, standards, and regulations, mitigate risk of damage to building, risk of accidents, and maintain overall building safety, maintain the facility in like-new condition, and create a positive experience for staff and all who utilize the facility.

COVID-19 precautions and protocols to deal with COVID positive facilities staff, visitors and residents of the multiple programs on the 3rd, 4th, 5th floors will be provided 30 days prior to starting work by County DMH staff.

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 (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's Monitoring Manager, upon request. 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

3.2 A record of all compliance inspections, audits, and program reviews conducted by the Contractor

3.2.1 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.

4.0 QUALITY ASSURANCE PLAN

The County will evaluate the Contractor's performance under this Contract using the quality assurance procedures as defined in the Contract, Paragraph 8.15, County's Quality Assurance Plan.

4.1 Meetings

Contractor shall attend any meetings that may be called by the County.

4.2 Contract Discrepancy Report (SOW Attachment 1 of Exhibit A-1)

Verbal notification of a Contract discrepancy will be made to the Facilities Manager or alternate, as soon as possible whenever a Contract discrepancy is identified. The problem shall be resolved within a time period mutually agreed upon by the County and the Contractor.

The County Monitoring Manager will determine whether a formal Contract Discrepancy Report shall be issued. Upon receipt of this document, the Contractor is required to respond in writing to the County Monitoring Manager within 10 workdays, acknowledging the reported discrepancies or presenting contrary evidence. A plan for correction of all deficiencies identified in the Contract Discrepancy Report shall be submitted to the County Monitoring Manager within 10 workdays.

4.3 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 DEFINITIONS

5.1 Department of Health Services (DHS) - Second largest municipal health system in the nation. DHS operates as an integrated health system, operating 26 health centers and four acute care hospitals, in addition to providing health care to youth in the juvenile justice system and inmates in the LA County jails.

5.2 Department of Mental Health (DMH) - The largest county mental health department in the United States that provides mental health services for LAC residents. DMH directly operates 75 program sites in the County and serves over 250,000 clients annually.

5.3 Department of Public Health (DPH) - County Department that works to protect and improve health and well-being in the largest county in the United States. With 14 Public Health Centers located throughout LAC, DPH provides free and/or low-cost services to those with no insurance or regular health care provider, including immunizations and communicable disease testing and treatment.

5.4 Probation Department - The largest probation services agency in the United States, and presumably the world. Provides probation services that include the supervision of 12,000 state parolees in the California; the supervision of at-home probation youth; and the supervision of youth in nine residential treatment service facilities (juvenile camps) and three juvenile halls.

5.5 Workforce Development, Aging and Community Services (WDACS) - County Department that provides comprehensive human services in partnership with community leaders, businesses, and private agencies. Assists residents to self-sufficiency, promotes the independence of older persons, provides employment and training, protects elderly and dependent adult victims of abuse and neglect, supports and strengthens communities impacted by hate violence, fosters positive intergroup relations to promote an informed inclusive society, and provides a neutral and impartial forum for the resolution of issues and problems involving the LAC Sheriff's Department.

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 6.0, 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, Sub-paragraph 8.1 - Amendments.

6.2 Intentionally Omitted

CONTRACTOR

6.3 Facilities Manager

6.3.1 Contractor shall provide a full-time, on-site Facilities Manager and designated alternate(s). Contractor shall provide a telephone number where the Facilities Manager and his/her designee may be reached 24/7/365.

6.3.2 Facilities Manager shall act as a central point of contact with the County.

6.3.3 Facilities Manager shall have, at least, five years of experience managing a facility of similar scope and size.

6.3.4 Facilities Manager and alternate(s) shall have full authority to act for Contractor on all matters relating to the daily operation of the Contract. Facilities Manager and alternate(s) shall be able to effectively communicate in English, both orally and in writing.

6.3.5 Facilities Manager's key functions shall include but are not limited to the following:

1. Facility Needs: Facilities Manager shall understand the building's design as well as the equipment, both medical and not, that is used within and identify the appropriate resources needed. This includes the maintenance and repair of equipment such as elevators. In addition, the Facilities Manager must also oversee policies regarding the removal of hazardous waste and general maintenance programs.

2. Code Compliance: Facilities Manager must know and understand all applicable federal, State, Local Municipal law and ordinances as well as all applicable industry codes and standards from healthcare organizations, such as but not limited to the Americans with Disabilities Act (ADA), requirements from the Environmental Protection Agency (EPA), Occupational Safety and Health Administration (OSHA) and Centers for Disease Control and Prevention (CDC) policies.

3. Day to Day Operations: Facilities Manager shall manage the day to day activities of all Contractor personnel assigned to work at the BHC. Facilities Manager shall coordinate with healthcare professionals and various departmental managers to execute work approved by the County with minimal disruption to normal operation of the BHC. Facility Manager shall participate in emergency training and drills held by County for all building staff and ensure all Contractor personnel assigned to work at the BHC are properly trained.

4. Finances: Facilities Manager shall track and report to County, upon request, on any and all expenditures including routine preventive and corrective maintenance, repairs, planned replacement, major maintenance, and deferred deficiencies (i.e. backlog reduction). Facilities Manager shall meet budget and schedule commitments; develop and adhere to an operating budget for the facility and shall understand the facility's overall finances in order to create the budget

and shall make the decision on new investments, spending priorities, and negotiate service agreements.

6.3.6 Contractor shall provide a support team that includes a Building Management Chief Engineer who will provide software and support to the program. The Contractor shall schedule preventive maintenance tasks by BMS to assure a uniform and detailed process that includes but is not limited to the following: all required building inspections, equipment and elevator lubrications, any required equipment and elevator tests, and adjustments.

6.4 Personnel

6.4.1 Contractor shall assign a sufficient number of employees/personnel and subcontracted staff to perform the required work in Paragraph 10.0, SPECIFIC WORK REQUIREMENTS. Personnel and subcontractors shall be skilled in various types of facility maintenance to include the service listed in Section 10.0.

6.4.2 Contractor shall conduct background checks on its employees as set forth in sub-paragraph 7.5 of the Contract – Background and Security Investigations. This requirement shall also apply to any subcontracted staff performing work at the BHC.

6.4.3 Contractor's staff shall maintain necessary qualifications in order to accomplish required work, including, but not limited to: access clearances, professional registrations, required licenses, etc.

6.4.4 Contractor shall hire, contract, or subcontract qualified and licensed service technicians to perform repairs and maintenance services stipulated in this SOW. Service Technicians used by the Contractor must be fully qualified in all aspects of maintenance to be performed, including repairs that may become necessary during the term(s) of this Contract.

6.4.5 The Contactor shall have and retain sufficient backup technicians who are qualified in all aspects of equipment repair and services requirements to assume the responsibilities for the maintenance of all building systems and equipment in case of emergency or other unforeseen conditions.

6.5 Identification Badges

6.5.1 Contractor shall ensure its employees are appropriately identified as set forth in sub-paragraph 7.4 of the Contract – Contractor’s Staff Identification.

6.6 Materials and Equipment

Contractor shall provide all personnel, equipment, tools, materials, supervision, and other items such as necessary PPE (i.e. safety glasses, masks, work boots, ear plugs, reflective vests, gloves, etc.) as necessary to perform all services, tasks, and functions defined in this Statement of Work (SOW). 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 employee(s).

6.7 Training

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

6.7.2 All employees shall be trained in their assigned tasks and in the safe handling of equipment. All equipment shall be checked daily for safety. All employees and subcontractors must wear safety and protective gear according to Occupational Safety and Health Administration (OSHA), State of California (State), and LAC standards.

6.7.3 Contractor and County shall coordinate mandatory trainings for all staff that work in County facilities. These may be offered by County and shall include mandatory trainings per federal, State and/or County mandates.

6.8 Contractor's Office

6.8.1 Contractor's Corporate/Administrative Headquarters

Contractor shall identify its corporate/administrative headquarters office with a telephone in the company's name where Contractor conducts business. The office shall be staffed during the hours of 8 a.m. to 5 p.m., Monday through Friday, by at least one employee who can respond to inquiries which may be received about the Contractor's performance of the Contract.

6.8.2 Contractor's On-Site Office

Contractor's Facilities Manager and alternate shall be housed at the MLK BHC where he/she shall receive work order and maintenance requests. An answering service shall be provided to receive calls when staff are out of the office. **The Facilities Manager or alternate shall answer calls received by the answering service within** 24 hours **of receipt of the call for routine requests. Emergency calls shall be answered as soon as reasonably possible.**

7.0 HOURS/DAY OF WORK

7.1 Contractor shall provide comprehensive on-site operations and maintenance services during the hours of 6:00 AM- 11:00 PM, Monday through Friday.

8.0 WORK SCHEDULES

8.1 Contractor shall submit a work schedule for Facilities Manager, alternate, and any other lead staff assigned to the BHC to the County within 30 days prior to starting work. Said work schedules shall be set on an annual calendar. Upon County's request, Contractor shall also identify all the required on-going maintenance tasks and task frequencies.

9.0 UNSCHEDULED WORK

9.1 The County may authorize the Contractor to perform unscheduled work, including, but not limited to, repairs and replacements when the need for such work arises out of extraordinary incidents such as accidental or unanticipated damage, vandalism, acts of God, and third party negligence, or to add to, modify or refurbish existing facilities.

9.2 Prior to performing any unscheduled work, the Contractor shall prepare and submit a written description of the work with an estimate of labor and materials. If the unscheduled work exceeds the Contractor's estimate, the County must approve the excess cost. In any case, no unscheduled work shall commence without written authorization from the County.

9.3 When a condition exists wherein there is imminent danger of injury to the public or damage to property, Contractor shall immediately perform unscheduled work. Contractor shall contact County for approval when reasonably possible, and provide a written estimate within 24 hours for approval. Contractor shall submit an invoice to County within five working days after completion of the work.

9.4 All unscheduled work shall commence on the established specified date. Contractor shall proceed diligently to complete said work within the time allotted.

9.5 The County reserves the right to perform unscheduled work itself or assign the work to another contractor.

10.0 SPECIFIC WORK REQUIREMENTS

10.1 Contractor shall collaborate with County and County-contracted agencies that provide services at the BHC, to provide full-service facility management services necessary to maintain the building and grounds at BHC. Services shall include but are not limited to the following:

10.1.1 Develop Standard Operating Procedures (SOPs) for building systems;

10.1.2 Develop Operations and Maintenance (O&M) protocols from O&M manuals gathered from General Contractor;

10.1.3 Develop and maintain an archive system that includes "as-built" documentation;

10.1.4 Grounds keeping/Landscape Services; Full Scope to be defined post go-live date.

10.1.4.1 Plant Materials

A. Turf

i. Mowing

1) Cold season turf shall be maintained at 2 inches.

2) Warm season turf shall be maintained at 1 ½ inches (or higher, as directed, if the turf is not scalped and over seeded annually).

ii. Edging

1) All turf edges adjacent to walks, curbs, paved areas, fixtures at grade, and shrub or groundcover areas shall be trimmed as needed to maintain a crisp and neat appearance.

2) A bare drift buffer zone shall be maintained around the circumference of all trees, as well as the perimeter of all buildings and raised fixtures in the turf.

iii. Aerating - Turf shall be aerated annually to reduce compaction, promote water penetration and limit runoff.

B. Groundcover

i. Edging and Trimming - Groundcover adjacent to walks, curbs, paved areas, buildings, shrubs, trees and other miscellaneous objects shall be trimmed as needed to maintain a neat, clean, well-defined edge and eliminate encroachment into turf or other plantings.

ii. Trimming Method - Established plantings shall be encouraged to grow and cover the ground in a solid and full manner.

C. Shrubs

i. Pruning and Trimming - Shrubs shall be pruned and trimmed as required for safety, removal of broken or diseased branches, general containment or appearance.

ii. Pruning Method - Shrubs shall be pruned and trimmed in such a manner as to retain and promote as much of the flowering and other natural characteristics of the shrub as possible.

D. Trees

i. Pruning and Trimming

1) Trees shall be pruned up to a height of 15-feet as required for safety, removal of broken or diseased branches, for pedestrian or vehicular access, or ingress or egress.

2) Pruning shall be done in observance of proper horticultural practices by those

experienced and skilled in pruning technique.

3) Pruning under this specification is limited to that which may be done from the ground.

4) Structural tree work shall be done only upon approval or as directed by County.

ii. Staking and Supporting

1) Tree stakes, ties, and guy wires shall be checked and corrected as needed.

2) Ties will be adjusted to prevent girdling.

3) Unnecessary stakes, ties and/or guy wire assemblies will be removed.

10.4.1.2 Irrigation

A. In General

i. In the irrigation of all plant materials, Contractor shall operate all irrigation systems in such a manner so as to obtain uniform moisture throughout the root zone.

ii. Contractor will adjust its watering schedule equal to the percolation rate each zone is capable of receiving based on topography, soil type, plant materials, season and/or climatic factors and shall utilize repeat cycles to maximize penetration and minimize runoff.

iii. Hours of scheduled operation will be programmed to minimize disease occurrence in plant materials and to reduce possible nuisance from sprinkler operation to pedestrians or vehicles (typically, early morning hours before sunrise).

B. Operations of System

iv. Contractor shall observe all systems during operation cycle at least once per month to verify effectiveness of sprinkler operation and preventive maintenance shall be performed on system as needed.

v. Contractor will adjust and clean, as necessary, all sprinkler heads, valves, and pressure reducers to continue operation at maximum efficiency and performance.

vi. Sprinkler heads in turf areas shall be kept clear of overgrowth which may hinder maximum efficiency and performance.

10.4.1.3 Weed & Disease Control

A. In General

i. Contractor shall maintain weed & disease free turf, groundcover and shrubs. Contractor shall also remove weeds from hardscape areas, including walkways, asphalt, brow ditches and curb lines.

ii. Contractor shall maintain disease and pest free trees where such diseases and/or pests are foreseeable, preventable and reasonably treatable through the application of chemical controls such as insecticides and provided that insecticides can be applied systemically or through ground level topical spraying. Any overhead treatment and/or treatment for unforeseen diseases or pest invasion will be handled as Unscheduled Work per Section 9.0.

iii. Contractor's responsibility for pest control shall be limited to invertebrates. Control of rodents and other vertebrates will be handled as Unscheduled Work per Section 9.0.

B. Pesticides

i. Adherence to Regulations – All materials used by Contractor shall be in strict accordance with the California Department of Pesticide Regulation. Application and disposal of pesticides shall be within the guidelines established in the California Food and Agriculture Code and the California Code of Regulations.

ii. Timing of Application – Pesticides will be applied at times which limit the possibility of contamination from climatic and other factors. Applicator shall monitor forecasted weather conditions to avoid making applications prior to inclement weather in order to eliminate potential runoff of treated areas.

iii. Method and Manner of Application- Care shall be taken in transferring and mixing pesticides to prevent contaminating areas outside the target area. Application methods shall be used which ensure that materials are confined to the target area.

10.1.4.4 Fertilization

A. Goal of Fertilization- Plant materials shall be fertilized as required to maintain healthy color and appearance and promote perpetual growth.

B. Number of Applications- While fertilizer requirements are dictated by the prevalent soil conditions at the site, the following is fairly typical with regard to the number of applications in a single year for specific plant materials: (a) turf – five times; (b) groundcover – four times; (c) shrubs – three times; and (d) trees – once per year. Contractor, however, may utilize slow-release fertilizers which reduce the typical amount of applications needed.

C. Manner of Application- In making applications of fertilizer, precautions will be taken to contain these materials in the planting areas and prevent the depositing of material onto paved area. Any fertilizer deposited on paved areas will be removed immediately.

10.1.4.5 Clean-Up

A. Removal of Debris- Contractor shall remove all green waste and other debris resulting from maintenance operations and dispose of it off-site. All grass clippings deposited on roadways or walks shall be removed after each mowing or trimming operation. On–site disposal of green waste shall be permitted with approval of Owner's Representative. Non-organic debris not generated by Contractor shall be disposed of at the job-site container, if one is available.

B. Timing of Removal/Observation- All debris resulting from Contractor's operations shall be removed by the end of the workday on each scheduled maintenance visit. All landscape areas shall be patrolled whenever on site to check for vandalism, broken tree branches, rodents, insects, snails, pests and/or diseases.

10.1.4.6 Tree Trimming

Tree Trimming- Tree trimming above the height of 15 feet and any tree trimming near the structural shall be considered Unscheduled Work per Section 9.0.

10.1.5 Pest Management and Control Services

A. Exterior Rodent Bait Station – 12 Services per Year

i. Rodent management equipment, including multicatch traps, tamper resistant rodent bait stations, glue boards,

wall markers, trap guards, etc. will be strategically placed on the interior and exterior of the facility to establish preventive management measures and to gain control of present activity.

B. Integrated Pest Management Program – 12 Services per Year

i. Exterior-only general pest/Interior only as requested - Includes inspection and documentation of any conducive conditions that can negatively impact pest pressures. Exterior treatments for covered pests as needed.

10.1.6 Building and Carpeting Maintenance and Repair- Contractor shall perform any work where materials are provided or not needed. If additional materials or third-party vendors/subcontractors are required, Contractor shall seek County's approval before any purchases are made.

10.1.7 Plumbing Maintenance and Repair- Contractor shall perform any work where materials are provided or not needed. If additional materials or third-party vendors/subcontractors are required Contractor shall seek County's approval before any purchases are made.

All equipment included within Asset Register attached herein as SOW Attachment 3 of Exhibit A to be serviced inline with industry standards/manufacturer guidelines and/or state or local regulations. All non maintenance items, not able to be completed during working hours by site personnel would be subject to additional cost, inclusive of materials.

10.1.8 HVAC Maintenance and Repair- Contractor shall perform any work where materials are provided or not needed. If additional materials are required Contractor shall seek County's approval before any purchases are made.

All equipment included within Asset Register to be serviced inline with industry standards/manufacturer guidelines and/or state or local regulations. All non-maintenance items, not able to be completed during working hours by site personnel would be subject to additional cost, inclusive of materials.

10.1.9 Electronic Systems Maintenance and Repair- Contractor shall perform any work where materials are provided or not needed. If additional materials are required Contractor shall seek County's approval before any purchases are made.

10.1.10 Electrical Maintenance and Repair- Contractor shall perform any work where materials are provided or not needed. If additional materials are required Contractor shall seek County's approval before any purchases are made.

10.1.11 Paint Maintenance and Repair;

10.1.12 Fire Alarm Systems; Contractor shall perform any work where materials are provided or not needed. If additional materials are

required Contractor shall seek County's approval before any purchases are made..

10.1.13 Equipment Rental;

10.1.14 Bulk Waste Removal; Maintain trash compactor on an as needed basis.

10.1.15 Elevator Maintenance and Repair;

10.1.16 Mail Delivery: transportation of mail between the US Post Office and Customer site and vice versa. Services shall be performed Monday through Friday. Pickup from US Post Office at 2:00 PM with delivery to Customer site by 2:30 PM and pickup from Customer site at 2:30 PM with delivery at US Post Office by 3:00 PM.

10.1.17 Cafeteria and food service equipment repair and/or maintenance tasks; Full scope to be defined post go-live date.

10.1.18 Move Management; Contractor's Onsite personnel shall support and manage move changes up until what is reasonable practically and does not hinder site operation., Any additional needs for moving resources shall be reported to County for direction.

10.1.19 Maintenance Planning and Scheduling;

10.1.20 Service Requests and Work Order Dispatch;

10.1.21 Quality Health Safety & Environmental (QHSE) Operations;

10.1.22 Materials/Inventory Management;

10.1.23 Hazardous Materials Management and Disposal;

A. Bio-Waste

i. On the day of the scheduled medical waste pick up, Contractor shall ensure that the packet is complete and that all supplies needed are packed and ready to go. Ensure that medical waste shipping containers are appropriately marked with UN/NA certification Numbers and container is in shippable condition.

ii. Ensure a medical waste spill kit is in the truck.

iii. ACT medical waste containers are embossed with the appropriate UN/NA certification.

iv. When using third party containers, verify that they have the appropriate UN/NA certification.

v. Check work order and scope of work to note any additional security and/or procedural requirements.

vi. All doors of the vehicle will be kept locked during transportation activities and during activities on client's site unless the activities involve use of the vehicle.

vii. In addition to the general PPE requirements, each employee picking up or handling medical waste containers must wear coveralls or a laboratory coat.

viii. Check-in with Contractor's client representative.

ix. Never reach in or segregate medical waste or sharps waste.

x. See below for appropriate procedures on completing the Medical Waste Tracking Document.

xi. Verify piece count before and after loading the vehicle and place paperwork in appropriate location in vehicle.

xii. Verify client has signed all paperwork.

10.1.24 Budget Management that includes the submission of an annual operating budget; submission of financial reports, upon request; and annual Common Area Maintenance (CAM) reconciliations;

10.1.25 Building Inspections: Identifying and coordinating capital repairs and improvement plans for office buildings and building operating systems;

10.1.26 Tenant Relations: Maintaining regular liaison with building tenants/occupants and resolving building oriented complaints;

10.1.27 Implementing cost control and savings measures to ensure the buildings are operated effectively, efficiently and within budget;

10.1.28 Subcontract Management

10.1.29 Modification or moving modular office furniture; Contractor's Onsite personnel shall support and manage move changes up until what is reasonably practical and does not hinder site operation. Any additional needs for moving resources shall be reported to County for direction.

10.1.30 Technical Maintenance HVAC, high and low voltage, management of fluid networks, managing security equipment for goods and people;

10.1.31 Facility engineering: managing technical installations to ensure maintainability and reliability;

10.1.32 Monitoring and prevention, 24 hours on call;

10.1.33 Computerized Maintenance Management System (CMMS);

10.1.34 Emergency Response Planning that includes leading emergency drills and development of evacuation plans in conjunction with County department lead;

10.1.35 Code Compliance;

10.1.36 Preventive Maintenance and Planning: Any planned maintenance activity that is designed to improve equipment life and avoid any unplanned maintenance activity;

10.1.37 Custodial/Janitorial Services; Contractor shall provide custodial/janitorial services as more fully described in SOW Attachment 4 of Exhibit A-1.

10.1.38 Other Miscellaneous Services (Elevators, Exterior Window Cleaning, Maintain Key Control Systems, Moving Services, Signage, etc.); and Contractor shall perform any work where materials are provided or not needed. If additional materials are required. Contractor shall seek County's approval before any purchases are made.

10.1.39 Water Treatment:

A. The Service includes a review of the Customer's water systems for potentially hazardous system conditions that can increase the risk of waterborne disease, and the identification of control measures thereof.
   i. Systems included: Potable Water Services, Cooling Tower Water Systems
   ii. Systems excluded: Other "at risk" water systems, any water device connected to buildings water systems (e.g. vending systems, coffee machines, medical devices, or other miscellaneous device supplied with potable water.)
   iii. Program includes quarterly legionella testing of potable water systems.

10.2 Service Requests: Contractor shall establish a formal electronic tracking process to receive and respond to both routine and emergency service requests from County and County-contracted service providers located at the MLK BHC. The formal process shall contemplate service requests that may be submitted 24/7/365. Said process should also provide updates to the requestor on the status of the request.

10.2.1 Contractor shall respond to service requests within a reasonable amount of time to prevent any type of service interruption. This includes the use of qualified technicians to complete all work within the response time frames specified, after notice is given to Contractor.

10.3 Disruption of Services: Contractor shall provide reasonable, prior notification to County administration and all service providers on the MLK BHC premises of any disruption of facility building services. Contractor shall coordinate scheduled outages with County administration and provide an anticipated schedule. Outages may include utility outages, road or facility closures, etc. or disruptions caused by any maintenance or construction work (such as blocked access, pest, or herbicide spraying, HVAC down for service, etc.). Contractor shall notify County of affected downtime due to emergency outages or interruptions.

10.4 Contractor shall report any service requests and/or outages (scheduled or emergency) that involve the physical harm of any person(s) at the BHC. These events shall be reported as soon as possible to County administration and to the affected service provider(s) on the premises. Report shall indicate steps taken to remedy the situation.

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 County’s Project Manager of Contractor’s new green initiatives prior to the contract commencement.

12.0 PERFORMANCE REQUIREMENTS SUMMARY

All listings of services used in the Performance Requirements Summary (PRS), Attachment 2 of Exhibit A-1 (SOW), are intended to be completely consistent with the Contract and the SOW, and are not meant in any case to create, extend, revise, or expand any obligation of Contractor beyond that defined in the Contract and the SOW. In any case of apparent inconsistency between services as stated in the Contract and the SOW and the PRS, the meaning apparent in the Contract and the SOW will prevail. If any service seems to be created in this PRS which is not clearly and forthrightly set forth in the Contract and the SOW, that apparent service will be null and void and place no requirement on Contractor unless and until incorporated into the Contract.

EXHIBIT-A-1

STATEMENT OF WORK

TABLE OF CONTENTS

Attachment 1

CONTRACT DISCREPANCY REPORT

TO:

FROM:

DATES: **Prepared:** _____

Returned by Contractor: _____

Action Completed: _____

DISCREPANCY PROBLEMS: _____

_____

_____

_____ _____

Signature of County Representative Date

CONTRACTOR RESPONSE (Cause and Corrective Action): _____

_____

_____

_____ _____

Signature of Contractor Representative Date

DMH EVALUATION OF CONTRACTOR RESPONSE: _____

_____

_____

_____ _____

Signature of Contractor Representative Date

DMH ACTIONS: _____

_____

_____

CONTRACTOR NOTIFIED OF ACTION:

DMH Representative's Signature and Date _____

Contractor Representative's Signature and Date _____

SPECIFIC PERFORMANCE REFERENCE	SERVICE	MONITORING METHOD AND PERFORMANCE TARGETS
SOW: Section 10.1 (Specific Work Requirements)	Contractor shall collaborate with County and County-contracted agencies that provide services at the MLK Jr. BHC, to provide full-service facilities management services necessary to maintain the building and grounds at MLK Jr. BHC.	• Contract Compliance Review
SOW: Section 10.2 (Specific Work Requirements)	Service Requests: Contractor shall establish a formal electronic tracking process to receive and respond to both routine and emergency service requests from County and County-contracted service providers located at the MLK Jr. BHC. The formal process shall contemplate service requests that may be submitted 24/7/365. Said process should also provide updates to the requestor on the status of the request.	• Contract Compliance Review
Fee Schedule: Paragraph 2	Contractor shall submit a complete and accurate monthly invoice to DMH Program Manager. The invoice shall include supplemental documentation for services which Contractor will charge DMH for their services.	• Review of monthly invoices
Fee Schedule: Paragraph 3	Contractor shall retain all relevant supporting documents and make them available to DMH at any time for audit purposes. Invoices submitted to DMH shall detail all monthly charges billed to DMH.	• Contract Compliance Review

ASSET REGISTER

The below equipment will be serviced and maintained to industries standards and service requirements. Material required to service the assets below but not limited to i.e., filters, belts, coolants, etc. will be billed at a separate cost.

Asset Number:	Asset Tag	SYSTEM DROP DOWN	Manufacture Master:	Model Number:	Serial Number:
0	Acorn Valve Control Panel	CONTROLS - CONTROL PANEL	Acorn Controls	LD-40W-24	D 27006200
LAB HC0397	AHU-4 RF FED FROM DPNPDHB-7 480V 3P 3W	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
LAB HC0396	AHU-4 RF FED FROM PPEPDHA-3 480V 3P 3W	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
0	AHU -4 RF	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
LAB HC0409	AHU-5	HVAC - AHU - EXTERNALLY LOCATED	Energy Labs Inc	C128213 - FC - L	2005-12330 - AHU-5
LAB HC0375	AHU-5 RF	CONTROLS - CONTROLLER	Danfoss	To Be Populated	To Be Populated
LAB HC0406	AHU-5 RF	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
LAB HC0407	AHU-5 RF	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
0	AHU--5 CONTROL PANEL	CONTROLS - BMS - OUTSTATIONS	Alerton	Not Observed	Not Observed
LAB HC0410	AHU-5 Return Fanwall	HVAC - AHU - EXTERNALLY LOCATED	Energy Labs Inc	C128213 - FC-L	2005-12330 - AHU-5

LAB HC0414	AHU-5 SF	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
LAB HC0323		HVAC - PIPEWORK - GAS GOVENOR	Pietro Fiorentini	30155-OPD	MC201202102738
LAB HC0313	CHWP-2	HVAC - PUMP	Bell and Gosset	Not Observed	C303418-01G02
LAB HC0415	AHU-5 SF	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
LAB HC0405	AHU-5 Supply Fanwall	HVAC - AHU - EXTERNALLY LOCATED	Energy Labs Inc	C128213 - FC -L	2005-12330 - AHU-5
LAB HC0413	AHU-3	HVAC - AHU - EXTERNALLY LOCATED	Energy Labs Inc	C128213 - FC -L	2005-12330 - AHU-3
LAB HC0425	AHU-3 Fanwall	HVAC - AHU - EXTERNALLY LOCATED	Energy Labs Inc	C128213 - FC -L	2005-12330 - AHU-3
LAB HC0427	AHU-3	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
LAB HC0428	AHU-3	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
LAB HC0411	AHU-3 RF	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
0	AHU-3 RF	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
LAB HC0424	AHU-3 RF	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
LAB HC0426	AHU-3 Return Fanwall	HVAC - AHU - EXTERNALLY LOCATED	Energy Labs Inc	C128213 - FC -L	2005-12330 - AHU-3

LAB HC0359	B-1	HVAC - BOILER - CONDENSING BOILER	Lochinvar	FBN2001	1846112615290
LAB HC0423	AHU-3 CONTROL PANEL	CONTROLS - BMS - OUTSTATIONS	Alerton	Not Applicable	Not Applicable
LAB HC0422	AHU-1	HVAC - AHU - EXTERNALLY LOCATED	Energy Labs Inc	C128296 - F CH - L	2005-12330 - AHU-1
LAB HC0421	AHU-1 Return Fanwall	HVAC - AHU - EXTERNALLY LOCATED	Energy Labs Inc	C128296 - FCH-L	2005-12330 - AHU-1
LAB HC0418	AHU-1 RF	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
LAB HC0417	AHU-1 RF	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
LAB HC0416	AHU-1 RF	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
LAB HC0377	AHU-1 CONTROL PANEL	CONTROLS - BMS - OUTSTATIONS	Alerton	Not Applicable	Not Applicable
0	AHU-1 Supply Fanwall	HVAC - AHU - EXTERNALLY LOCATED	Energy Labs Inc	C128296 - FC H-L	2005-12330 - AHU-1
LAB HC0420	AHU-1 SF	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
LAB HC0419	AHU-1 SF	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed
LAB HC0332	B-2	HVAC - BOILER - CONDENSING BOILER	Lochinvar	FBN2001	1842 112287145
LAB HC0311	Water Treatment	CONTROLS - CONTROL PANEL	Walchem	WCT910PAADNNN-PAFINN	2009281551

LAB HC0399	EF-18	HVAC - FAN - EXTRACT UNIT	Greenheck	CUE-080-VG-C	16703939	
LAB HC0371	EF-15	HVAC - FAN - EXTRACT UNIT	Greenheck	CUE-161HP-VG-10-X	16703935	
LAB HC0398	EF-17	HVAC - FAN - EXTRACT UNIT	Greenheck	USF-04-01-B3-00-01-01	16978873	
LAB HC0636	VAV-2-520	HVAC - VAV	Price	SDV5 003	1563618-003-020	
LAB HC0639	RA CONTROL PANEL CP-RAD 1-5		CONTROLS - BMS - OUTSTATIONS	Alerton	Not Applicable	Not Applicable
LAB HC0296	FCU 6-3	HVAC - TERMINAL UNIT - FAN COIL	Daikin	BC.H.D.020.1.E.R.W.Y.V.V.A.V.Y.Y.Y.MV.Y.YYY.Y.N.L.Y.Y	E031424000500	
LAB HC0292	FCU6-2	HVAC - TERMINAL UNIT - FAN COIL	Daikin	BC.H.D.020.1.E-RAN,Y.Y.V.A.M.Y.Y.Y.YV.Y.YVY.Y.N.L.Y.Y	E031424000500	
LAB HC0291	FCU 6-1	HVAC - TERMINAL UNIT - FAN COIL	Daikin	DC.H.D.020.1.E.R.W.Y.Y.Y.A.Y.Y.Y.Y.YY.Y.YYY.Y.N.L.Y.B	E071 494000500	
LAB HC0295	FCU 6-6	HVAC - TERMINAL UNIT - FAN COIL	Daikin	To Be Populated	To Be Populated	
0	FCU 7-2	HVAC - TERMINAL UNIT - FAN COIL	Daikin	To Be Populated	To Be Populated	
LAB HC0331	B-3	HVAC - BOILER - CONDENSING BOILER	Lochinvar	FBN2001	1848 112730626	
0	R3 / R7 / R2	HVAC - DOSING SET - CHILLED WATER DOSING	ProMinent	Not Applicable	Not Applicable	
LAB HC0641	VAV-2-521	HVAC - VAV	Price	SDV5 - 004	1618346-033-039	

LAB HC0642	FCU 5-2	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	MHWW-36-H-3	WQWHC3620030909
LAB HC0652	VAV-2-515	HVAC - VAV	Price	SDVS		
LAB HC0651	VAV-2-516	HVAC - VAV	Price	SDV5 - 001	1601500-001-082	
LAB HC0654	LPN5DHA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0655	LPLS5DLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0657	LPLS5DHA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0659	RPE5DLC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0661	RPN5DLD	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0662	RPN5DLC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0358	B-4	HVAC - BOILER - CONDENSING BOILER	Lochinvar	FBN2001	1848 112968547	
LAB HC0123	EF-3	HVAC - FAN - EXTRACT UNIT	Greenheck	CUE-101-vg-4-x	16703924	
LAB HC0665	DPN5DLA	ELECTRICAL - DIST BD	General Electric	Not Applicable	Not Applicable	
LAB HC0667	DPE5DLA	ELECTRICAL - DIST BD	General Electric	Not Applicable	Not Applicable	

LAB HC0666	TE5DA	ELECTRICAL - TRANSFORMER - RESIN	General Electric	9T10C1007G31	M0003FSF	
LAB HC0664	TN5DB	ELECTRICAL - TRANSFORMER - RESIN	General Electric	9T10C1008G31	1M0003FWB	
LAB HC0656	VAV-2-516	HVAC - VAV	Price	SDV5 - 004	1618346-033-051	
LAB HC0658	FCU 5-3	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	MHWW-38-H-3	WQWHC3620C30831
LAB HC0649	RPN5DLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0648	RPN5DLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0650	TF-24	HVAC - FAN - EXTRACT UNIT	Greenheck	SQ-80VG-X	16887632	
LAB HC0672	FCU 5-4	HVAC - ACU - SPLIT UNIT	Multi Aqua	MHWW-38-H-3	WQWHC3620030903	
LAB HC0330		PLUMBING - PUMP	Bell and Gosset	TG577	20190319 -01098	
LAB HC0122	EF-2	HVAC - FAN - EXTRACT UNIT	Greenheck	Cue-101hp-vg-4-x	16703923	
LAB HC0669	VAV-5-519	HVAC - VAV	Price	SDV5 - 003	1632168-012-062	
LAB HC0676	RPE5CLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0677	RPN5CLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	

LAB HC0678	RPN5CLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0679	TF-23	HVAC - FAN - EXTRACT UNIT	Greenheck	Not Observed	Not Observed	
LAB HC0683	RPE5BLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0682	RPN5BLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0681	RPN5BLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0684	TF-22	HVAC - FAN - EXTRACT UNIT	Greenheck	Not Observed	Not Observed	
LAB HC0337	RPNPALA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0120	EF-1	HVAC - FAN - EXTRACT UNIT	Greenheck	CUE-240-b-vgd-50-x	16703922	
LAB HC0673	UPS RPE5CLA-16,18	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0674	UPS RPE5CLA-20,22	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0643	UPS RPE5DLC-16,18	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0644	UPS RPE5DLC-20,22	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0691	UPS RPE5ALA-20,22	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	

LAB HC0692	UPS RPE5ALA-24,26	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0690	FCU 5-1	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	MHWW-36-W-3	WQWHC 3619060730
LAB HC0688	VAV—3-520	HVAC - VAV	Price	SDVS - L 004	Not Visible	
LAB HC0694	TF-21	HVAC - FAN - EXTRACT UNIT	Greenheck	Not Observed	Not Observed	
0		CONTROLS - BMS - OUTSTATIONS	Honeywell	301EM		
LAB HC0121	EF-4	HVAC - FAN - EXTRACT UNIT	Greenheck	Cue-131-vg-7-x	16703929	
LAB HC0697	RPE5ALA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0696	RPN5ALB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0695	RPN5ALA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0687	PAGING SYSTEM RPE5ALA-28	COMMS - CALL SYSTEMS - PAGING	Valcom	VP-6124	Not Observed	
LAB HC0670	PAGING SYSTEM RPE5CLA-28	COMMS - CALL SYSTEMS - PAGING	Valcom	VP-6124	Not Observed	
LAB HC0646	PAGING SYSTEM RPE5DLC-28	COMMS - CALL SYSTEMS - PAGING	Valcom	VP-6124	Not Observed	
LAB HC0317	VFD-CHWP2	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed	

LAB HC0312	VFD-CHWP1	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed	
LAB HC0001	RPN4DLA	ELECTRICAL - DIST BD	General Electric	Not Applicable	Not Applicable	
LAB HC0002	RPN4DLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
0		HVAC - TERMINAL UNIT - FAN COIL	Daikin	FXMQ54PBVJU	To Be Populated	
LAB HC0151	CU-7-4	HVAC - ACU - SPLIT UNIT	Daikin	RX36NMVJUA	E000418	
LAB HC0003	TF-20	HVAC - FAN - EXTRACT UNIT	Greenheck	Not Observed	Not Observed	
LAB HC0004		CONTROLS - LIGHTING CONTRL	Acuity Controls	To Be Populated	Not Applicable	
LAB HC0006	PAGING SYSTEM R PE4DLC-28	COMMS - CALL SYSTEMS - PAGING	Valcom	VP-6124	Not Observed	
LAB HC0005	VAV-1-409	HVAC - VAV	Price	SDV5 - 004	1618346-033-045	
LAB HC0010	UPS RPE4DLC-16,18	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0011	UPS RPE4DLC-20,22	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0007		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0008	FCU 4-2	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	Not Observed	Not Observed

LAB HC0645		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0689		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0343		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0338		CONTROLS - LIGHTING CONTRL	Acuity Controls	To Be Populated	Not Applicable	
0		SAFETY - CHECKS	Acorn Safety	S1340-BF	4456316*S1340BF	
LAB HC0119	EF-7	HVAC - FAN - EXTRACT UNIT	Greenheck	CUE-090-VG-X	16703928	
LAB HC0671		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0637		FIRE & SEC - DETECTOR - PASSIVE INFRA RED	Simplex	Not Observed	Not Observed	
LAB HC0592	5205	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
0	5201	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
LAB HC0601	5248B	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
LAB HC0602	5303A	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
LAB HC0588	5420	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
LAB HC0608	5500A	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	

LAB HC0012	4406	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
LAB HC0013	4500	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
LAB HC0342		HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	MHWW-38-H-3	WQWnc362003000 7
LAB HC0150	EF-9	HVAC - FAN - EXTRACT UNIT	Greenheck	CUE-240-B-VGD-50-X	16703930	
LAB HC0014	4201	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
LAB HC0015	4200B	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
LAB HC0016	4200A	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
LAB HC0017		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
0	PAGING SYSTEM RPE4ALA-28	COMMS - CALL SYSTEMS - PAGING	Valcom	VP-6124	Not Observed	
LAB HC0020	UPS RPE4ALA-16,18	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0021	UPS RPE4ALA-20,22	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0022	FCU 4-1	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	Not Observed	Not Observed
LAB HC0019	VAV-3-418	HVAC - VAV	Price	SDV5 - 004	1618346-033-080	

LAB HC0023	4103A	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
LAB HC0333		SAFETY - CHECKS	Acorn Safety	S1340-BF		
LAB HC0149	EF-6	HVAC - FAN - EXTRACT UNIT	Greenheck	CUE-121-VG-4-X	16703927	
LAB HC0024	RPN4ALA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0025	RPN4ALB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0026	RPE4ALA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0027	TF-18	HVAC - FAN - EXTRACT UNIT	Greenheck	Not Observed	Not Observed	
LAB HC0029		FIRE & SEC - DETECTOR - PASSIVE INFRA RED	Simplex	Not Observed	Not Observed	
LAB HC0028	RA CONTROL PANEL CP-RAD 1-4		CONTROLS - BMS - OUTSTATIONS	Climatec	Not Applicable	Not Applicable
LAB HC0031	VAV-1-401	HVAC - VAV	Price	SDV5 - 003	1632168-012-072	
LAB HC0640		FIRE & SEC - DETECTOR - PASSIVE INFRA RED	Simplex	Not Observed	Not Observed	
LAB HC0360	EF-1,2,3,4	CONTROLS - BMS - OUTSTATIONS	Alerton	VLC-444e	Not Applicable	
LAB HC0258	Elevator 2	TRANSPORT - ELEVATOR - TRACTION	Torin Drive	0TGL3A-5050-HV-SW5/8”	20CH00008	

0	5303B	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
LAB HC0033	4442	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
LAB HC0034	RPN4DLC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0035	PPN4DHA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0328	Heating Hot Water Control Panel		CONTROLS - BMS - OUTSTATIONS	Alerton	VLC-1188-E	Not Applicable
LAB HC0248		ELECTRICAL - DIRECT CURRENT	Motion Control Engineering Inc	RESIST-R-C	3453472	
LAB HC0036	PPN4DLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0037	PPE4DHA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0038	PPE4DLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0039	RPE4DLC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0040	DPE4DLA	ELECTRICAL - DIST BD	General Electric	Not Applicable	Not Applicable	
0	TN4DB	ELECTRICAL - TRANSFORMER - RESIN	General Electric	9T10C1008G31	1 M0003FVU	
LAB HC0042	TE4DA	ELECTRICAL - TRANSFORMER - RESIN	General Electric	9T10C1007G31	1 MO003FSC	
LAB HC0041	DPN4DLA	ELECTRICAL - DIST BD	General Electric	Not Applicable	Not Applicable	

LAB HC0043	TE4DB	ELECTRICAL - TRANSFORMER - RESIN	General Electric	9T10C1003G31	1M0004BR6	
LAB HC0049	TN4DA	ELECTRICAL - TRANSFORMER - RESIN	General Electric	Not Applicable	Not Applicable	
LAB HC0327	FCU 6-5, Control Panel	CONTROLS - BMS - OUTSTATIONS	Alerton	VLC-444e	Not Applicable	
LAB HC0247	2	ELECTRICAL - TRANSFORMER - RESIN	Hammond Power Solutions	Not Applicable	BB01063777	
LAB HC0044		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0047	DCE4DA	ELECTRICAL - HIGH VOLTAGE	General Electric	Busway Plugs	Not Observed	
LAB HC0048	DCN4DA	ELECTRICAL - HIGH VOLTAGE	General Electric	Busway Plugs	Not Observed	
LAB HC0045	FCU 4-3	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	Not Observed	Not Observed
LAB HC0668		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0050		FIRE & SEC - DETECTOR - PASSIVE INFRA RED	Simplex	Not Observed	Not Observed	
LAB HC0051	VAV-3-414	HVAC - VAV	Price	SDV5 - 004	1618346-033-040	
0	EWH-2	ELECTRICAL - WATER HEATER - DIRECT FIRED	AO Smith	DEL-10 102	2101122603583	
LAB HC0350		HVAC - DOSING SET - CHILLED WATER DOSING	Dawson Co	DB-5HD/RED	0420	

LAB HC0262	Elevator 6	TRANSPORT - ELEVATOR - TRACTION	Torin Drive	TMGL2-3550-HV-10MM	20BV00081	
LAB HC0054	VAV-4-401	HVAC - VAV	Price	SDV5-001	1601500-001-095	
LAB HC0059	4240	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
0	4300B	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
0	VAV-4-409	HVAC - VAV	Price	SDV5-002	1649911-018-058	
LAB HC0060	4300A	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
LAB HC0061	PAGING SYSTEM RPE4CLA-24	COMMS - CALL SYSTEMS - PAGING	Valcom	VP-6124	Not Observed	
LAB HC0064	UPS RPE4CLA-16,18	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0351		HVAC - TERMINAL UNIT - FAN COIL	Daikin	E031424000400	To Be Populated	
0	Elevator 5	HVAC - DOSING SET - CHILLED WATER DOSING	Torin Drive	TWGL2-3550-HV-10MM	19BV00020	
LAB HC0063	UPS RPE4CLA-20,22	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0062		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0066	FCU 4-4	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	Not Observed	Not Observed
LAB HC0065	VAV-5-414	HVAC - VAV	Price	SDV5 - 004	1618346-033-042	

LAB HC0070	RPN4CLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0073	RPN4CLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0071	RPE4CLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
0		PLUMBING - PUMP	Armstrong	ARMfIO E32.2B	100166402	
LAB HC0246		ELECTRICAL - DIRECT CURRENT	Motion Control Engineering Inc	RESIST-R-C	3453624	
LAB HC0072	TF-19	HVAC - FAN - EXTRACT UNIT	Greenheck	Not Observed	Not Observed	
LAB HC0154	RPN3DLC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0155	LPN3DHA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0156	LPLS3DLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0157	LPLS3DHA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0158	RPE3DLC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0159	DPE3DLA	ELECTRICAL - DIST BD	General Electric	Not Applicable	Not Applicable	
LAB HC0162	TE3DA	ELECTRICAL - TRANSFORMER - RESIN	General Electric	9T10C1007G31	1 M0003FSE	

LAB HC0167	DPN3DLA	ELECTRICAL - DIST BD	General Electric	Not Applicable	Not Applicable	
LAB HC0166	TN3DB	ELECTRICAL - TRANSFORMER - RESIN	General Electric	9T10C1008G31	*1 M0003FV	
LAB HC0245	5	ELECTRICAL - TRANSFORMER - RESIN	Hammond Power Solutions	Not Applicable	233570	
LAB HC0165	DCE3DA	ELECTRICAL - HIGH VOLTAGE	General Electric	Busway Plugs	Not Observed	
LAB HC0160	DCN3DA	ELECTRICAL - HIGH VOLTAGE	General Electric	Busway Plugs	Not Observed	
LAB HC0161		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0169		FIRE & SEC - DETECTOR - PASSIVE INFRA RED	Simplex	Not Observed	Not Observed	
LAB HC0175	VAV-3-318	HVAC - VAV	Price	SDV5-004	1563618-004-075	
LAB HC0176		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0187	RPE3ALA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	1208		
LAB HC0188	TF-14 EF-28 Control Panel	CONTROLS - BMS - OUTSTATIONS	Not Observed	Not Observed	Not Observed	
LAB HC0192	RPE3BLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0194	3300	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	

0	RPEPALA	ELECTRICAL - DIST BD - LOW VOLTAGE	ABB	Not Applicable	Not Applicable	
0	CHILLED WATER SYSTEM CONTROL PANEL (should be: REFRIGERANT LEAK DETECTION CONTROL PANEL)		CONTROLS - BMS - OUTSTATIONS	Climatec	Not Applicable	D 76995979
LAB HC0244		ELECTRICAL - DIRECT CURRENT	Motion Control Engineering Inc	RESIST-R-C	3453627	
LAB HC0199	FCU-3-4	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	Not Observed	Not Observed
LAB HC0198	RPE3CLA-24	COMMS - CALL SYSTEMS - PAGING	Valcom	VP-6124	Not Observed	
0	EF-27	HVAC - FAN - EXTRACT UNIT	Not Observed	Not Observed	Not Observed	
LAB HC0206	TF-16	HVAC - FAN - EXTRACT UNIT	Greenheck	Not Observed	Not Observed	
LAB HC0208		FIRE & SEC - DETECTOR - PASSIVE INFRA RED	Simplex	Not Observed	Not Observed	
LAB HC0215	RPE3DLC-1	COMMS - CALL SYSTEMS - PAGING	Valcom	VP-6124	Not Observed	
LAB HC0216	FCU 3-2	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	Not Observed	Not Observed
LAB HC0433	2200C	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
LAB HC0434	2590	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
LAB HC0438	RPN2BLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	

LAB HC0255	Elevator 9	TRANSPORT - ELEVATOR - TRACTION	Torin Drive	OTGL2A-4050-HV-SW-1/2”	20BW00047	
LAB HC0437	RPN2BLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0440	RPE2DLC-26	COMMS - CALL SYSTEMS - PAGING	Valcom	VP-6124	Not Observed	
LAB HC0441		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0446	2300A	FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
LAB HC0447	RPE2CLA-28	COMMS - CALL SYSTEMS - PAGING	Valcom	VP-6124	Not Observed	
LAB HC0448		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0456	RPE2CLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0455	RPN2CLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0454	RPN2CLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
0		ELECTRICAL - DIRECT CURRENT	Motion Control Engineering Inc	RESIST-R-C	3453638	
LAB HC0463	UPS RPE2ALA-19,21	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0465	UPS RPE2ALA-15,17	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	

LAB HC0466		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0464	VAV-4-2-19	HVAC - VAV	Price	SDV5-004	1618346-033-037	
LAB HC0470	RPN2ALA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0471	RPN2ALB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0475	Control Panel TF-9,10	CONTROLS - BMS - OUTSTATIONS	Climatec	Not Applicable	Not Applicable	
LAB HC0210	3468A	FABRIC - DOORS	Not Observed	Not Applicable	Not Applicable	
LAB HC0217	Lighting Control	CONTROLS - LIGHTING CONTRL	Acuity Controls	To Be Populated	Not Applicable	
LAB HC0219	RPN3DLD	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0256	9	ELECTRICAL - TRANSFORMER - RESIN	Hammond Power Solutions	Not Applicable	BB01063780	
LAB HC0220	RPN3DLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
0	Rpn3dlb	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0218	TF-17	HVAC - FAN - EXTRACT UNIT	Greenheck	SQ-80-VG-X	16722503	
LAB HC0171	VAV 1-306	HVAC - VAV	Price	SDV5-004	1554850-011-019	

LAB HC0174	RA CONTROL PANEL CP-RAD 1-3	HVAC - VAV	Price	SDV5-004	1554850-011-095	
LAB HC0178		FIRE & SEC - FIRE ALARM SYS - MAIN PANEL	Corning	To Be Populated	To Be Populated	
LAB HC0180	PAGING SYSTEM RPE3ALA-20	COMMS - CALL SYSTEMS - PAGING	Valcom			
LAB HC0183	DAS RPE3ALA-16	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0336	VFD-HHWP-2	CONTROLS - CONTROLLER	Danfoss	174Z2417	039004Y210	
LAB HC0129	EF-28	HVAC - FAN - EXTRACT UNIT	Not Observed			
LAB HC0184	TF-14	HVAC - FAN - EXTRACT UNIT	Greenheck			
LAB HC0186	RPN3ALB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
0	3280A	FABRIC - DOORS	Not Observed	Not Applicable	Not Applicable	
LAB HC0191	RPN3BLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0195		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0200	VAV-5-318	HVAC - VAV	Price	SDV5 - 003	1554850-010-089	
LAB HC0203	RPE3CLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	

LAB HC0209	3468B	FABRIC - DOORS	Not Observed	Not Applicable	Not Applicable	
LAB HC0320	RPNPCLA	ELECTRICAL - DIST BD	General Electric	AQF3422JTX	AXF2S5	
LAB HC0214		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0211	Vav-2-316	HVAC - VAV	Price	SDV5 - 004	1563618-004-090	
LAB HC0480	RPN2DLC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0482	PPN2DHA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0484	PPN2DLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0485	PPE2DHA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0489	PPE2DLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0490	RPE2DLC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0493	DPE2DLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0494	TE2DA	ELECTRICAL - TRANSFORMER - RESIN	General Electric	9T10C1007G31	1 M0003FS9	
LAB HC0310		HVAC - EXP VESSEL - CHILLED WATER EXPANSION	Not Observed	Not Observed	Not Observed	

LAB HC0497	DPN2DLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0495	TN2DB	ELECTRICAL - TRANSFORMER - RESIN	General Electric	9T10C1008G31	1M0003FVQ	
LAB HC0492	DCE2DA	ELECTRICAL - HIGH VOLTAGE	General Electric	Busway Plugs		
LAB HC0491	DCN2DA	ELECTRICAL - HIGH VOLTAGE	General Electric	Busway Plugs		
LAB HC0486	TE2DB	ELECTRICAL - TRANSFORMER - RESIN	General Electric	9T1OC1003G31	1M0004BER	
LAB HC0487	TN2DA	ELECTRICAL - TRANSFORMER - RESIN	General Electric			
LAB HC0488		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0483	FCU 2-3	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	To Be Populated	To Be Populated
LAB HC0481	VAV-2-220	HVAC - VAV	Price	SDV5 - 004	1563618-004-098	
LAB HC0319		HVAC - DOSING SET - CHILLED WATER DOSING	Not Observed	Not Observed	Not Observed	
LAB HC0179		FIRE & SEC - FIRE ALARM SYS - MAIN PANEL	Simplex			
LAB HC0457	TF-12	HVAC - FAN - EXTRACT UNIT	Greenheck	SQ-80-VG-X	16722497	
LAB HC0462	PAGING SYSTEM RPE2ALA-16	COMMS - CALL SYSTEMS - PAGING	Valcom			

LAB HC0467	FCU 2-1	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	To Be Populated	To Be Populated
LAB HC0498		CONTROLS - BMS - OUTSTATIONS	Cisco	Not Applicable	Not Applicable	
LAB HC0473	TF-9	HVAC - FAN - EXTRACT UNIT	Greenheck	SQ-80-VG-X	16722494	
LAB HC0472	RPE2ALA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0137	EF-10	HVAC - FAN - EXTRACT UNIT	Greenheck	CUE-240-B-VGD-50-X	16703931	
LAB HC0168		FIRE & SEC - DETECTOR - PASSIVE INFRA RED	Simplex			
LAB HC0177		HVAC - TERMINAL UNIT - FAN COIL		Daikin	To Be Populated	To Be Populated
LAB HC0181		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0182		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0185	RPN3ALA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
LAB HC0190	RPN3BLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
LAB HC0193	TF-15	HVAC - FAN - EXTRACT UNIT	Greenheck	To Be Populated	To Be Populated	
0	UPS RPE3CLA-20, 22	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	

LAB HC0196	UPS RPE3CLA-16, 18	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0197	RPN3CLB	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0134	EF-8	HVAC - FAN - EXTRACT UNIT	Greenheck	CUE-131-VG-7-X	16703929	
LAB HC0204	RPN3CLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
LAB HC0205	UPS RPE3DLC-7,9		General Electric			
LAB HC0212	RPE3DLC-11-13	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0213		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0436	RPE2BLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
LAB HC0439	TF-11	HVAC - FAN - EXTRACT UNIT	Greenheck	To Be Populated	To Be Populated	
LAB HC0442	UPS RPE2DLC-18, 20	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0443	UPS RPE2DLC-22, 24	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
0		HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	To Be Populated	To Be Populated
LAB HC0355		HVAC - CYLINDERS	Lochinvar	THG1500J	120707093	

0	FCU 6-6 CONTROL PANEL	CONTROLS - BMS - OUTSTATIONS	Climatec	VLC-444e	D 76995942	
LAB HC0135	EF-12	HVAC - FAN - EXTRACT UNIT	Greenheck	CUE-095-VG-6-X	16703933	
0	VAV-1-212	HVAC - VAV	Price			
LAB HC0450	RPE2CLA-17,18	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0451	UPS RPE2CLA-16,18	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
0	ADD-19	HVAC - VAV	Price			
LAB HC0499		FABRIC - DOORS	Not Applicable	Not Applicable	Not Applicable	
0	RPN1CLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
LAB HC0509	RPN1CLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
LAB HC0506	RPE1CLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
LAB HC0510	RPN1BLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
LAB HC0136	EF-11	HVAC - FAN - EXTRACT UNIT	Greenheck	CUE-095-VG-6-X	16703932	
LAB HC0512	RPN1BLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
LAB HC0513	RPE1BLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			

LAB HC05 16	RPE1CLA-15, 17	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC05 15		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC05 17	Gateway 5 Control Panel		0			
LAB HC05 22	RPE1DLC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
0	LPN1DHA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
0	LPLS1DHA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
LAB HC05 23	RPN1DLC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
0	DPE1DLA	ELECTRICAL - DIST BD	General Electric			
LAB HC01 32	KEF-1	HVAC - FAN - EXTRACT UNIT	Greenheck	UISF-27-3- B4 00-01-01	1674574420G	
0		ELECTRICAL - DIST BD	General Electric			
0	TE1DA	ELECTRICAL - TRANSFORMER - RESIN	General Electric			
LAB HC05 39	RPE1DLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
LAB HC05 37	RPN1DLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
LAB HC05 44	FCU 1-2	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	To Be Populated	To Be Populated
LAB HC05 55	UPS RPE1BLA-28, 30	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	To Be Populated	To Be Populated

LAB HC0558	RPE1ALA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
LAB HC0562		ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
LAB HC0807	control panel RF-14 Kef-2	FIRE & SEC - PUMP	Bell and Gosset			
LAB HC0808		CONTROLS - CONTROL PANEL	Firetrol Inc	To Be Populated	To Be Populated	
LAB HC0133	VFD-KEF-1	CONTROLS - CONTROLLER	ABB	ACH		
0		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
0	MUA-1	HVAC - AHU - EXTERNALLY LOCATED	Greenheck	MSX-P120-H22	16556378	
0		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0627	FCU B-7	HVAC - TERMINAL UNIT - FAN COIL	Daikin	To Be Populated	To Be Populated	
LAB HC0622	VAV-2-B07	HVAC - VAV	Price			
LAB HC0628	FCU B-9	HVAC - TERMINAL UNIT - FAN COIL	Daikin	To Be Populated	To Be Populated	
LAB HC0624	hv-1	ELECTRICAL - HIGH VOLTAGE - MAIN SWITCHGEAR	Not Observed			
LAB HC0623	FCU B-8	HVAC - TERMINAL UNIT - FAN COIL	Daikin	To Be Populated	To Be Populated	

LAB HC0626		DWS - BOOSTER	Wilo			
LAB HC0148	EF-13	HVAC - FAN - EXTRACT UNIT	Greenheck	CUE-161-A-X	16703934	
LAB HC0776	LPLBDHA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0777	TLB1DA	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0779	RPNBDLE	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0756	RPNBDLD	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0778	RPNBDLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0755	RPNBDLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
0	APNBDLA	ELECTRICAL - HIGH VOLTAGE	Not Observed			
LAB HC0757	RPEBDLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
LAB HC0786	ESWBDBDB-5	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0147	VFD-EF-13	CONTROLS - CONTROLLER	ABB	ACH		
LAB HC0789		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	

LAB HC0790		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0633		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0632		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0814	WH-1	DWS - CALORIFIER	Lochinvar			
LAB HC0818	ET-1	HVAC - EXP VESSEL	Not Observed			
LAB HC0791	FCUB-10	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	To Be Populated	To Be Populated
LAB HC0794		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
0		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0116	CU-7-3	HVAC - ACU - SPLIT UNIT	Daikin	RXTQ36TAVJ9A	E000992	
0	FCU B-14	HVAC - TERMINAL UNIT - FAN COIL	ABB			
LAB HC0703	RPNBBLC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0702	RPNBBLD	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
0	VAV 1-B51	HVAC - VAV	Price			
0	HV-4	ELECTRICAL - SWITCHGEAR	Not Observed			

LAB HC0706	FCU B-5	HVAC - TERMINAL UNIT - FAN COIL	Daikin	To Be Populated	To Be Populated	
0	RPNBBLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0718	300A Busduct	ELECTRICAL - HIGH VOLTAGE - MAIN SWITCHGEAR	General Electric			
LAB HC0719	RPNBBLA	ELECTRICAL - DIST BD	Not Observed			
LAB HC0152	CU-7-2	HVAC - ACU - SPLIT UNIT	Daikin	RXTO6OTAVJU	F005510	
LAB HC0722	RPNBBLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0717	FCU B-5	HVAC - TERMINAL UNIT - FAN COIL	Daikin	To Be Populated	To Be Populated	
LAB HC0519		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0514	RPE1CLA-2	COMMS - CALL SYSTEMS - PAGING	Valcom	VP-6124		
LAB HC0518	FCU 1-4	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	To Be Populated	To Be Populated
LAB HC0524	LPLS1DLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric			
LAB HC0530	TN1DB	ELECTRICAL - TRANSFORMER - RESIN	General Electric	9T10C1008G31	1M0003FW4	
LAB HC0525	DCE1DA	ELECTRICAL - HIGH VOLTAGE	General Electric	Busway Plugs		

LAB HC0531	DCN1DA	ELECTRICAL - HIGH VOLTAGE	ABB			
LAB HC0538	RPN1DLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0118	CU-6-1	HVAC - ACU - SPLIT UNIT	Daikin	RXTQ60TAVJU	F00549g	
LAB HC0543	TF-8	HVAC - FAN - EXTRACT UNIT	Greenheck		16624944	
LAB HC0550	VAV-1-117	HVAC - VAV	Price			
LAB HC0548	Gateway 1,2 & 4 Area D, Control Panel		CONTROLS - BMS - OUTSTATIONS	Not Observed		
LAB HC0549		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0552		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0554	Gateway 3 Area A, Control Panel	CONTROLS - BMS - OUTSTATIONS	Not Observed			
LAB HC0553	RPE1BLA-20	COMMS - CALL SYSTEMS - PAGING	Valcom			
LAB HC0561	RPN1ALC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0560	RPN1ALA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0806	EF-14	HVAC - FAN - EXTRACT UNIT	Greenheck	SQ-100-VG 4-X	16558969	

LAB HC0117	CU-7-1	HVAC - ACU - SPLIT UNIT	Daikin	RXTQ60TAVJU	F005512	
LAB HC0800		HVAC - CONDENSER - AIR COOLED	Refrigeration Design Technologies	ZS2-04Z-CT3-AEC	20-9-4-23792	
LAB HC0810		DWS - CALORIFIER	Chronomite Laboratories Inc	CHSON-208-104-125	1341526	
LAB HC0823	RPEBDLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0824	RPNBDLF	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0825	RPNBDLG	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0822		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0821	FCU B-7/8/9	CONTROLS - BMS - OUTSTATIONS	Climatec	Not Applicable	Not Applicable	
LAB HC0629	FCU B-12	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	To Be Populated	To Be Populated
LAB HC0770	PPEBDLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0771	ESWBDBDB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0356		HVAC - BOILER - GAS	Lochinvar	PFN1302	2034 120597826	
0	CH-1	HVAC - CHILLER - RECIPROCATING	Daikin	WME106CSCSNA	STNU200700069	

LAB HC0259	1	TRANSPORT - ELEVATOR - TRACTION	Torin Drive	OTCL3A-5050-HV-SN-5/8"	20CH00009	
LAB HC0773	PPNBDLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0774	PPNBDLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0751	PPNBDHA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0781		ELECTRICAL - HIGH VOLTAGE	General Electric	Busway Plugs		
LAB HC0784	SP136202	TRANSPORT - ELEVATOR - PASSENGER LIFT HYDRUALIC	Lincoln Motors	SD2S40Z61YEH3	WX20006679-8008	
0		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0812		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0811	RPEBCLA-25	COMMS - CALL SYSTEMS - PAGING	Valcom	VP-6124		
LAB HC0815	OF1465-50TM	DWS - SOFTENER	Watts	1465	020421	
LAB HC0793		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0260	FC-7-1	HVAC - TERMINAL UNIT - FAN COIL	Daikin	FXMQ54PBVJIJ	To Be Populated	
LAB HC0792	RPEBDLC-23	COMMS - CALL SYSTEMS - PAGING	Valcom	Vp-6124		

LAB HC0698	ATSEBDHC	ELECTRICAL - SWITCHGEAR	Zenith	ZBTSD0B10160F	151789010-300-1	
LAB HC0701	ATSLSBDHA	ELECTRICAL - SWITCHGEAR	Zenith	ZBTS00B00022F	151789010-10-1	
LAB HC0705	FCU B-14 Control Panel	CONTROLS - BMS - OUTSTATIONS	Climatec	Not Applicable	Not Applicable	
LAB HC0709	RPNBDLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0708	DPNBDLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0710		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0712	RPNBBLE	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0713	FCU B-4/5/6	CONTROLS - BMS - OUTSTATIONS	Climatec	Not Applicable	Not Applicable	
0		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0243	1	ELECTRICAL - DIRECT CURRENT	MCE	Resist-R-C	3453469	
LAB HC0728	RPEBALA-27	COMMS - CALL SYSTEMS - PAGING	Valcom	VP-6124		
LAB HC0729	RPEBALA-31	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0733	DAS	FIRE & SEC - FIRE ALARM SYS - MAIN PANEL	Advanced RF Technologies	ADXV-R-25VU-N4X		

LAB HC0736	RPEBALA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0737	RPNBALC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0741	RPEBALA	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0743	ESWBDBDB-4	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0764	RPEMPOEB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0765	RPEMPOEA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0766	RPNMPOEA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0238	1	ELECTRICAL - TRANSFORMER - RESIN	Hammond Power Solutions	Not Applicable	BB01063776	
LAB HC0767	ER-DAS HEADEND	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0748		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0749	FCU B-1 Control Panel	ELECTRICAL - BATTERY - UPS	Eaton	93PM-L-120	EQ144UJJ05	
LAB HC0763	FCU B-1	CONTROLS - BMS - OUTSTATIONS	Not Observed			
LAB HC0520	VAV-5-114	HVAC - VAV	Price	SDV - 5 005	1554830-012-019	

0	VAV-2-117	HVAC - VAV	Price			
LAB HC0526	FCU 1-3	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	To Be Populated	To Be Populated
LAB HC0239	6	ELECTRICAL - TRANSFORMER - RESIN	Hammond Power Solutions	Not Applicable	BB01063772	
LAB HC0533		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable	
LAB HC0540	RPN1DLF	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0541	RPN1DLE	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0542	RPN1DLD	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0545	PAGING SYSTEM RPE1 DLC-24	COMMS - CALL SYSTEMS - PAGING	Valcom	VP-6124		
LAB HC0546	UPS RPE1DLC-16,18	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0547	UPS RPC1DLC-20,22	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable	
LAB HC0551	VAV-3-124	HVAC - VAV	Price	SDV5 - 005	1492319-003-002	
LAB HC0559	RPN1ALB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable	
LAB HC0805	PPNDHA - 7,9,11	CONTROLS - BMS - OUTSTATIONS	Firetrol Inc	FZ1114237	2PATO2	

LAB HC0263	3	TRANSPORT - ELEVATOR - TRACTION	Torin Drive	0TGL3A-5050-HV-SW-678	ZOCH00007		
LAB HC0799	KEF-3	HVAC - FAN - EXTRACT UNIT	Danfoss	To Be Populated	To Be Populated		
LAB HC0798	VFD-KEF-3	CONTROLS - CONTROLLER	Danfoss	To Be Populated	To Be Populated		
LAB HC0797		ELECTRICAL - GENERATOR - DIESEL	Caterpillar	SA3ENG10853	92324E1		
LAB HC0616	VAV-2-B04	HVAC - VAV	Price	SDV5 - 002	1549592-009-078		
LAB HC0617	VAV-2-B10	HVAC - VAV	Price	SDV5 - 001	1549592-008-074		
0	HV-3	ELECTRICAL - SWITCHGEAR	Zinsco				
LAB HC0826		ELECTRICAL - HIGH VOLTAGE - MAIN SWITCHGEAR	Kinney		557760		
LAB HC0820	METERING CABINET SUBSTATION "A"		UTILITY - METER - ELECTRIC		Kinney	Not Applicable	557760
LAB HC0819		DWS - PUMP - BOOSTER SET	Baldor Relance				
LAB HC0819		DWS - PUMP - BOOSTER SET	Baldor Relance				
LAB HC0819		DWS - PUMP - BOOSTER SET	Baldor Relance				
LAB HC0264	4	TRANSPORT - ELEVATOR - TRACTION	Holistic Whitney	HW-624			

LAB HC0772	TEBDB	ELECTRICAL - TRANSFORMER - RESIN	General Electric				
LAB HC0750	TNBDA	ELECTRICAL - TRANSFORMER - RESIN	General Electric				
LAB HC0758	TEBDA	ELECTRICAL - TRANSFORMER - RESIN	General Electric				
LAB HC0752		ELECTRICAL - TRANSFORMER - RESIN	General Electric				
LAB HC0753	APNBDLE	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
LAB HC0754	APNBDLD	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
LAB HC0775	APNBDLC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
LAB HC0760	FCU B-11	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	To Be Populated	To Be Populated	
LAB HC0782		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable		
LAB HC0785	Elevator 10 Controller	CONTROLS - CONTROL PANEL - UNIT CONTROLLER LIFT	Otis				
LAB HC0267	3	ELECTRICAL - DIRECT CURRENT	MCE	Resist-R-C	3453475		
LAB HC0788		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable		
LAB HC0634	VAV-2-B06	HVAC - VAV	Price	SDV5 - 004	1554850-011-003		

LAB HC0631	PRV-1, PRV-2	HVAC - PIPEWORK - GAS GOVENOR	Maxitrol	Not Applicable	Not Applicable		
LAB HC0795	VAV-2-B09	HVAC - VAV	Price	SDV5 - 003	1492319-003-002		
LAB HC0699	ATSEBDHA	ELECTRICAL - MAIN SWITCH	Zenith	ZBTSDOB00040F	151789010-100-1		
LAB HC0700	ATSEBDHB	ELECTRICAL - SWITCHGEAR	Zenith	ZBTSDOB10200F	151789010-190-1		
LAB HC0704		ELECTRICAL - HIGH VOLTAGE - MAIN SWITCHGEAR	General Electric				
LAB HC0715	SUBSTATION D	ELECTRICAL - SWITCHGEAR	General Electric	OSP-0042-10	10095799P1		
LAB HC0721	METERING CABINET SUBSTATIONS C, D & E		UTILITY - METER - ELECTRIC		Kinney	Not Applicable	557760
LAB HC0714	UNIT SUBSTATION E	ELECTRICAL - SWITCHGEAR	Zinsco				
LAB HC0269	3	ELECTRICAL - TRANSFORMER - RESIN	Hammond Power Solutions	Not Applicable	BB01063775		
LAB HC0723	DPNBBLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
LAB HC0716	FCU B-4	HVAC - TERMINAL UNIT - FAN COIL		Daikin	To Be Populated	To Be Populated	
LAB HC0635		DRAINAGE - WASTE DISPOSAL - COMPACTOR	Marathon	51623888	5/17/21		
LAB HC0727	VAV—1-B49	HVAC - VAV	Price	SDV5 - 004	1563618-004-051		

LAB HC0734	FCU B-2	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	To Be Populated	To Be Populated	
LAB HC0732		ELECTRICAL - EARTHING	Not Applicable	Not Applicable	Not Applicable		
LAB HC0730	UPS RPEBALA-19,21	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable		
LAB HC0731	UPS RPEBALA-15,17	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable		
LAB HC0739	RPNBALA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
LAB HC0268	4	ELECTRICAL - TRANSFORMER - RESIN	Hammond Power Solutions	Not Applicable	BB01063774		
LAB HC0738	RPNBALB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
LAB HC0735	TF-1	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	Elevator 12 hydraulic pump motor		TRANSPORT - ELEVATOR - PASSENGER LIFT HYDRUALIC	Otis	AAA20390AF1	B 06 7741083-0002 M 0001	
LAB HC0761	Emergency Manual Release	FIRE & SEC - FIRE SUPP - FIRE SUPPRESSION SYSTEMS	Reliable				
LAB HC0769	FCU B-1	HVAC - TERMINAL UNIT - FAN COIL		Daikin	To Be Populated	To Be Populated	
LAB HC0768	TF-2	HVAC - FAN - EXTRACT UNIT	Greenheck				

LAB HC0746	DAS	FIRE & SEC - FIRE ALARM SYS - MAIN PANEL	Advanced RF Technologies	PSR-VU-9537-X			
LAB HC0747		FIRE & SEC - FIRE ALARM SYS - MAIN PANEL	Simplex	4100ES			
LAB HC0762	VAV-1-B46	HVAC - VAV	Price				
LAB HC0224		CONTROLS - CONTROL PANEL - UNIT CONTROLLER LIFT	Nidec MCE	i-AC-01	3453629		
LAB HC0357		HVAC - BOILER - GAS	Lochinvar	PFN1302	2034 120597825		
LAB HC0270		ELECTRICAL - DIRECT CURRENT	MCE	Resist-r-c	3453478		
LAB HC0223		CONTROLS - CONTROL PANEL - UNIT CONTROLLER LIFT	Nidec MCE	i-AC-01	3453632		
LAB HC0226		ELECTRICAL - TRANSFORMER - RESIN	Hammond Power Solutions	233568	BB01063779		
LAB HC0225	I-central-CUE	CONTROLS - CONTROL PANEL - UNIT CONTROLLER LIFT	Nidec MCE	I-Central-CUE	3453635		
LAB HC0362		HVAC - AHU - EXTERNALLY LOCATED	Energy Labs Inc				
LAB HC0387	EF-15,16,18,19	CONTROLS - BMS - OUTSTATIONS	Climatec	Not Applicable	Not Applicable		
0		CONTROLS - BMS - OUTSTATIONS	Alerton				
LAB HC0347	VFD-CT1-2	CONTROLS - CONTROLLER	Danfoss	177U2559	185B1398		

LAB HC0394		SAFETY - CHECKS	Acorn Controls	S1340-BF			
LAB HC0228	Elevator 7 Motor	TRANSPORT - ELEVATOR - TRACTION	Torin Drive	505d-HIV-SN-5/8	20CH00005		
LAB HC0227	Elevator 8 Motor	TRANSPORT - ELEVATOR - TRACTION	Torin Drive	OTGL3A-5050-HV-SN-5/8”	20CH0006		
LAB HC0266	FC-7-3	HVAC - TERMINAL UNIT - FAN COIL	Daikin	FXMQ36PBVJU	E014925		
LAB HC0230	Elevator 8 Resistor	ELECTRICAL - DIRECT CURRENT	Motion Control Engineering Inc	RESIST-R-C	2020095858		
LAB HC0361	AHU-2	HVAC - AHU - EXTERNALLY LOCATED	Energy Labs Inc	C128318 -F CH.L	2005-12330 - AHU-2		
LAB HC0389	AHU-2 Supply Fan Wall	HVAC - AHU - EXTERNALLY LOCATED	Not Observed				
0	AHU-2 SF FED FROM DPNPDH	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable		
LAB HC0388	AHU-2 CONTROL PANEL	CONTROLS - BMS - OUTSTATIONS	Alerton				
LAB HC0390	VFD- -EF-16	CONTROLS - CONTROLLER	Danfoss	177U2273	045204Y210		
LAB HC0380	CT-1	HVAC - COOL TOWER - GALVANISED METAL	Baltimore Aircoil Company	To Be Populated	To Be Populated		
LAB HC0393	VFD-CT1-1	CONTROLS - CONTROLLER	Danfoss	177U2559	044604Y210		
0	Cooling Tower Circulation Pump	HVAC - PUMP	Weg	01036E215JM-W22	12357277		

LAB HC0379	Cooling Tower Circulating Punp Control	CONTROLS - BMS - OUTSTATIONS	Amiad water systems	200107-000114	10180271 SO:262725		
LAB HC0254	FC-7-4	HVAC - ACU - SPLIT UNIT	Daikin	FTX36NVJU	E027463		
LAB HC0400	FXA-700	HVAC - EXP VESSEL	Wessels	HD186 2:1 SH.203	332169		
LAB HC0591		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0593		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0595		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0603		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0606		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0598		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0599		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0605		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0		PLUMBING - WATER TREATMENT	Not Observed	CN4-850	Part:100289340		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0075		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		

LAB HC0074		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0076		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0077		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0078		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0079		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0080		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0081		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0335	VFD-HHWP-1	CONTROLS - CONTROLLER	Danfoss	17422417	038904Y210		
LAB HC0082		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0083		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0084		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		

LAB HC0432		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0500		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0365		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0366		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0476		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0321	EF-8,10.11,12 CONTROL PANEL	CONTROLS - BMS - OUTSTATIONS	Alerton	VLC-444e	Not Applicable		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0368		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0369		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0431		FIRE & SEC - FIRE EXT	Not Observed				
LAB HC0370		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0222		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0128		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		

LAB HC0141		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0143		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0124		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0308		FABRIC - DOORS	Cookson	Service Door	SO 27243978-001		
LAB HC0202		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0145		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0207		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0146		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0127		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0189		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0126		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0	AHU-2 RF FED FROM DPNPDHB	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable		

LAB HC0318	RPBP-2	DWS - CHECKS	Watts	LF9090TRPZ	060800		
LAB HC0392	CDWP-1	HVAC - PUMP	Bell and Gosset	SSF 10.5	C303419-0G02		
LAB HC0384	VFD-CDWP1	CONTROLS - CONTROLLER	Danfoss	To Be Populated	To Be Populated		
LAB HC0391	VFD-CDWP2	CONTROLS - CONTROLLER	Danfoss	To Be Populated	To Be Populated		
LAB HC0092		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0107		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0108		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0109		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0111		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0		HVAC - DOSING SET - CHILLED WATER DOSING	Walchem	Not Applicable	Not Applicable		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0102		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0611		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		

LAB HC0094		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0783		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0563		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0		FIRE & SEC - FIRE EXT	Badger	Not Applicable			
LAB HC0565		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0576		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0459		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0286	HV-2	ELECTRICAL - SWITCHGEAR	Zinsco	Not Applicable	Not Applicable		
LAB HC0106		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0620		FABRIC - DOORS	Not Observed	Not Applicable	Not Applicable		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0114		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0115		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		

LAB HC0101		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0744		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0353	PRV	HVAC - PIPEWORK - GAS GOVENOR	Maxitrol	OPD210E	Not Collected		
0	CH-2	HVAC - CHILLER - RECIPROCATING	Daikin	WHE106CSCSNA	STNU200700052		
0	HV-3	ELECTRICAL - SWITCHGEAR	Zinsco	Not Applicable	Not Applicable		
LAB HC0745			0				
LAB HC0100		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0097		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0099		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0096		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0093		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0801		DWS - CHECKS	LF	LF909	060797		

LAB HC0287	No Tag	ELECTRICAL - HIGH VOLTAGE - MAIN SWITCHGEAR	Schneider Electric	PJ 1200	Ch-1: 0202411660430002 - Ch-2: 0202411660430002		
LAB HC0578		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0575			Potter Roemer Fire Pro				
LAB HC0579		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0572		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
LAB HC0573		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0574		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0564		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0566		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0568		FIRE & SEC - FIRE EXT	Underwriters Laboratories				
LAB HC0567		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0	Switchboard for DPNPDHC, CDWP-1, DPNPDHA, CDWP-2		ELECTRICAL - HIGH VOLTAGE - MAIN SWITCHGEAR	Schneider Electric			

LAB HC0569		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0571		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0614	PRV-9	HVAC - PIPEWORK - GAS GOVENOR	Not Observed	Not Applicable	Not Applicable		
LAB HC0615	Mpg 5	PLUMBING - VALVE	Flowserve Nordstrom	200 CWP 4	Not Applicable		
0		ELECTRICAL - WATER HEATER - DIRECT FIRED	AO Smith	DEL-10 102	2101122603584		
LAB HC0590		SAFETY - EVAC CHAIR	Med Sled	Not Applicable	Not Applicable		
LAB HC0086		SAFETY - EVAC CHAIR	Med Sled	Not Applicable	Not Applicable		
LAB HC0283	ELVPEPDHB	ELECTRICAL - DIST BD	General Electric	GTP0800U0820	SKJ20281 M0627		
LAB HC0140		SAFETY - EVAC CHAIR	Med Sled	Not Applicable	Not Applicable		
0		FABRIC - DOORS	Not Observed	Not Applicable	Not Applicable		
LAB HC0142		SAFETY - EVAC CHAIR	Med Sled	Not Applicable	Not Applicable		
LAB HC0479		SAFETY - EVAC CHAIR	Med Sled	Not Applicable	Not Applicable		
LAB HC0231		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable		

LAB HC02 32		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable		
LAB HC02 89	ESWBDP	ELECTRICAL - DIST BD	General Electric	SGLL3606L4XX	SGJ20301M0924		
LAB HC02 33	Elevator 7 110 V CAB LIGHTS	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable		
LAB HC02 34		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable		
LAB HC02 35	FC 6-2	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	To Be Populated	To Be Populated	
0		ELECTRICAL - TRANSFORMER - RESIN	Hammond Power Systems	Not Applicable	Not Applicable		
LAB HC02 29		ELECTRICAL - DIRECT CURRENT	Motion Control Engineering Inc	resist rc			
0		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable		
0		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable		
0		ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable		
0	VFD-CDWP1	CONTROLS - CONTROLLER	Danfoss	To Be Populated	To Be Populated		
0	VFD-CDWP2	CONTROLS - CONTROLLER	Danfoss	To Be Populated	To Be Populated		
LAB HC02 90	PPEPDHA	ELECTRICAL - DIST BD	General Electric	SKLL3608L4XX	SKJ20303M0424		
0	EF-19	HVAC - FAN - EXTRACT UNIT	Greenheck	To Be Populated	To Be Populated		
0	EF-16	HVAC - FAN - EXTRACT UNIT	Danfoss	To Be Populated	To Be Populated		

LAB HC0429		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0257		FIRE & SEC - FIRE EXT	Amerex	Not Applicable	Not Applicable		
LAB HC0430		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0236		FIRE & SEC - FIRE EXT	Amerex	Not Applicable	Not Applicable		
0		CONTROLS - LIGHTING CONTRL	Acuity Controls	To Be Populated	Not Applicable		
LAB HC0322		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0587		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0589		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0	DPNPDHA	ELECTRICAL - DIST BD	General Electric	SKHA36AT0800	SKJ20171M0203		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0087		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0104		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0584		FABRIC - DOORS	Cookson	Not Applicable	27243698-001		
LAB HC0585		FABRIC - DOORS	Cookson	Not Applicable	27243698-001		

LAB HC0088		FABRIC - DOORS	Cookson	Not Applicable	27242541-001		
0		FABRIC - DOORS	Cookson	Not Applicable	27242541-001		
LAB HC0273		FIRE & SEC - FIRE EXT	Amerex	Not Applicable	Not Applicable		
LAB HC0272		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0261		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0277	DPNPDHB	ELECTRICAL - DIST BD	General Electric	SKLL3608L4XX	SKJ20312M0908		
LAB HC0265		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
LAB HC0740		FIRE & SEC - FIRE EXT	Unknown				
LAB HC0787		FIRE & SEC - FIRE EXT	Advantage				
LAB HC0583		CATERING - ICE MACHINE	Follett	7CIT00A	2021-02-23		
LAB HC0586		CATERING - ICE MACHINE	Follett	7CI100A	2021-02-23		
0		FABRIC - DOORS	Cookson	Not Applicable	27242541-001		
0		CONTROLS - LIGHTING CONTRL	Acuity Controls	To Be Populated	Not Applicable		
LAB HC0477		FABRIC - DOORS	Cookson	Not Applicable	27242541-001		

LAB HC0501		FABRIC - DOORS	Cookson	Not Applicable	27242541-001		
LAB HC0461		FABRIC - DOORS	Cookson	Not Applicable	27242541-001		
LAB HC0281	TELVEPDA	ELECTRICAL - TRANSFORMER - RESIN	General Electric	9T10C1004G31	1M004A21		
LAB HC0619		FABRIC - DOORS	Not Observed	Not Applicable	Not Applicable		
LAB HC0804		ELECTRICAL - HIGH VOLTAGE - MAIN SWITCHGEAR	Eaton	Not Applicable	Not Applicable		
LAB HC0803	LPLSBDLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
LAB HC0607		SAFETY - EVAC CHAIR	Med Sled	Not Applicable	Not Applicable		
LAB HC0597		SAFETY - EVAC CHAIR	Med Sled	Not Applicable	Not Applicable		
LAB HC0600		SAFETY - EVAC CHAIR	Med Sled	Not Applicable	Not Applicable		
LAB HC0502		SAFETY - EVAC CHAIR	Med Sled	Not Applicable	Not Applicable		
LAB HC0091		SAFETY - EVAC CHAIR	Med Sled	Not Applicable	Not Applicable		
LAB HC0090		SAFETY - EVAC CHAIR	Med Sled	Not Applicable	Not Applicable		
LAB HC0288	TELVEPDA	ELECTRICAL - TRANSFORMER - RESIN	General Electric	9T10C1002G31	1M00049KE		

LAB HC0503		SAFETY - EVAC CHAIR	Med sled	Not Applicable	Not Applicable		
0	EF-5	HVAC - FAN - EXTRACT UNIT	Greenheck	CUE-240-B-VGD—50-X	16703926		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
0	FCU 3-3	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	To Be Populated	To Be Populated	
0	VAV 1-301	HVAC - VAV	Price	SDV			
0		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0		PLUMBING - PUMP	Armstrong	ARMfIO E32.2B			
LAB HC0297	TEPDA	ELECTRICAL - TRANSFORMER - RESIN	General Electric	9T10A1004	1M0003U4S		
0	STATE# 052889	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable		
0	110 V CAB LIGHTS	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable		
0		FIRE & SEC - FIRE EXT	Badger	Not Applicable			
0		FIRE & SEC - FIRE EXT	Badger	Not Applicable			
0	Elevator 5	TRANSPORT - ELEVATOR - TRACTION	Torin Drive	OTMGL2-3550-HV-10mm	19BV00020		
0		FIRE & SEC - FIRE EXT	Not Applicable	Not Applicable	Not Applicable		
0	FC 6-1	HVAC - TERMINAL UNIT - FAN COIL		Daikin	To Be Populated	To Be Populated	
0	ELEVATOR MACHINE ROOMS MONITORING PANEL		CONTROLS - BMS - OUTSTATIONS	Not Observed			
0	FU 6-1/2/3 CONTROL PANEL	CONTROLS - BMS - OUTSTATIONS	Not Observed				
0	HHWP-2	HVAC - PUMP	Bell and Gosset	Not Applicable	C303420-01F02		

LAB HC0284	TDPNPDA	ELECTRICAL - TRANSFORMER - RESIN	General Electric	9T10A1004	1M0003U4Y		
0	HHWP-1	HVAC - PUMP	Bell and Gosset	Not Applicable	C303420-02F02		
0	RPBP-4	DWS - CHECKS	Watts	LF009M2QT			
0	Hot Water Expansion Tank	HVAC - STORAGE	Not Visible				
0		COMMS - CALL SYSTEMS - PAGING	Valcom				
0	UPS RPEPALA-1,3	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable		
0	EF-16	HVAC - FAN - EXTRACT UNIT	Greenheck	CUE-180HP-A-X	16558718		
0	EF-19	HVAC - FAN - EXTRACT UNIT	Greenheck	CUE-090-VG-X	16703940		
0	CDWP-2	HVAC - PUMP	Bell and Gosset	Not Applicable	C303419-01C02		
LAB HC0280	DPNPDHC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	CONDENSER WATER SYSTE M CONTROL PANEL		CONTROLS - BMS - OUTSTATIONS	Climatec	Not Applicable	Not Applicable	
0	CT-2	HVAC - COOL TOWER - GALVANISED METAL	Baltimore Aircoil Company	To Be Populated	To Be Populated		
0	RPBP-3	DWS - CHECKS	Wilkins				
0	CU-6-A	HVAC - ACU - SPLIT UNIT	Daikin	RX36NMVJUA	E000419		
0	AHU-4 RF VFD FED FROM PPEPDHA-4	CONTROLS - CONTROLLER	Danfoss	To Be Populated	To Be Populated		
0	AHU-5 CONTROL PANEL	CONTROLS - BMS - OUTSTATIONS	Climatec	Not Applicable	Not Applicable		
0	AHU-3 RF VFD FED FROM PPEPDHA-1	CONTROLS - CONTROLLER	Danfoss	To Be Populated	To Be Populated		
0		FABRIC - DOORS	Not Applicable				
0	VAV-1-212	HVAC - VAV	Price	SDV	1563618-004-070		

0	FCU 2-2	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	To Be Populated	To Be Populated	
LAB HC0282	DPNPDLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0		HVAC - VAV	Price	SDV	1563618-004-093		
0	FCU 2-4	HVAC - ACU - SPLIT UNIT	Multi Aqua	To Be Populated	To Be Populated		
0		DWS - DRINK FOUNTAIN	Murdock	To Be Populated	Not Applicable		
0	TF-6	HVAC - FAN - EXTRACT UNIT	Greenheck	SQ-80-VG-X	16624943		
0	TF-5	HVAC - FAN - EXTRACT UNIT	Greenheck	SQ-80-VG-X	16624942		
0	LPN1DHA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	RPE1DLC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	DPF1DLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	TE1DA	ELECTRICAL - TRANSFORMER - RESIN	General Electric				
0	FCU 1-1	HVAC - TERMINAL UNIT - FAN COIL		Multi Aqua	To Be Populated	To Be Populated	
LAB HC0303	PPEPDLP	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	UPS RPE1BLA-24,26	ELECTRICAL - LOW VOLTAGE	Eaton	Not Applicable	Not Applicable		
0		FIRE & SEC - FIRE EXT	J.L Industries	Not Applicable	Not Applicable		
0	Door 1603	FABRIC - DOORS	Not Observed	Not Applicable	Not Applicable		
0		FABRIC - DOORS	Cookson	Not Applicable	To Be Populated		
0	5101	FABRIC - DOORS	Not Observed	Not Applicable	Not Applicable		
0		CONTROLS - LIGHTING CONTRL	Acuity Controls	To Be Populated	Not Applicable		
0	DCN5DA	ELECTRICAL - HIGH VOLTAGE	General Electric	Busway Plugs			

0	DCE5DA	ELECTRICAL - HIGH VOLTAGE	General Electric	Busway Plugs			
0	VAV-1-B51	HVAC - VAV	Price				
0	FCU B-6	HVAC - TERMINAL UNIT - FAN COIL		Daikin	To Be Populated	To Be Populated	
LAB HC0298	PPEPDLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	Sub-Station C	ELECTRICAL - SWITCHGEAR	Zinsco				
0	VAV-1-B50	HVAC - VAV	Price				
0		TRANSPORT - ELEVATOR - PASSENGER LIFT HYDRUALIC	Otis	AAA20390AF1	HYD-N1F431		
0	VAV-2-B05	HVAC - VAV	Price				
0	MUA-1	HVAC - AHU - EXTERNALLY LOCATED	Greenheck	MXS-P120-H22	16558378		
0		PLUMBING - PUMP	Baldor	84Z04051	F1911013271		
0	VAV5-219	HVAC - VAV	Price	SDV	1563618-004-093		
0	RCP-1	PLUMBING - PUMP	Bell and Gosset	103418LF 1K02			
0	WH-2	HVAC - BOILER - GAS	Lochinvar	NO. SNA501-125	2003 117791402		
0	HV-3	ELECTRICAL - SWITCHGEAR	Zinsco				
LAB HC0275	PPEPDHB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0		PLUMBING - VALVE	0				
0	VAV-2-B08	HVAC - VAV	Price	SDV5	1563618		
0	RPEBCLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	RPNBCLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	RPNBCLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	TF-3	HVAC - FAN - EXTRACT UNIT	Greenheck	SQ-80-VG-X	16563092		

0		CATERING - ICE MACHINE	Follett	7CI100A			
0		CONTROLS - LIGHTING CONTRL	Acuity Controls	To Be Populated	Not Applicable		
0	RPE2DLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	RPN2DLF	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
LAB HC0276	ELVPEPDLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	RPN2DLE	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	RPN2DLD	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	RPN2DLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	RPN2DLB	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	TF-13	HVAC - FAN - EXTRACT UNIT	Greenheck				
0	AC B-1	HVAC - TERMINAL UNIT - FAN COIL		Not Visible			
LAB HC0285	RPNPDLA	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
0	RPEPDLC	ELECTRICAL - DIST BD - LOW VOLTAGE	General Electric	Not Applicable	Not Applicable		
LAB HC0354	ET-2	HVAC - EXP VESSEL - CHILLED WATER EXPANSION	Wessels	L9747.5C	331607		
0	CHWP-1	HVAC - PUMP	Bell and Gosset	G-1510 SSS 10.625	C303148-02G02		
0	ELEVATOR MACHINE ROOMS MONITORING PANEL		CONTROLS - CONTROL PANEL - UNIT CONTROLLER LIFT	Climatec	Not Applicable	5420093	
0	FCU 6-1/2/3 CONTROL PANEL	CONTROLS - BMS - OUTSTATIONS	Climatec	VLC-1188-E	Not Applicable		

LAB HC0341	#5	CONTROLS - LIGHTING CONTRL	Acuity Controls	To Be Populated	Not Applicable		
LAB HC0395	AHU-4	HVAC - AHU - EXTERNALLY LOCATED	Energy Labs Inc	C128228 - F CH - L	2005-12330 - AHU4		
LAB HC0374	AHU SUPPLY FANWALL	HVAC - AHU - EXTERNALLY LOCATED	Energy Labs Inc	Not Observed	Not Observed		
LAB HC0404	AHU-4 SF	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed		
LAB HC0403	AHU-4 SF	CONTROLS - CONTROLLER	Danfoss	Not Observed	Not Observed		
LAB HC0376	EF-5,6,7,9 & KEF-1 CONTROL PANEL	CONTROLS - BMS - OUTSTATIONS	Climatec	VLC-1188-E	Not Applicable		
LAB HC0373	AHU-4 CONTROL PANEL	CONTROLS - BMS - OUTSTATIONS	Not Observed	Not Observed	Not Observed		
LAB HC0402	AHU-4 RETURN FANWALL	HVAC - AHU - EXTERNALLY LOCATED	Energy Labs Inc	Not Observed	Not Observed		
LAB HC0340	PRV	HVAC - PIPEWORK - GAS GOVENOR	Pietro Fiorentini	31154	Not Collected		
0	VAV-1-B01	HVAC - VAV	Price	SDV			
0	VAV-1-B10	HVAC - VAV	Price	SDV			
0	VAV-3-123	HVAC - VAV	Price	SDV			
0	VAV-4-101	HVAC - VAV	Price	SDV			
0	VAV-4-102	HVAC - VAV	Price	SDV			
0	VAV-4-103	HVAC - VAV	Price	SDV			
0	VAV-4-104	HVAC - VAV	Price	SDV			
0	VAV-4-105	HVAC - VAV	Price	SDV			
0	VAV-4-107	HVAC - VAV	Price	SDV			
0	VAV-4-108	HVAC - VAV	Price	SDV			
0	VAV-4-109	HVAC - VAV	Price	SDV			

0	VAV-4-110	HVAC - VAV	Price	SDV			
0	VAV-1-B11	HVAC - VAV	Price	SDV			
0	VAV-4-111	HVAC - VAV	Price	SDV			
0	VAV-4-112	HVAC - VAV	Price	SDV			
0	VAV-4-113	HVAC - VAV	Price	SDV			
0	VAV-4-114	HVAC - VAV	Price	SDV			
0	VAV-4-115	HVAC - VAV	Price	SDV			
0	VAV-4-117	HVAC - VAV	Price	SDV			
0	VAV-5-101	HVAC - VAV	Price	SDV			
0	VAV-5-102	HVAC - VAV	Price	SDV			
0	VAV-5-103	HVAC - VAV	Price	SDV			
0	VAV-5-104	HVAC - VAV	Price	SDV			
0	VAV-1-B12	HVAC - VAV	Price	SDV			
0	VAV-5-105	HVAC - VAV	Price	SDV			
0	VAV-5-106	HVAC - VAV	Price	SDV			
0	VAV-5-107	HVAC - VAV	Price	SDV			
0	VAV-5-108	HVAC - VAV	Price	SDV			
0	VAV-5-109	HVAC - VAV	Price	SDV			
0	VAV-5-110	HVAC - VAV	Price	SDV			
0	VAV-5-111	HVAC - VAV	Price	SDV			
0	VAV-5-112	HVAC - VAV	Price	SDV			
0	VAV-5-113	HVAC - VAV	Price	SDV			
0	VAV-1-101	HVAC - VAV	Price	SDV			
0	VAV-1-B13	HVAC - VAV	Price	SDV			
0	VAV-1-102	HVAC - VAV	Price	SDV			
0	VAV-1-103	HVAC - VAV	Price	SDV			
0	VAV-1-104	HVAC - VAV	Price	SDV			
0	VAV-1-105	HVAC - VAV	Price	SDV			
0	VAV-1-106	HVAC - VAV	Price	SDV			
0	VAV-1-107	HVAC - VAV	Price	SDV			
0	VAV-1-108	HVAC - VAV	Price	SDV			
0	VAV-1-109	HVAC - VAV	Price	SDV			
0	VAV-1-110	HVAC - VAV	Price	SDV			
0	VAV-1-111	HVAC - VAV	Price	SDV			
0	VAV-1-B14	HVAC - VAV	Price	SDV			
0	VAV-1-112	HVAC - VAV	Price	SDV			
0	VAV-1-113	HVAC - VAV	Price	SDV			
0	VAV-1-114	HVAC - VAV	Price	SDV			

0	VAV-1-115	HVAC - VAV	Price	SDV			
0	VAV-1-116	HVAC - VAV	Price	SDV			
0	VAV-2-118	HVAC - VAV	Price	SDV			
0	VAV-2-101	HVAC - VAV	Price	SDV			
0	VAV-2-102	HVAC - VAV	Price	SDV			
0	VAV-2-103	HVAC - VAV	Price	SDV			
0	VAV-2-104	HVAC - VAV	Price	SDV			
0	VAV-1-B15	HVAC - VAV	Price	SDV			
0	VAV-2-105	HVAC - VAV	Price	SDV			
0	VAV-2-106	HVAC - VAV	Price	SDV			
0	VAV-2-107	HVAC - VAV	Price	SDV			
0	VAV-2-108	HVAC - VAV	Price	SDV			
0	VAV-2-109	HVAC - VAV	Price	SDV			
0	VAV-2-110	HVAC - VAV	Price	SDV			
0	VAV-2-111	HVAC - VAV	Price	SDV			
0	VAV-2-112	HVAC - VAV	Price	SDV			
0	VAV-2-113	HVAC - VAV	Price	SDV			
0	VAV-2-114	HVAC - VAV	Price	SDV			
0	VAV-1-B16	HVAC - VAV	Price	SDV			
0	VAV-2-115	HVAC - VAV	Price	SDV			
0	VAV-2-116	HVAC - VAV	Price	SDV			
0	VAV-3-201	HVAC - VAV	Price	SDV			
0	VAV-3-202	HVAC - VAV	Price	SDV			
0	VAV-3-203	HVAC - VAV	Price	SDV			
0	VAV-3-204	HVAC - VAV	Price	SDV			
0	VAV-3-205	HVAC - VAV	Price	SDV			
0	VAV-3-206	HVAC - VAV	Price	SDV			
0	VAV-3-207	HVAC - VAV	Price	SDV			
0	VAV-3-208	HVAC - VAV	Price	SDV			
0	VAV-1-B17	HVAC - VAV	Price	SDV			
0	VAV-3-209	HVAC - VAV	Price	SDV			
0	VAV-3-210	HVAC - VAV	Price	SDV			
0	VAV-3-211	HVAC - VAV	Price	SDV			
0	VAV-3-212	HVAC - VAV	Price	SDV			
0	VAV-3-213	HVAC - VAV	Price	SDV			
0	VAV-3-214	HVAC - VAV	Price	SDV			
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0	VAV-5-210	HVAC - VAV	Price	SDV			
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0	VAV-5-212	HVAC - VAV	Price	SDV			
0	VAV-5-213	HVAC - VAV	Price	SDV			
0	VAV-5-214	HVAC - VAV	Price	SDV			
0	VAV-5-215	HVAC - VAV	Price	SDV			
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0	VAV-2-503	HVAC - VAV	Price	SDV			

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0	VAV-2-506	HVAC - VAV	Price	SDV			
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JANITORIAL SERVICES

1. Scope of Services

a. The facility janitorial requirements are broken down into two scopes of works as identified by below, supplier is to provide the necessary staffing and resources to perform services as detailed:

2. Service Level by Department

Department	Office Space's	EVS Cleaning Y | N
Common Areas	Yes	N
Probation	Yes	N
WDACS	Yes	N
DHS, Urgent Care, Primary Care	Yes	Y
DMH	Yes	Y
DPH	Yes	Y

3. Consumables: Contractor shall provide consumable supplies (trash liners, paper towels, toilet tissue, seat covers, deodorizers, hand soaps, hand sanitizer) on a reimbursable basis. Contractor shall provide a detailed monthly invoice that includes usage and cost per unit.

4. Commercial Cleaning:

Scope of Work Statement - Custodial Services	Recommended Frequency
Common Areas	
Building Entrances, Lobbies, and Hallways	
Exterior: Clean all entrance door glass and partition glass.	Daily
Exterior: Clean balconies and ledges, as required.	Daily
Exterior: Clean ashtrays and sand jars and damp wipe ashtrays. Provide and refill sand for sand jars.	Daily
Exterior: Sweep exterior areas such as steps, sidewalks, and landings adjacent to the building.	Daily
Exterior: Provide and place appropriate mats at entrances and in lobbies during rainy weather.	Daily
Exterior: Inspect parking areas and exterior grounds, collect and place waste in appropriate disposal area.	Daily
Interior: Dust all display cases. Damp wipe and dry all glass surfaces, removing fingerprints and smudges. Contractor shall take precautions to not disturb memorabilia on dusted surfaces.	Daily
Interior: Clean baseboards, walls, kick plates, furniture and other surfaces exposed to water and/or chemical splashing.	Daily
Interior: Clean public telephone stalls.	Daily
Interior: Clean and sanitize drinking fountains.	Daily
Interior: Clean custodial closets and keep supplies and equipment orderly.	Daily
Interior: Clean, vacuum sofas and chairs.	Daily
Interior: Clean all elevator floors, walls, doors, and tracks. Polish stainless steel, if applicable.	Daily
Interior: Sweep and/or dust stairs, landings, and handrails.	Daily
Interior: Vacuum/spot clean all carpeted areas.	Daily
Interior: Damp mop and/or scrub hard-surface (non-carpeted) floors, followed by high-speed buffing with light spray non-slip wax application.	Daily
Interior: Damp mop Spanish tiles with mild detergent. Note: never wax.	Daily
Interior: Empty waste containers, place waste in appropriate disposal area, and replace plastic liners (bags).	Daily

Scope of Work Statement - Custodial Services	Recommended Frequency
Restrooms (Private and Public) and Showers	
Dust ceiling vents.	Daily
Dust lounge sofas and chairs.	Daily
Clean sink basins and all surrounding surfaces.	Daily
Clean restroom and shower fixtures.	Daily
Check for stains in urinals, waterless urinals, toilet bowls, and basins, and remove.	Daily
Clean and sanitize toilets, toilet seats, urinals, and waterless urinals with germicidal solution.	Daily
Clean base of toilet bowls and below all urinals.	Daily
Clean behind toilet bowls and in corners of restroom floors.	Daily
Clean restroom mirrors, kick plates, and push plates.	Daily
Spot clean restroom walls, showers, partitions, and doors.	Daily
Clean and refill all restroom soap and paper dispensers.	Daily
Service sanitary napkin and/or tampon dispensers at County's option. Contractor will purchase sanitary napkins and/or tampons and retain all monies collected from dispensers.	Daily
Refill existing air freshener dispensers in restrooms, including battery replacement.	Daily
Clean restroom floors with disinfectant solution. Set up "wet floor" sign.	Daily
Remove/clean graffiti and vandalism.	Daily
Empty waste containers, place waste in appropriate disposal area, and replace plastic linters (bags), and damp-wipe containers inside and outside.	Daily
Dust door louvers.	Weekly
Check for build-up around faucets and remove.	Weekly
Clean underneath sink basins (lavatories), including traps and pipes.	Weekly
Clean and flush floor drains with water.	Weekly
Wash all stall partitions.	Weekly
Spot clean entrance doors.	Weekly
Damp mop and buff waxable floors. Set up "wet floor" signs.	Weekly

Scope of Work Statement - Custodial Services	Recommended Frequency
Tenant Private Space	
Offices and Conference Rooms	
Dust all furniture, including desks, tables, file cabinets, windowsills, and other dust catching surfaces.	Daily
Damp wipe and dry all glass surfaces.	Daily
Remove fingerprints and smudges from desk and tabletops, walls, doors, door facings, telephones, etc.	Daily
Clean door glass and frames.	Daily
Sweep and/or damp mop all hard-surface (non-carpeted) floor surfaces.	Daily
Vacuum and spot clean all carpeted areas.	Daily
Remove gum from all hard-surface (tile, terrazzo, and ceramic) floor surfaces, as needed.	Daily
Remove/clean graffiti and vandalism.	Daily
Empty waste containers, place waste in appropriate disposal area, and replace plastic liners (bags).	Daily
Dust ceiling vents.	Weekly
Dust top of high cabinets and shelves.	Weekly
Dust door jams and baseboards.	Weekly
Dust lower surfaces of chairs, chair rungs, desk sides, and ledges.	Weekly
Dust beneath movable desk files.	Weekly
Clean and dry face of desk drawers and file cabinets with damp cloth or sponge.	Weekly
Clean doorknobs, kick plates, and threshold plates.	Weekly
Spot clean doors and walls.	Weekly
Wash or polish desktops, as needed.	Weekly
Lunchrooms, Cafeterias, Eating and Vending Areas (Excludes area operated by vendor or food preparation area).	
Dust appliances.	Daily

Scope of Work Statement - Custodial Services	Recommended Frequency
Lunchrooms, Cafeterias, Eating and Vending Areas (Excludes area operated by vendor or food preparation area). Continued	
Dust chairs and sofas.	Daily
Dust window ledges.	Daily
Clean tables.	Daily
Clean sinks and chrome fittings.	Daily
Spot clean walls, as needed.	Daily
Remove/clean graffiti and vandalism.	Daily
Vacuum and spot clean all carpeted areas.	Daily
Sweep and/or damp mop tile floors.	Daily
Empty waste containers, place waste in appropriate disposal area, and replace plastic linters (bags), and damp-wipe containers inside and outside.	Daily
Dust ceiling vents.	Weekly
All Areas	
Dust high ledges and moldings.	Monthly
Dust or vacuum ceiling and wall vents.	Monthly
Dust and wipe vertical and/or horizontal blinds.	Monthly
Dust and wipe vertical and/or vertical walls.	Monthly
Dust handrails, sweep and mop stairs and landings in exit stairwells.	Monthly
Vacuum upholstered furniture.	Monthly
Vacuum draperies.	Monthly
Clean all wall and ceiling vents.	Monthly
Clean chairs and table legs.	Monthly
Clean and shampoo entrance mats.	Monthly
Clean baseboards, bottoms of cabinets, kick plates, furniture, walls, and other surfaces exposed to water and/or chemical splashing.	Monthly

Scope of Work Statement - Custodial Services	Recommended Frequency
All Areas Continued	
Clean escalators by polishing metal surfaces and cleaning escalator treads, risers, landings, and handrails.	Monthly
Wash partition glass.	Monthly
Wash marble walls.	Monthly
Mop, scrub, strip and wax hard-surface (non-carpeted) floors. If high-speed buffing program is utilized, floors only need to be stripped and waxed quarterly (every three months).	Monthly
Scrub or strip, and apply floor finish to resilient tile floors.	Monthly
Pressure wash and remove gum and other residues from all steps, sidewalks, and landing, adjacent to the building monthly in compliance with all applicable environmental laws and regulations.	Monthly

Special Areas

Court Detention Cells & Holding Tank Detention Cells	
Assemble necessary equipment, prepare disinfectant for mopping and wall washing; take to assigned area.	Daily
Remove large trash on floor and place in trash container.	Daily
Sweep floor with push broom starting at farthest corner working toward the door (use angle broom under benches and corners).	Daily
Spot wash walls with disinfectant solution (as necessary, wash walls from the bottom up).	Daily
Sanitize lavatory and drinking fountain with disinfectant and paper towel; rinse thoroughly. Ensure area beneath the basin, pipes, and walls around sink are clean.	Daily
Wash outside toilet fixtures(s) with disinfectant and wipe with disposable paper towels dipped in disinfectant solution. Scrub with toilet brush being careful to clean under lips. Flush toilet.	Daily
Mop floor with disinfectant solution by flooding floor with mop and let it sit for approximately five (5) minutes. Pick up mop water and rinse. Inspect and proceed to next assignment.	Daily
Supply toilet paper and paper towels in designated area and toilet paper in Sheriff's holding cells.	Daily
Remove/clean graffiti and vandalism.	Daily

Scope of Work Statement - Custodial Services	Recommended Frequency
Court Detention Cells & Holding Tank Detention Cells	
Dust vents with hand duster and extension.	Weekly
Dust rails and bars with treated dust cloth (as needed). Use radiator brush for crevices.	Weekly
Pressure wash all walls, cell bars, and cement floors throughout holding cell areas. (Holding tank cells only)	Monthly
Wash all rails, walls, and bars with disinfectant solution. (Holding tank cells only)	Monthly
Clean floor drains. Machine scrub floors. (Holding tank cells only)	Monthly
Empty waste containers, place waste in appropriate disposal area, and replace plastic liners (bags).	Daily
Parking Facility	
Replace plastic liners (bag) with heavy duty liner of no less than 3 mils thickness.	Daily
Clean all levels of parking facility and adjacent sidewalks, exit and entrance ramps and driveways, using conventional sweeping or vacuuming equipment.	Weekly
Remove oil, grease, and other spills or residues from parking lot surfaces, using conventional equipment.	Weekly
Remove dirt and litter around obstructions such as concrete wheel stops and borders, flower beds, bushes, walks and fences around lot.	Weekly
Remove grass and weeds from lot surface cracks, fences, and walls around parking facility.	Weekly
Clean stairways leading to and from parking lots/structures.	Weekly
Clean asphalt using appropriate non-petroleum-based cleaners only.	Weekly
Steam clean and/or power wash parking facility twice per year.	Semi-Annually
Specialty Services	
Carpet Cleaning	
All carpets must be shampooed four (4) times each year at three (3) month intervals.	Quarterly
Each facility must be shampooed in one cleaning cycle.	Quarterly
Window Cleaning (Interior/Exterior)	
All windows must be cleaned two (2) times each year, at six (6)month intervals.	Semi-Annually

Scope of Work Statement - Custodial Services	Recommended Frequency
Window Cleaning (Interior/Exterior) Continued	
Wash all interior and exterior glass or mirrors, metal frames, metal louvers, porcelain panels, inside an outside, window sills and legs completely, including stainless steel mullions, aluminum mullions, window screens, and outside building surfaces, such as marble and other smooth surfaces.	Semi-Annually
Leave windows and the adjacent surrounding areas in a clean condition. Lock all windows. Remove streaks and water marks from all windows, walls, and ledges. Remove excess water from floors or sidewalks in the immediate area; remove all water and cleaning agents before leaving the area.	Semi-Annually
Remove all cleaning equipment from areas after work completion.	Semi-Annually
Light Fixture Cleaning	
All lighting fixtures are to be cleaned once (1) a year, at all County Facilities.	Annually
Wash, clean, and dry all types of glass, plastics, and metal light fixtures, both disassembled and those remaining in the ceiling.	Annually
Clean light fixtures using water, soaps, solvents, cleaning tanks, and degreasers.	Annually
Clean and vacuum area after completion of work.	Annually
Graffiti and Vandalism Eradication	
Graffiti and vandalism eradication will be performed throughout the facility.	Daily
All graffiti and vandalism eradication requests for repainting shall be submitted to the County's Project Manager. County reserves the ability to paint surfaces, if appropriate.	Daily
Solid Waste Collection & Removal	
Collect and remove all solid waste from building and place in County provided trash bin(s).	Daily
Clean rooms used to collect solid waste before it is moved to trash bins.	Daily
Wash or steam clean inside and outside of waste cans used for food wastes.	Daily
Solid Waste Collection & Removal Continued	
Carts and containers used for the collection and/or storage of waste material shall be of non-combustible or flame resistant construction. Material labeled or listed by Underwriters Laboratories, Inc. will be acceptable.	Daily

Scope of Work Statement - Custodial Services	Recommended Frequency
Miscellaneous/Emergency Information	
Emergency Response Times	
Customers shall contact the Los Angeles County Operator at (213) 974-8000. County Operator will contact the appropriate ISD Representative within 2-hours.	
ISD will advise the customer as quickly as possible in those instances where the above stated timeframes cannot be met.	
Pest Control	
Pest control services are available on an as needed basis at an additional cost.	
Additional Services - Special Requests/Events	
Special requests/events services are available on an as-needed basis at an additional cost.	

6. **EVS Cleaning (adding to Commercial Cleaning)**

- **GENERAL SERVICE AREAS/ANCILLARY SERVICES AREAS/ AMBULATORY CARE CLINICS**

  Housekeeping services shall be provided at the highest level of intensity for the following areas utilizing dedicated (locked-in) housekeepers and equipment. The housekeeper must wear disposable scrubs, cap, shoe covers (trained when to use)and gloves when entering unit and remove same when leaving unit per departmental protocol. **Cleaning equipment for this area remains in area and is never used to clean other areas of the hospital.** Before starting to clean area, use clean cleaning equipment. Begin cleaning in sterile storage and workrooms with last cleaning in decontamination rooms.

- **MEDICAL AND BIO-HAZARDOUS WASTE**
  All Medical Waste must be handled in compliance with the California Medical Waste Management Act(CA Health and Safety Code Statue 11700-118360)

- **EMERGENCY DEPARTMENT (ED)**
  Housekeeping services for the Emergency Department utilizes dedicated Housekeepers. (Lock-in Housekeepers)

- **ISOLATION ROOMS/TERMINAL CLEANING OF PATENT AREAS FOLLOWING COMMUNICABLE DISEASE EXPOSURE**
  Housekeeping services for Isolation Rooms includes decontaminating equipment and disposing of solution after each cleaning of an isolation room as required by Hospital Infection Control Policy. Housekeeping services shall follow procedures for all housekeeping services cleaning activities as approved by the Infection Control Committee and written in the Infection Control Manual.

- **OPERATING ROOM (OR) SUITES Surgery/Recovery/Labor and Delivery/Pre-Op/Post-Op Holding Areas**
  Housekeepers shall wear disposable scrub suit, shoe covers, cap and mask upon entering Operating Room (OR) Suites and Housekeepers shall wear cover gowns over scrub suits when leaving. At the beginning of each shift, Housekeeper shall check with the OR supervisor or appointed representative for any special housekeeping services or duties which must be performed. All soiled mop heads will be taken to the Housekeeping Department to be exchanged for clean ones. Clean mop heads are to be used after each surgical case. Housekeepers shall provide additional or special housekeeping services for the Operating Suites utilizing dedicated equipment.

  THIS EQUIPMENT SHOULD NEVER BE REUSED TO CLEAN OTHER AREAS OF THE HOSPITAL.

Exhibit B-1

FACILITIES MANAGEMENT SERVICES
MARTIN LUTHER KING JR. BEHAVIORAL HEALTH CENTER
FEE SCHEDULE

1. TOTAL CONTRACT AMOUNT

The Department of Mental Health (DMH) shall pay Contractor for facilities management services per Exhibit A-1 (Statement of Work) rendered at the Martin Luther King Jr. Behavioral Health Center. The Total compensation for all services rendered shall not exceed the total contract award amounts noted below:

Year	Maximum Amount
Year One (2022)	$3,745,389
Year Two (2023)	$4,192,032
Year Three (2024)	$4,340,676

2. INVOICE SCHEDULE

Contractor shall submit complete and accurate monthly invoices to the DMH Program Manager. The invoice shall include supplemental documentation. Each invoice submitted for payment shall include the following information in the header of the invoice: agency name, address, phone number, vendor number, contract number, date along with the name, number, and email address of person to contact for questions.

DMH designated staff will review the invoices and supplemental documentation to ensure all the necessary elements for tracking purposes have been included.

3. PAYMENT PROCEDURES

Payment to Contractor for facilities management services rendered shall be based on monthly invoices from Contractor to DMH. No payment shall be made without prior approval of the designated DMH Project Manager. The DMH Project manager shall review the invoice and supplemental documents to determine whether Contractor is in substantial compliance with the terms and conditions of this contract. Contractor shall be paid for facilities management services based on complete and accurate monthly invoices. Payment will be based only on the Exhibit A–1 (Statement of Work).

Contractor shall retain all relevant supporting documents and make them available to DMH at any time for audit purposes. Invoices submitted to DMH shall detail all monthly charges billed to DMH.

Upon receipt of invoices from Contractor, DMH shall make payment to Contractor within 30 days of the date the invoice was received. If any portion of the invoice is disputed by DMH, DMH shall reimburse Contractor for the undisputed services

contained in the invoice and work diligently with the Contractor to resolve the disputed portion of the claim in a timely manner.

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

Name of Agency: _____
Address of Agency: _____
City, State Zip: _____

4. DESIGNATED LAC-DMH CONTACT PERSON

All questions and correspondence should be directed to:

Damien Parker, Chief Administrative Support Bureau
DMH Program Manager
County of Los Angeles – Department of Mental Health
510 S. Vermont Avenue, 20th Floor
Los Angeles, CA 90020
(213) 943-8579
Email: Dparker@dmh.lacounty.gov

BOARD LETTER/MEMO
CLUSTER FACT SHEET

DRAFT

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/24/2023
BOARD MEETING DATE	6/6/2023
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
DEPARTMENT(S)	Mental Health
SUBJECT	Adopt the Department of Mental Health's Mental Health Services Act Annual Update for Fiscal Year (FY) 2023-24
PROGRAM	MHSA
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☐ Yes ☒ No
SOLE SOURCE CONTRACT	☐ Yes ☒ No
DEADLINES/ TIME CONSTRAINTS	June 6, 2023
COST & FUNDING	Total cost: None / Funding source: N/A
	TERMS (if applicable): July 1, 2023 – June 30, 2024
	Explanation:
PURPOSE OF REQUEST	The purpose is to adopt the MHSA Annual Update for FY 2023-24 which builds upon the DMH approved MHSA Three-Year Program and Expenditure Plan for each MHSA component. The Update contains a summary of DMH's MHSA programs for FY 2021-22 and it describes the ongoing Community Planning Process qqand progress towards continued implementation of existing programs and/or program expansions and proposed new programs to be incorporated into the Three-Year Program and Expenditure Plan for FYs 2021-22 through 2023-24.
BACKGROUND (include internal/external issues that may exist including any related motions)	Each counties mental health program is required to prepare a MHSA Three-Year Program and Expenditure Plan and Annual Updates. The MHSA Three-Year Program and Expenditure Plan and Annual Updates are required to be circulated for public review and comment and that a public hearing be conducted at the close of the comment period. On March 24, 2023, DMH posted the Update on its website for 30 days for public comment. DMH, upon stakeholder request, allowed for an extended public comment period through 45 days. The Los Angeles County Mental Health (LACMH) Commission also convened a Public Hearing on April 27, 2023, where DMH presented the Annual Update and addressed public questions and the LACMH Commission voted to recommend the MHSA Annual Update for FY 2023-24.
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: Kalene Gilbert, Program Manager IV, (213) 943-8223, Kgilbert@dmh.lacounty.gov William Birnie, Senior Deputy County Counsel, (213) 972-5717, WBirnie@counsel.lacounty.gov

DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Director

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

Connie D. Draxler, M.P.A.
Acting Chief Deputy Director

June 6, 2023

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:

ADOPT THE DEPARTMENT OF MENTAL HEALTH'S MENTAL HEALTH SERVICES ACT ANNUAL UPDATE FOR FISCAL YEAR 2023-24 (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Request adoption of the Department of Mental Health's Mental Health Services Act Annual Update for Fiscal Year 2023-24.

IT IS RECOMMENDED THAT YOUR BOARD:

Adopt the Department of Mental Health's (DMH) Mental Health Services Act (MHSA) Annual Update for Fiscal Year (FY) 2023-24 as attached. The MHSA Annual Update has been certified by the Director of Mental Health (Director), or designee, and the Auditor-Controller (A-C) to meet specified MHSA requirements in accordance with Welfare and Institutions Code (WIC) Section 5847.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

The MHSA Annual Update for FY 2023-24 builds upon the DMH-approved MHSA Three-Year Program and Expenditure Plan for each MHSA component. It contains a summary of MHSA programs for FY 2021-22 including clients served by MHSA programs, and Service Area and program outcomes. Additionally, the Annual Update describes DMH's ongoing

Community Program Planning (CPP) and progress towards continued implementation of existing programs and/or program expansions and proposed new programs to be incorporated into the Three-Year Program and Expenditure Plan for FYs 2021-22 through 2023-24. Board adoption of the MHSA Annual Update is required by law and necessary for DMH to submit the Annual Update for FY 2023-24 to the Mental Health Services Oversight and Accountability Commission (Commission) and Department of Health Care Services (DHCS). Additionally, WIC Section 5848 requires the following: 1) the MHSA Three-Year Program and Expenditure Plan and the Annual Updates be certified by the Director, or designee, and the A-C attesting that the County has complied with all fiscal accountability requirements as directed by the State DHCS, and that all expenditures are consistent with the MHSA requirements; 2) a draft MHSA Three-Year Program and Expenditure Plan and Annual Updates be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans; and 3) the Los Angeles County Mental Health (LACMH) Commission conducts a Public Hearing on the draft MHSA Three-Year Program and Expenditure Plan and the Annual Updates at the close of the 30-day comment period.

In accordance with these requirements, DMH, on March 24, 2023, posted the MHSA Annual Update on its website for 30 days for public comment. The LACMH Commission also convened a Public Hearing on April 27, 2023, where DMH presented the Annual Update, addressed public questions, and the LACMH Commission voted to recommend the MHSA Annual Update for FY 2023-24.

Implementation of Strategic Plan Goals

The recommended action is consistent with the County Strategic Plan Goal III (Realize Tomorrow's Government Today), via Strategy III.4 (Engage and Share Information with Our Customers, Communities and Partners), and County Strategic Plan Goal I (Make Investments that Transform Lives), via Strategy I.2 (Enhance our Delivery of Comprehensive Interventions).

FISCAL IMPACT/FINANCING

DMH utilizes the budget process to appropriate the MHSA funds for use during the respective fiscal year. Sufficient funding will be included in DMH's Final Annual Adopted Budget for FY 2023-24 for this action.

There is no net County cost impact associated with the recommended action.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Assembly Bill (AB) 1467, chaptered into law on June 27, 2012, implemented changes to the MHSA law. More specifically, AB 1467 amended WIC and requires that each county mental

health program prepare a MHSA Three-Year Program and Expenditure Plan and Annual Updates, which were to be adopted by the County Board of Supervisors and submitted to the Commission. AB 1467 also amended WIC requiring that the MHSA Three-Year Program and Expenditure Plan and Annual Updates be certified by the Director and the A-C. This requirement includes the Director's certification as to the requisite stakeholder participation and compliance with MHSA non-supplantation provisions. Additionally, the statute was amended to require that the MHSA Three-Year Program and Expenditure Plan and Annual Updates be circulated for public review and comment and that a public hearing be conducted at the close of the comment period.

The Commission provided direction through a memo dated April 24, 2015, to all California counties to complete MHSA Annual Updates, and distributed the MHSA Fiscal Accountability Certification Form to be completed by the Director and A-C.

The public hearing notice requirements referenced in WIC Section 5848 (a) and (b), have been satisfied and are recorded in the MHSA Annual Update for FY 2023-24. Additionally, DMH has complied with the certification requirements referenced in WIC Section 5847(b)(8) and (9). Compliance has been recorded in the MHSA Annual Update for FY 2023-24 via a signed MHSA Fiscal Accountability Certification Form.

Additionally, with this update, there are service expansions and new programs underway in Los Angeles County, some of which depend almost exclusively on funding from MHSA, including:

- Expanding the number of sites and areas of availability for the Crisis Residential Treatment Program (CRTP). CRTPs are designed to provide short-term, intensive, and supportive services in a home-like environment through an active social rehabilitation program that is certified by the California Department of Health Services and licensed by the California Department of Social Services, Community Care Licensing Division. They are designed to improve the lives and adaptive functioning of those they serve.

- Expanding the number of full-time positions to the Homeless Outreach and Mobile Engagement Teams (HOME). HOME program provides field-based outreach, engagement, support, and treatment to individuals with severe and persistent mental illness who are experiencing unsheltered homelessness. Services are provided by addressing basic needs; conducting clinical assessments; providing street psychiatry; and providing linkage to appropriate services (including mental health services substance abuse treatment and shelter).

- Expanding the number of sites for the Transition Age Youth (TAY) Enhanced Emergency Shelter Program (EESP). EESP serves the urgent housing needs of the TAY population, ages 18-25, who are unhoused or at immediate risk of becoming unhoused with no alternative place to stay, no significant resources or income to pay for shelter, are experiencing mental health concerns, and are willing to accept the treatment we offer. The EESP offers a warm, clean, and safe place to sleep, hygiene facilities, hot meals (breakfast, lunch, dinner) and case management services.

- Expanding the number of sites and areas of availability for the Portland Identification and Early Referral Program (PIER). PIER is a Coordinated Specialty Care program for adolescents and young adults, ages 12-25, who are either at clinical high risk for psychosis or have had their first psychotic episode. Currently, referrals from East Los Angeles College Screening and Treatment for Anxiety and Depression, National Alliance Mental Illness Urban Los Angeles, schools, and various outpatient programs are exceeding the capacity of the current service level.

- Proposing an Innovation project that seeks to create new regional, field-based, multidisciplinary teams dedicated to serving people experiencing homelessness who are living in interim housing. The project is designed to address current gaps in behavioral health and physical health services, support interim housing stability, facilitate transition to permanent housing and prevent a return to homelessness. The Interim Housing Multidisciplinary Assessment and Treatment Teams will serve all eight Service Areas in Los Angeles County and will be assigned to support interim housing sites.

- Continued expansion of opportunities for capacity building and increased partnerships with grass roots organizations to serve at risk communities, including ethnic and other vulnerable communities that are unserved or underserved.

IMPACT ON CURRENT SERVICES

Board adoption of the MHSA Annual Update for FY 2023-24 will ensure compliance with the MHSA, as amended by AB 1467, and allow for uninterrupted access to vital mental health services.

Respectfully submitted,

LISA H. WONG, Psy D.
Director

LHW:CDD:DKH
SK:ZW:atm

Attachment

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

ATTACHMENT

MHSA ANNUAL UPDATE

Fiscal Year 2023-24

WELLNESS • RECOVERY • RESILIENCE

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

Posted for Public Review
March 24, 2023

TABLE OF CONTENTS

INTRODUCTION

Welfare and Institutions Code (WIC) Section 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan (Plan) followed by Annual Updates for Mental Health Services Act (MHSA) programs and expenditures. The MHSA Plan provides an opportunity for the Los Angeles County Department of Mental Health (LACDMH) to review its MHSA programs and services and obtain feedback from a broad array of stakeholders on those services. Any changes made to the MHSA programs would need to be in accordance with the MHSA, current regulations, and relevant State guidance.

LACDMH engaged in individual community planning processes for each component of the MHSA as guidelines were issued by the California Department of Mental Health. Implementation of each component began after plan approval by either the California Department of Mental Health or the Mental Health Services Oversight and Accountability Commission (MHSOAC) as shown below:

MHSA Component	Approval Dates
Community Services and Support (CSS) Plan	February 14, 2006
Workforce Education and Training (WET) Plan	April 8, 2009
Technological Needs (TN) Plan	May 8, 2009
Prevention and Early Intervention (PEI) Plan	September 27, 2009
Innovation 1 - Integrated Clinic Model, Integrated Services Management Model, Integrated Mobile Health Team Model and Integrated Peer-Run Model	February 2, 2010
Capital Facilities (CF) Plan	April 19, 2010
Innovation 2 - Developing Trauma Resilient Communities through Community Capacity Building	May 28, 2015
Innovation 3 - Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions (Renamed to Help@Hand)	October 26, 2017
Innovation 4 - Transcranial Magnetic Stimulation	April 26, 2018
Innovation 5 - Peer Operated Full Service Partnership	April 26, 2018
Innovation 7 - Therapeutic Transportation	September 26, 2018
Innovation 8 - Early Psychosis Learning Health Care Network	December 16, 2018
Innovation 9 - Recovery Supports for Conservatees	September 26, 2018
True Recovery Innovation Embraces Systems that Empower (TRIESTE) *Revised as Hollywood 2.0	May 23, 2019 May 27, 2021

DIRECTOR'S MESSAGE

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Director

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

Connie D. Draxler, M.P.A.
Acting Chief Deputy Director

Dear L.A. County,

It is an honor for me to serve as the new Director of L.A. County Department of Mental Health (LACDMH). Having been an LACDMH employee for more than 30 years, beginning as a student caring for the most vulnerable individuals on Skid Row, I have seen firsthand the unique challenges that have faced our mental health care delivery system. I have also experienced the unbridled fulfillment in helping to improve people's mental well-being and quality of lives. Without a doubt, the passage of the Mental Health Services Act (MHSA) was an extraordinary turning point in the way that LACDMH could serve and engage with our diverse communities to partner in developing impactful strategies and plans for providing mental health services to anyone who needs it most.

With a nationwide mental health crisis facing our youth and communities, increasing needs of people experiencing homelessness, and the unprecedented shortage of public mental health workforce members, LACDMH has never been more committed to our partnership with stakeholders and community to overcome these challenges and thrive. At LACDMH, we have worked to enhance our stakeholder process to include more and more diverse partners representative of the people we serve. We have expanded participation opportunities this year and are building a foundation to ensure continued, robust involvement in the next year and in years to come.

The results of successful partnerships with our stakeholders and LACDMH strategic planning include:

- Exploring creative incentives, bonuses and recruitment efforts to continue to build the LACDMH workforce and retain dedicated and passionate employees;
- Addressing the homelessness state of emergency by expanding our homeless outreach and mobile engagement (HOME) program to care for and house our most vulnerable clients on the street;
- Continued transformation of the Full-Service Partnership program so that we can best support our highest acuity outpatient clients on the path to recovery in the community and at the same time activating the grass roots through our Community Ambassador Network which empowers individuals through employment opportunities, access to available resources, increased awareness of mental illness, and reduction of stigma; and
- Enhancing our mobile response teams as part of the 9-8-8 crisis line implementation and optimizing the available mental health field responses as an alternative to law enforcement.

I look forward to working with stakeholders, partners and the dedicated LACDMH workforce to ensuring that our MHSA resources help those most in need live healthy, independent, meaningful lives.

Sincerely,

Lisa H. Wong

510 S. VERMONT AVENUE, LOS ANGELES, CA 90020 | HTTPS://DMH.LACOUNTY.GOV | (800) 854-7771

EXECUTIVE SUMMARY

PREFACE

In November 2004, California voters supported Proposition 63 and passed the Mental Health Services Act (MHSA) that imposes a 1% income tax on personal income in excess of $1 million. The Act provides the significant funding to expand, improve and transform public mental health systems to improve the quality of life for individuals living with a mental illness. MHSA funds an array of services that starts with prevention and integrates it into a comprehensive system of care to treat the whole person, with focus on wellness, recovery and resilience so that we may keep individuals out of hospitals, off the streets, and out of the jails.

Welfare and Institutions Code (WIC) Section 5847 requires county mental health programs prepare and submit a Three-Year Program and Expenditure Plan ("Three-Year Plan" or "Plan") followed by Annual Plan Updates for MHSA programs and expenditures. The Plan provides an opportunity for the Los Angeles County (County) - Department of Mental Health (LACDMH) to review its existing MHSA programs and services to evaluate their effectiveness. The Plan also allows LACDMH to propose and incorporate any new programs through a robust stakeholder engagement process, should additional funding be available. It is through this Community Planning Process that LACDMH will obtain important feedback from a broad array of stakeholders. Any changes made to any MHSA program must comply with MHSA regulations, as well as relevant State requirements.

PLAN LAYOUT

This Plan describes the programs that are funded by MHSA and is organized by the five MHSA components (Community Services and Supports; Prevention and Early Intervention; Innovation; Workforce Education and Training; and Capital Facilities and Technological Needs).

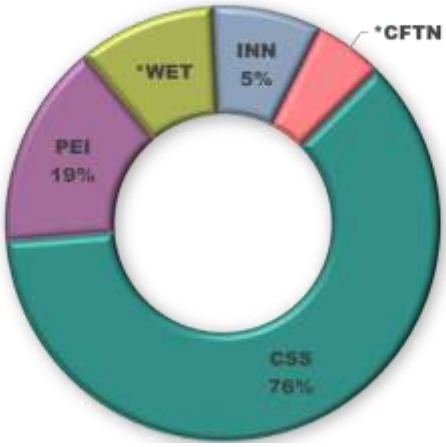
The information within this report is structured in the following sections:

- *MHSA Overview*
- *Development of the Annual Update*
- *Actions Since the Last Annual Update*
  The purpose of this section is to capture any posted Mid-Year Adjustments that occurred after the adoption of the FY 2022-23 Annual Update.
- *Existing Programs and Services by MHSA Component*
  The Plan provides relevant program outcomes specific to FY 2021-22 for programs previously approved.
- *Proposed Plan Changes*
  The Plan details significant changes that are either being proposed or will be explored within the next fiscal year.

MHSA OVERVIEW

The Mental Health Services Act (MHSA) was enacted in January 2005 following the passage of Proposition 63 in late 2004. The Act imposes a 1% income tax on personal income in excess of $1.0 million to provide resources that will greatly improve the delivery of community-based mental health services and treatment across the State.

WIC Section 5891 states that MHSA revenues may only fund mental health services, and MHSA programs and activities. MHSA addresses a broad continuum of county mental health services for all populations: children, transition-age youth, adults, older adults, families, and underserved. MHSA specifies five required components that support county mental health systems.



Community Services and Supports (CSS)

- Direct mental health services and supports for children and youth, transition age youth, adults, and older adults
- Permanent supportive housing for clients with serious mental illness
- Accounts of 75% of the total MHSA allocation

Prevention and Early Intervention (PEI)

- Services to engage individuals before the development of serious mental illness or at the earliest signs of mental health struggles
- Accounts of 18% of the total MHSA allocation

Workforce and Education Training (WET)*

- Enhancement of the mental health workforce through continuous education and training programs

Innovation (INN)

- Opportunities to design and test time-limited new or changing mental health practices that have not yet been demonstrated as effective, and to fuse such practices into the mental health system, thereby increasing access to underserved communities, promotion of interagency collaboration, and the overall quality of mental health services
- Accounts for 5% of the total MHSA allocation

Capital Facilities and Technological Needs (CFTN)*

- Building projects and improvements of mental health services delivery systems using the latest technology

**Transfers of CSS funds to WET and/or CFTN are permitted in accordance with MHSA guidelines*

DEVELOPMENT OF THE ANNUAL UPDATE

MHSA Requirements

WIC Section 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan and Annual Updates for MHSA programs and expenditures. Counties must also submit Annual Updates reflecting the status of their programs and services, as well as any changes.

WIC Section 5848 states the mental health board shall conduct a public hearing on the draft Three-Year Program and Expenditure Plan at the close of the 30-day comment period.

Plans and Annual Updates must be adopted by the county Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days of Board of Supervisor adoption.

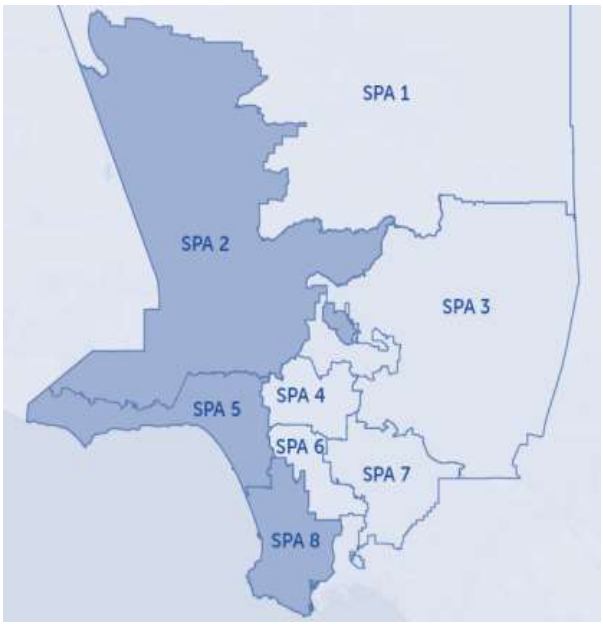
MHSOAC is mandated to oversee MHSA-funded programs and services through these documents, and evaluate how MHSA funding has been used, what outcomes have resulted, and how to improve services and programs.

County Demographics

The Los Angeles County (County) Department of Mental Health (LACDMH) is the largest county-operated mental health system in the United States. Serving as the local mental health plan in an area with over 10 million residents, LACDMH ensures access to quality mental health care through its provider network composed of directly operated clinic sites, contracted clinic sites, and co-located sites. These sites provide an array of programs and services to County residents within and beyond the physical clinic facilities in more than 85 cities within its boundaries.

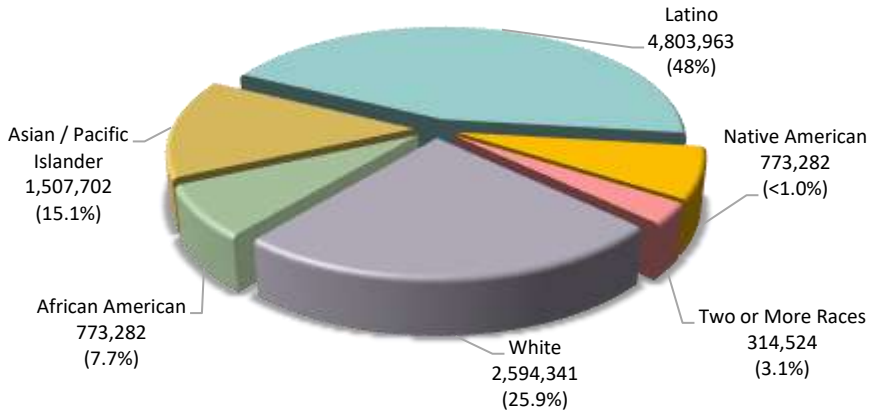
County residents represent one of the most diverse populations. This diverse racial and ethnic makeup are spread across approximately 4,000 miles that the County serves based on eight County defined Service Area (SA) boundaries.

Figure 1. Map of Los Angeles County Service Planning Areas



The Antelope Valley area, or SA 1, consists of two legal cities, or 3.9% of all cities in Los Angeles County. SA 1 is the largest geographical but the least densely populated. SA 2, the San Fernando area, consists of 11 legal cities, or 22% of all cities. SA 2 is the most densely populated. The San Gabriel Valley area, or SA 3, consists of 30 legal cities, or 17.6% of all cities. SA 4 is the county's Metro area and consists of two legal cities, or 11.5% of all cities. SA 4 has the highest number of individuals experiencing homelessness within its boundaries. SA 5 represents the West and comprises five legal cities or 6.5% of all. The South, or SA 6, consists of five legal cities, or 10.3% of all cities. It has the highest poverty rate in the county. The East, or SA 7, consists of 21 legal cities, or 12.9% of all cities. SA 8 is the South Bay area and consists of 20 legal cities, or 15.4% of all cities in Los Angeles County.

Figure 2. Total population by race/ethnicity



The next two tables provide the breakdown by race/ethnicity based on the SAs. Bold values shown in blue and brown represent the highest and lowest percentages, respectively, within each racial/ethnic group (Table 1) and across all SAs (Table 2).

Table 1. Population by race/ethnicity and Service Area

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	62,383	16,691	218,503	**1,471**	103,725	15,273	418,046
Percent	14.9%	4.0%	52.3%	**0.35%**	24.8%	3.7%	100.0%
SA 2	79,672	260,898	867,861	3,504	**918,778**	77,926	2,208,639
Percent	3.6%	11.8%	39.3%	0.16%	**41.6%**	3.5%	100.0%
SA 3	54,476	**546,511**	802,885	2,877	304,911	41,922	1,753,582
Percent	3.1%	**31.2%**	45.8%	0.16%	17.4%	2.4%	100.0%
SA 4	62,046	191,774	520,983	2,300	306,752	36,686	1,120,541
Percent	5.5%	17.1%	46.5%	0.21%	27.4%	3.3%	100.0%
SA 5	33,383	91,873	**105,216**	**952**	395,198	**38,168**	664,790
Percent	5.0%	13.8%	**15.8%**	**0.14%**	59.4%	**5.7%**	100.0%
SA 6	**235,154**	**24,396**	703,549	1,513	**32,713**	18,944	1,016,269
Percent	**23.1%**	**2.4%**	69.2%	0.15%	**3.2%**	1.9%	100.0%
SA 7	**38,727**	128,944	**950,243**	2,800	140,197	**20,138**	1,281,049
Percent	**3.0%**	10.1%	**74.2%**	0.22%	10.9%	**1.6%**	100.0%
SA 8	207,441	246,615	634,723	3,185	392,067	65,467	1,549,498
Percent	13.4%	15.9%	41.0%	0.21%	25.3%	4.2%	100.0%
Total	773,282	1,507,702	4,803,963	18,602	2,594,341	314,524	10,012,414
Percent	7.7%	15.1%	48.0%	0.19%	25.9%	3.1%	100.0%

Data source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH Chief Information Office Bureau (CIOB) in May 2022. Some totals and percentages reflect rounding

Table 2. Population by race/ethnicity and Service Area

Ethnic Group	Highest (in blue)	Lowest (in orange)
African-American	SA 6	SA 7
Asian/Pacific Islander	SA 3	SA 6
Latino	SA 7	SA 5
Native American	SA 1	SA 5
White	SA 2	SA 6
Two or More Races	SA 5	SA 7

SA 1 – Antelope Valley
SA 2 – San Fernando Valley
SA 3 – San Gabriel Valley
SA 4 – Metro Los Angeles
SA 5 – West Los Angeles
SA 6 – South Los Angeles
SA 7 – East Los Angeles County
SA 8 – South Bay

In addition to the racial and ethnic diversity, LACDMH also serves residents across their lifespan. Figure 2 and Tables 3 and 4 below provide a snapshot of the population breakdown by age group based on the SAs. Bold values shown in blue and brown in represent the highest and lowest percentages, respectively, within each age group (Table 3) and across all SAs (Table 4).

Figure 3. Total population by age group

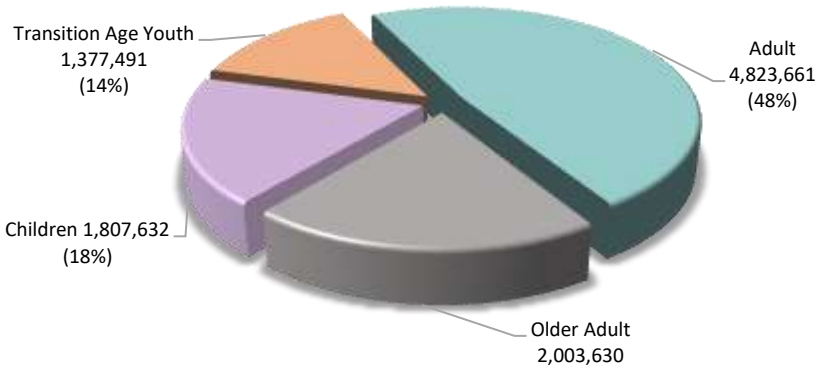


Table 3. Population by age group and Service Area

SA	0-15 years	16-25 years	26-59 years	60+ years	Total
SA 1	98,058	**69,473**	**181,543**	**68,972**	418,046
Percent	23.5%	**16.6%**	**43.4%**	**16.5%**	100.0%
SA 2	**389,938**	**285,219**	**1,063,968**	**469,514**	2,208,639
Percent	**17.7%**	**12.9%**	**48.2%**	**21.3%**	100.0%
SA 3	303,349	243,208	811,066	395,959	1,753,582
Percent	17.3%	13.9%	46.3%	22.6%	100.0%
SA 4	157,283	117,989	628,240	217,029	1,120,541
Percent	14.0%	10.5%	56.1%	19.4%	100.0%
SA 5	**85,539**	86,954	339,179	153,118	664,790
Percent	**12.9%**	13.1%	51.0%	23.0%	100.0%
SA 6	231,070	172,510	469,180	143,509	1,016,269
Percent	22.7%	17.0%	46.2%	14.1%	100.0%
SA 7	257,060	193,466	596,356	234,167	1,281,049
Percent	20.1%	15.1%	46.6%	18.3%	100.0%

SA	0-15 years	16-25 years	26-59 years	60+ years	Total
SA 8	285,335	208,672	734,129	321,362	1,549,498
Percent	18.4%	13.5%	47.4%	20.7%	100.0%
Total	1,807,632	1,377,491	4,823,661	2,003,630	10,012,414
Percent	18.1%	13.8%	48.2%	20.0%	100.0%

Data source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH Chief Information Office Bureau (CIOB) in May 2022. Some totals and percentages reflect rounding

Table 4. Population by age group and Service Area

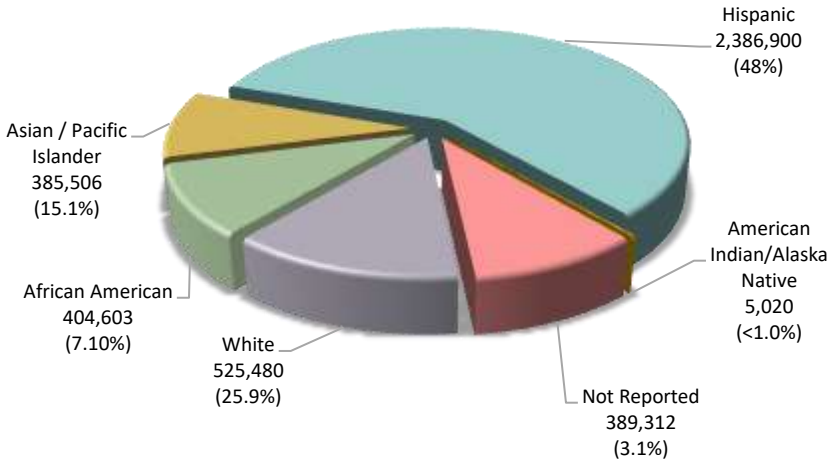
Age Group	Highest (in blue)	Lowest (in orange)
0-15	SA 2	SA 5
16-25	SA 2	SA 1
26-59	SA 2	SA 1
60+	SA 2	SA 1

SA 1 – Antelope Valley
SA 2 – San Fernando Valley
SA 3 – San Gabriel Valley
SA 4 – Metro
SA 5 – West
SA 6 – South
SA 7 – East
SA 8 – South Bay

Medi-cal eligibles

Approximately 40% of the Los Angeles County population makes up the Medi-cal Eligible population.

Figure 4. Distribution of Race/Ethnicity among Los Angeles County's Medi-Cal Eligibles



Data source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, and Age Group, downloaded on December 28, 2021. Due to rounding, some estimated totals and percentages may not total 100%.

Figure 5. Age Group Distribution among Medi-Cal Eligibles

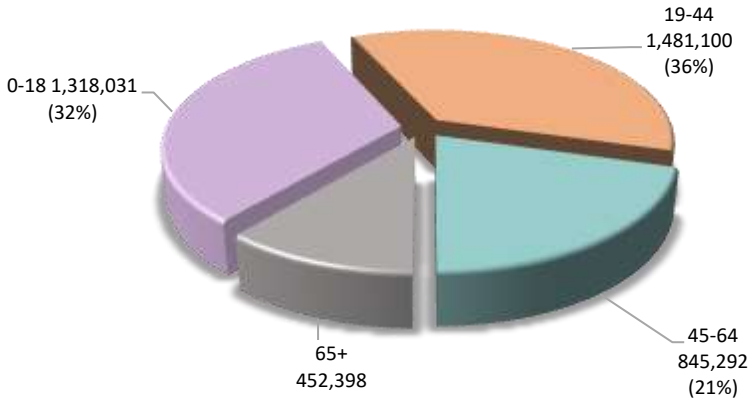


Figure 6. Countywide Poverty Estimates by Primary Language, Calendar Year 2020

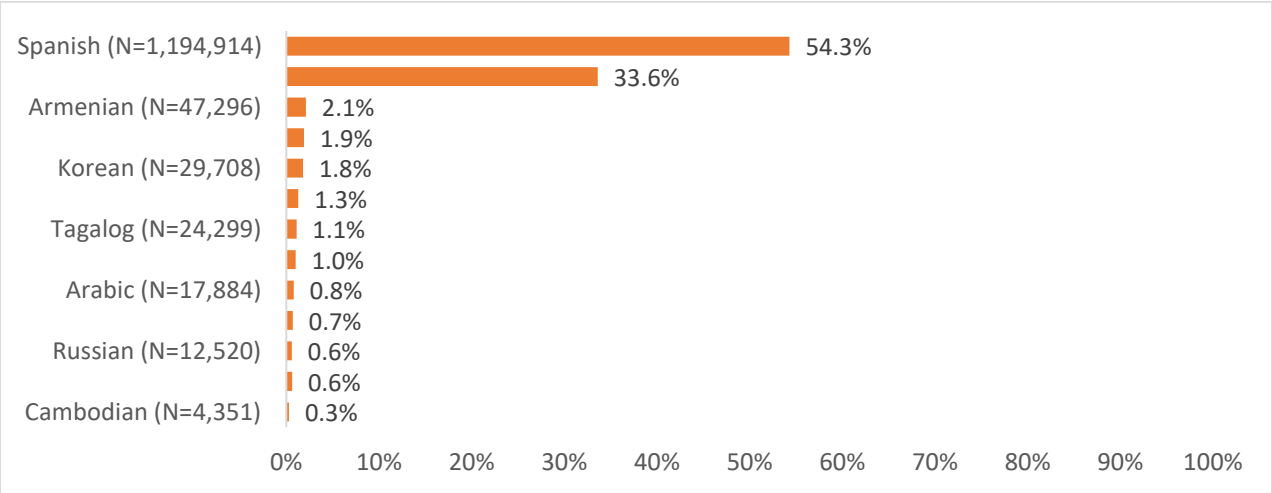
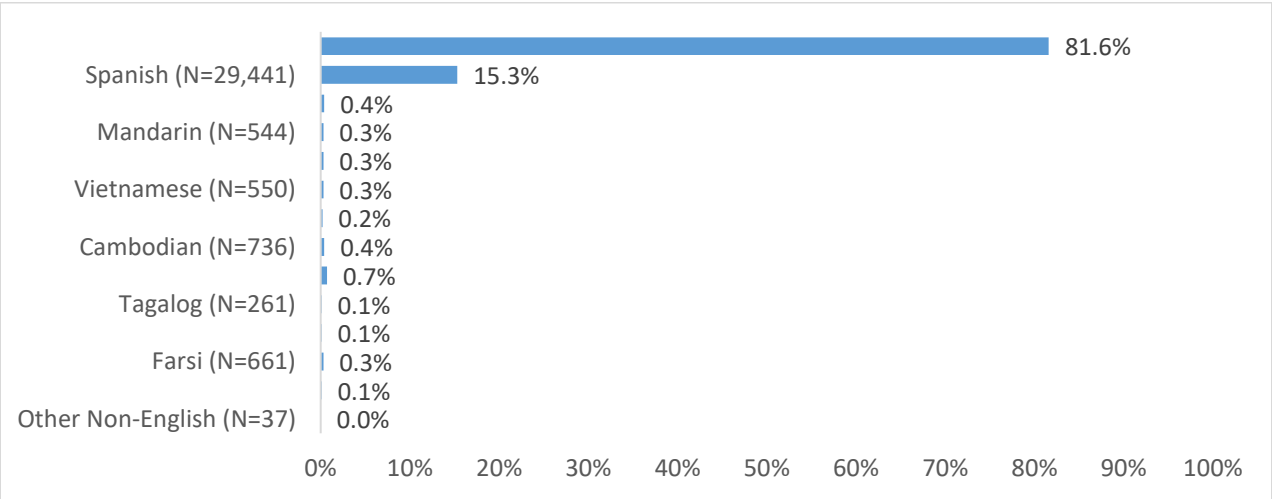


Figure 7. Countywide Consumers Served by Primary Language, FY 2019-20



Data source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH Chief Information Office Bureau (CIOB) in May 2022. Note: Numbers and percentages may not total to 100% due to rounding.

Practitioners speaking a non-English threshold language most commonly spoke Spanish (84.2%), followed by Korean (3.0%), Mandarin (2.1%), Armenian (1.9%), Tagalog (1.9%), and Farsi (1.4%). Spanish, Korean, Mandarin, Armenian, and Farsi were the primary languages most frequently spoken by clients in CY 2021 other than English.

Table 5. Practitioners Fluent and Certified in Non-English Threshold Languages, May 2022

Language	Number of Certified Practitioners	Number of Fluent Practitioners	Total	Percent
Arabic	9	26	35	**0.6%**
Armenian	29	89	118	1.9%
Cambodian	7	40	47	0.8%
Cantonese	8	62	70	1.1%
Farsi	10	75	85	1.4%
Korean	20	161	181	3.0%
Mandarin	17	109	126	2.1%
Other Chinese	**5**	55	60	1.0%
Russian	10	40	50	0.8%
Spanish	**544**	**4,594**	**5,138**	**84.2%**
Tagalog	18	96	114	1.9%
Vietnamese	8	50	58	1.0%

Note: Bolded numbers represent the highest and lowest values for that column.

Community Planning

The goal of the Community Planning Process is to ensure community stakeholders take an active role in advising the County on service needs across all Los Angeles County communities. LACDMH takes a collaborative and inclusive approach to understanding community priorities through a community-driven partnership that engages the large, multicultural, and diverse community stakeholder group within the County.

A. Partnership with Stakeholders: YourDMH

YourLACDMH is a collaborative and inclusive approach to engaging stakeholders across LA County. The purpose of this collaborative is to develop shared goals of hope, recovery, and well-being. This approach ensures identification of stakeholder priorities and the collection of feedback and guidance to LACLACDMH in the development of comprehensive plans for countywide service provision across the system. It is the foundation for planning and development for large system efforts, including the MHSA Three-Year Plan. Partners in YourLACDMH play an active role in setting the priorities for funding allocations for services funded by MHSA and provide feedback on priority populations and service models to be implemented.

The YourLACDMH partnership includes four diverse groups:

1. Service Area Leadership Teams (SALT)
2. Underserved Cultural Communities (UsCC)
3. Community Leadership Team (CLT)
4. Mental Health Commission

The following provides a brief description of each group:

1. Service Area Leadership Teams (SALT)

For the purposes of planning and operation, Los Angeles County is divided into eight Service Areas (SA) as shown in the table below.

Table 6. County Service Areas

SA 1 – Antelope Valley	SA 5 – West Los Angeles
SA 2 – San Fernando Valley	SA 6 – South Los Angeles
SA 3 – San Gabriel Valley	SA 7 – East Los Angeles County
SA 4 – Metro Los Angeles	SA 8 – South Bay

Each SA has a SALT - formerly known as Service Area Advisory Committee (SAAC). Each SALT functions as a local forum of consumers, families, service providers and community representatives to provide LACDMH with information, advice, and recommendations regarding the:

- Functioning of local service systems
- Mental health service needs of their geographic area
- Most effective/efficient use of available resources; and
- Maintenance of two-way communication between LACLACDMH and various groups and geographic communities.

2. Underrepresented Ethnic/Cultural Communities Subcommittees (UsCCs)

One of the cornerstones of MHSA is to empower underrepresented ethnic/cultural groups and to give them a voice in the stakeholder process. The term refers to communities historically unserved, underserved and inappropriately served, in terms of mental health services. As a result of MHSA, UsCC subcommittees were developed

by LACLACDMH to address the specific needs of ethnic/cultural communities and reduce cultural and ethnic disparities in access to care and service delivery. There are seven UsCC subcommittees.

Table 7. UsCC Subcommittees

African/African American	Eastern European/Middle Eastern
American Indian/Alaska Native	Latino
Asian Pacific Islander	Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Two-Spirit (LBGTQI2-S)
Deaf, Hard of Hearing, Blind, & Physical Disabilities	

The UsCC subcommittees are essential to the YourLACDMH community stakeholder engagement process. The UsCC subcommittees work closely with community partners and consumers to increase the capacity of the public mental health system and to develop culturally competent recovery-oriented policies and services specific to the UsCC communities. As a part of the YourLACDMH community stakeholder engagement process, the UsCC subcommittees have been allocated annual funding to develop capacity building projects that provide a unique opportunity to draw on the collective wisdom and experience of community members to determine the greatest needs and priorities related to mental health in their communities.

The goals of the UsCC capacity building projects include increasing knowledge about mental illness, increasing access to mental health resources, and decreasing stigma related to mental illness in the targeted UsCC community. These projects are not intended for the delivery of mental health services, but to increase access to care for unserved, underserved, and inappropriately served populations who may be uninsured/uninsurable.

These projects aim to reach ethnic populations across age groups (children, transitional aged youth, adult, and older adult) and seek to provide outreach and engage activities consistent with the language and cultural needs and demographics of those communities. The projects are driven by community needs and include culturally effective outreach, engagement, and education strategies and respond to historical and geographic disparities and barriers to services.

3. Community Leadership Team (CLT)

The CLT meets quarterly and is made up of Co-Chairs from two important networks of stakeholders: SALTs and UsCCs. CLT participants work together to discuss and consolidate stakeholder priorities. All stakeholder priorities that are officially endorsed by SALTs and the UsCCs and any other convening groups, are then included on the stakeholder priority list. The purpose of combining similar stakeholder priorities is to indicate which priorities have the support of multiple stakeholders and therefore must be relayed to LACDMH through the CLT.

This inclusive and ongoing community planning process allows the LACDMH to gather input about experiences with MHSA programs and the current mental health system; to gauge the overall impact and effectiveness of such programs; to record recommendations for improvement of programs and processes; and to acknowledge feedback regarding future and/or unmet needs pursuant to WIC Section 5848(a).

4. **Mental Health Commission (Commission)**

The role of the MHC is to review and evaluate the community's mental health needs, services, facilities, and special programs. The Commission consists of 16 members based on very specific requirements in adherence to WIC Section 5604. Membership requirements of the Commission include:

- Commission membership must consist of 50% consumers or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services.
- Consumers must constitute at least 20% of the total Commission membership.
- Families of consumers must constitute at least 20% of the membership
- One member of the Commission must be a member of the Board of Supervisors

The law also establishes special requirements on ethnic diversity and conflict of interest. To the extent feasible, Commission membership should reflect the Los Angeles County's ethnically diverse.

The Mental Health Commission provides input and recommendations to LACDMH regarding its developed plan for MHSA funded programs and services based on evaluated community needs.

B. Partnership with Stakeholders At Large:

To ensure opportunities for the broadest, most inclusive community planning process, LACLACDMH also engages Stakeholders At Large, in addition to the YourLACDMH framework. These stakeholders are community members, network providers and other groups that are impacted by programs and services planned by LACLACDMH. Stakeholders at Large may be impacted as they live, work or provide services to LA County residents that may be impacted by mental health related issues. These stakeholders are included in community planning meetings and provide feedback and recommendations to LACLACDMH on developed plans. Stakeholders at Large include, but are not limited to, the following groups:

- Community residents
- Other LAC Departments
- Community Based Network Service Providers
- City officials/representatives within LA County boundaries
- Business owners/workers within LA County boundaries
- Quazi-governmental partner agencies, such as LA Homeless Services Authority (LAHSA)

C. MHSA Planning Activities:

LACDMH engaged in an array of activities, training and several planning meetings to execute its current Community Planning Process towards the development of the FY 2022-23 Mid-Year Adjustment, the upcoming FY 2023-24 MHSA Annual Plan Update and the MHSA Two Year Program and Expenditure Plan for FYs 2024-25 through 2025-26. See Appendix C for a breakdown of the Stakeholders attending the events listed below.

September 2022
Number of Stakeholder Attendees: 113

LACDMH held a two-day retreat (9/23/22 and 9/30/22) to revitalize its Community Planning Process and strengthen its collaborative relationships with stakeholders from the most vulnerable unserved, underserved, and under-represented populations across the County. Participants had an opportunity to examine the past stakeholder engagement processes and outcomes and acknowledge what worked well, what has not worked and identify what is needed in the future to create and sustain a strong collaborative relationship necessary for LACDMH to deliver effective and culturally congruent programs and services under MHSA.

November 2022
Number of Stakeholder Attendees: 46

LACDMH met with community stakeholders (11/1/22,11/17/22,11/18/22) and presented proposed timelines and processes for meaningful engagement and input on the review of MHSA funding requests for the Mid-Year Adjustment, the upcoming FY 2023-24 MHSA Annual Plan update and the MHSA Two Year Program and Expenditure Plan for FYs 2024-25 through 2025-26.

December 2022

LACDMH conducted an annual MHSA foundational training (12/22/22) to LACDMH staff, provider network staff, and community stakeholders on MHSA policies, the Department's MHSA funding request procedure, the MHSA Three Year Program and Expenditure and Annual Update development and submission process and timeline, and the client resolution process.

January 2023
Number of Stakeholder Attendees: 378

LACDMH designed and developed a MHSA proposal submission and review process to efficiently present and consider a large volume of MHSA program and service proposals to its stakeholders through an equitable community engagement and planning process.

LACDMH conducted an annual MHSA foundational training (1/2/23) to LACDMH staff, provider network staff, and community stakeholders on MHSA policies, the Department's MHSA funding request procedure, the MHSA Three Year Program and Expenditure and Annual Update development and submission process and timeline, and the client resolution process. (See Appendix for training)

LACDMH conducted two community stakeholder meetings (1/23/23, 1/31/23) focused on educating participants on MHSA funding components, requirements, and spending regulations. Participants were also presented with a stakeholder planning calendar and a review of the formal process for requesting MHSA funding and asked to identify key gaps in the process. Stakeholders were presented with LACDMH and stakeholder proposals to be considered for inclusion in the FY 2023-24 MHSA Annual Update. LACDMH gathered feedback, recommendations and questions regarding these proposals.

LACDMH initiated a 30-day public review and comment period (1/20/23) for its Mid-Year Adjustment to the Los Angeles County FY 2022-23 MHSA Annual Update. The posting outlined proposed programs, expansion of existing programs and administrative changes ranging from new CSS, PEI and INN programs to administrative and operational actions programs. On January 31, 2023, the Mid-Year Adjustment was presented to stakeholders and feedback/recommendations were collected. Participants were encouraged to share this information with the communities they represent and offer their communities an opportunity to submit written feedback and written comment during the 30-day public review and comment period.

February 2023
Number of Stakeholder Attendees: 645

LACDMH conducted two community stakeholder meetings (2/17/23, 2/21/23) focused on reviewing DMH and stakeholder proposals to be considered for inclusion in the FY 2023-24 MHSA Annual Update and building consensus on which proposals presented in January and February meetings would receive final stakeholder recommendation for inclusion in the Plan. LACDMH gathered feedback, recommendations from participants and responded to questions regarding the proposals presented.

LACDMH completed the 30-day public posting, review and comment period (2/20/23) for its FY 2022-23 Mid-Year Adjustment.

March 2023
Number of Stakeholder Attendees: 155

LACDMH delivered a Provider MHSA 101 Training (3/23/23) (See Appendix for training).

LACDMH initiated a 30-day public review and comment period for its FY 2023-24 MHSA Annual Update (3/24/23).

LACDMH will conduct a community stakeholder meeting (3/30/23) with the objective of reviewing the draft FY 2023-24 MHSA Annual Update. Stakeholders will receive a presentation about all items included in the Update. LACDMH will collect their feedback and recommendations. Participants will be encouraged to share the information with the communities they represent and offer their communities an opportunity to submit written feedback during the 30-day public review and comment period.

April 2023

LACDMH completed the 30-day public posting and comment period and collection of submitted feedback for inclusion in the draft Annual Update.

The public hearing meeting occurred on April 27, 2023 with Spanish and Korean translation. The agenda, presentations and transcripts are included in Appendix D. Stakeholders were notified about the event via Instagram, email and the DMH website.

D. Stakeholder Feedback

A survey was posted in conjunction with the MHSA Annual Update to collect feedback in both English and Spanish during the public posting and comment period. The Department collected the following:

- 12 Survey responses were received, 12 in English and 0 in Spanish. There were 9 survey questions administered. Not all respondents answered all the questions.

- Various written and email correspondences were received and reflected in the stakeholder feedback toward review of the Plan.

Stakeholder Feedback, Themes, Questions and Responses:

The Commission and Stakeholders requested reporting on overall system budget, recruitment, and hiring status.

- DMH Finance provides and will continue to provide a quarterly update on the overall budget for the entire Department, including all funding streams.
    - The last update was provided at the Stakeholder community planning meeting on 01/23/23
- The Department will continue to explore strategies to provide budget expenditure by service area and supervisorial district and strategies for allocating funding based on an equity lens and unmet needs
- Funding for all MHSA components was also reported on 01/23/23.
- The DMH Director provides and will continue to provide a quarterly update on recruitment and hiring efforts to address the workforce shortage and collaboration with labor unions.

The Commission requested regular reporting, and side by side comparison of budget allocations, service utilization and trends, and funding utilization prior to, during and following the COVID pandemic. The comparison was requested to be reflected by geographic area, ethnic populations, and age group.

- DMH has currently developed a data dashboard that provides service utilization data collected by fiscal year, geographic area, ethnic population and age groups. This data, along with budget allocation information will be used to create the side by side assessment for the pre, during and post COVID fiscal years. This data will be shared and incorporated into a community needs assessment to support the Community Planning Process with the Commission and stakeholders for the development of the upcoming Two-Year Program and Expenditure Plan.

The Commission and Stakeholders requested updates on data and outcomes reporting:

- DMH has developed a data dashboard that provides service utilization data collected by fiscal year, geographic area, ethnic population and age groups. It will be used to review services to specific target populations, including unserved and underserved ethnic populations, primary language, and gender to address service gaps and recommend service priorities for the upcoming Two-Year Plan Community Planning Process, as requested. This dashboard will also provide a more detailed breakout of race/ethnicity data to ensure representation for unserved or unserved cultural communities.
- DMH convened a Data Disparities Workgroup with the goal of focusing on underserved and unserved ethnic population data. Using the Anti-Racism Diversity and Inclusion (ARDI) equity mapping tool and service utilization data, this workgroup will be tasked with monitoring service equity metrics to inform program planning and monitoring for program improvements.
- Specific to the draft Annual Update, the client count data by ethnicity on slide 7 does not balance. The reason for this is the report only reflects client counts for the top 5 ethnicities. In addition, due to client choice or intake circumstances, the ethnicity for

a large group of clients is not reported either . DMH is taking steps to improve reporting of ethnicity data.

- DMH reports on program outcomes and performance in the draft Annual Update. Program outcomes will be discussed as part of the upcoming Community Planning Process.

The Commission and Stakeholders requested specific responses to items reflected in the draft Annual Update

- Program expansions are reflected in the Update.
- In response to the inquiry on the expansion of Portland Identification and Early Referral (PIER) Program: The expansion adds new funding for PIER services in Service Areas 1 and 8 and increases the presence of PIER services in Service Area 6.
- In response to the inquiry of when Innovation proposals will be reviewed and considered for Board and State approval: Submitted Innovation proposals will undergo the review process during the upcoming Two-Year Plan Planning Process, pending available Innovations funding.

The Commission and Stakeholders requested responses to other questions/concerns

- In response to the Commission's inquiry, when will the summary/overview outlining the shift of the May Mental Health Month campaign from We Rise to Take Action be provided: The summary/overview of the shift will be reflected in the upcoming Two-Year Plan.
- The MHSA Annual Update did not incorporate treatment plans/programs for clients with a co-occurring disorder. Requested more information on what the Department is doing with harm reduction and how is the Department engaging the community.

The Commission and Stakeholders requested updates on the Community Planning Process going forward:

- The upcoming Community Planning Process will involve an expansion of stakeholder involvement to ensure greater participation of a more diverse group of stakeholders across LA County communities that is representative of peers and family members, ethnic/cultural populations, geographic areas, community based organizations, other county departments and stakeholders at large. The Community Planning Process will begin late May/early June 2023 and will begin with MHSA 101 training, stakeholder foundational training and a data and community needs assessment toward development of the Three-Year Plan.
- In response to the inquiry will the Mental Health Commission be considered a stakeholder group and be included earlier in the Community Planning Process and the MHSA Funding Request/Proposal submission and stakeholder process on behalf of the Board of Supervisors: Yes. The Mental Health Commission will be notified of the Community Planning Process and timelines for comment, feedback and for submission of MHSA Funding Proposal on behalf of the Board offices. The Mental Health Commission has a unique formal role as part of the Community Planning Process and holds the responsibility to ensure stakeholder voices are included in the process, while providing input in the process on behalf of the Board of Supervisors. DMH shared information with the Mental Health Commission during

the Community Planning Process for the draft Annual Update in Fall 2022 in preparation for stakeholder engagement meetings. DMH will continue to share the process going forward.

The Commission and Stakeholders requested updates and clarification on the MHSA Funding Request/Proposal Process

Responses to inquiries regarding the MHSA Funding Request/Proposal Process are listed below:

- How do stakeholders and community members submit proposals?
  - Requests/Proposal can be submitted 24 hours a day/7 days per week through the MHSA Funding Request Portal using online electronic forms. CSS, PEI, WET funding requests should be submitted using the form located at: https://forms.office.com/g/hFe6wc9LA2. Innovation funding requests should be submitted using the form found at https://forms.office.com/g/77BRkSWzUe. Both portals will be available to receive new proposals for the upcoming Two-Year Planning process from mid May 2023 through January 15, 2024.
- How are proposers notified of the review, approval or rejection status of their submissions?
  - Proposers are informed of the status of their submission via a phone call or through an email.
- Can the source of proposals be shared/released?
  - Yes. The source of proposals (e.g. CBOs, County Entities, or Community Stakeholders) can be made available upon request and are also posted publicly on the DMH MHSA page.

The Commission and Stakeholders requested updates and clarification on the MHSA Funding Request/Proposal Process

- Can the amount requested by proposers be shared?
  - Yes. The amount requested for proposals was shared with stakeholders during the Community Planning Process. This information is also available upon request. Amounts requested are estimated amounts and may change upon approval and during implementation based on actual confirmed costs and funded activities included in the proposal.
- Can the information on proposed target populations and geographic areas to be served be shared?
  - Yes. This information was shared with stakeholders during Community Planning Process. Upon Board approval and prior to actual implementation, the MHSA Administration Unit will consult with proposer to confirm proposed target populations and geographic areas. An analysis of each approved proposal will be conducted to ensure equity concerns and considerations are addressed and funding allocations support unmet needs for communities countywide.

E. Corrections Made After Posting

The following are changes made to the MHSA Annual Update based on substantive recommendations received during the 30-day public comment period:

- Portland Identification and Early Referral Program (PIER)

- The spelling for the PIER program was corrected.
- This program will expand the number of sites and areas of availability of the program to Service Areas 1 and 8 and expand services in Services Area 6. PIER is a Coordinated Specialty Care program for adolescents and young adults, ages 12-25 who are either at Clinical High Risk for psychosis or have had their first psychotic episode. Currently, referrals from ELAC STAND (UCLA), NAMI Urban LA, schools and various outpatient programs are exceeding the capacity of the current service level.
- Funding is Prevention and Early Intervention: Early Intervention.

- Full report of the Innovation proposal: Interim Housing Multidisciplinary Assessment & Treatment Teams was added to Appendix A.
- Psychiatric Mobile Response Teams (PMRT) description was added to the Alternative Crisis Service Program.
- Enriched Residential Care Program (ERC)
  - This program should be reflected as a change in Capital Facilities and Technological Needs (CFTN) as it involves a shift of funds from Community Services and Supports to CFTN.
  - The funding request is for $11.2 million for Fiscal Year 2023/24.
  - DMH has received approval from the Los Angeles County Board of Supervisors to accept $55.5 million in Community Care Expansion (CCE) Preservation Program funding from the State to help licensed residential facilities complete the capital repairs and improvements needed to remain in operation and serve as a housing resource for DMH clients. This funding, less DMH administrative costs, will be combined with the $11.2 million in one-time MHSA funding designated for licensed residential facility capital improvements, and transferred to the Los Angeles County Development Authority (LACDA), who will serve as the funding administrator as also approved by the Board. An additional $41.9 million in CCE Preservation Program funding will also be received by DMH and will be used to provide licensed residential facilities with operating subsidy payments through DMH's Enriched Residential Care (ERC) Program to help support operation costs and further prevent closures. This will allow the DMH ERC Program, in partnership with the Department of Health Services (DHS) and their fiscal intermediary, to support 475 clients each year over five years.
- Community Planning dates were incorrectly stated and have been corrected.
- The following programs are existing MHSA programs previously approved by Stakeholders set to expand in Fiscal Year 2023-24:
  - Homeless Outreach and Mobile Engagement (HOME)
    - Funding is CSS: Linkage
    - The expansion will include a total of 107 full time positions, (6 new multidisciplinary teams and 1 Service Area Navigation team) will be added between FY 2022-23 and FY 2023-24. The expansion will bring a total number of 16 multidisciplinary teams Countywide and 1 Service Navigation team.
  - Crisis Residential Treatment Programs (CRTP)
    - Funding is CSS: Alternative Crisis Services
    - Services will be delivered with by a new legal entity – Bel Aire Health Services to provide services in Downey and Sylmar.
  - TAY Drop-In Centers
    - Funding is PEI: Prevention and CSS: Outpatient Care Services

        - A total of 10 new sites will be added Countywide. Service Areas 2, 3, 4, 5, 7 and 8 will each receive one new site. Service Areas 1 and 6 will each receive two.
    - TAY Enhanced Emergency Shelter Program
        - Funding is CSS: Housing
        - Additional funding will be added to sites.
    - Full Service Partnership (FSP)
        - Funding is CSS: FSP
        - The expansion will add additional staff to FSP directly operated programs and create two new half teams. Additional staff will help to form FSP teams at Santa Clarita Mental Health, Antelope Valley Mental Health, and Arcadia Mental Health.

ACTIONS SINCE THE LAST ANNUAL UPDATE

A. MID-YEAR ADJUSTMENT

The following MHSA Mid-year Adjustment posted after the Fiscal Year 2022-23 MHSA Annual Update adopted on June 28, 2022 by the Board of Supervisors. The 30 day public review and comment period was: January 20, 2023 through February 20, 2023. It was adopted by the Board on May 2, 2023.

The following are the proposed new Community Services and Supports (CSS) programs:

Office of Diversion & Reentry (ODR) – Expansion: $25M

This project will equitably reduce the number of people incarcerated in LA County with serious mental illness or other complex health needs, and reduce homelessness, emergency services use, and healthcare cost for this population.

Key ODR expansion activities include:

- Receiving referrals from justice partners and target the jail mental health population to identify, screen, and recommend clients for diversion.
- Facilitating clients' diversion through pre-trail, and post-conviction mechanisms via LA County Superior Court.
- Establishing clinically supported interim housing to clients exiting custody
- Coordinating jail release and transportation
- Coordinating client care with Probation Department and LA Superior Court
- Providing ongoing clinical support to support client's mental health stability and general health needs.
- Partnering with Community Based Organizations to develop permanent supportive housing units and ensure access to affordable housing.

The program will serve 395 clients.

Project Impact – OCS: $.2M

In addition to providing PEI services and consistent with the MHSA Outpatient Care Service (OCS) Plan, Project IMPACT will also provide a continuum of care, ranging from children to transitional age youth/young adults as well as their parents/caregivers. All age groups will have access to outreach and engagement, assessments, culturally responsive mental health services, crisis intervention, case management, and medication support.

Project Impact will serve approximately 168 OCS clients.

The following is the proposed new PEI programs:

Project Impact – PEI:$.6M

The intent of Project Impact's PEI program is to serve children and young adults who have experienced or have been exposed to traumatic events such as child sexual abuse,

violence, traumatic loss and/or experiencing difficulty related to symptoms of Post-Traumatic Stress Disorder (PTSD), depression, anxiety, or additional co-occurring disorders; and to provide early intervention mental health services to reduce the impact of the identified symptoms and problems.

Project Impact will serve approximately 672 PEI clients

The following are necessary administrative and operational actions:

PEI Funding Realignment : $7.8M

Realign existing PEI funding as follows:

Work Plans	Description	Planned Realignment & Increase
Prevention	NAMI- Prevention Services for Peer & Family Support Services	($ 2,000,000)
	Mental Health Promoters/Promotors ; the services include Fiscal Intermediary to pay to promotors	(16,720,000)
	Community Ambassador Network (CAN) Project	29,550,000
	Prevention Sub-Total	**10,830,000**
Community Outreach	Community Ambassador Network (CAN) Project	(21,735,000)
	OC Sub-Total	**(21,735,000)**
Stigma & Discriminati on Reduction	Mental Health Promoters/Promotors ; the services include Fiscal Intermediary to pay to promotors	16,720,000
	Why We Rise Mental Health Campaign- A Sole Source Participation Agreement with CalMHSA to fund Mental Health Prevention Program*	17,000,000
	NAMI- Prevention Services for Peer & Family Support Services	2,000,000
	SDR Sub-Total	**35,720,000**
Suicide Prevention	Why We Rise Mental Health Campaign- A Sole Source Participation Agreement with CalMHSA to fund Mental Health Prevention Program	(17,000,000)
	SP Sub-Total	**(17,000,000)**
	Grand Total	**$ 7,815,000**

*The Why We Rise Mental Health Campaign will be called Take Action.

51% FSP Funding Requirement: $76.1M

Revise the CSS Budget to reflect the services that would correctly be attributed to the 51% FSP threshold

Capital Facilities Project: $6M

Transfer funds from CSS funding to Capital Funds and Technology Needs (CFTN) for anticipated capital facilities projects/tenant improvements including but not limited to:

a. Olive View Urgent Care Center
b. Children's medical HUB
c. Central administration expenditures
d. General County Funds pool dollars

Call Center Modernization: $2.8M

In FY 21-22, $3.5 M was allocated for Phase 1 of the project. In 2022-23, an additional $3.5M was allocated for Phase 2. However, an additional $2.8M is needed to fully fund this project.

End of Year Legal Entity Contract Amendments: $31M

Additional funding is needed to ensure continuation of services through end of the Fiscal Year.

TAY Supported Employment Shift

TAY Supported Employment to be funded by PEI instead of CSS.

B. PROPOSED INNOVATION PROGRAMS

The following Innovation programs were posted for a 30-day public review and comment period, January 20, 2023 through February 20, 2023.

Proposed INN programs will still go through further review processes including presentation to the Los Angeles County Mental Health Commission and Mental Health Services Oversight and Accountability Commission before final approval

The following are proposed new INN programs:

Kedren Restorative Care Village (RCV): $109M

The Kedren Restorative Care Village will promote interagency and community collaboration related to mental health services, supports and outcomes by building a continuum of care for children and their families in a single location. The levels of care include:

- Family Housing (24 units)
- Children and youth Crisis Residential (16 beds)
- Crisis and Stabilization Unit
- Outpatient Services including:
  - Rehabilitation services
  - Partial hospitalization
- Inpatient services will be available on site, but will not be funded with MHSA funds

The goals of this project include:

- Increasing step down care resources including a crisis stabilization unit (urgent care center) and crisis residential treatment program
- Increasing access to housing resources for families whose children are in Kedren RCV program, including 24 units of on-site housing children and families.
- Ensuring appropriate level of care is provided (i.e., decreasing number of emergency room visits, reduce number of inpatient bed days, etc.).

The existing 17 beds serve 316 children annually. By increasing the total capacity to 30 beds, a projection based on average monthly census shows that 480 children can be served annually. It is projected that the Crisis Residential Treatment Program (CRTP) will serve approximately 300 children annually and the Crisis Stabilization Unit (CSU) will serve a minimum of 3,000 clients. The innovation is providing a full continuum of care for children and their families on a single campus to ensure the right level of care. The learning will be focused on improved outcomes for children and families as a result of access to this continuum of services.

The proposed budget will cover 5 years of programming.

Interim Housing Multidisciplinary Assessment & Treatment Teams:$190M

This proposed Innovation project seeks to create new regional, field-based, multidisciplinary teams dedicated to serving people experiencing homelessness (PEH) who are living in interim housing. The project is designed to address current gaps in behavioral health and physical health services, support interim housing stability, facilitate transition to permanent housing and prevent a return to homelessness.

The Interim Housing Multidisciplinary Assessment and Treatment Teams will serve all eight Service Areas in Los Angeles County and will be comprised of staff from DMH, DPH-SAPC and DHS-HFH in an effort to ensure the full spectrum of client needs can be addressed. Teams will be assigned to support interim housing sites.

The current interim housing inventory in Los Angeles County is approximately 220 sites and 14,376 beds. The additional 11 interim housing sites in the pipeline provide an additional 1,037 beds to support PEH.

The key elements that make this project innovative are:

- The implementation of dedicated field-based multidisciplinary teams that are specifically outreaching, engaging and providing direct mental health, physical health and substance use services to clients in interim housing at their interim housing location, which is an entirely new service setting. This includes 24/7 crisis response.
- The partnership with the managed care organizations that will allow the County to leverage private resources from local health plans to support interim housing client needs.

By implementing this innovative project, LACDMH intends to learn if having dedicated field-based, multidisciplinary teams serving interim housing sites result in the following:

- Increased access to mental health services and co-occurring SUD services by interim housing residents?
- Increased exits to permanent housing?
- Decreased exits to homelessness?
- Interim housing provider staff increasing their knowledge and skills when serving individuals with severe mental illness and feeling more confident in being able to serve this population in their interim housing sites?

The proposed budget will cover 5 years of programming.
See Appendix A for complete Innovation proposal.

Care Court Peer Support : $12.7M

The implementation of SB1338—the Community Assistance, Recovery, and Empowerment (CARE) Court Program in Los Angeles County allows the Department of Mental Health to lead the county in working with individuals who are struggling to care for themselves and advocate with insight for their own care.

DMH was ordered by legislation/law to implement the CARE Act/Court. In January 2023, Governor Newsom, the County Board of Supervisors, the County CEO, and the Presiding

Judge of the Los Angeles County Superior Court issued a press release indicating LA County would begin implementation of Care Court in December 2023—a year earlier than mandated by law.

The process and options of CARE Court are set by legislation.

- CARE Court is a civil court process that gives clients many offers and opportunities to accept voluntary treatment.
- Once the client agrees and enrolls in a voluntary treatment program, the court may monitor progress or the case can be dismissed.
- CARE Court supports an individuals right to due process, the right to have a supporter and must be the least restrictive program to meet the individuals mental health needs.
- Care Court does not change LPS Criteria for WIC 5150

LA County anticipates approximately 6,000+ clients may be eligible for the CARE court program out of a 10,000,000 county population.

The LA County DMH implementation of Care Court will integrate elements of court based clinical services with field-based engagement operations to support care and treatment in field based community settings. While the final version of the law did not include the mandatory role of a “supporter” person——to work with the client during the court process and treatment planning process and help the CARE Court respondent in supportive decision making - this was an important part of the program which LA County DMH wanted to make sure was included in our implementation. DMH will incorporate peers o support individuals from the time a petition is filed to the point of case dismissal, graduation, or in the process failure when other services could then be explored.

It is DMH’s goal to have Care Court support individuals and their voluntary participation in mental health services within their own communities to stabilize, heal, and thrive ultimately without the necessity of court updates.

As an MHSA Innovation Project, DMH is proposing multiple peer supporters with lived experience to help develop the teams which engage clients at the beginning, middle, and end of the Care Court process. The purpose of the innovation project is for the Care Court process to utilize our peer supporters to develop and operate a client centered multipurpose mental health team to support clients through the entire Care Court process and assist with supported decision making skills. Peer supporters are a powerful voice speaking from their lived experience and have strong positive rapports and relationships often with individuals who are struggling with their risk of homelessness, institutionalization, incarceration, out-of home placement, or other serious health consequences due to long periods without proper care. An advocate with lived experience can provide a powerful example of Recovery, Wellbeing, and Hope.

DMH Peer Supporter Team members will be imbedded within the Care Court multidisciplinary mobile teams (stationed at the courthouse and in the community) to:

- Support prospective care court clients during their court appearances, court related appointments, and other meetings

- Provide transportation and attend appointments with individuals including their health and social appointments, court hearings, or other quality of life activities
- Participate in community outreach and engagement teams to other stakeholder groups sharing about Care Court programs
- Engage individuals recently released from jail and/or prison in coordination with other DMH field based programs to encourage participation in various voluntary services (to avoid Care Court)
- Provide individualized referrals and resources from culturally competent providers for those identifying as members of underserved communities, with military affiliations, and/or conditions which need support to have full and equal access to all services and facilities to meet their needs
- Provide specialized case management for those who have other acute medical concerns and other complex case needs
- Provide supported decision making and if appropriate assist the CARE Court respondent in completing a Psychiatric Advance Directive

The CARE court legislation is new. LACDMH's goal is to be highly successful in the number of individuals who will seek, obtain, and utilize the voluntary mental health services offered by DMH and successfully exit the Care Court process. The MHSA Innovation, having peer supporters be active advocates in the planning, implementation, and ongoing treatment teams during Care Court, is what we believe to be the reason we will see success as measured in defined outcomes/results. We expect through peer supporter participation that:

- the client rates of voluntary participation with mental health treatment programs will be achieved with less outreach activities and time frames
- the notable increase in one's level of overall health, functioning, and wellbeing will be achieved in a shorter time frame
- the longevity of the average length of outpatient treatment will be higher than other non-peer dominant outreach, engagement, and voluntary treatment interventions compared with other clinical settings

We humbly submit this innovation idea for your review, feedback, and welcome an opportunity soon to have an open dialogue and discuss ways to help clients receive treatment in their community full of hope, in recovery, and with wellbeing.

The proposed budget will cover 5 years of programming.

EXISTING PROGRAMS AND SERVICES BY COMPONENT

This section provides FY 2021-22 outcome data for existing MHSA programs and is organized by component: Community Services and Supports, Prevention and Early Intervention, Workforce Education and Training, Capital Facilities and Technological Needs and Innovation.

COMMUNITY SERVICES AND SUPPORTS (CSS)

As the largest component with 76% of the total MHSA allocation, CSS was designed with service categories that shape the integrated system of care for clients diagnosed with SMI. In FY 2021-22, approximately 147,143 unique clients received a direct mental health service through CSS. The two tables below provide additional detail.

The CSS component of the Plan includes the following programs:

- Full Service Partnership (FSP)
- Outpatient Care Services (OCS)
- Alternative Crisis Services (ACS)
- Housing Services
- Linkage to County-Operated Functions/Programs (Linkage)
- Planning, Outreach, and Engagement Services (POE).

Table 8. Clients served through CSS in FY 2021-22

Clients Served	New Clients Served
147,143 clients received a direct mental health service: - 36% of the clients are Hispanic - 20% of the clients are African American - 17% of the clients are White - 4% of the clients are Asian - 1% of the clients are Native American - 80% have a primary language of English - 13% have a primary language of Spanish	42,616 new clients receiving CSS services countywide with no previous MHSA service - 37% of the new clients are Hispanic - 15% of the new clients are African American - 15% of the new clients are White - 3% of the clients are Asian - 0.38% of the clients are Native American - 77% have a primary language of English - 12% have a primary language of Spanish

Table 9. CSS clients served by Service Area

Service Area	Number of Clients Served	Number of New Clients
SA 1 – Antelope Valley	10,969	2,852
SA 2 – San Fernando Valley	21,809	5,574
SA 3 – San Gabriel Valley	20,681	6,945
SA 4 – Metro Los Angeles	29,471	8,331
SA 5 – West Los Angeles	9,699	2,818
SA 6 – South Los Angeles	26,269	6,159
SA 7 – East Los Angeles County	13,027	2,994
SA 8 – South Bay	30,117	8,664

The next few pages provide a summary of information for each CSS program. The summary will include a follow-up on the last approved Three-Year Plan (FYs 2021-24), as well as outcome data for the specific program.

A. Full Service Partnership (FSP)

Status	☒ New	☒ Continuing	☒ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$163,545,000	$115,915,000	$95,397,000

Program Description

FSP programs provide a wide array of services and supports, guided by a commitment by providers to do "whatever it takes" within the resources available to help the highest acuity clients within defined populations make progress on their paths to recovery and wellness.

FSP services are provided by multi-disciplinary teams of professional and paraprofessional and volunteer providers who have received specialized training preparing them to work effectively with children and their families; FSP teams provide 24/7 crisis services and develop plans with families to do whatever it takes within the resources available and the recovery plan agreed between the client and the FSP provider team to help clients meet individualized recovery, resiliency, and development and/or recovery goals or treatment plan; and FSP teams are responsive and appropriate to the cultural and linguistic needs of the child and their family.

Intended Outcomes

Reduce serious mental health systems, homelessness, incarceration, and hospitalization
Increase independent living and overall quality of life

Key Activities

- Clinical services (24/7 assessment and crisis services; counseling and psychotherapy; field-based services; integrated treatment for co-occurring mental health and substance abuse disorder; case management to provide linkages to services to employment, education, housing and physical health care)
- Nonclinical services (peer and parent support services; self-help and family support groups; wellness centers; respite care)

FY 2021-22 ■ FULL SERVICE PARTNERSHIP Update

As part of the previous Three-Year Plan, FSP Programs and services were developed to provide comprehensive mental health services to clients requiring intensive treatment. Services are provided by a multi-disciplinary team based on a specific number of client slots. Services provided to clients enrolled in FSP may include, but are not limited to, 24/7 crisis response (in-person when needed); ongoing intensive mental health treatment; housing services; employment services; and co-occurring mental illness and substance use treatment services. Adult FSP Services aim to help clients, those adults enrolled in Adult FSP Services, increase their ability to function at optimal levels, decrease homelessness and incarcerations, and reduce unnecessary medical and psychiatric urgent care and emergency room visits and hospitalizations. For those Clients that are homeless, Adult FSP Services will help them transition from street to home by providing immediate and on-going assistance with securing and maintaining housing. Child/Young Adult (YA) FSP Services include but are not limited to individual and family counseling, 24/7 assessment and crisis services, Intensive Care Coordination (ICC), and Intensive Home Based Services (IHBS). The intent of these services is to help Clients and/or families increase their ability to function at optimal levels. Existing FSP programs serve children and young adults between the ages of 0-20 and adults 21+.

As of July 1, 2021, LACDMH began to transform the FSP program so that we can best support our highest acuity outpatient consumers on the path to recovery and well-being. This effort included:

- Changing the eligibility criteria to be more focused on those most in need of FSP care;

- Changing the FSP service model to utilize a multidisciplinary team/population approach, rather than individual caseloads;
- Began the integration of all specialty FSP programs into one FSP model (with the exception of Housing FSP which transitioned to housing support);
- Lowering staff to client ratios;
- Adding funding for additional staffing to enable Child FSP programs to provide Intensive Care Coordination (ICC) & Intensive Home Based Services (IHBS);
- Providing enhanced training and technical assistance to support FSP providers in achieving desired outcomes;
- Enhancing services and supports to ensure successful transitions between levels of care;
- Centralizing the authorization, enrollment, and disenrollment processes for FSP to ensure that those highest needs clients are able to access the FSP services;
- Standardizing rates to bring contracted provider staff salaries closer to parity with their counterparts in the LACDMH clinics, as a part of LACDMH's broader rate-setting exercise; and
- Changing the FSP contracts to add incentives for providers to help their clients achieve critical life outcomes, moving our system towards performance-based contracting; and
- Using data, and consumer & provider feedback to drive continuous improvement.

These changes were incorporated into the Service Exhibits within the contracts, which were included in the new Legal Entity agreements that were executed on July 1, 2021. The transformation of the FSP program began on July 1, 2021. Because this program redesign is new for both LACDMH and contract providers, we plan to work with existing FSP providers to pilot this new model over the next 3 years. Lessons learned from this pilot will inform the rebid of FSP contracts for FY 2024-25.

FY 2021-22 ■ FULL SERVICE PARTNERSHIP Data and Outcomes

As of June 30, 2022, LACDMH had 12,788 FSP slots as shown in the next table.

Table 10. FSP Slots summary: age group, slots, average cost per client, and unique clients served

Age Group	Number of Slots
Children (includes Wraparound and Intensive Field Capable Clinical Services)	3,683
Adult (includes Integrated Mobile Health Team, Assisted Outpatient Treatment, and Homeless)	9,105

Table 11. FSP summary: age group, average cost per client, unique clients served and total number to be served

Age Group	Average Cost per Client	Number of Unique Clients Served[1]	Total Number to be served in FY 2023-24[2]
Children	$19,428.14	3,267	3,544
TAY	$14,625	2,504	2,710
Adult	$15,146	6,672	7,145
Older Adult	$12,830	1,782	1,888

[1]Cost is based on Mode 15 services, not inclusive of community outreach ser-vices or client supportive services expenditures.

[2]FY 2023-24 Total Number to be served: Reflects average of two prior years

We assessed the impact of FSP enrollment on client outcomes by measuring changes in the proportions of clients and in the numbers of days spent with homelessness, justice involvement, psychiatric hospitalization, or independent living.

Comparing a client's life before and after, FSP enrollment shows that the program

- Reduces homelessness;
- Reduces justice involvement;
- Reduces psychiatric hospitalization; and
- Increases independent living.

Table 12. Impact of FSP on post-partnership residential outcomes

FSP Program	Percentage by Clients	Percentage by Days
Homeless		
TAY	19% reduction	44% reduction
Adult	30% reduction	66% reduction
Older Adult	27% reduction	58% reduction
Justice Involvement		
TAY	1% reduction	34% reduction
Adult	23% reduction	66% reduction
Older Adult	21% reduction	48% reduction
Psychiatric Hospitalization		
Child	41% reduction	11% increase
TAY	45% reduction	24% reduction
Adult	25% reduction	64% reduction
Older Adult	6% reduction	24% reduction
Independent Living		
TAY	31% increase	34% increase
Adult	45% increase	42% increase

Comparison of residential data for 12 months immediately prior to receiving FSP services (pre-partnership) and for 12 months of residential status while receiving FSP services (post-partnership) for client's outcomes entered through June 30, 2022. Data is adjusted (annualized) by a percentage based on average length of stay in the FSP program. Data must meet data quality standards to be included in the analysis.

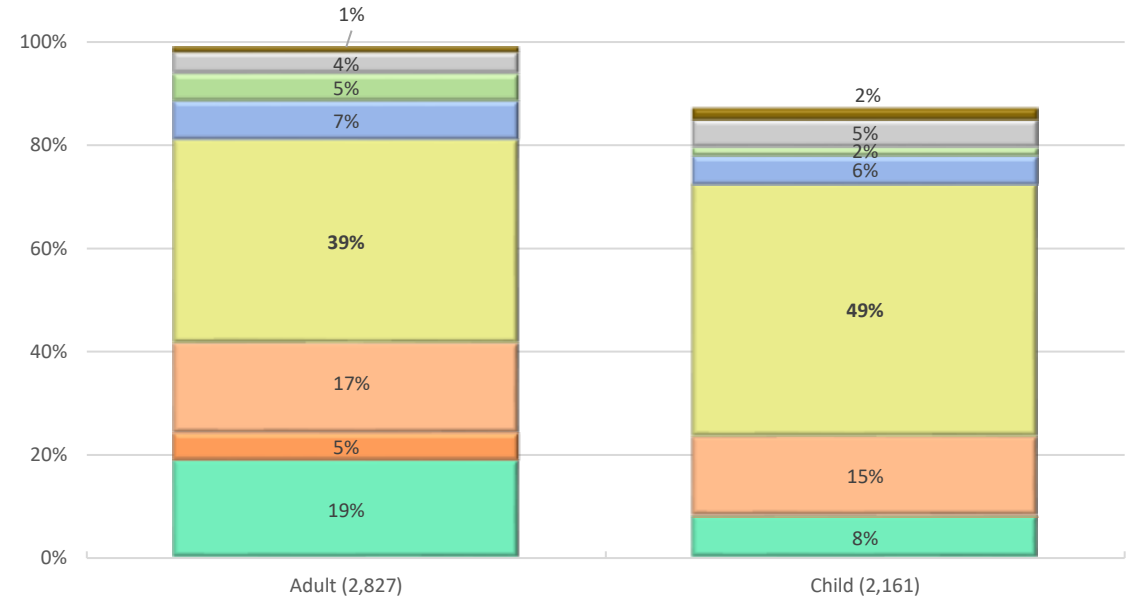
Children (n=13,905)
TAY (n=8,386)
Adult (n=19,337)
Older Adult (n=3,250)
Figures represent cumulative changes, inclusive of all clients through June 30, 2022

FSP disenrollment can apply to either an interruption or a discontinuation of service. An interruption of service is defined as a temporary situation in which the client is expected to return to services within 12 months or less from the date of last contact. A discontinuation of service is defined as a long-term situation in which the client is not expected to return to FSP services for more than 12 months from the date of last contact.

The reasons for disenrollment are as follows:

- Target population criteria not met;
- Client decided to discontinue FSP participation after partnership was established;
- Client moved to another county/service area;
- Client cannot be located after attempts to contact client;
- Community services/program interrupted - client will be detained or incarcerated in the juvenile or adult system for over 90 days;
- Community services/program interrupted - client will require residential/institutional mental health services - Institutions for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC) or State Hospital
- Client has successfully met his/her goals such that discontinuation of FSP is appropriate; or
- Client is deceased.

Figure 8. Reasons for FY 2021-22 FSP disenrollments



- Target population criteria not met
- Client moved to another county/service area
- Client has successfully met his/her goals such that discontinuation of FSP is appropriate
- Client cannot be located after attempts to contact client
- Community services/program interrupted - client is in a residential/institutional facility
- Community services/program interrupted - client is detained
- Client decided to discontinue FSP participation after partnership was established
- Client is deceased

B. Outpatient Care Services

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$234,019,000	$192,090,000	$182,950,000

Program Description

Outpatient Care Services (OCS) provides a broad array of integrated community-based, clinic and/or field-based services in a recovery-focused supportive system of care. This system of care provides a full continuum of services to all age groups. As part of this continuum clients can receive mental health services and supports in a timely manner in the most appropriate setting to meet their needs. OCS is inclusive and strives to provide culturally sensitive and linguistically appropriate services to meet the needs of the diverse communities of Los Angeles County.

The aim is for clients to move toward and achieve self-determined meaningful goals that promote connectedness, mental and physical wellbeing, and meaningful use of time. All age groups will have access to core components of mental health services such as assessments, individual and/or group therapy, crisis intervention, case management, peer support, co-occurring disorders treatment, medication support services (MSS) and Medication Assisted Treatment (MAT). The intensity, location (community/field or office/clinic) and duration of the service(s) will depend on the individualized need of each client and will likely change over time. While most clients generally move from more intensive to less intensive services, some clients may need more intensive services for periods of time due to a variety of factors. These factors include, but are not limited to, the emergence or exacerbation of a severe mental illness; non-adherence to treatment recommendations; a substance use disorder; and exposure to trauma, violence, or external psychosocial stressors such as housing, employment, relationship, or legal problems. These services meet the needs of all age ranges from child to TAY to adults and older adults.

Intended Outcomes

Our aim is to help our clients and families to

- Have a safe place to live
- Have healthy relationships
- Have access to public assistance when necessary
- Weather crises successfully

Key Activities

- Clinical services (individual, group, and family therapy; crisis resolution/intervention; evidence-based treatments; MSS, including MAT; outreach and engagement screenings and assessments to determine the level of functioning and impairment; case management)
- Non-clinical services (peer support; family education and support; co-occurring disorder services; linkage to primary care; housing services; vocational and pre-vocational services)

FY 2021-22 ■ OUTPATIENT CARE SERVICES Data and Outcomes

Table 13. FY 2021-22 Data for clients by Age Group served through various outpatient programs

Age Group	Number of Unique Clients Served
Children, Ages 0-15	19,699
TAY, Ages 16-25	19,166
Adult, Ages 26-59	60,473
Older Adult, Ages 60+	16,740

Table 14. FY 2021-22 Data for unique clients served through various outpatient programs and average cost per client

Unique Clients Served	Average Cost per Client
111,361	$4,278

B1. TAY Probation Camps

LACDMH staff provides MHSA-funded services to youth in camps operated by the Los Angeles County Probation Department, including youth with SED/SMI. LACDMH staff and contract providers are co-located in these camps along with Probation, DHS Juvenile Court Health Services (JCHS), and Los Angeles County Office of Education (LACOE). This inter-departmental team provides coordinated care to the youth housed at the camps.

Youth housed in the camps receive an array of mental health services, including assessments; individual group, and family therapy; medication support; and aftercare and transition services. These services are individually tailored to meet the needs of each youth, including co-occurring disorders and trauma. Interventions include evidence-based practices such as Aggression Replacement Training, Adapted Dialectical Behavior Therapy and Seeking Safety. MHSA funding has made it possible for youth to be housed in a broader array of camps and still receive psychotropic medications.

B2. TAY Drop-In Centers

TAY Drop-In Centers are intended as entry points to the mental health system for homeless youth or youth in unstable living situations. Drop-In Centers provide "low demand, high tolerance" environments in which youth can find temporary safety and begin to build trusting relationships with staff members who can connect them to the services and supports they need. They also help to meet the youths' basic needs such as meals, hygiene facilities, clothing, mailing address, and a safe inside place to rest. Generally, these centers are operated during regular business hours. However, MHSA funding allows for expanded hours of operation during the evenings and weekends when access to these centers is even more crucial.

Table 15. Drop-in Center locations

Service Area	Agency	Address
SA 1	Penny Lane Centers Yellow Submarine	43520 Division Street Lancaster, CA 93535
SA 2	The Village Family Services TVFS TAY Drop-In Center	6801 Coldwater Canyon Blvd North Hollywood, CA 91606
SA 3	Pacific Clinics Hope Drop-In Center	13001 Ramona Blvd Irwindale, CA 91706
SA 4	Los Angeles LGBT Center Youth Center on Highland	1220 N. Highland Ave Los Angeles, CA 90038
SA 5	Daniel's Place Step-Up on Second Street, Inc.	1619 Santa Monica Blvd Santa Monica, CA 90405
SA 6	Good Seed Church of God in Christ, Inc. Good Seed Youth Drop-in Center	2814 W. MLK Jr., Blvd Los Angeles, CA 90008
SA 7	Penny Lane Centers With A Little Help from My Friends	5628 E. Slauson Ave Commerce, CA 90040
SA 8	Good Seed Church of God in Christ, Inc. Good Seed on Pine Youth Drop-In Center	1230 Pine Ave Long Beach, CA 90813

B3. Integrated Care Program (ICP)

ICP is designed to integrate mental health, physical health, substance abuse, and other needed care such as nontraditional services to more fully address the spectrum of needs of individuals. The ICP service array will support the recovery of individuals with particular attention to those who are homeless and uninsured. ICP promotes collaboration and partnerships by and between service providers and community-based organizations utilizing an array of services that may include traditional and non-traditional services.

The target population for the ICP is individuals with SMI or SED who meet the Medi-Cal medical necessity criteria for receiving specialty mental health services, including those with co-occurring substance abuse and/or physical health issues, who are economically disadvantaged or uninsured.

B4. Transformation Design Team

The Older Adult Transformation Team provides system support to develop the infrastructure of older adult services within MHSA. The team monitors outcome measures utilized in the FSP utilizes performance-based contracting measures to promote program services.

This team is comprised of two health program analyst positions. The goal of the team is to ensure that our older adult consumers receive appropriate and timely mental health services from our provider agencies, and they do this by providing data and analytic support to their Program Manager and the Client Supportive Services team as they complete their regular site visits. Additionally, the Transformation Team reviews all aspects related to contracts, compliance, service delivery, operations, and budgets, and generates detailed reports to evaluate programmatic design and effectiveness.

B5. Service Extenders

Service Extenders are volunteers and part of the Older Adult RRR inter-disciplinary team. They are consumers in recovery, family members, or other individuals interested in working with older adults. They receive specialized training to serve as members of the team and are paid a small stipend. Service extenders receive supervision from professional clinical staff within the program in which they are placed.

B6. Older Adult Training

The Older Adult (OA)Trainings via Outpatient Service Division were impacted as a result of COVID-19, LA County restrictions. Below are the OA trainings which addresses the training needs of existing mental health professionals and community partners by providing the following training topics: medical/legal aspects, elder abuse, older adult consultation training, older adult law/abuse training, sleep impairments, co-occurring disorders, Medication in older adults, geriatric psychiatry, cognitive impairments, screening measures, Chronic Pain, Family Caregiving & Alzheimer's and evidence-based practices.

The following are achievements/highlights for FY 2021-22:

- **Older Adult Consultation Medical Doctor's (OACT-MD) Series:** Outpatient Services Division conducted this **ongoing** OACT-MD Series for training and consultation for psychiatrists, nurse practitioners, nurses & mental health clinicians to improve the accessibility and quality of mental health services for Older Adults.
    - **Neuropsychiatric Manifestations of COVID-19:** The Training provided a brief overview of societal effects of the COVID-19 pandemic on mental health. The presentation will serve to increase the familiarity with short-term and long-term neuropsychiatric complications of COVID-19 including depression, anxiety, stroke, delirium, dementia and PTSD. Lastly, the presentation provided a discussion for future investigation into neuropsychiatric sequelae of COVID-19.

- **Sleep: An Overview, Select Disorders in Older Populations and Treatment:** The training focused on sleep disorders, which disproportionately affect older populations and relevant information for clinicians and non-clinicians working with older adults. Discussion included primary insomnia and sleep disorders in dementia. Both pharmacologic and non-pharmacologic treatments were also discussed.
- **Psilocybin As Treatment for Existential Anxiety and Demoralization in Terminal Illness:** The training consisted of a discussion on the history of psychedelic use in general, for medicinal and spiritual purposes around the world. The presentation discussed its recent resurgence as a means of treatment for a variety of psychiatric conditions, and specifically for advanced cancer, focused on potential palliative effects in end of life settings associated with existential anxiety, distress, and demoralization.
- **Chronic Pain in Older Adults: A Neuroscience-Based Psychological Assessment and Treatment Approach:** The following training examined relationships between stress, emotions, the brain, and subtypes of chronic pain. In addition, the trainer identified disparities in care for treatment of patients with chronic pain. The training also provided a brief, integrative assessment to elicit evidence of pain centralization. Finally, the training discussed the use of basic principles from Pain Reprocessing Therapy (PRT) and Emotional Awareness and Expression Therapy (EAET) to address centralized chronic pain in older adults.

- **Medications for Serious Mental Illness: What Non-Prescribers Need to Know:**
  This training discussed the barriers to medication adherence. The training included discussions on cultural considerations, to approaching conversations about medications. It provided participants knowledge in developing an understanding of the positive outcomes that derive from medication adherence, and potential solutions for clients that are struggling with medication non-adherence.
- **Older Adult Legal Issues/Elder Law Trainings and Consultation:** OASOC as part of **ongoing** multi-disciplinary Older Adult Consultation team trainings, provided training and Elder Law consultation, curriculum training development and coordination on Elder Law for DMH and DMH-contracted clinical and non-clinical staff on best practices for working with Older Adult populations.
- **Medical Legal Pre-Elective Part I:** The purpose of this training is to educate participants on cognitive screening test, elements of decision-making capacity and legal report in the context of geriatric patients who requires evaluation for

conservatorship, testamentary capacity, undue influence, and other relevant issues that involve the overlap between geriatrics and the law.

- **Medical Legal Elective Part II Direct and Cross Examination:** The following training will educate mental health participants on strategies for expert witness court testimony specific to older adults with cognitive impairments. This training will prepare medical doctors and psychologists on ethnically diverse older adult cases with practiced simulated direct and cross examination situations.
- **Medical Legal Elective Part III Simulated Trails:** The following training will educate mental health participants on strategies for expert witness court testimony specific to older adults with cognitive impairments. The training will describe the evolution of mock trials and be involved in a simulated actual case, including practicing attorneys, and an experienced judge in a condensed version of a trial.
- **Effective Techniques in Working with Individuals with Mild to Moderate Cognitive Impairment:** A training request from LA County Board of Supervisor. The training outlined different types of cognitive impairment often observed among older adults, including normal aging, mild cognitive impairment, dementia, and impairments resulting from COVID and/or pandemic conditions.
- **Family Caregiving and Alzheimer's Disease:** The training provided a working definition of dementia, identify possible symptoms, and discuss techniques to help address problematic behaviors. Discussion will include identifying signs of potential abuse, enhancing communication, examining healthy coping strategies and identifying new treatments and policies that give families hope for the future. Finally, the training provided valuable information regarding the challenges of family caregiving who attend to individuals suffering from Alzheimer's Disease.
- **Problem Solving Treatment (PST):** Problem Solving Treatment (PST) is a brief intervention and will offer experiential activities to enhance clinical skills thereby supporting the model's effectiveness.
- **The Use of Cognitive Screening Measures: The Mini Mental State Exam (MMSE).** The purpose of this training is to provide an overview of a cognitive screening tool as well as hands on-experience using The Mini Mental State Exam (MMSE).

FY 2023-24 ■ OUTPATIENT CARE SERVICES Continued Work
In the next three years, the coming enhancements to improve service delivery will be the modernized Call Center to assist in access to services and the most appropriate level of care. LACDMH will also be building up and supporting capacity to ensure successful transitions from higher levels of care.

C. Alternative Crisis Services

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☐ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$132,177,000	$138,993,000	$132,069,000

Program Description

Alternative Crisis Services (ACS) provides a comprehensive range of services and supports for mentally ill individuals that are designed to provide alternatives to emergency room care, acute inpatient hospitalization and institutional care; reduce homelessness; and prevent incarceration. These programs are essential to crisis intervention and stabilization, service integration, and linkage to community-based programs, e.g., FSP and Assertive Community Treatment programs, housing alternatives, and treatment for co-occurring substance abuse. ACS serves individuals 18 years of age and older of all genders, race/ethnicities, and languages spoken.

In 2019, Countywide Resource Management integrated with the Managed Care Division and changed its name to the Intensive Care Division. It remains responsible for overall administrative, clinical, integrative, and fiscal aspects of programs that serve the most severely ill individuals with mental illness. This includes planning, developing, and implementing urgent care centers and enriched residential programs for these specialized populations. Also, it coordinates functions to maximize the flow of clients between various levels of care and community-based mental health services and supports.

LACDMH MHSA ACS programs:

- Residential and Bridging Care (RBC) Program
- Psychiatric Urgent Care Centers
- Enriched Residential Services (ERS)
- Crisis Residential Treatment Programs (CRTP)
- Law Enforcement Teams (LET)
- Restorative Care Villages
- Psychiatric Mobile Response Teams (PMRT)

Intended Outcomes

- Reduce utilization of psychiatric emergency rooms and inpatient acute psychiatry
- Reduce incarceration of persons with severe and persistent mental illness

Key Activities

- Divert clients as appropriate to mental health urgent cares
- Divert clients as appropriate to Crisis Residential Treatment Programs
- Utilize mental health clinician teams in the fields as alternatives to crisis response

FY 2021-22 ■ ALTERNATIVE CRISIS SERVICES Data and Outcomes

During FY 21-22, LACDMH continued its investment in the development of PSH for homeless or chronically homeless individuals and families who are living with SMI or serious emotional disturbances (SED).

C1. Residential and Bridging Program (RBC)

RBC involves psychiatric social workers and peer advocates assisting in the coordination of psychiatric services and supports for TAY, Adults, and Older Adults with complicated psychiatric and medical needs. The program ensures linkages to appropriate levels and types of mental health and supportive services through collaboration with Service Area Navigators, FSP, residential providers, self-help groups, and other community providers. Peer advocates provide support to individuals in subacute settings, Enriched Residential Services (ERS) facilities, and intensive residential programs to successfully transition to community living.

The County Hospital Adult Linkage Program is part of the RBC program. Its mission is to assist in the coordination of psychiatric services for LACDMH clients at County hospitals operated by DHS to ensure clients are discharged to the appropriate level of care and that they are provided relevant mental health, residential, substance abuse, or other specialized programs. This program promotes the expectation that clients are successfully reintegrated into their communities upon discharge and that all care providers participate in client transitions.

C2. Psychiatric Urgent Care Centers (UCC)

Psychiatric UCCs are Medi-Cal certified and Lanterman Petris Short (LPS) designated free-standing crisis stabilization units that provide rapid access to mental health evaluation and assessment, crisis intervention and medication support 24-hours per day, 7 days per week. UCCs also provide case management for individuals experiencing psychological distress and/or psychiatric crisis. UCC services, including integrated services for co-occurring disorders, are focused on stabilization and linkage to recovery-oriented community-based resources. Clients are permitted to stay in the UCC chair 23 hours and 59 minutes that are licensed by the California Department of Health Care Services.

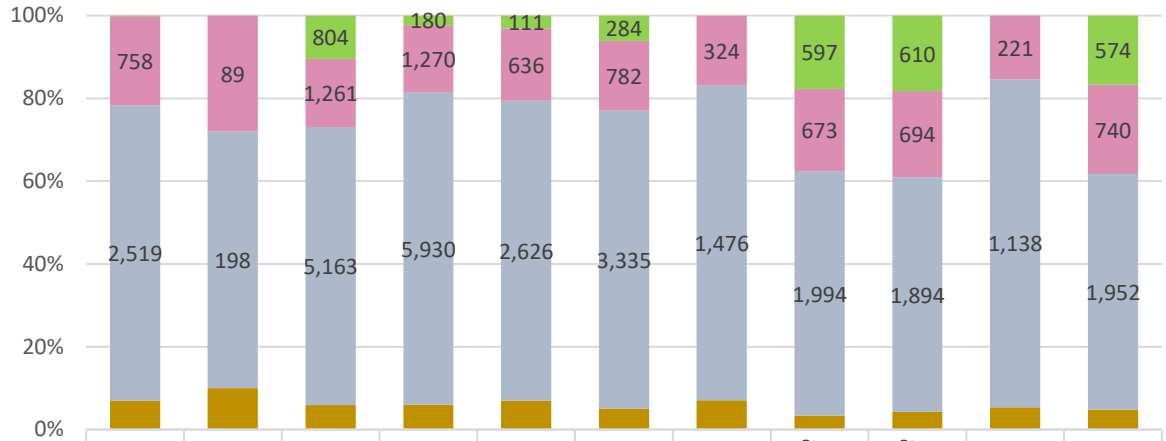
Table 16. Location of the current UCCs

Urgent Care Center	Service Area	Location	Address	Phone
Starview High Desert	1	Lancaster	415 East Avenue I Lancaster, CA 93535	Ph: (661) 522-6770 Fax: (661) 723-9079
Behavioral Health UCC	2	San Fernando Valley	14228 Saranac Lane Sylmar, CA 91342	Ph: (747) 315-6108 Office: (747) 315-6100
Olive View Community Care Services (OV UCC)	2	San Fernando Valley	14445 Olive View Drive Sylmar, CA 91342	(747) 210-3127
Star View BHUCC	3	East – City of Industry/East San Gabriel	18501 Gale Ave. Ste. 100 City of Industry, CA 91748	Ph: (626) 626-4997
Exodus (Eastside UCC)	4	Downtown Los Angeles	1920 Marengo Street Los Angeles, CA 90033	Ph: (323) 276-6400 Fax: (323) 276-6498
Exodus (Westside UCC)	5	West Los Angeles	11444 W. Washington Blvd., Ste D. Los Angeles, CA 90066	Ph: (310) 253-9494 Fax: (310) 253-9495
Exodus (MLK UCC)	6	South Los Angeles	12021 S. Wilmington Ave., Los Angeles, CA 90059	Ph: (562) 295-4617
Exodus (Harbor UCC)	8	Harbor-UCLA/Torrance	1000 W Carson Street, Bldg. 2 South Torrance, CA 90502	Ph: (424) 405-5888
Providence Little Company of Mary OBHC[2]	8	San Pedro	1300 W. 7th Street San Pedro, CA 90732	Ph: (310) 832-3311
Star View BHUCC	8	Long Beach	3210 Long Beach Blvd. Long Beach, CA 90807	Ph: (562) 548-6565
Telecare (La Casa[1] MHUCC[2])	SA 8	Long Beach	6060 Paramount Blvd. Long Beach, CA 90805	Ph: (562) 790-1860 Fax: (562) 529-2463

1 La Casa is an exception; it is not open 24-hours per day, 7 days a week. It is LPS-designated.
2 MHUCC = Mental Health UCC; OBHC = Outpatient Behavioral Health Center

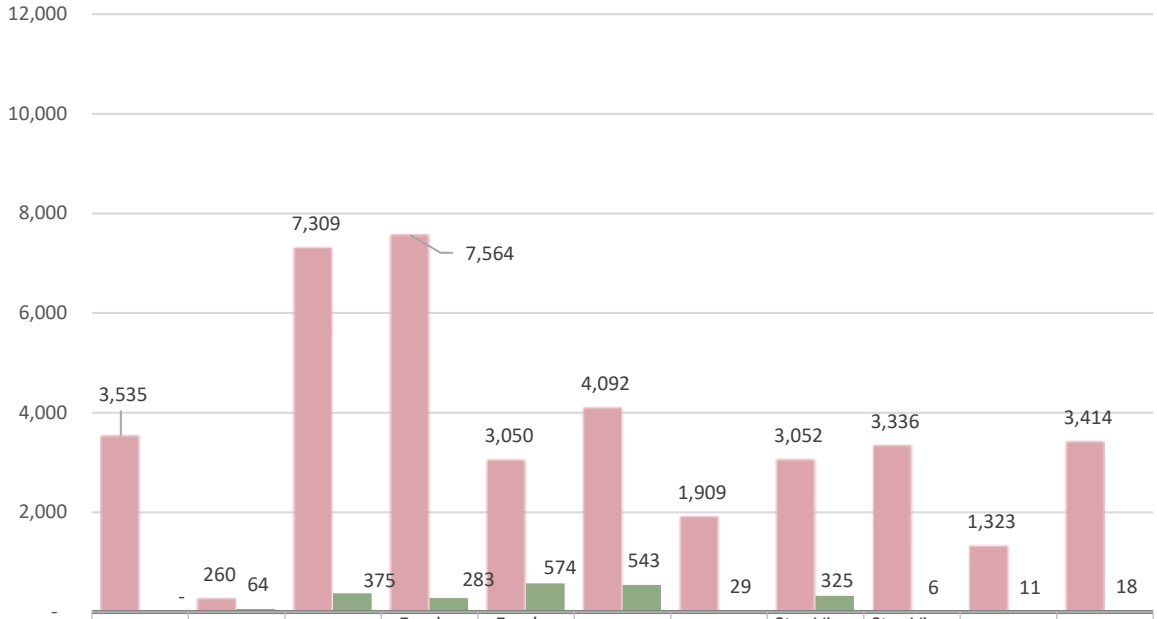
The following graphs provide an overview of FY 2021-22 outcomes of the UCCs. Olive View UCC has two components: Crisis Stabilization Unit (CSU) - 7913 and Outpatient UCC - 7591 that does not operate 24/7.

Figure 9. FY 2021-22 UCC New admissions by age group



	OV UCC 7591	OV CSU 7913	Exodus MLK UCC	Exodus Eastside UCC	Exodus Westside UCC	Exodus H-UCLA UCC	Providence OBHC	Star View Long Beach	Star View City of Industry	Telecare MHUCC	High Desert
Child	6	0	804	180	111	284	1	597	610	0	574
TAY	758	89	1,261	1,270	636	782	324	673	694	221	740
Adult	2,519	198	5,163	5,930	2,626	3,335	1,476	1,994	1,894	1,138	1,952
Older Adult	247	32	455	467	254	234	137	113	144	77	166

Figure 10. Clients with a psychiatric emergency assessment within 30 days of a UCC assessment

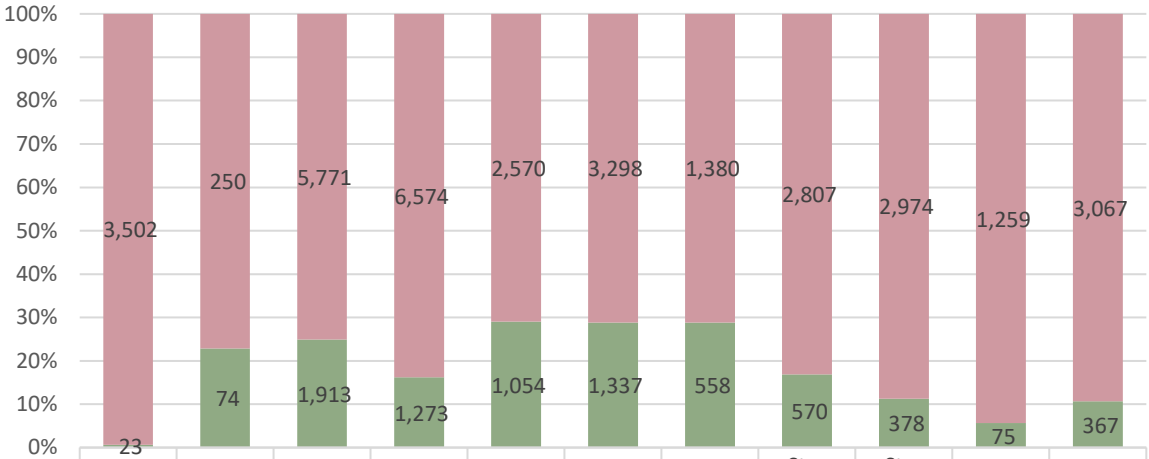


	OV UCC 7591	OV CSU 7913	Exodus MLK UCC	Exodus Eastside UCC	Exodus Westside UCC	Exodus H-UCLA UCC	Providence OBHC	Star View Long Beach	Star View City of Industry	Telecare MHUCC	High Desert
No	3,535	260	7,309	7,564	3,050	4,092	1,909	3,052	3,336	1,323	3,414
Yes	-	64	375	283	574	543	29	325	6	11	18

Figure 11. Clients returning to UCC within 30 days of prior UCC visit

	OV UCC 7591	OV CSU 7913	Exodus MLK UCC	Exodus Eastside UCC	Exodus Westside UCC	Exodus H-UCLA UCC	Providence OBHC	Star View Long Beach	Star View City of Industry	Telecare MHUCC	High Desert
No	2,196	294	7,214	7,454	3,442	4,367	1,851	3,000	2,854	1,289	2,820
Yes	1,329	30	470	393	182	268	87	377	488	45	612

Figure 12. Clients who were homeless upon admission to UCCs



	OV UCC 7591	OV CSU 7913	Exodus MLK UCC	Exodus Eastside UCC	Exodus Westside UCC	Exodus H-UCLA UCC	Providence OBHC	Star View Long Beach	Star View City of Industry	Telecare MHUCC	High Desert
No	3,502	250	5,771	6,574	2,570	3,298	1,380	2,807	2,974	1,259	3,067
Yes	23	74	1,913	1,273	1,054	1,337	558	570	378	75	367

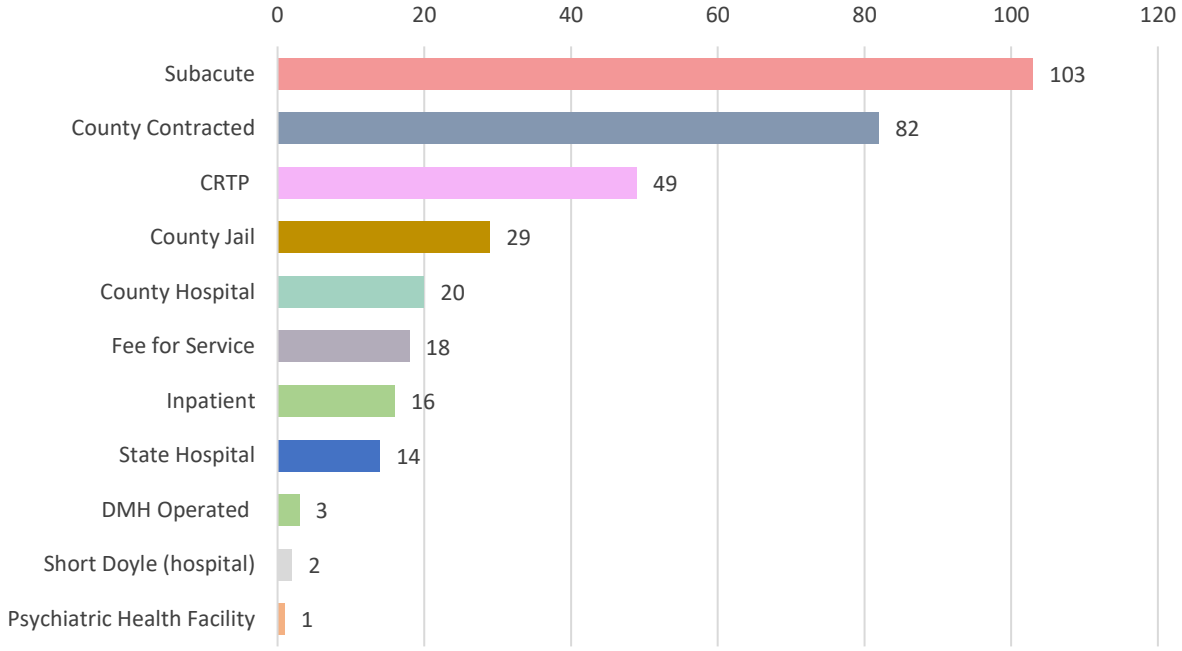
C3. Enriched Residential Services (ERS)

ERS is designed to provide supportive on-site mental health services at selected licensed Adult Residential Facilities, and in some instances, assisted living, congregate housing or other independent living situations. The program also assists clients transitioning from acute inpatient and institutional settings to the community by providing intensive mental health, substance abuse treatment and supportive services.

Table 17. Enriched Residential Services Facilities

Anne Sippi Clinic 5335 Craner Ave. North Hollywood, CA 91601 Ph: (818) 927-4045 Fax: (818) 927-4016	Bridges – Casitas Esperanza 11927 Elliott Ave. El Monte, CA 91732-3740 Ph: (626) 350-5304	Cedar Street Homes 11401 Bloomfield St. Bldg. 305 Norwalk, CA 90650 Ph: (562) 207-9660 Fax: (562) 207-9680	Percy Village 4063 Whittier Blvd., Suite #202 Los Angeles, CA 90023 (323) 268-2100 ext. 234 Fax (323) 263-3393 eFax 323-983-7530
Telecare 7 4335 Atlantic Blvd. Long Beach, CA 90807 Ph: (562) 216-4900 Fax: (562) 484-3039	Normandie Village East– 1338 S. Grand Ave Los Angeles, CA 90015 Ph: (213) 389-5820 Fax: (213) 389-5802	Special Services for Groups (SSG) 11100 Artesia Blvd. Ste. A Cerritos, CA 9070 Ph: (562) 865-1733 Fax: (213) 389-7993	

Figure 13. Source of client referrals for ERS admissions (n =339)



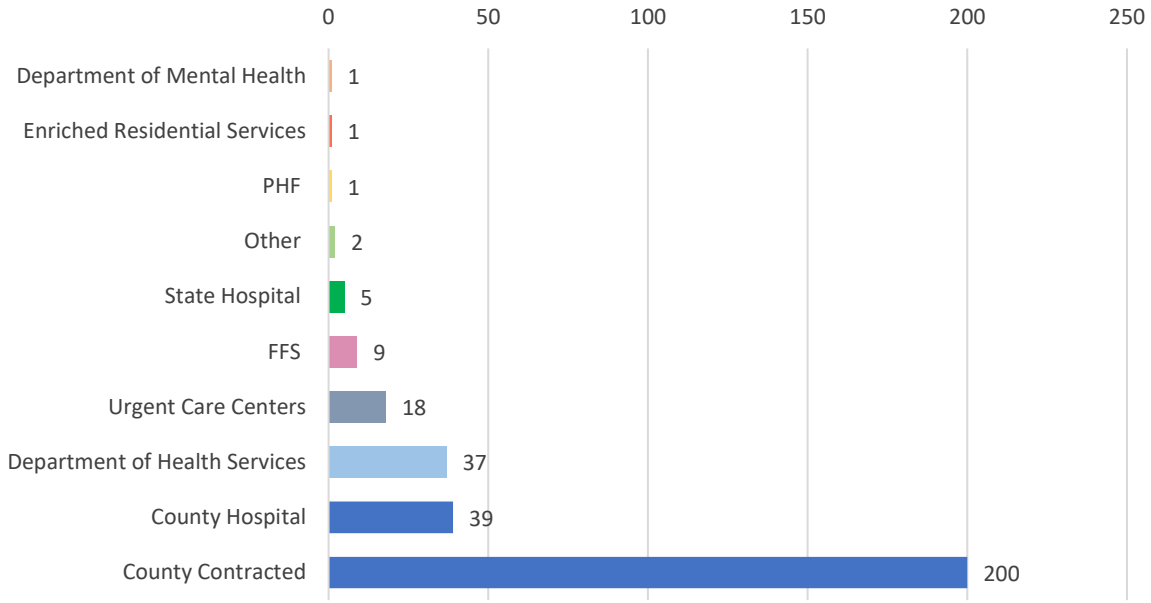
C4. Crisis Residential Treatment Programs (CRTP)

CRTPs are designed to provide short-term, intensive, and supportive services in a home-like environment through an active social rehabilitation program that is certified by the California Department of Health Services and licensed by the California Department of Social Services, Community Care Licensing Division. They are designed to improve the lives and adaptive functioning of those they serve. Those admitted to a CRTP can be expected to receive an array of services including self-help skills, peer support, individual and group interventions, social skills, community re-integration, medication support, co-occurring services, pre-vocational/ educational support, and discharge planning.

Table 18. List of current CRTPs

Hillview Crisis Residential 12408 Van Nuys Blvd., Bldg. C Pacoima, CA 91331 Ph: (818) 896-1161 x 401	Didi Hirsch Excelsior House DiDi Hirsch Comm. MH 1007 Myrtle Ave. Inglewood, CA 90301 Ph: (310) 412-4191 Fax: (310) 412-3942	Didi Hirsch Jump Street CRTP DiDi Hirsch Comm. MH 1233 S. La Cienega Blvd. Los Angeles, CA 90035 Ph: (310) 895-2343 Fax: (310) 855-0138
Exodus CRTP 3754-3756 Overland Avenue Los Angeles, CA 90034 Ph: (424) 384-6130 Fax: (213) 265-3290	Freehab (Teen Project) CRTP 8142 Sunland Blvd., Sun Valley, CA 91352 Phone: (818) 582-8832 Fax: (818) 582-8836	Gateways CRTP 423 N. Hoover Street Los Angeles, CA 90004 Ph: (323) 300-1830 Fax: (323) 664-0064
Safe Haven CRTP – 12580 Lakeland Rd. Santa Fe Springs, CA 90670 Phone: (562) 210-5751	SSG Florence House CRTP 8627 Juniper Street Los Angeles, CA 90002 Phone: (323) 537-8979	Valley Star MLK CRTP 12021 Wilmington Ave. Los Angeles, CA 90059 Phone: (213) 222-1681
Telecare Olive House CRTP 14149 Bucher Ave. Sylmar, CA 91342 Phone: (747) 999-4232	Telecare Citrus House CRTP 7725 Leeds Street Bldg. D Downey, CA 90242 Phone: (562) 445-3001	Telecare Magnolia House CRTP 1774 Zonal Ave RTP, Bldg. D Los Angeles, CA 90033 Phone: (323) 992-4323
Central Star Rancho Los Amigos 7745 Leeds St. Downey, Ca 90242 Phone: (562) 719-2866		

Figure 14. Source of Client Referrals for Crisis Residential Facility Admissions (n =465)



C5. Law Enforcement Teams (LET)

The countywide police and mental health co-responder teams consist of LACDMH staff working collaboratively with local police departments in Los Angeles County. The primary mission of LET is to assist patrol officers when responding to 911 calls involving persons with a mental illness. These crisis intervention services are aimed to reduce incarcerations, mitigate police use of force, and allow patrol officers to return quickly to patrol duties.

The County's diverse population requires compassionate and equitable intervention methods across the spectrum of care. LACDMH serves those most vulnerable and at-risk in our community through expanded personalized programs and collaboration with other County departments.

LET co-response teams consist of a law enforcement officer and a LACDMH mental health clinician who respond to 911 calls involving mental health crises. These teams ensure that the individuals in crisis receive appropriate, specialized care and safe transportation to the treatment facilities. LET and LACDMH's Psychiatric Mobile Response Teams (PMRT) support one another as resources permit. Mental health clinicians have already been assigned to work with 40 of the 46 police departments throughout the County.

During FY 2021-22, there were 12,446 incidents, of which 29% involved homeless individuals; 6% resulted in arrests; and 59% required hospitalizations.

C6. Psychiatric Mobile Response Teams (PMRT)

PMRT provides non-law enforcement-based mobile crisis response for clients experiencing a psychiatric emergency in the community. PMRT consists of LACDMH clinicians designated to perform evaluations for involuntary detention of individuals determined to be at risk of harming themselves or others, or who are unable to provide food, clothing, or shelter for themselves. PMRT enables successful triage of each situation involving mentally ill, violent or high-risk individuals. PMRT provides caring, deescalating and less traumatizing approaches to crisis intervention—and whenever possible avoids outcomes that involve hospitalization, incarceration, or additional injury. PMRTs' tactics support clients and their families through trust and attention, and ultimately contribute to reducing stigma surrounding

mental health and accessing help.

PMRTs also receive community calls that do not rise to the level of direct services; in these situations, staff provide information, referrals, and other kinds of alternative support. More than 23 entities send referrals to PMRT, making it a critical source of care and response across LA County.

■ **ALTERNATIVE CRISIS SERVICES Continued Work**

- LACDMH will continue to look for opportunities to enhance MHSA ACS funded program leveraging other potential funding sources while ensuring existing resources meet the varied needs of those served. Recent activities and future plans include:
- Focus on prevention and diversion to subacute and open residential treatment beds, as well as crisis residential beds that will help decompress County hospital beds
- Secure Measure J funding to expand treatment beds (UCCs, sobering centers, CRTPs, peer respite); acute, subacute, board and care, and congregate housing; and expand LET by an additional 10 teams to service different parts of the County
- Increase placement options at various levels of care to help fill current gaps/lack of availability of "back-end" referral resources for diversion and linkage

F. Housing

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☐ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$69,147,000	$45,289,000	$40,593,000

Program Description

The Department of Mental Health (DMH) provides a wide variety of housing resources and services for individuals who have a serious mental illness and are homeless or at risk of homelessness. In FY 2021-22, the Housing Services budget for the DMH Housing and Job Development Division (HJDD) and related programs totaled $76.1 million, of which $46 million was funded with Mental Health Services Act (MHSA) dollars. This report provides updates on the housing programs funded with MHSA support, with budget details specific for each program included in the chart below.

DMH HOUSING SERVICES BUDGET, FY 2021-22

Program Name	Budgeted Amount	MHSA Amount	MHSA %
Housing Supportive Services Program	$ 23,090,184	$ 3,410,706	15%
Intensive Case Management Services Program	$ 6,200,000	$ 6,200,000	100%
Housing for Mental Health	$ 10,000,000	$ 10,000,000	100%
Housing Assistance Program	$ 2,408,566	$ 1,169,115	49%
Enriched Residential Care Program	$ 17,841,612	$ 9,122,067	51%
Interim Housing Program - Adults	$ 13,987,179	$ 13,824,179	99%
Enhanced Emergency Shelter Program - TAY*	$ 2,638,853	$ 2,328,853	88%
Total	**$ 76,166,394**	**$ 46,054,920**	**60%**

Intended Outcomes

- Assist LACDMH clients who are homeless to obtain interim housing and permanent housing
- Assist LACDMH clients living in permanent housing to retain housing
- Increase the overall number of interim and permanent supportive housing (PSH) units and rental subsidies targeting LACDMH clients

Key Activities

- Provide immediate interim housing and supportive services to LACDMH clients who are homeless to get them off the streets
- Provide financial assistance to help LACDMH clients transition from homelessness to permanent housing (e.g., rental subsidies, security deposits, utility assistance, furniture, household goods, etc.)
- Provide mental health, case management and housing retention services to LACDMH clients who are formerly homeless and living in permanent housing
- Invest in the capital development of PSH for individuals who are homeless and have a SMI/SED in partnership with the Los Angeles County Development Authority (LACDA) and through the use of No Place Like Home funding and managing the current portfolio of PSH to ensure the intended population is targeted

D1. Capital Investments Program

Since 2008, DMH has invested over $1 billion in MHSA funding toward the development of project-based Permanent Supportive Housing (PSH) in Los Angeles County for individuals and families who are homeless and living with a serious mental illness or severe emotional disorder. The below chart details these one-time capital investments and the corresponding amounts.

Table 19. One-Time Capital Investments

DMH ONE-TIME CAPITAL INVESTMENTS (2008 – Present)		
Program Name	**MHSA Amount**	
No Place Like Home	$	744,903,877
Special Needs Housing Program/MHSA Housing Program	$	155,000,000
Mental Health Housing Program	$	103,300,000
Total	**$**	**1,003,203,877**

To date, $778.2 million of this $1.003 billion in MHSA funding has been committed toward the implementation and administration of capital efforts including providing capital funding for 154 PSH developments and 3,912 PSH units as well as providing capitalized operating subsidies for 13 of these developments to help make the units affordable for individuals with limited income. These PSH developments and units are intended to serve a wide range of DMH clients. Their target populations are further detailed in the chart below.

Table 20. MHSA Project-Based Permanent Supportive Housing Developments

TARGET POPULATION	NUMBER OF MHSA PROJECT-BASED PSH DEVELOPMENTS	NUMBER OF MHSA PROJECT-BASED PSH UNITS
Adults	87	2,427
Families	10	270
Older Adults	26	619
TAY	19	344
Veterans	12	252
TOTAL	**154**	**3,912**

By the end of FY 2021-22, 60 of the 154 PSH developments had finished construction, resulting in 1,479 units available for occupancy. PSH units ranged in size from studio to four-bedroom apartments and, throughout the fiscal year, provided housing for a total of 1,882 adult clients and adult family members along with 162 minor children. Specifically, during FY 2021-22, 15 PSH developments comprising 327 units began leasing up and 316 of those units were occupied by June 30, 2022. The other two developments will complete their lease up in the next fiscal year. Overall, the housing retention rate for the Capital Investments Program was 95%.

Included as part of DMH's $744 million No Place Like Home (NPLH) capital investment is $100 million that has been set aside to develop PSH on each of the County's five medical center campuses. This housing will be part of the Restorative Care Villages initiative, which will provide a continuum of clinical care and supportive services such as recuperative and respite care, psychiatric urgent care and Crisis Residential Treatment Program beds in addition to PSH. On October 19, 2021, the Los Angeles County Development Authority (LACDA), in partnership with DMH, released a Request for Proposals (RFP) to select a PSH developer for the first of the five Restorative Care Village sites, LAC+USC. Century Housing was recommended to receive the funding and is proposing a 300-unit project with 150 units targeting individuals who are homeless and who have a serious mental illness. DMH will continue to work with LACDA on developing RFPs for the other Restorative Care Village sites.

D2. Federal Housing Subsidies Unit

In addition to supporting project-based PSH, DMH maintained its 19 contracts with the City and County of Los Angeles Housing Authorities that provide DMH clients who are homeless with access to federal tenant-based PSH subsidies through such programs as Continuum of Care, Tenant Based Supportive Housing, Mainstream Voucher and Section 8. These subsidies make units affordable by allowing clients to pay 30% of their income as rent, with the balance paid to the property owner by the Housing Authority. DMH leverages MHSA-funded specialty mental health services, which are provided to DMH clients who access these tenant-based subsidies, to meet the match requirement for the Continuum of Care program. Leveraged services include the full range of specialty mental health services provided by DMH clinicians and case managers including housing supports such as assisting clients with the application, interview and housing location process as well as supporting clients in maintaining their housing once they move in.

During FY 2021-22, DMH Housing Authority contracts supported 2,778 tenant-based PSH units. These units helped to provide housing to 3,085 individuals, which included 1,821 single adults and 518 adults who had family members living with them including 746 minor children. New units that were leased up during the fiscal year totaled 315. The housing retention rate for DMH clients residing in these tenant-based PSH units was 94%.

D3. Supportive Services for Individuals in PSH

During FY 2021-22, Los Angeles County continued to use an integrated multi-Department service model to provide individuals living in PSH with the supportive services needed to promote housing stability and retention and to meet their recovery goals. Through this model, PSH residents were able to access specialty mental health services through the DMH Housing Supportive Services Program (HSSP), case management services through the Department of Health Services (DHS) Intensive Case Management Services (ICMS) program and substance use services through the Department of Public Health (DPH) Substance Abuse Prevention and Control (SAPC) Client Engagement and Navigation Services (CENS) program.

MHSA and County Measure H funding were used to provide 1,356 individuals with HSSP services throughout the course of the fiscal year including such services as individual and group therapy, crisis intervention and medication management. MHSA dollars were also used to fund ICMS for 1,183 individuals living in MHSA-funded PSH units and other PSH units targeting individuals with mental illness. Many of those in PSH received both HSSP and ICMS services.

D4. Housing for Mental Health

The Housing for Mental Health (HFMH) program uses MHSA funds to provide ongoing rental subsidies, as well as funding for security deposits, utility assistance and household goods, for highly vulnerable individuals with a serious mental illness who are enrolled in a FSP Program and are homeless. Twenty percent of HFMH rental subsidies are for individuals who were referred to FSP by the DHS Office of Diversion and Reentry and have criminal justice involvement. The HFMH program also collaborates closely with DHS ICMS teams who work alongside FSP staff to assist clients with obtaining and retaining housing.

As of June 30, 2022, a total of 490 DMH clients were in permanent housing supported by the HFMH program. Throughout the fiscal year, 104 individuals were newly referred to the program and 92 individuals newly moved into housing. Recognizing that the housing needs of referred clients vary, HFMH rental subsides can be used for various types of permanent housing including tenant-based PSH, project-based PSH at one of eight partnering housing developments and licensed residential facilities. The chart below details the types of permanent housing to which clients were referred as well as where they moved in. The housing retention rate for the HFMH program was 92%.

Table 21. Housing for Mental Health Program Client Referrals

HFMH HOUSING TYPE	TOTAL IN HOUSING	NEW REFERRALS	NEW MOVE-INS
Tenant-Based PSH	282	33	37
Project-Based PSH	186	63	49
Licensed Residential Facility	22	8	6
TOTAL	**490**	**104**	**92***

* Clients included in this total may have been referred to HFMH in FY 2020-21.

D5. Housing Assistance Program

The Housing Assistance Program (HAP) uses MHSA and other funding to assist DMH clients including directly-operated Full Service Partnership (FSP) clients who are homeless or at-risk of homelessness and who have limited or no income with security deposits, utility deposits, household goods, one-time rental assistance, time-limited rental assistance, permanent rental subsidies, eviction prevention assistance and client supportive services (CSS). In FY 2021-22, HAP provided financial assistance to 946 households. The chart below provides details on the number of clients receiving each type of HAP service.

Table 22. Housing Assistance Program Households Served

HAP SERVICE TYPE	NUMBER OF HOUSEHOLDS SERVED
Security Deposits	330
Utility Deposits	19
Household Goods	374
One-Time Rental Assistance	3
Time-Limited Rental Assistance	110

HAP SERVICE TYPE	NUMBER OF HOUSEHOLDS SERVED
Permanent Rental Subsidies	53
Eviction Prevention	1
Directly-Operated TAY FSP Housing Supports	5
Directly-Operated Adult FSP Housing CSS Supports	51
TOTAL	**946**

D6. Enriched Residential Care Program

The Enriched Residential Care (ERC) program assists DMH clients to obtain and maintain housing at an Adult Residential Facility (ARF) or Residential Care Facility for the Elderly (RCFE) when the additional supports provided by these facilities is needed to live successfully in the community. ARFs and RCFEs are unlocked residential facilities that are licensed by the State and provide residents with 24-hour care and supervision, medication management, three meals per day and assistance with activities of daily living. MHSA and other funds are used to pay for client rent at the ARFs and RCFEs as well as personal and incidental (P&I) expenses should the client not have Supplemental Security Income (SSI) or other adequate income to pay for these items. DMH has partnered with DHS' Countywide Benefits Entitlement Services Team (CBEST) program to assist ERC clients without income to apply for benefits for which they are eligible such as SSI. MHSA and other funds are also used to provide ARFs and RCFEs with an enhanced rate for the DMH clients they serve to help cover the costs of enhanced services that clients may require due to their higher acuity and complex needs.

As of June 30, 2022, the ERC program was serving a total of 995 clients. Throughout the fiscal year, 499 clients were newly referred to the program and 401 clients moved into an ARF or RCFE with ERC financial support. See chart below for further details on the types of financial support that were needed by those referred and served. Overall, the ERC program housing retention rate was 82%.

Table 23. ERC Program Housing Served

	TOTAL SERVED		NEW REFERRALS		NEW MOVE-INS	
	Number Served	%	Number Referred	%	Number Moved-In	%
ERC FUNDING NEEDED						
Rent and P&I Only	1	0.1%	0	0%	0	0%
Rent, P&I and Enhanced Rate	213	21.4%	358	71.7%	298	74.3%
Enhanced Rate Only	781	78.5%	141	28.3%	103	25.7%
TOTAL	**995**	**100%**	**499**	**100%**	**401**	**100%**

D7. Interim Housing

Interim Housing Program – Adults

The Interim Housing Program (IHP) is intended to provide short-term shelter services for adults with serious mental illness and their minor children who are homeless and do not

have adequate income to pay for temporary housing. Serving as a bridge to permanent housing, IHP provides clients with safe and clean shelter, 24-hour general oversight, three meals per day, linens, clothing, toiletries and case management services.

MHSA funds enabled DMH to contract for 570 IHP beds across 20 sites. This included 501 beds for individuals and 69 family units. However, during FY 2021-22, the capacity at some IHP sites was reduced to allow for safer occupancy in accordance with DPH COVID-19 guidelines. As a result, IHP served a total of 838 individuals and 89 families throughout the fiscal year. Hotel and motel rooms secured through Project Homekey were also made accessible to individuals who were homeless and served by DMH.

Enhanced Emergency Shelter Program – TAY

The Enhanced Emergency Shelter Program (EESP) serves the urgent housing needs of the TAY population, ages 18-25, who are unhoused or at immediate risk with no alternative place to stay, no significant resources or income to pay for shelter, are experiencing mental health concerns, and are willing to accept the treatment we offer. The EESP offers a warm, clean and safe place to sleep, hygiene facilities, hot meals (breakfast, lunch, dinner) and case management services. TAY are provided shelter in the EESP for up to 60 nights while working with the TAY Navigation Team to identify longer-term and more permanent housing resources to help ensure longer-term stability as well as linkage to needed mental health and other supportive services.

Using MHSA and other funds, there were approximately 82-84 beds contracted to serve TAY in six EESP shelters within the geographic area of Service Areas 4 and 6 throughout FY 2021-22. The total number of TAY served in the EESP during that time period was approximately 561. COVID restrictions, as well as closures due to COVID illness, created fluctuations throughout the fiscal year that led to reduced numbers of clients served overall, including clients staying in beds longer than the designated 60 nights.

■ **HOUSING Continued Work**

The Department of Mental Health (DMH) Housing and Job Development Division (HJDD) continues to look for opportunities to grow and enhance its housing and employment services and resources for those who are homeless or at risk of homelessness. Other recent activities and future plans include:

- As part of the Hollywood 2.0 initiative, HJDD is working in collaboration with community stakeholders, including Hollywood 4WRD, and other DMH Hollywood 2.0 leads to implement the Housing and Employment Strategies recommended by stakeholder groups. This includes growing the number of interim housing, licensed residential care facility and permanent supportive housing resources that are available to serve Hollywood 2.0 clients that are in the Hollywood region as well as taking the lead on the solicitation process to implement a clubhouse that will utilize the Clubhouse International standards for adults living, working and/or receiving mental health treatment in the Hollywood area who have a serious mental illness – many of whom may be unhoused or at risk of homelessness.
- To enhance our ability to critically analyze program effectiveness and racial and gender equity in terms of those served by DMH's housing resources and to make enhancements and improvements where needed, DMH has applied and been approved for a grant from the LA Care and Health Net health plans. This grant, which is funded with Housing and Homelessness Incentive Program (HHIP) dollars, will be used by the DMH Chief Information Office to secure the services of consultants who will assist with implementing long-needed technical infrastructure that will greatly enhance the Department's ability to capture, analyze and report out on housing data including data for DMH MHSA housing programs such as demographics.
- DMH is actively working on a proposal for MHSA Innovations funding that would allow DMH to implement new regional, field-based, multidisciplinary teams dedicated to serving people experiencing homelessness who are living in interim housing. These Interim Housing Multidisciplinary Assessment and Treatment Teams would serve

■ HOUSING Continued Work

all eight County Service Areas and be comprised of staff from DMH, DHS Housing for Health and Department of Public Health (DPH) Substance Abuse Prevention and Control (SAPC) to help ensure the full spectrum of client needs can be addressed. MHSA Innovations funding would specifically support the mental health component of this effort including the provision of on-site specialty mental health and co-occurring substance use disorder care and supports. This effort would also be a partnership with the L.A. Care and Health Net health plans, who would provide HHIP dollars for DHS to fund Assistance with Daily Living staff that would be a part of the interim housing multidisciplinary teams and help assess the activities of daily living (ADL) needs of interim housing clients and provide caregiving services as well as to fund Enriched Residential Care subsidies for those individuals who need to transition from interim housing to a licensed residential care facility.

- DMH is continuing its efforts to allocate the remaining No Place Like Home funding toward capital investments. In particular, a solicitation for $50 million is planned to be released in the Spring of 2023 to fund the development of additional permanent supportive housing Countywide that is dedicated to individuals with serious mental illness who are also homeless.

E. Linkage

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☐ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$50,878,000	$44,479,000	$34,545,000

Program Description

Linkage provides programming that works with those in the community to connect them to essential services that include treatment, housing and other mental health service programs throughout the County. Linkage programs include:

- Jail Transition and Linkage Services
- Mental Health Court Linkage
- Service Area Navigation
- Homeless Outreach and Mobile Engagement (HOME)

Intended Outcomes

- Linkage programming engages in joint planning efforts to ensure that an active locally-based support network comprised of community partners, including community-based organizations, other County departments, intradepartmental staff, schools, health service programs, faith-based organizations, and self-help and advocacy groups:
- Increase access to mental health services and strengthen the network of services available to clients in the mental health system
- Promote awareness of mental health issues and the commitment to recovery, wellness and self-help
- Engage with people and families to quickly identify currently available services, including supports and services tailored to a client's cultural, ethnic, age and gender identity

Key Activities

- Assist the judicial system with individual service needs assessments of defendants, link defendants to treatment programs, and provide support and assistance to defendants and families
- Assist a multi-disciplinary team in considering candidates' eligibility and suitability for pre-trial rapid diversion and linkage to treatment services
- Develop alternate sentencing, mental health diversion and post-release plans that consider best fit treatment alternatives and Court stipulations

FY 2021-22 ■ LINKAGE Data and Outcomes

E1. Jail Transition and Linkage Services

Client Contacts: 3,033

This program addresses the needs of individuals in collaboration with the judicial system by providing identification, outreach, support, advocacy, linkage, and interagency collaboration in the courtroom and in the jail. Linkage staff work with the MHSA Service Area Navigators as well as service providers to assist incarcerated individuals with accessing appropriate levels of mental health services and support upon their release from jail, including housing, benefits and other services as indicated by individual needs and situations. The goal is to successfully link individuals to community-based services upon discharge to prevent releasing them to the streets, thus alleviating the revolving door of incarceration and unnecessary emergency/acute psychiatric inpatient services.

E2. Mental Health Court Linkage Program

Client Contacts: 4,377

This program has two sub-programs funded by MHSA:

- The Court Liaison Program is a problem-solving collaboration between LACDMH and the Los Angeles County Superior Court. It is staffed by a team of mental health clinicians who are co-located at courts countywide. This recovery-based program serves adults with a mental illness or co-occurring disorder who are involved with the criminal justice system. The objectives of the program are to increase coordination and collaboration between the criminal justice and mental health systems, improve access to mental health services and supports, and enhance continuity of care.

- The Community Reintegration Program (CRP) offers an alternative to incarceration for defendants with a mental illness including those with co-occurring substance abuse. The goal of CRP and its participating providers is to reintegrate clients into the community with the skills and resources necessary to maintain stability and avoid re-arrest. Also, this program provides admission to two specialized mental health contract facilities for judicially involved individuals with mental illness who voluntarily accept treatment in lieu of incarceration.

E3. Service Area Navigation

Client Contacts: 18,163

Service Area Navigator Teams assist individuals and families in accessing mental health and other supportive services and network with community-based organizations to strengthen the array of services available to clients of the mental health system. Such networking creates portals of entry in a variety of settings that would make the long-standing goal of “no wrong door” achievable.

The following charts reflect FY 2021-22 data reported by the Service Area Navigators.

Figure 15. Number of phone contacts and outreach activities

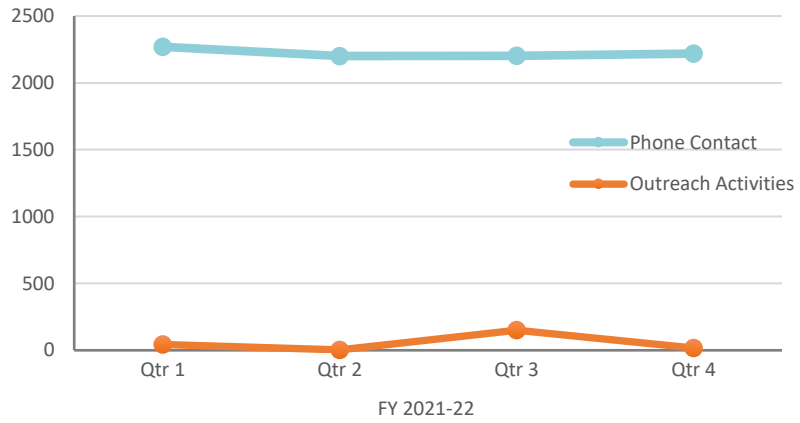


Figure 16. Number of clients referred to FSP services

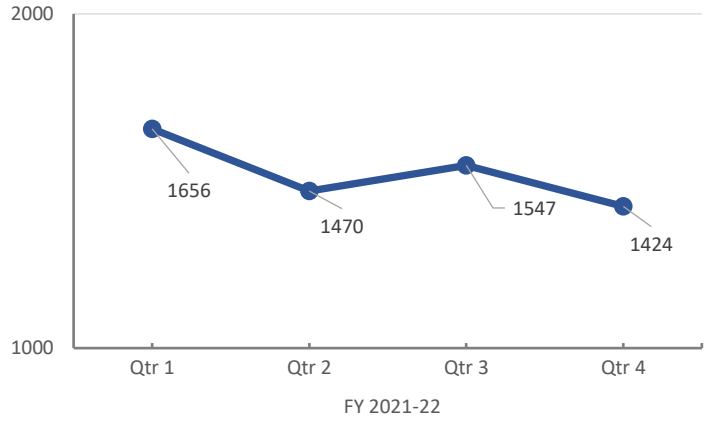
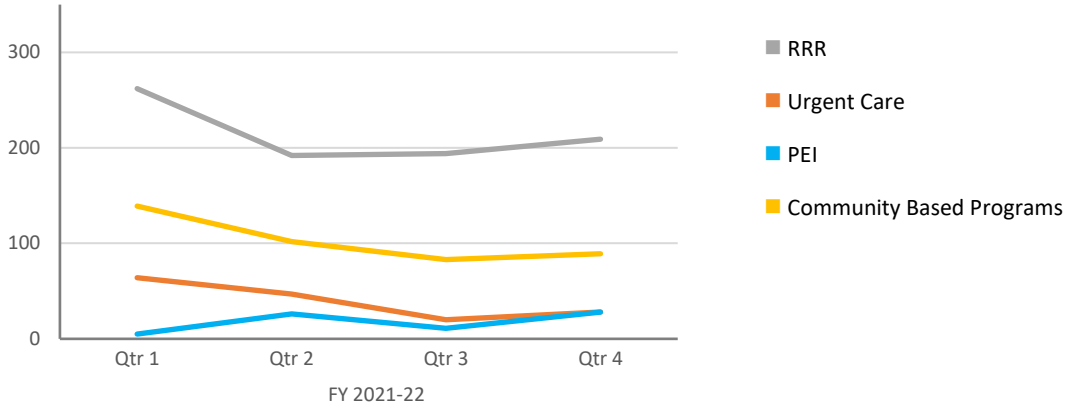


Figure 17. Number of clients referred to Non-FSP services



E4. Homeless Outreach and Mobile Engagement (HOME)

The Homeless Outreach & Mobile Engagement (HOME) program provides field-based outreach, engagement, support, and treatment to individuals with severe and persistent mental illness who are experiencing unsheltered homelessness. Services are provided by addressing basic needs; conducting clinical assessments; providing street psychiatry; and providing linkage to appropriate services (including mental health services substance abuse treatment and shelter).

HOME serves individuals 18 and over who are experiencing chronic unsheltered homelessness and who have profound mental health needs and associated impairments. These vulnerable and disengaged individuals struggle with securing appropriate food, clothing, and shelter due to their mental illness. In addition, they may have critical deficits in hygiene and communication, and are generally highly avoidant of services. They are unable to live safely in the community and require specialized mental health services to secure and sustain housing.

Most referrals are submitted by generalist homeless outreach providers who identify individuals with severe impairment that require specialized and intensive support and engagement.

FYs 2023-24 ■ LINKAGE Continued Work
• For FYs 2023-24, LACDMH will continue the indicated Key Activities by the following: • Secure Measure J funding to expand Court Linkage to additional courthouses • Expand rapid diversion programs to additional courthouses to better service the significant needs of the County • Expand and enhance videoconferencing capabilities and capacity in courthouse, lock-up, and jail facilities to more efficiently and rapidly provide diversion and linkage services to a greater number of clients, including leveraging flexible resource pools and economies of scale factors • Create direct communication and coordination channels/pathways between the judicial system and diversion and linkage referral resources, including LACDMH directly-operated and contracted service programs

F. Planning, Outreach and Engagement

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☐ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$16,970,000	$4,458,000	$6,178,000

Program Description

POE programs:

- Service Area Liaisons
- Underserved Cultural Communities Unit (UsCC)
- Stipend for Community Volunteers, examples include Wellness Outreach Workers (WOW) and the Countywide Client Activity Fund (CCAF)

Intended Outcomes

- Increase mental health awareness to all communities within the County
- Identify and address disparities amongst target populations
- Reduce stigma discrimination by educating and empowering communities to understand the importance of mental health care
- Increase access to care for mental health services provided by LACDMH and contract providers

Key Activities

- Outreach communities throughout the County by conducting conferences and special events
- Communities and education community members using various media and print media, as well as grassroot level community mental health presentations.
- Communicate and educate community members using various media and print media, as well as and grassroot level community mental health presentations
- Conduct surveys to gather results for data analysis to continue planning, outreach and engagement activities
- Enlist the help of community members to collaborate in outreach and engagement activities

FY 2021-22 ■ PLANNING, OUTREACH AND ENGAGEMNT Data and Outcomes

F1. Service Area Liaisons

In FY 2021-22, Service Area outreach staff attended multiple events with 63,135 participants. The population consisted of the community at large from UsCCs. Staff disseminated mental health information at job fairs, Veteran events, colleges, libraries, community events and activities at local senior centers.

Table 24. Event participants by Service Area

Service Area	Number of Participants
SA1 – Antelope Valley	10,679
SA2 – San Fernando Valley	967
SA3 – San Gabriel Valley	4,377
SA4 – Metro Los Angeles	891
SA5 – West Los Angeles	32,410
SA6 – South Los Angeles	6,210
SA7 – East Los Angeles County	7,048
SA8 – South Bay	553

F2. Underserved Cultural Communities

- One of the cornerstones of MHSA is to empower underrepresented ethnic populations. In June 2007, LACDMH established the Underserved Cultural Communities Unit (UsCC) to develop a stakeholder platform to historically underserved ethic and cultural communities in Los Angeles County. Subcommittees were established to work closely with the various underrepresented / underserved ethnic and cultural populations in order to address their individual needs.

- UsCC Subcommittees:
  - American Indian/Alaska Native
  - Asian Pacific Islander
  - Deaf, Hard-of-Hearing, Blind, and Physical Disabilities
  - Latino
  - Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, and Two-Spirit (LGBTQIA2-S)
-
- Each UsCC subcommittee is allotted one-time funding totaling $200,000 per fiscal year to focus on CSS-based capacity-building projects. This unique opportunity draws on the collective wisdom and experience of community members to determine the greatest needs and priorities in their communities. Project proposals are created and submitted via a participatory and consensus-based approach.

An overview of the FY 2021-2022 projects that were approved for each of the UsCC Subcommittees is provided below. Most projects in this cycle are currently being implemented and therefore outcomes will not be available to report until after June of 2023. For the Black & African Heritage (BAH) and Eastern European/Middle Eastern (EE/ME) UsCC subcommittees, the FY 2021-2022 projects were rolled over into FY 2022-2023.

A. ACCESS FOR ALL (DEAF, HARD OF HEARING, BLIND, AND PHYSICAL DISABILITIES) UsCC SUBCOMMITTEE

Project
Domestic Violence Task Force Workshops The goal of this project is to engage, empower, and enlist the Deaf, Hard of Hearing, Blind, and Physically Disabled community as well as their family members and caretakers into advocacy and activism around mental health. It aims to educate the participants on how to identify the signs of people who are victims of domestic violence and be able to provide the resources and access to appropriate help. The Facilitator is a clinician who specializes in domestic violence and providing mental health services to the Deaf, Hard of Hearing, Blind, and Physically Disabled populations. This project is designed to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County. It will enable this often underserved and marginalized population to access mental health services for themselves and empower other community members to access mental health services as well.
Disability Mental Wellness Round Table for the Deaf, Hard of Hearing, Blind, and Physically Disabled Community The goal of this project is to reduce mental health access barriers for this community by engaging the population into conversations about mental health where they can freely share their

Project
experiences with peers. This project aims to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County, as well as increase community member engagement in the LACDMH stakeholder process. Peers will be individuals aged 18+ who are members of the Deaf, Hard of Hearing, Blind, and Physically Disabled community with some experience with LACDMH mental health services, either directly or indirectly. This project will also include the testimony of at least three (3) Deaf/Hard of Hearing, three (3) Blind, and three (3) Physically Disabled community members with lived experience.
Podcast and YouTube Series Project The goal of this project is to provide better accommodation and accessibility to the targeted communities. This Consultant will deliver a total of 12 Podcast and YouTube sessions with different topics related to mental health and disabilities. Additionally, the Consultant will be responsible for recruiting panelists for each session including host/s, guests/participants, speakers, and presenters as well as the production and airing of all the shows. The objective of the project is to outreach and engage people from the deaf, hard of hearing, blind, and physically disabled populations into a virtual discussion regarding the mental health needs of these communities in a culturally appropriate and non-intrusive way as well as to reduce the stigma associated with mental health services. Additionally, this project aims to increase connections with mental health providers and provide opportunities to address concerns about mental health services and create a safe space with mental health resources available to those that utilize American Sign Language (ASL).

B. AMERICAN INDIAN/ALASKA NATIVE (AI/AN) UsCC SUBCOMMITTEE

Project
American Indian/Alaska Native Mending the Hoop Project The goal of this project is to promote mental health services for AI/AN community members, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County, as well as increase community member engagement in the LACDMH stakeholder process. This will enable this often underserved and marginalized population to access mental health services for themselves and empower other community members to access mental health services as well. The objectives of this project will include engaging this population into conversations about mental health and creating healing spaces for community members to come together to improve overall health outcomes.
American Indian/Alaska Native Mental Health Community Engagement Campaign The goal of this project is to reinforce that LACDMH is here to support AI/AN community members. The project should be tailored to resonate with the AI/AN community, reaching members using video-based content with culturally appropriate messages, distributed in the places where they already seek information and using visuals/design that complement LACDMH's current public outreach efforts. The Campaign includes production and distribution of five videos that will serve as the centerpiece of the engagement efforts. The selected Consultant is expected to have experience reaching the intended audiences and expertise in the specific outreach strategies being used to reach them. An initial project proposal must be approved by LACDMH before beginning work.
American Indian/Alaska Native Traditional Wellness Gathering Project The goal of the project to reduce mental health access barriers for AI/AN community members by engaging this population into conversations about the role of cultural traditions and language in mental health and healing. This will enable this often underserved and marginalized population to access mental health services for themselves and empower other community members to access mental health services as well. This project aims to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County, as well as

Project
increase community member engagement in the LACDMH stakeholder process. Additionally, this project aims to utilize traditional methods of healing such as language, prayer, spirituality, history, songs, and food to build connections and reclaim these traditions to improve overall health outcomes.
American Indian/Alaska Native Youth Academy Project The goal of the project is to identify mental health access barriers for AI/AN Transition Age Youth (TAY) (aged 16-24) by engaging this population in advocacy and activism around mental health all while building capacity using traditional forms of healing. This project aims to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County, as well as increase community member engagement in the LACDMH stakeholder process. The Facilitator will recruit twenty (20) AI/AN Transition Age Youth (TAY) (aged 16-24) to participate in the Youth Academy. Of those, at least ten (10) should identify as having lived experience either personally or as a family member/caregiver for someone with mental health conditions and will have some experience utilizing public mental health services. The Youth Academy should include a mental health stigma reduction program, art breakouts focused on traditional forms of healing, and athletic workshops. At the end of the Youth Academy, the youth and Facilitator will host a Community Forum to showcase their work.

C. ASIAN PACIFIC ISLANDER (API) UsCC SUBCOMMITTEE

Project
1000 Cranes - Healing Through Arts and Culture Project This project will target the API community County-wide, with a specific emphasis on the Japanese community throughout Los Angeles County by having API community members unite to fold 1000 origami cranes as symbol for wishing someone's emotional healing. The Japanese, red-crowned crane is an iconic bird that symbolizes many contexts such as resilience, recovery, and longevity giving the 1000 origami cranes a spiritual approach to encourage wellness in mental health. API communities continue to experience systemic inequities in mental health services and resources. In addition, over 30% of API Americans are not fluent in English. There is a significant gap in accessing treatment due to the lack of bilingual and bicultural mental health care providers. Cultural stigma and lack of understanding mental illness can lead to neglect and denial of mental health treatment particularly among the 1st generation API communities. In API's country of origin, often stigma, shame, and "losing face" will affect the whole family and result in being shunned by society. Families will go to great lengths to protect their reputation including isolation or suicide. This project aims to address the stigma, lack of knowledge, and cultural barriers that prevent many API community members from accessing quality mental health services in a timely manner.
Cambodian Americans Oral History Project A Consultant will be hired for the purpose of implementing a project to develop oral histories on the mental health impact of trauma on Cambodian American adults living in Los Angeles County who were children during the Khmer genocide. It would yield information on their mental health status and help reduce stigma in first generation Cambodian Americans. The goal is to fill a gap in knowledge and understanding as to the mental health impact of the historical trauma as a result of genocide of a Cambodian Americans who arrived as children. The culturally unresponsive mental health services and deeply embedded stigma prevents them from seeking or receiving mental health services resulting in mental health disparities that continue to persist. Culturally unresponsive services have also resulted in misunderstandings between therapist and patient, and barriers to successful access and engagement in treatment.

Project
Promoting MH Wellness in South Asian Americans This project proposes to enhance mental health and wellness of South Asian immigrant families. According to literature, South Asian families are collectivistic and hence engagement efforts are most effective if these efforts take a multi-generational and holistic approach rather than individual-focused. A bilingual (Hindi or Punjabi)/English consultant with extensive experience working with the South Asian community in Los Angeles County will be hired for the purpose of developing and implementing Promoting Mental Health Wellness in South Asian Americans Project. South Asian immigrants often want to protect and preserve their culture and pass cultural practices and traditions to their children. For South Asian families, this may create tension and stress as they struggle to adjust to changes in their cultural identity as a result of acculturation. Cultural identity represents a person's cultural practices, values, and identification. South Asian families may experience difficulties between preservation and adaptation of two very different cultures. A first-generation South Asian person may experience a range of emotions while they learn to adjust to the new culture, many times with minimal or no family support. First and Second-generation family members living in the same household may experience the acculturation process very differently, resulting in different degrees of acculturation. This may cause conflicts as children may not be comfortable confiding about their socio-emotional struggles or difficulties with their parents. This may put them at risk of developing mental health issues such as depression and anxiety and in some cases may even put them at risk of suicidal ideation or developing personality disorders.

D. LATINO UsCC SUBCOMMITTEE

Project
Empowering Latino Youth Mental Health Advocates Project The goal of this project is to reduce barriers to accessing mental health services for underserved members of the Latino community by providing education to empower young people to be mental health advocates for their communities throughout Los Angeles County. Youth will incorporate the media arts utilizing age and culturally appropriate practices to provide outreach, engagement, and education to reduce stigma in their communities. The primary objectives of this project are to empower Latino youth as the experts in developing innovative strategies using media arts to reach other Latino youth throughout Los Angeles County, provide education about the importance of mental health care, destigmatize mental health issues amongst Latino youth, develop culturally sensitive resources/tools, and to increase Latino youth engagement in the LACDMH stakeholder process.
La Cultura Cura: Engaging the Traditional Arts in Healing Project The goal of the project is to provide engagement and mental health education through a partnership with the Mental Health Promotors and/or people with community outreach experience. The Consultant will integrate the traditional arts and cultural/ancestral knowledge into community education about mental health in the Latino community. The Consultant will partner with Mental Health Promotors from three different Service Areas of Los Angeles County to present a mental health workshop series that integrates cultural knowledge and healthy coping when facing emotional and mental distress. This project will target the Latino community County-wide focused on individual adults and youth. As documented by a Surgeon General report, only about 20% of the Latino community with mental health challenges speak to their doctor about their mental health. Negative cultural attitudes contribute to Latino communities living in the U.S. perceiving a lower need for mental health care despite common mental health conditions increasing among the Latino

Project
population. Stigma, language barriers, and inequities in mental health care continue to be key barriers to the Latino community receiving culturally responsive mental health services. Research has shown that engagement in cultural practices enhances physical and mental health, positive self-perception, desire to grow and learn, self-actualization, community involvement, and increased clarity of future goals. In addition, studies also indicate that engagement with art activities outside of traditional health care settings can help community members voice their mental health needs and explore the multiple facets of their wellbeing issues, including seeking mental health services when needed.
Healing Grief and Loss Through Community Project The goal of this project is to outreach, educate, and increase knowledge pertaining to grief/loss and trauma as well as mental health services by utilizing a non-stigmatizing and empowering approach to help the community begin the healing process. A consultant will be hired for the purpose of developing and implementing the Healing Grief and Loss Through Community Project. This project will target the Latino community at-large. Latinos are over-represented in occupations that require wage earners to leave their homes and interact with co-workers and clients, such as farm workers and grocery store clerks. Many of these workers are predominantly first-generation Latino immigrants. Since March of 2020, Latinos have held many of the essential jobs that have kept Los Angeles County and California well-fed and functioning. Unfortunately, this has resulted in Latinos having the highest rate of infections and deaths in California and 2.3x more times compared to White, non-Latinos/Hispanics. The disproportionally high number of deaths and infections resulting from COVID-19 has resulted in many Latinos experiencing unprocessed grief and loss while mental health education and service utilization remains significantly low. This project aims to address the stigma, lack of knowledge, and language barriers that have prevented many Latinos from accessing quality mental health services.

E. LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, QUESTIONING, INTERSEX, ASEXUAL, TWO-SPIRIT (LGBTQIA2-S) UsCC SUBCOMMITTEE

Project
Black LGBTQ+ Community Engagement Initiative Project The goal of the project is to accomplish four specific goals relative to meeting the mental health needs of Black LGBTQ+ people living in Los Angeles County. The first is to increase the level of buy-in from community stakeholders through community outreach and engagement. The second goal is to develop and implement a targeted needs assessment of the Black LGBTQ+ community living in Los Angeles County. The third is to develop and implement non-traditional and Black centered innovation support systems that address the specific needs of the Black LGBTQ+ community. The fourth goal is to develop a detailed and comprehensive report including recommendations for long-term systemic change within LACDMH to meet the needs of Black LGBTQ+ people living in Los Angeles County. Additionally, this project has a goal of increasing community member involvement in the LACDMH stakeholder process. This project will involve four components. The first will include multi-stakeholder engagement that involves leading and managing a collaboration with multiple Black LGBTQ+ stakeholders that jointly addresses Black LGBTQ+ community priorities. The second component involves Black LGBTQ+ community education and empowerment involving closed biweekly meetings with community members that focus on specific issues of individual segments of the Black LGBTQ+ community. The third component involves Black LGBTQ+ community outreach and engagement. This will include planning a minimum of 2 community outreach events to hold discussions on Black LGBTQ+ community needs, share pertinent information with community stakeholders, and obtain input from community members. The fourth component consists of a community needs assessment and gap analysis.

Project
LGBTQIA2-S Griot Project The goal of the project is to bring together an intergenerational group of Black and African-American LGBTQIA2-S community members to share and record stories of Black and African-American LGBTQIA2-S elders. The project will help to bridge the disconnect between Black elders and younger generations in order to improve mental health outcomes. It will provide an opportunity for younger generations to explore the past lives of Black elders from the LGBTQIA2-S community through active listening and dialoguing about elder experiences. Additionally, this project has a goal of increasing community member involvement in the LACDMH stakeholder process. This project looks to strengthen intergenerational ties in the Black and African American LGBTQIA2-S community. Through the exploration of Black LGBTQIA2-S cultural history, participants will gain a greater sense of self, build self-esteem and confidence, grow their ability for compassion, and embrace self-expression. Participants will bring newly minted skills and an improved sense of self to their communities and beyond. This project will involve two components. The first will include outreach and engagement of a minimum of twenty-five (25) Black and African-American LGBTQIA2-S elders and youngers (elders aged 50 and older and youngers aged 25 and younger) into a cohort. Of those, at least ten (10) should identify as having lived experience either personally or as a family member/caregiver for someone with mental health conditions and will have some experience utilizing public mental health services. Cohort members will meet a minimum of eight (8) times to create a narrative videos/interviews of the elders' histories. The second component will involve conducting a community forum to present the finalized narrative videos/interviews.
LGBTQIA2-S Panthera Project The goal of the project is to provide an actionable and supportive environment for Black transmasculine community members navigating their mental health within the employment landscape. This project will provide insight and guidance on how strategy, education, and self-advocacy can be used to improve mental health outcomes for Black transmasculine community members. Tools will be developed to provide Black transmaculine community members the knowledge and capacity to secure their mental health while navigating employment with confidence and eliminate the stigma of coming out at work. Adverse experiences in workplace environments can lead to declining mental health and social standing as Black men, which can lead to other negative health outcomes. Additionally, this project has a goal of increasing community member involvement in the LACDMH stakeholder process. This project will involve two components. The first component will include outreach and engagement of 25 Black transmasculine community members into a Cohort. Cohort members will meet a minimum of 10 times. The purpose of the meetings will be to provide education on workplace rights as it relates to harassment in the workplace and accessing mental health during and after encounters with harmful workplace environments and educating community members on how to navigate toxic workplace environments while safeguarding their mental health. Additionally, the meetings will address the root causes of financial inequality that threaten self-sustainability amongst Black transmasculine community members. The meetings should also provide attendees with resources in the pursuit of affirming gainful employment and financial literacy in order to improve mental health outcomes. The second component will involve Facilitator and Cohort members designing a survey specific to Black transmasculine community members to identify the specific mental health concerns experienced by this underserved community and any gaps in service delivery, as well as learn how to best serve this community in a culturally sensitive way. This survey should also gather data relative to the employment needs amongst this community and the impact on mental health when facing toxic work environments. The goal will be for a minimum of 100 Black transmasculine community members in Los Angeles County to complete the survey.
LGBTQIA2-S What We Think Project

Project
The goal of the project is to identify the needs of Black Gay Male Elders, while educating and empowering this community about the importance of mental health care in an effort to build awareness and connection. This project aims to address the social isolation, trauma, and mental health issues experienced by Black Gay Male Elders by highlighting the diversity of the population and the need for culturally sensitive resources. Additionally, this project has a goal of increasing community member involvement in the LACDMH stakeholder process. This project will involve two components. The first will include outreach and engagement of a minimum of twenty-five (25) Black Gay Male Elders (aged 50+) into a cohort. Cohort members will meet a minimum of ten (10) times to support one another and to develop a survey to be disseminated to Black Gay Male Elder community members throughout Los Angeles County. The goal of the survey will be to identify the specific mental health concerns experienced by this underserved community and any gaps in service delivery, as well as learn how to best serve this community in a culturally sensitive and holistic way. The second component will involve conducting two (2) community town halls focused on the broader issues of aging, and in particular amongst the Black Gay Male Elder population.

FYs 2023-24 ■ PLANNING, OUTREACH AND ENGAGEMENT Continued Work
• LACDMH will continue outreach and engagement activities.

PREVENTION AND EARLY INTERVENTION (PEI)

This section outlines the services and activities associated with the various components of PEI. Over the last year, LACDMH has moved toward a more robust and upstream approach to PEI services. While the focus of early intervention continues to be evidence-based practices (EBP), promising practices and community-defined evidence practices, LACDMH is in the process of implementing prevention strategies in settings such as schools and libraries where access platforms are being established. By identifying individuals with specific risk factors, particularly for trauma, and through the promotion of protective factors, such as social connectedness and engagement, a prevention service platform is being developed that:

- Raises awareness of the importance of mental and emotional well-being and health, the impact of trauma and the promotion of resilience strategies on systems and communities;
- Builds organizational and community capacity to promote well-being and resiliency and to recognize and respond to trauma and mental health needs; and
- Builds bridges to mental health care when it is requested.

The prevention strategies involve, at a minimum, a combination of training, resource infusion at the site of the access platform, partnership development and consultation to educators.

PEI includes the following services:

- Prevention
- Early Intervention
- Stigma and Discrimination
- Suicide Prevention

Table 25. FY 2021-22 Clients served through PEI

Clients Served	New Clients Served
35,330 clients received a direct mental health service: - 63% of the clients are children - 21% of the clients are TAY - 13% of the clients are adult - 2% of the clients are older adult - 47% of the clients are Hispanic - 8% of the clients are African American - 9% of the clients are White - 1% of the clients are Asian/Pacific Islander - 0.29% of the clients are Native American - 2% of the clients are Multiple Races - 76% have a primary language of English - 21% have a primary language of Spanish	17,084 new clients receiving PEI services countywide: with no previous MHSA service - 42% of the new clients are Hispanic - 8% of the new clients are African American - 9% of the new clients are White - 1% of the new clients are Asian/Pacific Islander - 4% of the new clients are Multiple Races - 0.73% of the new clients are Native American - 75% have a primary language of English - 21% have a primary language of Spanish

Table 26. FY 2021-22 Clients served through PEI by Service Area

Service Area	Number of Clients Served	Number of New Clients
SA 1 – Antelope Valley	2,006	1,203
SA 2 – San Fernando Valley	5,565	2,465
SA 3 – San Gabriel Valley	5,968	3,225
SA 4 – Metro Los Angeles	5,399	2,997
SA 5 – West Los Angeles	1,280	739
SA 6 – South Los Angeles	3,668	1,964
SA 7 – East Los Angeles County	4,501	2,303
SA 8 – South Bay	6,202	3,078

SB 1004 PEI PROGRAM PRIORITY AREAS

All PEI programs are required to comply with WIC Section 5840.7 enacted by Senate Bill 1004 which requires counties to specify how they are incorporating the following six Commission-identified priorities in the FY20-23 MHSA plan:

1. Childhood trauma prevention and early intervention to deal with the early origins of mental health needs;
2. Early psychosis and mood disorder detection and intervention; and mood disorder and suicide prevention programming that occurs across the lifespan;
3. Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs;
4. Culturally competent and linguistically appropriate prevention and intervention;
5. Strategies targeting the mental health needs of older adults;
6. Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis

Each of these priorities outlined in WIC Section 5840.7/SB 1004 are integrated into our plan and aligned with our previously outlined strategies which are consistent with our community planning process.

Per WIC Section 5840.7/SB 1004, counties are also required to provide an estimate of the share of PEI funding allocated to each priority. The following table provides these estimates:

Table 27. PEI Priority Percentages by SB 1004 Priority Categories

SB 1004 PRIORITY CATEGORIES	% OF FUNDING ALLOCATED BY PRIORITY
Childhood Trauma Prevention and Early Intervention	94%
Early Psychosis and Mood Disorder Detection and Intervention	55%
Youth outreach and engagement strategies that target secondary school and transition age youth	92%
Culturally competent and linguistically appropriate prevention and intervention	95%
Strategies targeting the mental health needs of Older adults	28%
Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis	95%

A. EARLY INTERVENTION

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+
Total Number to be Served for FY 2023-24				
Child: 25,384	TAY: 8,481	Adult: 6,089	Older Adult: 1,007	
Average Cost per Client:	$4,018			
FY 2023-24 Estimated Gross Expenditures	**FY 2022-23 Estimated Gross Expenditures**	**FY 2021-22 Total Gross Expenditures**		
$106,479,000	$34,218,000	$28,379,000		
Program Description				
Early Intervention is directed toward individuals and families for whom a short (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve mental health problems and avoid the need for more extensive mental health treatment.				

FY 2021-22 ■ EARLY INTERVENTION Data and Outcomes

Table 28. FY 2021-22 EBPs
Note: Some age groups show the specific age(s) of clients served

Early Intervention EBP	Description
Aggression Replacement Training (ART) Children (ages 5-12) Skill Streaming Only Children (ages 12-15) TAY (ages 16-17) Unique Clients Served: 34 Gender: 59% Male, 41% Female Ethnicity: 29% Hispanic, 18% White, 6% African American, 47% Unreported	ART is a multimodal psycho-educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. Its goal is to improve social skills, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger control training, and training in moral reasoning. Skill-streaming teaches pro-social skills. In anger control training, youths are taught how to respond to their hassles. Training in moral reasoning is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others.
Alternatives for Families Cognitive Behavioral Therapy (AF-CBT) Children (ages 4-15) TAY (ages 16-17) Unique Clients Served: 74 Gender: 51% Male, 49% Female Ethnicity: 74% Hispanic, 7% African American, 1% Asian, 5% White, 11% Unreported, 1% Multiple Races	AF-CBT is designed to improve the relationships between children and parents/ caregivers in families involved in physical force/coercion and chronic conflict/hostility. This practice emphasizes training in both intrapersonal and interpersonal skills designed to enhance self-control, strengthen positive parenting practices, improve family cohesion/communication, enhance child coping skills and social skills, and prevent further instances of coercion and aggression. Primary techniques include affect regulation, behavior management, social skills training, cognitive restructuring, problem solving, and communication.
Brief Strategic Family Therapy (BFST) Children (ages 10-15) TAY (ages 16-18) Unique Clients Served: 1 Gender: 100% Male Ethnicity: 100% Hispanic	BSFT is a short-term, problem-oriented, family-based intervention designed for children and adolescents who are displaying or are at risk for developing behavior problems, including substance abuse. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems.
Center for the Assessment and Prevention of Prodromal States (CAPPS) TAY	The focus of CAPPS is to conduct outreach and engagement specifically to those youths who are experiencing their first-break psychosis and early onset of serious mental illnesses with psychotic features. In order to mitigate mental health

Early Intervention EBP	Description
Unique Clients Served: 24 Gender: 71% Male, 29% Female Ethnicity: 63% Hispanic, 17% Unreported, 13% White , 8% Multiple Races	challenges and reduce the progression of these challenges into mental health diagnoses, this project will also engage families and significant others of the youth as well as the youth themselves in PEI services.
Child-Parent Psychotherapy (CPP) Young Children (ages 0-6) Unique Clients Served: 1,217 Gender: 53% Male, 47% Female Ethnicity: 47% Hispanic, 13% African American, 1% Asian, 10% White, 24% Unreported 4% Multiple Races, 0.33% Native Hawaiian/Pacific Islander, 1% Other	CPP is a psychotherapy model that integrates psycho-dynamic, attachment, trauma, cognitive -behavioral, and social-learning theories into a dyadic treatment approach. CPP is designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of domestic violence. CPP is intended as an early intervention for young children that may be at risk for acting-out and experiencing symptoms of depression and trauma.
Crisis Oriented Recovery Services (CORS) Children TAY Adults Older Adults Unique Clients Served: 71 Gender: 20% Male, 80% Female Ethnicity: 17% Hispanic, 8% African American, 1% Asian, 3% White, 61% Unreported, 4% Multiple Races, 6% Other	CORS is a short-term intervention designed to provide immediate crisis intervention, address identified case management needs, and assure hard linkage to ongoing services. The primary objective is to assist individuals in resolving and/or coping with psychosocial crises by mitigating additional stress or psychological harm. It promotes the development of coping strategies that individuals can utilize to help restore them to their previous level of functioning prior to the crisis event.
Depression Treatment Quality Improvement (DTQI) Children TAY Adults Older Adults Unique Clients Served: 14 Gender: 57% Male, 43% Female Ethnicity: 29% Hispanic, 64% Unreported, 7% Other	DTQI is a comprehensive approach to managing depression that utilizes quality improvement processes to guide the therapeutic services to adolescents and young adults. The psychoeducation component helps individuals learn about major depression and ways to decrease the likelihood of becoming depressed in the future. The psychotherapy component assists individuals who are currently depressed to gain understanding of factors that have contributed to the onset and maintenance of their depression and learn ways to treat their disorder.
Dialectical Behavioral Therapy (DBT) Children (ages 12-15) TAY (ages 16-20) Unique Clients Served: 182 Gender: 20% Male, 79% Female, 1% Female to Male Ethnicity: 38% Hispanic, 9% African American, 4% Asian, 14% White, 26% Unreported, 2% Native Hawaiian/Pacific Islander, 5% Multiple Races, 2% Other	DBT serves individuals who have or may be at risk for symptoms related to emotional dysregulation, which can result in the subsequent adoption of impulsive and problematic behaviors, including suicidal ideation. DBT incorporates a wide variety of treatment strategies including chain analysis, validation, dialectical strategies, mindfulness, contingency management, skills training and acquisition (core mindfulness, emotion regulation, interpersonal effectiveness, distress tolerance and self-management), crisis management, and team consultation.
Families Over Coming Under Stress (FOCUS) Children TAY Adults Unique Clients Served: 70 Gender: 53% Male, 47% Female Ethnicity: 16% Hispanic, 1% African American, 1% White, 1% Asian, 73% Unreported, 1% Native Hawaiian/ Pacific Islander, 6% Multiple Races	Family resiliency training for Military families, couples, and children who experience difficulties with multiple deployments, injuries, PTSD, and combat operational issues. FOCUS believes that poor communication skills and combat operational stress leads to distortions in thinking and family detachment. Treatment is delivered to couples and/or the family by building upon existing strengths and positive coping strategies as well as increasing communication and decreasing stress.

Early Intervention EBP	Description
Functional Family Therapy (FFT) Children (ages 11-15) TAY (ages 16-18) Unique Clients Served: 14 Gender: 57% Male, 43% Female Ethnicity: 7% White, 64% Hispanic, 21% Unreported, 7% African American	FFT is a family-based, short-term prevention and intervention program for acting-out youth. It focuses on risk and protective factors that impact the adolescent, specifically intrafamilial and extrafamilial factors, and how they present and influence the therapeutic process. Major goals are to improve family communication and supportiveness while decreasing intense negativity these families experience.
Group Cognitive Behavioral Therapy for Major Depression (Group CBT) TAY (ages 18-25) Adults Older Adults Unique Clients Served: 4 Gender: 25% Male, 75% 6emale Ethnicity: 25% Asian, 75% Hispanic	Group CBT focuses on changing an individual's thoughts (cognitive patterns) to change his or her behavior and emotional state. Treatment is provided in a group format and assumes maladaptive, or faulty, thinking patterns cause maladaptive behaviors and negative emotions. The group format is particularly helpful in challenging distorted perceptions and bringing thoughts more in-line with reality. Cultural tailoring of treatment and case management shows increased effectiveness for low-income Latino and African-American adults.
Incredible Years (IY) Young Children (ages 2-5) Children (ages 6-12) Unique Clients Served: 102 Gender: 71% Male, 29% Female Ethnicity: 69% Hispanic, 4% African American, 2% Asian, 14% White, 8% Unreported, 3% Multiple Races, 1% Other	IY is based on developmental theories of the role of multiple interacting risk and protective factors in the development of conduct problems. Parent training intervention focuses on strengthening parenting competency and parent involvement in a child's activities to reduce delinquent behavior. Child training curriculum strengthens children's social/emotional competencies. Teacher training intervention focuses on teachers' classroom management strategies, promoting pro-social behaviors and school readiness.
Individual Cognitive Behavioral Therapy (Ind. CBT) TAY (ages 18-25) Adults Older Adults Directly Operated Clinics only Unique Clients Served: 8,394 Gender: 26% Male, 74% Female Ethnicity: 47% Hispanic, 7% African American, 3% Asian, 11% White, 24% Unreported, 1% Native Hawaiian/Pacific Islander, 4% Multiple Races, 0.29% Native American, 2% Other	CBT is intended as an early intervention for individuals who either have or may be at risk for symptoms related to the early onset of anxiety, depression, and the effects of trauma that impact various domains of daily living. CBT incorporates a wide variety of treatment strategies including psycho-education, skills acquisition, contingency management, Socratic questioning, behavioral activation, exposure, cognitive modification, acceptance and mindfulness strategies and behavioral rehearsal.
Interpersonal Psychotherapy for Depression (IPT) Children (ages 9-15) TAY Adults Older Adults Unique Clients Served: 1,048 Gender: 26% Male, 74% Female Ethnicity: 26% Hispanic, 5% African American, 3% Asian, 8% White, 40% Unreported, 0.38% Native American, 15% Multiple Races, 1% Native Hawaiian/Pacific Islander, 1% Other	IPT is a short-term therapy (8-20 weeks) that is based on an attachment model, in which distress is tied to difficulty in interpersonal relationships. IPT targets the TAY population suffering from non-psychotic, uni-polar depression. It targets not only symptoms, but improvement in interpersonal functioning, relationships, and social support. Therapy focuses on one or more interpersonal problem areas, including interpersonal disputes, role transitions, and grief and loss issues.

Early Intervention EBP	Description
Loving Intervention Family Enrichment Program (LIFE) Children (ages 0-8) Unique Clients Served: 1 Gender: 100% Female Ethnicity: 100% Hispanic	An adaptation of Parent Project, LIFE is a 22- week skills-based curriculum implemented with parenting classes/ support groups, youth mental health groups, and multi-family groups for parents with children at risk of or involved with the juvenile justice system. The program was designed for low-income Latino families with monolingual (Spanish) parents of children at high-risk of delinquency and/ or school failure.
Managing and Adapting Practice (MAP) Young Children Children TAY (ages 16-21) Unique Clients Served: 11,333 Gender: 45% Male, 55% Female Ethnicity: 44% Hispanic, 6% African American, 1% Asian, 9% White, 34% Unreported, 0.07% Native American, 4% Multiple Races 2% Native Hawaiian/Pacific Islander, 1% Other	MAP is designed to improve the quality, efficiency, and outcomes of children's mental health services by giving administrators and practitioners easy access to the most current scientific information and by providing user- friendly monitoring tools and clinical protocols. Using an online database, the system can suggest formal evidence-based programs or can provide detailed recommendations about discrete components of evidence-based treatments relevant to a specific youth's characteristics. MAP as implemented in the County has four foci of treatment, namely, anxiety, depression, disruptive behavior, and trauma.
Mental Health Integration Program (MHIP) **Formerly known as IMPACT** Adults Unique Clients Served: 986 Gender: 27% Male, 73% Female Ethnicity: 56% Hispanic, 11% African American, 2% Asian, 12% White, 12% Unreported, 3% Multiple Races, 2% Native Hawaiian/Pacific Islander, 0.20% Native American, 1% Other	MHIP delivers specialty mental health services to Tier 2 PEI and Low-Income Health Plan (LIHP)/Healthy Way LA enrollees with less intense mental health needs who are appropriately served through focused, time- limited early intervention strategies. An integrated behavioral health intervention program is provided within a primary care facility or in collaboration with a medical provider. MHIP is used to treat depressive disorders, anxiety disorders or PTSD, and to prevent a relapse in symptoms.
Multidimensional Family Therapy (MDFT) Children (ages 12-15) TAY (ages 16-18)	MDFT is a family-based treatment and substance-abuse prevention program to help adolescents to reduce or eliminate substance abuse and behavior/conduct problems, and improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. There are also two intermediate intervention goals for every family: 1) helping the adolescent achieve an interdependent attachment/bond to parents/family; and 2) helping the adolescent forge durable connections with pro-social influences such as schools, peer groups, and recreational and religious institutions.
Multisystemic Therapy (MST) Children (ages 12-15) TAY (ages 16-17) Unique Clients Served: 1,277 Gender: 41% Male, 59% Female Ethnicity: 53% Hispanic, 12% African American, 1% Asian, 16% White, 11% Unreported, 4% Multiple Races, 1% Native Hawaiian/Pacific Islander, 0.08% Native American, 2% Other	MST targets youth with criminal behavior, substance abuse and emotional disturbance, as well as juvenile probation youth. MST typically uses a home-based approach to reduce barriers that keep families from accessing services. Therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g. extended family, friends) and removing barriers (e.g. parental substance abuse, high stress).
Parent-Child Interaction Therapy (PCIT) Young Children (2-7) Unique Clients Served: 616 Gender: 65% Male, 35% Female Ethnicity: 48% Hispanic, 12% African American, 27% Unreported, 6% White, 5% Multiple Races 0.32% Native American, 2% Other	PCIT provides highly specified, step-by-step, live-coaching sessions with both the parent/ caregiver and the child. Parents learn skills through didactic sessions to help manage behavioral problems in their children. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. The emphasis is on changing negative parent/ caregiver-child patterns.

Early Intervention EBP	Description
Portland Identification and Early Referral (PIER) Children (ages 12-15) TAY (ages 16-25)	PIER provides early treatment for youth who pose a clinical-high-risk of developing severe mental illness, such as schizophrenia and psychosis. By detecting and treating patients at the onset of psychosis, the negative impact of psychosis may be mitigated. The PIER program assists youth and families to increase performance in all areas of life by building coping skills, reducing stress, and implementing problem-solving techniques.
Problem Solving Therapy (PST) Older Adults Unique Clients Served: 10 Gender: 30% Male, 60% Female, 10% Male to Female Ethnicity: 50% Hispanic, 10% African American, 10% White, 30% Unreported,	PST has been a primary strategy in IMPACT/ MHIP and PEARLS. While PST has generally focused on the treatment of depression, this strategy can be adapted to a wide range of problems and populations. PST is intended for those clients who are experiencing short-term challenges that may be temporarily impacting their ability to function normally. This intervention model is particularly designed for older adults who have diagnoses of dysthymia or mild depression who are experiencing early signs of mental illness.
Program to Encourage Active Rewarding Lives for Seniors (PEARLS) Older Adults Unique Clients Served: 12 Gender: 25% Male, 75% Female Ethnicity: 25% Asian, 8% White, 17% African American, 50% Unreported	PEARLS is a community-based treatment program using methods of problem solving treatment (PST), social and physical activation and increased pleasant events to reduce depression in physically impaired and socially isolated older adults.
Prolonged Exposure - Post Traumatic Stress Disorder (PE-PTSD) TAY (ages 18-25) Adults Older Adults Directly Operated Clinics Only Unique Clients Served: 7 Gender: 29% Male, 71% Female Ethnicity: 43% Hispanic, 14% African American, 43% Unreported,	PE-PTSD is an early intervention, cognitive behavioral treatment for individuals experiencing symptoms indicative of early signs of mental health complications due to experiencing one or more traumatic events. Individual therapy is designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety.
Reflective Parenting Program (RPP) Young Children (ages 2-5) Children (ages 6-12) Unique Clients Served: 3 Gender: 33% Male, 67% Female Ethnicity: 67% African American, 33% White	RPP consists of a 10-week workshop that includes instruction, discussions and exercises to involve parents in topics such as temperament, responding to children's distress, separation, play, discipline, and anger as they relate to issues in their own families. The workshops help parents/ caregivers enhance their reflective functioning and build strong, healthy bonds with their children.
Seeking Safety (SS) Children (13-15) TAY Adults Older Adults Unique Clients Served: 1,198 Gender: 31% Male, 69% Female Ethnicity: 44% Hispanic, 7% African American, 2% Asian, 9% White, 33% Unreported, 4% Multiple Races, 0.75% Native American, 1% Other	SS is a present-focused therapy that helps people attain safety from trauma or PTSD and substance abuse. It consists of 25 topics that focus on the development of safe coping skills while utilizing a self-empowerment approach. The treatment is designed for flexible use and is conducted in group or individual format, in a variety of settings, and for culturally diverse populations.

Early Intervention EBP	Description
Stepped Care (SC) Children TAY Adults Older Adults Unique Clients Served: 11,758 Gender: 42% Male, 58% Female Ethnicity: 42% Hispanic, 8% African American, 3% Asian, 9% White, 33% Unreported, 3% Multiple Races, 1% Native Hawaiian/Pacific Islander, 0.25% Native American, 1% Other	This service delivery option intends to improve access to services for clients and families who are experiencing early signs and symptoms of mental illness, require engagement into the mental health system, and are not ready to participate in evidence-based early intervention services. Client level of care received is determined by the initial and ongoing assessment.
Strengthening Families (SF) Children (ages 3-15) TAY (ages 16-18)	SF is a family-skills training intervention designed to enhance school success and reduce substance use and aggression among youth. Sessions provide instruction for parents on understanding the risk factors for substance use, enhancing parent-child bonding, monitoring compliance with parental guidelines, and imposing appropriate consequences, managing anger and family conflict, and fostering positive child involvement in family tasks. Children receive instruction on resisting peer influences.
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Honoring Children, Mending the Circle Children (ages 3-8) Unique Clients Served: 2,551 Gender: 36% Male, 64% Female Ethnicity: 41% Hispanic, 8% African American, 7% White, 33% Unreported, 1% Asian 0.31% Native Hawaiian/Pacific Islander, 0.24% Native American, 7% Multiple Races, 2% Other	This practice for Native American child trauma victims is based on TF-CBT. Treatment goals are to improve spiritual, mental, physical, emotional, and relational well-being. The EBP includes traditional aspects of healing with American Indians and Alaskan Natives from their world view.
Triple P Positive Parenting Program (Triple P) Young Children (ages 0-5) Children (ages 6-15) TAY (age 16) Unique Clients Served: 270 Gender: 65% Male, 35% Female Ethnicity: 33% Hispanic, 4% African American, 9% Asian, 7% White, 3% Multiple Races, 42% Unreported, 0.37% Native Hawaiian/Pacific Islander, 1% Other	Triple P is intended for the prevention and early intervention of social, emotional and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Levels Two and Three, which focus on preventive mental health activities, are being implemented through community- based organizations. Levels Four and Five, which are early interventions parenting and teen modules, are being implemented by LACDMH directly operated and contract agencies.
UCLA Ties Transition Model (UCLA TTM) Young Children (ages 0-5) Children (ages 6-12) Unique Clients Served: Gender: 50% Male, 50% Female Ethnicity: 25% Hispanic, 50% White, 25% Unreported	UCLA TTM is a multi-tiered transitional and supportive intervention for adoptive parents of high-risk children. Families participate in three 3-hour psycho- educational groups. Additional service and support options are available to families, including older children, for up to one year (e.g., monthly support sessions, adoption- specific counseling, home visiting if child is less than age 3, interdisciplinary educational and pediatric consultation).

Table 29. EBP Outcomes since 2009 through June 2022

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
ART	3,432	43%	- 21% Improvement in disruptive behaviors (as reported by parents and children) - 10% Reduction in the severity of problem behaviors (as reported by parents and children) - 14% Improvement in disruptive behaviors (as reported by teachers) - 6% Reduction in the severity of problem behaviors (as reported by teachers)
ART Skillstreaming	328	54%	- 21% Reduction in disruptive behaviors - 19% Reduction in the severity of problem behaviors
AF-CBT	1,729	52%	- 58% Reduction in trauma related symptoms
BFST	203	63%	- 50% Reduction in behavioral problems - 66% Reduction in anxiety symptoms - 60% Reduction in attention problems - 100% Reduction in psychotic behaviors - 50% Reduction in aggressive behaviors
CFOF	733	67%	- 30% Improvement in disruptive behaviors - 20% Reduction in the severity of problem behaviors
CAPPS	211	42%	- 60% Reduction in prodromal symptoms
CPP	211	47%	- 17% Improvement in mental health functioning following a traumatic event
CBITS	131	71%	- No Data to Report (n=12)
CORS	4,177	60%	- 19% Improvement in mental health functioning
DBT	303	54%	- 8% Improvement in emotional regulation
DTQI	1,354	65%	- 55% Reduction in symptoms related to depression
FOCUS	754	71%	- 50% Improvement in direct communication
FC	24	44%	- No Data to Report (n=1)
FFT	1,725	66%	- 31% Improvement in mental health functioning
Group CBT	1,143	42%	- 42% Reduction in symptoms related to depression
IY	2,864	64%	- 35% Reduction in disruptive behaviors - 18% Reduction in the severity of problem behaviors
Ind. CBT	Anxiety 3,972 Depression 7,946 Trauma 1,154	Anxiety 46% Depression 45% Trauma 48%	- 63% Reduction in symptoms related to anxiety - 58% Reduction in symptoms related to depression - 60% Reduction in trauma related symptoms
IPT	8,604	49%	- 54% Reduction in symptoms related to depression
LIFE	433	65%	- 50% Reduction in disruptive behaviors - 23% Reduction in the severity of problem behaviors
MAP	69,118	50%	- 43% Reduction in disruptive behaviors - 25% Reduction in the severity of problem behaviors - 55% Reduction in symptoms related to depression - 44% Reduction in symptoms related to anxiety - 48% Reduction in trauma related symptoms
MHIP	Anxiety 2,995 Depression 6,933 Trauma 302	Anxiety 38% Depression 33% Trauma 29%	- 54% Reduction in symptoms related to anxiety - 57% Reduction in symptoms related to depression - 24% Reduction in trauma related symptoms
MPG	16	86%	- No Data to Report (n=1)
MDFT	77	89%	- No Data to Report (n=6)
MST	126	72%	- No Data to Report (n=0) Pediatric Symptom Checklist 35 is used for this practice
NPP	N/A	N/A	- No Data to Report (n=0)
PCIT	4,868	40%	- 61% Reduction in disruptive behaviors - 36% Reduction in the severity of problem behaviors
PIER	75	18%	- No Data to Report

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
PST	412	63%	- 45% Reduction in symptoms related to depression
PEARLS	173	49%	- 45% Reduction in symptoms related to depression
PE-PTSD	99	57%	- No Data to Report (n=14)
PATHS	747	33%	- 33% Reduction in disruptive behaviors - 19% Reduction in the severity of problem behaviors
RPP	252	71%	- 15% Reduction in disruptive behaviors - 6% Reduction in the severity of problem behaviors
SS	21,273	40%	- 51% Reduction in trauma related symptoms (Adults) - 44% Reduction in trauma related symptoms (Children)
SC	10,559	100%	- 24% Improvement in mental health functioning
SF	237	89%	- No Data to Report (n=15)
TF-CBT	26,904	54%	- 51% Reduction in trauma related symptoms
Triple P	6,545	60%	- 50% Reduction in disruptive behaviors - 27% Reduction in the severity of problem behaviors
UCLA TTM	196	50%	- No Data to Report (N=11)

B. Prevention

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☐ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$132,105,000	$85,010,000	$63,021,000

Program Description

The following prevention activities and services are geared toward addressing, through awareness, education, training, outreach and/or navigation, the risk factors associated with the onset of mental illness or emotional disturbances, including a focus on enhancing protective factors such as social connectedness and support.

Prevention services are also administered by the California Mental Health Services Authority (CalMHSA). CalMHSA is a Joint Powers of Authority (JPA) providing administrative and fiscal services in support of the Department of Mental Health.

FY 2021-22 ■ PREVENTION Data and Outcomes

B1. Community Partnerships

- Antelope Valley Community Family Resource Centers (AV-CFRC)

  The Antelope Valley Community Family Resource Centers are intended to reimagine service delivery, create career pathways, reduce stigma related to mental health while also reducing risk factors, improving protective factors and to embrace children, families and communities as change agents. The AV CFRC is designed to create a coordinated (public/private) community owned and driven space, or network of spaces, where families and individuals in the AV can easily access the services they need to enhance their wellbeing. The CFRCs will be using Community Outreach Services to support, create and share tools and resources that help residents and partner agencies take actions that build upon the resilience of the community to respond to the major stressors that impact individual, child and family wellbeing. Part of the AV-CFRC support is to get true community buy in and support by using Community Ambassadors and co-located partners (such as Antelope Valley Partners for Health (AVPH), Foundation Christian Ministries, and the Wilsona School district) to provide such resources and linkages to address social, housing, food, clothing, employment and any other resource that could mitigate mental health issues.

  The number of surveys collected for the Community Outreach Services (COS) under the Antelope Valley Community Family Resource Center (AV-CFRC) came to a total of 83 surveys, while the number of people served in this program exceeded 500 individuals. Unfortunately, there was a gap between service delivery and survey administration, and only a percentage of the individuals served elected to respond to the surveys. That said, there was a significant positive response to the single event services provided as evidenced by verbal testimonials and via the one-time event surveys, as they demonstrated that the over 70% of those who completed one-time event surveys reported strong in social connectedness/sense of belonging, knowledge of human behavior/development, family functioning/resiliency, nurturing/attachment, concrete supports, hopefulness. Additionally, over 75% reported that they would return for future events/activities and recommend others.

Table 29. FY 2021-22 Demographics – AV-CFRC

Demographics	FY 21-22 (n = 83)		Demographics	FY 21-22 (n = 83)
▪ Primary Language			▪ Ethnicity	
English	65		Hispanic or Latino	
Spanish	14		Central American	3
Declined to Answer	4		Mexican/Mexican-American	30
▪ Sex Assigned at Birth			South American	2
Male	8		Other Hispanic	2
Female	72		Non-Hispanic or Non-Latino follows:	
Declined to Answer/Missing/Unknown	3		Other Non-Hispanic or Non-Latino	14
▪ Current Gender Identity			More than one ethnicity	5
Male/Man	9		Declined to Answer/Missing/Unknown	27
Female/Woman	72		▪ Race	
Another Gender Identity	2		American Indian or Alaska Native	1
Declined to Answer/Missing/Unknown	2		Black or African-American	29
▪ Sexual Orientation			White	23
Gay or Lesbian	2		More than one race	7
Heterosexual or Straight	60		Other	15
Bisexual	1		Declined to Answer/Missing/Unknown	8
Declined to Answer/Missing/Unknown	20		▪ Age	
▪ Disability			16-25	7
No	55		26-59	68
Yes	19		60+	7
Mental disability	7		Declined to Answer/Missing/Unknown	1
Physical/mobility disability	6		▪ Veteran Status	
Chronic health condition	9		Yes	2
Difficulty seeing	1		No	79
Difficulty hearing	2		Declined to Answer/Missing/Unknown	2
Another type of disability	3			
Declined to Answer/Missing/Unknown	9			

- Friends of the Children LA (FOTC-LA)

  FOTC-LA ("Friends") aims to prevent foster care entry and improve family stability and wellbeing for families identified by DCFS as being at high risk of entering foster care, and who are facing challenges like intergenerational poverty and multiple Adverse Childhood Experiences. The program currently focuses on children residing in the Antelope Valley, where professional "friends" support a child and their family for 12+ years. The focus is on developing parental resilience, social connections, knowledge of parenting and child development, concrete supports, and social and emotional competence of children.

  Twenty-nine parents or caregivers were surveyed (some have multiple children enrolled in FOTC-LA) about their participation in the program.
  - 92% said Friends connected them to concrete supports that enrich and stabilize their family
  - 88% said their child's behavior had improved, making their home a more positive place
  - 91% said Friends helped them support their child's school success
  - 86% said Friends supported them to better understand their child's needs and strengths

Table 30. FY 2021-22 Demographics – FOTC-LA

Demographics	Count (n = 48)		Demographics	Count (n = 48)
▪ Primary Language			▪ Ethnicity	
English	44		Hispanic or Latino as follows:	
Spanish	4		Other/Unknown Hispanic	22
▪ Age			Non-Hispanic or Non-Latino as follows:	
<16	48		African	23
▪ Sex Assigned at Birth			Declined to Answer	3
Male	32		▪ Race	
Female	16		Black or African-American	23
▪ Disability			White	25
No	48			

- Incubation Academy

  The Incubation Academy is a capacity-building project in collaboration with Community Partners. The project provides mentorship, training, technical support and financial resources for 29 small and mid-sized grassroot organizations that are providing prevention-related mental health activities within their communities. The organizations vary in their programming and target population as the goal is to prepare such organizations to compete for future contracting with DMH.

Table 31. FY 2021-22 Demographics – Incubation Academy

Demographics	Count (n = 13,836)	Demographics	Count (n = 13,836)
▪ Primary Language		▪ Ethnicity	
Arabic	3	Hispanic or Latino as follows:	
Armenian	1	Caribbean	10
Cantonese	1	Central American	115
English	2,094	Mexican/Mexican American/Chicano	665
Farsi	4	Puerto Rican	7
Korean	3	South American	18
Mandarin	1	Other Hispanic/Latino	122
Spanish	406	Non-Hispanic or Non-Latino as follows:	
Tagalog	4	African	144
American Sign Language	1	Asian Indian/South Asian	6
Other	16	Cambodian	1
Declined to answer/Missing/Unknown	11,286	Chinese	3
▪ Sex Assigned at Birth		Eastern European	32
Male	790	European	393
Female	1,388	Filipino	14
Declined to answer/Missing/Unknown	11,658	Japanese	3
▪ Current Gender Identity		Korean	3
Male/Man	841	Middle Eastern	12
Female/Woman	1,331	Vietnamese	1
Transgender	6	Other	63
Genderqueer/Non-Binary	19	More than one ethnicity	70
Another Gender Identity	2	Declined to answer/Missing/Unknown	12,154
Declined to answer/Missing/Not sure what question means	11,328	▪ Race	
		American Indian or Alaska Native	70
▪ Sexual Orientation		Asian	52
Gay or Lesbian	106	Black or African-American	489
Heterosexual or Straight	1,040	Native Hawaiian or Pacific Islander	14
Bisexual	32	White	883
Questioning or Unsure	16	More than one race	105
Queer	20	Other	487
Another Sexual Orientation	2	Declined to answer/Missing/Unknown	11,736
Declined to answer/Missing/Unknown	12,314	▪ Age	
▪ Disability		<16	724
No	1,423	16-25	568
Yes	250	26-59	1,158
Mental domain	106	60+	309
Physical/mobility domain	58	Declined to answer/Missing/Unknown	11,077
Chronic health condition	52	▪ Veteran Status	
Difficulty seeing	34	Yes	96
Difficulty hearing	19	No	1,684
Another type of disability	8	Declined to answer/Missing/Unknown	11,750
Declined to answer/Missing/Unknown	12,163		

- Los Angeles Unified School District (LAUSD)

  LAUSD conducts a variety of mental health promotion and risk prevention activities with students and their parents. In FY 2021-22, some of the programs provided included Bounce Back, CBITS, Erika's Lighthouse, FOCUS Resilience Curriculum, Second Step,

and Seeking Safety. In FY 2020-21, these programs served over 32,000 students and parents.

Table 32. FY 2021-22 Demographics - LAUSD

Demographics	Count (n = 32,841)		Demographics	Count (n = 32,841)
▪ Primary Language			▪ Ethnicity**	
English	14,982		Hispanic or Latino as follows:	
Arabic	52		Mexican/Mexican-American/Chicano	5
Armenian	148		Other/Unknown Hispanic	24,933
Farsi	75		Non-Hispanic or Non-Latino as follows:	
Cambodian	7		Cambodian	15
Cantonese	37		Chinese	62
Korean	68		Filipino	394
Mandarin	17		Japanese	27
Russian	69		Korean	95
Spanish	16,499		Vietnamese	45
Vietnamese	26		Other Non-Hispanic	454
Other	527		More than one ethnicity	672
Declined to answer/missing	334		Declined to answer/missing	6,139
▪ Age			▪ Race**	
<16	23,974		Asian	645
16-25	8,867		Black or African-American	4,277
▪ Disability*			Native Hawaiian or other Pacific Islander	574
No	27,645		White	23,395
Yes	5,196		Other	778
Mental disability	250		Declined to answer/missing	3,172
Physical/mobility disability	36		▪ Gender	
Difficulty seeing	7		Male	14,715
Difficulty hearing	1,287		Female	18,126
Another type of disability	3,616			

*Disability is not collected by LAUSD. In the past, students enrolled in Special Education were coded as "Yes" while those not enrolled in Special Education were coded as "Declined to answer/missing" while this year they were coded as "No".

**Ethnicity and race were collected as one category by LAUSD. In the past, students identified as Hispanic or Latino were re-coded as "Other" race while this year they were re-coded as "White" race.

- My Health LA Behavioral Health Expansion Program

  On October 1, 2014, DHS formally launched the My Health LA (MHLA) Program with the goal of increasing access to primary health care services for low income, uninsured residents of Los Angeles County. On November 20, 2018, the Board of Supervisors approved numerous changes to the MHLA agreement with Community Partner Clinics (CPs). A workgroup was formed to understand gaps in behavioral healthcare access and how to address those gaps. The group identified as a priority the need to better support CPs who provide mental health care services to MHLA participants in a primary care setting. It was determined DMH would fund and support mental health prevention services and/or activities (MHPS) to reduce/manage risk factors associated with the onset of serious mental illness, as well as to cultivate and support protective factors of MHLA participants at CPs through a Prevention Program. As of September 2019, approximately 142,000 individuals were enrolled in the program.

  In this second year of this piloted program of integrating MHPS into CPs, a primary objective was to address any implementation challenges that surfaced in year one, and where feasible, make the necessary program modifications to further the original mission and objectives established in year one. As in year one of this piloted program, the ongoing Covid-19 Pandemic continued to impact each of the participating CPs' workforce. These community-based health care clinics remained on the front line in their respective communities for handling Covid-19 education and information dissemination, treatment, testing, and vaccinations. The CP staff had again been pulled in multiple directions to help their community manage the Pandemic while continuing with their implementation efforts of this MHPS Program. Some new program implementation challenges from year one, such as staffing logistics (new hires), revisions to business workflows (claiming and billing processes) and clinical workflows (referrals to and from MHPS), etc. remained as second year challenges as well.

  Despite the challenges outlined above, in this second year of the piloted program, MHPS outcome metrics [Patient Health Questionnairre-9 (PHQ-9) as the required measure in the MHPS screening, and the Generalized Anxiety Disorder-7 (GAD-7) as the optional second measure] were able to be collected, aggregated, data mined and reported. The number of unique MHLA patients receiving at least one MHPS for the period of July 1, 2021 through and including April 30, 2022 was 28,593*.

  Table 33. FY 2021-22 Outcomes - MHPS

Name of Outcome Measure	Total Number of Reported Cases with both a Pre and Post Score	Average Pre-Score	Average Post Score	Average Percentage Score Change	Average Number of Sessions
Anxiety (GAD-7)	114	7.51	4.25	43.34%	6.8
Depression (PHQ-9)	336	7.92	4.32	45.40%	7.2

  Among those who were assessed at both the beginning of the program and end of the program, the average GAD-7 score decreased by more than 43%, while the average PHQ-9 score decreased by more than 45%, indicating there was an overall decline in both self-reported anxiety and depression symptoms through the course of programming (Table 5).

  *At the time this information was generated, data for the months of May and June were not yet available. Additionally, the number of MHLA enrollees fluctuated in a downward trend with the final number of enrollees for FY21-22 at 94,892. Much of the final decline

in the number of MHLA enrollees was attributed to the new California law which gave full scope Medi-Cal to adults 50 years of age and older, regardless to immigration status.

Table 34. FY 2021-22 Demographics – MHPS

Demographics	Count (n = 28,593)		Demographics	Count (n = 28,593)
▪ Primary Language			▪ Ethnicity**	
English	1,746		Hispanic or Latino as follows:	
Arabic	1		Other/Unknown Hispanic	26,907
Armenian	89		Non-Hispanic or Non-Latino as follows:	
Farsi	2		Asian Indian/South Asian	9
Khmer/Cambodian	6		Cambodian	6
Korean	11		Chinese	5
Chinese (multiple dialects)	20		Filipino	340
Hindi	5		Japanese	1
Russian	17		Korean	18
Spanish	26,459		Vietnamese	4
Tagalog	23		Other Non-Hispanic	1
Thai	129		▪ Race**	
Vietnamese	4		Asian	365
Other	16		Black or African-American	44
Declined to answer/missing	65		Native Hawaiian or other Pacific Islander	5
▪ Age			White	161
26-64	25,881		Other/mixed	63
65+*	2,712		Declined to answer/missing	664
▪ Gender				
Male	10,038			
Female	18,548			
Other	7			

*DHS uses 65+ to indicate elderly whereas MHSA uses 60+.
**Ethnicity and race were collected as one category by DHS.

- Nurse Family Partnership (NFP)

The Nurse Family Partnership (NFP) is a program implemented by the Department of Public Health which targets high-risk, low-income, pregnant women, or parents/caregivers with children between the ages of 0 and 5 years old. A woman can receive services through the child's second birthday. As a result of the pandemic, the majority of services were delivered via telehealth and a small portion were delivered in person. Screenings for mental health and protective factors were integrated into existing services in an effort to decrease risk factors and provide support and services. The skills of NFP home visitors were also enhanced through trainings so that they can recognize mental health risk factors and refer for mental health treatment when deemed necessary.

Nurse Family Partnership (NFP) targets child abuse and neglect, preterm births, risky health behaviors, reliance on public assistance, and crime. Home visitors target potential negative outcomes by working with parents/caregivers in the following areas: personal health; parental role; child health and development; reproductive health practices; and case management including referral and linkage to concrete supports. NFP interventions target the improvement of the following protective factors: parental resilience, social connections, concrete support, knowledge of parenting and child development, and social and emotional competence of children.

NFP uses the Parents' Assessment of Protective Factors (PAPF) to determine outcomes. However due to the limited number of home visits because of the pandemic, results were not conclusive. NFP served 267 parents/caregivers in FY 2021-22. Demographics are provided for those who were newly enrolled in FY 2021-22.

Table 35. FY 2021-22 Demographics - NFP

Demographics	Count (n = 149)	Demographics	Count (n = 149)
▪ Primary Language		▪ Ethnicity	
English	91	Hispanic or Latino as follows:	
Spanish	53	Central American	17
Other	1	Mexican/Mexican American/Chicano	69
Declined to answer	4	Puerto Rican	3
▪ Age		South American	5
0-15	2	Other Hispanic	43
16-25	76	Non-Hispanic or Non-Latino as follows:	
26-59	61	African	4
Declined to answer	10	Filipino	3
▪ Gender Assigned at Birth		More than one ethnicity	2
Female	140	Declined to answer	3
Declined to answer	9	▪ Race	
▪ Current Gender Identity		American Indian	4
Female/Woman	140	Asian	6
Declined to answer	9	Black or African-American	3
▪ Sexual Orientation		White	131
Heterosexual or Straight	129	More than one race	2
Declined to answer	20	Declined to answer	3
▪ Disability		▪ Veteran Status	
No	42	No	126
Yes	93	Declined to answer	23
Mental domain	33		
Chronic health condition	1		
Other	8		
Declined to answer	14		

- Prevention & Aftercare (P&A)

Prevention and Aftercare (P&A) is a DCFS-monitored program of ten leading community agencies proving a variety of services to the community to empower, advocate, educated, and connect with others. The services increase protective factors by providing support and community to mitigate the adverse effects of Adverse Childhood Experiences (ACEs) and social determinants of health. Program services are delivered in-person and virtually and can be from one time to a year or ongoing.

Prevention and Aftercare program services are to be offered and rendered to all families Countywide, who meet one or more of the following criteria:

1. Children and families at-risk of child maltreatment and/or DCFS involvement self-referred or referred by community stakeholders such as DMH Specialized Foster Care (SFC) offices, schools, hospitals, and law-enforcement agencies.
2. Children and families with unfounded, closed child abuse DCFS referrals.
3. Children and families with evaluated out DCFS child abuse and/or neglect referrals.
4. DCFS referred clients, who are receiving Family Reunification services.

5. DCFS referred children and families who have exited the public child welfare system and are in need of services to prevent subsequent child maltreatment and/or DCFS involvement.

Negative outcomes identified by MHSA and which participants of P&A may be risk of that may result from untreated, undertreated or inappropriately treated mental illnesses are: 1) suicide, 2) incarceration, 3) school failure or dropout, 4) unemployment, 5) prolonged suffering, 6) homelessness, and 7) removal of children from their homes.

It was estimated that 8,464 people attended P&A single events. With only one person per family completing a survey, there were 2,290 surveys collected. On average over 85% of families surveyed reported that they felt that because of the one-time event they were able to:

- Connect with others
- Learn something new about themselves
- Learn about community programs and/or resources that can be useful and increase access
- Learned something new and will be doing something different with their family

The following findings are based on 1,049 Protective Factors Surveys administered at baseline and after completion of multi-session P&A case navigation services. There was a general increase in protective factors from families from baseline to end of services. The most notable increases were in:

- Parent/caregiver resilience: score increased from 2.8 to 3.1
- Social connections: score increased from 2.7 to 3.0
- Knowledge of parenting and child development: score increased from 2.7 to 3.0
- Social and emotional competence of children: 4.0 to 4.2
- Social and emotional competence of adults: 4.0 to 4.1
- Caregiver/Practitioner Relationship: 3.0 to 3.2

Table 36. FY 2021-22 Demographics – P&A

Demographics	Count (n = 1,049)	Demographics	Count (n = 1,049)
▪ Primary Language		▪ Ethnicity	
Cambodian	1	Hispanic or Latino as follows:	
Cantonese	1	Caribbean	3
English	487	Central American	91
Farsi	1	Mexican/Mexican American/Chicano	367
Korean	7	Puerto Rican	6
Spanish	233	South American	11
Declined to answer/Missing/Unknown	319	Other Hispanic/Latino	70
▪ Sex Assigned at Birth		Non-Hispanic or Non-Latino as follows:	
Male	141	African	63
Female	601	Asian Indian/South Asian	6
Declined to answer/Missing/Unknown	307	Cambodian	4
▪ Current Gender Identity		Chinese	7
Male/Man	138	European	10
Female/Woman	597	Filipino	11
Genderqueer/Non-Binary	1	Japanese	1
Another Gender Identity	1	Korean	7
Declined to answer/Missing/Not sure what question means	312	Middle Eastern	5
		Other	13
▪ Sexual Orientation		More than one ethnicity	18
Gay or Lesbian	3	Declined to answer/Missing/Unknown	356
Heterosexual or Straight	676	▪ Race	
Bisexual	14	American Indian or Alaska Native	56
Questioning or Unsure	3	Asian	31
Queer	3	Black or African-American	116
Another Sexual Orientation	23	Native Hawaiian or Pacific Islander	1
Declined to answer/Missing/Unknown	352	White	132
▪ Disability		More than one race	26
No	402	Other	310
Yes	219	Declined to answer/Missing/Unknown	377
Mental domain	51	▪ Age	
Physical/mobility domain	30	16-25	46
Chronic health condition	93	26-59	459
Difficulty seeing	17	60+	16
Difficulty hearing	10	Declined to answer/Missing/Unknown	528
Another type of disability	18	▪ Veteran Status	
Declined to answer/Missing/Unknown	428	Yes	10
		No	700
		Declined to answer/Missing/Unknown	339

- Prevent Homelessness Promote Health (PH^2)

Prevent Homelessness Promote Health (PH^2) is a collaboration between Los Angeles County Department of Health Services (DHS): Housing for Health (HFH) and Department of Mental Health (DMH). It is a Countywide program that conducts field-based outreach services to assist previously homeless individuals and families who are experiencing untreated serious and persistent medical and mental illness avoid returning to homelessness due to lease violations.

The DMH Prevent Homelessness Promote Health - PH^2 employs an interdisciplinary, multicultural, and bilingual staff, utilizing a collaborative approach through coordination with Department of Health Services (DHS), Housing for Health (HFH) Intensive Case Managers (ICMS), Department of Mental Health (DMH), and community housing

agencies. This program provides services within the 8 Service Areas of Los Angeles County. All initial outreach is provided in the community where the individual lives to promote access to care. The PH^2 team conducts triage, coordination of services, and brief clinical interventions, as well as incorporating Motivation Interviewing (MI), Harm Reduction, Trauma Informed therapy, Solution Oriented therapy, Cognitive Behavior therapy, and Seeking Safety. Services are delivered primarily in person or can be delivered by phone or virtually.

Individuals are referred with the following identified problems, among others: Aggressive/Violent Behavior, Destruction of Property, Failure to Pay Rent, Fire Safety/Health Hazard, Hoarding, Infestation of Unit, Legal Issues, Relationship Conflicts, and Substance Abuse. The PH^2 team meets with individuals weekly, depending on acuity and need. The program may see participants from two weeks to 18 months, with an average of six months.

The cumulative number of new individuals served during this reporting period is 172. This is not inclusive of 21 unique individuals that carried over from last reporting period that continued to be provided service. Total individuals served during this reporting period is 213.

The effectiveness of the program can be demonstrated by examining three sources of data in the Integrated Behavior Health Information System (IBHIS):

- The first tool is the Service Request Log (SRL). The SRL documents the name of the individual being referred and other pertinent details of the referral.
- The second tool is the PH^2 Referral Log. This log contains referring party information (agency), reason for referral, service provider area, type of housing, eviction status, safety issues, referral type (physical or mental health related), type of housing voucher, gender identity, sexual orientation, disability and veteran status.
- The third tool is the PH^2 Activity Log. The purpose of this log is to capture what type of services were offered and/or provided that prevented the return to homelessness. The PH^2 Activity Log is completed for each corresponding billable note in IBHIS (direct or indirect). The categories include resources offered, linkages obtained, peak eviction risk, eviction prevented, eviction date (if applicable) and closure reason.

Housing insecurity is addressed when an individual's protective factors are increased and/or their risk factors are decreased. The PH^2 Activity Log in IBHIS tracks Peak Eviction Risk Level during the participant's engagement in PH^2. Meanwhile, linkage to resources like mental health services, medical care, In Home Supportive Services, and food and other basic necessities, indicate progressive housing stabilization. As such, the number of referrals with linkages and the number of evictions prevented serve as good proxies for reduced homelessness and the conditions caused or exacerbated by homelessness.

Table 37. FY 2021-22 PH^2 Linkages to Each Resource

Mental Health Services	257
Primary Care Physician	45
Department of Health Services	41
Housing and Supportive Services	29
Food Bank	22
Emergency Services	14
Transportation	12
Adult FSP	10
CBEST	6
Calfresh	4
Social Security	3
General Relief	3
Other (ICMS, IHSS, IHCG, groceries, clothing, utility assistance, etc.)	100

Note: Referrals can have multiple linkages

The most common linkages provided by PH^2 were to mental health services, followed by primary care physicians, DHS, and housing and supportive services (Table 9).

Of the 156 closed cases, 74 clients had an eviction prevented. 68 clients were linked to appropriate mental health services. For only seven closed cases was eviction not prevented (Table 10).

Table 38. FY 2021-22 PH^2 Disposition of Closed Cases

	Count (n = 156)
Eviction Prevented	74
Linked to Appropriate MHS	68
No Current Risk of Eviction	19
Eviction not Prevented	7
Could not Locate	29
Declined Services	45
Unknown/Other	19

Note: clients can have more than one closure reason.

Table 39. FY 2021-22 Demographics – PH^2

	Count (n = 171)
▪ Primary Language	
English	146
Spanish	7
Declined to answer/Missing/Unknown	18
▪ Sex Assigned at Birth	
Male	99
Female	72
▪ Current Gender Identity	
Male/Man	91
Female/Woman	67
Transgender man/Transmasculine	2
Undecided/unknown	8
Declined to answer/ask or Missing or Not sure what question means	3
▪ Sexual Orientation	
Heterosexual or Straight	53
Gay or Lesbian	7
Undecided/Unknown	112
▪ Age	
16-25	1
26-59	118
60+	52
▪ Disability	
No	20
Yes	62
Mental domain	43
Physical/mobility domain	28
Chronic health condition	14
Difficulty seeing	2
Difficulty hearing	1

	Count (n = 171)
▪ Ethnicity	
Hispanic or Latino as follows:	
Caribbean	1
Central American	2
Mexican/Mexican American/Chicano	20
Puerto Rican	1
Other Hispanic/Latino	7
Non-Hispanic or Non-Latino as follows:	
Asian Indian/South Asian	2
European	1
Korean	3
Middle Eastern	1
Other	68
More than one ethnicity	2
Declined to answer/Missing/Unknown	63
▪ Race	
American Indian	1
Asian	4
Black or African-American	39
White	25
More than one race	2
Other*	37
Declined to answer/Missing/Unknown	63
▪ Veteran Status	
Yes	5
No	74
Declined to answer/ask or Missing or Unknown	92

	Count (n = 171)			Count (n = 171)
▪ Primary Language			▪ Ethnicity	
English	146		Hispanic or Latino as follows:	
Spanish	7		Caribbean	1
Declined to answer/Missing/Unknown	18		Central American	2
▪ Sex Assigned at Birth			Mexican/Mexican American/Chicano	20
Male	99		Puerto Rican	1
Female	72		Other Hispanic/Latino	7
▪ Current Gender Identity			Non-Hispanic or Non-Latino as follows:	
Male/Man	91		Asian Indian/South Asian	2
Female/Woman	67		European	1
Transgender man/Transmasculine	2		Korean	3
Undecided/unknown	8		Middle Eastern	1
Declined to answer/ask or Missing or Not sure what question means	3		Other	68
			More than one ethnicity	2
▪ Sexual Orientation			Declined to answer/Missing/Unknown	63
Heterosexual or Straight	53		▪ Race	
Gay or Lesbian	7		American Indian	1
Undecided/Unknown	112		Asian	4
▪ Age			Black or African-American	39
16-25	1		White	25
26-59	118		More than one race	2
60+	52		Other*	37
▪ Disability			Declined to answer/Missing/Unknown	63
No	20		▪ Veteran Status	
Yes	62		Yes	5
Another communication disability	1			
Another type of disability	2			
Declined to answer/ask or Missing or Unknown	89			

*Ethnicity and race were collected as one category by IBHIS. Therefore, participants identified as Hispanic or Latino were coded as "Other" race.

- Strategies for Enhancing Early Developmental Success (SEEDS) Trauma-Informed Care for Infants & Toddlers

  In fall 2020, SEEDS launched its Trauma-Informed Care for Infants & Toddlers ("SEEDS Infants & Toddlers series"), a four-part trauma-informed, attachment-based virtual training series designed for professionals who work with young children and families. As of the writing of this report, SEEDS has completed 12 cohorts of this training series with 317 total participants.

  SEEDS Infants & Toddlers series explores how to co-regulate with and promote self-regulation in infants and toddlers, including those who have experienced trauma and other early adversities. Self-regulation skills in young children have been found to be highly predictive of positive educational, social, and mental health outcomes throughout childhood, adolescence, and later in adult life.

  In total, the series provides 6 hours of specialized training in trauma-informed care for young children (ages birth to 3 years old), including:
  - Part 1: Learning how to recognize the types of cues that infants and toddlers demonstrate
  - Part 2: Practicing how to understand (or seek to understand) the meaning of these cues in light of what we know about early childhood trauma and early adversities

- Part 3: Preparing to respond to infant and toddler cues in hot moments (that is, when the child and/or the adult is distressed, upset, or dysregulated)
- Part 4: Preparing to respond to infant and toddler cues in cool moments (that is, when the child and the adult are comfortable, calm, and able to play, engage, or have fun together)

On an item measuring global satisfaction with the series (rated on a 10-point scale, with 1 = extremely unsatisfied and 10 = extremely satisfied), participants' mean rating was 9.38, suggesting a high level of satisfaction overall with the training series.

In addition, participants completed a 10-item measure (with possible scores ranging for 0 to 10) to assess their knowledge of concepts and skills covered in SEEDS Infants & Toddlers series. At the pre-training assessment, participants had a mean score of 6.1, whereas at the post-training assessment they had a mean score of 8.5, indicating a mean improvement of 2.4.

Table 40. FY 2021-22 Outcomes - SEEDS

Knowledge/Skill Domain	Pre-training % correct	Post-training % correct	Change from pre- to post-
1. Trauma-informed approach/using observation with infants	100%	100%	0%
2. Co-regulating using sensory inputs	23%	75%	+52%
3. Self-regulation in infants and toddlers	77%	75%	-2%
4. Trauma-informed approach: using observation with toddlers	54%	100%	+46%
5. Trauma-informed approach: what types of questions to ask ourselves before intervening	69%	75%	+6%
6. Goal for adult caregivers is not to prevent the child's dysregulation, but to attempt co-regulation to strengthen relationship	39%	88%	+49%
7. Relationships as crucial for infants' and toddlers' development	62%	88%	+26%
8. Responding in hot moments	69%	100%	+31%
9. Child-led play, skills of duplicate and elaborate	54%	63%	+9%
10. Hot and cool moments	62%	88%	+26%

The percentage of participants that answered correctly improved dramatically in several domains (by about 50% each), including the skills *co-regulating using sensory inputs* and *trauma-informed approach of using observation with* toddlers, and the knowledge domain *goal for adult caregivers is not to prevent the child's dysregulation, but to attempt co-regulation to strengthen relationship* (Table 12).

- Veterans Peer Access Network (VPAN)

Veteran Peer Access Network (VPAN) is a Prevention program which serves Veterans and Military family members in Los Angeles County. The goals are to: 1) increase protective factors such as financial stability, resiliency, socio-emotional skill building, and social connectedness, and 2) reduce risk factors such as suicidality, homelessness, and under/unemployment.

1. Under VPAN, DMH and SoCal Grantmakers, as well as other Community-based Organizations (CBOs), provide peer support and linkage to services, reducing mental health services utilization. The goal of prevention services provided through VPAN CBOs is to implement a set of strategies that will augment existing programs. In addition, new preventative and trauma-informed community supports are provided to Veterans and Veteran family members in order to promote protective factors and diminish risk factors for developing a potentially serious mental illness.

Peer services are provided from 8:00am-6:00pm, five days per week, Monday through Friday. Community events may be held on weekends. The program is delivered based on the client's needs in-person, by phone, or virtually. In FY 2021-22, 3,324 veterans and military family members were served through VPAN CBOs.

2. The VPAN Support Line is dedicated to assisting active-duty military personnel, veterans, reservists and guard members. The peers who staff the VPAN Support Line understand the unique sacrifices and emotional needs that come with military life. The VPAN Support Line offers Emotional First Aid related to stressors, referrals to community services, real-time psychoeducation on mental health services, and direct access to field-based teams for additional support and follow-up.

In FY 2021-22, the Veteran Support Line received a total of 10,546 calls, of which 162 were assigned to VPAN field staff for follow-up. Due to the nature of the support line, a referral is generated, and demographics collected only when the caller is requesting services and/or benefits.

3. In addition, under the VPAN Veteran System Navigators program, the Department of Military and Veterans Affairs (DMVA) provides benefits establishment, reducing potential negative outcomes like homelessness, food insecurity, and associated stress. Prevention programing serves to increase protective factors which include resilience, socio-emotional skill building in Veterans and Veteran family members, and social connectedness through specialty programming. The DMVA County Veterans Service Office has secured more than $ 27 million dollars in benefits for veterans, their dependents, and survivors. Veterans Systems Navigators lead the way in ensuring veterans in the community apply for and secure benefits they have earned, relieving financial stress during transition periods, preventing homelessness by assisting with housing resources, and enrolling veterans into Department of Veterans Affairs Healthcare/Mental Health to include Veterans Centers so veterans can receive the care they need and deserve.

DMVA served a total of 812 clients in FY 2021-22.

The different VPAN programs have different data collection procedures, with variable questions and response options, such that in many cases entire categories are missing. It is also possible that some participants are represented in multiple datasets. That said, the following is available demographic data on VPAN participants.

Table 41. FY 2021-22 Demographics – VPAN

	Count (n=15,824)			Count (n=15,824)
▪ Age			▪ Ethnicity	
0-15	3		Hispanic or Latino as follows:	
16-25	320		Mexican/Mexican-American/Chicano	192
26-59	2,903		Other Hispanic	861
60+	2,046		Non-Hispanic or Non-Latino as follows:	
Declined to Answer/Missing/Unknown	10,552		Other Non-Hispanic	1,962
▪ Sex Assigned at Birth			Declined to Answer/Missing/Unknown	12,809
Male	4,017		▪ Race	
Female	1,024		American Indian or Alaska Native	50
Declined to Answer/Missing/Unknown	10,783		Asian	200
▪ Current Gender Identity			Black or African-American	1,047
Male / Man	4,017		Native Hawaiian or other Pacific Islander	55
Female / Woman	1,024		White	1,570
Genderqueer / Non-Binary	7		Other	811
Another Gender Identity	4		More than one race	152
Declined to Answer/Missing/Unknown	10,772		Declined to Answer/Missing/Unknown	11,939
▪ Sexual Orientation			▪ Primary Language	
Heterosexual or Straight	812		English	4,136
Declined to Answer/Missing/Unknown	15,012		Declined to Answer/Missing/Unknown	11,688
▪ Disability			▪ Veteran	
No	978		No	519
Yes	1,992		Yes	4,656
Mental Disability	112		Declined to Answer/Missing/Unknown	10,649
Physical/Mobility Disability	92			
Chronic Health Condition	617			
Difficulty Seeing	20			
Difficulty Hearing	83			
Declined to Answer/Missing/Unknown	12,854			

- Youth-Community Ambassador Network (CAN-Youth)

  The Los Angeles Trust for Children's Health (The L.A. Trust) was contracted by California Mental Health Services Authority (CalMHSA) to support the Los Angeles County Department of Mental Health (LACDMH) by developing the Youth Community Ambassador Program. The aim is to co-create a Youth Peer Ambassador Program in partnership with students and LAUSD school mental health staff focused on prevention and navigation to care. The L.A. Trust provides oversight of the activities, training, staffing, and student stipend distribution, for the Community Ambassador Network-Youth (CAN Youth) program within the Los Angeles Unified School District (LAUSD). High school students within selected LAUSD school sites are recruited and vetted to serve on the Student Advisory Boards as trained Youth Community Ambassadors and serve as mental health access agents, navigators, and mobilizers within their school communities. Youth Community Ambassadors leverage their peer relationships to support mental health, driving a collective self-help model to promote healing, recovery, and youth empowerment.

  In FY 2021-22, 16,792 youth were served through CAN Youth. A survey was developed by the UCLA evaluators. However, the requirements for approval from LAUSD and parental consent delayed data collection such that surveys were only completed by 11 respondents.

Table 42. FY 2021-22 Demographics – CAN Youth

	Count (n = 11)			Count (n = 11)
▪ Primary Language			▪ Ethnicity	
English	11		Hispanic or Latino as follows:	
▪ Age			Central American	1
16-25	11		Mexican/Mexican-American/Chicano	5
▪ Current Gender Identity			Other Hispanic	1
Declined to answer/Missing	11		Non-Hispanic or Non-Latino as follows:	
▪ Sex Assigned at Birth			Asian	3
Male	1		Other Non-Hispanic	1
Female	10		▪ Race	
▪ Sexual Orientation			Black or African-American	2
Heterosexual or Straight	8		White	1
Bisexual	1		Other	2
Questioning or Unsure	1		More than one race	1
Declined to Answer/Missing	1		Declined to answer	5
▪ Veteran			▪ Disability	
No	11		No	10
			Declined to Answer/Missing	1

- Center for Strategic Partnership
  Joint collaboration to support philanthropic engagement and strategic consultation on various complex countywide Board directed initiatives and priorities.

- Los Angeles County Office of Education
  LACOE CS focus on both academic and out-of-school factors that impact high school students' lives. LACOE CS targets high school students from 15 school districts. Currently each of the 15 districts has one identified high school site. The LACOE CS model supports schools in becoming centralized hubs for students and their families to receive greater access to a continuum of services that range from concrete supports, school resources, staff support, mental health prevention services and referrals/linkages to community resources.

- SEED School of Los Angeles (SEED LA)
  SEED LA is the County's first public, charter, college-preparatory, tuition-free boarding high school for at-risk youth. The curriculum, grounded in science, technology, engineering, and mathematics (STEM), will prepare youth for career and college pathways in the transportation and infrastructure industry. The school provides on-site support, wellness services and socio-emotional counseling for students.

B2. Prevention: Community Outreach

LACDMH has expanded its PEI Community Outreach Services (COS) in order to achieve the following:

- Increase the number of individuals receiving prevention and early intervention services;
- Outreach to underserved communities through culturally appropriate mental health promotion and education services; and
- Provide mental health education and reduce stigma on mental health issues in our communities.

COS affords an avenue for the LACDMH PEI network to provide services such as education and information to individuals who are not formal clients of the mental health system and

providers who are outside the county mental health system. Often individuals, as well as their parents, family, caregivers, and other support system, who need or would benefit from prevention and early intervention mental health services do not seek traditional clinic-based services due to a multitude of factors. Community outreach is a key component in initiating and providing effective mental health supportive services to these individuals. Most programs are not evidence-based practices, but nonetheless have significant data and research indicating the effectiveness of their services.

COS Outcomes

In previous years, LACDMH in collaboration with RAND, developed questionnaires that asked individuals to report on general wellness and risk and protective factors for our COS programs. For each different population (adult, parent, youth), surveys were administered to clients at the start of a prevention activity and follow-up surveys were administered to clients after they participated in the prevention activity.

In FY 2020-21, LACDMH suspended the use of the instrument created by the RAND corporation to collect outcomes for COS programs. LACDMH recently made changes to the data collection protocol for Prevention programs funded under MHSA Prevention and Early Intervention (PEI). These changes were proposed after consulting with subject matter experts based on input from our stakeholders to reduce the burden of collecting additional measures while still ensuring data satisfies PEI evaluation regulations set forth by the Mental Health Oversight and Accountability Commission (MHSOAC). It is anticipated that these outcomes and demographics will be available starting in FY 2022-23.

Table 43. Programs approved for billing PEI COS

Prevention Program	Description
Active Parenting Parents of children (3-17)	Active Parenting provides evidence-based, video-based, group parenting classes that cover topics including parenting skills training, step-parenting, managing divorce, school success, and character education. Active Parenting classes can be delivered in 1, 3, 4, or 6 group sessions. Curriculum addresses: child development, appropriate discipline, communication skills, decision-making and prevention of risk behaviors.
Arise Children (4-15) TAY (16-25) Adult (26-59) Older Adult (60-64)	Arise provides evidence-based life skills group based curricula and staff training programs. Programs are geared towards at-risk youth; however, the program is adaptable for adults as well. Program content focuses on violence reduction, goal setting, anger management, drug and alcohol avoidance and other life management skills.
Asian American Family Enrichment Network (AAFEN) Parents of Children (12-15) TAY (16-18)	AAFEN is for Asian immigrant parents and/or primary caregivers with inadequate parenting skills to effectively discipline and nurture their teenage children. Because of the cultural and linguistic barriers experienced by many of these immigrant parents, they often feel overwhelmed and incompetent in terms of effectively managing their family lives. Moreover, their children experience reduced family attachment and social functioning, as well as increased family conflict. The children are thus at high risk for emotional and behavioral problems. Their immigrant parents and/or primary caregivers are at high risk for depressive disorders and for being reported to DCFS to corporal punishment.
Childhelp Speak Up and Be Safe Children (3-15) TAY (16-19)	This is a child-focused, school-based curriculum designed to build safety skills within the child while addressing today's societal risks, such as bullying and Internet safety. The program helps children and teens learn the skills to prevent or interrupt cycles of neglect, bullying, and child abuse. The program focuses on enhancing the child's overall sense of confidence regarding safety and promotes respect for self and peers that can be applied to general as well as potentially harmful situations. In addition to increasing children's ability to recognize unsafe situations or abusive behaviors and building resistance skills, lessons focus on helping children build a responsive safety network with peers and adults that the child identifies as safe.

Prevention Program	Description
Coping with Stress Child (13-15) TAY (16-18)	This course consists of 15 one-hour sessions, which can be offered at a pace of 2 to 4 times per week, depending on site capabilities and needs. The first few sessions provide an overview of depression, its relationship to stressful situations, and an introduction to other group members. Subsequent sessions focus on cognitive-restructuring skills and techniques for modifying irrational or negative self-statements and thoughts which are hypothesized to contribute to the development and maintenance of depressive disorders.
Erika's Lighthouse: A Beacon of Hope for Adolescent Depression Children (12-14)	Erika's Lighthouse is an introductory depression awareness and mental health empowerment program for early adolescence. The program educates school communities about teen depression, reduces the stigma associated with mental illness, and empowers teens to take charge of their mental health. "The Real Teenagers Talking about Adolescent Depression: A Video Based Study Guide" is a depression and mental health school program designed for middle and high school classrooms and is listed in the Suicide Prevention Resource Center and the American Foundation for Suicide Prevention "Best Practices Registry for Suicide Prevention."
Guiding Good Choices Parents of Children (9-14)	Guiding Good Choices is a five-session parent involvement program that teaches parents of children ages 9-14 how to reduce the risk that their children will develop drug problems. The goal of the program is to prevent substance abuse among teens by teaching parents the skills they need to improve family communication and family bonding. Participants learn specific strategies to help their children avoid drug use and other adolescent problem behaviors and develop into healthy adults. They also learn to set clear family guidelines on drugs, as well as learn and practice skills to strengthen family bonds, help their children develop healthy behaviors, and increase children's involvement in the family.
Healthy Ideas (Identifying Depression, Empowering Activities for Seniors) Older Adults (60+)	This is a community program designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations. The program incorporates four evidence-based components into the ongoing service delivery of care/case management or social service programs serving older individuals in the home environment over several months. Program components include screening and assessment of depressive symptoms, education about depression and self-care for clients and family caregivers, referral and linkage to health and mental health professionals, and behavioral activation.
Incredible Years (Attentive Parenting) Parents	The Attentive Parenting program is a 6-8 session group-based "universal" parenting program. It can be offered to ALL parents to promote their children's emotional regulation, social competence, problem solving, reading, and school readiness.
Life Skills Training (LST) Children (8-15) TAY (16-18)	LST is a group-based substance abuse prevention program developed to reduce the risks of alcohol, tobacco, drug abuse, and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. This comprehensive program utilizes collaborative learning strategies taught through lecture, discussion, coaching, and practice to enhance youth's self-esteem, self-confidence, decision-making ability and ability to resist peer and media pressure. LST provides adolescents and young teens with the confidence and skills necessary to successfully handle challenging situations.
Love Notes Children (15) TAY (16-24)	Love Notes consists of 13 lessons for high risk youth and TAY in which they discover, often for the first time, how to make wise choices about partners, sex, relationships, pregnancy, and more. Love Notes appeals to the aspirations and builds assets in disconnected youth.
Making Parenting a Pleasure (MPAP) Parents of children (0-8)	MPAP is a 13-week, group-based, parent training program designed for parent educators of parents and/or caregivers of children from birth to eight years of age. The program is designed to address the stress, isolation, and lack of adequate parenting information and social support that many parents experience. The curriculum focuses first on the need for self -care and personal empowerment and moves from an adult focus to a parent/child/family emphasis. Its content is adaptable and flexible to fit a wide range of parent education programs and has broad appeal to families from a wide spectrum of socioeconomic, educational, cultural and geographical background.

Prevention Program	Description
More than Sad Parents/Teachers/Children (14-15) TAY (16-18)	This is a curriculum for teens, parents and educators to teach how to recognize the signs of depression. The program for teens teaches how to recognize signs of depression in themselves and others, challenges the stigma surrounding depression, and demystifies the treatment process. The program for parents teaches parents how to recognize signs of depression and other mental health problems, initiate a conversation about mental health with their child, and get help. The program for teachers teaches educators to recognize signs of mental health distress in students and refer them for help. The program complies with the requirements for teacher education suicide prevention training in many states.
Nurturing Parenting Parents of children (0-18)	These are family-based programs utilized for the treatment and prevention of child abuse and neglect. Program sessions are offered in group-based and home-based formats ranging from 5-58 sessions. Programs are designed for parents with young children birth to 5 years old, school-aged children 5-11 years old, and teens 12-18 years old. Developed from the known behaviors that contribute to the maltreatment of children, the goals of the curriculum are: (1) to teach age-appropriate expectations and neurological development of children; (2) to develop empathy and self-worth in parents and children; (3) to utilize nurturing, non-violent strategies and techniques in establishing family discipline; (4) to empower parents and children to utilize their personal power to make healthy choices; and (5) to increase awareness of self and others in developing positive patterns of communication while establishing healthy, caring relationships.
Peacebuilders Children (0-15)	PeaceBuilders is a violence prevention curriculum and professional development program for grades pre-K to 12. Its essence is a common language - six principles, taught, modeled and practiced.
Prevention of Depression (PODS) - Coping with Stress (2nd Generation) Child (13-15) TAY (16-18)	This is the second-generation version of the Coping with Stress program. PODS is an eight-session curriculum developed for the prevention of unipolar depression in adolescents with increased risk. It is not meant to be a treatment for active episodes of depression. It is designed to be offered either in a healthcare setting or in schools.
Positive Parenting Program (TRIPLE P) Levels 2 and 3 Parents/Caregivers of Children (0-12)	Triple P is intended for the prevention of social, emotional, and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Selected Triple P (Levels 2 and 3) is a "light touch" parenting information presentation to a large group of parents (20 to 200) who are generally coping well but have one or two concerns. There are three seminar topics with each taking around 60 minutes to present, plus 30 minutes for question time.
Project Fatherhood Male Parents/Caregivers of Children (0-15) TAY (16-18)	Project Fatherhood program provides comprehensive parenting skills to men in caregiving roles using an innovative support group model. The program was developed to give urban, culturally diverse caregivers an opportunity to connect with their children and play a meaningful role in their lives. The program continues to be recognized nationally for effectively addressing the problem of absentee fathers. Through therapy, support, parenting education and other services, fathers learn to be more loving, responsible parents and active participants in their children's lives.
Psychological First Aid (PFA) All Ages	PFA is an evidence-informed approach for assisting children, adolescents, adults, and families in the aftermath of disaster and terrorism. The practice is a partnership between the National Child Traumatic Stress Network and the National Center for PTSD. The Core Actions of PFA include Contact and Engagement; Safety and Comfort; Stabilization; Information Gathering: Current Needs and Concerns; Practical Assistance; Connection with Social Supports; Information on Coping; and Linkage with Collaborative Services.
School, Community and Law Enforcement (SCALE) Children (12-15) TAY (16-18)	SCALE Program is for Asian immigrant youths who are at high risk for, or are exhibiting the beginning signs of, delinquent behavioral problems. These behavioral problems include, but are not limited to, school truancy, academic failure, association with gang members, and early stages of law enforcement encounter and detention (such as by police or probation officers).
Second Step Children (4-14)	A classroom-based program, this practice teaches socio-emotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. The

Prevention Program	Description
	program builds on cognitive behavioral intervention models integrated with social learning theory, empathy research, and social information-processing theories. The program consists of in- school curricula, parent training, and skill development. Second Step teaches children to identify and understand their own and others' emotions, reduce impulsiveness and choose positive goals, and manage their emotional reactions and decision-making process when emotionally aroused in developmentally and age-appropriate ways.
Shifting Boundaries Children (10-15)	Shifting Boundaries is a six session, group based, dating violence prevention program that focuses on peer sexual harassment. The intervention consists of classroom-based curricula designed to reduce the incidence and prevalence of dating violence and sexual harassment among middle school students. The program aims to: Increase knowledge and awareness of sexual abuse and harassment; Promote pro-social attitudes and a negative view of dating violence and sexual harassment; Promote nonviolent behavioral intentions in bystanders; Reduce the occurrence of dating and peer violence; and Reduce the occurrence of sexual harassment.
Teaching Kids to Cope Children (15) TAY (16-22)	This 10-session group intervention is designed to reduce depression and stress by enhancing coping skills. Program components include group discussions, interactive scenes, videos, group projects, and homework assignments. Group discussions include a variety of topics, such as family life situations, typical teen stressors, self-perception issues, and interactions with others.
Why Try Children (7-15) TAY (16-18)	Why Try is a resilience education curriculum designed for dropout prevention, violence prevention, truancy reduction, and increased academic success. It is intended to serve low income, minority students at risk of school failure, dropping out of school, substance use/abuse, and/or juvenile justice involvement. Why Try includes solution-focused brief therapy, social and emotional intelligence, and multisensory learning.

C. STIGMA AND DISCRIMINATION REDUCTION (SDR)

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$81,836,000	$21,301,000	$6,940,000

Program Description

The purpose of SDR is to reduce and eliminate barriers that prevent people from utilizing mental health services by prioritizing information and knowledge on early signs and symptoms of mental illness through client-focused, family support and education and community advocacy strategies. Core strategies have been identified to reduce stigma and discrimination, increase access to mental health services, and reduce the need for more intensive mental health services in the future. The services include anti-stigma education specifically targeting underrepresented communities through outreach utilizing culturally sensitive and effective tools; educating and supporting mental health providers; connecting and linking resources to schools, families, and community agencies; and client and family education and empowerment.

FY 2021-22 ■ STIGMA AND DISCRIMINATION REDUCTION Data and Outcomes

C1. Mental Health First Aid (MHFA)

MHFA is an interactive 8-hour evidence based training that provides knowledge about the signs and symptoms of mental illness, safe de-escalation of crisis situations and timely referral to mental health services. The use of role-playing and other interactive activities enhances the participants' understanding and skill set to assess, intervene and provide initial help pending referral/linkage to a mental health professional. Participants are also provided information about local mental health resources that include treatment, self-help and other important social supports.

C2. Mental Health Promoters/Promotores

Many underserved communities have been shown to have high rates of mental health related stigma as well as cultural/linguistic barriers that limit their access to mental health services and mental health resources available. Often these barriers limit/prevent the utilization of mental health services until symptoms are chronic and severe. Underserved communities, such as the API and Latino communities in Los Angeles County show high levels of ongoing disparities in their access and use of public mental health services. The Promotores program represents a promising approach to mental illness & disease prevention as it increases knowledge about mental illness, increases awareness about available mental health services and promotes early use of mental health services. The criteria will be to decrease mental health and stigma.

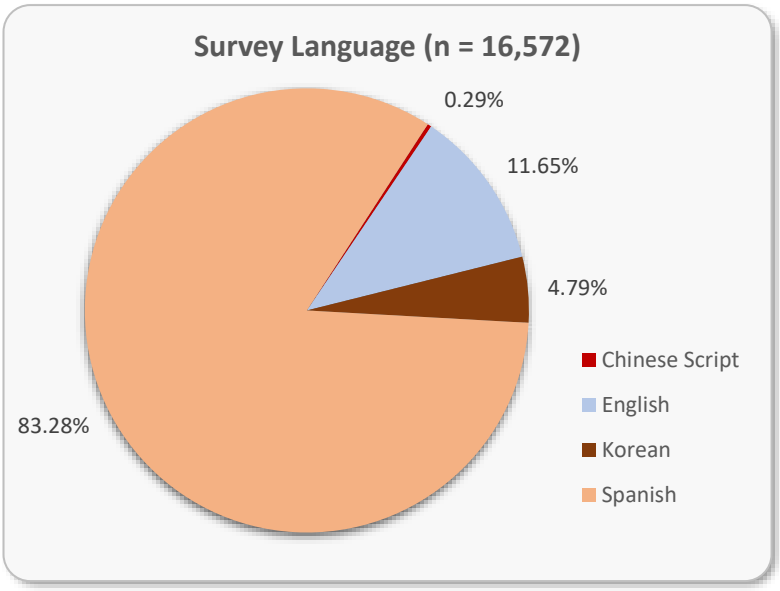
C4. SDR Outcomes

Los Angeles County's Department of Mental Health has implemented Stigma Discrimination Reduction (SDR) programs in the form of training and education. Trainings have the goals of decreasing stigma and discrimination against people who have a mental illness and increase knowledge about the topic of mental health. To determine the effectiveness of its SDR trainings, Los Angeles County used the California Institute of Behavioral Health Services' (CiBHS) SDR Program Participant Questionnaire, a brief measure that assesses the impact of trainings on participants': 1) attitudes and behavior toward persons with mental illness 2) knowledge about stigma towards persons with mental illness 3) awareness of ways to support persons who may need mental health resources. In addition, the questionnaire measures training quality and participant demographics.

This write-up discusses the results of data analyses performed on the SDR questionnaires administered to assess SDR trainings that were conducted during the 2021-2022 Fiscal Year (FY), from July 2021 through June 2022. The number of surveys collected in FY 21-22 (16,572) increased dramatically from the previous FY (109). Collection in FY 2020-21 was atypically low due to the County not having electronic SDR surveys translations available when SDR trainings switched from in person to online due to the COVID-19 pandemic.

Seven electronic translations were introduced during FY 2021-22. Most critical was the addition of the Spanish translation. The majority of SDR trainings are delivered in Spanish to participants who report Spanish (69%) as their primary language; the Spanish translation comprised the majority of surveys submitted (83%, see Survey Language graph). The County introduced six other electronic translations during the fiscal year (Arabic, Armenian, Cambodian, Chinese (Traditional), Korean, Vietnamese). The translations comprise 88% of all surveys submitted in the FY (Spanish 83%, Korean 5%, Chinese 0.3%)

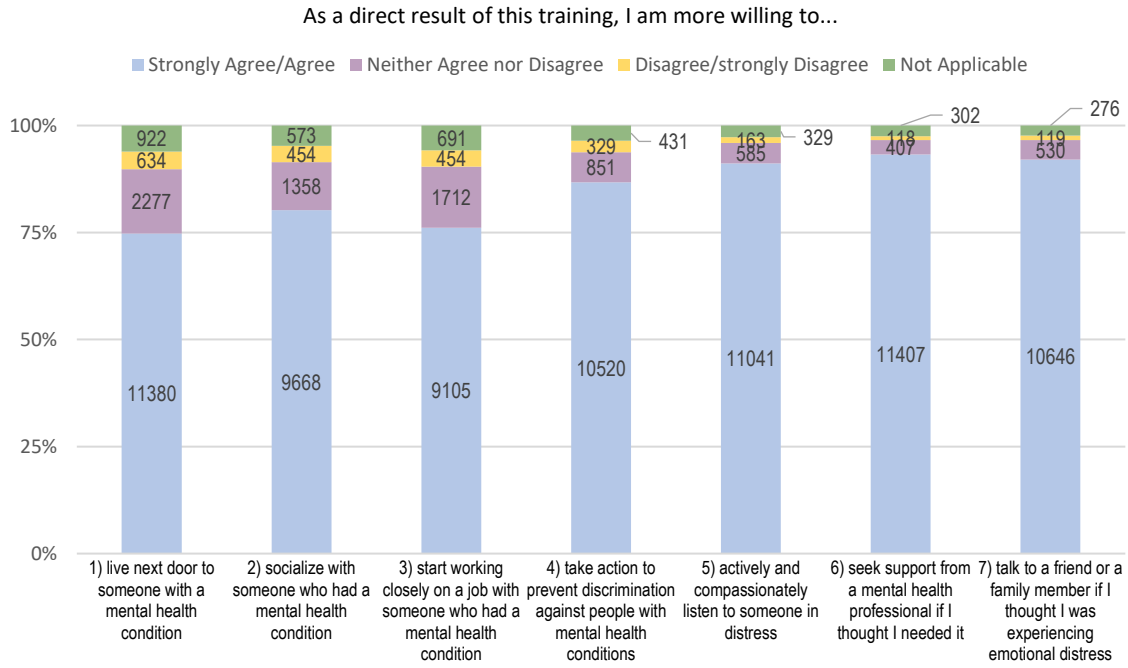
Figure 18. Survey languages



The following chart assesses the impact of SDR trainings on participants' willingness to engage in behaviors that support persons with mental illness. Item ratings are: *Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree*. Agreeing suggests the participant believes the training positively influenced their future behavior (e.g. willingness to advocate for a person who has a mental illness). Results suggest participants believed the trainings: 1) decreased the likelihood of discriminating against persons with mental illness; 2) increased the likelihood of acting in support of individuals who have a mental illness; and 3) and greatly increased the likelihood of seeking support for themselves in times of need:

- On all 7 items, the majority of participants agreed the training had a positive influence, with a high of 93% agreeing (37%) or strongly agreeing (56%) with item 6: "As a direct result of this training I am more willing to seek support from a mental health professional if I thought I needed it."

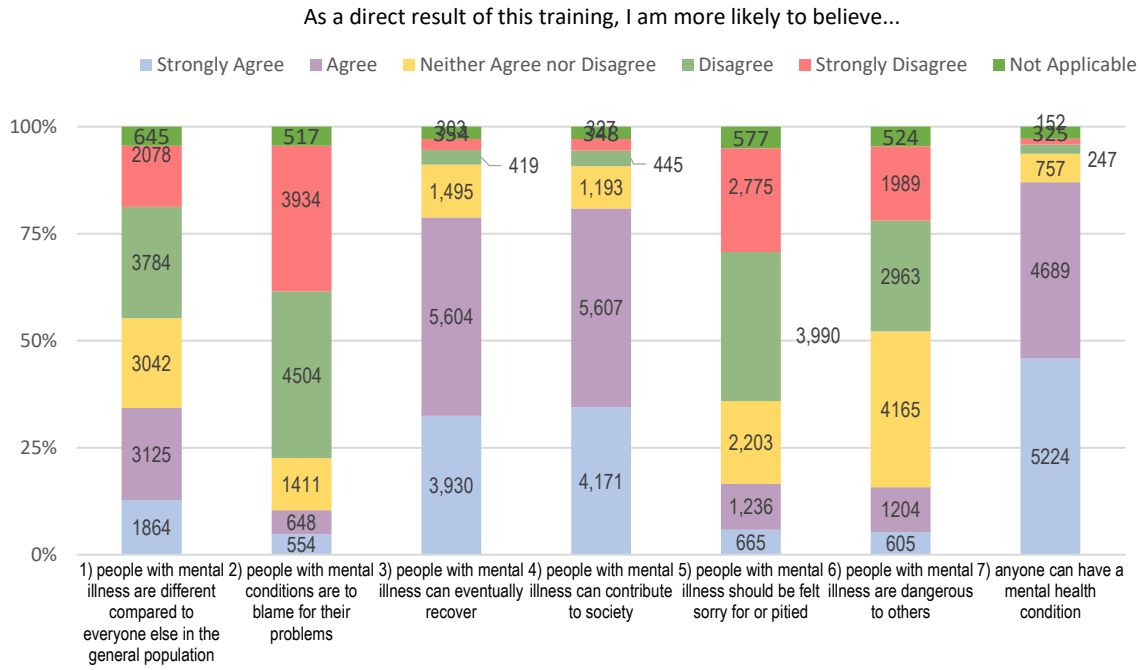
Figure 19. Changes in behavior



The following chart assesses change resulting from attending an SDR training in knowledge about mental illness and beliefs about mentally ill people. Items may be rated: *Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree*. Disagreeing suggests the participant believes training had a positive influence (e.g., decreasing with the belief mentally ill people are dangerous) and agreeing suggests the opposite, for all but the third item (see previous figure in the *Changes in Behavior* ratings). Survey results suggest trainings tended to positively influence participants' knowledge about the topic of mental illness and beliefs about people who have a mental illness.

- On five of 7 items, results showed the trainings had a positive influence, with a high of 87% agreeing (41%) or strongly agreeing (46%) with item14, "anyone can have a mental health condition"

Figure 20. Changes in knowledge and beliefs



The next figure assesses the quality of SDR trainings. Items may be rated: *Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree*. Agreeing suggests the participant had positive perceptions about the training quality and disagreeing suggests the opposite. Participants tended to have extremely positive perceptions of the trainings' quality, particularly in their perceptions of presenters. . At least 95% of participants agreed or strongly agreed with every item:

- a high of 97% agreed (39%) or strongly agreed (59%) with item 15, "The presenters demonstrated knowledge of the subject matter."
- a high of 97% agreed (39%) or strongly agreed (59%) with item 16, "The presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.)."

Figure 21. Training Quality

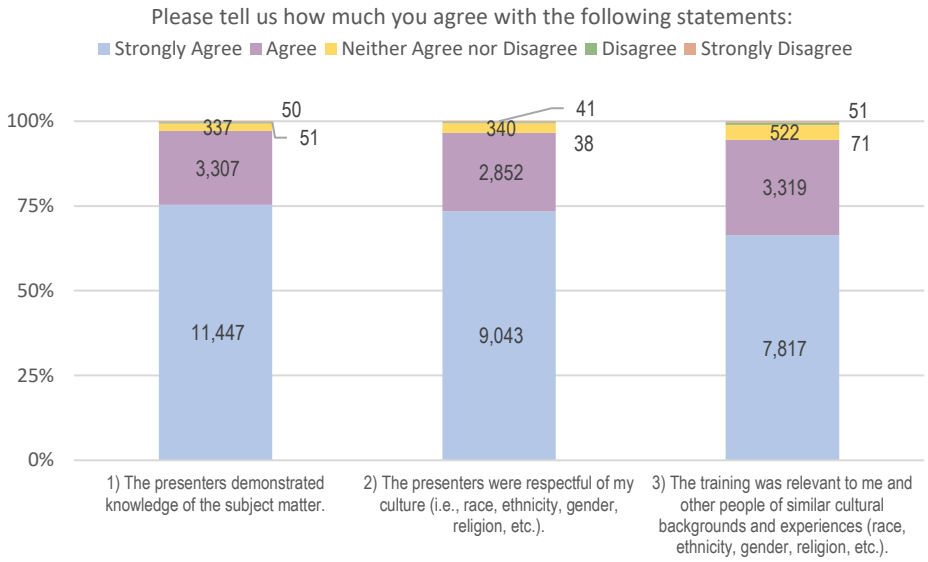


Table 44. Survey demographics (n = 16,572)

Sex at Birth	Female - 75% Male - 12%	Declined to answer - 13%
Sexual Orientation	Heterosexual or straight - 61% Gay or lesbian - 1% Questioning or unsure of sexual orientation – 0.17% Queer – 0.17%	Declined to answer - 35% Bisexual – 2% Another sexual orientation – 0.39%
Ethnicity	Mexican/Mexican-American/Chicano - 48% Central American - 14% South American - 4% More than one ethnicity - 1%	Other - 18% Declined to answer - 15%
Veteran Status	Yes - 1% No - 84%	Declined to answer - 15%
Age Groups	Children (0-15) – 0.26% TAY (16-25) – 3.41% Adult (26-59) - 72%	Older Adult (60+) - 12% Declined to answer - 13%
Disability	Yes -6% No - 78%	Declined to answer - 17%
Primary Language	English - 13% Spanish - 69% Korean – 5%	Other – 1% Declined to answer - 12%
Race	White - 39% Black or African American – 1.5% Asian - 6%	More than one race - 3% Other - 18% Declined to answer - 32%

D. SUICIDE PREVENTION

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$6,146,000	$5,682,000	$5,638,000

Program Description

The Suicide Prevention Program provides suicide prevention services through multiple strategies by strengthening the capacity of existing community resources and creating new collaborative and comprehensive efforts at the individual, family, and community level. These services include: community outreach and education in the identification of the suicide risks and protective factors; linking direct services and improving the quality of care to individuals contemplating, threatening, or attempting suicide; access to evidence-based interventions trained suicide prevention hotlines; and building the infrastructure to further develop and enhance suicide prevention programs throughout the county across all age groups and cultures.

In response to the needs in our community, the Los Angeles County Suicide Prevention Network, with support from LACDMH, has developed a strategic plan for suicide prevention to guide our efforts towards the goal of zero suicides in the County.

Some of the key elements to suicide prevention are:

- Focus on fostering prevention and well-being through connections, education, outreach, advocacy and stigma reduction;
- Promote early help seeking where people know the warning signs and resources and are confident to intervene with someone they care about or get help for themselves;
- Ensure a safe and compassionate response during and in response to crises by focusing on stabilization and linkages to services in the least restrictive setting; and
- Implement a system of short- and long-term support for individuals, families, schools and communities following a suicide attempt or death.

FY 2021-22 ■ SUICIDE PREVENTION Data and Outcomes

D1. Latina Youth Program (LYP)

The primary goals of LYP are to:

- Promote prevention and early intervention for youth to decrease substance use and depressive symptoms, which are major risk factors for suicide.
- Increase youth awareness of high-risk behaviors and provide immediate assessment and treatment services.
- Increase access to services while decreasing barriers and stigma among youth in accepting mental health services.
- Increase family awareness about high-risk behaviors and empower families through education about the benefits of prevention and early intervention and health promotion.
- Enhance awareness and education among school staff and community members regarding substance abuse and depression.

D2. 24/7 Crisis Hotline

During FY 2021-22, the 24/7 Suicide Prevention Crisis Line responded to a total of 145,254 calls, chats, and texts originating from Los Angeles County, including Spanish-language crisis hotline services to 13,087 callers. Korean and Vietnamese language services are also available on the crisis hotline. Additionally, various outreach events were conducted in Los Angeles and Orange County.

Table 45. Call analysis

Total calls	126,833
Total chats	15,265
Total texts	3,153
Total*	145,254

*Calls from Lifeline Lifeline Spanish, SPC Local Line, Teenline, and Disaster/Distress.

Table 46. Total calls by language

Korean	43
Spanish	13,087
English	113,703
Total	126,833

Figure 22. Call, chat and text volume by month

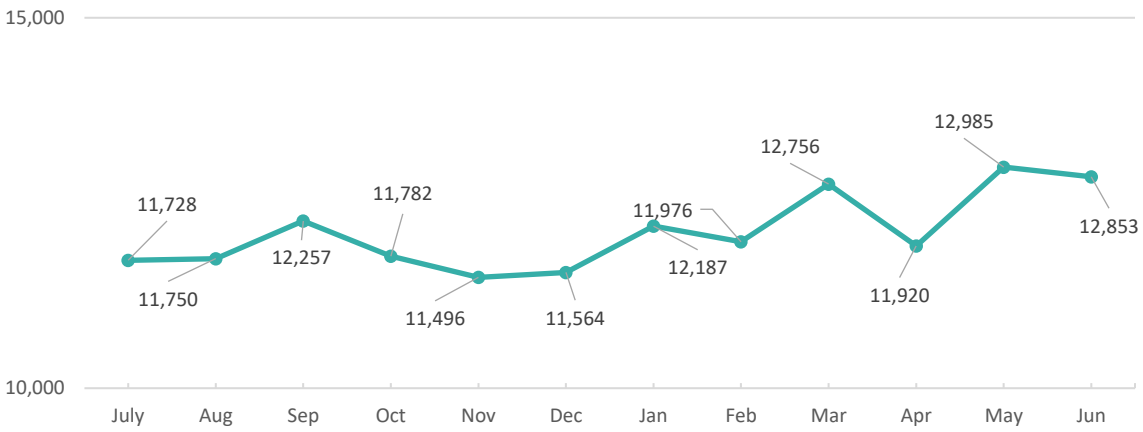


Table 47. Calls and chats by ethnicity

Ethnicity	Call (n = 63,403)	Chat/Text (n = 3,186)
White	36%	58%
Hispanic	35%	12%
Black	12%	13%
Asian	8%	5%
Native American	1%	1%
Pacific Islander	0%	0%
Other Race	8%	0%

Table 48. Calls and chats by age groups

Age Groups	Call (n = 66,941)	Chat (n = 15,741)
5 to 14	5%	23%
15 to 24	35%	46%
25 to 34	28%	19%
35 to 44	13%	7%
45 to 54	7%	3%
55 to 64	6%	1%
65 to 74	4%	1%
75 to 84	1%	0%
85 and up	0%	0%

Table 49. Calls and chats by suicide risk assessment

Suicide Risk Assessment	Calls	Chats
History of psychiatric diagnosis	43%	0%
Prior suicide attempt	24%	6%
Substance abuse - current or prior	15%	0%
Suicide survivor	8%	1%
Access to gun	3%	3%

Presence of the above factors significantly increases an individual's risk for suicide attempts; thus, all callers presenting with crisis or suicide-related issues are assessed for these risk factors. Percentages are calculated based on the total number of calls in which suicide or crisis content was present.

Table 50. Suicide risk status

Suicide Risk Status	Calls (n = 50,865)	Chats (n = 2,008)
Low Risk	52%	29%
Low-Moderate Risk	23%	23%
Moderate Risk	14%	17%
High-Moderate Risk	3%	8%
High Risk	7%	17%
Attempt in Progress	1%	0%

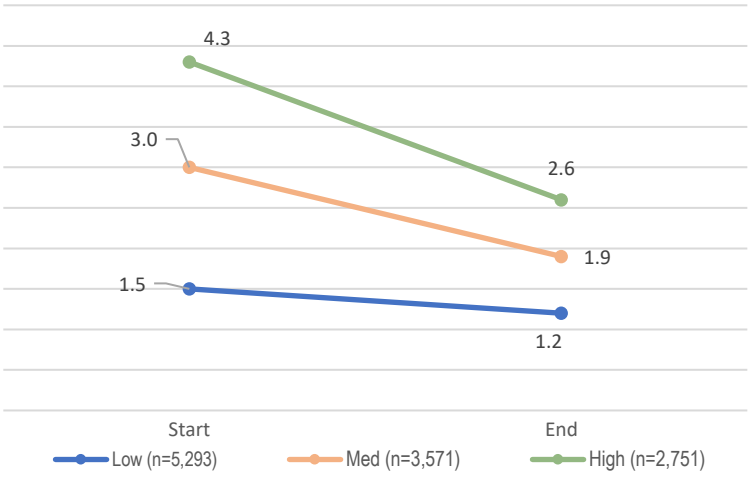
Percentages are calculated based on the total number of callers with reported risk levels.

Risk assessment is based on the four core principles of suicide risk: suicidal desire, suicidal capability, suicidal intent, and buffers/connectedness. A caller's risk level is determined by the combination of core principles present. For example, a caller who reports having only suicidal desire, as well as buffers, would be rated as low risk. A caller with suicidal desire, capability, and intent present would be rated as high risk, regardless of the presence of buffers.

Intervention Outcomes: Self-rated Intent

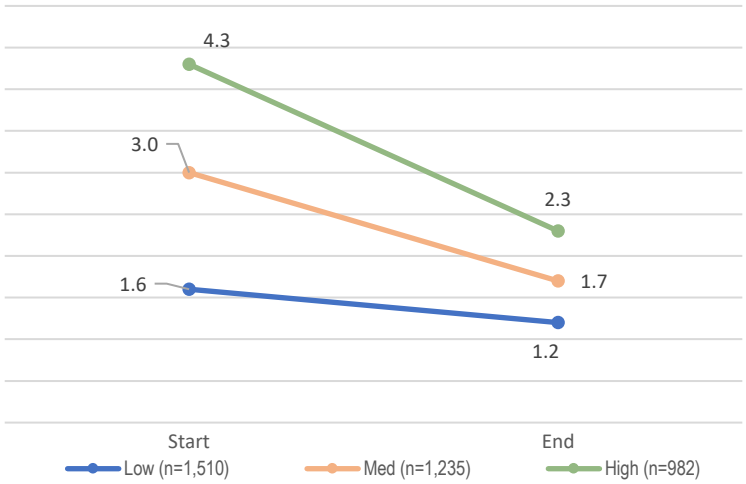
Callers are asked to answer the question: "*On a scale of 1 to 5, how likely are you to act upon your suicidal thoughts and feelings at this time, where 1 represents not likely and 5 represents extremely likely?*" Callers rate their intent both at the start and end of the call. Note: This data is on calls for which information was reported.

Figure 23. Self-rated suicidal intent calls



Callers rating of suicidal intent at the beginning of the call:
4 or 5 = high or imminent risk
3 = medium risk
1-2 = low risk

Figure 24. Self-rated suicidal intent chats

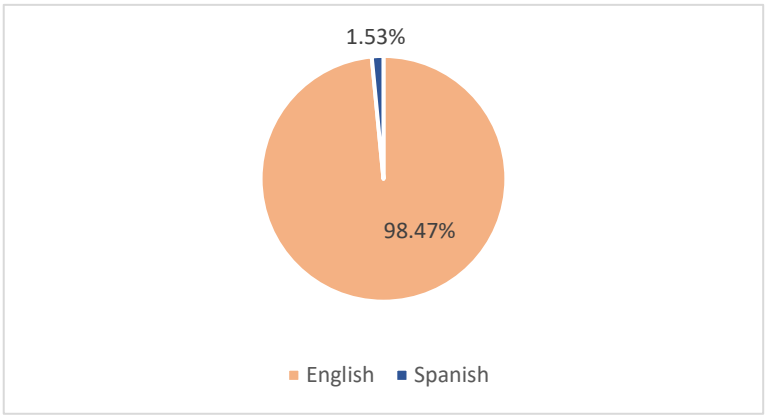


D3. Suicide Prevention Outcomes

LACDMH has chosen to implement a suicide prevention program in the form of training and education that has shown effectiveness in changing attitudes, knowledge, and/or behavior regarding suicide. Participants in these trainings include, but are not limited to, first responders, teachers, community members, parents, students, and clinicians.

To determine the effectiveness of its SP trainings, Los Angeles County utilized the California Institute of Behavioral Health Services' (CiBHS) SP Program Participant Questionnaire, which assessed the impact of trainings on participants' attitudes, knowledge, and behaviors related to suicide. In addition, the questionnaire measured training quality and participant demographics. This write-up discusses the results of a data analyses performed on the1309 questionnaires received for SP trainings conducted during the 2021-2022 Fiscal Year (FY).

Figure 25. Survey Language (n=1,309)

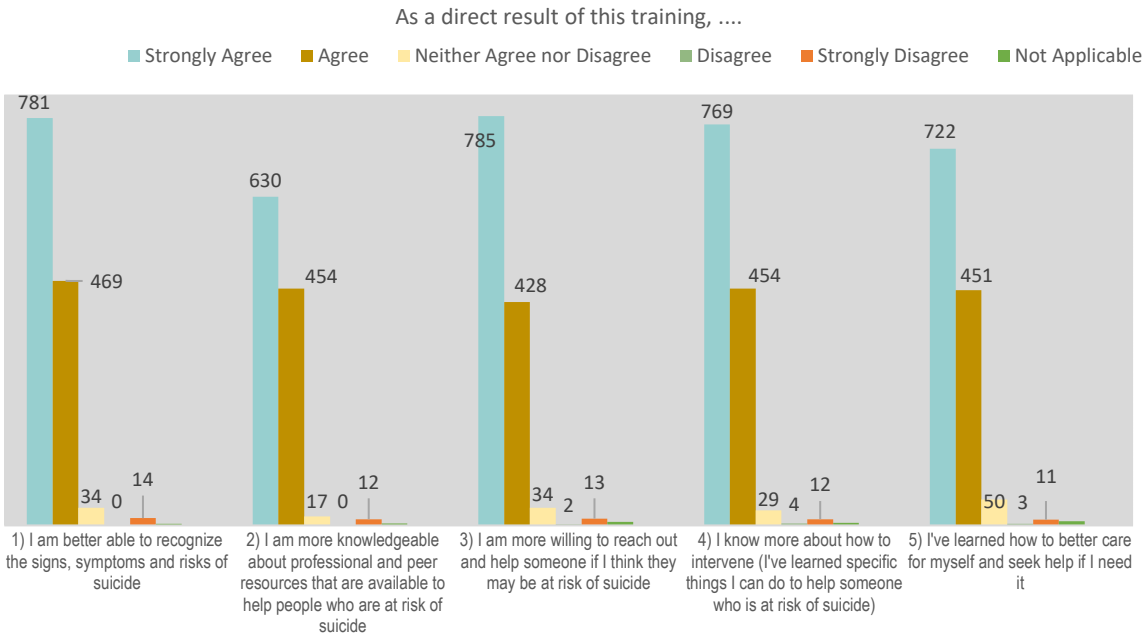


Changes in Attitudes, Knowledge, and Behavior

The three primary goals of the SP program are: 1) increasing knowledge about suicide and ways to help someone who may be at risk of suicide 2) increasing willingness to help someone who may be at risk of suicide 3) increasing the likelihood participants will seek support for themselves in times of need. The questionnaire includes five items (see Results Graph 1 for items and results) assessing the success of SP trainings in meeting program goals. Items may be rated: Strongly Agree, Agree, Neither Agree or Disagree, Disagree, and Strongly Disagree. Agreeing with an item suggests the training met a program goal(s), disagreeing suggests the opposite. Data analyses of questionnaire results found that at least 94% of participants agreed or strongly agreed with all 5 items, suggesting that, overall, the SP programs were tremendously successful in meeting their program goals

- Participants had the highest percentage of agreement with the 2nd item; 97% agreed (41%) or strongly agreed (56%) that, "as a direct result of this training I am more knowledgeable about professional and peer resources that are available to help people who are at risk of suicide,"

Figure 26. Responses to suicide prevention training



Training Quality

The questionnaire includes three items (see Results Graph 2 for items and results) assessing the quality of SP trainings. Items may be rated: Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree. Agreeing suggests the participant had positive perceptions about the training quality and disagreeing suggests the opposite.

Participants tended to have extremely positive views of the trainings' quality as at least 97% agreed or strongly agreed with all 3 items.

- A high of 99% of participants agreed (20%) or strongly agreed (80%) with item 6: "The presenters demonstrated knowledge of the subject matter."

Figure 27. Responses to suicide prevention training

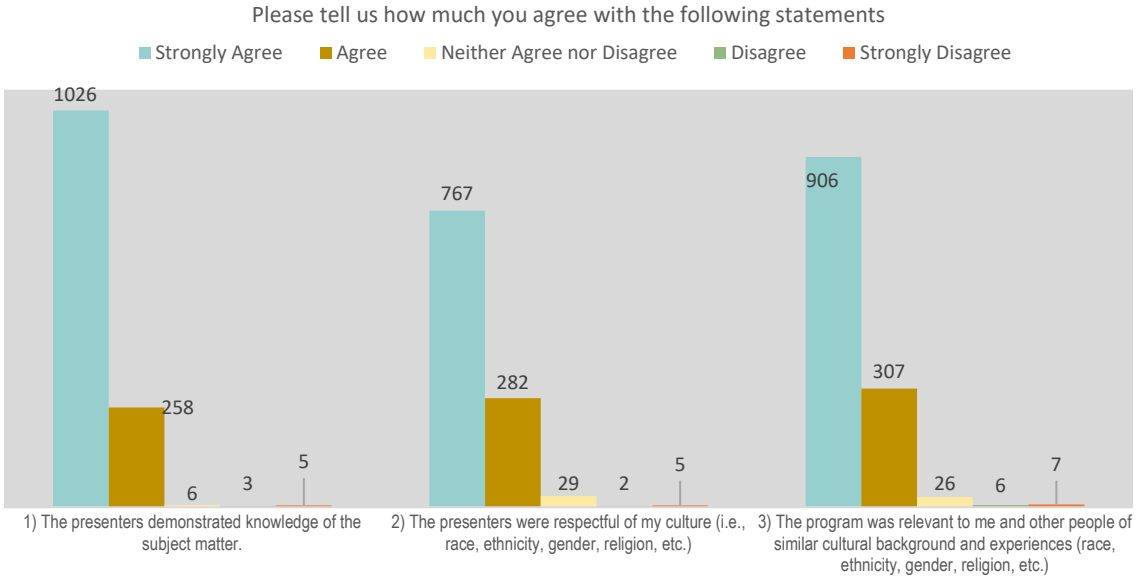


Table 51. FY 2020-21 Survey demographics

Gender Identity	Female – 81% Male – 15%	Declined to answer – 4%
Age Groups	TAY (16-25) – 5% Adult (26-59) – 84%	Declined to answer – 5% Older Adult (60+) – 6%
Race	White – 29% African American – 13% Asian – 1% American Indian – 1%	Other – 28% Declined to answer – 21% More than one race – 7%
Sexual Orientation	Heterosexual – 82% Gay/Lesbian – 3% Bisexual – 2%	Queer – 2% Declined to answer – 9%
Ethnicity	Central American – 9% European – 7% More than one ethnicity – 7% Other – 23% Mexican/Mexican-American/Chicano – 35%	Declined to answer – 14% African – 5%
Veteran Status	Yes – 1% No – 79% Declined to answer – 20%	
Disability	Yes – 6% No – 86% Declined to answer – 8%	
Primary Language	English – 74% Spanish – 16% Armenian – 2%	Other – 4% Declined to answer – 4%

D4. School Threat Assessment Response Team (START)

START has years of partnership with various threat management teams in the Los Angeles Community College District (LACCD), the largest community college system in the nation.

Through its partnership with the Los Angeles County Sheriff's Department and the LACCD, START has established protocol for managing threats in educational settings. The services include, but are not limited to, faculty consultation on threat management; close monitoring of potentially violent individuals; development of threat management plans and interventions specific to individuals; trainings extended to students and their families; and linkage to a wide range of community resources. Additionally, START participates in LAUSD's Threat Assessment Response Partners (TARP) collaborative, and the higher education Threat Assessment Regional Group Evaluation Team (TARGET) to provide on-going consultations and trainings on threat cases. START will continue with its mission to be the driving force in establishing a safe, healthy school environment in the County.

E. Outreach for Increasing Recognition of Early Signs of Mental Illness

The Department funds this function through CSS, specifically through Planning, Outreach and Engagement and through the work of Promotores/Promoter Community Mental Health Workers.

F. Access and Linkage to Treatment for Individuals with Serious Mental Illness/Serious Emotional Disturbance Seeking Services through PEI

The Department's provider network provides a full continuum of services and generally do not have PEI services in stand-alone buildings. Individuals presenting for services are assessed and referred according to need. Consequently, this PEI component does not apply to the Los Angeles County and cannot be reported on.

WORKFORCE EDUCATION AND TRAINING (WET)

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
FY 2023-24 Estimated Gross Expenditures	**FY 2022-23 Estimated Gross Expenditures**	**FY 2021-22 Total Gross Expenditures**		
$28,997,000	$17,200,000	$63,021,000		
Program Description				
The Los Angeles County MHSA – WET Plan seeks to address the fundamental concepts of creating and supporting a workforce (both present and future) that is culturally competent, consumer/family driven, and promotes the transformation of mental health services to a strength based approach that is inclusive of recovery, resilience and wellness. Such tenets are cornerstones of MHSA. The Plan provides opportunities to recruit, train and re-train public mental health staff to meet those mandates.				

FY 2021-22 ■ WORKFORCE EDUCATION AND TRAINING Data and Outcomes

A. Training and Technical Assistance:

1. Public Mental Health Partnership

The mission of the UCLA-DMH Public Mental Health Partnership (PMHP) is to implement exemplary training and technical assistance activities focused on vulnerable populations with serious mental illness in ways that build excellence in public mental health care across Los Angeles County (LAC); and to do so in the context of a transparent, trusting partnership with the Los Angeles County Department of Mental Health (DMH) that generates benefits for both the University and public health communities. The PMHP is comprised of two sections focused on serious mental illness – the Initiative for Community Psychiatry (ICP) and the Full-Service Partnership (FSP) and HOME Training and Implementation Program. During FY 2021-22, UCLA provided the following trainings services:

During the reporting period, the PMHP delivered 111 live trainings and 387 anytime trainings with over 819.5 training hours, with an attendance of 13,026 participants. The training team provided trainings on a wide variety of topics including Person Centeredness, Cultural Humility, and Psychiatric Disorders and Symptoms. The training topics delivered to the most participants include “Crisis & Safety Intervention” (1,598 participants) and “Continuous Quality Improvement” (1591 participants)

Table 52. Public Mental Health Partnership Trainings

Topic Name	Number of Trainings	Training Hours	Number of Participants
Cultural Humility	26	76	1,774
Crisis & Safety Intervention	28	85	1,598
Continuous Quality Improvement	78	81	1,591
Ethical Issues	9	22.5	1,417
Manualized Evidence-Based Practices	31	65.5	1,150
Psychiatric Disorders & Symptoms	16	60.5	943
Co-Occurring Disorders	19	70.25	781
Service Delivery Skills	16	17	579
Team-Based Clinical Services	46	71.5	541
Provider Wellbeing	35	51.5	457
Trauma	10	40	439
Manualized Evidence-Based Practices (HR)	19	46	395
Person Centeredness	13	47	383
Everyday Functioning	14	16	244

Topic Name	Number of Trainings	Training Hours	Number of Participants
Manualized Evidence-Based Practices (ROC)	13	20.75	244
Persistent & Committed Engagement	4	6	190
Manualized Evidence-Based Practices (TIC)	2	3	177
Whole Person Care	8	40	143
TOTAL:	**387**	**819.5**	**13,026**

2. Bilingual and Spanish Interdisciplinary Clinical Training (BASIC-T):

BASIC T: The Hispanic Neuroscience Center of Excellence (HNCE) had two broad focus: 1) work with Promotores de Salud and 2) build relationships with faith- and community-based organizations (FBO/CBO). For both groups, the Center provided training on psychological first aid and recovery to help reduce stigma around mental health topics and care. In the final quarter of the fiscal year, BASIC-T focused on completing the training of its postdoctoral fellows in neuropsychology as part of the Pipeline Program and adapting a series of prior live-interactive trainings developed for LACDMH to be produced as videos in both English and Spanish to facilitate broader dissemination of culturally and linguistically responsive content for the Latina/x community.

During the 4th quarter, BASIC-T continued to make progress in training neuropsychology fellows as part of its Pipeline program. It also worked to adapt and transition previously developed live and interactive training content to a format that could be digitized to facilitate additional asynchronous learning opportunities. This included the production of a total of 32 videos: 24 (12 in English, 12 in Spanish) focused on the United Mental Health Promoter Curriculum, and 8 videos (4 in English, 4 in Spanish) focused on the theme of FBOs and CBO Mental Health Ministries. BASIC-T also continued to migrate a large cache of previously recorded interviews and informational PSAs on various mental health topics within Spanish language media that were produced as part of its FBO and CBO engagement strategy during the COVID-19 pandemic.

During the reporting period, the HNCE delivered 56 trainings with 101 training hours, with an attendance of 986 participants. With guidance from the HNCE, the Promotores program was strengthened going from 120 to almost 300 Promotores and 47 clinicians, expansion of the Spanish language arm of the program, and the opportunity to offer services in other languages. The team has created resources and worked to support mental health ministries with local faith-based organizations including the Los Angeles Diocese, to help reach communities that were previously unreachable and raise awareness of mental wellbeing outside of clinics. The training team provided bilingual trainings in English and Spanish on a wide variety of topics, including mental health stigma among communities of color during COVID-19 and support groups for isolated older adults and parents of children with developmental disabilities during COVID-19. Some of the training topics that were delivered to the most participants in FY 2021/2022 included Culturally Competent COVID-19 and Creating Mental Health Ministries (including Psychological First Aid & Skills for Psychological Recovery) for Faith Based Organizations and Churches (159 participants) and Culturally Competent COVID-19 Mental Health Intervention with Community Based Organizations (431 participants).

Table 53. BASIC-T Outcomes for FY 2021-22

Topic Name	Number of Trainings	Training Hours	Number of Participants
Culturally Competent COVID-19 and Creating Mental Health Ministries (including Psychological First Aid & Skills for Psychological Recovery) for Faith Based Organizations and Churches	20	39.5	826
Culturally Competent COVID-19 Mental Health Intervention with Community Based Organizations	30	36	431
Culturally Competent COVID-19 Skills for Psychological Recovery for Faith Based Organizations and Churches	6	8.5	191
Virtual Support Groups for Isolated Older Adults during COVID-19 (Genesis)	10	22	163
An introduction to creating a Mental Health Ministry	60	120	233
Child Abuse Prevention During COVID-19	45	45	118
COVID-19 and Impact of Childhood Disorders-Other Bipolar, PTSD, ODD, Conduct Disorders	16	24.5	244
Drug and Alcohol Use and Prevention During COVID-19	5	12	87
Family Violence Prevention During COVID-19	3	6	74
Depression and Anxiety - Separation anxiety, generalized anxiety, panic disorder, severe depression, persistent depression—English Pediatrics	3	6	71
Neurodevelopmental Disorders - Learning disabilities, intellectual disability, autism, ADHD—English Pediatrics	2	4	38
Grief, Loss and Resilience—Spanish Lifespan	2	4	33
Impact of COVID-19 on Anxiety Disorders with Adults—English Lifespan	4	8	183
Impact of COVID-19 on Anxiety Disorders with Adults—Spanish Lifespan	1	2	20
Suicide Prevention During COVID-19—Spanish Lifespan	4	10	153

Topic Name	Number of Trainings	Training Hours	Number of Participants
Cultural and linguistic considerations when assessing Latina/o patients	6	12	311
Culturally Competent COVID-19 Psychological First Aid for Faith Based Organizations and Churches	3	6	159
Totals:	56	101	986

The HNCE has developed a strong relationship with Spanish media and Catholic radio and TV to get information out on a weekly basis to communities, filling a void where Spanish language information on mental health had not existed before.

3. Navigator Skill Development Program

The Health Navigation Certification Training targets individuals employed as community workers, medical case workers, substance abuse counselors, peer specialists, and their supervisors on knowledge and skills needed to assist consumers navigate and advocate in both the public health and mental health systems. During FY 2021/2022, 23 individuals completed this model, with all representing an un- or under- served community.

The Peer Housing Navigation Specialists Training targets peer to prepare them to assist consumers with housing insecurities to work towards establishing and meeting steps to a goal of housing permanency. During FY 2021/2022, 22 individuals competed the training, of these 60% spoke a threshold language (other than English), and all represented un- or under- served communities.

4. Interpreter Training Program (ITP)b

The Interpreter Training Program (ITP) offers trainings for bilingual staff currently performing or interested in performing interpreter services and monolingual English speaking mental health providers. The use of linguistically and culturally competent interpreters is important to bridging the language and cultural gap in the delivery of services in public mental health. FY 2021/2022 Outcomes:

Table 54. ITP Outcomes for FY 2021-22

Training	# of Attendees
Increasing Armenian Mental Health Clinical Terminology	7
Increasing Mandarin Mental Health Clinical Terminology	17
Increasing Spanish Mental Health Clinical Terminology	88
Introduction To Interpreting in Mental Health Settings	22
Therapeutic Cross-Cultural Communication	11
TOTAL	145

5. Learning Net System

The Department has developed an online registration system called eventsHub that manages both registration and payment for trainings and conferences coordinated by the Department. eventsHub is fully operational with most if not all clinical training administratively processed by the system inclusive of posting, registration, and other training logistics important for tracking purposes. Enhancement and maintenance of eventsHub continues through FY 2023-24.

6. Licensure Preparation Program (MSW, MFT, PSY)

In an effort to increase the pool of licensed mental health professionals, the Department offers subsidized study preparation material for Part 1 and Part 2 licensure examination for Social Workers, Marriage and Family Therapists, Licensed Professional Clinical Counselors and Psychologists. During FY 2021/2022, the Department subsidized 58 individuals across these professions, with 55% self-identifying from a un- or under-served community, and 48% speaking a threshold language in addition to English.

7. Academy of Cognitive Therapy

Effective FY 2022-23, MHSA WET will initiate funding a multi-year effort to increase the number of staff utilizing this clinical approach. Individual Cognitive Behavioral Therapy (Ind CBT) is one of the most frequently utilized evidence-based practice (EBP), with considerable research supporting its effectiveness and adaptability in clinical practice. Ind CBT integrates the rationale and techniques from both cognitive therapy and behavioral therapy, thereby challenging automatic negative thoughts with more direct methods of behavioral therapy. Ind CBT helps individuals deal with their difficulties by changing their thinking patterns, behaviors, and emotional responses. Treatment focuses on identifying more positive reinforcing thoughts to elicit a more desired behavior. The Ind CBT program shall target its services to consumers age 16 years and older throughout the Los Angeles County (LAC). Specifically, the EBP will treat transition-age youth dealing with early onset of mental illness; adults facing traumatic experiences which lead to depression, anxiety, or post-traumatic stress disorder; and older adults to prevent or alleviate depressive symptomology. The treatment is intended for consumers seeking services to address depression, anxiety, or trauma in an individual or group setting consisting of 18 to 56 weeks of sessions.

8. Staff Development Training

Historically, public mental health systems across the county have experienced ongoing staffing shortages. Unfortunately, in recent years Covid-19 has exasperated this shortage. The Department will fund a new program targeting further professional skill development of its existing workforce alongside am increase recruitment effort.

B. Residency and Internship

1. Charles R. Drew Affiliation Agreement: Psychiatric Residency Program

The County Board of Supervisors formed the Los Angeles County Health Agency in 2015 to better integrate the Departments of Health Services, Mental Health and Public Health. The Health Agency contracted with Charles Drew University to develop a new psychiatric residency program and to manage, administer, and coordinate training of resident physicians at DHS and DMH facilities, as well as the University itself and private non-profit facilitates contracted by or in partnership with the County.

The first class started in Academic Year 2018-2019 and at the program's capacity, we will have 24 trainees raging from Post Graduate Year Is to IVs. The first class graduated in June 2022.

Table 54. Outcomes for FY 2021-22

Post Graduates	Number of Psychiatric Residents	Rotations
Year 1 Post Graduates	6	• 1 month of university onboarding is done at CDU • Veterans Administration (VA) Long Beach (Inpatient Psychiatry): 4 months • Rancho Los Amigos (Inpatient Medicine): 2 months • Rancho Los Amigos (Neurology): 2 months • Kedren (Outpatient Medicine): 2 months • Harbor-UCLA (Emergency Psychiatry): 1 month
Year 2 Post Graduates	6	• VA Long Beach (Inpatient Psychiatry): 3 months • VA Long Beach (Consultation and Liaison): 2 months • VA Long Beach (Emergency Psychiatry): 1 month • VA Long Beach (Substance Abuse): 2 months • VA Long Beach (Geriatric Psychiatry): 1 month • Kedren (Inpatient Psychiatry): 1 month • Resnick Neuropsych Hospital UCLA (Child and Adolescent Psychiatry): 2 months *The above PGY 2 rotation times represent averages. Individual resident rotations vary in their second year depending on areas of focus.
Year 3 Post Graduates	6	Rotations in DMH Directly Operated Clinics and Programs: • Augustus F. Hawkins MHC • West Central MHC • Compton MHC Child & Adolescent Psychiatry • Women's Community & Reintegration Center • Harbor UCLA Medical Center HIV Clinic
Year 4 Post Graduates	6	Rotations in DMH Directly Operated Clinics and Programs: • Augustus F. Hawkins MHC • West Central MHC • Street Psychiatry/HOME Team and Disaster Service • Collaborative Care/Telepsychiatry • CDU Didactics Training

2. LACDMH + Semel Institute National Clinician Scholars Program (NCSP) Professional Trainees (UCLA Public Partnership for Wellbeing Agreement)

Public Psychiatry Professional trainees of the LACDMH + Semel Institute position for National Clinician Scholars Program consisted of 1 Adult Psychiatrist/Researcher who provided 114 patient visits.

NCSP serves to advance and promote the work of clinician leaders (physicians, nurses) who address health equity over the course of their career, through postdoctoral training as part of the National Clinician Scholars Program, with DMH as their sponsor. The National Clinician Scholars Program is a multi-site program for all physician specialties and nurses with a PhD. The program provides training in partnered research, quality improvement, health services and policy research and leadership. Scholars are selected within a competitive process with applicants from across the country.

DMH funds one fellowship slot at a time (new fellows eligible every two years). Scholars Program activities include:

- Participating in coursework, the equivalent of a master's program or auditing as an option.
- Conducting up to 20% clinical work with DMH and participate in leadership activities.
- Conducting 1-4 projects, at least 1 of which is in partnership with DMH.
- Participating in a policy elective their second year when possible.
- Attending annual NCSP meetings and other local and national meetings.
- Access to research funds and a mentorship team

For Fiscal Year 2023-24:

- The Department may begin developing a curriculum for a new Child Psychiatry Fellowship class that will start in FY 2024-25 under the Charles Drew university Agreement.
- The Department will also have a three early care Neuropsychologist providing services at DMH directly operated sites as part of the BASIC T SOW under the UCLA Agreement.

3. DMH + UCLA General Medial Education (GME): UCLA Public Partnership for Wellbeing Agreement

Psychiatry Residency and Fellowships Professional Trainees – Public Psychiatry Professional trainees of the UCLA Graduate Medical Education program at the Jane and Terry Semel Institute for Neuroscience and Human Behavior consisted of adult residents and fellows specializing in child and adolescent, geriatric, and forensic psychiatry. During the reporting period, the 12 trainees provided a total of 7,073 patient visits during their public psychiatry rotations.

Table 55. Outcomes for FY 2021-22

NCSP/GME	# Fellows/Residents	Estimated # of Patient Visits
Adult Psychiatrist/Researcher	1	862
Adult Psychiatry Residency	3	1,124
Child Psychiatry Fellowship	4	1,672
Geriatric Psychiatry Fellowship	1	1,098
Forensic Psychiatry Fellowship	3	2,317
Total	**12**	**7,073**

C. Financial Incentive

1. Mental Health Psychiatrist (MHP) Student Loan Repayment Incentive
   DMH offers a financial incentive towards the outstanding balance of student loans for full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one-year of continuous service at DMH and have active, unpaid, graduate, or medical, student loans. Eligible psychiatrists who have not participated in or have received funds from the MH Psychiatrist Recruitment Incentive program, will receive a maximum annual amount of up to $50,000 for a period of five years which equates to a lifetime total of $250,000. During FY 2021/2022, 2 mental health psychiatrists participated in this program. This program is expected to increase awards during the following Fiscal Years.

2. MHSA Relocation Expense Reimbursement
   Available to full-time, newly hired Mental Health Psychiatrists or Supervising Mental Health Psychiatrists who have been recruited by DMH. The maximum reimbursement amount for eligible relocation expenses is $15,000. If the employee leaves DMH within one-year from employment start date, the full reimbursement amount must be repaid. During FY 2021/2022, no individuals were awarded. This program is expected to increase awards during the following Fiscal Years.

3. MHP Recruitment Incentive Program
   This program targets recruitment of potential Mental Health Psychiatrists for employment in the public mental health system. For eligible full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one year of continuous service in DMH and who have not participated in or received funds from the Student Loan Repayment Incentive program, a one-time award of $50,000 will be granted consisting of $25,000 upon completion of the first year of continuous service at DMH, and an additional payment of $25,000 upon completion of the second year of continuous service. During FY 2021/2022, 1 individual was recruited and awarded. This program is expected to increase awards during the following Fiscal Years.

4. Stipend Program for MSWs, MFTs and Psychiatric Nurses

LACDMH provides 2nd year students with education stipends in the amount of $18,500 in exchange for a contractual work commitment (a minimum of 1 year) to secure employment in a hard-to-fill/hard to recruit program/area. This program targets students who are linguistically and/or culturally able to service the traditionally unserved and underserved populations of the County.

During FY 2021/2022, due to the Covid-19 pandemic, no stipends were awarded. The contracted fiscal intermediaries provided past stipend recipients job seeking assistance; work commitment extensions were given on a case-by-case basis. Tracking and administrative functions continued throughout the Fiscal Year. Program needs, funding, and hiring freezes impacted reinstatement of the program.

Stipend awards will resume during FY 2022/2023. Program will include Psychologists, in addition to MSWs, MFTs, LPCC, PNP and Psychiatric Techs. The Department is ready to disburse over 100 awards.

In addition to the stipends, 9 post-doctoral fellows were also funded as part of the Department's Psychology Post-Doctoral Fellowship Program. Of these fellows, 5 represented un- or under- served communities and 5 individuals spoke a second language, other than English.

5. MHSA WET Regional Partnership Match

Pending the availability of additional MHSA WET Regional Partnership funding from the State, the Department may be required to provide a 33% local match to accept and implement and recruitment or retention efforts mandated in future Fiscal Years.

D. Mental Health Career Pathway

1. Intensive Mental Health Recovery Specialist Training Program

Intensive Mental Health Recovery Specialist Training Program prepares individual, mental health consumers and family members to work in the mental health field as psycho-social (recovery) rehabilitation specialists. This program is delivered in partnership with a mental health contractor. Successful completion of this program ensures that participants are qualified to apply for case management level career opportunities in the public mental health system. Two cohorts were delivered this training. Of the 39 individuals that began this training, 37 completed the training with 77% identifying from an un- or under- served community, 47% speaking a second language and 90% indicating lived experience as peers or family members. Of those that completed the training, 38% have secured employment, with all but one working in the mental health field. No changes are expected through 2023-24.

2. Parent Partners Training Program

This training program promotes knowledge and skills relevant to individuals interested in working as Parent Advocates/Parent Partners in the public mental health system servicing families and their children. It enhances resilience and wellness understandings increasing the availability of a workforce oriented to self-help, personal wellness and resilience grounded in parent advocate/parent partner empowerment. Lastly, the training program supports employment of parents and caregivers of children and youth consumers. During FY 2021/2022, 2,387 individuals receiving this training through 26 training events.

3. Continuum of Care Reform

Assembly Bill (AB) 403, also known as Continuum of Care Reform (CCR) provides comprehensive transformation of the foster care system with the intent of achieving permanency planning for foster youth and their families. In particular, this legislation brings forth significant changes for group homes and respective providers that necessitate training for legislative compliance and provider readiness. To that end, in the prior year the Department utilized MHSA WET to deliver training to these populations. Such training included topics such as introduction to mental health, diagnosis/assessment, and self-care. During FY 2021/2022, these mandated trainings were funded by other MHSA WET allocations.

4. Expanded Employment and Professional Advancement Opportunities for Peers, Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System

The Department continues to develop new, innovative training opportunities to prepare peers, parent advocates, child advocates and caregivers for employment in the public mental health system. During FY 2021-2022 the Department delivered the following trainings:

a. Intentional Peer Support Advanced Training

It's an innovative practice that has been developed by and for people with shared mental health experiences that focuses on building and growing connected mutual relationships. In this interactive training, participants learn the principles of IPS, examine and challenge assumptions about how we have come to know what we know, and explore ways to create relationships in which power is negotiated, co-learning is possible, and support goes beyond traditional notions of "service." This innovative curriculum details the difference between peer support and other helping practices, and has been widely used as foundational training for people working in both traditional and alternative mental health settings. In FY 2021/2022, 15 people completed the IPS Core training.

b. Online Wellness Recovery Action Plan (WRAP)

This training is an introduction to WRAP® and how to use it to increase personal wellness and improve quality of life. The training is highly interactive and encourages participation and sharing from all present. It also lays a broad foundation for building and supporting a skilled peer workforce. Participants will learn to apply the Key Concepts of Recovery and use tools and skills to address encountered thoughts, feelings, and behaviors for improved states of wellness. The history, foundation, and structures of WRAP® will be discussed. Successful completion of this training fulfills the prerequisites for the WRAP® Facilitator Training. During FY 2021/2022, we provided two online WRAP Seminars I. A total of 24 participants have completed this training.

c. Online Wellness Recovery Action Plan Facilitator Refresher Training

The WRAP® Refresher Training is an interactive training to sharpen and expand facilitation skills of trained facilitators to further engage groups they facilitate in the implementation of their Wellness Recovery Action Plan®. Participants in this training will be expected to interact in learning activities and demonstrate their own experience with WRAP®. This training is for the current WRAP facilitators who will lead WRAP® groups, work with others to develop their own WRAP® and give presentations on mental health recovery-related issues to groups or organizations. Participants are expected to have a solid working knowledge of WRAP® and share their experiential knowledge of how WRAP® can work. A total of 6 people have been recertified to facilitate the WRAP groups for the department.

d. Wellness Recovery Action Plan (WRAP) Facilitator Training:

This training equips participants to facilitate WRAP® classes in the community and within their organizations. The WRAP® Facilitator training provides an experiential learning environment based on mutuality and self-determination. Participants are expected to join in interactive learning activities and demonstrate their own experience with WRAP®. Upon completion of this training, participants will be able to lead WRAP® groups, work with others to develop their own WRAP® and give presentations on mental health recovery-related issues to groups or organizations. Lastly, participants are expected to have a solid working knowledge of WRAP® and share their experiential knowledge of how WRAP® can work. One WRAP Facilitator Training has been provided in FY 2021/2022 and 7 people have successfully completed the training. They are now able to facilitate the WRAP groups for the department programs.

INNOVATION (INN)

Status	☐ New	☒ Continuing	☐ Modified	☒ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

FY 23-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$33,007,000	$15,600,000	$36,189,000

Programs for FY 2021-22

- INN2: Community Capacity Building to Prevent and Address Trauma
- INN4: Transcranial Magnetic Stimulation (TMS)
- INN7: Therapeutic Transportation (TT)
- INN8: Early Psychosis Learning Healthcare Network

FY 2021-22 ■ INNOVATION Data and Outcomes

A. INN 2: Community Capacity Building to Prevent and Address Trauma

This project centers on building the capacity of the community to identify and support community members at risk of trauma or experiencing trauma. The project aims to utilize the assets of the community to test strategies that allow local communities to work together in ways that will ultimately lead to better mental health and reductions in trauma, through the building of shared community values, leadership development and community member empowerment.

See report on next page.

Evaluation of MHSA Innovation (INN) 2 Trauma Resilient Communities: Executive Summary

The **Innovation 2 (INN 2)** initiative centers on the creation and implementation of place-based community partnerships within geographically-defined communities to foster the collective will to support and develop trauma-resilient communities. This objective is accomplished using 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.

- A **community capacity building approach** identifies and builds on the assets and skill sets that currently exist within a community. The community's capacity is strengthened by collaborating with community members to identify their needs and strengths, and utilizing strategies that embody shared community values, leadership development, and community member empowerment.

Over the past four years of the initiative, the Los Angeles County Department of Mental Health (LACDMH) has supported **nine** lead agencies and their community partners as they have implemented community-driven capacity building strategies to address the trauma and challenges within specific target populations within communities (see chart below for a list of each strategy). These strategies target the needs and experiences of specific populations, such as parents of young children, transition-age youth, older adults, and multigenerational families, through innovative outreach and education, providing needed resources and supports and facilitating connection and community spaces.

Building Trauma-Resilient Families (Caregivers with children who are 0-5 years old)	Alma Family Services (Alma) Children's Institute, Inc. (CII) Para los Niños The Children's Clinic (TCC) Westside Infant-Family Network (WIN)
Trauma-Informed Psycho-Education and Support for School Communities	Alma Family Services (Alma) Children's Institute, Inc. (CII) Para los Niños Westside Infant-Family Network (WIN)
Transitional Age Youth (TAY) Support Network (16-25-year-old TAY)	Alma Family Service (Alma) Children's Clinic of Antelope Valley (CCAV) Mental Health America of Los Angeles (MHALA) Pasadena Public Health (PPH) Safe Places for Youth (SPY)
Coordinated Employment within a Community	Mental Health America of Los Angeles (MHALA)
Community Integration for Individuals with Recent Incarcerations or Diverted from the Justice System	Children's Clinic of Antelope Valley (CCAV)
Geriatric Empowerment Model (GEM) for Older Adults (60+) who are experiencing Homelessness	Pasadena Public Health (PPH)
Culturally Competent Activities for Multigenerational Families	Alma Family Services (Alma) The Children's Clinic (TCC)

Purpose of this Executive Summary

With an emphasis on collective learning, this executive summary seeks to describe the impacts of outreach and engagement activities and benefits of community capacity building on strengthening communities who have experienced trauma. This report includes various data sources collected between **September 17, 2018 – April 14, 2022**, including surveys completed by INN 2 participants and partners, observation notes, interviews, and events and linkage tracking input into the Innovation 2 Health Outcomes Management System (iHOMS), a secure data collection and reporting database, to highlight the objectives and achievements of the INN 2 initiative.

The comprehensive evaluation of INN 2, including reporting of outcomes data, best practices and learnings that have emerged during the initiative, will be delivered at the end of the current fiscal year (June 2022).

Capacity Building within Partnerships

Collaboration within Partnerships during the Early Phase of the Initiative (February 2019 – February 2020)

- The Wilder Collaboration Factors Inventory is an assessment tool used by the evaluation to measure changes in six characteristics of successful collaboration and capacity building within partnerships.
  - During the first year, partnerships grew, as agencies formed new relationships with partners and hired new staff to do the INN 2 work. To put the baseline data into context, the Wilder was completed during a period when several partnerships were still experiencing challenges related to forming their partnerships.
- Compared to ratings on the first assessment (completed February 2019), Environmental, Membership Characteristics, Process & Structure, Communication, and Purpose category scores increased significantly during the first year of the initiative.
  - This progress observed at the end of the first year was likely facilitated by relationship building, using partnership data to identify areas for growth, which helped frame Learning Session agendas, and agencies collaborating to develop the vision and implementation plans for INN 2.

Scores of 4.0 to 5.0 - strengths to leverage

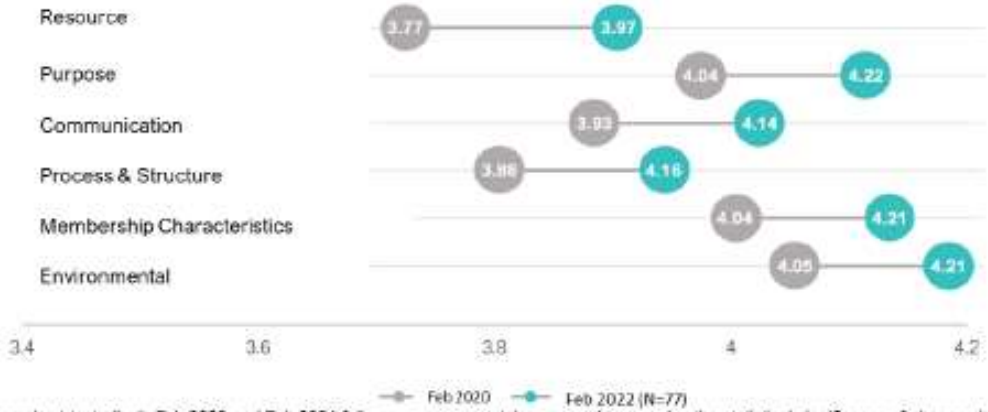
Scores of 3.0 to 3.9 - opportunity for growth & deserves discussion

Scores of 2.9 or lower - concern that should be addressed

* Paired samples t-tests (both baseline and Feb 2020 follow-up assessments) were used to examine the statistical significance of changes in scores on the measures over time. Average Wilder scores range from 1 to 5 with 5. Displayed values of graph axis have been changed to provide easier viewing of changes of scores.

Collaboration within Partnerships during the Pandemic (February 2020- February 2022)

- Partnerships grew by 13% as INN 2 partnerships expanded to include new organizations and community members during the pandemic.
  - Having an available network to leverage resources and collaboration with the community to test new ideas likely contributed to INN 2's ability to successfully pivot and incorporate the community ambassador network while supporting communities during this pandemic.
- Compared to ratings completed in February 2020, all Wilder category scores increased significantly, suggesting a strengthening of capacity within the partnerships.



* Paired samples t-tests (both Feb 2020 and Feb 2021 follow-up assessments) were used to examine the statistical significance of changes in scores on the measures over time. Average Wilder scores range from 1 to 5 with 5. Displayed values of graph axis have been changed to provide easier viewing of changes of scores.

Community Outreach and the Community Ambassador Network (CAN)

Community Ambassador Network

In June 2020, LACDMH proposed the use of Coronavirus Aid, Relief, & Economic Security (CARES) Act and rollover INN 2 funding to integrate community mental health workers (community ambassadors) to support INN 2 agencies in COVID-19 support, education and community outreach. The CAN program expanded in July 2021 to incorporate CAN Interns through collaboration between LACDMH, CalWorks and DPSS.

The concept of the Community Ambassador Network (CAN) leverages existing networks of trusted community-based providers and organizations to have the right people in the right place at the right time to provide necessary resources to those in need.

- As of April 14, 2021, 334 individuals have been a part of the Community Ambassador Network. This includes 41 CAN interns, 80 community members hired in 2021 or 2022, 84 community members hired through the CARES ACT, as well as 129 INN 2 peers, navigators, parent partners and Promatores who are now part of the CAN.
- **Two hundred and nine (209) individuals are active Community Ambassadors.**
- The most prevalent language spoken by CAN (aside from English) is Spanish (50%), and 7% of CAN speak Khmer.
- The majority of CAN (45.5%) identify as Latino/Latina/ Latinx, Hispanic or Mexican. Fifteen percent (15.3%) of CAN identified as Black and/or African American, 9.6% Asian, Cambodian, Filipino, Korean, East Indian, or Tongan (Asian and Pacific Islander), 5.1% as Multiracial and 3.8% as White.

Connecting with the Community

An objective of INN 2 focuses on the importance of building awareness and knowledge, social connectedness, and coping skills to foster resiliency and, ultimately, lead to better mental health and wellness for community members. Many people have recognized that direct delivery of mental health services is not always the optimal entry point for community members. Part of the community capacity vision of INN 2 has been to test non-traditional outreach methods and pathways to connect with community services and social supports. The Event Tracker is intended to capture the larger outreach and engagement efforts, as well as community member participation in programs and activities. During the past two years, it has also been widely used to capture COVID-19 relief and recovery efforts within the communities. The following sections provide a summary of the types of events INN 2 agencies have provided throughout the initiative.

Outreach and Engagement Activities during the Early Phase of the Initiative (2018-2020)

- During the early implementation phase of the initiative (Sept 2017-March 2020), agencies invested time building relationships with their partners and the community and creating awareness about INN 2 through targeted community outreach and community events.
    - We heard during the interviews with agency leads that taking the time to get to know people in the community and involving the communities' preferences and needs into programming and group activities was essential for building trust, which in turn is a precursor for people to open up about their individual needs.

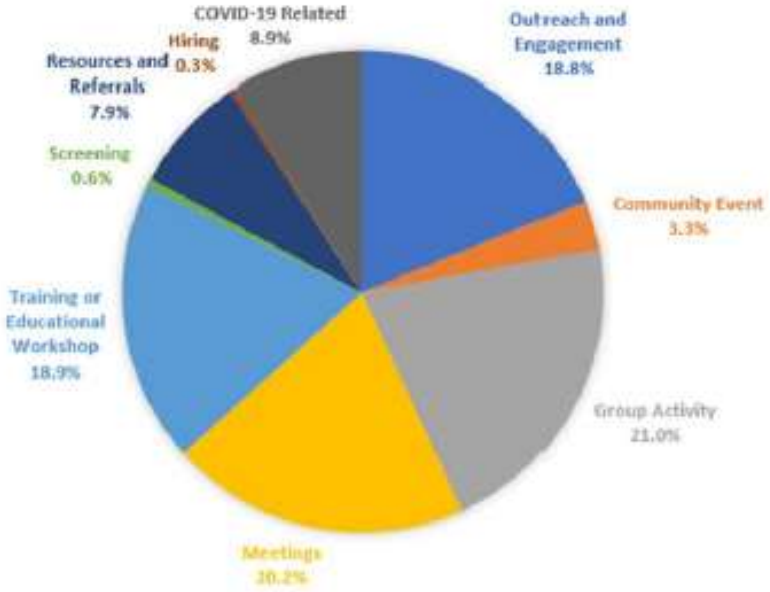
Rank	Type of Event	Event Category	Total # of Events
1	Community Outreach	Outreach & Engagement	1,334
2	Training in the Community	Training or Educational Workshop	450
3	Group Activity	Group Activity	439
4	Partnership Meeting	Meetings	387
5	Community Event	Community Event	358
6	Training for Partners/INN2 Staff	Training or Educational Workshop	349

Data recorded in the Event Tracker (IHOMS system) between 9/18/2017 and 4/30/2020. This table provides information on the top six event categories across all INN 2 programs. There may be variability in how agencies determine the number of attendees during community outreach and events.

Impact and Reach of INN 2

Outreach and Engagement Activities during the Early Pandemic (2020-2021)

- Non-traditional approaches to "meet people where they are at" and the flexibility afforded by the learning approach of the initiative were critical to partnerships' responsiveness to the COVID-19 crisis and social unrest during the first year of the COVID-19 pandemic.
- As evident by the **pie chart**, the pandemic may have changed the way INN 2 partners connected with each other and the community, but agencies were still able to move the work forward while worked together to meet the challenges and unknowns facing communities because of the COVID-19 pandemic and civil unrest.
  - Programming and capacity building approaches were adapted, and partnerships leveraged their existing relationships and developed new partnerships to support the community.
  - Creating awareness and outreach through Community events decreased because of COVID-related closures and social distancing safety guidelines.
- Significant effort was placed on COVID-19 education and relief efforts.
- Group activities have been used as an integral part of programming among agencies to provide community specific engagement and provide meaningful and innovative support to their participants.
  - These group activities included family and parent support groups, play sessions, storytelling workshops, Zumba classes, and self-care and mindfulness sessions, along with many other innovative activities.



The pie chart above summarizes the percentages of overall outreach and engagement categories recorded in iHOMS. The table below summarizes the top six event types and their corresponding category across all INN 2 programs.

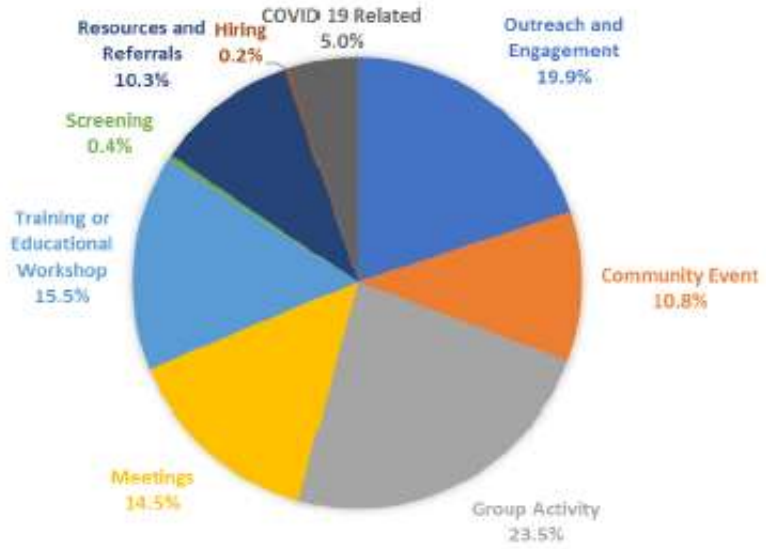
Rank	Type of Event	Event Category	Total # of Events
1	Group Activity	Group Activity	2,989
2	Partnership & Other Meetings	Meetings	2,698
3	Community Outreach	Outreach & Engagement	1,964
4	Training in the Community	Training or Educational Workshop	1,646
5	COVID-19 Education Efforts	COVID-19 Related	1,078
6	Training for Partners/INN2 Staff	Training or Educational Workshop	1,044

Data recorded in the Event Tracker (iHOMS system) between 5/1/2020 and 4/30/2021.

Impact and Reach of INN 2

Outreach and Engagement Activities during the Past Year of the Pandemic (2021-2022)

- INN 2 providers recorded a total of **13,841 outreach and engagement events** the past year.
- Through these innovative events, partnerships have reached hundreds of thousands of community members.
- INN 2 providers have consistently supported a high number of annual outreach and engagement events over the past two years of the project.
- General community outreach, meetings, trainings, and community events represent the other top outreach and engagement activities.
- As pandemic related restrictions have lifted over the past year, it is notable to see that community events have increased substantially. Agencies have been able to host larger community-wide events such as community cookouts, mental health fairs, and cultural festivals.
- While there was significant effort placed on COVID-19 education and relief efforts last year, programs have slightly decreased direct COVID-19 related outreach efforts this year as they focus on building back pre-COVID in-person activities.
- It is promising to see that programs have continued to make trainings a priority throughout the initiative. Trainings in the community have remained consistently high and have been an integral way for partnerships to help build capacity within their communities.
- As expected with partnerships in the sustainability phase of the project, there were less trainings for partners and staff over the past year as compared to previous years.



The pie chart above summarizes the percentages of overall outreach and engagement categories recorded in iHOMS. The table below summarizes the top six event types and their corresponding category across all INN 2 programs.

Rank	Type of Event	Event Category	Total # of Events
1	Group Activity	Group Activity	3,247
2	Community Outreach	Outreach & Engagement	2,200
3	Partnership & Other Meetings	Meetings	1,890
4	Training in the Community	Training or Educational Workshop	1,576
5	Community Event	Community Event	1,440
6	Training for Partners/INN2 Staff	Training or Educational Workshop	573

Data recorded in the Event Tracker (iHOMS system) between 5/1/2021 and 4/14/2022.

Connecting INN 2 Participants with Resources and Supports

Supporting the Community

Individuals who are reached though community outreach and events may later become an INN 2 participant. INN 2 participants are community members who participate in ongoing INN 2 group activities, educational classes or programs, which vary by capacity building strategy and partnership. These activities may include parenting classes or play groups, knitting groups, trauma-informed trainings, gardening groups, or case management services for older adults who are experiencing homelessness. Through participation in classes and groups, INN 2 staff can develop relationships based on trust and learn more about their individual or family needs and strengths. This approach allows staff to tailor support and linkages with resources or services to meet an individuals' goals and needs. As of 4/14/2022, **12,316 participants have been registered in iHOMS.**

The following table summarizes the top five types of referrals made for resources and supports during INN 2.

Total Referrals: 71,635

Agency provided a participant with information about specific resources and/ or support services to enable or empower the participant to obtain support independently.

Total Linkages: 66,473

Participant shared that they connected with resource and/or service provided by agency staff.

Linkage Not Made: 1,437

Participant did NOT connect with resource and/or service provided by agency staff.

Referred: 3,725

Agency provided a referral for a specific resource and/or service but the participant has not connected yet or has not shared that they connected with referred support.

Top 5	Type of Resource or Service	Total Referrals	Total Linked
1	Food	24,460 (34%)	23,687
2	Basic Needs	11,023 (15%)	10,647
3	Education (including civics/ESL, special education, financial and digital skills classes)	7,471 (10%)	7,194
4	Housing	5,843 (8%)	4,818
5	Mental Health	3,819 (5%)	3,360

- INN 2 providers made a total of **71,635 referrals** to community resources and supports **for 8,901 participants** during the initiative.
  - Ninety-three (93%) percent of referrals were noted as successful linkages, meaning that agency staff provided a warm handoff or followed up with the participant to confirm that they had connected with the referred support or resource.
  - Because of the community trust and capacity building infrastructure built through relationships and collaboration with organizations and community leaders during the first two years of INN 2, providers were able to continue to provide much needed support and resources during the past two years of the pandemic.
- The most common referrals during the initiative were for basic needs, including food and housing, education and mental health services and supports.
  - Linkages with food included vouchers or gift cards for local markets, support applying for Cal-Fresh, and distribution of food boxes or groceries through curbside pick-up or delivery services. Prior to the pandemic, food only accounted for 5% of the referrals made, which highlights how the pandemic exacerbated the already pressing issue of food insecurity for many individuals within Los Angeles County.
  - Referrals for basic needs includes linkages with backpacks and sleeping bags for TAY, clothes, diapers and wipes for families, and hygiene and household cleaning products.

To illustrate how INN 2 partnerships tailored their approaches to build capacity and meet the needs of the target populations and communities they support, outreach and linkages with supports are reported for each capacity building strategy. The following linkage and events reporting does not include participants registered to more than one strategy, or those enrolled under Strategy 8, which is used to denote COVID-19 related recovery efforts associated with CARES ACT. Reporting of resiliency, coping and community connectedness outcomes will be included in the final evaluation report delivered in June 2022.

Strategy 1: Building Trauma-Resilient Families

Strategy Description and Objectives

Strategy 1's approach to build capacity within the community targets children ages 0-5 and their caregivers who have experienced trauma and/or are at risk of complex childhood trauma (i.e., children exposed to domestic violence, abuse, neglect, traumatic grief and other traumas and adverse childhood experiences).

Activities were tailored for each community and designed to enhance parent/caregiver knowledge of child development, common reactions children might experience after a traumatic event, socio-emotional skills, promote positive social skills in children, and facilitate access to needed natural social support networks and resources.

Strategy 1 has been implemented by five lead agencies (Alma Family Services, Children's Institute, Inc., Para los Niños, The Children's Clinic, and Westside Infant-Family Network) and their community partners.

As of April 14, 2022, **3,020** participants have been registered in iHOMS under Strategy 1 or Strategies 1 and 8.

Intended Outcomes

- Increase positive coping strategies to reduce impact of trauma among at-risk children and their families.
- Social isolation reported by parents or caregivers and children will decrease.
- At-risk children with trauma symptoms who have been underserved will receive referrals to mental health treatment/systems when necessary.

NOTE: The total number of referrals does not reflect the total number of people served. INN 2 participants may have more than one linkage or referral. Events and the total number of people reached is not de-duplicated.

Events and Activities

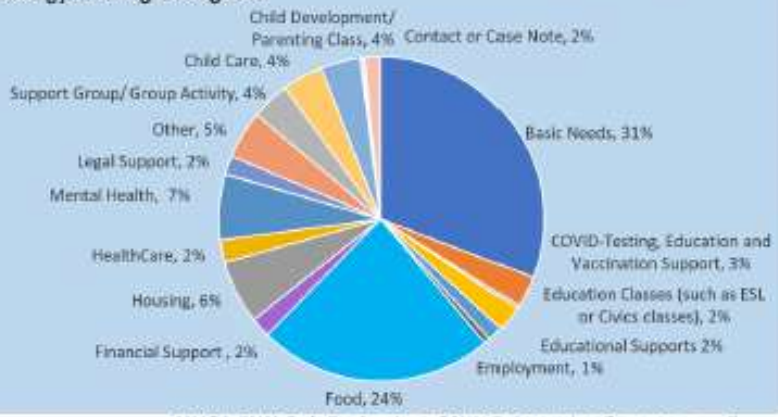
Outreach, community activities and group and linkages with supports were unique to each partnership and community's needs and were tailored to support young children and their families. It is evident from the types of events recorded in iHOMS that partnerships focused on creating safe spaces for families to connect, strengthen their knowledge of child development and attachment as well as self-care and wellness and create awareness within the community for resources and supports.

- Agencies recorded more than **6,000 events** in iHOMS, reaching hundreds of thousands of families and their young children through their Strategy 1 outreach and events.
- Strategy 1 programming focused on providing group activities, making up nearly **40%** of all their event-related activities. These group activities included family and parent support groups, play sessions for children, art and music classes, wellness activities, and many other innovative activities.
- All Strategy 1 programs were able to adapt these group activities to a virtual format using Zoom or via live streaming when the pandemic restricted in-person groups and remained connected with their families.
    - **51,882 community members** were reached through a total of **2,201** community events and outreach, group activities and posts on social media between June 1, 2020, and December 6, 2021.
- Part of outreach efforts has included creating awareness about resources, trauma-informed care, wellness, and COVID-19 to educate the community and partners.
    - Staff provided **68 trainings to 1,790 partners and community members**, and **278 COVID-19 testing and education events for 29,770 community members.**

Linkages for Strategy 1 Participants

- Referrals and resources recorded in iHOMS focus on supporting the diverse needs the community.
    - Overall, there were **7,775** referrals for resources and services provided to 63% (1,907) of Strategy 1 participants during the initiative.
    - Eighty eight percent **(88%)** of referrals were reported as successful linkages.
    - Food, basic needs (such as diapers and wipes), mental heath and housing were the most frequent linkages for Strategy 1 participants.

Strategy 1 Linkage Categories



Strategy 2: Trauma-Informed Psycho-education and Support for School Communities

Strategy Description and Objectives

Strategy 2's approach to build capacity within the community targets school administrators' teachers, and after-school staff. Trainings/workshops center on recognizing behaviors and symptoms of stress and trauma in children in early care/education (EC/E), school personnel and community mentors who work with children ages 3-15. Teachers and care providers learn to recognize behaviors associated with trauma; how family trauma, historic trauma and poverty contribute to further instability within families and their school/care environments; and how to support children dealing with complex trauma through relationship-building, providing scaffolding and effective, positive discipline. Another component of the strategy focuses on addressing burn-out, stress, and vicarious trauma amongst teachers by teaching them mindfulness and other self-care practices.

Strategy 2 has been implemented by four lead agencies (Alma Family Services, Children's Institute, Inc., Para los Niños, and Westside Infant-Family Network) and their community partners.

As of April 14, 2022, **504** participants have been registered in iHOMS.

Intended Outcomes

- Increase knowledge about trauma among educators and staff.
- Reduce stress amongst educators and at-risk students.
- At-risk students with trauma symptoms who have been underserved will receive referrals to mental health treatment/systems when necessary.

NOTE: The total number of referrals does not reflect the total number of people served. INN 2 participants may have more than one linkage or referral. Events and the total number of people

Events and Activities

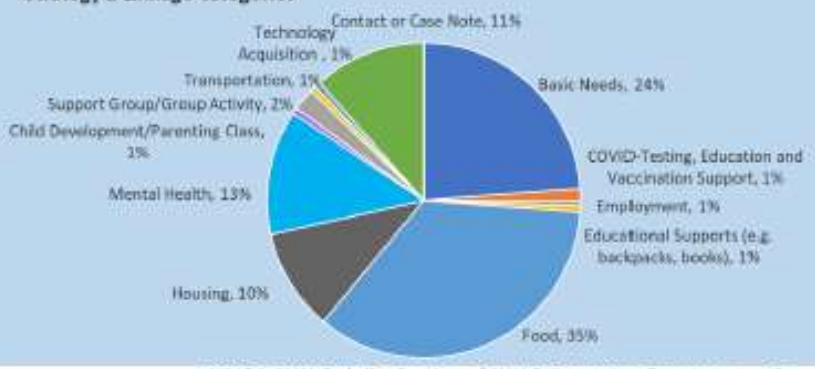
Outreach, community activities and group and linkages with supports were unique to each partnership and community's needs and were tailored to support children and educators. It is evident from the types of events recorded in iHOMS that partnerships focused on creating safe spaces for educators to connect and strengthen their knowledge of trauma and using a trauma-informed lenses to reframe children's 'challenging behaviors'.

- Agencies recorded more than **1,854 events** in iHOMS, connecting with school staff and providing classroom-based education and supports through Strategy 2.
- Strategy 2 programming focused on providing **trainings** to school staff and educators, making up over **60%** of all their event-related activities. These trainings provided specialized consultation and education on trauma-informed psycho-education support.
- The pandemic greatly impacted the efforts of Strategy 2 due to school closures and the shift to virtual learning. In-person trainings shifted to online training forums and curriculums were adapted to address the needs of educators, incorporating topics such as grief, mindfulness, and self-care.
    - However, there has been a significant increase in Strategy 2 activities, with over 90% of events occurring after January 1, 2021.
- To meet each community's needs during the pandemic, outreach and education extended beyond the original scope of the strategy to include schoolwide and parent/student focused support groups to address the challenges of access and learning new technologies and coping with stress and isolation.

Linkages for Strategy 2 Participants

- Given the strategy's focus on trainings and education, resources and linkages are not generally provided like other strategies.
    - Overall, there were **172** referrals for resources and services provided to 28 Strategy 2 participants during the initiative.
    - Ninety two percent **(92%)** of referrals were reported as successful linkages.
    - Referrals focused on basic needs, such as food, family supports and housing, and referrals for mental health services. This reflects the shift towards including families who attended the partnering schools as a response to the needs of the community during the pandemic.
    - INN 2 staff used the linkage tracker to document check-ins with teachers (contact notes) and sharing informational or event flyers.

Strategy 2 Linkage Categories



Strategy 3: Transition Age Youth (TAY) Support Network

Strategy Description and Objectives

Strategy 3's approach to build capacity within the community targets TAY (ages 13-25) who are currently or formerly experiencing homelessness and who are emotionally and physically vulnerable. Certain populations of TAY are at higher risk of experiencing homelessness and social isolation due to the identities they hold, including LGBTQ TAY, TAY who have experienced racism, and TAY who have been victims of abuse or crime.

Strategy 3 was designed as a peer-to-peer model that meets TAY where they are at through trauma informed programs and integrating social media into their outreach strategies to build awareness and educate TAY on trauma, stress and wellness, COVID-19, self-care and mindfulness practices. Within Strategy 3, partners facilitate safe spaces and opportunities for TAY to develop the protective factors of social connectedness within Support Networks, and support their housing, employment or education goals through case management.

Strategy 3 has been implemented by five lead agencies (Alma Family Services, Children's Clinic of Antelope Valley, MHALA, Safe Places for Youth, and Pasadena Public Health and their community partners.

As of April 14, 2022, **2,944** participants have been registered in iHOMS under Strategy 3 or Strategies 3 and 8.

Intended Outcomes

- Increase positive coping strategies to reduce impact of trauma.
- Decrease social isolation/withdrawal and negative social connections among youth.
- Maintain and/or secure housing

Events and Activities

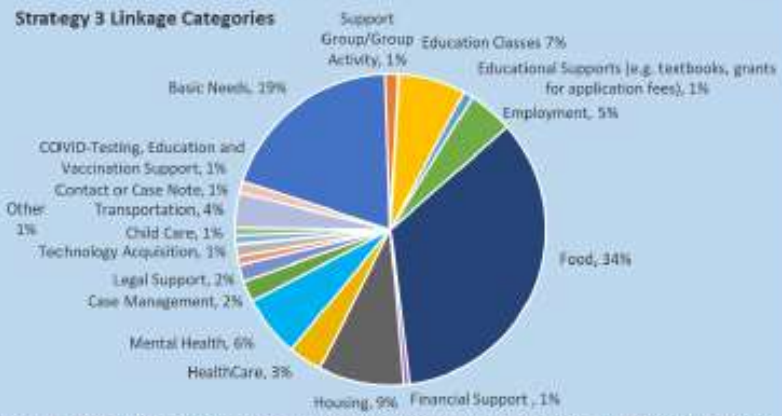
Outreach, community activities and group and linkages with supports were unique to each partnership and community's needs and were tailored to support TAY. Examples of core programing for Strategy 3 TAY include housing, behavioral health, job skills and career development, and youth advocacy. It is evident from the types of events recorded in iHOMS that partnerships focused on creating safe spaces for TAY to connect, strengthen their self-autonomy and create awareness within the community for resources and supports.

- Agencies recorded more than **5,000 events** in iHOMS, reaching TAY through extensive outreach and engagement efforts in the community and providing their TAY participants with necessary resources and referrals.
- Strategy 3 provided the widest variety of event types of any of the strategies.
  - Almost half of Strategy 3 activities are split between **outreach and engagement (23.0%)** and **resources and referrals (23.1%)**.
- Strategy 3 implemented innovative outreach methods to reach the TAY population in their communities, including outreach at the boardwalks and skate parks, via social media live streaming and virtual "hang-outs", free haircut and laundry events, and presentations at the community colleges.

Linkages for Strategy 3 Participants

- Referrals and resources recorded in iHOMS focus on supporting the diverse needs the community.
  - Overall, there were **33,948** referrals for resources and services provided to 83% (2,454) of Strategy 3 participants during the initiative.
  - Ninety six percent **(96%)** of referrals were reported as successful linkages.
  - Food, basic needs (such as clothing, backpacks and sleeping bags), housing and education/skills classes were the most frequent linkages for Strategy 3 participants.
    - Agencies provided shelter, rent and motel support, and linkages to a multitude of housing programs. Some housing linkages have been innovative, utilizing relationships with the community to temporarily house individuals in motels during the early COVID shelter in place closures and with their bridge housing partner.

Strategy 3 Linkage Categories



NOTE: The total number of referrals does not reflect the total number of people served. INN 2 participants may have more than one linkage or referral. Events and the total number of people reached is not de-duplicated.

Strategy 4: Coordinated Employment within a Community

Strategy Description and Objectives

Strategy 4's approach is to build capacity to assist individuals who were previously homeless, currently homeless and at risk of or experiencing symptoms of mental illness related to trauma to advance their educational, vocational and employment goals. Strategy 4 partners approach employment as a protective factor for individuals living with severe and persistent mental illness. They intentionally put in the practice the belief that employment can be a strong tool for recovery.

During 2020, the department approved a pivot to the strategy to address a challenge within the community intensified by the pandemic and shelter in place restrictions (the need to bridge the digital divide to improve employment opportunities and reduce economic exclusion). The objective of the pivot, called *Project Opportunity*, is to inform and empower individuals through education and skills development while at the same time expanding the economic opportunities and community connections available to the target population.

MHALA (and their community partners) is the only agency to implement Strategy 4.

As of April 14, 2022, **98** participants have been registered in iHOMS under Strategy 4 or Strategies 4 and 8.

Intended Outcomes of *Project Opportunity*

- Improvement in financial wellbeing.
- Increase social connectedness.
- Participants will make progress towards educational/vocational goals.
- Increase access to technology

NOTE: The total number of referrals does not reflect the total number of people served. INN 2 participants may have more than one linkage or referral. Events and the total number of people

Events and Activities

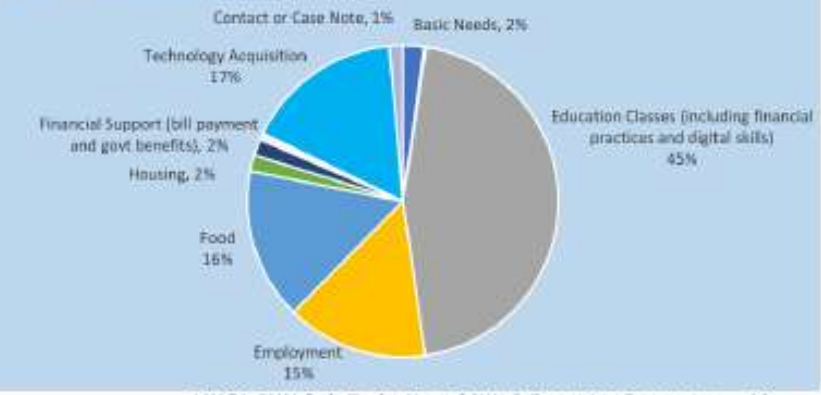
Outreach, community activities and group and linkages with supports were unique to each partnership and community's needs and were tailored to support participants' employment and education goals. It is evident from the types of events recorded in iHOMS that the partnership focused on supporting community members to advance their educational, employment and financial goals through trainings and skill development opportunities.

- **718 events** were recorded in iHOMS for Strategy 4, supporting individuals entering the workforce with trainings and resources.
- During the pandemic, strategy 4's approach towards outreach and education pivoted to focus on financial literacy and technology acquisition/skills as a way to address economic exclusion because of the digital divide.
  - **Trainings** to their partnering agencies and their participants on digital skills and financial practices to support individuals in the workforce, made up **over 40% of their event-related activities.**
  - These included hosting a digital skills training series, money management workshops, and employment and education webinars.
- In addition to trainings, 33.4% of their events were strategy development meetings including Project Opportunity team meetings and curriculum development meetings for their digital and financial tools.

Linkages for Strategy 4 Participants

- Referrals and resources recorded in iHOMS focus on supporting the diverse needs the community.
  - Overall, there were **591** referrals for resources and services provided to 88% (86) of Strategy 4 participants during the initiative.
  - Eighty one percent **(81%)** of referrals were reported as successful linkages, while twelve percentage of referrals are documented as in progress.
  - The top linkages reported in iHOMS align with the strategy pivot. *Project Opportunity* provides most resources and supports for participants to obtain laptops and WIFI and enroll in education and skills training. *Project Opportunity* also provided linkages to support volunteer opportunities, education, and employment goals.
    - Financial Wellness focuses on highly individualized interventions including, financial education and coaching, credit and debt management, tax filing assistance and savings programs.

Strategy 4 Linkage Categories



Strategy 5: Community Integration for Individuals with a Mental Illness with Recent Incarcerations or Who Were Diverted from the Justice System

Strategy Description and Objectives

The purpose of Strategy 5 was to provide programming to reduce the impact of trauma associated with incarceration and mental illness. 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. Strategy 5 focuses on empowering individual's who are often discriminated against or have little voice to make demands on the larger community for increased resources or equal treatment. In order to ensure community members are accessing the resources they need, Strategy 5 partners focus on providing "warm handoff" referrals and bringing resources out into the community via mobile services. Engagement in the community and foot in the door outreach is crucial for this strategy, so strategy 5 partners focus on providing concrete supports (showers, food, clothing, haircuts, etc.) to build trust within the community.

The Children's Clinic of Antelope Valley (and their community partners) is the only agency to implement Strategy 5.

As of April 14, 2022, **1,321** participants have been registered in iHOMS.

Intended Outcomes

- Secure housing for individuals with recent incarcerations.
- Reduce re-incarcerations.
- Increase connection with the community.
- Increase access to care within the community.

NOTE: The total number of referrals does not reflect the total number of people served. INN 2 participants may have more than one linkage or referral. Events and the total number of people reached is not de-duplicated.

Events and Activities

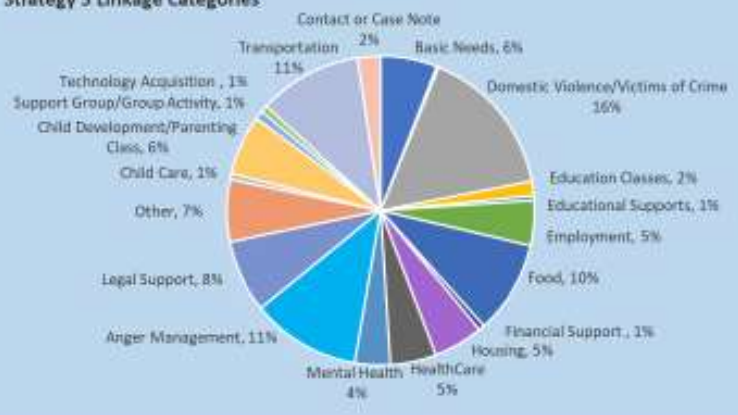
Outreach, community activities and groups, and linkages with supports were unique to each partnership and community's needs and were tailored to support community members with recent incarcerations or involvement with the justice system. It is evident from the types of events recorded in iHOMS that the partnership focused on creating safe spaces for justice involved individuals and their families to receive the help and support they need and assist in successful re-integration.

- **Over 3,500 events** were recorded in iHOMS for Strategy 5, providing trainings and support to community members with recent incarcerations or involvement with the justice system.
- Strategy 5 focused on providing **trainings** to their participants, making up over **75%** of all their event-related activities.
  - These trainings included domestic violence classes, anger management classes, legal and justice system educational trainings.
  - These trainings are often provided for individuals with court mandated requirements to assist them in meeting their requirement and to promote successful re-integration for those recently incarcerated.

Linkages for Strategy 5 Participants

- Referrals and resources recorded in iHOMS focus on supporting the needs of the target population of previously justice-involved individuals reconnect with the community.
  - Overall, there were **4,527** referrals for resources and services provided to 93% (1,235) of Strategy 5 participants during the initiative.
  - Ninety two percent **(92%)** of referrals were reported as successful linkages.
  - Resources for domestic violence/victims of crime and anger management classes were the most frequent linkages for Strategy 5 participants, which aligns with the objectives of the strategy.
  - Transportation, such as linking participants with free bus pass programs, and legal support services, were also common supports provided.

Strategy 5 Linkage Categories



Strategy 6: Geriatric Empowerment Model (GEM)

Strategy Description and Objectives

The purpose of Strategy 6 was to provide programming to reduce the impact of trauma associated with homelessness for Older Adults. Older Adults experiencing the trauma of homelessness are living with a multitude of losses, including isolation and stigma within the larger community, and represent one of the most vulnerable populations at risk for harm. There is a compelling need for a safe environment for older adults, which would include a place for them to visit on a daily basis 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. Homeless shelters are not the optimal setting for older adults who are homeless because they often do not address the unique needs of this population as services and programs in these locations generally have an emphasis on the needs of younger individuals and/or families who are homeless.

Partners who are part of the GEM Program work with the community to develop effective strategies for interacting with older adults who are homeless, establish a homeless senior center for seniors to access during the day, and provide case management and supportive services to meet the complex psychiatric and social needs of older adults.

As of April 14, 2022, **296** participants have been registered in iHOMS.

Intended Outcomes

- Decrease homelessness among seniors
- Increase access to care
- Improve knowledge of and linkages to community resources

Events and Activities

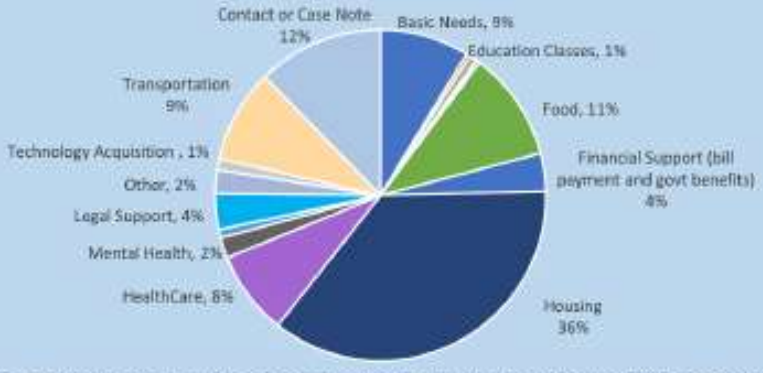
Outreach, community activities and groups, and linkages with supports were unique to each partnership and community's needs and were tailored to support older adults, 60 and over, who are at risk of or experiencing homelessness. It is evident from the types of events recorded in iHOMS that the partnership focused on creating safe spaces to empower older adults experiencing homelessness to receive the care and resources they need as they work towards permanent housing.

- **737 events** were recorded in iHOMS for Strategy 6, focusing on outreach and engagement to older adults at risk of or experiencing homelessness.
- **Community outreach** made up over **90%** of all Strategy 6 events.
  - This included general outreach and community canvassing as well as outreach and engagement efforts through providing community members with free meals, showers, and laundry services.

Linkages for Strategy 6 Participants

- Referrals and resources recorded in iHOMS focus on supporting the unique needs the older adults.
  - Overall, there were **5,080** referrals for resources and services provided to 93% (275) of Strategy 6 participants during the initiative.
  - Seventy three percent **(73%)** of referrals were reported as successful linkages, while sixteen percentage of referrals are documented as in progress.
  - The top linkages reported during the initiative highlights a focus on supporting basic needs. Strategy 6 programs provided most resources and supports for GEM participants in the way of housing assistance, food, and transportation. The INN 2 staff also provided many linkages for healthcare services.
    - Linkages with housing during the pandemic has been innovative. GEM staff partnered with a local motel to assist in temporarily housing their older adult participants experiencing homelessness who were at a higher risk for severe illness or death from COVID-19 in motels that were not being booked during the early months of the pandemic and with their community housing partner. GEM staff were able to help participants establish more permanent housing

Strategy 6 Linkage Categories



NOTE: The total number of referrals does not reflect the total number of people served. INN 2 participants may have more than one linkage or referral. Events and the total number of people reached is not de-duplicated.

Strategy 7: Culturally Competent Activities for Multigenerational Families Experiencing Trauma

Strategy Description and Objectives

The purpose of Strategy 7 is to provide programming to reduce the impact of community or societally-induced trauma experienced by intergenerational families. Working with intergenerational families means that partners need to be responsive to the multi-faceted needs of a family. Within Strategy 7, partners focus on implementing culturally appropriate outreach, education and engagement (OEE), culturally appropriate intergenerational family wellness screenings, and intergenerational family healing activities.

Examples of topics that have been discussed during family activities include working together with area schools, healthy lifestyles, community resources, and family wellness. These programs promote healing and reconnection by identifying and accessing inherent strengths within intergenerational families and communities. Partners within Strategy 7 also works to bring specific cultural activities that are representative of the communities and families.

Strategy 7 has been implemented by two lead agencies (Alma Family Services and The Children's Clinic) and their community partners.

As of April 14, 2022, **2,823** participants have been registered in iHOMS.

Intended Outcomes

- Increase sense of social connectedness among multigenerational families
- Increase positive coping strategies
- Reduce shame and stigma related to trauma/mental illness
- Increase access to care

Events and Activities

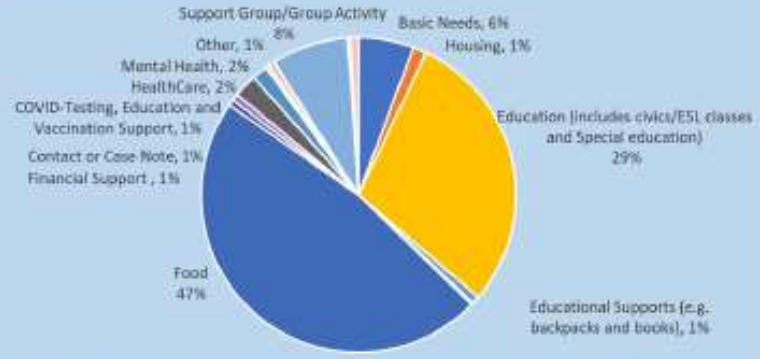
Outreach, community activities and groups, and linkages with supports were unique to each partnership and community's needs and were tailored to support multigenerational families through culturally competent programming. It is evident from the types of events recorded in iHOMS that partnerships focused on creating safe spaces for families to connect, share their culture, break down mental health stigmas and barriers, and create awareness within the community for resources and supports.

- Agencies recorded more than **4,000 events** in iHOMS, providing culturally competent activities to thousands of families through their Strategy 7 outreach and events.
- Strategy 7 programming focused on providing innovative and culturally appropriate group activities for families to participate in together, making up over **60%** of all their event-related activities.
    - These group activities included story telling groups, language specific parenting groups (i.e. hosted in Spanish or Khmer), spiritual activities, ESL classes, along with many other innovative activities.
- Strategy 7 programs were also able to adapt many of these group activities to a virtual format and hold them online when the pandemic restricted in-person groups and remained connected with their families.

Linkages for Strategy 7 Participants

- Referrals and resources recorded in iHOMS focus on supporting the diverse needs the community.
    - Overall, there were **15,688** referrals for resources and services provided to 75% (2,115) of Strategy 7 participants during the initiative.
    - Ninety five percent **(95%)** of referrals were reported as successful linkages.
    - Food and basic needs (such as diapers and wipes) were linkages for Strategy 7 participants.
    - Strategy 7 providers also reported linking participants with needed classes, support groups and group activities. Most notably, strategy seven providers linked participants to Civics and ESL classes to assist them as they prepared for the immigration process.

Strategy 7 Linkage Categories



NOTE: The total number of referrals does not reflect the total number of people served. INN 2 participants may have more than one linkage or referral. Events and the total number of people reached is not de-duplicated.

B. INN 4: Transcranial Magnetic Stimulation (TMS)

Los Angeles County Department of Mental Health (LACDMH) implemented Mobile Transcranial Magnetic Stimulation (TMS) as the Innovation 4 project as of May 2019. TMS is FDA approved for the treatment of depression and is a non-invasive treatment that can enhance or suppress the activity of neurons in targeted areas of the brain through the use of electromagnetic stimulation. According to the American Psychiatric Association best practice guidelines for the treatment of major depressive disorder, TMS is now a first-line treatment for depression that has not responded to one antidepressant medication (APA 2010) as well as being effective for treatment-resistant depression.

TMS uses precisely targeted magnetic pulses similar to those used in Magnetic Resonance Imaging (MRI) to stimulate key areas of the brain that are underactive in clients with depression. The client reclines comfortably in the treatment chair and is awake and alert during treatment. An electromagnetic coil is then placed on the skull directly to the target area of the brain where the device generates magnetic fields that alter the electrical activity of neurons. The enhancing or suppressing of neuron activity depends upon a number of variables including the frequency of the TMS pulses. During treatment, the client hears a clicking sound and feels a tapping sensation on the head. The client can go back to their normal activities immediately after treatment. Treatment sessions can last between 3-45 minutes and services are typically administered once per day for 5 consecutive days per week for 4-8 weeks.

In April 2018, LACDMH was approved to implement a Mobile TMS program in a van outfitted with the technology, delivered to fully consenting clients receiving treatment in adult outpatient programs. The target population includes individuals receiving outpatient services that have depression as a major part of their psychiatric symptoms and *one or more of the following*:

- Resistance to treatment with psychopharmacologic agents as evidenced by a lack of a clinically significant response to at least two psychopharmacologic agents in the current depressive episode; or
- Inability to tolerate psychopharmacologic agents as evidenced by two trials of psychopharmacologic agents from two different agent classes; or
- History of response to TMS in a previous depressive episode; or
- A history of response to ECT in a previous or current episode or an inability to tolerate ECT, or is a candidate for, but has declined ECT and TMS is considered a less invasive treatment option.

Because of the nature of the TMS treatment, individuals with a history of seizure disorder and those with metal implants in the head or upper torso (e.g., cardiac pacemakers) are excluded.

The goals of the INN 4 Mobile TMS Project include:

- Provide access to new and effective treatment to clients with chronic and severe mental illness
- Increase adherence to treatment by bringing the treatment to the client
- Reduce use of other resources (i.e., psychiatric hospitalization, Emergency Room visits, intensive supportive services, etc.)

- Improve social and occupational functioning that would lead to successful community reintegration
- Increase the quality of life of clients with histories of poorly treated depression.

Overall, the primary purpose of this Innovation project is to improve the quality of mental health services and achieve greater outcomes by providing new and effective treatment to clients with chronic and severe mental illness. This project seeks to introduce a new approach or an approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.

Status of Implementation as of June 30, 2022:

Provision of service for this project began on May 30, 2019, after obtaining a mobile TMS unit. The mobile TMS unit consists of a customized van with modifications that allow a small treatment team to deliver TMS services within it. Clients of directly operated LACDMH clinics are referred to the TMS program by their outpatient providers (psychiatrists or clinicians). After receiving referrals, clients have an in-person consultation with the TMS program director (Marc Heiser, MD, PhD) during which their symptoms, treatment history, and medical history are reviewed, and a safety screening form and initial symptom rating scales are completed. The treatment is explained and demonstrated for the clients and clients are given the opportunity to ask any questions. If they are interested and the treatment is deemed appropriate, an informed consent form is completed, and they are scheduled for their initial treatment.

Until March 13, 2020, clients were being referred and receiving daily (Monday-Friday) treatments within the mobile TMS unit at one location, the Harbor UCLA Outpatient Psychiatry Clinic. While the TMS unit has been at one location, the program has received referrals and treated clients from six LACDMH clinics located throughout LA County (including Service Areas 2, 3, 5 and 8).

INN 4 Mobile TMS services were put on hold as of March 14, 2020, due to the COVID-19 pandemic. Due to the intensive treatment schedule that TMS services require (5 days per week for approximately 4-6 weeks), in general, clients sometimes have difficulty adjusting to the change and experience a sudden worsening of depressive symptoms. Therefore, TMS staff completed phone check-ins with TMS clients as soon as was possible to assess how clients were coping with the transition and continued to conduct phone check-ins 1-2 times per week while clients were not receiving TMS services, to the extent possible. PHQ-9 scores were also completed over the phone weekly with each client while they were not receiving TMS services in order to track depressive symptomology. This information was used to monitor clients and determine the need for a client to return for TMS treatments with a decreased frequency (provided 1-2 times per week) until TMS services were back up to scale.

In November 2020, TMS services restarted once weekly treatment for clients who had been receiving treatment prior to COVID-19 and who were struggling with worsening mood symptoms. By February 2021, TMS services were being provided to current clients 5 days per week and the TMS team began treating new clients. TMS services are currently being

provided five days per week. In addition, due to the small size of interior space of the Mobile TMS van and concern for client and staff safety during COVID-19 pandemic, the TMS device was moved from the van into an office space in Long Beach in February of 2021. As of December 2022, TMS services continue to be administered 5 days a week and take place inside a designated office space.

Number of clients served:

As of **June 30, 2022,** the program had received **135** referrals. Between May 1, 2019, and June 30, 2022, **110** client consultations/initial evaluations were completed. A total of **51** of these clients completed a full TMS treatment course. Common reasons for not completing a full TMS treatment include a disruption due to COIVD-19, difficulty with transportation, and perceived lack of efficacy.

Below is a summary of the demographic information on the **51** clients who completed a full treatment course of TMS as of **June 30, 2022**:

- The majority were adults (ages 26-59) 82%, while 14% were older adults (60 years or older) and 4% were transitional age youth (ages 15-25). In this sample, the two transitional age youth were both 23 years old.
- The majority identified as male (53%) and 47% identified as female.
- The majority identified as Non-Hispanic/Latino (49%), while 29% identified as Hispanic/Latino and for 11% of the clients, the ethnicity was unknown.
- 22% of clients identified their race as White and 12% identified as Mexican. Other races included Asian Native (2%), Black/African American (4%), Cambodian (2%), Central/South American (6%), Korean (2%), and Vietnamese (2%). 14% of clients were of another race and the race of 35% of clients was unknown.
- The majority of clients stated that their preferred language was English (75%). Other preferred languages included Spanish (15%), Cambodian (4%), Farsi (4%), Vietnamese (4%).

Outcome data being collected and analysis of impact:

The Overarching Learning Questions for this project include the following:

1. Will these individuals be adherent with a mobile TMS treatment program?
2. Is TMS an effective treatment for this population?
3. Does TMS for depression lead to improvement in comorbid symptoms (i.e., substance use, psychotic symptoms, etc.)?
4. If TMS is an effective treatment for this population, should the program be expanded to treat a larger part of the population?

In order to assess the impact of TMS, depression outcome measures are administered at the beginning of treatment and weekly throughout the course of treatment. Measures include the following: Quick Inventory of Depressive Symptoms (QIDS-SR-16, client rated), the Hamilton Depression Rating Scale (HAMD-17, clinician rated), and the Patient Health Questionnaire (PHQ-9, client rated). Client satisfaction with TMS services is also assessed at the end of each

session, utilizing a verbal check in, and using a Client Satisfaction Survey at the end of treatment. Additionally, the providers in the client's treatment team are asked to complete a brief survey to assess their impression on the impact of TMS services in the clients overall recovery and functioning at the end of treatment. These assessment tools enable clinicians to track improvements in depressive symptoms and functional outcomes that, in turn, are used to judge the efficacy of this program.

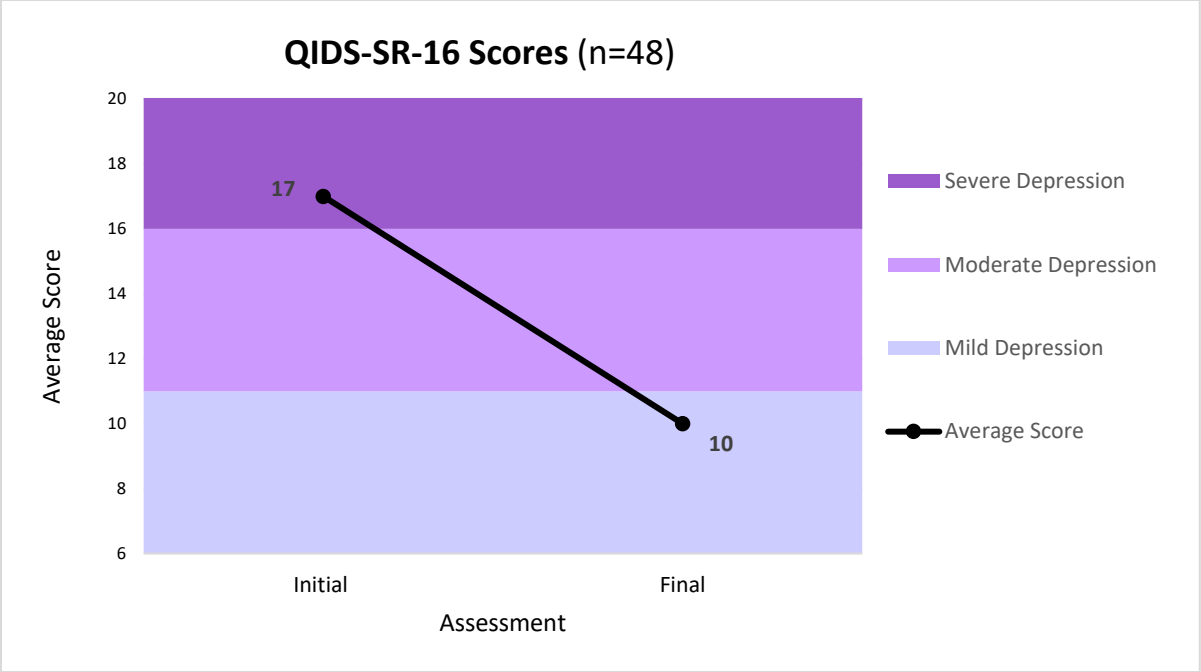
Below are the average initial scores and final scores for each of the three depression measures (QIDS-SR-16, PHQ-9, and HAMD-17) for clients who completed a full TMS treatment course between May 1, 2019, and June 30, 2022. Data included is for clients who received at least two treatments of TMS and completed the respective measure at least twice.

Quick Inventory of Depressive Symptomatology-Self-Report (QIDS-SR-16)

The QIDS-SR-16 is a 16-item self-report measure of depressive symptom severity derived from the 30-item Inventory of Depressive Symptomatology (IDS). There are nine depression symptoms measured across the 16 items (sleep, mood, appetite/weight, concentration, view of self, suicidal ideation, interest, fatigue, and psychomotor). Scores 1-5 indicate no depression; scores of 6-10 indicate mild depression; scores of 11-15 indicate moderate depression; scores of 16-20 indicate severe depression; scores 21-27 indicate very severe depression.

For the clients who received TMS treatment during this period:

- The average initial QIDS-SR-16 score was 17, which indicates severe depression. At the end of treatment, the average final QIDS-SR-16 score was 10, which indicates mild depression. **There was an average change in score of 7 points (41% decrease), which indicates that there was an overall improvement in depressive symptoms at the end of the course of TMS treatment.**
- Of those who completed a full course of TMS treatment, 12 clients (**25%**) of clients met criteria for remission (no depressive symptoms) at the end of treatment.
- 14 clients had an initial score that indicated very severe depression (score of 21 or more). Depressive symptoms improved for **64%** of these clients (scores of 20 or less) at the end of the course of TMS treatment.



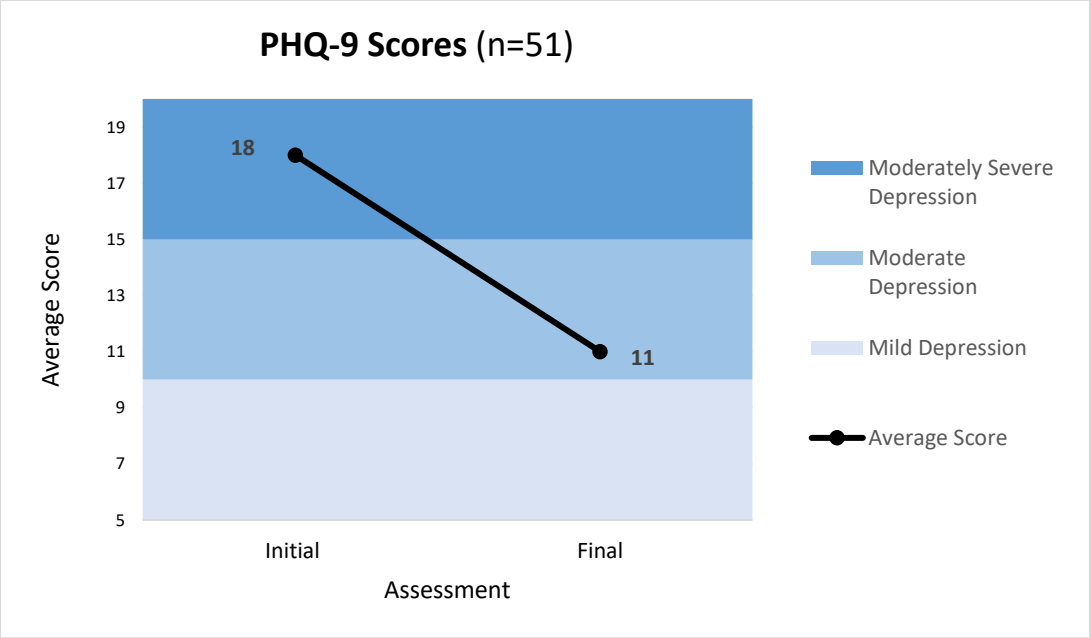
Graph 1. Summary of Average QIDS-SR-16 Scores for Mobile TMS clients.

Patient Health Questionnaire (PHQ-9)

The PHQ-9 is a concise, self-administered screening tool for assessing depression. It incorporates DSM-IV depression criteria with other leading major depressive symptoms into a brief self-report instrument that is commonly used for screening and diagnosis, as well as selecting and monitoring treatment. Scores of 0-4 indicate minimal depression; scores of 5-9 indicate mild depression; scores of 10-14 indicate moderate depression; scores of 15-19 indicate moderately severe depression; and scores 20-27 indicate severe depression.

For the clients who received TMS treatment during this period:

- The average initial PHQ-9 score was 18, which indicates moderately severe depression. At the end of treatment, the average final PHQ-9 score was 11, which indicates moderate depression. **There was an average change in score of 7 points (39% decrease), which indicates that there was an improvement in depressive symptoms at the end of the course of TMS treatment.**
- Of those who completed a full course of TMS treatment, 11 clients (**22%**) of clients met criteria for remission (no depressive symptoms) at the end of treatment.
- 25 clients had an initial score that indicated severe depression (score of 20 or above). Depressive symptoms improved for **60%** of these clients (scores less than 20) at the end of the course of TMS treatment.



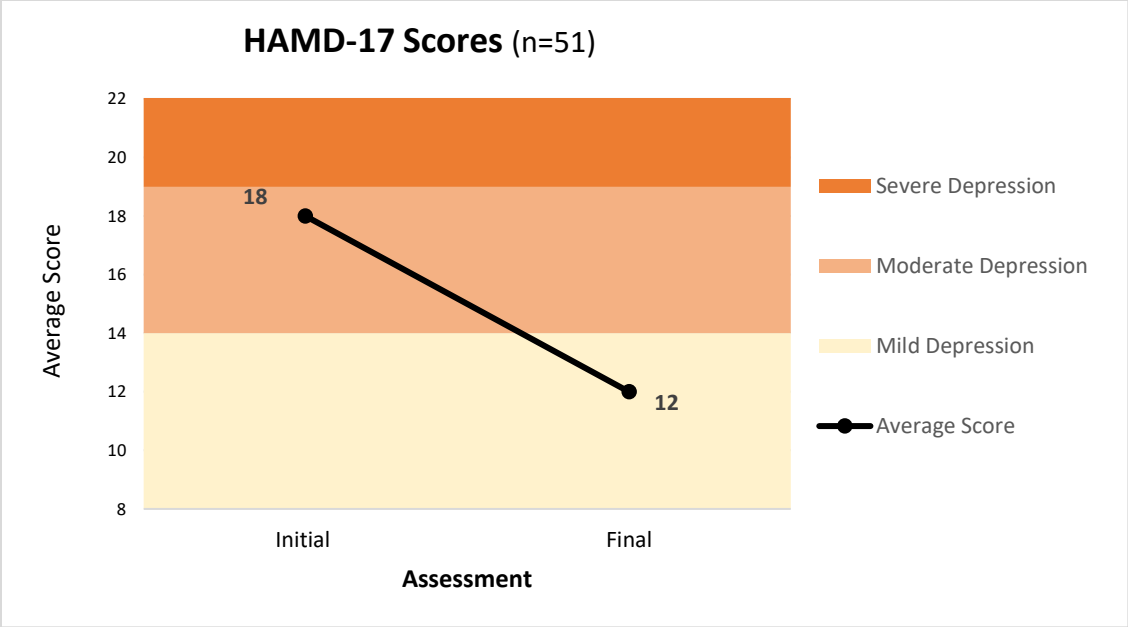
Graph 2. Summary of Average PHQ-9 Scores for Mobile TMS clients.

Hamilton Depression Rating Scale (HAMD-17)

The HAMD-17 is one of the longest standing and most widely used measures of depression in research and clinical practice. The HAMD-17 is a clinician completed measure that includes 17-items. Total scores of 0-7 indicate no depression; scores of 8-13 indicate mild depression, scores of 14-18 indicate moderate depression, scores of 19-22 indicate severe depression, and scores 23-50 indicate very severe depression.

For the clients who received TMS treatment during this period:

- The average initial HAMD-17 score was 18 which indicates moderate depression. At the end of treatment, the average final HAMD-17 score was 12, which indicates mild depression. **There was an average change in score of 6 points (33% decrease), which indicates that there was an overall improvement in depressive symptoms at the end of the course of TMS treatment.**
- Of those who completed a full course of TMS treatment, 9 clients (**18%** of clients) met criteria for remission (no depressive symptoms) at the end of treatment.
- 3 clients had an initial score that indicated severe depression (scores of 25 and above). Depressive symptoms improved for **33%** of these clients (final scores of 24 and below) at the end of the course of TMS treatment.



Graph 3. Summary of Average HAMD-17 Scores for Mobile TMS clients.

TMS Client Satisfaction Survey

The TMS Client Satisfaction Survey was developed by LACDMH and was completed by clients who completed a full course of TMS treatment. The Client Satisfaction Survey includes 11 items that assess the client's satisfaction with various aspects of TMS treatment and the client's perceived impact of TMS services on the client's overall well-being and functioning.

Overall Satisfaction [Chart 1]:

- Overall, a majority (**95%**) of clients who completed a CSS were "Very Satisfied" or "Satisfied" with their TMS experience, which is a **22% increase since December 1, 2019.**
- None of the clients were dissatisfied with their TMS experience.

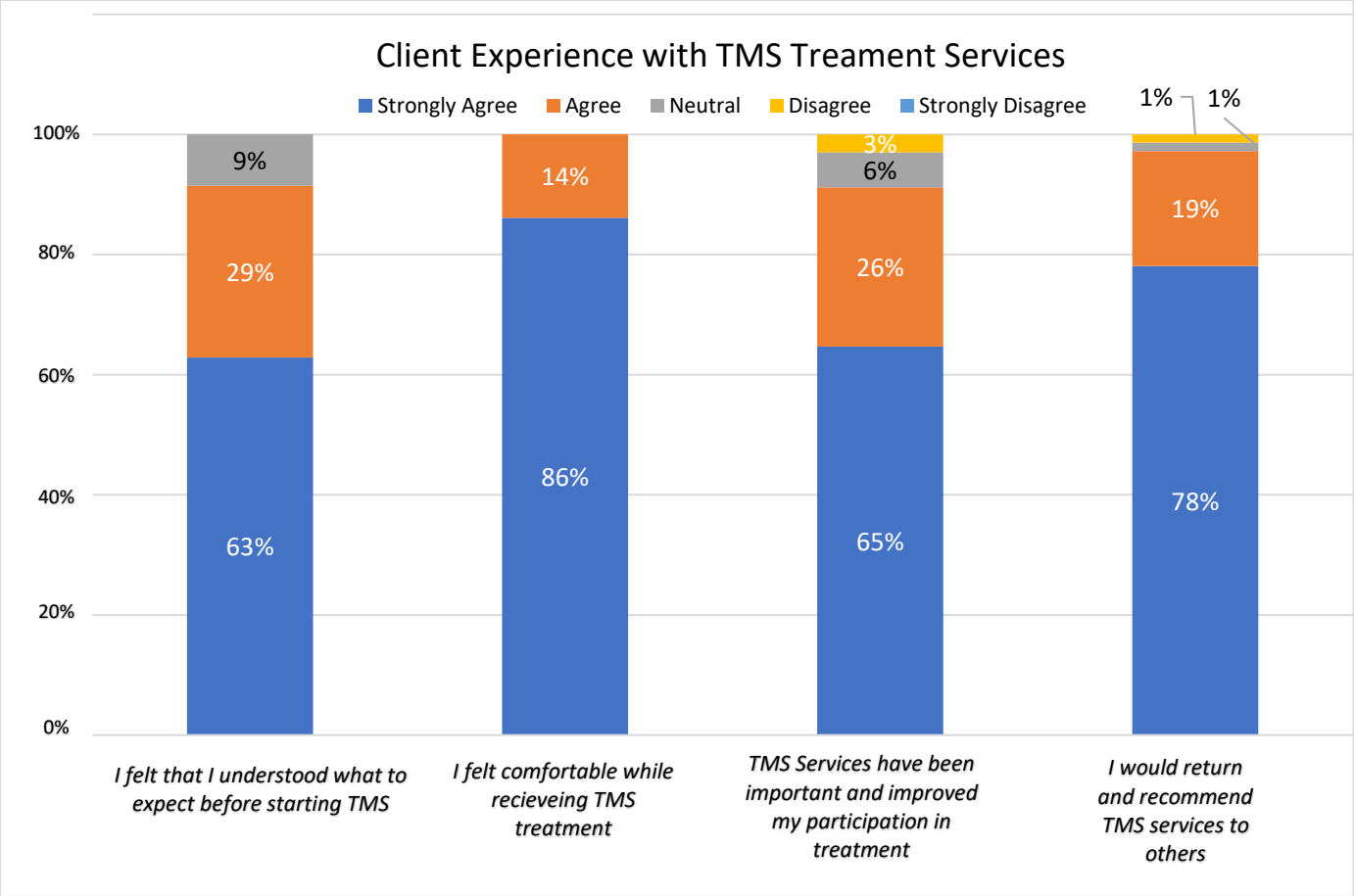


Chart 1. Overall Client Satisfaction with Mobile TMS services

TMS Treatment Experience [Chart 2]:

- A majority of clients who completed a CSS (**94%**) "Strongly Agreed" or "Agreed" that they understood what to expect before starting TMS treatment.
- All clients (**100%**) "Strongly Agreed" or "Agreed" that they felt comfortable while receiving TMS services.
- A majority of clients (**91%**) "Strongly Agreed" or "Agreed" that TMS services have been an important part of their treatment and that TMS services have improved their participation in their treatment.
- Finally, a majority of clients (**97%**) "Strongly Agreed" or "Agreed" that they would return for more TMS treatments in the future if recommended by their clinician and would recommend TMS to others if they are experiencing depression.

Level of Discomfort/Pain during and after TMS Treatment [Chart 3]:

Clients were asked to rate their discomfort/pain during TMS treatments and after TMS treatments on a scale of 1-10, with 1 corresponding to "No Pain" and a score of 10 corresponding to "Very Painful".

- On average, respondents felt mild discomfort/pain during TMS treatments (*2 out of 10*) and less mild discomfort/pain after TMS treatments (*1 out of 10*).
- Clients most often described discomfort/pain as “annoying” and the the discomfort usually decreased over the course of treatment and resolved after treatment.

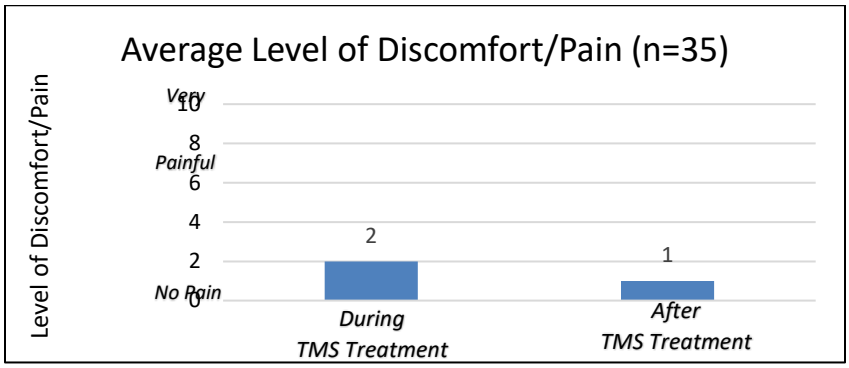


Chart 3. Average Level of Discomfort/Pain During and After Mobile TMS Treatments

Percieved Benefits of TMS Services [Chart 4]:

Clients were asked how they felt they benefitted from participating in TMS services. All answers are listed below and the most endorsed benefits are shown in Chart 4.

- **60%** of clients stated that they that they feel happier.
- **57%** of clients stated that they feel less worried/anxious.
- **51%** of clients stated that they are less frustrated.
- **49%** of clients stated that they have more motivation to engage in meaningful activities and that that they are able to focus better.
- **46%** of clients stated that they feel more relaxed.
- **40%** of clients stated that they have more energy and an increased abilty to do the things that they want to do.
- **34%** of clients stated that they have more contact with family/friends.
- **31%** of clients stated that they are sleeping better.
- **29%** of clients stated that they have more self-confidence and that they are getting along better with family/friends.
- **17%** of clients stated that they are eating better.
- **14%** of clients stated that they feel less body pain.

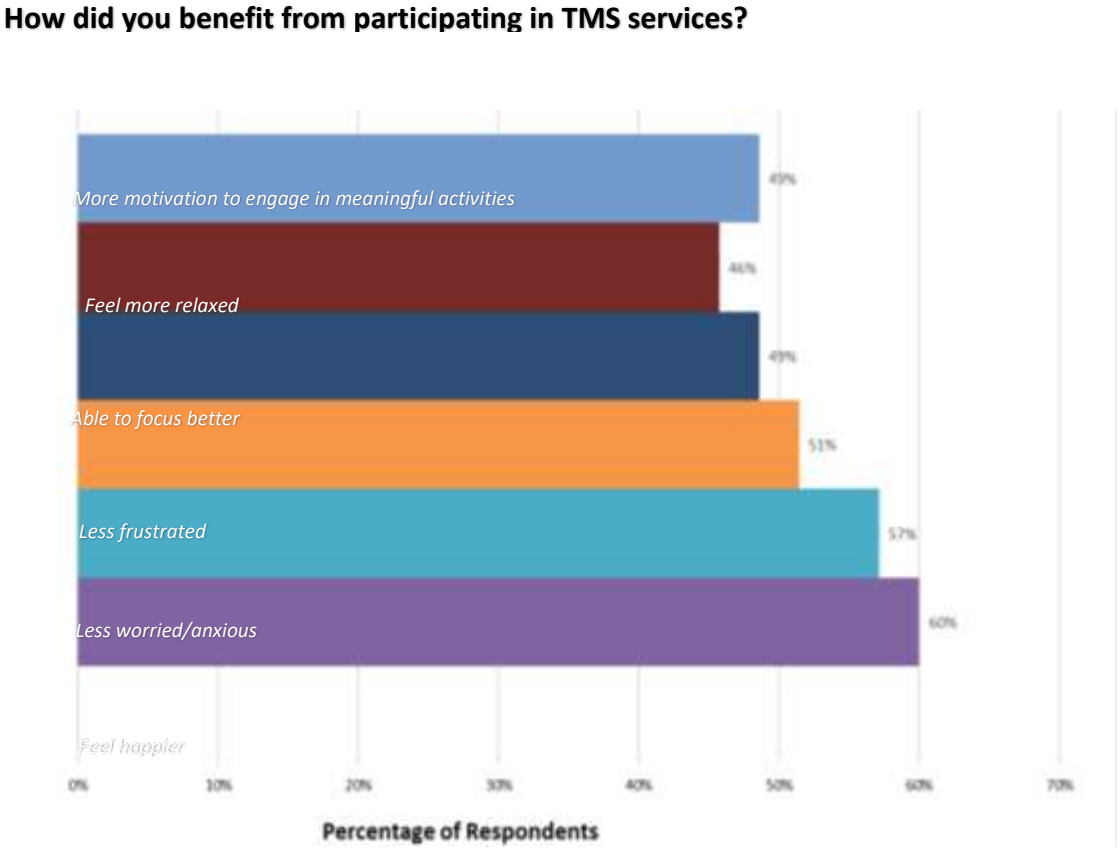


Chart 4. Most Common Percieved Benefits of TMS Services by Clients After Mobile TMS Treatment.

Additional Client Feedback:

Upon treatment completion, clients were asked to share any additional feedback that they may have regarding their experience with TMS services through client exit interviews and on the Client Satisfaction Survey. Some of their feedback is listed below:

- "…the overall process was friendly and calm."
- "I think that TMS helps to reduce my headache. My brain is more clearer than before. My mood is more happier because of reducing headache."
- "[I] finally feel hope."
- "Slightly more conversational. A bit more improvement with depression."
- "The staff was very nice and helpful."
- "TMS has been extremely beneficial. My depression has at least been cut in half and all the benefits from the above list. Thank you so much."
- "[I] have better clarity and less feelings of shame guilt."
- "No longer crying and suicidal"
- "A lot less depressed. Feel more ok."

Treatment Team Survey

A survey was provdied to each of the client's treatment team of providers at the end of treatment. The providers were asked to rate their client's improvement in mood, behavior, overall funcitoning, and progress made toward treatment goals as a result of TMS services. A total of **32** surveys (for **26** clients) were completed by treatment team staff (16 Psychiatrists/Medical Doctors, 5 Therapists, 3 Case Managers, and 1 Registered Nurse).

- A majority (**58%**) of providers "Strongly Agreed" or "Agreed" that their client demonstrated improvements in mood, behavior, and overall functioning (family, community, occupational) as a result of TMS services **[Chart 5].**
- A majority of providers (**55%**) "Strongly Agreed" or "Agreed" that their client made progress towards her/his treatment goals as a result of TMS Services **[Chart 6].**
- A majority (**89%**) of providers "Strongly Agreed" or "Agreed" that they would refer future clients for TMS services **[Chart 7].**

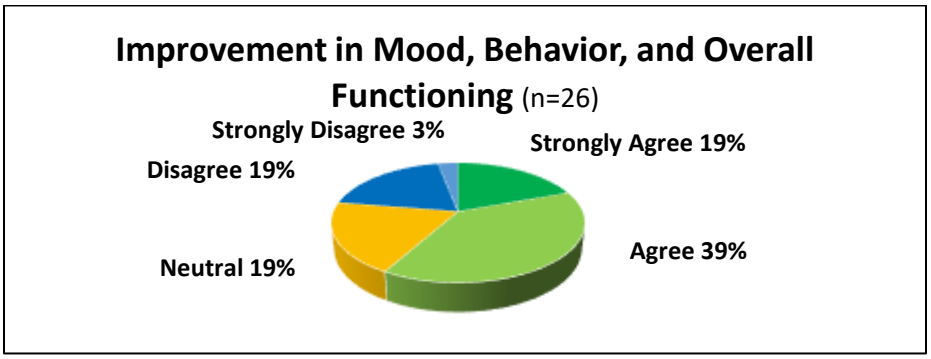


Chart 5. Provider Perception on the Impact of TMS Services on Client's Mood, Behavior, and Overall Functioning

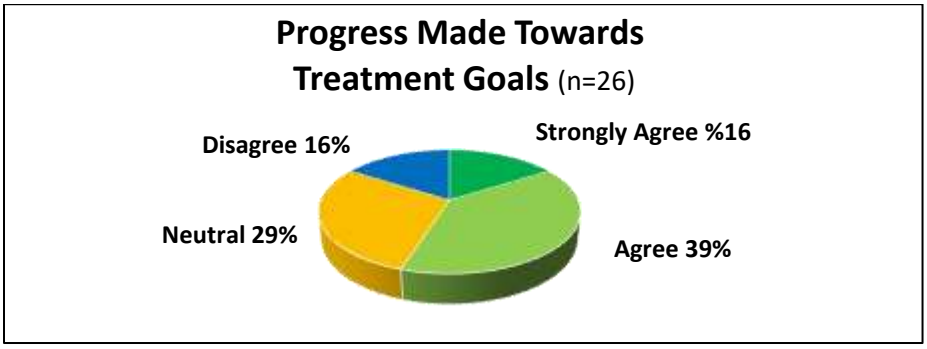


Chart 6. Provider Perception on the Impact of TMS Services on Client's Progress Toward Treatment Goals

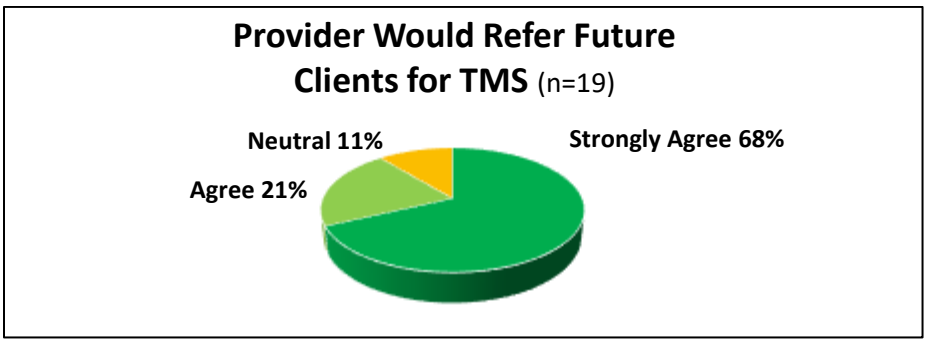


Chart 7. Likelihood of Provider Referral to TMS Services for Future Clients

Provider staff were also asked to share any additional feedback, which is listed below:

- "Patient was appreciative of the opportunity and enjoyed the experience..." (Psychiatrist)
- "[The client] was able to make it to TMS every day and that was the biggest progress." (Case Manager)
- "Client appeared more engaged at his last appointment and...he noted overall improvement with mood and focus." (Nurse)
- "The notable change that seems to have remained since TMS treatment is that the client is more socially engaged and involved with community activities." (Case Manager)
- "Client comes to dance group and MD's appointments regularly. He is noticed to be more interactive and sociable." (Case Manager)
- "His headaches and sleep improved significantly." (Psychiatrist)
- "The client had improvement in ability to function despite pain and chronic headaches." (Psychiatrist)
- "Eliminated suicidal ideation. Reduced negative thinking/rumination. Increased hope." (Therapist)
- "Client was more open to the therapeutic process after receiving services. Client reported that services were very helpful in being able to lift the feelings of severe depression." (Therapist)
- "Patient reports that it was beneficial for her mood! That's a big deal for her, as medications have not been particularly helpful for her. The only issue was transportation/location." (Psychiatrist)
- "There has been a significant change in her symptoms (particularly her suicidal thought and mood)..." (Psychiatrist)
- "Anger reduced" (Psychiatrist)
- "The supportive structure and daily visits helped this client through some incredibly stressful times that likely would have resulted in more crises without the daily interventions." (Therapist)
- "[The client] …was also proud of accomplishment of going to TMS, it was behavioral activation, and it was motivating for her." (Psychiatrist)
- "Client reported improved mood that she has not experienced in a while." (Case Manager)

Client Testimonials:

"For over a year I have benefitted from Transcranial Magnetic Therapy at Harbor-UCLA. I suffer from Major Depressive Disorder and have been a county mental health patient for years. Medications have worked intermittently but I have not had a sustained recovery where I can manage my mood consistently. TMS has made things better. Since starting treatment I have not had completely immobilizing depression. I have been depressed but I bounce back sooner. I have a more confident outlook. I feel that I have an underlying sense of support. For me, this is big progress. I was fearful of the treatment at first because I was unfamiliar it and it initially hurt. This quickly changed because Dr. Heiser and his team helped me feel calm and safe. Despite the unusual treatment in a van, they made me feel comfortable and I even once fell

asleep once during treatment. The opportunity to get this treatment from the county facility was a surprise. I had thought it was only available to wealthy patients. In this way the TMS program works to mitigate health disparities. I hope it can expand."

"I have been undergoing TMS for several months. It's been a Godsend me. I had been going through constant suicidel [sic] thoughts for years, if not for the TMS I would have most likely followed through with them. Thanks to the TMS, Dr. Heiser and his team, I am still alive. It has given me hope to keep going. Hopefully this treatment can help other peopol [sic]. To me it is the rock of my treatment. Thank you 😊 "

"I have had years of therapy and I have tried different medications for depression and they did not work like TMS did. I wish the whole world could get TMS. We would be better to each other if we could. Thank you, Violet, Desta, Desiree, and Dr. Heiser & Thank you to the TMS machine."

"Before I started I was so depressed to the point of daily suicidal ideation. Felt helpless, worthless, undeserving, and didn't understand why I even existed. It was daily torture to the extreme of suicide attempts and multiple hospitalizations. Now, on this day of leaving final treatment, I feel ALIVE! I feel like living. I'm very seldom depressed and haven't had a suicidal thought in 4 months. That is so new for me. This TMS has helped me more than words can say. Thank you 😊"

"I am extremely thankful for being informed of considered for and accepted as a patient whom can benefit from TMS treatments. I consider myself blessed by the kindness, acceptance, professionalism, care, attention and support that I have received from your wonderful DMH staff."

"I notice that even when I feel down I am still able to function at a higher level as far as getting tasks done. The initial wave of happiness I felt the first few weeks of treatment has dissipatted [sic] but I still feel it has had a positive effect for the entire treatment."

"I am truly grateful to have been able to have this treatment. While I still have issues with depression, anxiety and pain, the TMS treatment has made a treatment has made a tremendous difference. The physicians and all of the clinicians involved in treatment have been wonderful. Thank you all very much."

C. INN 7: Therapeutic Transportation (TT)

TT program was partially implemented on January 30, 2022. Since then, DMH staff have been housed at Los Angeles City Fire Department (LAFD) Station 4 - Downtown area, providing services 24/7. 4 Licensed Psychiatric Technicians, 4 Community Health Workers, and 4 Drivers were trained by LAFD on communications and how to utilize the radios and IPad for deployment purposes.

The overall goals of the Pilot Therapeutic Transportation Project - INN 7 are to: (1) increase access and enhance the quality of mental health services to individual callers in crisis; (2) decompress EDs; (3) reduce the use of Los Angeles Fire Department (LAFD) resources for mental health responses; and (4) leverage partnerships to develop a community-driven approach toward improving outcomes for individuals experiencing a mental health crisis.

LACDMH has developed a collaborative with Los Angeles City (City) LAFD to implement INN 7. The City estimates tens of thousands of emergency calls per year to its police and fire dispatch centers that involve people suffering from a mental health crisis. LAFD Emergency Medical Technicians (EMTs)/paramedics do not have the training or experience to deal with mental health crises and in turn, need the support of LACDMH to provide a mental health field response operation.

Currently, LACDMH triages mental health crises through its ACCESS hotline and deploys the Psychiatric Mobile Emergency Response Team (PMRT). PMRT is staffed with licensed clinicians, who have legal authority per Welfare and Institutions Code Sections 5150 and 5585, to initiate applications for evaluation of involuntary detention of individuals determined to be at risk of harming themselves or others due to a mental health disorder. If transportation is necessary for an individual, PMRT staff utilize the ACCESS hotline to request an ambulance to transport the individual.

Therapeutic Transportation January – December 2022

IMPLEMENTATION DATES

STATION #	SD	IMPLENTATION DATE	HOURS OF OPERATION	COMMENTS
4	1	01/30/22	24/7	
59	3	03/06/22	24/7	LPT resigned on 2/15/23 – 12/7 since January 2023
77	5	05/16/22	12/7	Difficulties hiring LPTs for noc shift
94	2	08/08/22	12/7	Difficulties hiring LPTs for noc shift
40	4	09/26/22	12/7	Difficulties hiring LPTs for noc shift

TOTAL NUMBER OF CALLS

During the months of January through December 2022, Therapeutic Transportation Teams received **1,680** calls. Station 4 received **65%** (N=1,090) of the calls while station 59 received **15%** (N=246) followed by Station 94 which received **11%** (N=182)

Months	Station 4	Station 40	Station 59	Station 77	Station 94	Total
Jan*	3					**3**
Feb	129					**129**
Mar*	88		20			**108**
Apr	120		30			**150**
May*	94		23	1		**118**

Months	Station 4	Station 40	Station 59	Station 77	Station 94	Total
Jun	93		11	15		**119**
Jul	108		32	19		**159**
Aug*	102		30	28	4	**164**
Sep*	96		39	21	44	**200**
Oct	105	16	31	19	50	**221**
Nov	82	15	16	17	42	**172**
Dec	70	4	14	7	42	**137**
Total	**1,090**	**35**	**246**	**127**	**182**	**1,680**
Percentage	**65%**	**2%**	**15%**	**8%**	**11%**	**100%**

*Month Station open

TRANSPORTED

57% of calls were transported by Therapeutic Transportation Teams. The table below illustrates the number and percentage of transported calls by station and month.

Station	Station 4		Station 40		Station 59		Station 77		Station 94			
Transported	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	Transport	No Transport
Jan*	2	1									**2**	**1**
Feb	79	50									**79**	**50**
Mar*	68	20			10	10					**78**	**30**
Apr	83	37			16	14					**99**	**51**
May*	66	28			15	8		1			**81**	**37**
Jun	51	42			7	4	7	8			**65**	**54**
Jul	64	44			23	9	6	13			**93**	**66**
Aug*	60	42			13	17	15	13	2	2	**90**	**74**
Sep*	59	37			18	21	9	12	22	22	**108**	**92**
Oct	52	53	9	7	13	18	9	10	29	21	**112**	**109**
Nov	42	40	9	6	10	6	5	12	20	22	**86**	**86**
Dec	37	33	3	1	3	11	5	2	17	25	**65**	**72**
Total	**663**	**427**	**21**	**14**	**128**	**118**	**56**	**71**	**90**	**92**	**958**	**722**
Percentage Transported	**61%**		**60%**		**52%**		**44%**		**49%**		**57%**	

OUTCOMES

36% (N=598) of calls during this period we placed on an involuntary hold, **21%** (N=360) of calls during this period were evaluated, did not meet criteria, or transported for services (6000), **4%** (N=75) were evaluated and accepted voluntarily accepted services while **38 %** (N=636) of calls were cancelled due to various reasons. The table below illustrates the various dispositions by station during this reporting period.

Station #	5150	6000	Cancelled	Refer	Refused	Voluntary	Total
Station 4	404	250	386	2	4	44	**1,090**
Station 40	8	3	14	0	0	10	**35**
Station 59	67	63	107	2	0	7	**246**
Station 77	40	17	62	2	1	5	**127**
Station 94	79	27	67	0	0	9	**182**
Total	**598**	**360**	**636**	**6**	**5**	**75**	**1,680**
Percentage	**36%**	**21%**	**38%**	**0%**	**0%**	**4%**	**100%**

DESTINATION

57% of TT calls were transported to a facility. Majority of transported calls, **43%** (N=413) were transported to UCC, followed by **32%** (N=310) were transported to a hospital. **11%** (N=107) were transported to the emergency room and **10%** (N=98) were transported to a clinic.

Station #	CLINIC	ER	Hospital	Other Facility	UCC	No Transport	Total
Station 4	43	55	235	26	320	411	**1,090**
Station 40	5	2	5	1	8	14	**35**
Station 59	18	14	47	13	30	124	**246**
Station 77	8	28	6	4	14	67	**127**
Station 94	24	8	17	0	41	92	**182**
Total	**98**	**107**	**310**	**44**	**413**	**708**	**1,680**
Percentage	**10%**	**11%**	**32%**	**5%**	**43%**		

D. INN 8: EARLY PSYCHOSIS LEARNING HEALTHCARE NETWORK

The Department received approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) for this multi-county 5-year project on December 17, 2018 and DMH entered a contract with UC Davis to execute this project as of July 1, 2020 after initial approval by the Human Subjects Research Committee on April 23, 2020. The Early Psychosis Learning Healthcare Network (LHCN) allows counties who use a variety of Coordinated Specialty Care models to treat early psychosis to collect common outcome data. They can then use this outcome data to inform treatment and engage in cross-county learning.

Participation in this learning collaborative connects California counties with a national effort to promote evidence-based Coordinated Specialty Care models to effectively treat first episode psychosis and to collect common outcome data. It is a very unique California effort to join a national movement to reduce the duration of untreated psychosis and improve the outcomes and lives of individuals experiencing a first psychotic break. Los Angeles County has expanded its population to also include those who are identified as at clinical high risk for experiencing a first psychotic episode.

Beehive is a tablet- and web-based application developed by the UC Davis-led Learning Healthcare Network that is being used by programs to collect client and clinician-reported outcome data and help clinicians, clinic management and County administration visualize client outcome data to help inform treatment and track clinic and Countywide program outcomes. The goals of the Statewide Early Psychosis Evaluation and LHCN are to increase the quality of mental health services including measurable outcomes, and to introduce a mental health practice or approach that is new to the overall mental health system.

Additional funding by the National Institutes of Health (NIH) obtained by UC Davis has allowed the project to further expand to add additional sites across the State. The overarching name of the project, which encompasses the LHCN and the NIH-funded components, is now "EPI-CAL." In this and future reports, we will refer to the LHCN only when describing components of the project that are specific to the LHCN evaluation (e.g., county data analysis).

The Department's early psychosis coordinated specialty care model is the Portland Identification and Early Referral (PIER) program to identify and comprehensively treat individuals ages 12-25 who are at clinical high risk for psychosis (i.e., prodromal) or have experienced their first psychotic episode. Five (5) contractor teams have been trained in the PIER Model as of December 2019 and began community outreach and direct service in January 2020. As of November 30, 2022, there are 105 clients enrolled at five (5) clinics across Los Angeles County.

Status of Implementation as of June 30, 2022:

Stakeholder Advisory Committee and Multi-County Quarterly Leadership Meetings

The Advisory Committee for the LHCN is comprised of a county representative from each participating county, a representative from each participating EP program, and consumers and family members who have been, or are being served, by EP programs. Attendees receive updates and provide feedback on project elements biannually. Advisory Committee meetings during this reporting period were held on December 15, 2021, and June 10, 2022.

The December 15, 2021 meeting focused on updates on expansion of the LHCN committee to include Napa and Stanislaus Counties along with acknowledgment of the collection of initial services data from participating counties, including Los Angeles County. The Beehive training progress and barrier were discussed as well as changes implemented in Beehive from user feedback as well an update on Spanish language Beehive services. The June 10, 2022 meeting further discussed the expansion of training and the barriers to providers integrating Beehive into their workflow. Following this, breakout rooms focused on Incorporating Beehive in Care, Consumer Engagement and Training and Beehive Learning Curve to come up with collaborative solutions to barriers.

EP Program Fidelity Assessments

Each early psychosis clinic undergoes a fidelity assessment using the First Episode Psychosis Services Fidelity Scale (FEPS-FS). The FEPS-FS represents a standardized measure of fidelity to EP program best practice and was recently revised to meet the agreed upon standards of EP care in the US and allow large-scale fidelity evaluation. However, most programs within EPI-CAL, including Los Angeles County, also provide services to individuals with the clinical high-risk syndrome (CHR), for whom evidence-based best practice differs from FEP care in several respects. To provide a program assessment that most accurately

represents the care delivered, alongside the FEP-FS, research team will be piloting a new scale under development designed to assess the components of care delivered to individuals with the diagnosis of CHR, known as the CHRP-FS.

Each EP program will participate in an assessment of EP program components using the revised FEPS-FS/CHRPS-FS, which will be completed via web-based teleconference. The fidelity assessment will be used to identify program strengths and possible areas for improvement, which can serve an important driver to improving early psychosis care delivered in EP programs in the LHCN. Assessments are completed by trained clinical staff with expertise in early psychosis care and supported by evaluation administrative and research staff. As of June 30th, 2022, Los Angeles County was scheduled to be reviewed in July-September 2022. However, because of site scheduling issues and staff availability, fidelity reviews are scheduled to be completed by the end of December 2022.

Training and implementation of outcomes measurement on app

The Epi-Cal team provided core training on the Beehive application to non-pilot EP programs, including Los Angeles County. Due to the COVID-19 pandemic, trainings were provided remotely. The core trainings begin with a pre-training meeting with leadership and IT staff from each program to discuss which program staff members would be designated as providers, group analysts, or group and clinic admin in Beehive, as well as to cover topics around integrating Beehive into their current data collection system and IT systems. Next, the team conducted a training series consisting of a pre-training meeting with program leadership to introduce the training plan, three training sessions to introduce Beehive to each program (Part 1, Part 2, and Part 3), and an intake-workflow meeting with key clinic staff to understand clinic workflow and brainstorm how to best implement Beehive within their program context. Note that booster trainings (for entire program or for individuals at the program) have also been conducted in addition to the core trainings and are not included on the table below.

Figure 1: EPI-CAL Program Training Completion

Program	Pre-Training	Training 1	Intake Workflow	Training 2	Training 3
LAC- IMCES 3	5/10/2021	6/21/2021	8/11/2021	11/10/2021	12/8/2021
LAC - IMCES 4	5/10/2021	6/21/2021	8/11/2021	11/10/2021	12/8/2021
LAC - SFVCMHC	5/11/2021	6/18/2021	7/19/2021	11/18/2021	12/9/2021
LAC- The Whole Child	5/13/2021	6/17/2021	7/21/2021	11/23/2021	1/25/2022
LAC- The Help Group	5/14/2021	6/14/2021	8/10/2021	11/29/2021	1/5/2022

The End User License Agreement (EULA) video was also reviewed with staff to streamline the registration process for staff during the training and to orient them to what consumers and families also see when they first access the Beehive system. The EULA video in English can be accessed here: https://youtu.be/3E8hiEkIvSQ. The Spanish EULA video is available here: https://youtu.be/UgY7ZUhe-Fk. The EULA video was developed through focus groups with EPI-CAL community partners (consumers, family members and providers) to ensure that core aspects of Beehive (e.g., purpose, security, consent and data sharing) were clear to users. Every new user of Beehive was presented with the EULA video before making their data sharing choices.

After training, each program has an EPI-CAL staff point person to provide regular check-ins to provide training and implementation support. Additionally, point persons may also

provide booster trainings to individuals at the program or to groups of program staff. These may be conducted remotely via web conferencing. More recently the EPI-CAL team has begun to visit sites in-person as initially proposed and planned prior to COVID-19 in-person meeting restrictions. The site visit for Los Angeles County is tentatively planned for January 25-27, 2023.

Preliminary results on program-level data from 3 pilot EP programs

A pilot study was conducted by UC Davis to understand barriers and facilitators to Beehive app implementation, including interviews with pilot EP programs. After initial Beehive trainings, EDAPT/SacEDAPT in Sacramento County, Solano SOAR Aldea programs and Kickstart in San Diego County began enrolling consumers into Beehive in March 2021. LACDMH was not part of this pilot, however a similar Beehive enrollment process below was implemented by the County after the pilot period.

Basic demographic information is entered into Beehive by clinic staff when initially registering a consumer and their support persons. Consumers are then invited by clinic staff to join Beehive via email link or in person using an electronic tablet. All consumers complete the EULA before being presented with outcome surveys. Their choices are explained in the EULA video. When consumers complete the EULA, they indicate whether they want to share their data with UC Davis and/or the NIH for research purposes beyond using Beehive for the purpose of their clinical care. Consumers then complete their registration and can complete surveys.

The goal is to have 70% of consumers agree to share their data with UC Davis and NIH. For this annual report, data collected in those three pilot programs was through December 3rd, 2021 for those who agreed to share their data with UC Davis. One hundred and twenty-five consumers were registered in Beehive across the three pilot clinics, and of those, 66 completed their EULA indicating their data sharing permissions. Of those who completed their EULA, 55 consumers agreed to share their data with UC Davis (83%).

The majority of these 55 consumers were ages 18-23 (49%) with the next largest group being ages 12-17 (33%). Fifty-three percent (53%) of consumers selected male as their sex at birth and 49% identified their gender as male. The largest consumer group by race was Hispanic/Latinx only (25%) followed by African/African American/Black and White/Caucasian (24% each). Most consumers were diagnosed with First Episode Psychosis diagnoses. It is important to note that 25 consumers were missing a diagnosis at the time of data collection.

After registration is complete, the EPI-CAL Enrollment Life Questions are made available for the consumer to complete. If a consumer is in a survey window (e.g., at intake or six months), Beehive makes available 15 additional surveys that assess various community partner-chosen outcomes including family functioning, education, social relationships, demographics and background, medications, and symptoms (see Figure 2). These surveys are presented in different bundles that are grouped based on subject matter and/or timing of the surveys (i.e., whether they receive the survey just at enrollment, or at enrollment and every six months thereafter). The pilot data only tracked EPI-CAL enrollment and required bundles, and 80% off consumers completed all three Enrollment surveys.

Figure 2: EPI-CAL Enrollment and Required Survey Bundles

Bundle Name	Survey Name	Bundle Timing
EPI-CAL Enrollment Life Questions	EPI-CAL Enrollment Life Questions	Enrollment only
	Adverse Childhood Experiences (ACES)	
	Primary Caregiver Background	
EPI-CAL Experiences Bundle	Life Outlook	Every 6 months, including intake
	Questionnaire About the Process of Recovery (QPR)	
	Modified Colorado Symptom Index (MCSI)	
	Substance Use	
	Legal Involvement and Related	
EPI-CAL Treatment bundle	Intent to Attend and Complete Treatment Scale	Every 6 months, including intake
	End of Survey Questions	
	Hospitalizations	
	Shared Decision Making (SDM)	
	Medications	
EPI-CAL Life Bundle	SCORE-15	Every 6 months, including intake
	Demographics and Background	
	Social Relationships	
	Employment and Related Activities	
	Education	

Enrollment and follow up completion rates for LHCN app in all EP programs

After the pilot, EPI-CAL staff monitor enrollment progress and symptom survey completion for LHCN across all EP programs in LHCN on a weekly basis. The following metrics are monitored and visualized: Beehive registrations, Beehive enrollments (i.e., consumers with a completed EULA), opt-ins for data sharing with UCD and/or NIH for research purposes, and completion of the Modified Colorado Symptom Index (MCSI) at Baseline, 12 months, and 24 months.

While reviewing these figures each week, the EPI-CAL team discusses observed barriers for sites which are enrolling at a rate below the average LHCN enrollment rate. The team will also discuss solutions or interventions to address barriers. Even when barriers are outside the scope of EPI-CAL project, (e.g., program turnover, dedication of program staff efforts), the EPI-CAL team will still attempt to understand how to can accommodate the program given their needs at that moment. The EPI-CAL team also discusses the facilitators for sites which are enrolling above the average LHCN enrollment rate. EPI-CAL staff develop strategies to disseminate facilitators among all LHCN sites.

LHCN enrollment and follow up completion rates for LHCN software application and dashboard in all EP Programs

Figure 3 shows the LHCN Progress towards EPI-CAL Enrollment targets as of June 10, 2022. Consumers are considered enrolled if they have completed the Beehive EULA and agreed to share their data with UC Davis for use in research. If consumers do not allow their data for use in research but agree to use Beehive as part of clinical care, their data may be used for quality management or quality assurance purposes only. The goal at this point in the project was to have 405 individuals enrolled (endpoint of black line in figure below). The observed rate of enrollment across the LHCN is 145 consumers (solid blue line in figure below). There

are an additional 142 consumers who have been registered by the clinic in Beehive (dashed blue line in figure below), but who have not engaged with Beehive by completing the EULA or starting their surveys. The number of registered individuals is monitored because it serves as a proxy for program census (though most clinics do not yet have all active consumers registered) and allows the EPI-CAL team to see what possible enrollment across the network could be.

Figure 3: LHCN Progress Towards EPI-CAL Enrollment Targets

Figures 4-5 show a site-by-site breakdown of the proportion of individuals who agreed to data sharing with UC Davis for research purposes as of June 10, 2022. Figure 4 shows all registered consumers, regardless of EULA completion status. For Los Angeles County, 26% of consumers had completed their EULA status. EPI-CAL Team members met with County project leadership to discuss barriers to EULA completion and to create a plan of action to improve completion. Significant barriers noted were staff turnover at sites, difficulties with consumers accessing the web-based Beehive app while receiving telehealth services, and challenges with program staff integration of Beehive into their workflow. Individual meetings between EP Programs and County staff were scheduled in the weeks after, the results of which improved EULA and registration completion, in the next fiscal year.

Figure 4: Proportion of Data Sharing with UCD for Research by Site

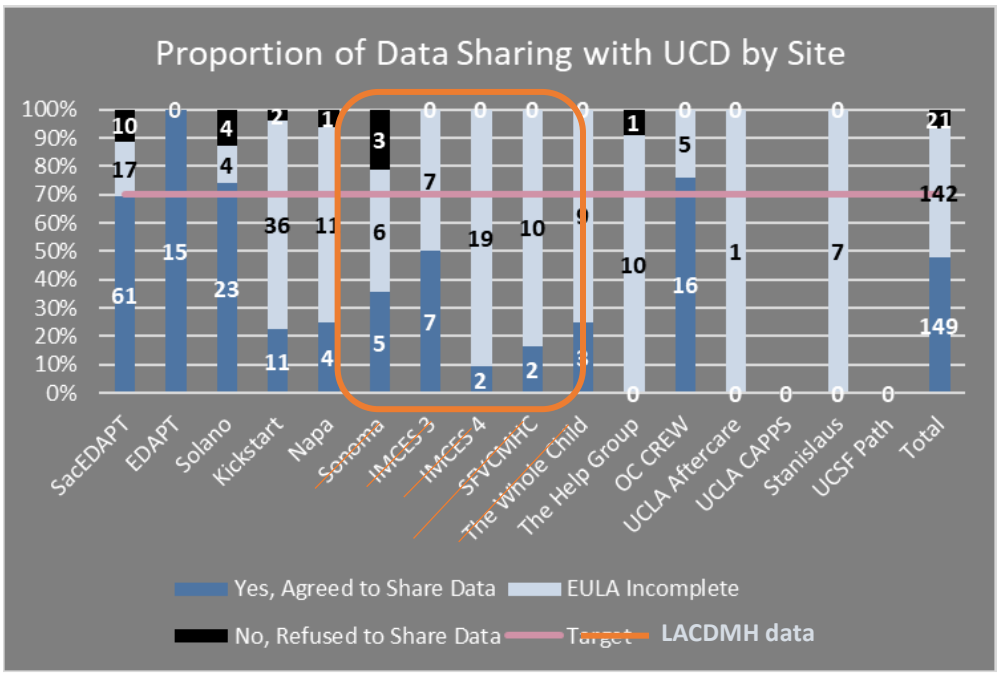
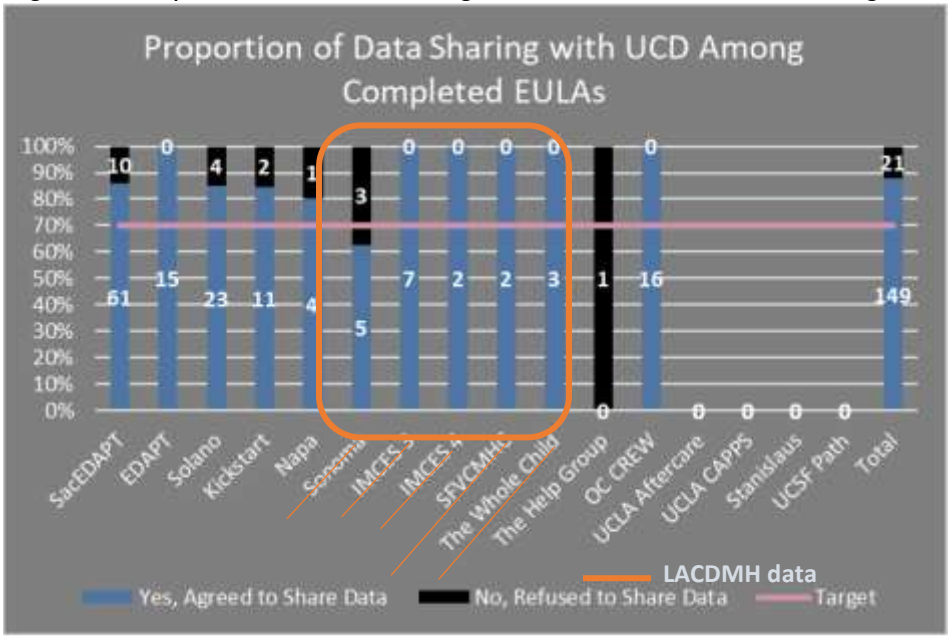


Figure 5 shows the proportion of data sharing choices made by those consumers who have completed their EULA in Beehive. The goal is that 70% of active consumers at each site agree to use Beehive and share their data for research purposes. When considering all consumers known to EPI-CAL, only a few sites are meeting this metric. However, among those individuals who have engaged with Beehive and completed the EULA, the target was exceeded across the network. For Los Angeles County, 93% of clients who completed the EULA agreed to data sharing.

Figure 5: Proportion of Data Sharing with UCD for Research among Completed EULAs



As of May 26, 2022, 76% of all enrolled consumers (n=107) have completed at least one enrollment survey. As of May 19, 2022, 92% of enrolled Los Angeles County consumers (n=13) have completed at least one enrollment survey. Note that all consumers can complete enrollment surveys regardless of when in their treatment they are enrolled. Consumers are not able to complete some survey windows (e.g., baseline) if they are enrolled later in treatment. Some consumers have completed surveys at more than one time point.

Subcontractor to revise dashboard to include feedback from programs and community partners

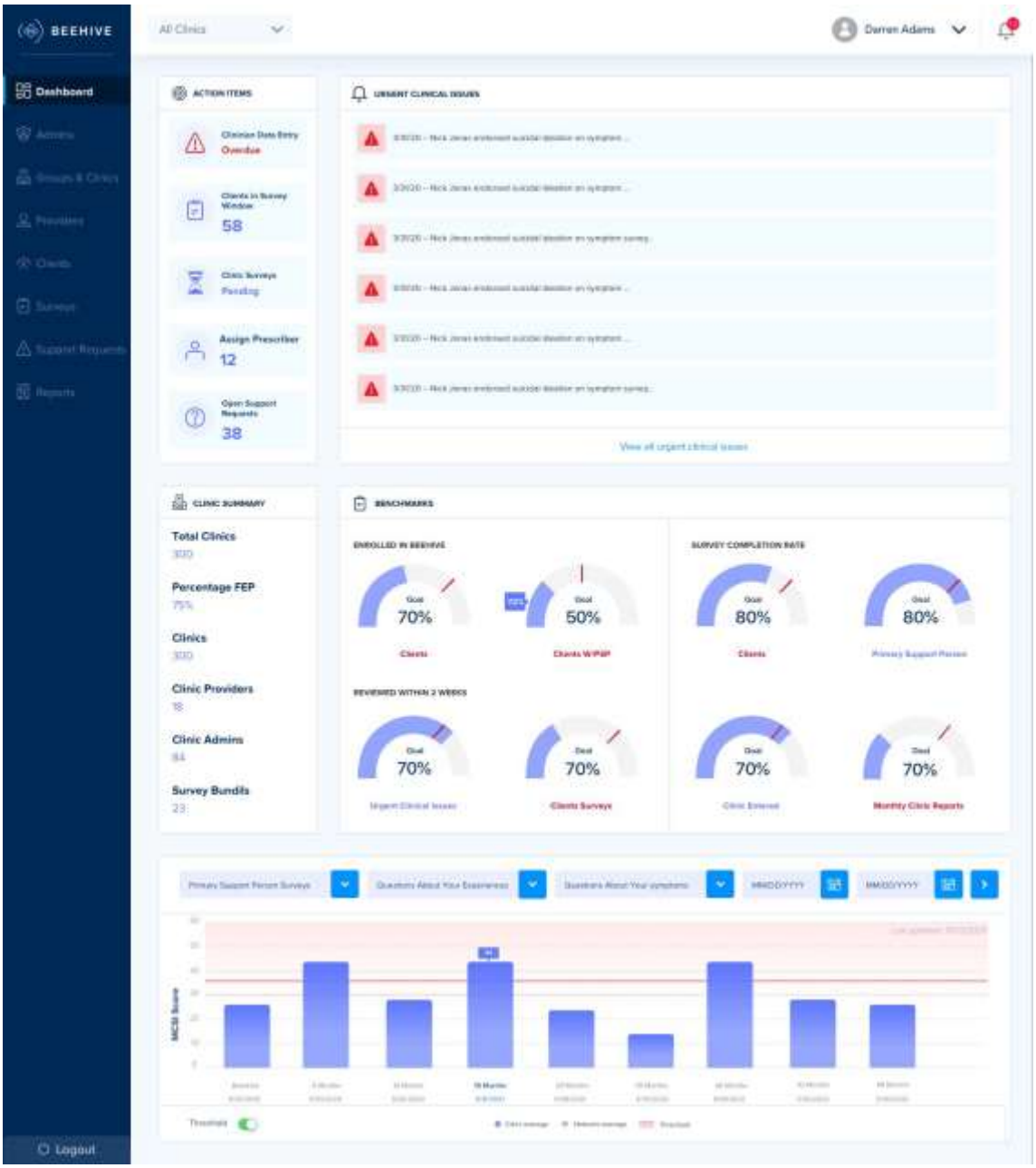
As Beehive has been designed for EP Programs, the needs and preferences of EP programs and the institutions of which they are a part have driven the design of Beehive. Security requirements of counties and institutions have led to increases in the security of Beehive. Feedback from users at EP Programs has identified several aspects of the application that could be improved to increase compatibility with their existing workflows and facilitate implementation of this novel technology.

Notably, pentesting was conducted by Azacus.io Cybersecurity on the Beehive application as a security requirement for several programs, including Los Angeles County. Penetration testing, or pentesting, is a simulated hack to test the security of a system. Azacus.io conducted pentesting on both the web and iOS applications between June 21, 2021 and July 3, 2021. Azacus.io delivered the results of pentesting to the EPI-CAL team on July 12, 2021. All issues of vulnerability that were identified in the testing were addressed by the developers. On September 10, 2021, Azacus.io completed a retest of the application that proved all identified vulnerabilities had been fixed. Annual pentesting will be completed per Los Angeles County request.

User feedback has also contributed to the development of Beehive. Updates to the Survey Status Screen, including a New Data Icon for unreviewed consumer data, and bolding of newly answered consumer surveys in bold in dropdown menus.

The Beehive dashboard was also redesigned with input from programs. The goal of the dashboard is to provide users with the information that is of the highest priority for them when using Beehive. However, feedback from beta users indicated that they weren't sure what was most important, and the dashboard seemed busy. With this in mind, the dashboard was redesigned with input from community partners across all EP programs.

Figure 6: Updated Beehive Dashboard



To prioritize community partner preferences and needs, the EPI-CAL team has implemented a system of formally gathering user feedback before planning each sprint series with the developers. A survey was sent out to all beta sites to solicit their feedback to prioritize the issues and ideas they had reported over the beta testing period.

Feedback from interviews with EP community partners about experience in EP treatment programs.

Interviews were conducted with EP community partners about the barriers and facilitators to implementing a Learning Health Care Network into EP treatment programs.

The interview guide was developed by the qualitative lead, with input from the rest of the research team, the LHCN advisory group and community partner feedback. The interview guide is structured to explore provider experiences related to each component of Beehive

implementation, including enrolling consumers into the application, consenting and other steps prior to consumers inputting data, the data inputting process itself, and then incorporating Beehive and the data in care. Finally, provider experiences of training and ongoing support were explored.

Four clinics with the highest engagement with the Beehive platform (Solano, EDAPT, SacEDAPT, and OC CREW) were interviewed. Preliminary findings centered on five prominent domains: training, enrollment workflow, clinical utility, the learning curve to understanding Beehive, and consumer engagement in surveys. More interviews with staff at additional clinics as well as consumer interviews are needed to fully understand the barriers and facilitators to implementing a LHCN into EP programs.

Finalize statistical methods and identify county-level available data for multi-county-integrated evaluation of costs and utilization data

The proposed data analysis is based on pilot work conducted in Sacramento County, scaled to multiple counties (Niendam et al., 2016). It focuses on consumer-level data related to program service utilization, other outpatient services utilization, crisis/ED utilization, and psychiatric hospitalization and costs associated with these utilization domains during two time periods: 1) the three years prior to implementation of project tablet in the Early Psychosis (EP) programs (e.g., Jan 2017 – Dec 2019), to harmonize data across counties and account for potential historical trends, and 2) for the 2.5 year period contemporaneous with the prospective EP program level data collection via the tablet (Jan 2020 - June 2022). Data will de-identified and be shared through an encrypted and password protected SFTP server, which is housed on UCD secure servers.

Early Psychosis (EP) sample

First, all individuals entering the EP programs January 1, 2017 – December 31, 2019 will be identified using County Electronic Health Record (EHR) data. Because LACDMH did not begin enrolling consumers into the PIER program until January 2020, Los Angeles County identified 91 consumers who received EP services under the Center for Assessment and Prevention of Prodromal States (CAPPS) Program during the study period at three legal entity providers (Special Services Group – Occupational Therapy Training Program, The Help Group and San Fernando Valley Community Mental Health Inc.). Programs identified those individuals who received treatment versus only eligibility assessment and referral to another service. Comparison was restricted to individuals diagnosed with first-episode psychosis (FEP), and not include those at Clinical High-Risk (CHR) for psychosis, due to an inability to reliably identify individuals with CHR in the comparator group.

Comparator Group (CG) sample

The EPI-CAL team will compare the utilization and costs of the FEP participants in EP programs to utilization and cost among a group of FEP individuals with similar demographic and clinical characteristics who do not receive care in the EP program during the same timeframe in the same County. FEP individuals meeting the same eligibility criteria for the EP program (e.g., FEP diagnoses, within the same age group) who enter standard care outpatient programs in the County during that same period will be identified as part of the comparator group (CG). Los Angeles County identified 19,956 consumers in the initial comparator group.

Service Utilization

Next, data will be requested from the County EHR on all services received by individuals in both groups including 1) any non-EP outpatient services; 2) inpatient services and 3)

crisis/ED services. LACDMH identified over 2.6 million relevant inpatient and outpatient service claims.

Costs
LACDMH was able to identify cost data on each service and worked with the EPI-CAL team to provide information on service contracts, cost reports and published rates to determine additional cost data. The EPI-CAL team will determine whether to apply a single cost across all services (by type of service) or to apply costs that are county or provider specific. We will include billable and non-billable services. Outcomes will be calculated per month to account for varying lengths of time receiving services during the active study period.

The data will be harmonized on demographics, diagnoses, and service types across Los Angeles, San Diego, Orange, Napa, Stanislaus, and Solano counties for EP and CG groups, then merged into a single dataset for our primary analyses. The EPI-CAL team will identify an EP group consisting of individuals served by the EP program, and a CG group, consisting of individuals with EP diagnoses, within the same age group, who enter standard care outpatient programs during that same time period. For each county, the EPI-CAL team held meetings with the EP program managers and the LACDMH data analysts to determine service delivery, program characteristics, staffing, billing and funding sources for the CAPPS and PIER programs. The information from LACDMH was combined with other counties into a multi-county data table.

Cost and utilization data from preliminary multi-county integrated evaluation, identification of problems and solutions for county-level data analysis
Preliminary analysis comparing the EP and CG groups in San Diego County on service utilization and related costs data was provided in the EPI-CAL team's final report to the MHSOAC. Due to the challenges outlined at the end of this section, the EPI-CAL team was not yet able to integrate or analyze cost data from Solano County, Orange County, and Los Angeles County. The team is confident that the cost comparison analysis, along with a finalized comparison analysis of service utilization, will be completed for the next deliverable, due December 2022.

Following the preliminary analysis of San Diego County data, a preliminary multi-county comparison of the service utilization was completed. Service utilization of individuals with FEP treated at the participating EP programs was compared to service utilization of a similar group served between January 1, 2017- December 31, 2019. Consumers were ages 12-25. The eligible diagnoses were based on the psychotic disorder diagnoses accepted by the EP programs, standardized across counties, and included psychotic disorders and when no psychotic disorder was present, a mood disorder with psychotic features. Clients excluded from the comparable group included those with intellectual disabilities, those with a psychotic disorder more than 2 years prior to the index service date during the study period, or if the first outpatient service was a Full-Service Partnership (FSP) OR the consumer received FSP services in the two years prior to the study period. The data set included outpatient, day/crisis stabilization and 24-hour services such as psychiatric inpatient hospitalization or residential treatment.

Demographic categories of age, sex and race/ethnicity were harmonized across counties. Only EP consumers who were publicly insured (e.g., Medi-Cal) were included. Duration of EP treatment was focused on the first 24 months of service as most programs had a maximum

treatment period of about two years. To account for variation in intensity of services and attrition over time, the team defined service periods as index service date to 6 months, 7-12 months, 13-18 months, 19-24 months and 25 months+ (until last service date). The final cohort includes a sample of 506 individuals served by EP programs and 17,092 individuals from the CG group.

The EP sample had an average age of 17.0 years, 59% of whom identified as male. Of those receiving treatment in the CG group, the mean age was 20.1, and 61% of them identified as male. The average age of CG individuals was significantly older than the average age of EP individuals in this sample (p<.001). No statistical difference in the distribution of sex was found. The EP group included a significantly higher number of individuals who identified as Hispanic/Latino (56%) compared to the proportion of individuals from the CG clinics (44%, p<.001). In addition, a higher percentage of EP individuals identified as Caucasian (27%) compared to CG individuals (17%). However, a majority of CG individuals reported Unknown race (54%).

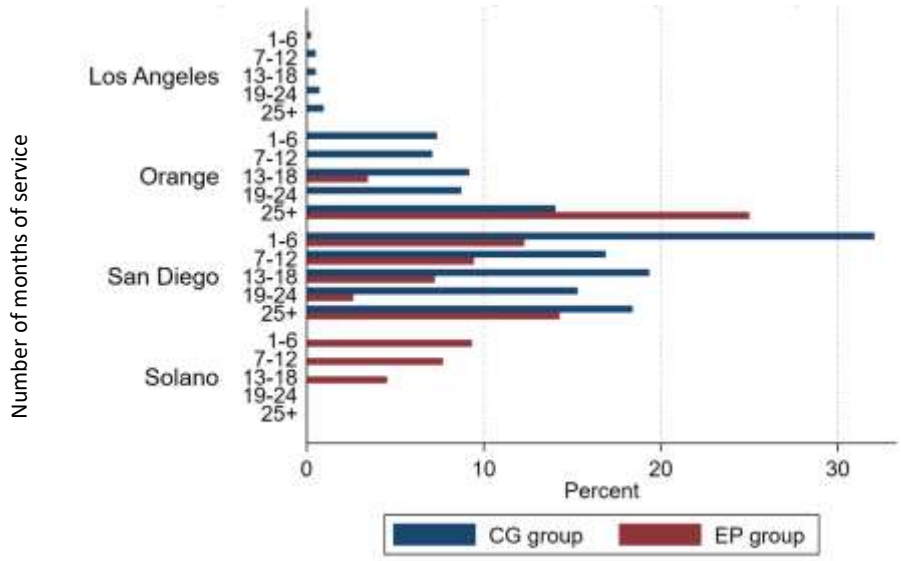
A higher proportion of individuals in the EP group had a Psychosis Spectrum disorder as the primary index diagnostic category compared to the CG group (EP Group: 80%; CG Group: 61%, p<.001). For both groups, Mood Spectrum disorders represented a smaller proportion of the primary diagnoses (EP Group: 6%; CG Group: 21%).

On average, individuals receiving treatment in both groups tended to remain in treatment for roughly one year (EP group: 11.1 months, CG group: 12.2 months), but average duration of treatment was significantly higher for CG individuals (*p*<.05). A roughly equal proportion of EP and CG individuals ended treatment within the first 6 months (43% and 44%, respectively). A greater proportion of EP individuals ended treatment between 7 and 12 months compared to CG consumers (28% vs. 13%, respectively). However, compared to EP individuals, a larger proportion of CG individuals ended treatment after they had received over 25 months of services (5% vs. 24%, respectively).

The EP and CG clinics offered similar types of outpatient services, including assessment, case management, collateral, crisis intervention, group therapy, individual therapy, medication support, plan development, and rehabilitation.

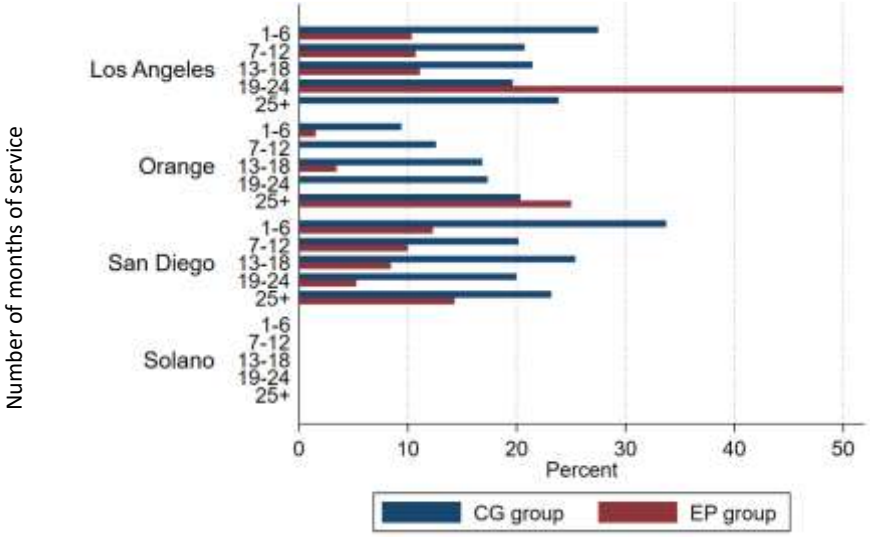
In examining the total minutes of outpatient services provided to individuals per month, those served in the EP group received significantly more minutes of service across all time points compared to the CG group. When specific services are examined individually, the greatest difference is observed between groups in minutes of collateral, per person, per month (EP group: 140 minutes; CG group: 66 minutes) and individual therapy (EP group: 239 minutes; CG group: 188 minutes) per person.
The use of day services was rare for both groups, as only 2.0% of EP and 4.7% of CG individuals received these services while enrolled in EP or general outpatient treatment (see Appendix V – Table 22). Calculated as the proportion of individuals with one or more visits, use of day services was greater in the CG group across all time points (*p*<.001). Further, the rate of day service visits was the highest among individuals that had been enrolled in treatment for 25 months or more (EP group: 3.3%; CG group: 5.7%, see Figure 7).

Figure 7: Proportion of consumers with at least one day service visit by time period by county



A significantly greater proportion of CG individuals experienced at least one 24-hour service or inpatient hospitalization during their enrollment compared to EP individuals (22.4% vs. 8.9%, *p*<.001). As shown in Figure 12, 24-hour services occurred most frequently during the first 6 months of treatment (EP group: 9.4%; CG group: 24.8%) and after 25 months of treatment (EP group: 17.0%; CG group: 23.7%), although we did not test these differences statistically. This data was unavailable for Solano County.

Figure 8: Proportion of consumers with at least one 24-hour service by time period by county



The cost comparison analysis goal was not met due to the complexity of the data required to be harmonized across counties and the variety of data sources. Nearly all programs and counties, as well as the EPI-CAL central team, have been impacted by staff shortages due to unfilled positions and redeployment of staff during the COVID-19 pandemic, which has delayed project coordination and data extraction. The team continues to meet with counties including LACDMH to clarify questions about received cost and utilization data, and to troubleshoot issues related to incomplete or unclear data elements.

Limitations in the preliminary analysis of service utilization data have attempted to be addressed by the EPI-CAL team. The County Data evaluation team is reviewing CG and EP group data to identify ways to improve the harmonization of data across the counties in the evaluation. In addition to methodological improvements, the county data evaluation team is working with county staff to extract additional data required for the analytic methods. The team requested historical data for consumers in our county EP groups to be used in the weighting methodology described above. LACDMH staff were able to identify previously unavailable service data for 24-hour service categories for all consumers.

Summary
Across all time periods, the total minutes of outpatient services per month was higher among EP individuals compared to CG individuals. However, the proportion of individuals in the EP group with one or more day services and/or 24-hour services/ inpatient hospitalizations was lower compared to the CG group.

Interpretations
Regarding duration of enrollment in treatment, the EP and CG groups are generally similar, with more EP consumers receiving 7-12 months of service, and the CG group having a substantial proportion of consumers who received longer-term treatment (25+ months), past the standard end-point of EP treatment at 24 months. In both groups, nearly half of the consumers received services for less than 6 months, which may represent challenges in engagement with this population, as well as the mobility of TAY youth, who may also have received services elsewhere.

The groups were both predominantly male, as is often typical in early psychosis clinical samples. There was a slightly older average age in the CG group, and more Hispanic/Latino consumers and Caucasian consumers in the EP group. This may reflect the focus of programs on outreach and staffing availability predominantly in English and Spanish. They identified as predominantly heterosexual across both groups. The results of this preliminary analysis are consistent with the intent of EP programs- to offer more intensive and evidence-based outpatient services to reduce the need for higher levels of care and to promote recovery. This is evident in the higher overall outpatient minutes for the EP group. Greater time spent in individual therapy likely reflects the treatment models of the EP programs, which focus on CBT for psychosis or other similar forms of therapy. EP programs make a concerted effort to involve families of these transition age youth, reflected in the results of more collateral services than the CG group.

Similarly, the significantly greater proportion of CG individuals who had inpatient hospitalizations during the study period may demonstrate the effectiveness of early intervention in reducing hospitalization rates. Day services were so rare in both groups that we only analyzed the proportion of individuals with at least one service. Overall, these group differences are quite promising, although at this time, we cannot rule out differences in severity and needs between the EP and CG groups at baseline that could partly or fully explain the service utilization differences. As noted previously, access to hospitalization data may have been limited (e.g., by treatment outside county); however, these issues should have affected the EP and CG groups in a county similarly.

Next Steps

In the next project period, the EPI-CAL team will continue to conduct fidelity assessments with EPI-CAL programs and meet with county and program leadership to provide detailed feedback on fidelity results. The team will also continue and complete training of EP programs from both the LHCN and larger EPI-CAL network, especially as new programs join. As implementation of Beehive continues, the team will elicit feedback from EP programs how to improve both the training process and Beehive itself via feedback surveys, regular check-ins from point people, and qualitative interviews. The goal is to continue to improve Beehive in an iterative process and to incorporate community partner feedback so that Beehive be a useful data collection and visualization tool for the programs using it. We are also working with sites to understand why enrollments are not matching the original projections and to support them to increase the degree to which they are integrating Beehive into their standard practice.

In addition, for all counties participating in the county data component of the LHCN, meetings will be scheduled over the next several months with each county to review the details of the EP and CG retrospective data pulls, the cost data, and to problem-solve any issues that arise. We will then conduct the statistical analyses for individual counties and across the integrated dataset. In anticipation of the prospective data analysis, we have met with each county to discuss the timeline for obtaining their data and details of what will be included in the data pull. We will submit the formal data extraction requests in writing in July 2022, after we complete meetings with all relevant parties.

Another major goal of the next project period is to develop the final analysis plan for all LHCN data, with a particular focus on the consumer outcomes data collected via Beehive. This will integrate results from the fidelity assessments.

Niendam et al., 2022. *Annual Innovation Report: Summary Report of the Activities of the LHCN Fiscal Year 2021-2022.* Pending final submission. Prepared by UC Davis, San Francisco and San Diego.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
FY 2023-24 Estimated Gross Expenditures		**FY 2022-23 Estimated Gross Expenditures**		**FY 2021-22 Total Gross Expenditures**
$70,400,000		$22,800,000		$27,639,000
Program Description				
• LAC + USC Crisis Residential Treatment Programs (CRTPs) • Rancho Los Amigos Crisis Residential Treatment Programs (CRTPs) • Olive View Crisis Residential Treatment Programs (CRTPs) • Olive View Medi-UCC • Olive View Mental Health Wellness Center • MLK Child and Family Center				

CAPITAL FACILITIES

Crisis Residential Treatment Programs (CRTPS)

- LAC + USC Crisis Residential Treatment Programs: Construction was comprised of four approximately 9,400 square foot, three-story buildings, each with 16-beds. Full certificate of occupancy was issued on April 7, 2022.
- Rancho Los Amigos Crisis Residential Treatment Programs: Construction was comprised of five approximately 9,400 square foot, two-story buildings, each with 16-beds. Full certificate of occupancy was issued on July 16, 2021.
- Olive View Crisis Residential Treatment Programs: Construction was comprised of five approximately 9,500 square foot, two-story buildings, each with 16-beds. Full certificate of occupancy was issued on November 4, 2021.

Olive View Medi-UCC (Olive View Mental Health Urgent Care Center): Construction was comprised of one approximately 9,900 square foot, one-story building. The facility has 16 adult chairs and eight adolescent chairs. Full certificate of occupancy was issued on July 1, 2021.

Olive View Mental Health Wellness Center: Construction was comprised of one approximately 9,900 square foot, one-story building. Full certificate of occupancy was issued on July 1, 2021.

MLK Child and Family Center (now called the Jacqueline Avant Child and Family Center per a motion introduced by SD2): DMH has space on the first floor and the entire third floor of this 55,000 square foot, three-story facility. Construction was delayed due to the builder of record not completing its scope of work by the substantial completion date of December 14, 2021. Construction of the first floor space was completed in November 2022. Construction of the third floor, which will house a crisis stabilization unit and children's outpatient program, is anticipated to be completed by November 2023.

PROPOSED PLAN CHANGES FOR FISCAL YEAR 2023-24

These are the projects/concepts in the table below proposed by Stakeholders and other County Departments during the Stakeholder process from October 2022 through February 23, 2023. LACDMH is committed to working with proposers to finalize project details, budget and the ability to implement the program.

Table 56. Program Proposals for FY 2023-24

Program	Target Population
Component: Prevention and Early Intervention	
Community Family Resource Center (CFRC) The CFRC is designed to create a coordinated, community owned and driven space where families and individuals can easily access the services they need to enhance their wellbeing. The CFRCs will create partnerships with trusted networks of care, individual community leaders, CBOs, and public and private entities to leverage the strengths and capacities of each to best respond to the needs of individuals and families in the community it serves.	All Age Groups and Populations - Families
Community Schools Initiative (CSI) CSI serves 15 high schools that serve as hubs for a range of support services for students, families, and school staff. The program provides each site with a Community Schools Specialist to assist with coordinating services and Educational Community Worker to support parent engagement. Services focus on prevention, helping caregivers and students access a variety of services to prevent stress and possible mental health concerns.	Middle school and high school youth
United Mental Health Promoters Network The Mental Health Promoters Network project is a community outreach effort, serving to strengthen communities and create career paths for those community members functioning under the umbrella of Mental Health Promoters.	Underserved Cultural Populations
Friends of the Children (FOTC) - Los Angeles FOTC aims to prevent foster care entry and improve family stability and wellbeing for families identified by DCFS as being at highest risk of entering foster care. FOTC provides professional 1:1 mentorship to children for 12+ years; starting around the age of 4-6 years old. Mentors are trained to support caregivers, promote self-advocacy and created opportunities for culturally responsive community and peer-to-peer connections.	Children and youth under 18, starting at 4-6 years old
Medical Legal Services Addresses clients' legal problems and increases awareness of their rights to which lessens undue stress and empowers them with the information. These legal services can eliminate barriers to sustaining stable income through employment	All Age Groups
Home Visitation: Deepening Connections and Enhancing Services Healthy Families America (HFA) and Parents as Teachers (PAT) are evidence-based, research-proven, national home visiting programs that gather family information to tailor services to the whole family. The programs offer home visits delivered weekly or every two weeks to promote positive parent– child relationships and healthy attachment. This Home Visiting Program will prioritize areas where data indicates there is a high number of families involved with child protective services.	Parents and Caregivers with Children 0-to-5 Years Old
New Parent Engagement-Welcome to the Library and the World Public Libraries and DHS Women's Health will offer a Welcome to the Library and the World kit which will include information on the library Smart Start Early Literacy programs and services. The program will be offered at 45 locations twice a year, and though a a virtual program every quarter.	New Parents and Caregivers
Our SPOT Teen Program: Social Places and Opportunities for Teens After-School Program Our SPOT: Social Places and Opportunities for Teens is a comprehensive after-school teen program aimed at engaging and providing community youth with the support,	Children and youth under 18

Program	Target Population
life-skills and positive experiences that will empower them to create bright futures for themselves.	
We Rise Parks at Sunset We Rise a prevention program which creates access to self-care programming in 58 LA County parks and is offered during mental health awareness month. It provides repeated opportunities to access esources and information on mental health support including free mental well-being workshops.	24 years old and below - Families
Parks after Dark Parks at Sunset Designed for families and adults to participate in workshops and classes promoting self-care and healing, three evenings a week over 8-weeks. Activities include sports, fitness, arts and culture, movies and concerts and more.	24 years old and below - Families
DPR Safe Passages: Community Engagement and Safe Passages for Youth and Communities DPR Safe Passages Initiative utilizes trained gang interventionists and ambassadors to implement peace maintenance among gang neighborhoods to ensure safety to and from parks, and during park activities and provide crisis intervention services at the parks.	Children and youth under 18
Triple P Parent/Caregiver Engagement Triple P is an effective evidence-based practice that gives parents and caregivers with simple and practical strategies to help them build strong, healthy relationships, confidently manage their children's behavior and prevent problems developing.	Parents and caregivers
Patient Health Navigation Services This proposal will augment existing Patient Health Navigation Services by adding mental health prevention focused services, including assessment, referral and linkage to community supports and education that increase protective factors for individuals at-risk of a mental illness.	All Age Groups
School Readiness An early literacy program designed for toddlers and preschoolers to help empower parents and guardians in supporting the education needs of their children. While enjoying books, songs, rhymes and fun, kids build early literacy skills, basic math skills, and social skills, and other essential school readiness competencies.	2 to 4 Year Old (Toddlers to Preschoolers)
Creative Wellbeing: Arts, Schools, and Resilience A non-traditional, arts and culture–based approach for promoting mental health in young people and caregivers. . The model offers non-traditional strategies for promoting mental health and wellness that include culturally relevant, healing-centered, arts-based workshops for youth, as well as professional development, coaching, and emotional support for the adults who work with them. Project activities support positive cognitive, social, and emotional development, and encourage a state of wellbeing.	24 years and below and Caregivers
Abundant Birth Project This program is a private-public partnership that seeks to provide support to a minimum of 400 pregnant people in LA County from marginalized populations most likely to experience the worst birth outcomes with a variety of supports for 18 months (i.e. mental health, financial coaching, wellness supports, housing assistance, education, etc. This would be a randomized control study to evaluate the effects of this type of support.	Pregnant People and Parents with Children 0-18 Months Old
Credible Messenger Mentoring Model This program consists of mentoring by peer youth to increase access to resources and services for young people of color disproportionately negatively impacted by traditional systems and services. Services are targeted to Youth 18-25 and include training of messenger peers, needs assessment of youth to paired mentors, 1:1 mentorship by youth with lived experience, group activities, crisis intervention, family engagement, referral and resource linkage.	Transition Age Youth 18-25
Youth Development Regions This program will support youth by providing and/or referring to a range of youth development services based on an assessment of individual strengths, interests, and needs. The target population is youth 18-25 and is projected to serve approximately	Transition Age Youth 18-25

Program	Target Population
6,500 youths annually. Services are provided through contracted CBOs and referral and linkage and will include school engagement, conflict resolution training, mentoring/peer support, educational support, employment/career services, arts/creative expression and social/emotional wellbeing resources.	
A Local Approach to Preventing Homelessness The Long Beach Department of Health and Human Services will convene local partners to identify gaps in homeless prevention services and develop interventions strategies addressing short term housing, mobile and clinic services and supportive transition programs for young adults exiting the foster care system.	Young adults exiting foster care and at risk for homelessness
Laugh Therapy & Gratitude Enlighten the public on therapeutic alternatives that don't necessarily require the use of drugs to improve one's state of mind and the importance of embracing emotions rather than masking them.	Older Adults - Latino
Older Latino Adults & Caregivers Create opportunities for elderly Latino immigrants to prosper and grow independent by teaching them not fear technology but rather, use it as a helpful tool to stay connected to loved ones, learn new things, find entertainment, and use it as a tool for self improvement.	Older Adults - Latino
Search to Involve Pilipino Americans (SIPA) Provide strength based, youth-centered mental health support services to youth and underserved individuals in SPA 4, with a focus on Historic Filipinotown and adjacent areas	Youth
K-Mental Health Awareness & K-Hotline Seeks to normalize mental illness and treatment in the Korean community so individuals will seek therapy and services without shame or hesitation.	All Age Groups - Korean
FosterALL WPW ReParenting Program FosterAll's WisdomPath Way Program addresses both the adults and children in foster care and provides positive outcomes to prevent additional trauma, stress and mental illness for both adults and children	Adults and Children Involved with Foster Care System
Cultural Reflections Newsletter Provide opportunities for peer produced mental health related content to be developed and shared throughout the County.	LACDMH Consumers
Hope & Healing: **Mental Health Wellness Support to Victim Families & Relatives** Bring Faith and Mental Wellness together to normalize the conversation and consciousness of families to seek mental health services and eliminate common stigmas preventing many traumatized persons from getting the help they need.	African American families who have suffered loss due to violence
TransPower Project Increase access and remove treatment barriers such as lack of resources, transportation needs and privacy concerns by offering specialized affirmative mental health services at no cost.	Youth Trans* Population
Open Arms Community Health & Service Center Provide quality health care, mental health support, housing, case management, employment referrals and supportive services such as food, clothing, hygiene kits, transportation anger management, substance use, sex trafficking, and parenting classes.	All Age Groups
Consumer Empowerment Network Educate LACDMH consumers on the history of MHSA, the role of LACDMH consumers and consumers from through the state, components and required processes, county, and state stakeholder events and opportunities to make public comments, recommendations, and legislative process.	LACDMH Consumers
INN 2/ PEI To help build trauma-informed communities and resilient families through Community Resource Specialists (CRSs) who work in-home with families to ensure that food, medical or housing crises don't destabilize families.	Transition Age Youth within Deaf, BIPOC, Disabled, LGBTQIA2S and Asian Pacific Islander communities

Program	Target Population
Mental Health Services for the Deaf & Hard of Hearing Provide American Sign Language (ASL) interpreters who can translate mental health terms and concepts accurately and effectively to deaf and hard of hearing people.	All Age Groups - Deaf & Hard of Hearing
Steven A. Cohen Military Family Clinic at VVSD, Los Angeles The Cohen Clinic offers personalized, evidence-based mental health care along with outreach and timely access to comprehensive case management support and referrals to address early intervention and suicide prevention, unemployment, finances, housing, and legal issues.	Veterans and Their Families
Component: Workforce Education and Training	
DBT Expansion This project would provide support for the clinic's DBT program by providing dedicated funding for medical staff, direct therapy services staff, peer workers/support staff, and management/supervision staff to have paid time to be trained on DBT certification, practices, and implementation.	Targets Workforce for All LACDMH Consumers

PROGRAM EXPANSIONS FOR FISCAL YEAR 2023-24

Programs below are existing MHSA programs previously approved by Stakeholders set to expand in Fiscal Year 2023-24.

MHSA Component	Program Name	Action
PEI: Early Intervention	Portland Identification and Early Referral Program (PIER)	This program will expand the number of sites and areas of availability of the program to Service Areas 1 and 8, and expand services in Services Area 6. PIER is a Coordinated Specialty Care program for adolescents and young adults, ages 12-25 who are either at Clinical High Risk for psychosis or have had their first psychotic episode. Currently, referrals from ELAC STAND (UCLA) , NAMI Urban LA, schools and various outpatient programs are exceeding the capacity of the current service level.
CSS: Linkage	Homeless Outreach and Mobile Engagement (HOME)	The expansion will include a total of 107 full time positions, (6 new multidisciplinary teams and 1 Service Area Navigation team) will be added between FY 2022-23 and FY 2023-24. The expansion will bring a total number of 16 multidisciplinary teams Countywide and 1 Service Navigation team.
CSS: Alternative Crisis Services	Crisis Residential Treatment Programs (CRTP)	Services will be delivered with by a new legal entity – Bel Aire Health Services to provide services in Downey and Sylmar.
CSS: Outpatient Care Services PEI: Prevention	TAY Drop-In Centers	A total of 10 new sites will be added Countywide. Service Areas 2, 3, 4, 5, 7 and 8 will each receive one new site. Service Areas 1 and 6 will each receive two.
CSS: Housing	TAY Enhanced Emergency Shelter Program	Additional funding will be added to sites.
CSS: Full Service Partnership	Full Service Partnership	The expansion will add additional staff to FSP directly operated programs and create two new half teams. Additional staff will help to form FSP teams at Santa Clarita Mental Health, Antelope Valley Mental Health, and Arcadia Mental Health.

EXHIBITS

EXHIBIT A – BUDGET SUMMARY

County: Los Angeles

Date: 4/25/23

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Training	Capital [illegible] Needs	Prudent Reserve
A. Estimated FY 2023/234 Funding						
1. Estimated Unspent Funds	711,600,000	297,700,000	211,000,000	8,900,000	14,400,000	116,483,541
2. Estimated New FY2023/24 Funding	688,500,000	175,000,000	48,000,000	100,000	500,000	
3. Transfer in FY2023/24 a/	(89,000,000)			25,000,000	64,000,000	
4. Access Local Prudent Reserve in FY 2023/24						
5. Estimated Available Funding for FY2023/24	1,311,100,000	472,700,000	259,000,000	34,000,000	78,900,000	116,483,541
B. Estimated FY2023/24 MHSA Expenditures	668,785,660	326,824,278	33,006,963	28,996,983	70,400,000	
G. Estimated FY2023/24 Unspent Fund Balance	642,314,340	145,875,722	225,993,037	5,003,017	8,500,000	116,483,541

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CSS Programs						
1. Full Service Partnerships	360,780,442	151,587,276	153,415,852		55,470,571	306,743
2. Outpatient Care Services	522,765,877	216,907,729	215,900,212		88,905,835	1,052,101
3. Alternative Crisis Services	200,176,455	122,512,681	70,045,377		7,608,286	10,111
4. Planning Outreach & Engagement	15,859,159	15,728,743	130,416			
5. Linkage Services	53,886,644	47,158,493	4,280,817		369,848	2,077,486
6. Housing	66,140,935	66,140,935				
CSS Administration	48,749,803	48,749,803				0
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	1,268,359,315	668,785,660	443,772,674	0	152,354,540	3,446,441

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs						
1. SUICIDE PREVENTION	5,866,764	5,787,478	65,030		14,256	
2. STIGMA DISCRIMINATION REDUCTION PROGRAM	77,060,907	77,060,907				
3. PREVENTION (WITH OUTREACH & NAVIGATION SERVICE	125,397,244	124,396,549	844,532		156,163	
4. EARLY INTERVENTION	278,227,068	100,522,973	106,797,935		69,955,744	950,416
PEI Administration	19,056,371	19,056,371				
Total PEI Program Estimated Expenditures	505,608,354	326,824,278	107,707,497	0	70,126,163	950,416

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. TTA	8,071,305	8,071,305				
2. MHCPATHWAY	2,818,573	2,818,573				
3. Residency	6,284,554	6,284,554				
4. Financial Incentive	10,240,770	10,240,770				
WET Administration	1,581,781	1,581,781				
Total WET Program Estimated Expenditures	28,996,983	28,996,983	0	0	0	0

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Capital Project -Tenant Improvement/New Facilities	6,000,000	6,000,000				
2. Exodus	25,000,000	25,000,000				
CFTN Programs - Technological Needs Projects						
3. IBHIS -Netsmart	11,000,000	11,000,000				
4. IBHIS - Microsoft Agreement	2,000,000	2,000,000				
5. Technology Improvements	20,000,000	20,000,000				
CFTN Administration	6,400,000	6,400,000				
Total CFTN Program Estimated Expenditures	70,400,000	70,400,000	0	0	0	0

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Innovation 7 - Therapeutic Transportation	7,097,195	6,653,266	217,045		33,669	193,215
2. Innovation 8 - Early Psychosis Learning Health Care Network	252,600	252,600				
3. Hollywood Mental Health Cooperative (formally known Hollywood 2.0 project)	28,356,097	23,101,097	4,947,289		307,711	
INN Administration	3,000,000	3,000,000				
Total INN Program Estimated Expenditures	38,705,892	33,006,963	5,164,334	-	341,380	193,215

EXHIBIT B – MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Los Angeles

☐ Three-Year Program and Expenditure Plan
■ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	Interim County Auditor-Controller
Name: Lisa H. Wong, Psy.D.	Name: Oscar Valdez
Telephone Number: (213) 974-6670	Telephone Number: (213) 974-0729
E-mail: LWong@dmh.lacounty.gov	E-mail: OValdez@auditor.lacounty.gov

Local Mental Health Mailing Address:

County of Los Angeles - Department of Mental Health
510 S. Vermont Avenue, 22nd floor
Los Angeles, CA 90020

I hereby certify that the **Annual Update** is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the state Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for other counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/report is true and correct to the best of my knowledge.

Lisa H. Wong, Psy.D.
Local Mental Health Director

Signature

4/12/2023
Date

I hereby certify that for the fiscal year ended June 30, 2022, the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892 (f)); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated 12/19/22 for the fiscal year ended June 30, 2022. I further certify that for the fiscal year ended June 30, 2022, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County has complied with WIC section 5891 (a), in that local MSHA funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached report is true and correct to the best of my knowledge.

Oscar Valdez
County Auditor Controller (PRINT)

Signature

4/21/23
Date

[1]Welfare and Institutions Code Sections 5847 (b)(9) and 5899 (a)
Three-Year Program and Expenditure Plan, Annual Update County/City Certification

EXHIBIT C – MENTAL HEALTH COMMISSION LETTER

Los Angeles County
Mental Health Commission
"Advocacy, Accountability and Oversight in Action"

First District	Second District	Third District	Fourth District	Fifth District
Susan Friedman	Kathleen Austria	Teresa Banko	Michael Molina	Judy Cooperberg
Imelda Padilla-Frausto	Jack Barbour	Stacy Dalgleish	Marilyn Sanabria	Lawrence Schallert
Bennett W. Root, Jr.	Reba Stevens	Vacant	Vacant	Brittney Weissman

Kyla Coates, BOS Representative, Fourth District

May 05, 2023

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

Lisa H. Wong, Psy.D.
Director, Department of Mental Health
510 S. Vermont Ave
Los Angeles, California 90020

Dear Supervisors and Director:

MENTAL HEALTH SERVICES ACT PUBLIC HEARING
FISCAL YEAR 2023-2024 ANNUAL UPDATE

On April 27, 2023, the Chair, and a quorum of the Los Angeles County Mental Health Commission (Commission) hosted the FY 2023-2024 Mental Health Services Act Annual Update (Annual Update) Public Hearing. The Department of Mental Health's submission of the Annual Update was for a 30-day Comment Period, on March 24, 2023, through April 22, 2023. The Commission, established under Section 5604, conducted a public hearing of the draft Annual Update at the close of the 30-day comment period. In accordance with Section 5848, the adopted Annual Update shall summarize and analyze the Commission's recommended revisions.

We commend the Department of Mental Health for its continued efforts to strengthen its engagement with community stakeholders through the geographic Service Area Leadership Teams (SALTs), Unserved/Underserved Cultural Communities (UsCCs), and Community Leadership Team (CLT) in the ongoing planning and implementation of the Mental Health Services Act and on the outcomes being achieved.

It is with pleasure that the Los Angeles County Mental Health Commission submits these recommendations for your review and consideration. While our recommendations represent the consensus of the Commission and public comment received during the MHSA Public Hearing, we urge you and the Board of Supervisors (Board) to review all stakeholder testimony

received during the entire public comment period when rendering your final decisions on the Annual Update. Our recommendations center around five broad themes

1. **Budget and Accountability**
2. **Criminal Justice**
3. **Housing/Homelessness**
4. **Inequities/Disparities**
5. **Workforce, Education, and Training (WET)**

Budget and Accountability
The Commission recommends and expects that the Department will include conducting a quantitative and qualitative needs assessment of public mental health needs to inform the next Fiscal Year MHSA Three Year Plan. Furthermore, the Commission expects accountability for unspent funds as this is critical to understanding unmet community needs.

Criminal Justice
The Commission acknowledges that a significant number of the jail's population have Serious Mental Illness and commends the progress made by the County's Department of Health Services Office of Diversion and Re-Entry (DHS-ODR) in moving forward the Board's Care First, Jail Last Initiative as a strategy within.

Housing & Homelessness
The Commission acknowledges the dedicated efforts made by the Department to expand services and increase mental health beds and services. As public comment about the need for these services and better access for children and older adults continues, the Commission recommends continued funding and efforts to increase access for this population.
In addition, we recommend allocation of MHSA funds for additional workforce. Specifically, the Commission recommends the Department to consider creating and funding peer support specialist positions to support and create linkage to services for persons suffering from mental health disorders and experiencing homelessness.

The Commission recommends providing day services, including direct onsite mental health services, for individuals experiencing homelessness throughout the County which are low barrier services that help link people to housing and mental health services (e.g., the Bridge to Home Shelter Services in Santa Clarita). Additionally, collaboration between Street Medicine, HOME, LAHOP, FSP, DMH Navigators, ODR, Veterans Homeless Outreach programs, Adult Mental Health Clinics, AOT and local shelters and homeless programs should be seamless, especially considering limited funding and the urgency of recently declared states of emergency and the coming Care Court System.

Inequities and Disparities
State law, Welfare Institutions Code (WIC) Section 5812.5(d), 5868(b), 5878.1(a); and 9 California Code of Regulations (CCR) Section 3200.100 requires a county's MHSA Three Year Plan to address disparities, and cultural and linguistic competency by incorporating and working

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to achieve stated goals in all aspects of policymaking, program design, administration, and service delivery. To accomplish this, the Commission urges action in the following areas:

Cultural Humility and Linguistic Competency

The Commission acknowledges recent efforts by the Department to enhance the Department's language capacity with respect to all programming, external relations, and treatments. However, more efforts are needed to prioritize effective communication and delivery of mental health information. The Commission recommends that the Department work with community members, leaders, and population-specific experts in the development of communication strategies and written materials to ensure these are written in plain language and high-quality translations. In addition, the Commission encourages the department to practice cultural humility in its implantation of projects and partnerships to better address mental health inequities and disparities.

Data

The Commission acknowledges the Department's inclusion of data metrics in this year's Annual Update and its efforts to improve data collection. However, the Commission recommends additional efforts in providing data that report out by Service Planning Area (SPA), Supervisorial District (SD), and by clinics (e.g., non-profit or for profit, directly operated clinics, physician status reports) to identify inequities and identify data sources that can be used to help with clarifying unmet needs. In addition, we recommend data collection about met and unmet needs and data that identifies services for people with development disabilities.

The Commission recognizes the benefits of the new MHSA data dashboard and thanks the Department for its efforts to address recommendations made in the MHSA Annual Update FY 2022-23 recommendation letter. With the prospect of having this new tool, the Commission recommends and will support any efforts by the Department, as this tool goes live for public use, to increase stakeholder/community-based organizations/providers/consumer confidence in using this important tool by hosting live training sessions, creating recorded trainings, proving a written guide, and having this accessible in multiple languages.

The Commission recommends data collection of all stakeholder hearings include the number of attendees. The Commission also requests these data of attendees be categorized (e.g., staff, providers, and stakeholders).

Demographics

The Department should be sensitive to and accountable for resolving inequities around: race and ethnicity, immigration status, geographic location, age (with an option for clients to elect their choice of programs from TAY, Adult or Older Adult categories) and physical and mental health condition. Special attention should be paid toward inequities in populations with physical disabilities and others who qualify under Americans with Disabilities Act status. The Commission also recommends special attention on increasing the access and resources for

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specific populations like the Asian Pacific Islander American (APIA), American Indian, American Native, Black Indigenous People of Color (BIPOC), and Lesbian Gay Bisexual Transgender Questioning (LGBTQ) +.

We continue to urge you to correct for disparities in funding across underserved and unserved populations, including ethnic populations in all service areas. This includes expanding funding for additional TAY drop-in centers to take advantage of full continuum of health, mental health, and supportive services, including areas that are geographically isolated such as Antelope and Santa Clarita Valley.

MHSA Proposal Process

The Commission recognizes and offers commendations to DMH's MHSA Administration team for the improvement in efforts to streamline an efficient Request for Proposals (RFP) process. The Commission recommends the Department implement an RFP process that includes providing enough details (e.g., define the scope and boundaries of the project in detail) that can allow applicants to accurately assess their capacity to commit to the project. Furthermore, increasing accessibility to the RFP process by implementing start-up sessions in multiple languages and platforms will give all potential applicants an opportunity to ask questions and to ensure that they understand requirements and technical support.

School-Based Mental Health Services

The Commission acknowledges DMH's efforts to increase access for students and their families through robust collaboration with both Los Angeles Unified School District (LAUSD) and Los Angeles County Office of Education (LACOE). The Commission recommends continuing to increase efforts to expand school-based mental health services by identifying additional school districts beyond LAUSD that lie outside of the city of Los Angeles boundaries (e.g., William S Hart, Sulphur Springs, Newhall, Castaic, Saugus, Burbank, Glendale and/or La Canada School Districts).

Stakeholder Engagement

While the Commission acknowledges the efforts of the Department to increase community input and participation in the Community Planning Process, the Commission recommends additional efforts to expand stakeholder engagement by increasing the number of meetings, meeting locations, and time of day. In addition, the Commission requests that the Department increase its outreach efforts to the general community, other LA County Agencies and Commissions (e.g., HIV, Public Health, Hospital and Care Delivery, Peer Advisory Council, and Alliance for Health Integration). Efforts to increase stakeholder engagement must include creating dedicated spaces for the community to engage. The Commission recommends the Department consider building Peer Centers in each SPA and requests that the proposal from SALT 8 for a Peer Center be prioritized.

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Workforce, Education, and Training (WET)
Utilize MHSA category, Workforce, Education and Training (WET) to fund an enhanced recruitment and retention of DMH employees/Legal Entity (LE) agreements, especially as DMH/LE faces high vacancy rates and heavy turnover while trying to expand our programs and services. One objective to fund such an effort is to incentivize mental health clinicians to join DMH and make sure that those presently employed do not "get burnt out and leave."

Additional Recommendations:

- Alternative Crisis Services: Maintain or expand funding for Alternative Crisis Services.
- Evaluate the composition of stakeholder groups to increase collaboration and representation across all communities/populations.
- Mental Health Urgent Services: The Commission recommends further funding and support of Mental Health Urgent Cares (e.g., an EmPath Center in collaboration with Henry Mayo Hospital in Santa Clarita) that will serve adolescents and adults that can bill Medi-Cal as well as private insurance.
- Behavioral Health Unit (BHU): Plan and implement the decades long requested Behavioral Health Unit (BHU) for adolescents and children in the Santa Clarita and/or San Fernando Valley Areas. Identify if the concept/model can be funded by MHSA for some or part of the model.
- Consider innovative strategies to reduce paperwork for line working clinical staff to increase efficiency, improve morale, staff retention, recruitment, and satisfaction, decrease burnout, increase caseloads, and improve clinical quality.
- Maximize scope of service/practice for Occupational Therapists, Recreation Therapists, and Psychiatric Technicians to alleviate staffing shortages.

Acknowledgments:

- The Commission acknowledges the outstanding efforts to fund, expand and improve ODR services; to stand up Restorative Care Villages, and Programs.
- The Commission acknowledges the outstanding progress the department has made with Alternative Crisis Services as part of its Community Services and Support (CSS) efforts and coordination. To this effort, the Commission recommends maintaining and supporting expansion of Alternative Crisis Services countywide rather than a decrease in funding to this program. Furthermore, the Commission recommends the expansion of DMH's staffing to support work and collaboration in programs like the LA County Sheriff's Mental Health Evaluation Team (MET) and Los Angeles Police Department's Systemwide Mental Health Assessment Team (S.M.A.R.T).

The Commission recognizes that the above recommendations should remain in direct relation to the MHSA Annual Update FY 2023-24. However, we cannot adequately provide the above recommendations without also mentioning broader aspects that also impact budget and accountability. We would like to include the following as an additional recommendation or comment related to California Advancing and Innovating Medi-Cal (CalAIM) and indirectly

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related to the overall MHSA budget. The Commission asks the Department to measure the effects of CalAIM on equity, evaluate fairness with the new reimbursement guidelines related to intensive services (e.g., FSP), and report if there will be any increases to services for individuals and families.

Sincerely,

Kathleen Austria

Kathleen Austria
Chair, Mental Health Commission

KA: KF

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EXHIBIT D – LACDMH RESPONSE TO THE MENTAL HEALTH COMMISSION

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Director

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

Connie D. Draxler, M.P.A.
Acting Chief Deputy Director

May 11, 2023

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

Kathleen Austria
Chair, Mental Health Commission
510 South Vermont Avenue
Los Angeles, CA 90020

RESPONSE TO MENTAL HEALTH COMMISSION INQUIRIES ON THE PUBLIC HEARING FOR THE MENTAL HEALHT SERVICES ACT ANNUAN UPDATE FOR FISCAL YEAR 2023-2024

On Friday, May 5, 2023, the Los Angeles County Mental Health Commission (Commission) submitted a letter reflecting their comments and inquiries to the Los Angeles County Board of Supervisors (Board) and the Department of Mental Health (DMH) pertaining to the April 27, 2023, public hearing on the Fiscal Year (FY) 2023-24 Mental Health Services Act (MHSA) Annual Update (Annual Update).

In the Commission's letter, DMH was commended for its continued efforts to strengthen the community engagement process related to the Annual Update development and its partnership with key stakeholder groups to ensure the Annual Update represented and addressed the expressed needs of each community with special attention to those communities most at risk and those disproportionately impacted by disparities. The Commission submitted several recommendations for the review, centering around five broad themes:

1. **Budget and Accountability**
2. **Criminal Justice**
3. **Housing/Homelessness**
4. **Inequities/Disparities**
5. **Workforce, Education, and Training (WET)**

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The following are DMH's responses to the Commission's recommendations:

Budget and Accountability
The Commission recommended the Department include a quantitative and qualitative needs assessment of public mental health needs to inform the next FY MHSA Three Year Plan. Furthermore, the Commission stated their expectation of accountability for unspent funds as this is critical to understanding unmet community needs.

The Needs Assessment is a critical component Community Planning process to determine priorities and gaps in services. DMH has begun the process of planning for the Needs Assessment and Community Planning Process (CPP) with Stakeholders. Department leads for this process have engaged Commission members familiar with data as well as stakeholder groups to identify key data sets to be presented as part of the CPP. The MHSA Administration will engage the Mental Health Commission with updates and solicit input throughout the process.

Criminal Justice
The Commission acknowledged that a significant number of the jail's population have Serious Mental Illness and commended the progress made by the County's Department of Health Services Office of Diversion and Re-Entry (DHS-ODR) in moving forward the Board's Care First, Jail Last Initiative as a strategy within.

Housing & Homelessness
The Commission acknowledged the dedicated efforts made by the Department to expand services and increase mental health beds and services. As public comment about the need for these services and better access for children and older adults continues, the Commission recommended continued funding and efforts to increase access for this population. In addition, the Commission recommended allocation of MHSA funds for additional workforce. Specifically, the Commission recommended the Department to consider creating and funding peer support specialist positions to support and create linkage to services for persons suffering from mental health disorders and experiencing homelessness.

The Commission recommended providing day services, including direct onsite mental health services, for individuals experiencing homelessness throughout the County which are low barrier services that help link people to housing and mental health services (e.g., the Bridge to Home Shelter Services in Santa Clarita). Additionally, collaboration between Street Medicine, Homeless Outreach and Mobile Engagement (HOME), Los Angeles Homeless Outreach Program LA-HOP), Full Service Partnership (FSP), DMH Navigators, Office of Diversion and Re-Entry (ODR), Veterans Homeless Outreach programs, Adult Mental Health Clinics, Assisted Outpatient Treatment (AOT) and local shelters and homeless programs should be seamless, especially considering limited

funding and the urgency of recently declared states of emergency and the coming Care Court System.

DMH acknowledges these recommendations. Implementation of new services, and expansion of existing services to meet the needs of the unhoused is a priority both for DMH and for Los Angeles County to ensure access to care and success in permanent housing. In response to this crisis, DMH has committed to the following:

- Development of the Innovations Interim Housing Multidisciplinary Assessment and Treatment teams to serve individuals onsite in all interim housing settings across Los Angeles County, and which includes both 55 Peer positions (titled Community Health Workers) and 11 Supervising Peer positions (Titled Supervising Community Health workers). This proposal has been submitted to the Oversight and Accountability Commission for hearing but has not yet been approved.
- Significant program expansions for FSP and HOME, two programs that target services to persons who are unhoused, include Peer positions.
- The launch of Hollywood 2.0, an Innovations funded program, focused on serving the needs of the unhoused with mental illness in the Hollywood area.
- DMH has developed a recruitment campaign focused on recruitment of Community Health Workers and Clinicians to staff new programs and program expansions.
- To ensure continuity, the newly proposed program will fall under the leadership of the Countywide Engagement Division which also oversees Home, ODR, Veterans, and AOT. This will support program development that is integrated with access to intensive care services.

Inequities and Disparities
The Commission identified State law, Welfare Institutions Code (WIC) Section 5812.5(d), 5868(b), 5878.1(a); and 9 California Code of Regulations (CCR) Section 3200.100 which requires a county's MHSA Three Year Plan to address disparities, and cultural and linguistic competency by incorporating and working to achieve stated goals in all aspects of policymaking, program design, administration, and service delivery. To accomplish this, the Commission urged action in the following areas:

Cultural Humility and Linguistic Competency
The Commission acknowledged recent efforts by the Department to enhance the Department's language capacity with respect to all programming, external relations, and treatments. The Commission recommended improved communication and delivery of mental health information. The Commission recommended the Department work with community members, leaders, and population-specific experts in the development of communication strategies and written materials to ensure these are written in plain language and high-quality translations. In addition, the Commission encouraged the

Department to practice cultural humility in its implantation of projects and partnerships to better address mental health inequities and disparities.

Data

The Commission acknowledged the Department's inclusion of data metrics in this year's Annual Update and its efforts to improve data collection. However, the Commission recommended additional efforts in providing data that report out by Service Planning Area (SPA), Supervisorial District (SD), and by clinics (e.g., non-profit or for profit, directly operated clinics, physician status reports) to identify inequities and identify data sources that can be used to help with clarifying unmet needs. Data collection about met and unmet needs and data that identifies services for people with development disabilities was also recommended.

The Commission recognized the benefits of the new MHSA data dashboard and thanked the Department for its efforts to address recommendations made in the MHSA Annual Update FY 2022-23 recommendation letter. With the prospect of having this new tool, the Commission recommended and will support any efforts by the Department, as this tool goes live for public use, to increase stakeholder/community-based organizations/ providers/consumer confidence in using this important tool by hosting live training sessions, creating recorded trainings, proving a written guide, and having this accessible in multiple languages.

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The Commission urged the Department to correct for disparities in funding across underserved and unserved populations, including ethnic populations in all service areas. This includes expanding funding for additional TAY drop-in centers to take advantage of full continuum of health, mental health, and supportive services, including areas that are geographically isolated such as Antelope and Santa Clarita Valley.

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The Commission acknowledged DMH's efforts to increase access for students and their families through robust collaboration with both Los Angeles Unified School District (LAUSD) and Los Angeles County Office of Education (LACOE). The Commission recommended continuing to increase efforts to expand school-based mental health services by identifying additional school districts beyond LAUSD that lie outside of the City of Los Angeles boundaries (e.g., William S Hart, Sulphur Springs, Newhall, Castaic, Saugus, Burbank, Glendale and/or La Canada School Districts).

Stakeholder Engagement

The Commission acknowledged the efforts of the Department to increase community input and participation in the Community Planning Process and recommended additional efforts to expand stakeholder engagement by increasing the number of meetings, meeting locations, and time of day. In addition, the Commission requested that the Department increase its outreach efforts to the general community, other Los Angeles County Agencies and Commissions (e.g., HIV, Public Health, Hospital and Care Delivery, Peer Advisory Council, and Alliance for Health Integration). The Commission encouraged the Department to increase stakeholder engagement by creating dedicated spaces for the community to engage. The Commission recommended the Department consider building Peer Centers in each SPA and requests that the proposal from SALT 8 for a Peer Center be prioritized.

DMH is committed to identifying and addressing disparities in services among our population served as well as in the community through Prevention efforts. Examples of these efforts include:

- Enhancing our commitment to the Anti-Racism and Diversity Initiative (ARDI) through the appointment of a dedicated manager and team to addressing Race and Disparity in the workforce, in communities, and in services.
- Development and public posting of the DMH Demographics dashboard as well as the development of the MHSA dashboard. These dashboards, available to the

public, reflect services delivered by Ethnicity, Language, Age, Diagnosis, each of which can be viewed by Supervisorial District and Service Area.

- DMH has significantly expanded the United Mental Health Promoters program to enhance engagement in all regionals and underserved cultural communities in Los Angeles County.
- DMH has developed a Disparities Review Committee to identify metrics for review throughout the year which may reflect progress in addressing disparities.
- DMH is committed to using the CEO Equity Explorer Tool, a heat map which identifies areas of need by a variety of metrics, to identify communities in need for new services and service expansion.
- DMH acknowledges the need to improve reporting on services to individuals with disabilities and better identify their service needs.
- DMH providers offer prevention and early intervention services in 79 of the 81 districts in Los Angeles County. DMH provides school-based services. In addition, the Community Schools initiative is currently serving 17 school Districts in addition to the Los Angeles Unified School District.

DMH will continue its efforts to expand and improve the stakeholder process through:

- Expanding the stakeholder body to include representation by other Los Angeles County Agencies and Commissions and as identified in the MHSA regulations, including but not limited to representation from Health, Public Health, Substance Use, Schools, Veterans Groups. The MHSA Administration will engage the Commission for feedback during the expansion process.
- Work to support and improve recruitment and advocacy among our Service Area Leadership Teams by providing support, advocacy training, and support for development of standards and responsibilities among SALT groups.
- Ensuring materials offered in stakeholder settings as part of the CPP are available in multiple languages, and access needs are met for each meeting (interpretation, sign language, and CART services).
- DMH will develop materials and provide training on the MHSA proposal process.

Workforce, Education, and Training (WET)
The Commission recommended DMH utilize MHSA category, Workforce, Education and Training (WET) to fund an enhanced recruitment and retention of DMH employees/Legal Entity (LE) agreements, especially as DMH/LE faces high vacancy rates and heavy turnover while trying to expand our programs and services. One objective to fund such an effort is to incentivize mental health clinicians to join DMH and make sure that those presently employed do not "get burnt out and leave".

DMH recognizes the significant impacts of the staffing shortage on service access and has made significant strides in the past year to increase the size and quality of the workforce. DMH has and will continue to focus on recruitment and hiring efforts, while addressing culture change within the Department to maintain the workforce. Incentive programs have included:

- Stipends programs for Marriage and Family Therapists, Nurse Practitioners, Masters in Social Work, and Psychology (PsyD. /PhD) students for entry into the public mental health system.
- DMH Loan Repayment Program, available to both DMH and DMH Contract providers.
- DMH Psychiatrist Incentive Programs.
- DMH is planning a partnership to fund tuition for Psychiatric Technicians in the coming Fiscal Year.
- DMH has developed a recruitment campaign "do worthwhile work" and is currently working with a media company to disseminate this campaign with a focus on Community Health Workers/Peers and Clinicians.

Additional Recommendations:

- Alternative Crisis Services: Maintain or expand funding for Alternative Crisis Services.
- Evaluate the composition of stakeholder groups to increase collaboration and representation across all communities/populations.
- Mental Health Urgent Services: The Commission recommends further funding and support of Mental Health Urgent Cares (e.g., an EmPath Center in collaboration with Henry Mayo Hospital in Santa Clarita) that will serve adolescents and adults that can bill Medi-Cal as well as private insurance.
- Behavioral Health Unit (BHU): Plan and implement the decades long requested BHU for adolescents and children in the Santa Clarita and/or San Fernando Valley Areas. Identify if the concept/model can be funded by MHSA for some or part of the model.
- Consider innovative strategies to reduce paperwork for line working clinical staff to increase efficiency, improve morale, staff retention, recruitment, and satisfaction, decrease burnout, increase caseloads, and improve clinical quality.
- Maximize scope of service/practice for Occupational Therapists, Recreation Therapists, and Psychiatric Technicians to alleviate staffing shortages.

In response to the additional recommendations, DMH is expanding Alternative Crisis Services. This includes expansions to Psychiatric Mobile Response Teams (PMRT) and expansions to crisis residential services.

To address paperwork reduction, DMH has updated documentation guidelines according to the new California Advancing and Innovating Medi-Cal (CalAIM) standards, with a focus on reducing burden on staff and incentivizing up-front engagement with new clients.

I'd like to thank the Commission for its collaboration during this transition period and thoughtful approach to ensuring the stakeholder voices are valued in the planning process.

Recommendations listed by the Commission will be explored by DMH and vetted with stakeholders. DMH MHSA Administration leadership will be available to provide ongoing updates to these recommendations and priorities identified by stakeholders.

I look forward to working with stakeholders, partners, and the Commission to ensure our MHSA resources help those most in-need live health, independent, meaningful lives.

If there are any questions you can contact me at (213) 947-6670, or staff can contact Kalene Gilbert, MHSA Services Coordinator, at Kgilbert@dmh.lacounty.gov.

Sincerely,

Lisa H. Wong
Director

LHW:CDD:KG:lm

APPENDICES

Appendix A - Interim Housing Multidisciplinary Assessment & Treatment Teams

County Name:	Los Angeles County
Date submitted:	March 7, 2023
Project Title:	Interim Housing Multidisciplinary Assessment and Treatment Teams
Total Amount Requested:	$155,927,580 INN
Duration of project:	5 Years

Section 1: Innovations Regulations Requirements Categories

CHOOSE A GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- ☒ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☒ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

CHOOSE A PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☒ Increases access to mental health services to underserved groups
- ☐ Increases the quality of mental health services, including measured outcomes
- ☒ Promotes interagency and community collaboration related to mental health services or supports or outcomes
- ☒ Increase access to mental health services, including but not limited to services provided through permanent supportive housing

Primary Purpose

The purpose of this program is to create new regional, field-based, multidisciplinary teams dedicated to serving people experiencing homelessness (PEH) who are living in interim housing to learn if this multidisciplinary/multi-agency, on-site site service approach will result in:

- Increased access to mental health services and co-occurring substance use disorder (SUD) services,
- Increased exits to permanent housing,
- Decreased exits to homelessness,
- Increase in housing provider staff increasing their knowledge and skills when serving individuals with severe mental illness,
- Reduce incidence of overdose related fatalities.

Section 2: Project Overview

Primary Problem

According to the 2022 Greater Los Angeles Point-In-Time Homeless Count conducted by the Los Angeles Homeless Services Authority (LAHSA), there are 69,144 PEH in Los Angeles County. Of this number, 48,548 are unsheltered on any given night, marking Los Angeles County with the unfortunate distinction of having the largest unsheltered homeless population in the nation. Further examination of the Homeless Count notes that 39.5% of individuals experiencing homelessness in Los Angeles County have mental health and/or substance use disorders[1].

Although significant efforts and resources have been allocated to the development of permanent affordable housing solutions, including Permanent Supportive Housing (PSH), there is no question that interim housing continues to play a significant role in addressing the immediate and future needs of unsheltered PEH. To this end, there has been a significant investment in interim housing by Los Angeles County and many partnering cities over the last five years including interim housing developed in response to the COVID-19 pandemic such as the State-funded Project Roomkey sites. Amongst the 8 service planning areas (SPA) in Los Angeles County the current interim housing inventory totals approximately 220 sites and 14,376 beds. Another 11 interim housing sites are in the pipeline which will make available an additional 1,037 beds to support PEH. Further, in fiscal year 23-24 the Los Angeles County Homeless Initiative has budgeted 182.2 million (30% of the total budget) for interim housing.

Los Angeles County - Estimated Interim Housing Inventory by SPA*						
	Existing Sites	Existing Beds	Pipeline Sites	Pipeline Beds	Total Sites	Total Beds
SPA 1	9	278	1	38	10	316
SPA 2	35	2,787	1	148	36	2,935
SPA 3	11	487	2	132	13	619
SPA 4	64	5,013	3	239	67	5,252
SPA 5	19	525	-	-	19	525
SPA 6	43	3,211	3	400	46	3,611
SPA 7	15	932	1	80	16	1,012
SPA 8	24	1,143	-	-	24	1,143
Total	**220**	**14,376**	**11**	**1,037**	**231**	**15,413**

** Estimate based on excluding the following interim housing sites: Department of Public Health – Substance Abuse Prevention and Control (DPH-SAPC) sites, Department of Health Services – Office of Diversion and Re-entry (DHS-ODR) sites, DHS – Housing for Health (DHS-HFH) Safe Landing, LACDMH Care First Community Investment (CFCI) sites, Veterans Affairs (VA) sites and Project Homekey sites being converted to PSH.*

While interim housing sites in Los Angeles County are funded by a collection of public and private dollars (including but not limited to Measure H, Los Angeles Homeless Service Authority (LAHSA), Departments of Health, Mental Health and Public Health) and available to any person experiencing homelessness, the reality is that PEH often have a variety of complex needs that limit their ability to successfully access and/or maintain stability in these settings despite their desperate need for shelter. For example, interim housing sites are traditionally staffed by homeless service providers who are ill-equipped to serve individuals with more complex medical needs (e.g., colostomy bags, wound care), mental health conditions (e.g., psychotic spectrum disorders, bipolar

[1] Health & disability indicators are not mutually exclusive; a single person may report more than one condition and thus be represented among more than one health & disability subpopulation.

disorders) and/or substance use disorders (e.g., alcohol, methamphetamine or opioid addiction) as well as individuals who need support with activities of daily living (ADLs) such as bathing, eating and dressing and/or independent activities of daily living (IADLs) such as managing medication and finances. This was highlighted in the 2020 preliminary report conducted by LAHSA entitled *Higher Level of Care Needs Among People Experiencing Homelessness at Los Angeles County Project Roomkey Sites*. The report found that a subset of individuals that had complex health and/or mental health conditions which significantly impaired their ability to engage in ADLs/IADLs were recommended for a higher level of care by site operators and LAHSA site coordinators.

The housing service agencies charged with operating the Project Roomkey sites did not have adequate funding or staff trained to provide the needed supports resulting in an increased risk of returning to homelessness for the identified subset. Our experience has also found that individuals who experience behavioral impairments as a result of their mental illness and/or substance use disorders are at high-risk of being exited from interim housing, which often results in them returning to the streets without proper care.

Accordingly, as part of the system of care in Los Angeles County, Department of Mental Health (LACDMH), Department of Health Services (DHS) and Department of Public Health have been intentional about designing, implementing and partnering in programs that can address the wide range of needs that PEH may experience. This included providing specialized psychiatric street outreach through the LACDMH Homeless Outreach & Mobile Engagement (HOME) teams as well as providing integrated specialized supportive services once someone is in permanent housing through the LACDMH Housing Supportive Services Program, DHS Intensive Case Management Services Program (ICMS) and DPH-Substance Abuse Prevention and Control (SAPC) Client Engagement and Navigation Services Program. However, the County currently lacks the dedicated resources needed to be able to respond to requests for field-based, on-demand and proactive health, mental health and substance use services in interim housing settings for individuals living with symptoms and functional impairments associated with severe mental illness, chronic health conditions and/or substance addiction. In fact, the need for these types of augmented services in interim housing was also identified during the community and stakeholder engagement process for Los Angeles County's Measure H funding recommendations and by the Board of Supervisors in a December 20, 2022 Board Motion for the County to support the City of Los Angeles in their State of Emergency on Homelessness.

Given the prevalence of health, mental health and substance use disorders among PEH, there is no doubt that providing interim housing residents with on-site access to health, mental health and substance use services and supports would fill an important gap in the homeless services system and offer assistance that is imperative to supporting a successful interim housing stay and transition to permanent housing and preventing individuals from returning to homelessness by providing critical skills and supports.

Proposed Project

Overview

Through the proposed Innovation project, LACDMH seeks to create new regional, field-based, multidisciplinary teams that are specifically dedicated to serving people experiencing homelessness (PEH) who are living in interim housing. The project is designed to address current gaps in behavioral health, including substance use, and physical health services, support interim housing stability, facilitate transition to permanent housing and prevent a return to homelessness. The Interim Housing Multidisciplinary Assessment and Treatment Teams will serve all eight Service Areas in Los Angeles County and will be comprised of staff from LACDMH, DPH-SAPC and DHS-

Housing For Health (HFH) in an effort to ensure the full spectrum of client needs can be addressed. LACDMH Innovations funding will be used to support the mental health component of this effort including the provision of on-site specialty mental health and co-occurring SUD care and supports.

Mental health services will include crisis response, outreach, triage, screening/assessment, individual and/or group rehabilitation and therapy, medication evaluation/administration, including medications for addiction treatment (MAT) and ambulatory withdrawal management; crisis intervention including non-MHSA funded psychiatric hospitalization when deemed clinically appropriate, linkage to longitudinal care and consultation DPH-SAPC will provide substance use outreach, engagement, screening and referrals to SUD services including linkage to DPH-SAPC treatment providers who offer MAT in situations where the client's need for MAT and/or ambulatory withdrawal management is not met by an existing mental health service provider.

In addition, DPH-SAPC will provide educational sessions (individual and group) at the interim housing locations that will offer individuals an overview of SUDs and the treatment system as well as a more specific curriculum targeting those at risk of SUDs that is focused on overdose and relapse prevention; recognizing the health consequences of substance use and the connection to mental health; and harm reduction services including naloxone and fentanyl test strip distribution to interim housing residents and providers. For interim housing residents who may need traditional SUD treatment but are reluctant or unable to participate at a SUD treatment site, outpatient treatment services can be provided to residents onsite via DPH-SAPC's network of Field-Based Service treatment providers, including connections to MAT. DPH-SAPC will also coordinate referrals and linkage to appropriate harm reduction services, such as syringe services programs (contracted by DPH and/or DHS), for individuals who continue to use substances.

DPH-SAPC's network consists of 72 residential service (American Society for Addiction Medicine-ASAM) treatment level 3.1, 3.3, and 3.5) providers. Of the 72 residential providers, 16 providers identify as serving the Co-Occurring Disorder (COD) population, consisting of 31 sites. DPH-SAPC proposes a total of 10 residential beds to be dedicated to the COD population residing in interim housing sites, with the proposed INN funds supporting the non-Drug Medi-Cal cost, including room and board. When an interim housing resident needs residential substance use disorder treatment the IH teams will prioritize placement in a treatment location closest in proximity to the IH site whenever possible. INN Funding will also support 16 psychiatric social workers embedded in approximately 31 DPH-SAPC contracted residential treatment sites for the purpose of co-occurring disorder crisis de-escalation, assessment, treatment planning, and care coordination for the provision of integrated mental health and SUD care for patients receiving residential SUD treatment. Psychiatric social workers would be positioned to provide care coordination that links patients with co-occurring disorders to any necessary continuity mental health services, that aren't otherwise accessible from the residential provider directly, in parallel with their SUD treatment.

DHS-HFH will also contribute nursing and other staff to the teams who will be able to provide short-term, physical health care services to residents including but not limited to wound care, medication administration and ADL/IADL support until a dedicated In-Home Supportive Services (IHSS) provider can be established. To fund the physical health component, DHS has received Housing and Homelessness Incentive Program (HHIP) funding from managed care organizations (e.g., L.A. Care, Health Net, etc.).

Program Development & Implementation

a) Identify which of the three project general requirements specified above [per CRR, Title 9, Sect. 3910(a)] the project will implement

This project proposal will make a change to an existing practice in the field of mental health, including but not limited to, application to a different population. Outreach and engagement and field-based service delivery are standards of care. Most often, individual participants are enrolled in one of many community-based mental health programs. While LACDMH has street teams who do community outreach for individuals, none are assigned to settings such as an Interim housing site. In addition, multi-agency partnership and supports, including funding from managed care partners, is a new approach for Los Angeles County.

The project proposal supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite. Interim housing is often a necessary first step in the journey to permanent housing for people experiencing homelessness. For many individuals these settings serve as a stabilizing resource allowing one to gather the skills, resources and service connections they need to move to permanent housing. The sites are generally staffed by paraprofessional and security staff who lack training and clinical skills to manage complex behavioral health, health and substance addiction needs of the residents. The result is that individuals with such complex needs are frequently deemed inappropriate for admission or prematurely exited from interim housing due to the provider's limited capacity to manage their needs. The proposed project will fill this service gap by providing critical mental health, health, and addiction treatment onsite, harnessing the collective expertise of three public entities to stabilize their living situation and support a successful transition to permanent housing.

b) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

The proposed Innovation project will not only adapt critical lessons learned from the interim housing efforts implemented during the height of the pandemic (e.g., Project Roomkey) but expand the scope and availability of the services to the entirety of the interim housing portfolio in Los Angeles County. Instead of the current model which requires PEH to connect to specialty care independently, the project will use a multi-Department and multidisciplinary support model to provide tailored mental health, physical health, and substance use services onsite at interim housing facilities.

The teams providing these services will be the first of their kind in Los Angeles County to target residents in interim housing, allowing PEH with complex mental health, health and/or substance use disorders to be provided, for the first time, with augmented care in interim housing settings that will not only support their access to, and stay in interim housing, but also assist residents with obtaining the necessary services and care needed to transition to appropriate permanent housing and prevent a return to homelessness.

Additionally, the partnership with the managed care organizations to use HHIP funding for physical health services would be an innovative way to leverage private resources to provide nursing and other staff onsite at interim housing facilities to complete assessments and provide ADL/IADL supports while working to successfully connect the individuals to longitudinal care such as CalAIM Community Supports-funded caregiving services. HHIP funding will also support those individuals for whom a licensed residential care program would be more appropriate. Overall, we anticipate that this innovative approach to supporting PEH

in interim housing will increase positive health outcomes for those served and, ultimately, reduce health care costs.

c) Estimate the number of individuals expected to be served annually and how you arrived at this number.

According to the Los Angeles County Point-In Time Homeless Count 25% of individuals experiencing homelessness self-report having a diagnosis of a serious mental illness and 26% self-report having a substance use disorder[2]. The current inventory of interim housing beds in Los Angeles County (14,376) combined with those is the pipeline (1037) is 15,413 beds. Using the 2022 homeless count self-report percentages LACDMH anticipates serving 4000 individuals in interim housing sites annually, 20,000 over the life of the Innovations project.

d) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate.)

The target population for this Innovation project are individuals 18 and older who are homeless and residing in interim housing in Los Angeles County. These individuals will also have mental health, health and/or substance use disorders and can benefit from augmented supports to successfully access and maintain their interim housing, transition to appropriate permanent housing and prevent a return to homelessness. Services and supports will be provided in interim housing settings serving single adults and families. When working with families mental health treatment for children will be coordinated with LACDMH Children's System of Care.

According to data gathered for the Los Angeles Homeless Services Authority (LAHSA) the current demographic breakdown for their interim housing portfolio is as follows:

Ethnicity

- Hispanic/Latino -4 0%
- Black/African American – 43%
- White – 21%
- Mixed or Multi Race – 2.5%
- Asian - .9%
- American Indian 2%
- Native Hawaiian/ Pacific Islander - .2%

Age

- Under 18 – 28%
- 18-54 - 55%
- 55 and Older – 17%

Gender

- Male - 51%
- Female – 48%
- Non-Binary – .003%
- Questioning – 1 %
- Transgender – .004%

[2] Health & disability indicators are not mutually exclusive; a single person may report more than one condition and thus be represented among more than one health & disability subpopulation.

Research on INN Component

A. What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

The proposed INN project aligns with the Governor's proposal for mental health reform by: 1. Focusing on the intersection of mental illness and homelessness. 2. Building out the entire continuum of care as it relates to mental health services in community; 3. Building regional centers of care and support for people experiencing homelessness, mental illness and co-occurring substance use disorders and 4. Leveraging broader strategies related to Medicaid reform. Additionally, the project aligns with LACDMH's strategic plan as it touches our three domains of care 1. Re-Entry Initiatives, Crisis Care and Community Services. Our Re-Entry Initiatives are comprised of programs designed to deploy specialty mental health treatment to help clients who have fallen out of community into the "open-air" asylum of homelessness, "closed-air" asylum of the jail, and the "personal asylum" of deep isolation (i.e. Regional IH Teams) Crisis Care includes the intensive care resources deployed to help individuals in crisis who are falling out of community (e.g. Psychiatric Mobile Response Teams, law enforcement and other first responders); and our North Star, Community Services where the clients we serve are at the center of community, connected not only to treatment but also stable housing, purpose in their lives (e.g. employment, school volunteer opportunities) and meaningful supportive relationships. The entirety of the proposal is focused on moving individuals from the Re-Entry level of care, eliminating the need for Crisis Care, and increasing connections to Community Services.

While some aspects of the proposed project are remotely similar to services/linkages provided by Full Service Partnership and other programs n Humbolt, Santa Barbara and even Los Angeles County, none provide comprehensive services with two key elements that make this project truly innovative:

- The implementation of dedicated field-based multidisciplinary teams that are specifically outreaching, engaging and providing direct mental health, physical health and substance use services to clients in interim housing at their interim housing location, which is an entirely new service setting. This includes 24/7 psychiatric crisis response.
- The partnership with the managed care organizations that will allow the County to leverage private resources from local health plans to support interim housing client needs.

The most widely recognized and revered wrap-around treatment protocol for individuals with severe mental illness (SMI) in Los Angeles County are Full-Service Partnership (FSP) programs. These programs offer comprehensive intensive mental health treatment (including wrap around support) to individuals with severe and persistent mental illness. Without question FSP is effective in treating individuals with SMI however the program has eligibility requirements and is enrollment based, thereby limiting services to those with prior treatment failures and those fortunate enough to be connected to a provider. The proposed regional interim housing teams differ from FSP in several ways. First, no eligibility or enrollment criteria is required for an IH resident to receive services. Second, services are provided in the interim housing setting thus increasing access to care and likely, participation rates. Third, services extend beyond specialty mental health to include treatment for substance use and complex medical conditions, and support with ADLs/IADLs and, as clinically indicated, connection to managed care behavioral health resources and other Medicaid reform resources (e.g. Enhanced Care Management). Finally, consistent with the Governor's focus the modernization of the Mental Health Services Act, the interim housing teams described in this proposal are focused on the twin epidemics in the state of California, homelessness and behavioral health. The primary goals of the team's interventions are to increase access to housing resources for individuals with complex, behavioral health, substance use, and/or health needs; prevent

unnecessary return to homelessness due to behavioral health, medical or substance use concerns; and support successful transition to permanent housing.

Humboldt County's Resident Engagement and Support Team (REST) program seeks to improve housing stability in transitional housing via the assignment of case workers and peer staff in the outpatient setting. The primary focus is to help individuals create daily structure and routines, linkage, care management, and providing supportive/problem solving interventions with landlords. REST is different than the proposed project in that services are provided in the outpatient setting and a predominantly aimed at linkage and care and coordination. The services to be provided by the proposed project are 100% on site and entirely dedicated to the interim housing portfolio in Los Angeles County. The multi-disciplinary teams are able to provide interventions on-site in real time through face-to-face intervention and/or telemedicine (including 24/7 crisis response) in addition to being able to connect individuals to longitudinal mental health, health and substance abuse treatment as they transition to permanent housing.

Santa Barbara County currently has a Housing Retention Team facilitated by Good Samaritan Shelters and is funded by a grant from the Santa Barbara County Department of Housing and Community Development. It provides intensive wraparound services including a 24-hour help line for recipients of Emergency Housing Vouchers (EHV) in Santa Barbara County, of which they have approximately 230 EHV recipients. The distinction between Santa Barbra's Housing Retention Team and the project proposed herein is the focus on interim housing residents; comprehensive support which includes assistance with ADL/IADLs, substance abuse prevention, harm reduction and treatment (including medication assisted treatment); and multi-county department collaboration in partnership with managed care plans.

In general, while some homeless service providers in Los Angeles County e.g., LA Family Housing, People Assisting The Homeless (PATH), employ Masters level Social Workers as part of their shelter leadership structure, the services they provide are primarily in the domain of linkage and referral rather than on-site structured treatment and/or crisis response. When residents demonstrate significant behavioral, substance useor physical health needs paraprofessional and paraprofessional staff in these settings rely on the various LACDMH (directly operated and contracted), DPH-SAPC and DHSaccess points to link and obtain services for the clients serve. Due to the myriad of specialized programs and referral process within these bureaucracies finding the appropriate level of care or specialized resource for an interim housing resident can be a daunting and time consuming endeavor.

An example of more dedicated support in IH settings in Los Angeles County is the recently established interim housing model operated by Special Services for Groups (SSG), the Community First Community Investment (CFCI) model. SSG is a LACDMH legal entity and also manages the IH location. Services to these residents are provided via enrollment in the SSG Full Service Partnership Program. The CFCI model is limited in terms of its target population in that all referrals originate from Twin Towers Correctional Facility and are Misdemeanor Incompetent to Stand Trial (MIST). This approach essentially ties enrollment based intensive mental health supports to IH residents including 24/7 crisis response as part of their service array. The project is dissimilar to the proposed project in multiple ways: residents must be released from correctional institution, be MIST and meet criteria for FSP services; While specialty mental health services are provided, interventions for complex health and substance use treatment needs are not; partnership between County entities and managed care organizations is absent.

Prevent Homelessness Promote Health $(PH)^2$ is a joint program between the L.A. County Departments of Mental Health and Health Services Housing for Health that focuses on housing

stabilization. $(PH)^2$ works with adults and families countywide to address risk factors and build skills that support the maintenance of permanent and stable housing. Services consist of brief interventions and other appropriate treatment modalities which are provided by an integrated team of mental health clinicians and physical health care staff and providers. Individuals are referred to $(PH)^2$ by case managers in permanent supportive housing sites when a tenant is deemed at risk for eviction. Though the program does offer collaboration between County departments it is fundamentally different than the proposed project in that interventions take place in permanent supportive housing settings with the intention of preventing eviction. Conversely, the IH multidisciplinary teams will provide treatment interventions and supportive services while individuals are in transitional housing thereby reducing premature exists from interim housing and increasing the likelihood of successful transition to, and maintenance of, permanent housing. Further, IH multidisciplinary teams have the added layer of interventions related not only to physical health with the Department of Health Services but also substance use via onsite harm reduction interventions (e.g., distribution of naloxone and fentanyl test strips), group treatment and immediate access to dedicated inpatient substance use treatment beds for IH residents.

In response to the COVID-19 pandemic, multiple types of interim housing sites were established in 2020 to serve PEH deemed to be at high risk for adverse health outcomes if infected with the virus. Project Roomkey, for example, used hotels and motels to provide PEH with non-congregate shelter and managed to significantly increase the interim housing bed capacity in Los Angeles County almost overnight. In addition, there were congregate interim housing sites that were temporarily established at recreation centers operated by the City of Los Angeles Department of Recreation and Parks as well as Quarantine & Isolation interim housing sites that were set up at hotels and recuperative care sites for those testing positive or exposed to COVID-19.

Disaster Service Workers (DSWs) from across County Departments were deployed to these interim housing sites to respond to a wide variety of individual needs. LACDMH DSWs, for example, were called upon to provide mental health support, triage, assessment, treatment and crisis intervention to individuals who were experiencing symptoms associated with severe mental illness and/or psychiatric crisis. In fact, throughout the course of the pandemic, in excess of 10,000 individuals from these interim housing sites were served (10,435 as of January 2022) with over 46% of them (or approximately 4,800) having a diagnosis of severe mental illness. Similarly, DSWs from DHS, DPH and the Department of Public Social Services also provided support to residents of these same interim housing sites including on-site medical care for chronic health conditions, assessment and linkage to substance abuse treatment services and connection to in-home supportive services to aid individuals with ADLs/IADLs.

The resulting collaboration between County Departments served as a lifeline to support the interim housing providers and the individuals staying in the interim housing sites and allowed for coordinated and ongoing care across the various County systems for those individuals with more complex needs and co-occurring disorders. Unfortunately, the practice of using DSWs was short term and did not extend to the hundreds of other interim housing locations throughout Los Angeles County that had been established prior to the pandemic.

B. Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

In developing the proposed project in interim housing settings, we investigated local models of service delivered by interim housing providers in Los Angeles County, including models established during the COVID pandemic. Additionally, we reviewed literature focused on the provision of services in interim housing/shelter settings. Search terms in EBSCOhost and Google Scholar were as follows:

- Services in interim housing settings
- Services in homeless shelters
- Mental health treatment in homeless shelters
- Multidisciplinary treatment in homeless shelters

A review of literature was conducted to assess research related to integrated service delivery in interim housing/shelter settings. There are clear gaps in literature focused on the integration of services in adult settings. Though little research on this specific topic was available as a whole, most proximal research on the topic pertains to interventions made for women and families, more specifically, child and family traumatic stress interventions in emergency family shelters (Snyder 2002) and the use of trauma focused cognitive behavioral therapy for children in shelters (Spiegel et al 2022).

In studies focused on adult populations, the research questions pertained to shelter resident's access (or lack thereof) to social services in traditional settings. Stenius-Ayoade, A (2017) for example, examined the degree to which residents of homeless shelters accessed mainstream social service resources such as primary care and emergency room visits based on a diagnosis of mental illness, substance use disorders of co-occurring mental illness and substance use. Fokuo, J et al (2020) explored the feasibility of implementing a screening, testing and treatment protocol for treat hepatitis C in homeless shelters as a means of reducing hepatitis C infections amongst people experiencing homelessness. In study on the establishment of behavioral services in homeless shelters (Kalahasthi, R. et al 2022) held small similarities to the mental health treatment aspect to be implemented in the proposed innovations project, however the sample size was substantively smaller than the target population for this project (n=98).

The analysis illustrated that focusing on shelter residents' distress at the time of intake in homeless shelter settings significantly reduced mental health stress levels. Further, residents who at intake reported negative experiences with outside mental health agencies and where thereby reluctant to engage in treatment, indicated they were willing to engage in mental health services within the shelter setting. The implications from this study while promising for the proposed interventions of the multidisciplinary teams do not reflect the scale and scope of the proposed project wherein the focus is on multiple vulnerabilities (i.e., psychiatric and physical illness, and substance use) that impact health and wellbeing and potentially limit one's ability to access interim housing successfully and/or transition to and maintain permanent housing. Further, the study did not expressly provide interventions catered to those with severe mental illness and lacked the multiagency (public and private), complex vulnerability focus outlined in the proposed project.

Finally, in a study to understand the health care experiences of people experiencing homeless in non-traditional settings (Ramirez, J et all 2022) concluded to achieve optimal health care outcomes for PEH clinical interventions should: (1) utilize shared-decision making during the visit, (2) foster a sense of trust, compassion, and acceptance, (3) emphasize continuity of care, including consistent providers and staff, and (4) integrate social services into Health Care for the Homeless sites. The proposed project addresses all four of the objectives via provision of comprehensive integrated services in a manner that creates maximum accessibility for interim housing residents and

collaborative care coordination between mental health, health and substance use treatment providers. It should be noted that no research articles contained the comprehensive integrated approach outlined in the LACLACDMH multidisciplinary approach to interim housing services proposal.

Citations:
Los Angeles Homeless Services Authority (2022) Greater Los Angeles Homeless Count Deck (2022) https://www.lahsa.org/documents?id=6545-2022-greater-los-angeles-homeless-count-deck slide 12

Los Angeles County Homeless Initiative FY 2023-24 Budget (2023) https://homeless.lacounty.gov/fy-2023-24-budget/

Los Angeles Homeless Services Authority (2022) LA County HC22 Data Summary https://www.lahsa.org/documents?id=6515-lacounty-hc22-data-summary

Stenius-Ayoade, A., Haaramo, P., Erkkilä, E. *et al.* (2017). Mental disorders and the use of primary health care services among homeless shelter users in the Helsinki metropolitan area, Finland. *BMC Health Serv Res* **17**, 428
https://doi.org/10.1186/s12913-017-2372-3

Snyder, Sean (2022) Meeting them where they are at': A practice note on implementation of the child and family traumatic stress intervention in an emergency family homeless shelter. Child & Family Social Work August 8, 2022 https://onlinelibrary.wiley.com/doi/abs/10.1111/cfs.12962

Spiegel, Jamie A. (2022) Addressing Mental Health and Trauma-Related Needs of Sheltered Children and Families with Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) Administration & Policy in Mental Health & Mental Health Services Research. Sep2022, Vol. 49 Issue 5, p881-898. 18p.
https://link.springer.com/article/10.1007/s10488-022-01207-0

Fokuo, J. Konadu et al (2020) Recommendations for Implementing Hepatitis C Virus Care in Homeless Shelters: The Stakeholder Perspective https://aasldpubs.onlinelibrary.wiley.com/doi/full/10.1002/hep4.1492

Kalahasthi, Rupa et al (2022) Establishing behavioral health services in homeless shelters and using telehealth digital tools: best practices and guidelines. Advances in Dual Diagnosis; November 2022, Vol. 15 Issue: Number 4 p208-226, 19p
https://www.emerald.com/insight/content/doi/10.1108/ADD-07-2022-0019/full/html

Ramirez, Jahanett et al (2022) Understanding the primary health care experiences of individuals who are homeless in non-traditional clinic settings BMC Primary Care 23, Article number: 338
https://link.springer.com/article/10.1186/s12875-022-01932-3

Learning Goals & Objectives

A. What is it that you want to learn or better understand over the course of the INN project, and why have you prioritized these goals?
B. How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project.

By implementing the proposed Innovation project, LACDMH's goal is to determine if this approach is a best practice for addressing the needs of the PEH population and supporting their transition to permanent housing. Specifically, LACDMH is interested in answering the questions below.

Does having dedicated field-based, culturally responsive, multidisciplinary, multi-agency teams serving interim housing sites result in the following:

- Increased access and linkages to specialty mental health, health and co-occurring SUD services by interim housing residents?
- Increase and streamline access to non-specialty mental health care provided by managed care plans for interim housing residents.
- Increased linkages to SUD outpatient residential treatment services?
- Increased exits to permanent housing?
- Decreased exits to homelessness?

Decreased use of crisis/emergency services?

- Interim housing provider staff increasing their knowledge and skills when serving individuals with severe mental illness, complex health and substance use disorders and feeling more confident in being able to serve this population in their interim housing sites?
- Increase interim housing providers' ability to discern their capacity to stabilize a interim housing resident's mental health, health and/or substance use disorder in-house versus the necessity to request crisis services or specialty assessment?
- Improve care coordination amongst county departments and managed care organizations?
- Improve our ability to link interim housing to the appropriate level of care/permanent housing resource
- Improve the quality of care in interim housing settings?
- Improve interim housing resident experience and sense of well-being?

Information gained from this Innovation project will inform the way LACDMH and its homeless services system partners design and implement interim housing projects across the County. It will also provide a clearer understanding of the services and supports needed for individuals with severe mental illness and other complex health and substance use conditions who are in interim housing to successfully transition to and maintain permanent housing.

Additionally, we anticipate that the supports offered through this project will enhance accessibility to interim housing for those who otherwise would be regarded as needing a higher level of care due to the complexity and severity of their mental illness and, thereby, help facilitate an opportunity for these individuals to be safely indoors and to have a clear path to permanent housing and recovery in the least restrictive setting.

Evaluation or Learning Plan

LACLACDMH intends to contract the evaluation portion of this project to an external, independent vendor.

Section 3: Additional Information for Regulatory Requirements

Contracting

LACDMH intends to provide the mental health support and mental health promotion and education services using directly operated providers and contracted providers if needed.

-LACDMH will fund services provided by Department of Public Health-Substance Abuse Prevention and Control. DPH-SAPC will expand the capacity of its existing network of providers to provide substance use prevention, harm-reduction and treatment services. Health Services will be provided by DHS. Finally, the managed care partners will fund their own service delivery and work in collaboration with the LACDMH/DPH-SAPC/DHS teams.

Community Program Planning

Los Angeles County Homeless Initiative Planning

The recommendation for this plan was developed as part of the community stakeholder process for the Homeless Initiative. This process engaged community members, local government, persons with lived experience with homelessness, and the Spanish speaking Community.

August-October 2022
18 virtual Listening Sessions that drew more than 750 attendees

- Eight Service Planning Area (SPA) Sessions, one in each SPA
- Seven City/Councils of Government (COG) Sessions, one in each COG area
- Two Sessions with People with Lived Expertise
- One Countywide Session in Spanish

August –October 2022
10 Stakeholder Planning Meetings

- One Homeless Service Provider (Executive Director) Meeting
- Five Homeless Rehousing System Lead Agency planning meetings
- Four Homeless Strategy Lead Department Agency Meetings

Recommendations released November 8, 2022
Public Comment period from November 8-22, 2022

January 31, 2023

- Presentation to LACDMH stakeholders including Underserved Community Leads and the Service Area Leadership Team. Materials were available in Spanish translation and live interpretation was offered in Spanish, Korean and ASL.

February 23, 2023

- Presentation to Los Angeles County Mental Health Commissioners materials were available in Spanish translation and live interpretation was offered in Spanish, Korean and ASL.

This concept was also recommended by the Housing and Homeless Incentive Program stakeholder process implemented by the Housing and Homeless Incentive Program. This process also resulted in a recommendation for an Activities of Daily Living Expansion strategy which will provide funding for:

- DHS's physical health nurses that are part of the multidisciplinary teams
- Caregiving services in interim housing for people with ADL needs
- Enhanced services funding to support health plan members in Adult Residential Facilities and/or Residential Care Faculties for the Elderly

MHSA General Standard
Community Collaboration

A. Cultural Competency

LACDMH is committed to the provision of services that are delivered in a culturally and linguistically responsive, accessible manner. Our Cultural Competency Unit (CCU) ensures that cultural responsiveness is central in the delivery of all services. The CCU promotes a collective sense of shared responsibility for the delivery of services that address health inequities and meets the needs of Los Angeles County's cultural diversity inclusive of racial, ethnic, linguistic, age, gender identity, sexual orientation, socioeconomic status, degree of physical and cognitive ability and disability, spirituality and religious beliefs, and lifestyle choices among others.

The CCU is housed within the departmental Anti-Racism, Diversity and Inclusion (ARDI) Division and has reporting responsibilities to LACDMH's executive management, the California Department of Health Care Services (DHCS), and the Los Angeles County Board of Supervisors (BOS). The ARDI Division provides cultural competency training and technical assistance to LACDMH staff and programs. Additionally, LACDMH's Human Resources Division seeks to aligns its recruitment efforts with diversity needs of LA County residents. All aspects of program delivery will be provided by a culturally competent work force. Further, recruitment strategies will include intentionality to employ staff with lived experience at all levels, thereby optimizing the degree of empathy and impact in supporting the recovery journey of IH residents.

B. Consumer-Driven:

LACDMH is committed to Recovery based treatment in which there is shared decision making and the client is at the center of the treatment planning process, The County's directly operated system of care currently has over 500 designated peer positions within its workforce in addition to a large number of peers and family members in leadership roles throughout the Department. The project has a considerable peer lead component. Each regional planning area has at least one (more in densely populated areas) peer team which will drive treatment planning, service connection and support for interim housing residents.

C. Family-Driven: Youth and Families?

The services provided in the proposed project will be dedicated to the portfolio of interim housing sites throughout Los Angeles County including family shelters. In all instances wherein a IH resident has family and/or significant other whom they wish to involve in their recovery journey, project staff will actively engage them in the planning and treatment plan implementation process. Additionally, family members are represented in the Service Area Leadership Team stakeholder groups which have informed the development of this Innovations project and will be involved in its ongoing updates and evaluations.

D. Wellness, Recovery and Resilience-Focused:

Wellness, Recovery and Resilience are at the heart of the proposed project. The goal of all interventions provided in this project is to support residents interim housing who have severe mental illness and other complex needs (e.g., co-occurring substance use or health disorders) successfully transition to, and maintain permanent housing.

E. Integrated Service Experience for Clients and Family:

Integrated services, health, mental health and substance use, are a core feature of this project. The teams will be made up of multi-agency staff, providing access to all three critical services. Additionally, services will be integrated into the interim housing service system, allowing residents to easily access the supports/ treatment they need without delays and/or barriers (e.g., transportation, accessibility limitations).

Cultural Competence and Stakeholder Involvement in Evaluation

Presentations will be made semi-annually to LACDMH Stakeholder body, LA County Board Homeless and Mental Health Deputies, and LAHSA Interim Housing Service Providers to solicit input on program effectiveness and quality improvement. Additionally, the aforementioned entities as well as the LACDMH Underserved Cultural Communities and Service Area Leadership Team advisory groups will be invited to participate in the academic evaluation of the program.

Innovation Project Sustainability and Continuity of Care.

Communication and Dissemination Plan

A. How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

Updates will be provided to stakeholders on a semi-annual basis via stakeholder meetings which will be offered in person and virtually. The sharing of updates with the community at large (including other counties) will be achieved via positing of the Annual Update and Final Report on for the Innovation project on the County website MHSA webpage. LACDMH will leverage the Service Area leadership Team (SALT) and the Underserved Cultural Communities (UCC) convenings to provide updates, receive community feedback to inform opportunities for quality improvement. Updates on progress will also be provided in the Annual Update and Three-Year plan reports. Annual updates and the final report for the Innovations project will be posted on the County website.

Should the project prove successful LACDMH will assess the level of need, adjust the program accordingly, and continue the provision of specialty mental health treatment by the regional IH teams through the use of MHSA Community Services & Supports paired with Medi-Cal drawdown and consider other local, state and/or federal funding streams (e.g. Measure H, Substance Abuse and Mental Health Service Administration - SAMHSA). DHS and DPH will explore the use of Measure H, Medi-Cal and Drug Medi-Cal to fund ongoing services. Regardless of outcome, LACDMH, DHS and DPH-SAPC will ensure all IH residents in care are connected to ongoing services.

B. KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

Shelter, Interim Housing, In Home Supportive Services, Services in Shelter Settings

Timeline

Specify the expected start date and end date of your INN Project

A. Specify the total timeframe (duration) of the INN Project

B. Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

Quarter	Activities
1 YEAR One Q3	LACDMH: 1. Submit Board Letter to request delegated authority to accept Innovations funding and delegated authority to hire 2. Develop Statement of work to identify independent evaluator 3. Release solicitation for independent evaluator 4. Identify and secure office space for regional teams in collaboration with DHS and DPH-SAPC 4. Establish a workgroup with LACDMH, DHS and DPH-SAPC and Managed Care Plans to develop protocols, polices & procedures, and workflows DPH-SAPC: 1. Amend provider contracts 2. Modify EHR to capture project data 3. Develop/amend internal policies for this project 4. Begin training contracted agency staff 5. Initiate SUD services at identified IH locations 5. Establish relevant memorandums of understanding and data sharing agreements between respective county departments and managed care organizations.
2 YEAR One Q4	1. Recruit, hire and onboard staff 50% of staff 2. Identify training needs for staff 3. Select independent evaluator 4. 5. Develop and implement curriculum to address training needs 6. Establish quarterly convenings with County Depts, Managed Care organizations and interim housing providers 7. Finalize regional interim housing locations to be served 8. Establish team assignment/rotations 9. Begin orientation sessions for service staff and interim housing providers 10. Establish forum for quarterly updates for LACDMH stakeholder groups
3 YEAR Two Q1	1. Recruit, hire and onboard remaining staff 2. Orient and train remaining staff 3. Establish baseline measures for quantitative learning objectives 4. Build out project qualitative goals 5. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers 6. In collaboration with county partners, managed care plans and LACDMH stakeholders develop program evaluation metrics and protocols 7. Develop quarterly report dashboard
4 YEAR Two Q2	1. Roll out regional teams to provide specialty mental health, health and substance abuse treatment for interim housing residents. 2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers 3. Develop and release quarterly report

Quarter	Activities
5 YEAR Two Q3	1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents 2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers 3. Develop and release quarterly report
6 YEAR Two Q4	1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents 2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers 3. Develop and release quarterly report
7 YEAR Three Q1	1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents 2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers 3. Develop and release quarterly report
8 YEAR Three Q2	1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents 2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers 3. Develop and release quarterly report
9 YEAR Three Q3	1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents 2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers 3. Develop and release quarterly report
10 YEAR Three Q4	1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents 2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers 3. Develop and release quarterly report
11 YEAR Four Q1	1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents 2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers 3. Develop and release quarterly report
12 YEAR Four Q2	1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents 2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers 3. Develop and release quarterly report
13 YEAR Four	1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents

Quarter	Activities
Q3	2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers 3. Develop and release quarterly report
14 YEAR Four Q4	1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents 2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers 3. Develop and release quarterly report
15 YEAR Five Q1	1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents 2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers 3. Develop and release quarterly report
16 YEAR Five Q2	1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents 2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers 3. Develop and release quarterly report
17 YEAR Five Q3	1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents 2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers 3. Develop and release quarterly report 4. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers 5. Develop and release quarterly report
18 YEAR Five Q 4	1. Final quarterly convenings with County Depts, Managed Care organizations and interim housing providers 2. Develop final project report

Section 4: INN Project Budget and Source of Expenditures

Budget Narrative

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, “$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000”) and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, “Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…”). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

LACDMH seeks to create new regional, field-based, multidisciplinary teams that are specifically dedicated to serving people experiencing homelessness (PEH) who are living in interim housing. The project is designed to address current gaps in behavioral health and physical health services, support interim housing stability, facilitate transition to permanent housing and prevent a return to homelessness. The Interim Housing Multidisciplinary Assessment and Treatment Teams will serve all eight Service Areas in Los Angeles County and will be comprised of staff from LACDMH, DPH-SAPC and DHS-HFH to ensure the full spectrum of client needs can be addressed. LACDMH Innovations funding will be used to support the mental health component of this effort including the provision of on-site specialty mental health and co-occurring SUD care and supports. Mental health services will include crisis response, outreach, triage, screening/assessment, medication evaluation/administration, crisis intervention (including psychiatric hospitalization when deemed clinically appropriate), linkage to longitudinal care and consultation.

The estimated MHSA cost of the proposed Innovation project will be approximately $156 million. This will support the implementation and administration of 24 teams countywide comprised of multidisciplinary staff providing on-site specialty mental health and co-occurring SUD care and supports including psychiatrists, clinicians, medical case workers, community health workers, licensed vocational nurses, substance abuse counselors and clerical support. This does not include the physical health services provided by DHS-HFH, which is anticipated to be funded using HHIP dollars from the managed care organizations.

MHSA funds are used to support the following INN Program positions and administrative costs.

DIVISION ADMINISTRATIVE TEAM:

1. One (1) Mental Health Program Manager III @ 1.0 Total FTE (Amount = $153,262). This position provides program planning, implementation, and evaluation of program services. The MHPM III will have an active role in directing and participating in the design of this project. The MHPM III has primary responsibility for clinical and administrative oversight, and coordination involving different programs in the service continuum.

2. One (1) Health Program Analyst II @ 1.0 FTE (Amount = $102,231). This position provides administrative oversight and management of INN funding including monitoring data, budgetary oversight, compiling and submission of quarterly and annual reports communication with state etc.

3. One (1) Senior Information Systems Analyst @ 1.0 FTE (Amount = $132,305). This position prepares detailed specifications, addressing scope and boundaries of the system, data requirements, algorithms, user functions, forms and reports, work continuity requirements. Creates data reports and works with the Program to formulate the data elements to report outcomes based on Department and State requirements.

4. One (1) Senior Secretary III @ 1.0 FTE (Amount = $65,437). This position provides support to the Mental Health Program Manager III to manage the clinical and administrative operations of the INN Project more effectively.

5. One (1) Staff Assistant II @ 1.0 FTE (Amount = $66,408). This position provides administrative support to the MH Program Manager III. The Staff Assistant II ensure staff adhere to County policies, procedures, and guidelines; and manages the administrative and office operations at the direction of the Program Manager III.

6. One (1) Senior Typist Clerk @ 1.0 FTE (Amount = $57,787). This position provides administrative and clerical support to the team with data entry into eHR; data tracking and reporting; procurement of services and supplies; managing program assets and facility operations.

PROGRAM ADMINISTRATIVE TEAM:

7. Two (2) Mental Health Program Manager II @ 2.0 Total FTE (Amount = $277,616). This position provides program implementation, management, training, and leadership for the team. The MHPM II has primary responsibility for clinical and administrative oversight.

8. Two (2) Health Program Analyst I @ 2.0 FTE (Amount = $183,448). This position provides administrative oversight and management including monitoring data, budgetary oversight, compiling and submission of reports etc.

9. Two (2) Staff Assistant I @ 2.0 FTE (Amount = $109,853). This position provides administrative support to the MH Program Manager II. The Staff Assistant I ensure staff adhere to County policies, procedures, and guidelines; and manages the administrative and office operations at the direction of the Program Manager II.

10. Two (2) Secretary III @ 2.0 FTE (Amount = $107,716). This position provides support to the Mental Health Program Manager II to manage the clinical and administrative operations of the INN Project more effectively.

11. Two (2) Senior Typist Clerk @ 2.0 FTE (Amount = $97,117). This position provides administrative and clerical support to the team with data entry into eHR; data tracking and reporting; procurement of services and supplies; managing program assets and facility operations.

SERVICE TEAMS:

12. Twelve (12) Mental Health Clinical Supervisor @ 12.0 Total FTE (Amount = $1,112,704). This position Supervises a multi-disciplinary clinical team including assignment and review of work, conducts orientation, trains, and evaluates work performance. Provides clinical consultation to full time staff, prepares daily work schedules, responds to field calls, monitors monthly productivity reports, and reviews reports on a regular basis.

13. Twenty-four (24) Psychiatric Social Worker II @ 24.0 Total FTE (Amount = $1,991,693). This position provides outreach and engagement, screenings and assessments, crisis intervention, case management including referrals, mental health and substance use treatment, habilitation, legal advocacy, and housing services to clients.

14. Twenty-Four (24) Medical Case Worker IIs @ 24.0 Total FTE (Amount = $1,536,017). This position provides outreach and engagement, screenings, crisis intervention, case management services including referrals, habilitation, and housing services to clients.

15. Twelve (12) Licensed Vocational Nurse I @ 12.0 Total FTE (Amount = $629,436). This position provides medical services such as injections, labs, and blood work.

16. Eleven (11) Supervising Community Health Workers @ 11.0 Total FTE (Amount = $608,699). This position provides Supervision to a team of Community Health Workers and/or MH Advocates.

17. Fifty-five (55) Community Health Workers @ 55.0 Total FTE (Amount = $2,504,709). This position provides peer support, outreach and engagement, crisis intervention, case management and housing services to clients.

18. Twelve (12) Intermediate Typist Clerk @ 12.0 FTE (Amount = $516,316). This position provides general clerical support, including data entry and filing, and assists with producing data reports.

SERVICE NAVIGATION & DISPATCH TEAM:

19. One (1) Senior Mental Health Counselor RN @ 1.0 Total FTE (Amount = $133,568). This position Supervises a multi-disciplinary clinical team including assignment and review of work, conducts orientation, trains, and evaluates work performance. Provides clinical consultation to full time staff, prepares daily work schedules, responds to field calls, monitors monthly productivity reports, and reviews reports on a regular basis. This position also provides clinical supervision and consultation to nursing staff.

20. One (1) Mental Health Clinical Supervisor @ 1.0 Total FTE (Amount = $92,725). This position Supervises a multi-disciplinary clinical team including assignment and review of work, conducts orientation, trains, and evaluates work performance. Provides clinical consultation to full time staff, prepares daily work schedules, responds to field calls, monitors monthly productivity reports, and reviews reports on a regular basis.

21. Two (2) Mental Health Counselor RN @ 2.0 Total FTE (Amount = $299,652). This position performs mental and physical clinical assessments and medication management duties. Conducts interviews to assess a client's mental status, developmental status, substance abuse problems as well as needs in the areas of both mental and physical health. As part of this team triages referrals and directs the flow to appropriate level of care.

22. Four (4) Psychiatric Social Worker II @ 4.0 Total FTE (Amount = $331,949). This position provides outreach and engagement, screenings and assessments, crisis intervention, case management including referrals, mental health and substance use treatment. As part of this team triages referrals and directs the flow to appropriate level of care.

23. Four (4) Patient Financial Services Worker @ 4.0 FTE (Amount = $216,496). This position assists the program on determining patients' financial eligibility to reimburse the County for healthcare services; interviews and refers patients for benefits; verifies information and explains County policies; may secure payments and arrange payment plans on behalf of the program.

24. Two (1) Senior Typist Clerk @ 2.0 FTE (Amount = $97,117). This position provides administrative and clerical support to the team with data entry into eHR; data tracking and reporting; procurement of services and supplies; managing program assets and facility operations.

PSYCHIATRIC TEAM:

25. One (1) Supervising MH Psychiatric @ 1.0 Total FTE (Amount = $303,556). This position provides clinical and administrative supervision to psychiatrists and medical prescribers including directing patient care with a caseload of more complex clients.

26. Eight (8) Mental Health Psychiatrists @ 8.0 Total FTE (Amount = $2,081,943). This position allows LACDMH to evaluate and determine client needs for psychotropic medications; prescribe and administer medications as necessary; and monitor the client's response to medication. The

Psychiatrist writes 72-hour holds for assessment of involuntary treatment and provides strong and credible advocacy for continued in-patient care.

27. Fringe Benefits are the sum of Variable Employee Benefits @ 43% of salaries (Amount = $10,270,000). This includes such employee benefits as medical, dental, vision, short and long-term disability, and retirement.

28. Services and Supply costs (Amount = $3,853,800). These costs are for staff supplies and equipment to conduct business related to the INN program including telephone, telecommunication (Cell Phone), Office Supplies, Personal Computer Software, Computers

Printer/Peripherals (Scanner), Space, Training, Mileage, Travel, Utilities and Uniforms. Equipment will be used for data entry, prepare documentation and related reports as part of the outreach and engagement, screenings, crisis intervention, case management services including referrals, habilitation and housing services to clients.

29. Client Services and Supplies costs consist of client support services such as personal supplies including but not limited to food, water, toiletries, clothing, shoes, etc. that may be provided to clients during the outreach and engagement process (Amount = $140,000) and CAL-cards costs (Amount = $560,000).

30. Other Charges include Direct Service Order to LAC Department of Public Health to provide 28 CENS staff, 10 Residential Treatment beds, and harm reduction kits (Amount = $8,977,060.00)

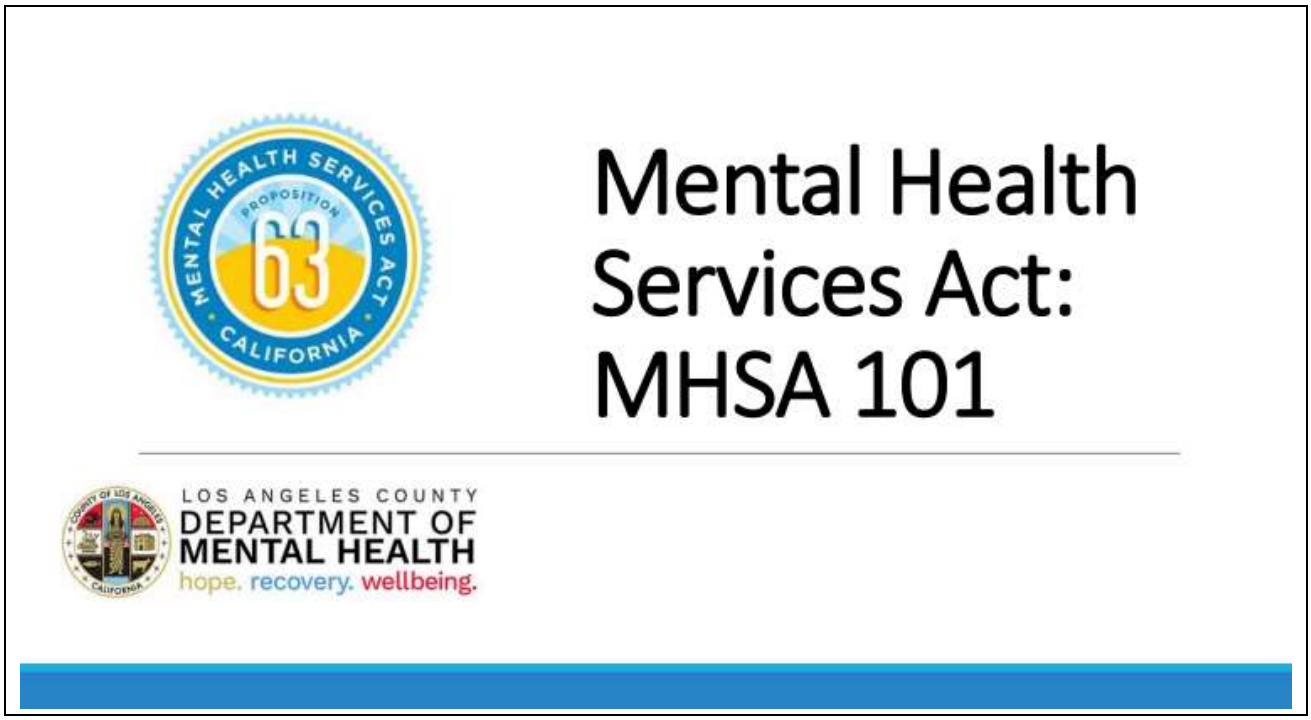
31. Other Expenses include capital assets for the purchase of county vehicles. Capital asset costs for the purchase of fifty (50) vehicles to transport clients to access services and supports such as housing providers, medical services, DPSS, and related community supports to provide linkage and access to care (Amount = $1,406,760).

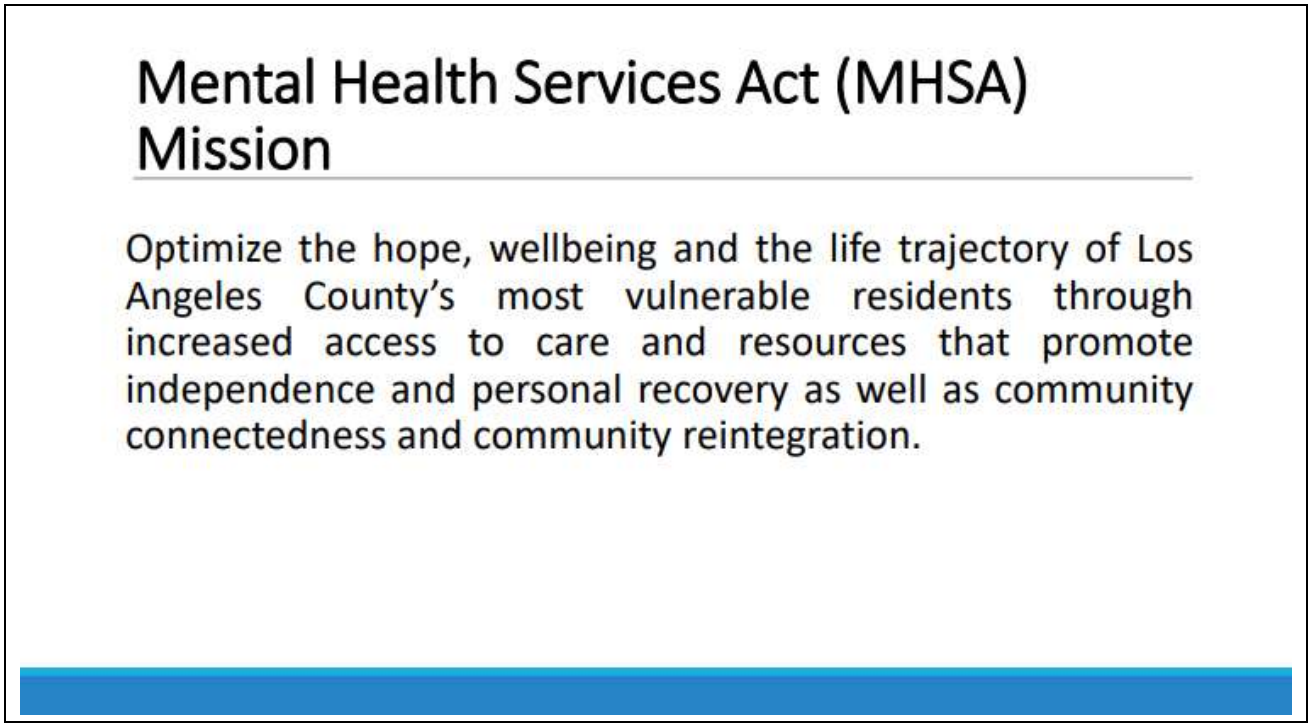
32. County Indirect Administrative Costs (MHSA Amount = $3,894,055). LACDMH does not have a negotiated indirect cost rate agreement and has elected to claim the 10 percent de minimis indirect rate, although our actual rates exceed this amount. LACDMH's indirect costs are comprised of various administrative cost pools, which include but are not limited to Financial Services, Human Resources, Information Technology, Procurement and Contracts.

5 Year Budget	FY 23/24	FY 24/25	FY 25/26	FY 26/27	FY 27/28	TOTAL
Personnel	$24,019,433	$24,019,433	$24,019,433	$24,019,433	$24,019,433	$120,097,163
Operating Costs	$13,530,860	$13,530,860	$13,530,860	$13,530,860	$13,530,860	$67,654,300
Non-recurring costs	$1,406,760	$	$-	$-	$-	$1,406,760
Evaluation	$750,000	$1,000,000	$1,000,000	$1,000,000	$ 1,000,000	$4,750,000
Indirect Costs	$3,895,705	$3,755,029	$3,755,029	$3,755,029	$3,755,029	$18,915,822
Total	**$43,602,758**	**$42,305,322**	**$42,305,322**	**$42,305,322**	**$42,305,322**	**$212,824,045**

Funding Source	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
Innovation Funds	$32,173,465	$30,876,029	$30,876,029	$30,876,029	$30,876,029	$155,927,580
Medi-Cal Funding	$11,429,293	$11,429,293	$11,429,293	$11,429,293	$11,429,293	$57,146,465
Total	**$43,602,758**	**$42,305,322**	**$42,305,322**	**$42,305,322**	**$42,305,322**	**$212,824,045**

Appendix B – Mental Health Services Act Trainings





MHSA Vision

The MHSA pledges to look beyond "business as usual" to build a community mental health system where access to care is easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists.

Presentation Overview

- Prevalence of Mental Health Disorders
- Lack of Access and Impact
- Proposition 63: Legislation to Address Mental Health Need
- MHSA: What it is and how it works
- Core Principles
- Focus
- Stakeholders Engagement is Essential
- The Five MHSA Program Components
- MHSA Key Findings
- MHSA Oversight
- Additional Resources
- MHSA Proposal Process
- MHSA Resolution Process

Prevalence of Mental Health Disorders

Mental illnesses are among the most common health conditions in the United States

Mental disorders are common in the United States, with 1 in 5 adults, 52.9 million people, having a mental disorder in any one year

More than half of Americans report that COVID-19 has had a negative impact on their mental health

In California, 1,243,000 adults have a serious mental illness

396,000 Californians age 12–17 have depression

Lack of Access and Impact

- More than half of people with a mental health condition in the U.S. did not receive any treatment in the last year
- Of the 1,562,000 adults in California who did not receive needed mental health care, 35.3% did not because of cost
- In February 2021, 46.1% of adults in California reported symptoms of anxiety or depression. 21.9% were unable to get needed counseling or therapy
- It should be noted that cultural, racial, and ethnic populations have been disproportionately affected as they access mental health services at a lower rates

Proposition 63: Legislation to Address Mental Health Needs

On November 2, 2004, California voters passed Proposition 63 by majority.

Prop 63, also known as the millionaires' tax, became effective as a statute, the Mental Health Services Act (MHSA) on January1, 2005.

MHSA seeks to expand and improve mental health services across the state by providing additional funding and oversight and accountability.

Prior to MHSA funding for mental health services was deficient, for example Los Angeles County authorities estimated providing services to only half of those needing public mental health services.

Thirty years ago, the State of California cut back on its services in state hospitals for people with severe mental illnesses, without providing adequate funding for mental health services in the community many people became homeless.

What is MHSA?

A 1% tax on personal income above $1 million dollars to fund MHSA programs and projects to greatly improve the delivery of community-based mental health services and treatment across California.

Welfare and Institutions Code (WIC)5891 states that MHSA revenues may only fund mental health services, MHSA programs and activities and prohibits these funds from supplementing other existing County funds.

Since the State of California decentralized its behavioral health system, most MHSA funding is administered by each California counties.

How does MHSA work?

Funds programs and services that seek to reduce the long-term adverse impact of untreated mental illness

Transforms the public mental health system from "fail first," often resulting in treatment delivery through the criminal justice system, the courts, and emergency rooms to "help first," with a commitment to service, support, and assistance through community based intensive and preventative treatments and interventions on individual need.

MHSA addresses a broad continuum of county mental health services for all populations: children, transitional age youth, adults, older adults, families, unserved and underserved.

MHSA Core Principles

- Client/Family Driven Services
- Cultural Competence
- Community Collaboration
- Service Integration
- Focus on Recovery, Wellness, and Resilience

- Increased and targeted access to services for un-served and underserved populations
- Prioritizing individuals' recovery and wellness goals
- Implementation of effective and sustainable programs and services
- Administration and oversight of cost-effective expenditures
- Engaging stakeholder in meaningful involvement in the ongoing development and implementation of programs and services based on their individual community needs

Focus of MHSA

Stakeholder Engagement is Essential

- Title 9 CCR 3300 requires CA Counties to provide a Community Program Planning Process (CPPP) for developing MHSA 3-YR Plans and Annual Updates and to ensure stakeholders have the opportunity to participate in the CPPP (referred to as CPP)
- Stakeholders must represent all populations across all 8 service areas in LAC and must represent unserved and underserved populations and their families, cultural communities reflecting their demographics and geographic locations.
- In addition to the CPP, stakeholders provide DMH with feedback on nonMHSA funded programs and services to ensure community feedback on all programs and services across the system

Meaningful Stakeholder Involvement is Essential

"Meaningful" stakeholder involvement should be reflected in mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocation."

Stakeholder Engagement is Essential

MHSA funded initiatives should engage:

- Families of Children, Adults, and Seniors with serious mental illness or severe emotional disturbance
- Providers of Mental Health Services
- Law Enforcement agencies
- Education and Social Services agencies
- Veterans and representatives from Veterans organizations
- Providers of alcohol and drug services
- Health Care organizations
- Other important interests

Stakeholder Bill of Rights

Transformation: We have the right to a Public Mental Health System (PMHS) that embraces the Recovery Model of Care and is fully committed to all General Standards for programs and services set forth by the MHSA

Information: We have the right to full transparency in our PMHS

Education: We have the right to fully understand the meaning and implications of facts and data relevant to our PMHS

Representation: We have the right to competent and adequate representation when important decisions are made in our PMHS

Participation: We have the right to shape policy and meaningfully participate in all important programming and funding decisions in our PMHS

Consideration: We have the right to submit grievances to our PMHS, to have our grievances acknowledged, and to receive thorough and timely responses to our grievances

MHSA Components

CSS Community Services and Supports (CSS)

Direct mental health services and supports for children and youth, transition age youth, adults, and older adults. The largest of the 5 components.

Permanent supportive housing for clients with serious mental illness

WET Workforce, Education and Training

Enhancement of the mental health workforce through continuous education and training programs

PEI Prevention and Early Intervention

Services to engage individuals before the development of serious mental illness or at the earliest signs of mental health struggles. The second largest of the 5 components

Statewide projects: Suicide Prevention, Student Mental Health Initiative, Stigma and Discrimination Reduction

CFTN Capital Facilities and Technological Needs

Building projects and improvements of mental health services delivery systems using the latest technology

INN Innovation

Opportunities to design and test time-limited new or changing mental health practices that have not yet been demonstrated as effective, and to fuse such practices into the mental health system, thereby increasing:

- access to underserved communities,
- promotion of interagency collaboration, and
- the overall quality of mental health services

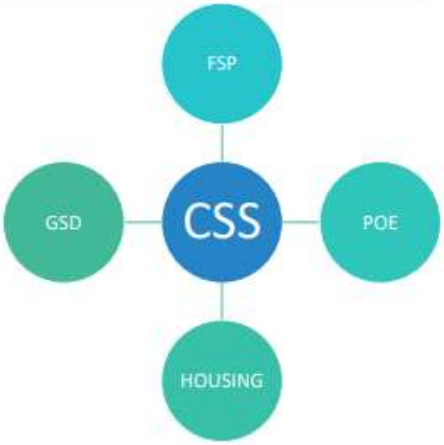
Community Services and Supports

Full Service Partnership (FSP): Community collaboration and a "whatever it takes" approach to ensure full spectrum community-based mental health service delivery to individuals from identified focal populations

General Service Development (GSD): Services that include programs to improve mental health services and supports for all consumers

Planning Outreach and Engagement (POE): Activities aimed at engaging the unserved, underserved, and inappropriately served populations

Housing: Partnership with the California Housing Finance Agency, CSS provides funding for permanent supportive, affordable housing for individuals with mental illnesses and their families, especially those who are homeless



CSS Funded Programs

- Outpatient Care Services (OCS)
  - Transition Age Youth (TAY) Probation Camps
  - TAY Drop-In Centers
  - Integrated Care Program (ICP)
  - Service Extenders
  - Older Adult Training
- Alternative Crisis Services (ACS)
  - Residential and Bridging Program
  - Psychiatric Urgent Care Centers
  - Enriched Residential Services
  - Crisis Residential Treatment Programs
  - Law Enforcement Teams
- Full Service Partnership (FSP)
  - Adult (Integrated Mobile Health Team (IMHT), Assisted Outpatient Treatment (AOT), Homeless, and General)
  - Children (General, Wraparound and Intensive Field Capable Clinical Services (IFCCS))
- Housing Services
  - Interim Housing Program
  - Enriched Residential Care (ERC) Program
  - Housing Assistance Program (HAP)
  - Housing for Mental Health
  - Federal Housing Subsidies Program
- Linkage to County-Operated Functions/Programs (Linkage)
  - Mental Health Court Linkage Program
  - Jail Transition and Linkage Services
  - Service Area Navigation
- Planning, Outreach, and Engagement Services (POE).
  - Underserved Cultural Communities Unit (UsCC)
  - Service Area Outreach Teams

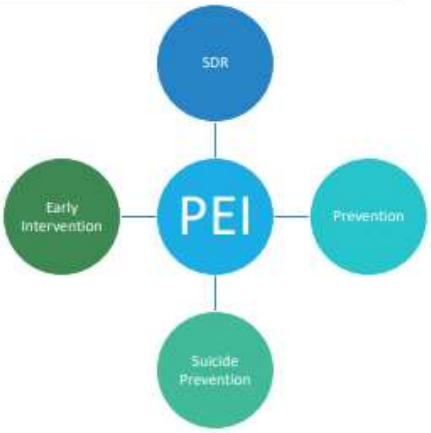
Prevention and Early Intervention

Prevention: Proactive approach that targets those with risk factors or increases protection factors

Stigma and Discrimination Reduction (SDR): Training, campaigns and activities to reduce and eliminate barriers that prevent people from accessing mental health services. Services feature anti-stigma education specifically targeting underrepresented communities through outreach utilizing culturally sensitive tools; connecting and linking resources to schools, families, and community agencies; and educating and empowering clients and families

Suicide Prevention: Services and training to strengthen the capacity of existing community resources and creating new collaborative and comprehensive efforts at the individual, family, and community level. Services include: community outreach and education to identify suicide risks and protective factors; linking services, including access to trained suicide hotline agents, to individuals contemplating, threatening, or attempting suicide

Early Intervention: Of individuals and families for whom a short, relatively low-intensity intervention is appropriate to resolve or improve mental health issues and avoid the need for higher levels of care



PEI Funded Programs

- Library Child, Family and Community Prevention Programs
- My Health LA Behavioral Health Expansion Program
- Prevent Homelessness Promote Health (PH2)
- SEEDS Trauma-Informed Care for Infants & Toddlers
- Veterans Peer Access Network (VPAN)
- Mental Health First Aid (MHFA)
- Mental Health Promoters
- Latina Youth Program
- 24/7 Crisis Hotline
- School Threat Assessment Response Team (START
- Youth Diversion and Development (YDD)

Innovation (INN)

Up to 5 percent of MHSA funds received for CSS and PEI may be used for innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

An Innovation project must have one of the following primary purposes:

- Increase access to mental health services to underserved groups
- Increase the quality of mental health services, including measurable outcomes
- Promote interagency and community collaboration related to mental health services or supports or outcomes
- Increase access to mental health services

Workforce Education and Training (WET)

WET supports programs designed to address the fundamental concepts of creating and supporting a workforce (present and future) that is culturally competent, provides consumer/family centered mental health services and adheres to the principles of wellness, recovery, and resilience.

This component aims to train more people to remedy the shortage of qualified individuals who provide services to address severe mental illness. Counties may use funds to promote employment of mental health clients and their family members in the mental health system and increase the cultural competency of staff and workforce development programs.

WET Funded Programs

- UCLA and Charles Drew Affiliation
- Training and Technical Assistance
- Navigator Skill Development Program
- Licensure Preparation Program
- Intensive Mental Health Core Training Program
- Peer Specialist/ Parent Partner Training
- Financial Incentive Programs
- Stipend Program for Psychologists, MSWs, MFTs, and NPs

Capital Facilities and Technological Needs

CFTN's objective is to increase and improve existing capital facilities infrastructure and support technology projects to accommodate the implementation of MHSA plans.

This component finances necessary capital and infrastructure to support implementation of other MHSA programs. It includes funding to improve or replace technology systems and other capital projects.

Capital Facilities Needs Projects

- Funding is used for land and building acquisitions
- Construction of mental health service facilities and administrative space
- Renovation and expansion of existing County-owned facilities which require modernization and transformation to provide an environment for clients and families

Technological Needs Projects

- IBHS
- Contract Provider Technology Projects
- Consumer/Family Access to Computer Resources
- Personal Health Record Awareness and Education
- Data Warehouse Re-design
- Virtual Care: Tele-Psychiatry

MHSA Key Findings

- ✓ The Los Angeles County Department of Mental Health has used funding from California's Mental Health Services Act to offer mental health and support services to at-risk populations.
- ✓ The mental health programs evaluated provided services to vulnerable and diverse individuals across the county.
- ✓ Prevention and Early Intervention programs for youth were associated with staying well and improvement in mental health outcomes.
- ✓ Full-Service Partnership programs, which focus on doing "whatever it takes" to improve the lives of those with serious mental illness, were associated with improvements in life circumstances and health

MHSA Reporting

THREE YEAR PROGRAM AND EXPENDITURE PLAN AND THE ANNUAL UPDATE

Welfare and Institutions Code (WIC) Section 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan (Plan) followed by Annual Updates for Mental Health Services Act (MHSA) programs and expenditures.

The MHSA Plan provides an opportunity for the Los Angeles County Department of Mental Health (LACDMH) to review its MHSA programs and services and obtain feedback from a broad array of stakeholders on those services. Any changes made to the MHSA programs would need to be in accordance with the MHSA, current regulations, and relevant State guidance.

MHSA Oversight

State Department of Mental Health	State Department of Health Care Services (DHCS)	Mental Health Services Oversight and Accountability Commission (OAC)
• The former SDMH was responsible for planning the sequential phases of development for the five MHSA components and overseeing county implementation of MHSA	• DHCS is primarily responsible for overseeing local mental health agencies' spending of MHSA funds. • DHCS contracts with each county for the following components: PEI programs; Children's services; and Adult services	• The OAC oversees MHSA implementation; develops strategies to overcome stigma; reviews and approves innovation's projects; and provides technical assistance and training to counties, providers, and stakeholders.

Additional Resources

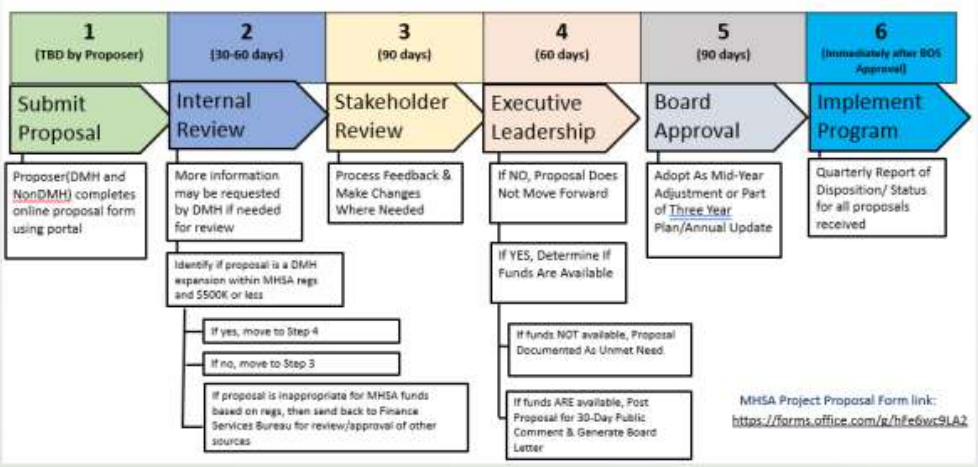
- MHSA Announcements - Department of Mental Health (lacounty.gov)
- Mental Health Services Act (MHSA) (ca.gov)
- MHSA Publication and Resources

Proposing New or Expansion of Existing MHSA Programs and Services

- Stakeholders, DMH directly operated and contracted services providers can propose new programs or services or expansion of existing programs and services;
- Proposals must be submitted electronically at https://forms.office.com/g/hFe6wc9LA2
- Proposals will be reviewed based on the Proposal Review Process and associated timeline
- A quarterly report will be published to confirm the status of proposals submitted.

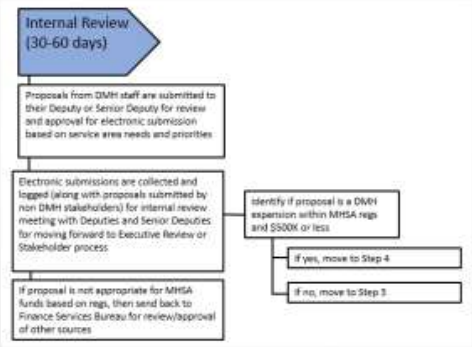
Process for Proposing MHSA Projects

Step 1

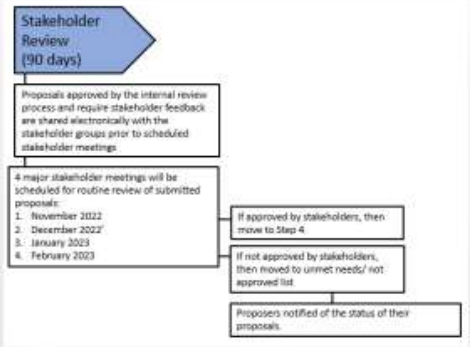


Process for Proposing MHSA Projects

STEP 2



STEP 3



MHSA Issue Resolution Process

The Los Angeles County Department of Mental Health is committed to resolving issues related to the implementation and ongoing operations of its programs. The resolution of issues associated with MHSA-funded programs is part of the Department's overall issue resolution process.

We strive to address and resolve issues as quickly as possible, with an emphasis on increasing service quality. If an MHSA planning, implementation, or operations issue cannot be resolved by the MHSA Issue Resolution & Oversight Division, it will be reviewed by the Department's appointed Community Leadership Team (CLT).

MHSA Issue Resolution Process

TYPES OF MHSA ISSUES THAT MAY BE RESOLVED THROUGH THIS PROCESS:

- Concerns about access or quality of MHSA programs and services
- Inconsistencies between the approved MHSA Plan and implementation
- County MHSA Planning Process

WHAT TO EXPECT WHEN FILING AN ISSUE

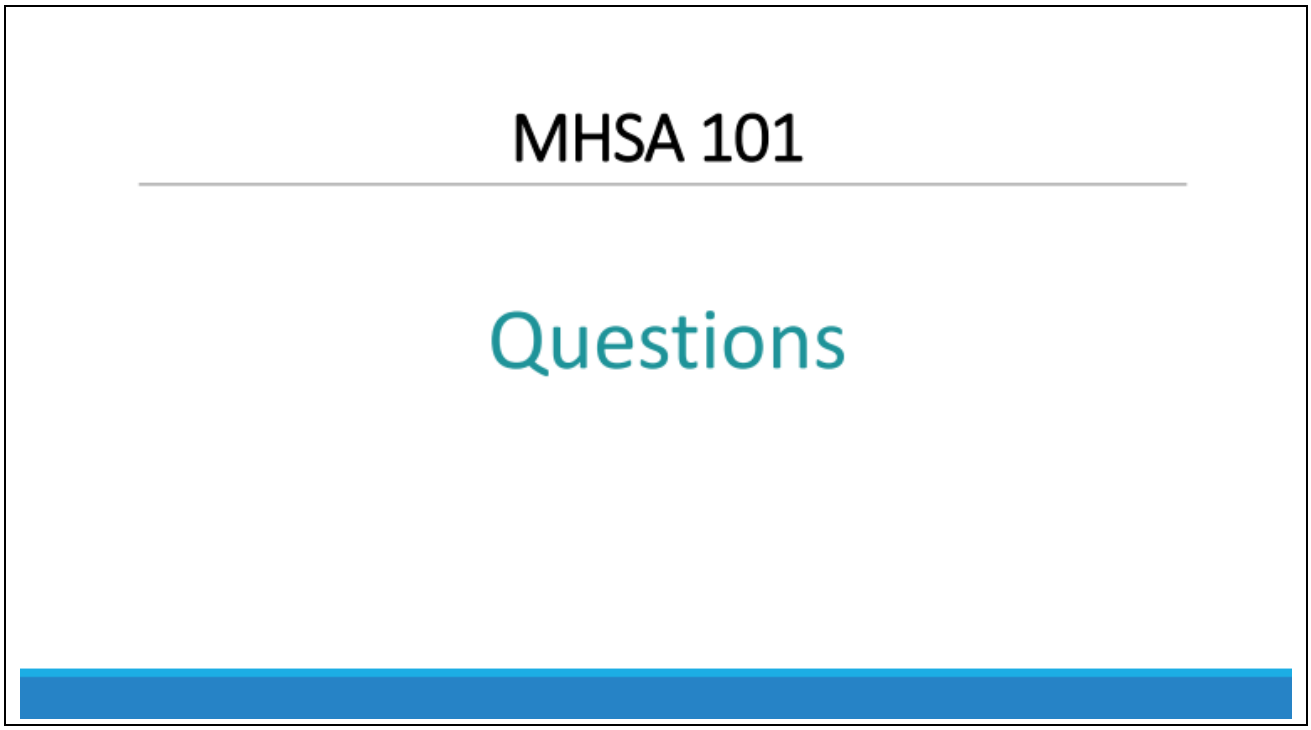
1. The MHSA Administration & Oversight Division will investigate the issue and try to resolve it.
2. If the issue is resolved, the Issue Filer will receive a notification of resolution in writing.
3. If the issue cannot be resolved by the MHSA Administration & Oversight Division, the issue will be referred to the CLT for further review.
4. If the issue was resolved by the CLT, the Issue Filer will receive a notification of resolution in writing.
5. If the CLT did not resolve the issue, the Issue Filer will receive a notification of resolution in writing and he/she may appeal to the State.

MHSA Issue Resolution Process

To file an issue using the MHSA Issue Resolution process, you can:

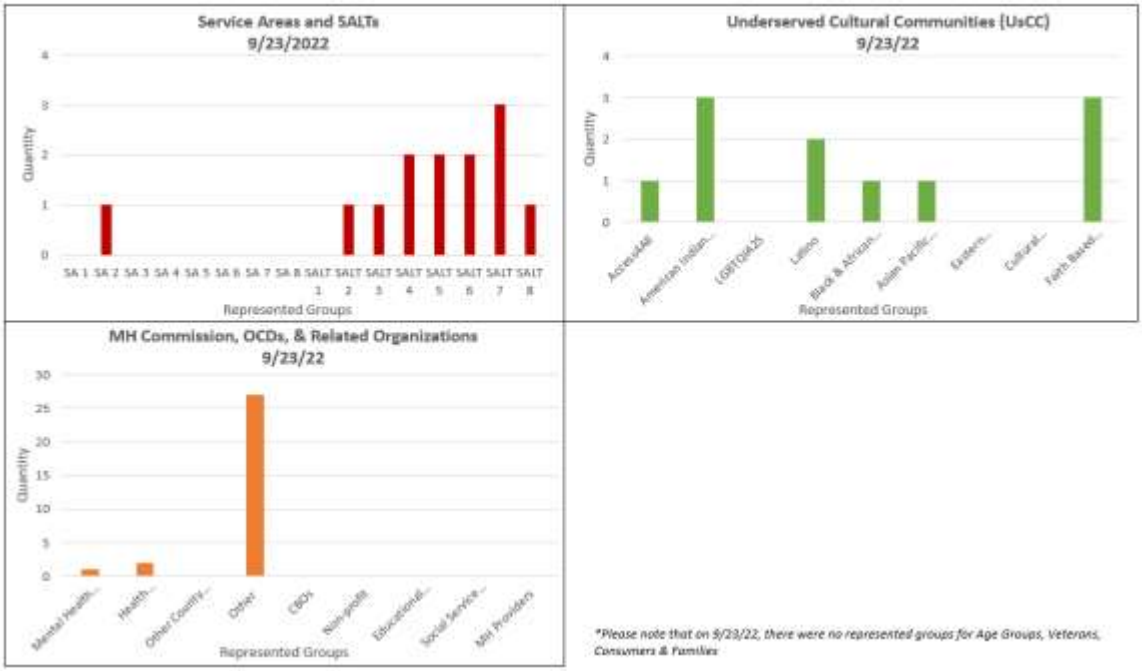
- **File electronically by clicking on the link:** MHSA Issue Resolution Form
- **Type in the URL:** https://forms.office.com/pages/responsepage.aspx?id=SHJZBzjqG0WKvqY47dusgV9p7rKgDu5CmdNEEMqM9uVURDdJSzdESTA3QkRWTE00MFU3NjkzWUFDNi4u&web=1&wdLOR=c2D85291E-11A5-492D-BDF2-60EE147D560B
- File **in-person:** 510 South Vermont Avenue, 1st Floor, Los Angeles, CA 90020
- **For clients receiving mental health services including Medi-Cal Beneficiaries:** Contact the Patients' Rights Office with the Los Angeles County Department of Mental Health at the following (213) 738-4888 or dmh.lacounty.gov/our-services/patients-rights

For more info, contact Darlesh Horn, DPA, Division Chief, at Dhorn@dmh.lacounty.gov or at (213) 943-8475


MHSA 101
Questions

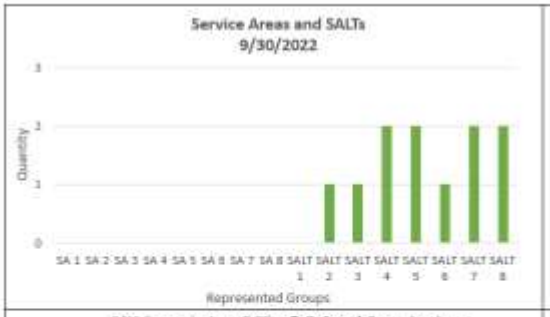
Appendix C – Stakeholder Meeting Participation by Date: September 2022 through March 2023

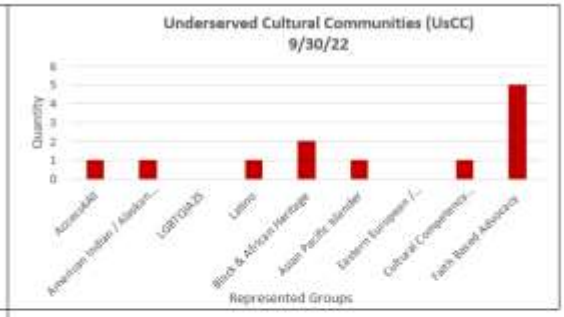
MHSA STAKEHOLDER EVENT DEMOGRAPHICS – September 23, 2022

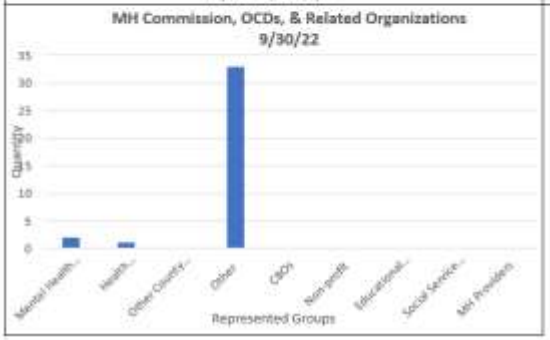


Please note that on 9/23/22, there were no represented groups for Age Groups, Veterans, Consumers & Families

MHSA STAKEHOLDER EVENT DEMOGRAPHICS – September 30, 2022

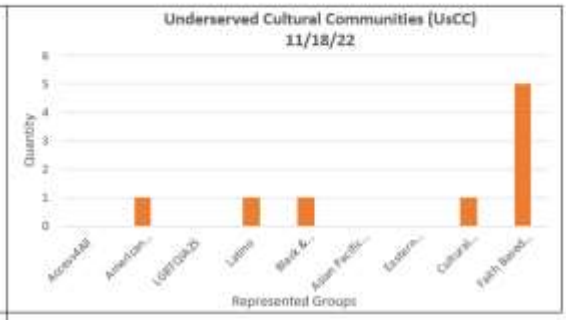


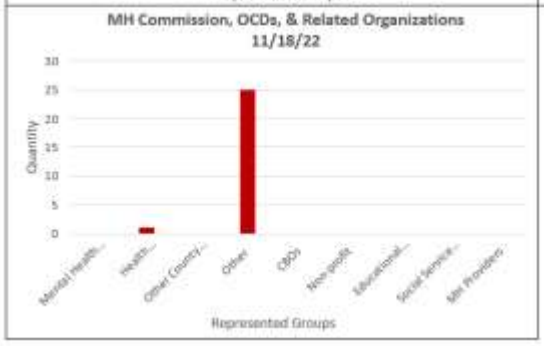




Please note that on 9/30/22, there were no represented groups for Age Groups, Veterans, Consumers & Families

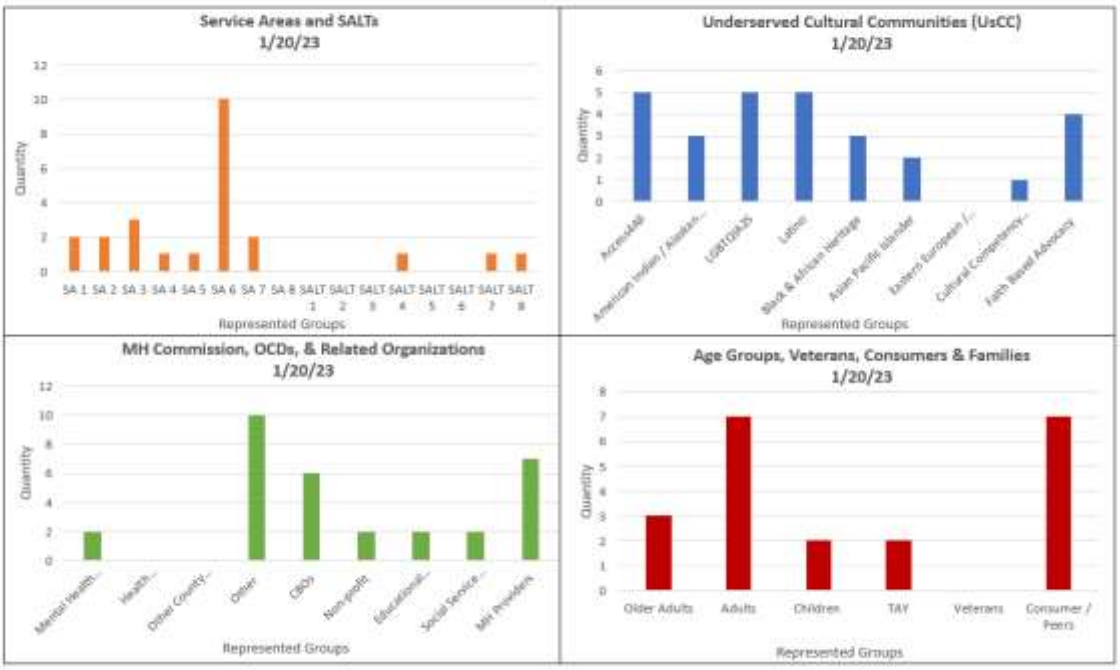
MHSA STAKEHOLDER EVENT DEMOGRAPHICS – November 18, 2022



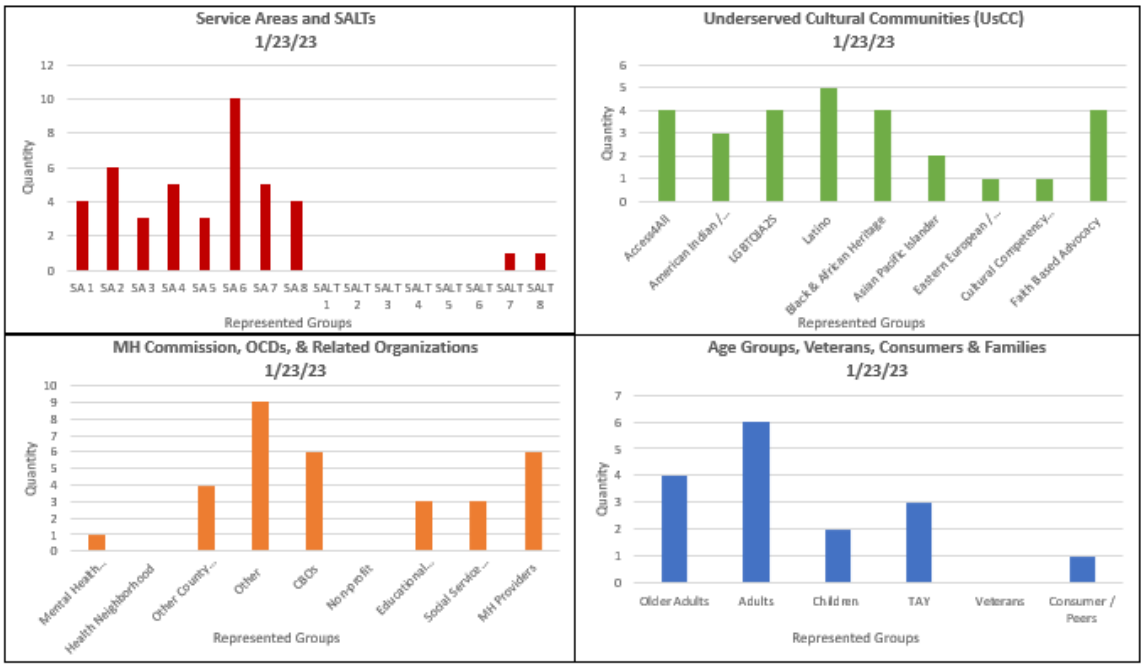


Please note that on 11/18/22, there were no represented groups for Age Groups, Veterans, Consumers & Families

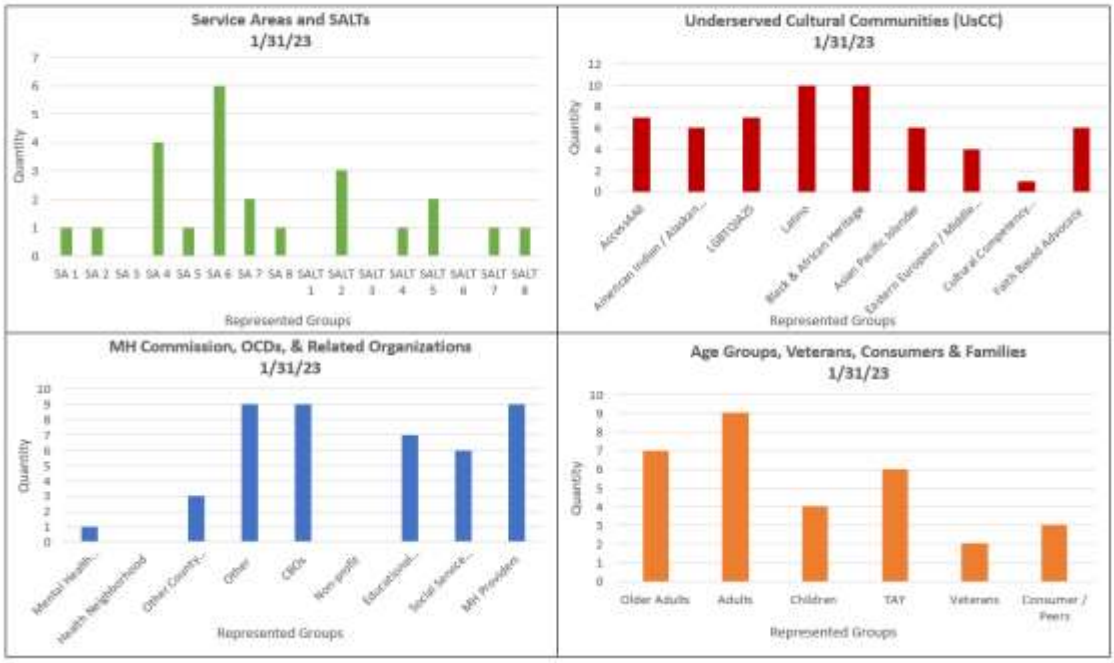
MHSA STAKEHOLDER EVENT DEMOGRAPHICS – JANUARY 20, 2023



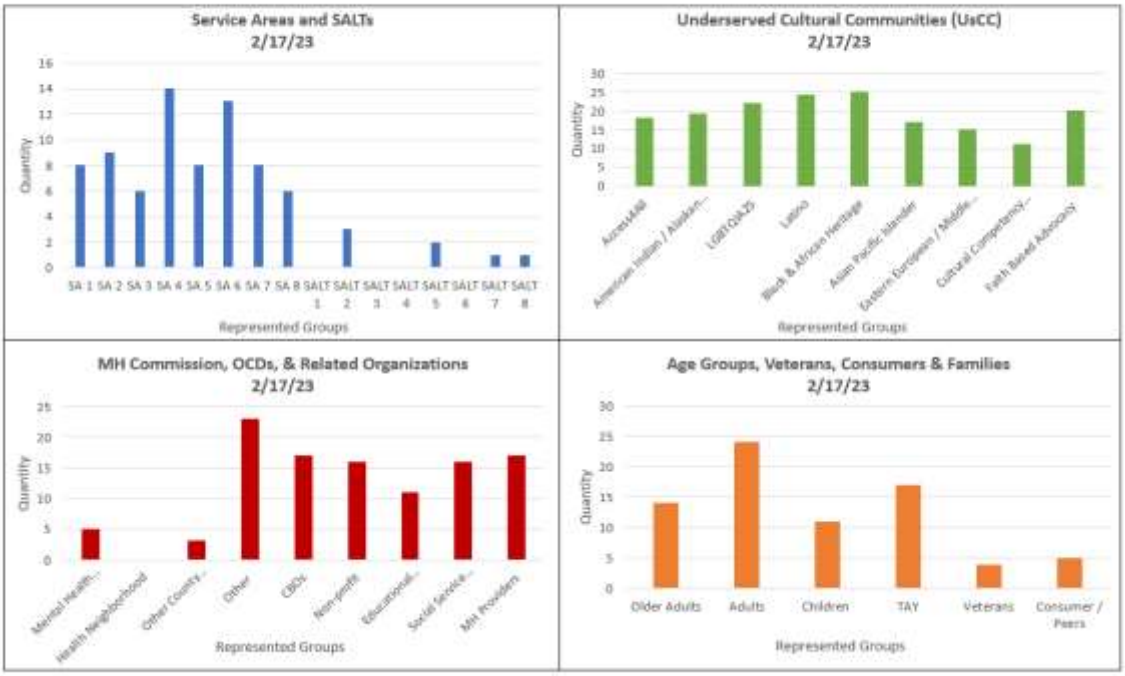
MHSA STAKEHOLDER EVENT DEMOGRAPHICS – JANUARY 23, 2023



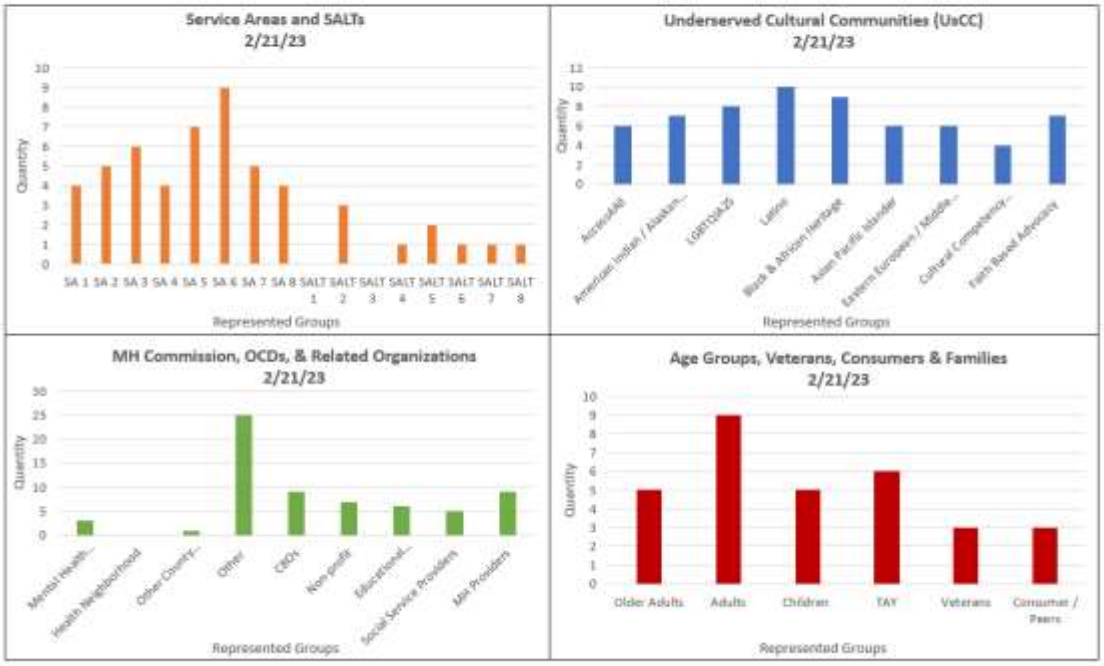
MHSA STAKEHOLDER EVENT DEMOGRAPHICS – JANUARY 31, 2023



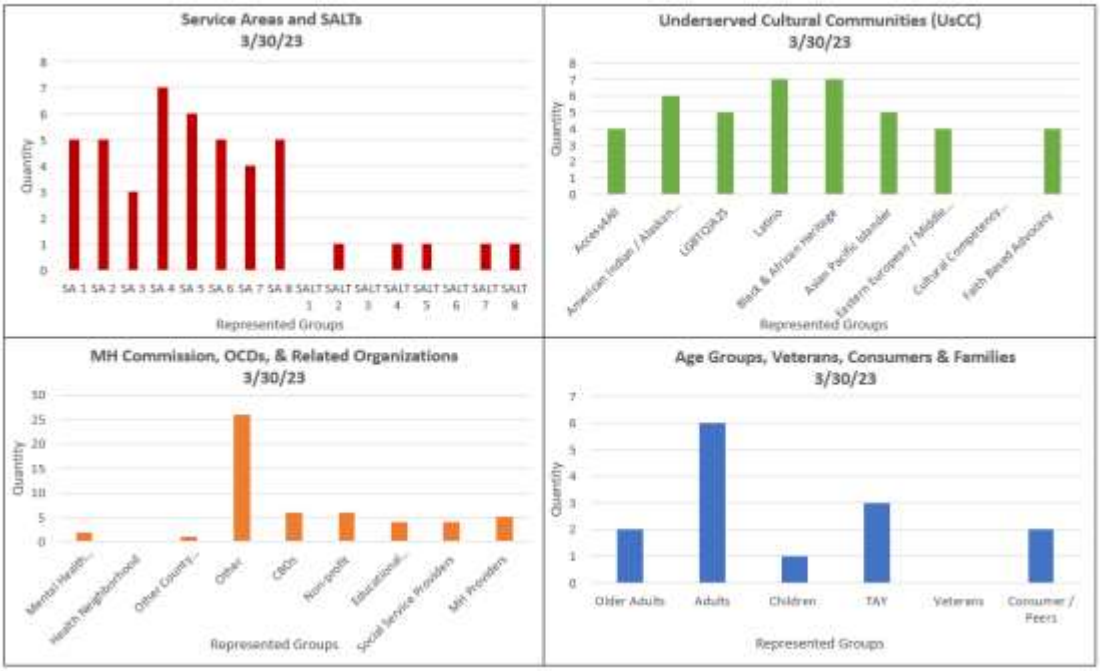
MHSA STAKEHOLDER EVENT DEMOGRAPHICS – February 17, 2023



MHSA STAKEHOLDER EVENT DEMOGRAPHICS – February 21, 2023



MHSA STAKEHOLDER EVENT DEMOGRAPHICS – March 30, 2023



Appendix D – Public Hearing Presentation and Transcripts, April 27, 2013

Public Hearing Agenda (English)

MENTAL HEALTH COMMISSION (MHC) REGULAR MEETING
COUNTY OF LOS ANGELES, CALIFORNIA
"Advocacy, Accountability and Oversight in Action"
Thursday, April 27, 2023, @ 10:30 a.m.

IMPORTANT PUBLIC NOTICE
Hybrid Meeting
Members of the public can attend the MHC meetings in multiple ways:

Attend virtually: MS Teams Link
or scan the QR Code below

Or join the MHC in-person (Voluntary registration requested for in-person attendance, click HERE to register): 510 South Vermont Ave., 9th floor (T) Level Conference Room, Los Angeles 90020.

Free validated parking is available at:
523 Shatto Place, Los Angeles, CA 90020. When entering structure, take a parking ticket and bring it with you to the meeting. Security will validate your ticket.

Other access options:

To listen only via telephone in Spanish	To listen only via telephone in Korean 한국어로 전화로만 들으려면	For Live Closed Captioning (CART)	For American Sign Language (ASL)
Please call 1-888-204-5987 enter access code when prompted: **Participant Access Code 9639884**	1-888-204-5987 866-434-5269 로 전화하여 메시지가 표시되면 액세스 코드를 입력합니다. 참가자 액세스 코드 6699393	Click HERE	Click HERE

Members of the public can address the MHC during the live meeting by attending in-person (see location above), by phone, by email, or by regular mail.

Instructions:

1. **Telephonic Public Comment Instructions:** During the live event, the Commission Chair will make the announcement for public comment, at that time, please call **(844) 291-6362 and enter Participant Code: 4972277**. Press 1 and then 0 to address the Commission. Do not repeat. Repeating removes you from the queue. You may provide your name to the moderator, but you are not required to do so. Public comment is limited to 2 minutes per caller.
2. **Electronic Mail (Email) Written Public Comment**: Email public comment may be submitted to the Commission via email at mhcommission@dmh.lacounty.gov prior to or by the date of the meeting.
3. **Regular Mail Written Public Comment:** Regular mail public comment may be submitted to the Commission by regular mail by prior to or by the date of the meeting to the following address: Attention: Los Angeles County Mental Health Commission, Vermont Corridor Headquarters, 510 S. Vermont Avenue, (22-111), Los Angeles, CA 90020.

Address: 510 South Vermont Avenue, Los Angeles, CA 90020
E-mail: MHCommission@dmh.lacounty.gov Website: http://dmh.lacounty.gov/about/mental-health-commission/

If you need accommodations beyond what is listed above, please contact the MHC support staff at (213) 947-6487 or (213) 947-6628 at least 3 days before the meeting to request additional accommodations. You can also submit this request by email to mhcommission@dmh.lacounty.gov .

AGENDA POSTED: April 20, 2023

(AGENDA ON PAGE 3)

Address: 510 South Vermont Avenue, Los Angeles, CA 90020
E-mail: MHCommission@dmh.lacounty.gov Website: http://dmh.lacounty.gov/about/mental-health-commission/

MENTAL HEALTH COMMISSION (MHC) REGULAR MEETING
"Advocacy, Accountability and Oversight in Action"
Thursday, April 27, 2023, @ 10:30 a.m.
Public Access:
In-person Location (Voluntary registration requested): 510 South Vermont Avenue, 9th Floor (T) Level Conference Room, Los Angeles, CA 90020.
Attend virtually: MS Teams Link
Kathleen Austria, Chair, Second District

Agenda published April 20, 2023, at https://dmh.lacounty.gov/event/mhc-full-commission-meeting-apr-27-2023/

Commissioners by District

First District
Susan Friedman
Imelda Padilla-Frausto
Bennett W. Root, Jr.

Second District
Kathleen Austria
Jack Barbour
Reba Stevens

Third District
Teresa Banko
Stacy Dalgleish
Vacant

Fourth District
Michael Molina
Marilyn Sanabria
Vacant

Fifth District
Judy Cooperberg
Lawrence Schallert
Brittney Weissman

Kyla Coates,
BOS Representative, Fourth District

1. **Welcome & Call to Order– Chair Austria**

2. **Roll Call – Commission Staff**

NOTE: To allow sufficient time for the MHSA Annual Updates Plan Public Hearing, all committee/ad hoc group proposals/updates, commission updates, stakeholder group reports, and standing items have been deferred to the May 11, 2023, Executive Committee meeting for consideration for the May 25, 2023, MHC regular meeting.

3. **Updates/Action Items**
   a. **Administrative**
      i. Approval of Minutes - February 23, 2023
      ii. Approval of Minutes - March 23, 2023
   b. **Election of Executive Committee Officers Update**

4. **Presentations/Reports:**
   a. **MHSA Annual Updates Plan**

To review/download the entire MHSA Annual Update, please click on the links below:
- MHSA Annual Update FY 2023-2024 English / Spanish

5. **MHSA Public Hearing:**
   a. **Telephonic Public Comment**: Please call the Public Comment Line at **1-844-291-6362**, enter conference code **9271524**. **(2 min per caller).**
   b. **In-Person:** Please form a line and wait to be called upon to speak and address the MHC and MHSA group.

Adjourn

Address: 510 South Vermont Avenue, Los Angeles, CA 90020
E-mail: MHCommission@dmh.lacounty.gov Website: http://dmh.lacounty.gov/about/mental-health-commission/

Public Hearing Agenda (Spanish)

REUNION ORDINARIA DE LA COMISION DE SALUD MENTAL (MHC)
CONDADO DE LOS ÁNGELES, CALIFORNIA
"Promoción, rendición de cuentas y supervisión en acción"
Jueves 27 de abril de 2023, @ 10:30 am

AVISO PÚBLICO IMPORTANTE

Reunión híbrida

Los miembros del público pueden asistir a las reuniones del MHC de múltiples maneras:

Asistir virtualmente: MS Teams Link
o escanee el código QR a continuación

O únase al MHC en persona (Se solicita inscripción voluntaria para asistencia en persona, haga clic AQUÍ para registrarse): 510 South Vermont Ave., 9Th floor (T) Level Conference Room, Los Angeles 90020.

Hay estacionamiento gratuito disponible en:
523 Shatto Place, Los Ángeles, CA 90020. Al ingresar a la estructura, tome un boleto de estacionamiento y tráigalo con usted a la reunión. La seguridad validará su boleto.

Otras opciones de acceso:

Escuchar solo por teléfono en español	Escuchar solo por teléfono en coreano 한국어로 전화로만 들으려면	Para subtítulos en vivo (CART)	Para el lenguaje de señas americano (ASL)
Llame al 1-888-204-5987 e ingrese el código de acceso cuando se le solicite: **Código de acceso del participante 9639884**	1-888-204-5987 866-434-5269로 전화하여 메시지가 표시되면 액세스 코드를 입력합니다. 참가자 액세스 코드 6699393	**Haga clic AQUI**	**Haga clic AQUI**

Los miembros del público pueden dirigirse al MHC durante la reunión en vivo asistiendo en persona (ver ubicación arriba), por teléfono, por correo electrónico o por correo postal.

Instrucciones:

1. **Instrucciones telefónicas para comentarios públicos: Durante el evento en vivo, el Presidente** de la Comisión hará el anuncio para comentarios públicos, en ese momento, llame al **(844) 291-6362 e ingrese el Código del participante: 4972277**. Pulse 1 y, a continuación, 0 para dirigirse a la Comisión. No repetir. La repetición le quita de la cola. Puede proporcionar su nombre al moderador, pero no está obligado a hacerlo. Los comentarios públicos están limitados a 2 minutos por persona que llama.
2. **Comentario público escrito por correo electrónico**: El comentario público por correo electrónico puede enviarse a la Comisión por correo electrónico a mhcommission@dmh.lacounty.gov antes o antes de la fecha de la reunión.
3. **Comentario público escrito por correo regular: Los comentarios públicos por correo regular** pueden enviarse a la Comisión por correo regular antes o antes de la fecha de la reunión a la siguiente dirección: Atención: Comisión de Salud Mental del Condado de Los Ángeles, sede del corredor de Vermont, 510 S. Vermont Avenue, (22-111), Los Ángeles, CA 90020.

Dirección: 510 South Vermont Avenue, Los Angeles, CA 90020
Correo electrónico: MHCommission@dmh.lacounty.gov Sitio web: http://dmh.lacounty.gov/about/mental-Salud-comisión/

Si necesita adaptaciones más allá de lo mencionado anteriormente, comuníquese con el personal de apoyo de MHC al (213) 947-6487 o al (213) 947-6628 al menos 3 días antes de la reunión para solicitar adaptaciones adicionales. También puede enviar esta solicitud por correo electrónico a mhcommission@dmh.lacounty.gov .

AGENDA PUBLICADA: Abril 20, 2023

(ORDEN DEL DÍA EN LA PÁGINA 3)

Dirección: 510 South Vermont Avenue, Los Angeles, CA 90020
Correo electrónico: MHCommission@dmh.lacounty.gov Sitio web: http://dmh.lacounty.gov/about/mental-Salud-comisión/

Agenda publicada el 20 de abril de 2023, a las https://dmh.lacounty.gov/event/mhc-full-commission-meeting-apr-27-2023/

Comisionados por distrito

Primer Distrito
Susan Friedman
Imelda Padilla-Frausto
Bennett W. Root, Jr.

Segundo Distrito
Kathleen Austria
Jack Barbour
Reba Stevens

Tercer Distrito
Banco Teresa
Stacy Dalgleish
Vacante

Cuarto Distrito
Michael Molina
Marilyn Sanabria
Vacante

Quinto Distrito
Judy Cooperberg
Lawrence Schallert
Brittney Weissman

Kyla Coates,
Representante de BOS, Cuarto Distrito

REUNIÓN ORDINARIA DE LA COMISIÓN DE SALUD MENTAL (MHC)

"Promoción, rendición de cuentas y supervisión en acción"

Jueves 27 de abril de 2023, @ 10:30 am

Acceso público:

Ubicación en persona (se solicita inscripción voluntaria): 510 South Vermont Avenue, 9th Floor (T) Level Conference Room, Los Angeles, CA 90020.

Asistir virtualmente: MS Teams Link

Kathleen Austria, Presidenta, Segundo Distrito

1. **Bienvenido y llamada al orden – Presidente Austria**

2. **Pase de lista – Personal de la Comisión**

NOTA: Para dar tiempo suficiente a la Audiencia Pública del Plan de Actualizaciones Anuales de MHSA, todas las propuestas/actualizaciones del comité / grupo ad hoc, las actualizaciones de la comisión, los informes del grupo de partes interesadas y los puntos permanentes se han aplazado hasta la reunión del Comité Ejecutivo del 11 de mayo de 2023 para su consideración para la reunión ordinaria del MHC del 25 de mayo de 2023.

3. **Actualizaciones/Elementos de acción**
   a. Administrativo
      i. Aprobación del Acta - 23 de febrero de 2023
      ii. Aprobación del Acta - 23 de marzo de 2023
   b. Actualización de la elección de la Mesa del Comité Ejecutivo

4. **Presentaciones/Informes:**
   a. **Plan de actualizaciones anuales de MHSA**

Para revisar/descargar la actualización anual completa de MHSA, haga clic en los siguientes enlaces:

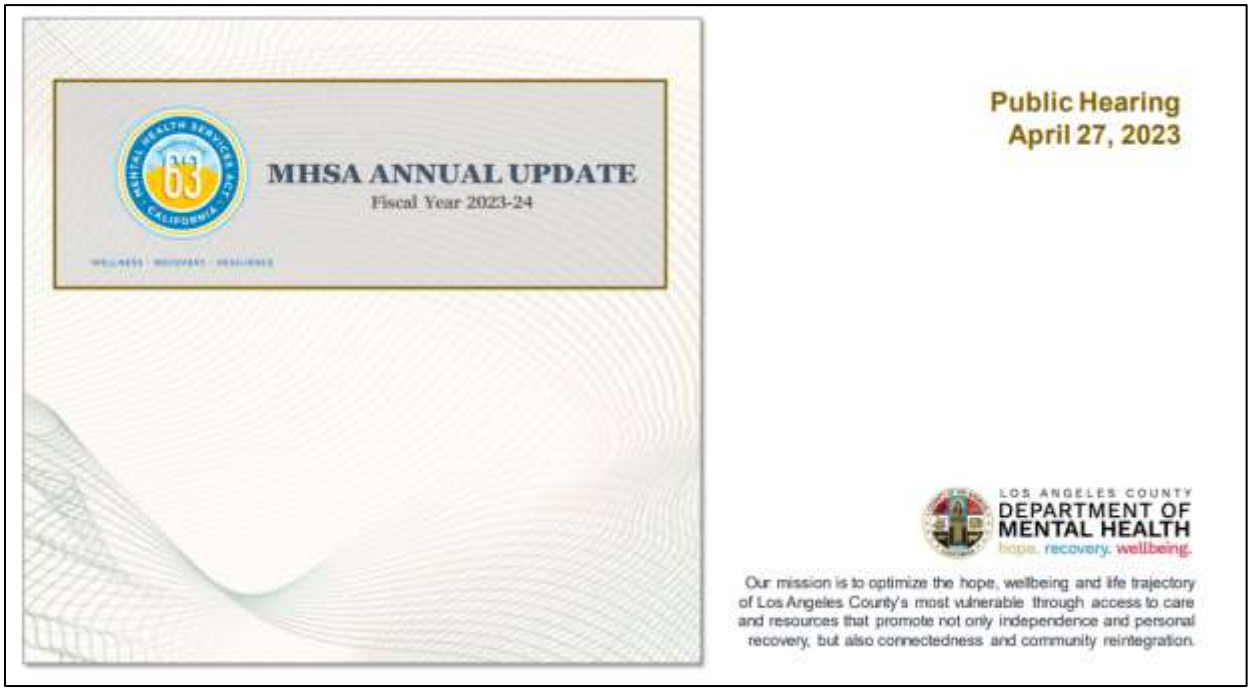
- Actualización anual de MHSA FY 2023-2024 Inglés / Español

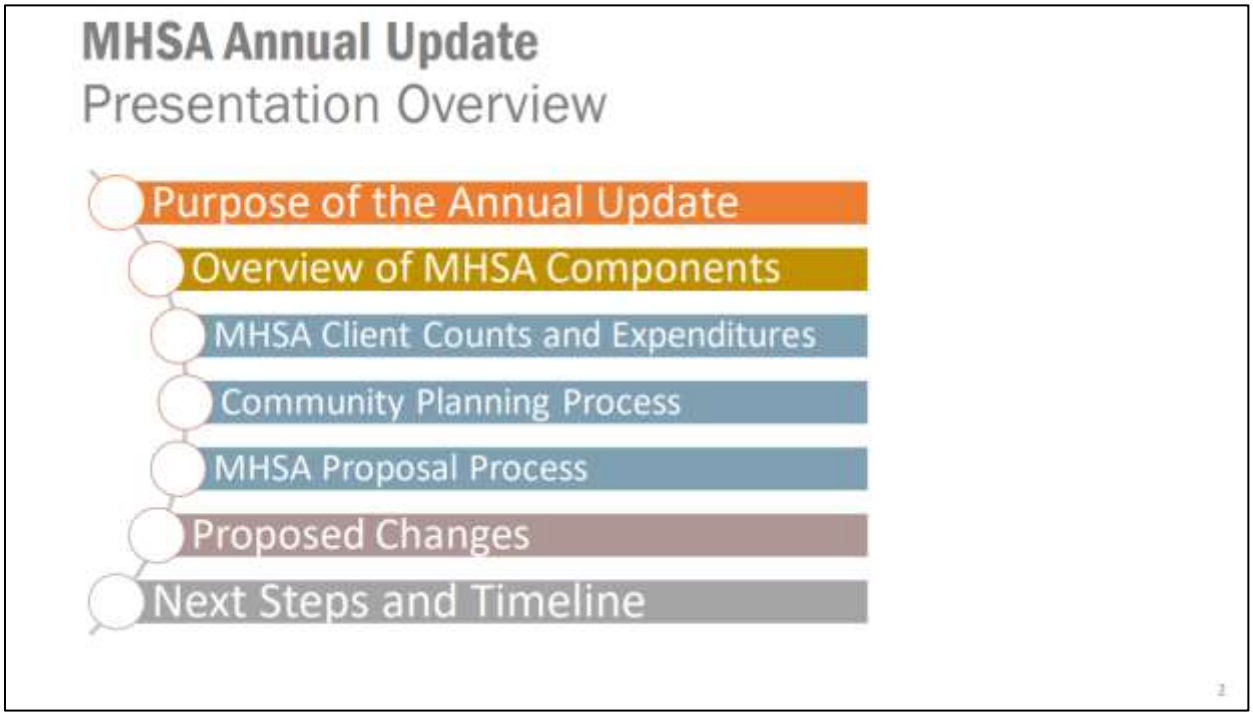
5. **Audiencia pública de MHSA:**
   a. **Comentario público telefónico: Llame a la Línea de comentarios públicos, 1-844-291-6362, escriba el código de conferencia 9271524. (2 min por persona que llama).**
   b. **En persona: Por favor, forme una fila y espere a que lo llamen para hablar y dirigirse al grupo MHC y MHSA.**

Aplazar

Dirección: 510 South Vermont Avenue, Los Angeles, CA 90020
Correo electrónico: MHCommission@dmh.lacounty.gov Sitio web: http://dmh.lacounty.gov/about/mental-Salud-comisión/

Public Hearing PowerPoint Presentation (English)





MENTAL HEALTH SERVICES ACT AND THE PURPOSE OF THE ANNUAL UPDATE

- In November 2004, California voters supported Proposition 63 and passed the Mental Health Services Act (MHSA) that imposes a 1% income tax on personal income in excess of $1 million.
- The Act provides the significant funding to expand, improve and transform public mental health systems to improve the quality of life for individuals living with a mental illness.
- Welfare and Institutions Code (WIC) Section 5847 requires county mental health programs prepare and submit a Three-Year Program and Expenditure Plan followed by Annual Plan Updates for MHSA programs and expenditures.
- The Plan provides an opportunity for counties to
  - Review its existing MHSA programs and services to evaluate their effectiveness; and
  - Propose and incorporate any new programs from what was described in the MHSA Three-Year Program and Expenditure Plan
- It is through this Community Planning Process that important feedback is gathered from stakeholders.
- The MHSA Three-Year Plan for Fiscal Years 2021-2024 was adopted by the County Board of Supervisors on June 22, 2021.

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FY 2021-22 Final Adopted Budget $3.034 Billion Funding Sources

Primary Funding Sources:

- **45% State and Federal Medi-Cal ($1.36 Billion)**
  Mandated specialty mental health services for eligible clients who meet medical necessity criteria for Medi-Cal
- **26% MHSA ($801.6 Million)**
  Outreach, engagement, prevention, outpatient services, housing, capital, technology, workforce enrichment, and projects for mental health innovations
- **20% Sales Tax Realignment ($599.5 Million)**
  Treatment services mainly in institutional settings, including Probation halls/camps; Short Term Residential Treatment Programs and Community Treatment Facilities for youth and locked mental health treatment beds for adults; and inpatient beds, specialty mental health services to uninsured clients and administration

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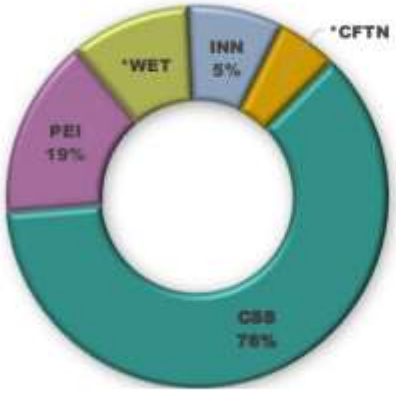
MHSA OVERVIEW BY COMPONENTS

- CSS, PEI and INN percent of total annual MHSA allocations shown below
- *WET and CFTN allocations are funded by transfers from CSS



COMMUNITY SERVICES AND SUPPORTS (CSS)

PREVENTION AND EARLY INTERVENTION (PEI)

WORKFORCE EDUCATION AND TRAINING (WET)

INNOVATIONS (INN)

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

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MHSA FY 2022-23 BUDGET (millions)

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MHSA CLIENT COUNTS FISCAL YEAR 2021-22

Community Service and Supports (CSS)

- Largest MHSA component with 76% of the total MHSA allocation
- For clients with a diagnosed serious mental illness

CSS PROGRAMS:

- Full Service Partnership
- Outpatient Care Services
- Alternative Services Crisis
- Housing
- Linkage
- Planning, Outreach and Engagement

UNIQUE CLIENTS SERVED

147,143 unique clients received a direct service.

Ethnicity
- 36% Hispanic
- 20% African American
- 17% White
- 4% Asian/Pacific Islander
- 1% Native American

Primary Language
- 80% English
- 13% Spanish

NEW CLIENTS WITH NO PREVIOUS MHSA SERVICE

42,616 new clients were served with no previous MHSA service.

Ethnicity
- 37% Hispanic
- 15% African American
- 15% White
- 3% Asian/Pacific Islander
- 0.38% Native American

Primary Language
- 77% English
- 12% Spanish

CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	10,989	2,852
SA2 – San Fernando Valley	21,809	5,574
SA3 – San Gabriel Valley	20,681	6,945
SA4 – Metro	29,471	8,331
SA5 – West	9,699	2,818
SA6 – South	26,269	6,159
SA7 – East	13,027	2,994
SA8 – South Bay	30,117	8,664

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MHSA EXPENDITURES & ESTIMATES – APRIL 2023

Community Services and Supports (CSS)

Program	FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
Full Service Partnership	$163,545,000	$115,915,000	$95,397,000
Outpatient Care Services	$234,019,000	$192,090,000	$182,950,000
Alternative Crisis Services	$132,177,000	$138,993,000	$132,069,000
Housing	$69,147,000	$45,289,000	$40,593,000
Linkage	$50,878,000	$44,479,000	$34,545,000
Planning, Outreach, and Engagement	$16,970,000	$4,485,000	$6,178,000
Grand Total	**$666,736,000**	**$541,224,000**	**$491,732,000**

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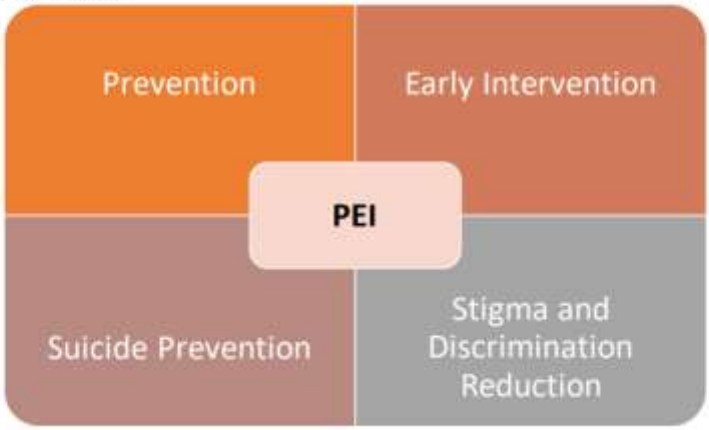
PREVENTION AND EARLY INTERVENTION (PEI)

Components

- Second largest MHSA component with 19% of the total MHSA allocation
- Focus on providing preventative and early intervention strategies, education, support and outreach to those at risk of developing mental illness or experiencing early symptoms.



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PREVENTION AND EARLY INTERVENTION PROGRAMS

Prevention Services

Prevention activities and services are geared toward addressing, through awareness, education, training, outreach and/or navigation, the risk factors associated with the onset of mental illness or emotional disturbances, including a focus on enhancing protective factors such as social connectedness and support.

FISCAL YEAR 2021-22 PREVENTION SERVICES:

Community Partnership Programs	Number of Clients Surveyed
Antelope Valley Community Family Resource Centers (AV-CFRC)	83
Friends of the Children LA (FOTC-LA)	48
Incubation Academy	13,836
Los Angeles Unified School District (LAUSD)	32,841
My Health LA Behavioral Health Expansion Program	28,593
Nurse Family Partnership	149
Prevention and Aftercare	1,049
Prevent Homelessness Promote Health (PH^2)	171
Veterans Peer Access Network (VPAN)	15,824
Strategies for Enhancing Early Developmental Success (SEEDS) Trauma-Informed Care for Infants & Toddlers	317

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PREVENTION AND EARLY INTERVENTION PROGRAMS

Early Intervention Services

Directed toward individuals and families for whom a short (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve mental health problems and avoid the need for more extensive mental health treatment.

MHSA DIRECT SERVICE CLIENT COUNTS, FISCAL YEAR 2021-22:

UNIQUE CLIENTS SERVED

35,330 unique clients received a direct service.

Ethnicity
- 47% Hispanic
- 8% African American
- 9% White
- 1% Asian/Pacific Islander
- 0.29% Native American

Primary Language
- 76% English
- 21% Spanish

NEW CLIENTS WITH NO PREVIOUS MHSA

17,084 new clients were served with no previous MHSA service

Ethnicity
- 42% Hispanic
- 8% African American
- 9% White
- 2% Asian/Pacific Islander
- 0.64% Native American

Primary Language
- 75% English
- 21% Spanish

CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	2,006	1,203
SA2 – San Fernando Valley	5,565	2,465
SA3 – San Gabriel Valley	5,968	3,225
SA4 – Metro	5,399	2,997
SA5 – West	1,280	739
SA6 – South	3,668	1,964
SA7 – East	4,501	2,303
SA8 – South Bay	6,202	3,078

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PREVENTION AND EARLY INTERVENTION PROGRAMS

Suicide Prevention

The Suicide Prevention program provides services through multiple strategies by strengthening the capacity of existing community resources and creating new collaborative and comprehensive efforts at the individual, family, and community level.

FISCAL YEAR 2021-22 SUICIDE PREVENTION DATA AND OUTCOMES:

- The 24/7 Suicide Prevention Crisis Line responded to a total of **145,254 calls, chats, and texts** originating from Los Angeles County, including Spanish-language crisis hotline services to **13,087 callers**.
- Los Angeles County received **1,309 surveys** from its Suicide Prevention training and education services.

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PREVENTION AND EARLY INTERVENTION PROGRAMS

Stigma and Discrimination Reduction (SDR)

The purpose of SDR is to reduce and eliminate barriers that prevent people from utilizing mental health services by prioritizing information and knowledge on early signs and symptoms of mental illness through client-focused, family support and education and community advocacy strategies. Los Angeles County's Department of Mental Health has implemented Stigma Discrimination Reduction (SDR) programs in the form of training and education.

FISCAL YEAR 2021-22 SDR DATA AND OUTCOMES: 16,572 SURVEYS COLLECTED

- The majority of participants agreed the training had a positive influence, with a high of 93% agreeing/strongly agreeing with the statement: "As a direct result of this training I am more willing to seek support from a mental health professional if I thought I needed it.
- Results showed the trainings had a positive influence, with a high of 87% agreeing/strongly agreeing with the statement: "anyone can have a mental health condition"
- A high of 97% agreed/strongly agreed with the statement: "The presenters demonstrated knowledge of the subject matter."
- A high of 97% agreed/strongly agreeing with the statement: "The presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.)."

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MHSA EXPENDITURES & ESTIMATES – APRIL 2023

Prevention and Early *Intervention* (PEI)

Program	FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
Early Intervention	$106,479,000	$34,218,000	$28,379,000
Prevention	$132,105,000	$85,010,000	$63,021,000
Stigma and Discrimination	$81,836,000	$21,301,000	$6,940,000
Suicide Prevention	$6,146,000	$5,682,000	$5,638,000
Grand Total	**$326,566,000**	**$146,211,000**	**$103,978,000**

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COMMUNITY PLANNING PROCESS

Stakeholder Process

September 2022

- LACDMH held a two-day retreat (9/23/22 and 9/30/22) to revitalize its Community Planning Process and strengthen its collaborative relationships with stakeholders from the most vulnerable unserved, underserved, and under-represented populations across the County.
- Participants had an opportunity to examine the past stakeholder engagement processes and outcomes and acknowledge what worked well, what has not worked and identify what is needed in the future to create and sustain a strong collaborative relationship necessary for LACDMH to deliver effective and culturally congruent programs and services under MHSA.

November 2022

- LACDMH met with community stakeholders (11/1/22, 11/17/22, 11/18/22) and presented proposed timelines and processes for meaningful engagement and input on the review of MHSA funding requests for the Mid-Year Adjustment, the upcoming FY 2023-24 MHSA Annual Plan update and the MHSA Two Year Program and Expenditure Plan for FYs 2024-25 through 2025-26.

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COMMUNITY PLANNING PROCESS

Stakeholder Process

December 2022

- LACDMH met with community stakeholders (12/22/22) and presented proposed timelines and processes for meaningful engagement and input on the review of MHSA funding requests for the Mid-Year Adjustment

January 2023

- LACDMH conducted an annual MHSA foundational training (1/2/23) to LACDMH staff, provider network staff, and community stakeholders on MHSA policies, the Department's MHSA funding request procedure, the MHSA Three Year Program and Expenditure and Annual Update development and submission process and timeline, and the client resolution process.
- LACDMH conducted two community stakeholder meetings (1/23/23, 1/31/23) focused on education participants on MHSA funding components, requirements and spending regulations.

February 2023

- LACDMH conducted two community stakeholder meetings (2/17/23, 2/21/23) focused on reviewing DMH and stakeholder proposals to be considered for inclusion in the FY 2023-24 MHSA Annual Update and building consensus on which proposals presented in January and February meetings would receive final stakeholder recommendation for inclusion in the Plan.

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COMMUNITY PLANNING PROCESS

Stakeholder Process

March 2023

- LACDMH delivered a Provider MHSA 101 Training (3/23/23).
- LACDMH initiated a 30-day public review and comment period for its FY 2023-24 MHSA Annual Update(3/24/23).
- LACDMH conducted a community stakeholder meeting (3/30/23)with the objective of reviewing the draft FY 2023-24 MHSA Annual Update. Stakeholders received a presentation about all items included in the Update.

April 2023

- LACDMH 4/24/23-Completion of the 30-day public posting and comment period and collection of submitted feedback for inclusion in the draft Annual Update
- 4/27/23 (Today)-The Mental Health Commission will hold a public hearing to provide feedback and recommendations for revisions, if any.

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COMMUNITY PLANNING PROCESS

Stakeholder Process

STAKEHOLDER FEEDBACK THEMES, QUESTIONS AND RESPONSES:

1. **The Commission and Stakeholders requested reporting on overall system budget, recruitment, and hiring status.**

   - DMH Finance provides and will continue to provide a quarterly update on the overall budget for the entire Department, including all funding streams.

     The last update was provided at the Stakeholder community planning meeting on 01/23/23 (see overall DMH budget on Slide 17.

   - The Department will continue to explore strategies to provide budget expenditure by service area and supervisorial district and strategies for allocating funding based on an equity lens and unmet needs
   - Funding for all MHSA components was also reported on 01/23/23 and is reflected on Slide 18.
   - The DMH Director provides and will continue to provide a quarterly update on recruitment and hiring efforts to address the workforce shortage and collaboration with labor unions.

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COMMUNITY PLANNING PROCESS

Stakeholder Process

STAKEHOLDER FEEDBACK THEMES, QUESTIONS AND RESPONSES (cont.):

2. **The Commission requested regular reporting, and side by side comparison of budget allocations, service utilization and trends, and funding utilization prior to, during and following the COVID pandemic. The comparison was requested to be reflected by geographic area, ethnic populations, and age group.**

   - *DMH has currently developed a data dashboard that provides service utilization data collected by fiscal year, geographic area, ethnic population and age groups. This data, along with budget allocation information will be used to create the side by side assessment for the pre, during and post COVID fiscal years. This data will be shared and incorporated into a community needs assessment to support the Community Planning Process with the Commission and stakeholders for the development of the upcoming Two-Year Program and Expenditure Plan.*

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COMMUNITY PLANNING PROCESS

Stakeholder Process

STAKEHOLDER FEEDBACK THEMES, QUESTIONS AND RESPONSES (cont.):

3. **The Commission and Stakeholders requested updates on data and outcomes reporting:**

   - *DMH has developed a data dashboard that provides service utilization data collected by fiscal year, geographic area, ethnic population and age groups. It will be used to review services to specific target populations, including unserved and underserved ethnic populations, primary language, and gender to address service gaps and recommend service priorities for the upcoming Two-Year Plan Community Planning Process, as requested. This dashboard will also provide a more detailed breakout of race/ethnicity data to ensure representation for unserved or unserved cultural communities.*
   - *DMH convened a Data Disparities Workgroup with the goal of focusing on underserved and unserved ethnic population data. Using the Anti-Racism Diversity and Inclusion (ARDI) equity mapping tool and service utilization data, this workgroup will be tasked with monitoring service equity metrics to inform program planning and monitoring for program improvements.*
   - *Specific to the draft Annual Update, the client count data by ethnicity on slide 7 does not balance. The reason for this is the report only reflects client counts for the top 5 ethnicities. In addition, due to client choice or intake circumstances, the ethnicity for a large group of clients is not reported either . DMH is taking steps to improve reporting of ethnicity data.*
   - *DMH reports on program outcomes and performance in the draft Annual Update. Program outcomes will be discussed as part of the upcoming Community Planning Process.*

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COMMUNITY PLANNING PROCESS

Stakeholder Process

STAKEHOLDER FEEDBACK THEMES, QUESTIONS AND RESPONSES (cont.):

4. The Commission and Stakeholders requested specific responses to items reflected in the draft Annual Update

- *DMH will add information on program expansion in the finalized draft of the Annual Update prior to Board review and hearing. Program expansions to be reflected in the Update are listed in this presentation. (Slides 39-40)*
- *Slide 11 on the draft Annual Update PowerPoint was reported as incorrect in the presentation to Mental Health Commission Executive Committee. The dates reflected in the slide were in fact accurate and will be reviewed during today's public hearing (4/27/23).*
- *In response to the inquiry on the expansion of Portland Identification and Early Referral (PIER) Program: The expansion adds new funding for PIER services in Service Areas 1 and 8 and increases the presence of PIER services in Service Area 6.*
- *In response to the inquiry of when Innovations proposals will be reviewed and considered for Board and State approval: Submitted Innovations proposals will undergo the review process during the upcoming Two-Year Plan Planning Process, pending available Innovations funding.*

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COMMUNITY PLANNING PROCESS

Stakeholder Process

STAKEHOLDER FEEDBACK THEMES, QUESTIONS AND RESPONSES (cont.):

5. The Commission and Stakeholders requested responses to other questions/concerns:

- *In response to the Commission's inquiry, when will the summary/overview outlining the shift of the May Mental Health Month campaign from We Rise to Take Action be provided: The summary/overview of the shift will be reflected in the upcoming Two-Year Plan.*

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COMMUNITY PLANNING PROCESS

Stakeholder Process

STAKEHOLDER FEEDBACK THEMES, QUESTIONS AND RESPONSES (cont.):

6. The Commission and Stakeholders requested updates on the Community Planning Process going forward:

- *The upcoming Community Planning Process will involve an expansion of stakeholder involvement to ensure greater participation of a more diverse group of stakeholders across LA County communities that is representative of peers and family members, ethnic/cultural populations, geographic areas, community based organizations, other county departments and stakeholders at large. The Community Planning Process will begin late May/early June 2023 and will begin with MHSA 101 training, stakeholder foundational training and a data and community needs assessment toward development of the Three-Year Plan.*
- *In response to the inquiry will the Mental Health Commission be considered a stakeholder group and be included earlier in the Community Planning Process and the MHSA Funding Request/Proposal submission and stakeholder process on behalf of the Board of Supervisors: Yes. The Mental Health Commission will be notified of the Community Planning Process and timelines for comment, feedback and for submission of MHSA Funding Proposal on behalf of the Board offices. The Mental Health Commission has a unique formal role as part of the Community Planning Process and holds the responsibility to ensure stakeholder voices are included in the process, while providing input in the process on behalf of the Board of Supervisors. DMH shared information with the Mental Health Commission during the Community Planning Process for the draft Annual Update in Fall 2022 in preparation for stakeholder engagement meetings. DMH will continue to share the process going forward.*

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COMMUNITY PLANNING PROCESS

Stakeholder Process

STAKEHOLDER FEEDBACK THEMES, QUESTIONS AND RESPONSES (cont.):

7. The Commission and Stakeholders requested updates and clarification on the MHSA Funding Request/Proposal Process

Responses to inquiries regarding the MHSA Funding Request/Proposal Process are listed below:

How do stakeholders and community members submit proposals?

- *Requests/Proposal can be submitted 24 hours a day/7 days per week through the MHSA Funding Request Portal using online electronic forms. CSS, PEI, WET funding requests should be submitted using the form located at: https://forms.office.com/g/hFe6wc9LA2. Innovation funding requests should be submitted using the form found at https://forms.office.com/g/77BRkSWzUe. Both portals will be available to receive new proposals for the upcoming Two-Year Planning process from mid May 2023 through January 15, 2024.*

How are proposers notified of the review, approval or rejection status of their submissions?

- *Proposers are informed of the status of their submission via a phone call or through an email.*

Can the source of proposals be shared/released?

- *Yes. The source of proposals (e.g. CBOs, County Entities, or Community Stakeholders) can be made available upon request and are also posted publicly on the DMH MHSA page.*

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COMMUNITY PLANNING PROCESS

Stakeholder Process

STAKEHOLDER FEEDBACK THEMES, QUESTIONS AND RESPONSES (cont.):

8. The Commission and Stakeholders requested updates and clarification on the MHSA Funding Request/Proposal Process

Can the amount requested by proposers be shared?

- *Yes. The amount requested for proposals was shared with stakeholders during the Community Planning Process. This information is also available upon request. Amounts requested are estimated amounts and may change upon approval and during implementation based on actual confirmed costs and funded activities included in the proposal.*

Can the information on proposed target populations and geographic areas to be served be shared?

- *Yes. This information was shared with stakeholders during Community Planning Process. Upon Board approval and prior to actual implementation, the MHSA Administration Unit will consult with proposer to confirm proposed target populations and geographic areas. An analysis of each approved proposal will be conducted to ensure equity concerns and considerations are addressed and funding allocations support unmet needs for communities countywide.*

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FORMAL PROCESS FOR REQUESTING MHSA FUNDING

1 **MHSA Funding Request Submission**	2 **MHSA Admin Review** (7-60 days)	3 **Stakeholder Review & Recommendation** (90 days)	4 **DMH Executive Review & Approval** (60 days)	5 **Public Comment, Posting, & Hearing** (30 days)	5 **Board and OAC Approval** (90 days)
All requests for MHSA funding are submitted through the DMH portal. Submissions are categorized into the following three types: • A new mental health program • A change/expansion to an existing MHSA mental health program • Request for additional funding for a legal entity	Submissions are initially reviewed by MHSA Administration to ensure MHSA regulation compliance and to verify all critical information pertaining to target populations, outcomes, etc. has been included. Submissions meeting MHSA regs are queued for Stakeholder Review and those that don't are forwarded to Financial Services Bureau to determine other potential funding sources.	MHSA Administration approved submissions are presented to Stakeholders to collect feedback. Feedback is reviewed and any changes deemed necessary are made to the proposal.	Approved, funded submissions are included in a 30 day Public Comment Posting. Submissions that are approved but not funding is available for are documented as an Unmet Need	All DMH approved submissions are included in a draft Three Year Plan, Annual Update or Mid Year Adjustment which is posted on the MHSA public facing website for 30 days for public viewing and comment. Upon completion of 30 day posting, any changes based on feedback are made, and a Mental Health Commission Public Hearing is held.	Final draft of the Three Year Plan and Annual Update is submitted to LA County Board of Supervisors for approval. Upon Board approval, Three Year Plan and Annual Update is submitted to the MHSA Oversight and Accountability Commission.

MHSA Project Proposal Form link:
https://forms.office.com/g/hFe6wc9LA2
https://forms.office.com/g/77BRkSWzUe

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PROPOSED CHANGES
FISCAL YEAR 2023-24

Projects/concepts below were proposed by Stakeholders and other County Departments during the Stakeholder process from October 2022 through February 23, 2023. LACDMH is committed to working with proposers to finalize project details, budget and the ability to implement the program.

Community Family Resource Center (CFRC)

Target Population: All Age Groups and Populations - Families

The CFRC is designed to create a coordinated, community owned and driven space where families and individuals can easily access the services they need to enhance their wellbeing. The CFRCs will create partnerships with trusted networks of care, individual community leaders, CBOs, and public and private entities to leverage the strengths and capacities of each to best respond to the needs of individuals and families in the community it serves.

Community Schools Initiative (CSI)

Target Population: Middle school and high school youth

CSI serves 15 high schools that serve as hubs for a range of support services for students, families, and school staff. The program provides each site with a Community Schools Specialist to assist with coordinating services and Educational Community Worker to support parent engagement. Services focus on prevention, helping caregivers and students access a variety of services to prevent stress and possible mental health concerns.

United Mental Health Promoters Network

Target Population: Underserved Cultural Populations

The Mental Health Promoters Network project is a community outreach effort, serving to strengthen communities and create career paths for those community members functioning under the umbrella of Mental Health Promoters.

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PROPOSED CHANGES (continued)
FISCAL YEAR 2023-24

Projects/concepts below were proposed by Stakeholders and other County Departments during the Stakeholder process from October 2022 through February 23, 2023. LACDMH is committed to working with proposers to finalize project details, budget and the ability to implement the program.

Friends of the Children (FOTC) - Los Angeles

Target Population: Children and youth under 18, starting at 4-6 years old

FOTC aims to prevent foster care entry and improve family stability and wellbeing for families identified by DCFS as being at highest risk of entering foster care. FOTC provides professional 1:1 mentorship to children for 12+ years; starting around the age of 4-6 years old. Mentors are trained to support caregivers, promote self-advocacy and created opportunities for culturally responsive community and peer-to-peer connections.

Medical Legal Services

Target Population: All Age Groups

Addresses clients' legal problems and increases awareness of their rights to which lessens undue stress and empowers them with the information. These legal services can eliminate barriers to sustaining stable income through employment

Home Visitation: Deepening Connections and Enhancing Services

Target Population: Parents and Caregivers with Children 0-to-5 Years Old

Healthy Families America (HFA) and Parents as Teachers (PAT) are evidence-based, research-proven, national home visiting programs that gather family information to tailor services to the whole family. The programs offer home visits delivered weekly or every two weeks to promote positive parent– child relationships and healthy attachment. This Home Visiting Program will prioritize areas where data indicates there is a high number of families involved with child protective services.

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PROPOSED CHANGES (continued)

FISCAL YEAR 2023-24

Projects/concepts below were proposed by Stakeholders and other County Departments during the Stakeholder process from October 2022 through February 23, 2023. LACDMH is committed to working with proposers to finalize project details, budget and the ability to implement the program.

New Parent Engagement: Welcome to the Library and the World

Target Population: New Parents and Caregivers

Public Libraries and DHS Women's Health will offer a Welcome to the Library and the World kit which will include information on the library Smart Start Early Literacy programs and services. The program will be offered at 45 locations twice a year, and though a virtual program every quarter.

Our SPOT Teen Program: Social Places & Opportunities for Teens After-School Program

Target Population: Children and Youth under 18

Our SPOT: Social Places and Opportunities for Teens is a comprehensive after-school teen program aimed at engaging and providing community youth with the support, life-skills and positive experiences that will empower them to create bright futures for themselves.

We Rise Parks at Sunset

Target Population: 24 years old and below - Families

We Rise a prevention program which creates access to self-care programming in 58 LA County parks and is offered during mental health awareness month. It provides repeated opportunities to access resources and information on mental health support including free mental well-being workshops.

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PROPOSED CHANGES (continued)

FISCAL YEAR 2023-24

Projects/concepts below were proposed by Stakeholders and other County Departments during the Stakeholder process from October 2022 through February 23, 2023. LACDMH is committed to working with proposers to finalize project details, budget and the ability to implement the program.

Parks after Dark Parks at Sunset

Target Population: 24 years old and below - Families

Designed for families and adults to participate in workshops and classes promoting self-care and healing, three evenings a week over 8-weeks. Activities include sports, fitness, arts and culture, movies and concerts and more.

DPR Safe Passages: Community Engagement and Safe Passages for Youth and Communities

Target Population: Children and Youth under 18

DPR Safe Passages Initiative utilizes trained gang interventionists and ambassadors to implement peace maintenance among gang neighborhoods to ensure safety to and from parks, and during park activities and provide crisis intervention services at the parks.

Triple P Parent/Caregiver Engagement

Target Population: Parents and Caregivers

Triple P is an effective evidence-based practice that gives parents and caregivers with simple and practical strategies to help them build strong, healthy relationships, confidently manage their children's behavior and prevent problems developing.

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PROPOSED CHANGES (continued)

FISCAL YEAR 2023-24

Projects/concepts below were proposed by Stakeholders and other County Departments during the Stakeholder process from October 2022 through February 23, 2023. LACDMH is committed to working with proposers to finalize project details, budget and the ability to implement the program.

Patient Health Navigation Services

Target Population: All Age Groups

This proposal will augment existing Patient Health Navigation Services by adding mental health prevention focused services, including assessment, referral and linkage to community supports and education that increase protective factors for individuals at-risk of a mental illness.

School Readiness

Target Population: 2 to 4 Year Old (Toddlers to Preschoolers)

An early literacy program designed for toddlers and preschoolers to help empower parents and guardians in supporting the education needs of their children. While enjoying books, songs, rhymes and fun, kids build early literacy skills, basic math skills, and social skills, and other essential school readiness competencies.

Creative Wellbeing: Arts, Schools, and Resilience

Target Population: 24 years old and Caregivers

A non-traditional, arts and culture–based approach for promoting mental health in young people and caregivers. . The model offers non-traditional strategies for promoting mental health and wellness that include culturally relevant, healing-centered, arts-based workshops for youth, as well as professional development, coaching, and emotional support for the adults who work with them. Project activities support positive cognitive, social, and emotional development, and encourage a state of wellbeing.

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PROPOSED CHANGES (continued)

FISCAL YEAR 2023-24

Projects/concepts below were proposed by Stakeholders and other County Departments during the Stakeholder process from October 2022 through February 23, 2023. LACDMH is committed to working with proposers to finalize project details, budget and the ability to implement the program.

Abundant Birth Project

Target Population: Pregnant People and Parents with Children 0-18 Months Old

This program is a private-public partnership that seeks to provide support to a minimum of 400 pregnant people in LA County from marginalized populations most likely to experience the worst birth outcomes with a variety of supports for 18 months (i.e. mental health, financial coaching, wellness supports, housing assistance, education, etc. This would be a randomized control study to evaluate the effects of this type of support.

Credible Messenger Mentoring Model

Target Population: Transition Age Youth 18-25

This program consists of mentoring by peer youth to increase access to resources and services for young people of color disproportionately negatively impacted by traditional systems and services. Services are targeted to Youth 18-25 and include training of messenger peers, needs assessment of mentors, 1:1 mentorship by youth with lived experience, group activities, crisis intervention, family engagement, referral and resource linkage.

Youth Development Regions

Target Population: Transition Age Youth 18-25

This program will support youth by providing and/or referring to a range of youth development services based on an assessment of individual strengths, interests, and needs. The target population is youth 18-25 and is projected to serve approximately 6,500 youths annually. Services are provided through contracted CBOs and referral and linkage and will include school engagement, conflict resolution training, mentoring/peer support, educational support, employment/career services, arts/creative expression and social/emotional wellbeing resources.

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PROPOSED CHANGES (continued)

FISCAL YEAR 2023-24

Projects/concepts below were proposed by Stakeholders and other County Departments during the Stakeholder process from October 2022 through February 23, 2023. LACDMH is committed to working with proposers to finalize project details, budget and the ability to implement the program.

A Local Approach to Preventing Homelessness

Target Population: Young adults exiting foster care and at risk for homelessness

The Long Beach Department of Health and Human Services will convene local partners to identify gaps in homeless prevention services and develop interventions strategies addressing short term housing, mobile and clinic services and supportive transition programs for young adults exiting the foster care system.

Laugh Therapy & Gratitude

Target Population: Older Adults - Latino

Enlighten the public on therapeutic alternatives that don't necessarily require the use of drugs to improve one's state of mind and the importance of embracing emotions rather than masking them.

Older Latino Adults & Caregivers

Target Population: Older Adults - Latino

Create opportunities for elderly Latino immigrants to prosper and grow independent by teaching them not fear technology but rather, use it as a helpful tool to stay connected to loved ones, learn new things, find entertainment, and use it as a tool for self improvement.

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PROPOSED CHANGES (continued)

FISCAL YEAR 2023-24

Projects/concepts below were proposed by Stakeholders and other County Departments during the Stakeholder process from October 2022 through February 23, 2023. LACDMH is committed to working with proposers to finalize project details, budget and the ability to implement the program.

Search to Involve Pilipino Americans (SIPA)

Target Population: Youth

Provide strength based, youth-centered mental health support services to youth and underserved individuals in SPA 4, with a focus on Historic Filipinotown and adjacent areas

K-Mental Health Awareness & K-Hotline

Target Population: All Ager Groups - Korean

Seeks to normalize mental illness and treatment in the Korean community so individuals will seek therapy and services without shame or hesitation.

FosterALL WPW ReParenting Program

Target Population: Adults and Children Involved with Foster Care System

FosterAll's Wisdom Path Way Program addresses both the adults and children in foster care and provides positive outcomes to prevent additional trauma, stress and mental illness for both adults and children.

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PROPOSED CHANGES (continued)

FISCAL YEAR 2023-24

Projects/concepts below were proposed by Stakeholders and other County Departments during the Stakeholder process from October 2022 through February 23, 2023. LACDMH is committed to working with proposers to finalize project details, budget and the ability to implement the program.

Cultural Reflections Newsletter

Target Population: LACDMH Consumers

Provide opportunities for peer produced mental health related content to be developed and shared throughout the County.

Hope & Healing: Mental Health Wellness Support to Victim Families & Relatives

Target Population: African American families who have suffered loss due to violence

Bring Faith and Mental Wellness together to normalize the conversation and consciousness of families to seek mental health services and eliminate common stigmas preventing many traumatized persons from getting the help they need.

TransPower Project

Target Population: Youth Trans* Population

Increase access and remove treatment barriers such as lack of resources, transportation needs and privacy concerns by offering specialized affirmative mental health services at no cost.

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PROPOSED CHANGES (continued)

FISCAL YEAR 2023-24

Projects/concepts below were proposed by Stakeholders and other County Departments during the Stakeholder process from October 2022 through February 23, 2023. LACDMH is committed to working with proposers to finalize project details, budget and the ability to implement the program.

Open Arms Community Health & Service Center

Target Population: All Age Groups

Provide quality health care, mental health support, housing, case management, employment referrals and supportive services such as food, clothing, hygiene kits, transportation anger management, substance use, sex trafficking, and parenting classes.

Consumer Empowerment Network

Target Population: LACDMH Consumers

Educate LACDMH consumers on the history of MHSA, the role of LACDMH consumers and consumers from through the state, components and required processes, county, and state stakeholder events and opportunities to make public comments, recommendations, and legislative process.

Innovation 2/Prevention and Early Intervention

Target Population: Transition Age Youth within Deaf, BIPOC, Disabled, LGBTQIA2S and Asian Pacific Islander communities

To help build trauma-informed communities and resilient families through Community Resource Specialists (CRSs) who work in-home with families to ensure that food, medical or housing crises don't destabilize families

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PROPOSED CHANGES (continued)

FISCAL YEAR 2023-24

Projects/concepts below were proposed by Stakeholders and other County Departments during the Stakeholder process from October 2022 through February 23, 2023. LACDMH is committed to working with proposers to finalize project details, budget and the ability to implement the program.

Mental Health Services for the Deaf & Hard of Hearing

Target Population: All Age Groups - Deaf & Hard of Hearing

Provide American Sign Language (ASL) interpreters who can translate mental health terms and concepts accurately and effectively to deaf and hard of hearing people.

Steven A. Cohen Military Family Clinic at VVSD, Los Angeles

Target Population: Veterans and Their Families

The Cohen Clinic offers personalized, evidence-based mental health care along with outreach and timely access to comprehensive case management support and referrals to address early intervention and suicide prevention, unemployment, finances, housing, and legal issues.

DBT Expansion

Target Population: Targets Workforce for All LACDMH Consumers

This project would provide support for the clinic's DBT program by providing dedicated funding for medical staff, direct therapy services staff, peer workers/support staff, and management/supervision staff to have paid time to be trained on DBT certification, practices, and implementation.

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EXPANSION

FISCAL YEAR 2023-24

Programs below are existing MHSA programs previously approved by Stakeholders set to expand in Fiscal Year 2023-24.

Portland Identification and Early Referral Program (PIER)

PEI: Early Intervention

This will expand the number of sites and areas of availability of the program to SA 1 and 8, and expand services in SA 6. PIER is a Coordinated Specialty Care program for adolescents and young adults, ages 12-25 who are either at Clinical High Risk for psychosis or have had their first psychotic episode. Currently, referrals from ELAC STAND (UCLA) , NAMI Urban LA, schools and various outpatient programs are exceeding the capacity of the current service level.

Homeless Outreach and Mobile Engagement (HOME)

CSS: Planning Outreach and Engagement

The HOME program provides field-based outreach, engagement, support, and treatment to individuals with severe and persistent mental illness who are experiencing unsheltered homelessness.

The expansion will include a total of 94 full time positions, (6 new multidisciplinary teams and 1 Service Area Navigation team) will be added between FY 2022-23 and FY 2023-24. The expansion will bring a total number of 16 multidisciplinary teams Countywide and 1 Service Navigation team.

Crisis Residential Treatment Programs (CRTP)

CSS: Alternative Crisis Services

CRTPs are designed to provide short-term, intensive, and supportive services in a home-like environment through an active social rehabilitation program that is certified by the California Department of Health Services and licensed by the California Department of Social Services, Community Care Licensing Division.

Awarded a new legal entity contract to Bel Aire Health Services to provide services at 2 locations: Downey and Sylmar.

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EXPANSION (continued)

FISCAL YEAR 2023-24

Programs below are existing MHSA programs previously approved by Stakeholders set to expand in Fiscal Year 2023-24.

TAY Drop-In Centers

PEI: Prevention
CSS: Outpatient Care Services

TAY Drop-In Centers are intended as entry points to the mental health system for homeless youth or youth in unstable living situations.
A total of 10 new sites will be added Countywide. Service Areas 2, 3, 4, 5, 7 and 8 will each receive one new site. Service Areas 1 and 6 will each receive two.

TAY Enhanced Emergency Shelter Program

CSS: Housing

The Enhanced Emergency Shelter Program (EESP) serves the urgent housing needs of the TAY population, ages 18-25, who are unhoused or at immediate risk with no alternative place to stay, no significant resources or income to pay for shelter, are experiencing mental health concerns, and are willing to accept the treatment we offer.

Additional funding was added to 5 sites.

Full Service Partnership (FSP)

CSS: Full Service Partnership

The expansion will add a total of 66 additional staff to FSP directly operated programs. Some of these additional items will staff two new half teams at Edelman Child and Youth and Valley Coordinated Child Services. Additional staff will help to form FSP teams at Santa Clarita Mental Health, Antelope Valley Mental Health and Arcadia Mental Health. Six FSP teams will also receive additional staff.

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NEXT STEPS/TIMELINE

The following timeline outlines next steps to Board adoption of the FY 2023-24 MHSA Annual Update.

May 2023

- LACDMH will receive the Public Hearing feedback and recommendation on the FY 2023-24 Annual Update for inclusion in the final draft to be heard and adopted by the Board of Supervisors (5/15/23).
- LACDMH will initiate a Community Needs Assessment and Recommendation process to inform the Community Planning Process for the upcoming MHSA Two Year Program and Expenditure Plan for FYs 2024-25 through 2025-26.

June 2023

- LACDMH will present the draft FY 2023-24 MHSA Annual Update, including all stakeholder and Mental Health Commission's feedback and responses to the Board of Supervisors review, hearing, and adoption. (6/6/23)
- Adopted FY 2023-24 MHSA Annual Update will be presented to the Mental Health Oversight and Accountability Commission for approval and final execution to continue existing or begin implementation of programs and services within the Update. (6/30/23)

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THANK YOU
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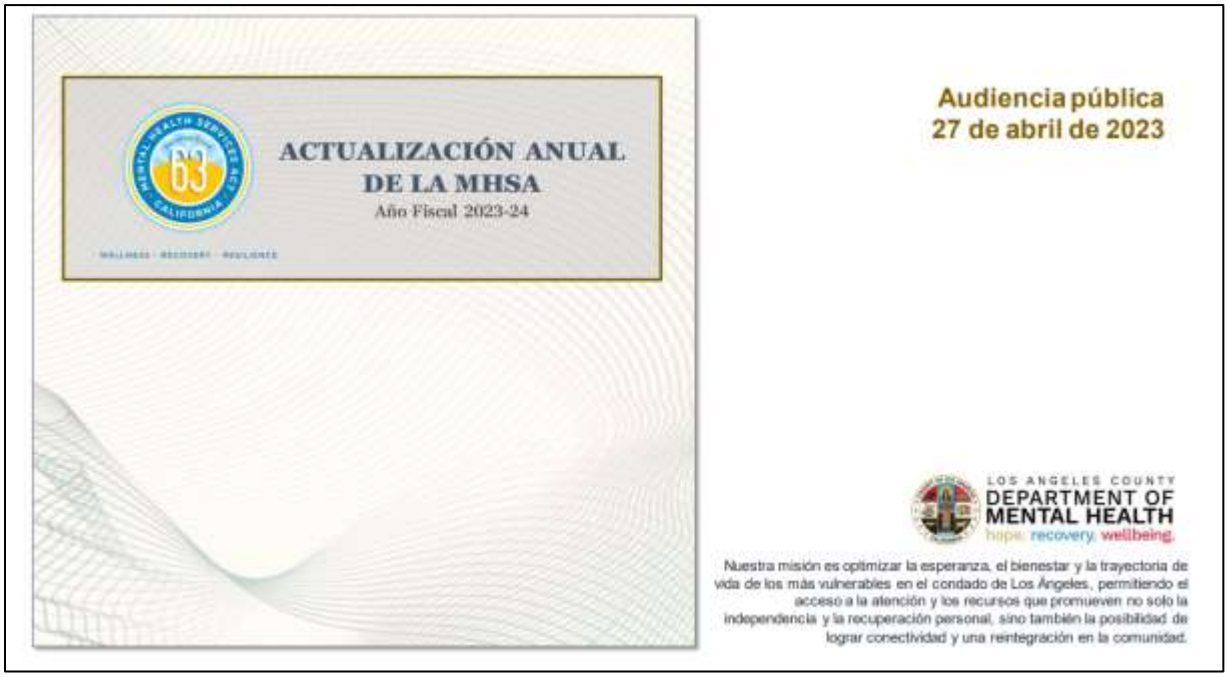
Public Hearing PowerPoint Presentation (Spanish)



LEY DE SERVICIOS DE SALUD MENTAL Y EL OBJETIVO DE LA ACTUALIZACIÓN ANUAL

- En noviembre de 2004, los votantes de California apoyaron la Proposición 63 y aprobaron la Ley de Servicios de Salud Mental (MHSA), que impone un impuesto del 1% sobre la renta respecto de los ingresos personales mayores a $1 millón.
- La Ley brinda una importante financiación que permite expandir, mejorar y transformar los sistemas públicos de salud mental para aumentar la calidad de vida de las personas que sufren una enfermedad mental.
- El artículo 5847 del Código Asistencial e Institucional (WIC, sus siglas en inglés) establece que los programas de salud mental del condado deben preparar y presentar un Plan de Programa de 3 Años y Gastos, seguido de Actualizaciones anuales del plan en el caso de los programas y gastos de la MHSA.
- El Plan brinda la posibilidad de que los condados:
  - Revisen los actuales programas y servicios de la MHSA para evaluar su eficacia.
  - Propongan e incorporen nuevos programas, además de los descriptos en el Plan de Programa de 3 Años y Gastos de la MHSA.
- A través de este Proceso de Planificación Comunitaria se reúnen importantes comentarios de las partes interesadas.
- El 22 de junio de 2021, el Consejo de Supervisores del condado adoptó el Plan de 3 Años para el Año Fiscal 2021-2024 de la MHSA.

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Presupuesto final aprobado para el AF 2021-22 $3.034 mil millones en fuentes de financiación

Principales fuentes de financiación:

- **45% de Medi-Cal estatal y federal ($1.36 mil millones)**
  Servicios especializados de salud mental obligatorios para los clientes que cumplan los criterios de necesidad médica de Medi-Cal.
- **26% de MHSA ($801.6 millones)**
  Alcance, compromiso, prevención, servicios ambulatorios, vivienda, capital, tecnología, enriquecimiento de la fuerza laboral y proyectos para innovaciones en salud mental.
- **Reajuste del 20% del impuesto sobre las ventas ($599.5 millones)**
  Servicios de tratamiento principalmente en entornos institucionales, incluyendo centros y campos de libertad condicional, programas de tratamiento residencial temporal e instalaciones de tratamiento comunitario para jóvenes y camas de tratamiento de salud mental cerradas para adultos y camas de hospitalización, servicios especializados de salud mental para clientes no asegurados y administración.

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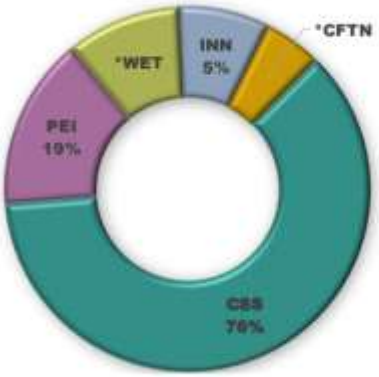
RESUMEN DE LA MHSA POR COMPONENTES

- A continuación se muestra el porcentaje total de adjudicaciones anuales de MHSA a los CSS, la PEI y la INN.
- *Las adjudicaciones de la WET y las CFTN son financiadas por transferencias desde los CSS.



SERVICIOS Y APOYOS COMUNITARIOS (CSS)

PREVENCIÓN E INTERVENCIÓN TEMPRANA (PEI)

EDUCACIÓN Y ENTRENAMIENTO DE LA FUERZA LABORAL (WET)

INNOVACIONES (INN)

INSTALACIONES DE CAPITAL Y NECESIDADES TECNOLÓGICAS (CFTN)

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PRESUPUESTO DE LA MHSA PARA EL AF 2022-23
(en millones)

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CIFRAS DE CLIENTES DE LA MHSA - AÑO FISCAL 2021-22

Servicios y Apoyos Comunitarios (CSS)

- Mayor componente de la MHSA: 76 % de las adjudicaciones de la MHSA.
- Para clientes que sufren una enfermedad mental grave diagnosticada.

PROGRAMAS DE CSS:

- Asociación de Servicio Completo
- Servicios de Atención Ambulatoria
- Servicios Alternativos en casos de Crisis
- Vivienda
- Vinculación
- Planificación, Alcance y Compromiso

CLIENTES ÚNICOS ATENDIDOS

147,143 clientes únicos recibieron un servicio directo.

Etnia
- 36 % hispanos
- 20 % afroamericanos
- 17 % blancos
- 4 % asiáticos e isleños del Pacífico
- 1 % nativos americanos

Lengua principal
- 80 % inglés
- 13 % español

NUEVOS CLIENTES SIN SERVICIO DE MHSA PREVIO

42,616 nuevos clientes atendidos sin servicio de la MHSA previo.

Etnia
- 37 % hispanos
- 15 % afroamericanos
- 15 % blancos
- 3 % asiáticos e isleños del Pacífico
- 0.38% nativos americanos

Lengua principal
- 77 % inglés
- 12 % español

DATOS DE CLIENTES POR ÁREA DE SERVICIOS

Área de servicios	Cant. clientes atendidos	Cant. nuevos clientes
SA1 – Antelope Valley	10,969	2,852
SA2 – San Fernando Valley	21,809	5,574
SA3 – San Gabriel Valley	20,681	6,945
SA4 – Metro	29,471	8,331
SA5 – West	9,699	2,818
SA6 – South	26,269	6,159
SA7 – East	13,027	2,994
SA8 – South Bay	30,117	8,664

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GASTOS Y ESTIMADOS DE LA MHSA – ABRIL DE 2023

Servicios y Apoyos Comunitarios (CSS)

Programa	Gastos brutos estimados – AF 2023-24	Gastos brutos estimados – AF 2022-23	Gastos brutos totales – AF 2021-22
Asociación de Servicio Completo	$163,545,000	$115,915,000	$95,397,000
Servicios de Atención Ambulatoria	$234,019,000	$192,090,000	$182,950,000
Servicios Alternativos en casos de Crisis	$132,177,000	$138,993,000	$132,069,000
Vivienda	$69,147,000	$45,289,000	$40,593,000
Vinculación	$50,878,000	$44,479,000	$34,545,000
Planificación, Alcance y Compromiso	$16,970,000	$4,485,000	$6,178,000
Total general	**$666,736,000**	**$541,224,000**	**$491,732,000**

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PREVENCIÓN E INTERVENCIÓN TEMPRANA (PEI)

Componentes

- Segundo componente más importante de la MHSA, con el 19% de la asignación total de la MHSA.
- Se basa en proporcionar estrategias preventivas y de intervención temprana, educación, apoyo y llegada a las personas en riesgo de desarrollar enfermedades mentales o que experimentan síntomas en una fase temprana.

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PROGRAMAS DE PREVENCIÓN E INTERVENCIÓN TEMPRANA

Servicios de prevención

Las actividades y servicios de prevención están orientados a abordar, a través de la concienciación, la educación, la formación, la divulgación y la orientación, los factores de riesgo asociados con la aparición de enfermedades mentales o trastornos emocionales, haciendo especial énfasis en la mejora de los factores de protección, como la conexión social y el apoyo.

SERVICIOS DE PREVENCIÓN PARA EL AÑO FISCAL 2021-22:

Programas de asociación comunitaria	Cantidad de clientes encuestados
Antelope Valley Community Family Resource Centers (AV-CFRC)	83
Friends of the Children LA (FOTC-LA)	48
Incubation Academy	13,836
Los Angeles Unified School District (LAUSD)	32,841
Programa de extensión de salud conductual My Health LA	28,593
Asociación enfermero-familiar	149
Prevención y cuidados posteriores	1,049
Prevent Homlessness Promote Health (PH2)	171
Veterans Peer Access Network (VPAN)	15,824
Strategies for Enhancing Early Development Success (SEEDS) Atención basada en el trauma para lactantes y niños en edades tempranas	317

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PROGRAMAS DE PREVENCIÓN E INTERVENCIÓN TEMPRANA

Servicios de Intervención Temprana

Dirigido a personas y familias que necesitan una intervención a corto plazo (menos de 1 año) y de relativamente baja intensidad para mejorar considerablemente sus problemas de salud mental , evitando así la necesidad de un tratamiento de salud mental más extenso.

CIFRAS DE CLIENTES DE SERVICIOS DIRECTOS DE LA MSHA – AÑO FISCAL 2021-22

CLIENTES ÚNICOS ATENDIDOS

36,330 clientes únicos que recibieron un servicio directo.

Etnia
- 47 % hispanos
- 8 % afroamericanos
- 9 % blancos
- 1 % asiáticos e isleños del Pacífico
- 0.29 % nativos americanos

Lengua principal
- 76 % inglés
- 21 % español

NUEVOS CLIENTES SIN SERVICIO DE MHSA PREVIO

17,084 nuevos clientes sin servicio de la MHSA previo.

Etnia
- 42 % hispanos
- 8 % afroamericanos
- 9 % blancos
- 2 % asiáticos e isleños del Pacífico
- 0.64 % nativos americanos

Lengua principal
- 75 % inglés
- 21 % español

DATOS DE CLIENTES POR ÁREA DE SERVICIOS

Área de servicios	Cant. clientes atendidos	Cant. nuevos clientes
SA1 – Antelope Valley	2,006	1,203
SA2 – San Fernando Valley	5,565	2,465
SA3 – San Gabriel Valley	5,968	3,225
SA4 – Metro	5,399	2,997
SA5 – West	1,280	739
SA6 – South	3,668	1,964
SA7 – East	4,501	2,303
SA8 – South Bay	6,202	3,078

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PROGRAMAS DE PREVENCIÓN E INTERVENCIÓN TEMPRANA

Prevención del Suicidio

El programa de Prevención del Suicidio brinda servicios a través de múltiples estrategias mediante el fortalecimiento de la capacidad de los recursos comunitarios existentes y la creación de nuevos esfuerzos de colaboración e integrales a nivel individual, familiar y comunitario.

DATOS Y RESULTADOS DE LA PREVENCIÓN DEL SUICIDIO PARA EL AÑO FISCAL 2021-22:

- La Línea de Crisis 24/7 para la Prevención del Suicidio respondió un total de **145,254 llamadas, chats y mensajes de texto** procedentes del condado de Los Angeles, incluyendo línea directa de asistencia en crisis en español a **13,087 personas**.
- El condado de Los Angeles recibió **1,309 encuestas** sobre sus servicios de formación y educación para la prevención del suicidio.

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PROGRAMAS DE PREVENCIÓN E INTERVENCIÓN TEMPRANA

Reducción del estigma y la discriminación (SDR)

El propósito de la SDR es reducir y eliminar las barreras que impiden que las personas utilicen los servicios de salud mental priorizando la información y el conocimiento sobre los primeros signos y síntomas de las enfermedades mentales a través de estrategias centradas en el cliente, de apoyo y educación familiar y de defensa de la comunidad. El Departamento de Salud Mental del condado de Los Ángeles ha puesto en marcha programas de Reducción del Estigma y la Discriminación (SDR) a través de la formación y la educación.

DATOS Y RESULTADOS DE LA SDR PARA EL AÑO FISCAL 2021-22: 16,572 ENCUESTAS REALIZADAS

- La mayoría de los participantes estuvieron de acuerdo en que la formación tuvo una influencia positiva, con un 93% de acuerdo o muy de acuerdo con la afirmación: "como resultado directo de esta formación, estoy más dispuesto a buscar el apoyo de un profesional de la salud mental si creo que lo necesito".
- Los resultados mostraron que la formación tuvo una influencia positiva, con un 87% de acuerdo o muy de acuerdo con la afirmación: "cualquiera puede tener un problema de salud mental".
- El 97% estaba de acuerdo o muy de acuerdo con la afirmación: "los presentadores demostraron conocimiento del tema".
- Un 97% estuvo de acuerdo o muy de acuerdo con la afirmación: "los presentadores fueron respetuosos con mi cultura (es decir, raza, etnia, género, religión, etc.)".

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GASTOS Y ESTIMADOS DE LA MHSA – ABRIL DE 2023

Prevención e Intervención Temprana (PEI)

Programa	Gastos brutos estimados – AF 2023-24	Gastos brutos estimados – AF 2022-23	Gastos brutos totales – AF 2021-22
Intervención Temprana	$106,479,000	$34,218,000	$28,379,000
Prevención	$132,105,000	$85,010,000	$63,021,000
Estigma y Discriminación	$81,836,000	$21,301,000	$6,940,000
Prevención del Suicidio	$6,146,000	$5,682,000	$5,638,000
Total general	**$326,566,000**	**$146,211,000**	**$103,978,000**

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PROCESO DE PLANIFICACIÓN COMUNITARIA

Proceso de las partes interesadas

Septiembre de 2022

- El LACDMH realizó un retiro de 2 días (9/23/22 y 9/30/22) para revitalizar el Proceso de planificación comunitaria y fortalecer las relaciones de colaboración con sus partes interesadas de las poblaciones más vulnerables, desatendidas, marginadas y subrepresentadas de todo el condado.
- Los asistentes tuvieron la oportunidad de examinar los anteriores procesos de compromiso y resultados de partes interesadas y reconocer qué funcionó, qué no e identificar lo que se necesita a futuro para crear y sostener una fuerte relación de colaboración para que el LACDMH ofrezca programas y servicios culturalmente pertinentes en virtud de la MHSA.

Noviembre de 2022

- El LACDMH se reunió con las partes interesadas (11/1/22, 11/17/22, 11/18/22) y presentó una propuesta de tiempos y procesos para lograr un compromiso y aporte importantes en la revisión de los pedidos de financiación de la MHSA para el Ajuste de mitad de año, la Actualización del Plan anual de la MHSA para el AF 2023-24 y el Plan de Programa de 2 Años y Gastos de la MHSA para los AF 2024-25 y 2025-26.

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PROCESO DE PLANIFICACIÓN COMUNITARIA

Proceso de las partes interesadas

Diciembre de 2022

- El LACDMH se reunió con las partes interesadas de la comunidad (12/22/22) y presentó los plazos y procesos propuestos para una participación y aporte significativos en la revisión de las solicitudes de financiación de MHSA para el Ajuste de mitad de año.

Enero de 2023

- El LACDMH llevó a cabo una capacitación fundacional anual de la MHSA (1/2/23) para el personal de LACDMH, el personal de la red de proveedores y las partes interesadas de la comunidad sobre las políticas de la MHSA, el procedimiento de solicitud de fondos de la MHSA del Departamento, el proceso y el cronograma de desarrollo y presentación del Programa de tres años y Gastos y Actualización anual de la MHSA y el proceso de resolución de clientes.
- El LACDMH llevó a cabo dos reuniones con las partes interesadas de la comunidad (1/23/23, 1/31/23) enfocadas en la educación de los participantes sobre los requisitos, las regulaciones de gastos y los componentes de financiamiento de la MHSA.

Febrero de 2023

- El LACDMH llevó a cabo dos reuniones con las partes interesadas de la comunidad (2/17/23, 2/21/23) enfocadas en la revisión de las propuestas del DMH y de las partes interesadas que se considerarán para su inclusión en la Actualización anual de la MHSA del año fiscal 2023-24 y la creación de un consenso sobre qué propuestas presentadas en las reuniones de enero y febrero recibirían la recomendación final de las partes interesadas para su inclusión en el Plan.

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PROCESO DE PLANIFICACIÓN COMUNITARIA

Proceso de las partes interesadas

Marzo de 2023

- El LACDMH realizó un Entrenamiento para proveedores de la MHSA 101 (3/23/23).
- El LACDMH dio inicio a un período de 30 días de revisión pública y comentarios para la Actualización anual de la MHSA para el AF 2023-24 (3/24/23).
- El LACDMH realizó una reunión de partes interesadas de la comunidad (3/30/23) con el objetivo de revisar el borrador de la Actualización anual de la MHSA para el AF 2023-24. Las partes interesadas recibieron una presentación sobre todos los elementos incluidos en la Actualización.

Abril de 2023

- El LACDMH para el 4/24/23: completar el período de publicación y comentarios públicos de 30 días y recopilar los comentarios enviados para incluirlos en el borrador de la Actualización anual.
- 4/27/23 (Hoy): la Comisión de Salud Mental llevará a cabo una audiencia pública para proporcionar comentarios y recomendaciones para las revisiones, si las hubiere.

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PROCESO DE PLANIFICACIÓN COMUNITARIA

Proceso de las partes interesadas

TEMAS, PREGUNTAS Y RESPUESTAS DE LAS PARTES INTERESADAS:

1. **La Comisión y las partes interesadas pidieron que se informara sobre el presupuesto global del sistema, el reclutamiento y el estado de las contrataciones.**

   - DMH Finance proporciona y continuará proporcionando una actualización trimestral del presupuesto general para todo el Departamento, incluyendo todas las fuentes de financiación.

     La última actualización se proporcionó en la reunión de planificación comunitaria de las partes interesadas celebrada el 01/23/23 (véase el presupuesto general del DMH en la diapositiva 17).
   - El Departamento continuará explorando estrategias para proporcionar el gasto presupuestario por área de servicios y distrito de supervisión y estrategias para asignar la financiación en base a una perspectiva de equidad y necesidades insatisfechas.
   - La financiación de todos los componentes de la MHSA también se comunicó el 01/23/23 y se refleja en la diapositiva 18.
   - El Director del DMH brinda y seguirá brindando una actualización trimestral sobre los esfuerzos de reclutamiento y contratación para abordar la escasez de mano de obra y la colaboración con los sindicatos.

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PROCESO DE PLANIFICACIÓN COMUNITARIA

Proceso de las partes interesadas

TEMAS, PREGUNTAS Y RESPUESTAS DE LAS PARTES INTERESADAS (continuación):

2. **La Comisión solicitó la presentación de informes periódicos y la comparación directa de las asignaciones presupuestarias, la utilización y las tendencias de los servicios y la utilización de los fondos antes, durante y después de la pandemia por COVID. Se solicitó que la comparación se reflejara por zonas geográficas, poblaciones étnicas y grupos etarios.**

   - *El DMH ha desarrollado actualmente un panel de datos que brinda datos de utilización de servicios recopilados por año fiscal, área geográfica, población étnica y grupos etarios. Estos datos, junto con la información de asignación presupuestaria, se utilizarán para crear la evaluación directa para los años fiscales anteriores, durante y posteriores al COVID. Estos datos serán compartidos e incorporados a una evaluación de las necesidades de la comunidad para apoyar el Proceso de planificación comunitaria con la Comisión y las partes interesadas para el desarrollo del próximo Plan de Programa de 2 años y Gastos.*

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PROCESO DE PLANIFICACIÓN COMUNITARIA

Proceso de las partes interesadas

TEMAS, PREGUNTAS Y RESPUESTAS DE LAS PARTES INTERESADAS (continuación):

3. **La Comisión y las partes interesadas solicitaron información actualizada sobre datos y resultados:**

   - *El DMH ha desarrollado un panel de datos que proporciona datos de utilización de servicios recopilados por año fiscal, área geográfica, población étnica y grupos etarios. Se utilizará para revisar los servicios a poblaciones de interés específicas, incluyendo las poblaciones étnicas desatendidas y subatendidas, el idioma primario y el género para abordar las grietas en los servicios y recomendar prioridades de servicio para el próximo Proceso de planificación comunitaria del Plan de 2 años, según se solicite. Este tablero también proporcionará un desglose más detallado de los datos de raza /etnia para garantizar la representación de las comunidades culturales desatendidas o subatendidas.*
   - *El DMH convocó un Grupo de Trabajo sobre Disparidades de Datos con el objetivo de centrarse en los datos de la población étnica desatendida y subatendida. Utilizando la herramienta de mapeo de equidad Anti-Racismo, Diversidad e Inclusión (ARDI) y los datos de utilización de servicios, este grupo de trabajo tendrá la tarea de supervisar las métricas de equidad de servicios para informar la planificación de programas y la supervisión de las mejoras del programa.*
   - *Específicamente para el borrador de la Actualización anual, los datos de cifras de clientes por etnia en la diapositiva 7 no están equilibrados. Esto se debe a que el informe solo refleja el recuento de clientes de las 5 etnias principales. Además, debido a la elección del cliente o a las circunstancias de admisión, tampoco se informa el origen étnico de un grupo grande de clientes. El DMH está implementando medidas para mejorar la presentación de los datos étnicos.*
   - *El DMH informa sobre los resultados y el rendimiento del programa en el borrador de la Actualización anual. Los resultados del programa se abordarán como parte del próximo Proceso de planificación comunitaria.*

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PROCESO DE PLANIFICACIÓN COMUNITARIA

Proceso de las partes interesadas

TEMAS, PREGUNTAS Y RESPUESTAS DE LAS PARTES INTERESADAS (continuación):

4. La Comisión y las partes interesadas solicitaron respuestas específicas a los puntos reflejados en el proyecto de actualización anual:

- *El DMH agregará información sobre la expansión del programa en el borrador finalizado de la Actualización anual antes de la revisión y audiencia del Consejo. Las expansiones de programas que se reflejarán en la Actualización se detallan en esta presentación (Diapositivas 39-40).*
- *La diapositiva 11 del borrador del PowerPoint de Actualización anual se informó como incorrecta en la presentación al Comité Ejecutivo de la Comisión de Salud Mental. Las fechas reflejadas en la diapositiva eran correctas y se revisarán durante la audiencia pública de hoy (4/27/23).*
- *En respuesta a la consulta sobre la ampliación del Programa de Identificación y Derivación Temprana de Portland (PIER): la ampliación añade nueva financiación para los servicios PIER en las Áreas de servicios 1 y 8 y aumenta la presencia de los servicios PIER en el Área de servicios 6.*
- *En respuesta a la pregunta sobre cuándo se revisarán y considerarán las propuestas de Innovaciones para su aprobación por parte del Consejo y el estado: las propuestas de Innovación presentadas se someterán al proceso de revisión durante el próximo Proceso de planificación del plan de 2 años, en función de la financiación disponible para Innovaciones.*

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PROCESO DE PLANIFICACIÓN COMUNITARIA

Proceso de las partes interesadas

TEMAS, PREGUNTAS Y RESPUESTAS DE LAS PARTES INTERESADAS (continuación):

5. La Comisión y las partes interesadas solicitaron respuestas a otras preguntas y preocupaciones:

- *En respuesta a la pregunta de la Comisión sobre cuándo se facilitará el resumen general que describe el cambio de la campaña del Mes de la Salud Mental de mayo de We Rise a Take Action: el resumen del cambio se reflejará en el próximo Plan de 2 años.*

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PROCESO DE PLANIFICACIÓN COMUNITARIA

Proceso de las partes interesadas

TEMAS, PREGUNTAS Y RESPUESTAS DE LAS PARTES INTERESADAS (continuación):

6. La Comisión y las partes interesadas solicitaron información actualizada sobre el futuro Proceso de planificación comunitaria:

- *El próximo Proceso de planificación comunitaria implicará una expansión de la participación de las partes interesadas para garantizar una mayor participación de un grupo más diverso de partes interesadas de las comunidades del condado de Los Angeles que sea representativo de los pares, las familiares, las poblaciones étnicas/culturales, las áreas geográficas, las organizaciones comunitarias, otros departamentos del condado y las partes interesadas en general. El Proceso de planificación comunitaria comenzará entre fines de mayo y principios de junio de 2023 y empezará con la capacitación en MHSA 101, la capacitación básica de las partes interesadas y una evaluación de las necesidades de la comunidad y los datos para el desarrollo del Plan de 3 años.*
- *En respuesta a la pregunta: ¿se tomará en consideración a la Comisión de Salud Mental como grupo interesado y se la incluirá antes en el Proceso de planificación comunitaria y en el proceso de presentación de Solicitudes y Propuestas de Financiación de la MHSA y de grupos interesados en nombre del Consejo de Supervisores? Sí. Se notificará a la Comisión de Salud Mental sobre el Proceso de planificación comunitaria y los plazos para dejar comentarios, opiniones y para presentar una Propuesta de Financiamiento de la MHSA en nombre de las oficinas del Consejo. La Comisión de Salud Mental tiene un papel formal único como parte del Proceso de planificación comunitaria y tiene la responsabilidad de garantizar que las voces de las partes interesadas se incluyan en el proceso, mientras que brinda información en el proceso en nombre del Consejo de Supervisores. El DMH compartió información con la Comisión de Salud Mental durante el Proceso de planificación comunitaria para el borrador de la Actualización anual en el otoño de 2022, como preparación para las reuniones de participación de las partes interesadas. El DMH continuará compartiendo el proceso en el futuro.*

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PROCESO DE PLANIFICACIÓN COMUNITARIA

Proceso de las partes interesadas

TEMAS, PREGUNTAS Y RESPUESTAS DE LAS PARTES INTERESADAS (continuación):

7. La Comisión y las partes interesadas solicitaron actualizaciones y aclaraciones sobre el Proceso de solicitud y propuestas de financiación de la MHSA.

Se incluyen las respuestas a las preguntas sobre el Proceso de solicitud/propuestas de financiación de la MHSA:

¿Cómo presentan las propuestas las partes interesadas y los miembros de la comunidad?

- *Las solicitudes/propuestas pueden presentarse 24 horas al día/7 días a la semana a través del Portal de solicitud de financiación de la MHSA utilizando los formularios electrónicos en línea. Las solicitudes de financiación de CSS, PEI y WET deben presentarse mediante el formulario que se encuentra en: https://forms.office.com/g/hFe6wc9LA2.* Las solicitudes de financiación de Innovación deben presentarse utilizando el formulario que se encuentra en: *https://forms.office.com/g/77BRkSWzUe. Ambos portales estarán disponibles para recibir nuevas propuestas para el próximo proceso de Planificación de 2 años desde mediados de mayo de 2023 hasta el 15 de enero de 2024.*

¿Cómo se notifica a los proponentes el estado de revisión, aprobación o rechazo de sus propuestas?

- *Se informará a los proponentes el estado de su presentación mediante una llamada telefónica o un correo electrónico.*

¿Puede compartirse o divulgarse la fuente de las propuestas?

- *Sí. La fuente de las propuestas (por ejemplo, OBC, entidades del condado o partes interesadas de la comunidad) puede facilitarse previa solicitud y también se publican en la página del DMH MHSA.*

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PROCESO DE PLANIFICACIÓN COMUNITARIA

Proceso de las partes interesadas

TEMAS, PREGUNTAS Y RESPUESTAS DE LAS PARTES INTERESADAS (continuación):

8. La Comisión y las partes interesadas solicitaron actualizaciones y aclaraciones sobre el proceso de solicitud y propuestas de financiación de la MHSA.

¿Puede compartirse el importe solicitado por los proponentes?

- *Sí. La cantidad solicitada para las propuestas se compartió con las partes interesadas durante el Proceso de planificación comunitaria. Esta información también está disponible previa solicitud. Los importes solicitados son estimados y pueden variar tras la aprobación y durante la ejecución en función de los costos reales confirmados y de las actividades financiadas que figuren en la propuesta.*

¿Puede compartirse la información sobre las poblaciones de interés propuestas y las zonas geográficas a las que se prestará servicio?

- *Sí. Esta información se compartió con las partes interesadas durante el Proceso de planificación comunitario. Tras la aprobación del Consejo y antes de la implementación real, la Unidad de Administración de la MHSA consultará con el proponente para confirmar las poblaciones de interés y las áreas geográficas propuestas. Se realizará un análisis de cada propuesta aprobada para garantizar que se aborden las preocupaciones y consideraciones de equidad y que las asignaciones de fondos respalden las necesidades insatisfechas de las comunidades de todo el condado.*

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PROCESO FORMAL DE SOLICITUD DE FINANCIACIÓN DE LA MHSA

1 **Presentación de solicitud de financiación de la MHSA**	2 **Revisión administrativa de la MHSA** (7-60 días)	3 **Revisión y recomendación de partes interesadas** (90 días)	4 **Revisión y aprobación ejecutiva del DMH** (60 días)	5 **Comentarios del público, publicación y audiencia** (30 días)	6 **Aprobación del Consejo y de la OAC** (90 días)
Todas las solicitudes de financiación de la MHSA se presentan a través del portal del DMH. Las solicitudes se clasifican en los siguientes tres tipos: • Un nuevo programa de salud mental. • Un cambio o ampliación de un programa actual de salud mental de la MHSA. • Solicitud de financiación adicional para una entidad jurídica.	Las presentaciones son revisadas inicialmente por la Administración de la MHSA para garantizar el cumplimiento de la normativa de la MHSA y verificar que se haya incluido toda la información crítica relativa a las poblaciones de interés, los resultados, etc. Las propuestas que cumplen las normas de la MHSA se someten a revisión de las partes interesadas y las que no lo hacen se remiten a la Oficina de Servicios Financieros para determinar otras posibles fuentes de financiación.	Las propuestas aprobadas por la Administración de la MHSA se presentan a las partes interesadas para brindar sus comentarios. Se revisan los comentarios y se introducen en la propuesta los cambios que se consideren necesarios.	Las propuestas aprobadas y financiadas se incluyen en un anuncio público de 30 días. Las propuestas aprobadas, pero para las que no se dispone de financiación se documentan como una Necesidad insatisfecha.	Todas las presentaciones aprobadas por el DMH se incluyen en un borrador del Plan de 3 años, la Actualización anual o el Ajuste de mitad de año que se publica en el sitio web público de la MHSA durante 30 días para que el público lo vea y haga comentarios. Una vez transcurridos los 30 días de publicación, se realizan los cambios necesarios en función de los comentarios recibidos y se celebra una Audiencia pública de la Comisión de Salud Mental.	El borrador final del Plan de 3 años y la Actualización anual se presenta al Consejo de Supervisores del condado de Los Angeles para su aprobación. Tras la aprobación del Consejo, el Plan de 3 años y la Actualización anual se presentan a la Comisión de Supervisión y Rendición de Cuentas de la MHSA.

Enlace al formulario de propuesta de proyecto de la MHSA:
https://forms.office.com/g/hFe6wcSLA2
https://forms.office.com/g/77BRkSWrUe

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CAMBIOS PROPUESTOS

AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

Centro de Recursos Familiares de la Comunidad (CFRC)

Población de interés: todos los grupos etarios y poblaciones - Familias

El CFRC está diseñado para crear un espacio coordinado, motivado y propio de la comunidad donde familias y personas puedan acceder fácilmente a los servicios que necesitan para mejorar su bienestar. Los CFRC crearán sociedades con redes de atención, líderes individuales y organizaciones comunitarias y entidades públicas y privadas de confianza para aprovechar las fortalezas y capacidades de cada uno para atender mejor las necesidades de las personas y familias de su comunidad.

Iniciativa de Escuelas de la Comunidad (CSI)

Población de interés: jóvenes de la escuela secundaria y preparatoria

La CSI atiende a 15 escuelas preparatorias que sirven como centros para una variedad de servicios de apoyo para estudiantes, familias y personal escolar. El programa asigna a cada sitio un Especialista de Escuelas Comunitario para asistir con los servicios de coordinación y un Trabajador Comunitario Educativo para ayudar en el compromiso de los padres. Los servicios se enfocan en la prevención, ayudando a los cuidadores y a los estudiantes a acceder a una variedad de servicios para prevenir el estrés y posibles enfermedades mentales.

Red de Promotores de la Salud Mental Unidos

Poblacion de interés: poblaciones culturalmente marginadas

El proyecto de la Red de Promotores de la Salud Mental constituye un esfuerzo de alcance comunitario que sirve para fortalecer a las comunidades y ofrecer orientación laboral a aquellos miembros de la comunidad que funcionan bajo el auspicio de los Promotores de la Salud Mental.

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CAMBIOS PROPUESTOS (continuación)

AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

Amigos de los Niños (FOTC) - Los Angeles

Población de interés: niños y jóvenes menores de 18, a partir de 4-6 años

FOTC tiene como objetivo evitar el ingreso en hogares de acogida y mejorar la estabilidad y bienestar de las familias identificadas por el DCFS con mayor riesgo de ingresar en el sistema de acogida. FOTC ofrece tutorías individuales profesionales para niños a partir de los 12 años, comenzando desde los 4 a 6 años. Los mentores son entrenados para apoyar a los cuidadores, fomentar la autodefensa y crear oportunidades para lograr conexiones de pares y con la comunidad culturalmente receptivas.

Servicios legales médicos

Población de interés: todos los grupos etarios

Aborda los problemas legales de los clientes y aumenta la conciencia respecto de sus derechos, reduciendo el exceso de estrés y empoderándolos por medio de la información. Estos servicios legales pueden eliminar los obstáculos para mantener un ingreso estable a través del empleo.

Visitas domiciliarias: profundizar conexiones y mejorar servicios

Población de interés: padres y cuidadores de niños de 0 a 5 años

Healthy Families America (HFA) y Parents as Teachers (PAT) son programas nacionales de visitas domiciliarias basados en la investigación y la evidencia que reúnen información familiar para diseñar los servicios para toda la familia. Estos programas ofrecen visitas al hogar cada 1 o 2 semanas para fomentar relaciones positivas entre padres e hijos y un vínculo saludable. Además, darán prioridad a las áreas en donde los datos indican que hay un mayor número de familias con servicios de protección de niños.

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CAMBIOS PROPUESTOS (continuación)

AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

Nuevo compromiso de padres: bienvenidos a la biblioteca y al mundo

Población de interés: padres y cuidadores nuevos

Las bibliotecas públicas y Salud de la Mujer del DHS ofrecerán un kit Bienvenidos a la biblioteca y al mundo con información sobre los programas y servicios Smart Start Early Literacy. El programa será ofrecido en 45 sitios dos veces al año y a través de un programa virtual trimestral.

Programa para jóvenes SPOT: Oportunidades para Jóvenes luego de la Escuela

Población de interés: niños y jóvenes de menos de 18

Nuestro SPOT: se trata de un programa extenso para después de la escuela que tiene como objetivo involucrarse con los jóvenes de la comunidad y brindarles apoyo, habilidades para vivir y experiencias positivas que los empoderen para forjarse un futuro brillante.

We Rise Parques al Atardecer

Población de interés: más o menos de 24 años de edad - familias

We Rise es un programa de prevención que brinda acceso a una programación de autocuidado en 58 parques del condado de LA y se ofrece durante el mes de conciencia sobre la salud mental. Incluye oportunidades constantes para acceder a recursos e información sobre el cuidado de la salud mental, incluyendo talleres gratuitos sobre bienestar mental.

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CAMBIOS PROPUESTOS (continuación)

AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

Parques a la Noche Parques al Atardecer

Población de interés: más o menos de 24 años de edad - familias

Diseñado para familias y adultos con el fin de participar en talleres y clases que promueven el autocuidado y la sanación 3 noches a la semana durante 8 semanas. Las actividades incluyen deportes, entrenamiento personal, arte y cultura, películas y conciertos, entre otros.

Pasos seguros DPR: compromiso comunitario y pasos seguros para jóvenes y comunidades

Población de interés: niños y jóvenes menores de 18 años

La iniciativa Pasos seguros DPR utiliza interventores y embajadores de bandas entrenados para implementar el mantenimiento de la paz entre los vecindarios de bandas con el fin de asegurar la seguridad a/desde los parques y durante las actividades en los parques y brindar servicios de intervención en casos de crisis en los parques.

Compromiso de padres/cuidadores Triple P

Población de interés: padres y cuidadores

Triple P es una práctica eficaz basada en la evidencia que brinda a los padres y cuidadores estrategias simples y prácticas para ayudarlos a construir relaciones fuertes y saludables, manejar con confianza los comportamientos de los niños y evitar el desarrollo de problemas.

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CAMBIOS PROPUESTOS (continuación)

AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

Servicios de Navegación de Salud del Paciente

Población de interés: todos los grupos etarios

La propuesta aumentará los actuales Servicios de Navegación de Salud del Paciente sumando servicios enfocados en la prevención de la salud mental, que incluye evaluación, derivación y vinculación a apoyos comunitarios y a educación para aumentar los factores de protección para las personas con riesgo de sufrir una enfermedad mental.

Preparación para la Escuela

Población de interés: de 2 a 4 años (niños pequeños y en edad pre-escolar)

Un programa de alfabetización temprana diseñado para niños pequeños y en edad pre-escolar para ayudar a los padres y tutores a apoyar las necesidades de educación de sus niños. A través de libros, canciones, rimas y diversión, los niños construyen habilidades de educación temprana, de matemáticas básicas y sociales, además de otras capacidades esenciales de preparación para la escuela.

Bienestar creativo: arte, escuelas y resiliencia

Población de interés: 24 años y cuidadores

Un enfoque no tradicional basado en el arte y la cultura que promueve la salud mental en gente joven y cuidadores. El modelo ofrece estrategias no tradicionales para fomentar la salud mental y el bienestar e incluye talleres artísticos culturalmente adecuados y sanadores para gente joven, además de brindar apoyo para el desarrollo profesional, entrenamientos de vida y apoyo emocional para los adultos que trabajan con ellos. Las actividades incluidas apoyan el desarrollo positivo cognitivo, social y emocional y fomentan un estado de bienestar.

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CAMBIOS PROPUESTOS (continuación)

AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

Proyecto de nacimiento abundante

Población de interés: personas embarazadas y padres de niños de 0 a 18 meses

Este programa es una asociación pública-privada que busca brindar apoyo como mínimo a 400 personas embarazadas en el condado de LA de poblaciones marginadas, que tienen mayor probabilidad de sufrir el peor resultado durante el nacimiento con una variedad de apoyos durante 18 meses (salud mental, ayuda financiera, apoyos de bienestar, asistencia en vivienda, educación, etc.). Se trata de un estudio de control para evaluar los efectos de este tipo de asistencia.

Modelo de mentoría de mensajeros creíble

Población de interés: jóvenes en edad de transición de 18 a 25

Este programa involucra un entrenamiento de jóvenes pares para aumentar el acceso a recursos y servicios para los jóvenes de color desfavorecidos por los sistemas y servicios tradicionales. Los servicios están dirigidos a jóvenes entre 18 y 25 años e incluyen entrenamiento de pares mensajeros, evaluación de necesidades de los mentores, orientación por jóvenes con experiencia de vida, actividades grupales, intervención en crisis, participación familiar, derivación y vinculación de recursos.

Regiones de desarrollo para la juventud

Población de interés: jóvenes en edad de transición de 18 a 25

Este programa brinda apoyo/derivación a una serie de servicios de desarrollo para jóvenes, tras una evaluación de fortalezas, intereses y necesidades de cada uno. Dirigido a jóvenes de 18 a 25 y diseñado para ayudar a cerca de 6,500 por año. Los servicios se ofrecen por medio de organizaciones comunitarias contratadas, derivación y vinculación. Incluye recursos para participación escolar, entrenamiento en solución de conflictos, apoyo de mentores/pares, apoyo escolar, servicios de empleo/laborales, expresión artist./creativa y bienestar social / emocional.

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CAMBIOS PROPUESTOS (continuación)

AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

Enfoque local para evitar la falta de techo

Población de interés: adultos jóvenes que salen de hogares de acogida y en riesgo de no tener techo

El Departamento de Servicios de Salud y Sociales de Long Beach convocará a socios locales para identificar brechas en los servicios de prevención de la falta de techo y desarrollar estrategias de intervención para abordar la vivienda a corto plazo, los servicios móviles y en clínica y los programas de apoyo para jóvenes adultos que salen del sistema de hogares de acogida.

Terapia de la risa y la gratitud

Población de interés: adultos mayores latinos

Ilustrar al público sobre alternativas terapéuticas que no necesariamente involucran la utilización de medicamentos para mejorar el estado de ánimo y sobre la importancia de aceptar las emociones en lugar de ocultarlas.

Adultos mayores latinos y cuidadores

Población de interés: adultos mayores latinos

Crear oportunidades para los inmigrantes mayores latinos para que prosperen y sean más independientes enseñándoles a no temerle a la tecnología sino a utilizarla como una herramienta para estar conectados con los seres queridos, aprender cosas nuevas, encontrar entretenimiento y que se convierta en una herramienta útiles para la superación personal.

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CAMBIOS PROPUESTOS (continuación)

AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

Búsqueda para Involucrar a los Americanos Pilipino (SIPA)

Población de interés: jóvenes

Brindar servicios de apoyo de la salud mental basados en la fortaleza y dirigidos a la juventud y a las personas marginadas en SPA 4, con especial énfasis en las áreas de Historic Filipinotown y alrededores.

Conciencia de la salud mental y línea de ayuda para coreanos

Poblacion de interés: todos los grupos etarios coreanos

Busca normalizar las enfermedades mentales y su tratamiento dentro de la comunidad coreana, para que las personas busquen ayuda y servicios sin verguenza ni duda.

Programa de revinculación WPW de FosterALL

Poblacion de interés: adultos y niños dentro del sistema de hogares de acogida

El Programa Wisdom Path Way de FosterALL se ocupa de niños y adultos en hogares de acogida y brinda resultados positivos para evitar traumas, estrés y enfermedades mentales adicionales, tanto para los niños como para los adultos.

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CAMBIOS PROPUESTOS (continuación)

AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

Boletín informativo: Cultural Reflections

Población de interés: consumidores del LACDMH

Brindar oportunidades para que los pares generen contenido relacionado con la salud mental con el fin de ser desarrollado y distribuido en todo el condado.

Esperanza y curación: apoyo del bienestar de la salud mental para familias y familiares de víctimas

Población de interés: familias afroamericanas que han sufrido pérdidas por la violencia

Aportar esperanza y bienestar mental para normalizar la conversación y la conciencia para que las familias acudan a los servicios de salud mental y se eliminen los estigmas comunes relacionados que evitan que muchas personas traumadas reciban la ayuda que necesitan.

Proyecto TransPower

Población de interés: población de jóvenes Trans*

Aumentar el acceso y eliminar los obstáculos relacionados con el tratamiento, tales como la falta de recursos, las necesidades de transporte y las cuestiones de privacidad, ofreciendo servicios positivos y especializados en la salud mental sin costo.

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CAMBIOS PROPUESTOS (continuación)

AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

Centro de Servicios y de Salud Comunitarios *Open Arms*

Población de interés: todos los grupos etarios

Brinda atención a la salud de calidad, apoyo de la salud mental, vivienda, manejo de casos, referencias laborales y servicios de respaldo, tales como comida, vestimenta, kits de aseo personal, transporte, manejo de la ira, uso de sustancias, tráfico sexual y clases para padres.

Red de empoderamiento del consumidor

Población de interés: consumidores del LACDMH

Educar a los consumidores del LACDMH sobre la historia de la MHSA, el rol de los consumidores del LACDMH y de todo el estado, los componentes y procesos necesarios, los eventos de las partes interesadas a nivel estatal y del condado, las oportunidades para hacer comentarios y recomendaciones públicas y el proceso legislativo.

Innovación 2 / Prevención e Intervención Temprana

Población de interés: jóvenes en edad de transición dentro de comunidades de sordos, BIPOC, discapacitados, LGBTQIA2S y asiáticos e isleños del Pacífico.

Ayudar a construir comunidades informadas sobre el trauma y familias resilientes a través de Especialistas en Recursos Comunitarios (CRS) que trabajen con las familias en sus hogares, para asegurse de que las crisis de alimentos, médicas o de vivienda no las desestabilicen.

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CAMBIOS PROPUESTOS (continuación)

AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

Servicios de salud mental para sordos e hipoacúsicos

Población de interés: todos los grupos etarios de sordos e hipoacúsicos

Ofrecer intérpretes del Lenguaje Americano de Señas (ASL, en inglés) que puedan traducir eficazmente y con precisión términos y conceptos de salud mental a personas sordas e hipoacúsicas.

Clínica de familia militar Steven A. Cohen en VVSD, Los Angeles

Población de interés: veteranos y sus familias

La Clínica Cohen ofrece atención de salud mental personalizada y basada en la evidencia junto con alcance y acceso a apoyos para el manejo de casos integrales y derivaciones para abordar la intervención temprana y la prevención del suicidio, el desempleo, las finanzas, la vivienda y cuestiones legales a tiempo.

Expansión de DBT

Población de interés: fuerza laboral para los consumidores del LACDMH

Este proyecto ofrecerá apoyo al programa DBT de la clínica, brindando financiación específica para el personal médico, de servicios de terapia directa, de trabajadores / apoyo de pares y de gerencia/supervisión para que reciban un entrenamiento pago con el fin de obtener certificación, prácticas e implementación de DBT.

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EXPANSIÓN

AÑO FISCAL 2023-24

Los que siguen son programas actuales de la MHSA aprobados previamente por las partes interesadas para su expansión en el Año Fiscal 2023-24.

Identificación de Portland y Remisión temprana (PIER)

PEI: Prevención

Actualmente, el DMH tiene 5 sitios de programas PIER prácticamente llenos. Esto aumentará la cantidad de sitios y áreas disponibles para el programa. PIER es un programa de Atención Especializada Coordinada para adolescentes y adultos jóvenes, de 12 a 25 que estén en Alto Riesgo Clínico de sufrir psicosis o hayan tenido su primer episodio psicótico. Actualmente, las derivaciones desde ELAC STAND (UCLA), NAMI Urban LA, escuelas y varios programas ambulatorios exceden la capacidad del actual nivel de servicio.

Extensión y Participación Móvil para Personas sin Techo (HOME)

CSS: Alcance y compromiso de planificación

El programa HOME brinda alcance, compromiso, apoyo y tratamiento de campo para personas con enfermedades mentales graves y recurrentes que sufren la falta de techo sin refugio.

La expansión permitirá un total de 94 puestos a tiempo completo (6 nuevos equipos multidisciplinarios y 1 equipo de Navegación de Área de Servicios) que serán agregados entre los AF 2022-23 y 2023-24. La expansión aportará un total de 16 equipos multidisciplinarios en el condado y 1 equipo de Navegación de Servicios.

Programa de Tratamiento Residencial de Crisis (CRTP)

CSS: Servicios de crisis alternativos

Los CRTP están diseñados para brindar servicios a corto plazo intensos y de apoyo en un ambiente hogareño a través de un programa de rehabilitación social activo certificado por el Departamento de Servicios de Salud de California y licenciado por la División de Licencias de Cuidado Comunitario del Departamento de Servicios Sociales de California.

Recibió un nuevo contrato de entidad jurídica para Bel Aire Health Services con el fin de brindar servicios en 2 lugares: Downey y Sylmar.

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EXPANSIÓN (continuación)

AÑO FISCAL 2023-24

Los que siguen son programas actuales de la MHSA aprobados previamente por las partes interesadas para su expansión en el Año Fiscal 2023-24.

Centros de atención inmediata para TAY

PEI: Prevención
CSS: Servicios de Atención Ambulatoria

Los Centros de atención inmediata para TAY sirven como puertos de entrada al sistema de salud mental para jóvenes sin techo o con una situación de vivienda inestable.
Se agregarán 10 sitios en total en el condado. Las Áreas de Servicios 2, 3, 4, 5, 7 y 8 recibirán un nuevo sitio cada una y las 1 y 6 recibirán 2 cada una.

Programa de Refugio de Emergencia Mejorado para TAY

CSS: Vivienda

El Programa de Refugio de Emergencia Mejorado (EESP) atiende las necesidades urgentes de vivienda de la población TAY de 18 a 25 años que no tiene techo, está en riesgo de perderlo y no tiene otro lugar, tampoco tiene recursos ni ingresos importantes para pagar un refugio, está teniendo complicaciones con la salud mental y está dispuesta a aceptar el tratamiento que le ofrecemos.

Se sumó financiación adicional a 5 sitios.

Asociación de Servicio Completo (FSP)

CSS: Asociación de Servicio Completo

La expansión sumará un total de 66 empleados a programas de FSP operados directamente. Algunas de estas adiciones armarán 2 nuevos equipos por la mitad en Edelman Child and Youth y Valley Coordinated Child Services. El resto del personal ayudará a formar los equipos de FSP en Santa Clarita Mental Health, Antelope Valley Mental Health y Arcadia Mental Health. 6 equipos de FSP también recibirán más personal.

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PRÓXIMOS PASOS/CRONOGRAMA

El siguiente cronograma incluye los pasos que se darán para la adopción de la Actualización anual del AF 2023-24 de la MHSA por parte del Consejo.

Mayo de 2023

- El LACDMH recibirá comentarios y recomendaciones de la Audiencia Pública sobre la Actualización anual del AF 2023-24 para su incorporación en el borrador final que será analizado y adoptado por el Consejo de Supervisores (5/15/23).
- El LACDMH comenzará un proceso de Evaluación y Recomendación de Necesidades de la Comunidad para informar el Proceso de planificación comunitaria para el próximo Plan de Programa de 2 años y Gastos de la MHSA para los AF 2024-25 y 2025-26.

Junio de 2023

- El LACDMH presentará el borrador de la Actualización anual de la MHSA para el AF 2023-24, que incluye todas las opiniones y respuestas de las partes interesadas y de la Comisión de Salud Mental, al Consejo de Supervisores para su revisión, análisis y adopción (6/6/23).
- La Actualización anual de la MHSA para el AF 2023-24 será persentada a la Comisión de Supervisión y Responsabilidad de los Servicios de Salud Mental para su aprobación y ejecución final con el fin de seguir operando o comenzar la implementación de programas y servicios incluidos en la Actualización (6/30/23).

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GRACIAS
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LOS ANGELES COUNTY

DEPARTMENT OF MENTAL HEALTH

MENTAL HEALTH COMMISSION FULL MEETING

THURSDAY, APRIL 27, 2023

10:30 AM

>> KENIA FUENTES: Good morning, LA County. Welcome to LA County Mental Health Commission. My name is Kenia, and I am the executive assistant. Today is April 27, 2023. Before I hand it over to Canetana for roll call and

then to our Chair Austria for our official meeting, just a few items. Please make sure that your phone devices are silent. If you are in-person, our restrooms are directly outside of the store, quickly through the hallway to your right. For those who are intending to have attendance verification, please make sure you sign in if you're in person. For those online, a link will be shared so that you can sign in online. Thank you so much.

>> AT&T OPERATOR: Hi, this is Don with AT&T.

>> JULIO MIRANDA: Hi, Don. Thank you so much. My name is Julio. I'll be the tech running online today. And at a later time, we will ask you to provide instructions for queuing up. However, at this time, please just open the line for the public to listen. Thank you so much.

>> AT&T OPERATOR: Okay. Thank you.

[Roll call]

>> KENIA FUENTES: Thank you. And I will do a roll call.

>> COMMISSIONER FRIEDMAN: [Absent]

>> COMMISSIONER PADILLA-FRAUSTO: [Absent]

>> COMMISSIONER ROOT: Present.

>> CHAIR AUSTRIA: Here.

>> COMMISSIONER BARBOUR: Present.

>> COMMISSIONER STEVENS: Present.

>> COMMISSIONER DALGLEISH: Present.

>> COMMISSIONER MOLINA: Present.

>> COMMISSIONER SANABRIA: [Absent]

>> COMMISSIONER COOPERBERG: Here.

>> COMMISSIONER SCHALLERT: Present.

>> COMMISSIONER WEISSMAN: Here.

>> KENIA FUENTES: Okay. Chair Austria, you have the floor.

>> KENIA FUENTES:

>> CHAIR AUSTRIA: Good morning, everyone. Thank you for being here.

[Approval of meeting minutes]

>> CHAIR AUSTRIA: Our first item is our approval of minutes for both February and March. We'll start with the approval of the minutes for February. Any comments or questions from the commission?

>> COMMISSIONER DALGLEISH: Do you have a microphone or is it loud enough? Can people hear me?

>> JULIO MIRANDA: Yes. Yes, they can.

>> CHAIR AUSTRIA: And they can hear me.

>> KENIA FUENTES: Can you hear from this?

>> CHAIR AUSTRIA: Okay. Is there a motion to approve --

>> COMMISSIONER MOLINA: I move for approval for February and March.

>> COMMISSIONER DALGLEISH: Second.

>> CHAIR AUSTRIA: It's been seconded, our motion. So all those in favor say "aye."

[Ayes]

>> CHAIR AUSTRIA: Opposed?

[No response]

>> CHAIR AUSTRIA: Thank you. And the next one, approval of the minutes for March 23rd. Again, questions or comments?

>> COMMISSIONER MOLINA: Molina moves approval.

>> COMMISSIONER DALGLEISH: Second.

>> CHAIR AUSTRIA: It's been moved and seconded to approve the March minutes. All those in favor say "aye."

[Ayes]

>> KENIA FUENTES: Can I know who seconded?

>> CHAIR AUSTRIA: Stacy.

>> KENIA FUENTES: Thank you.

>> CHAIR AUSTRIA: Mike Molina and Stacy Dalgleish for both motions.

[Elections]

>> CHAIR AUSTRIA: The next item really is elections. So we need to have an election exercise for the board Executive Committee. Right now we have one person who is a volunteer to be on the elections committee. That's Reba Stevens. Thank you, Reba. We need one more person to volunteer. If we don't have a volunteer, then what I will do is have the staff distribute the paperwork that we need to submit to run. And at that point we will have the election -- Stacy.

>> COMMISSIONER DALGLEISH: Is it still the case according to whichever bylaws we're operating from that you are not to be on the nomination committee if you are planning to run for an office? Because that would exclude me, but --

>> CHAIR AUSTRIA: Yes.

>> COMMISSIONER DALGLEISH: Okay. All right. Thank you.

>> CHAIR AUSTRIA: Yes. Reba.

>> COMMISSIONER STEVENS: I would like to nominate Judy Cooperberg to join me again and be on the committee.

>> COMMISSIONER COOPERBERG: I thought you didn't like me.

[Overlapping Speakers]

[Laughing]

>> COMMISSIONER STEVENS: Well, as you can see, I love you.

[Laughing]

>> COMMISSIONER COOPERBERG: Okay, I'll second.

>> COMMISSIONER STEVENS: So she and I are -- commissioner Cooperberg and I are --

>> CHAIR AUSTRIA: So for the record, Judy Cooperberg and Reba Stevens will be our nominating committee. So if you're interested in running for a position, please contact them, copy Canetana so we can get you the proper paperwork and then we'll help that next. I just want to personally thank you both.

[Annual reports]

>> CHAIR AUSTRIA: Okay. So then we're going to the presentation reports or let me just say annual report. And following that, we will have a public hearing at -- for the public comment on the MHSA Update plan. And our main goal here is for the commission to listen to the community and get feedback on the plan. And we may also have some comments of our own at the end. Thank you. Kalene.

[MHSA Annual Update report]

>> KALENE GILBERT: Going to start. Can folks hear me okay from here?

>> JULIO MIRANDA: Yes.

>> KALENE GILBERT: Great. Thank you. So good morning, commissioners, and -- good morning, commissioners, and good morning to all of our stakeholders who've also joined us today. I do want to say a big thank you to all of our stakeholders that have taken the time to come to these meetings, sometimes at a great distance to participate in this process. So I'm really pleased to be able to present our Annual Update. Julio, could you please bring up my slides?

>> JULIO MIRANDA: They should be up.

>> KALENE GILBERT: Okay. And can I -- and can I also ask if you can or if you don't mind, could you please add the link to the Annual Update itself into the chat box for anybody online who'd like to access it? There's one in -- a link for both English and Spanish.

>> JULIO MIRANDA: Both those links are posted as an announcement at this time.

>> KALENE GILBERT: You like more space to see? Yeah. Okay. Is it possible, and I apologize, Julio, one more. Is it possible to make it just a little bit bigger? Nope.

>> JULIO MIRANDA: That would be what Kenia said. She's showing her screen. Kenia, can you maximize your viewable window or click on the presentation if you swapped views.

>> KENIA FUENTES: So if I do that, I take out CART and it's an access issue, I apologize for that.

>> COMMISSIONER WEISSMAN: Or it can't be smaller to the right, you can't minimize that -- smaller? Are you expecting them to read that?

>> KENIA FUENTES: Yes. They're reading, so okay. Okay.

>> KALENE GILBERT: All right. So with that, I'll go ahead and get started. This is our Annual Update for fiscal years '22 -- I'm sorry, '23-'24. I'm going to go into a little detail on MHSA and the Annual Update, but just so folks know, before I dive in, the Annual Update tends to cover outcomes and data and budget for the prior fiscal year,

which in this case would be '21-'22. It covers the stakeholder process for this year and some of the planning for next year and the budget for this year. And it also covers our planned updates for next year and the budget for next year. So it kind of covers three fiscal years. So you'll notice we might kind of go back and forth on the dates when I'm talking about budget. And that's because that's what's included in the Annual Update. So if you go to the next slide, please.

So today I will spend some time talking about the purpose of the Annual Update. I'm going to go over the overview of the MHSA components. I'm going to talk a little bit about client counts and expenditures for some of the major components. I'll talk a little bit about the Community Planning Process and some community feedback that we've received to date from online and from commissioners. We'll talk about the proposal process, the proposed changes, and the next steps in the timeline. So next slide, please.

So for those that aren't familiar, the Mental Health Services Act, which we refer to as MHSA, was passed in November of 2004. Prop 63, it was a voter initiative. And it imposed a 1 percent income tax on income in excess of a million. So any of our millionaires here in the state of California, every dollar over a million with 1 percent of that went to fund our public mental health system.

And it was intended to provide significant funding to expand, improve, and transform the system. It really was intended to fill that gap, that promise from when, you know, for our community mental health, that once we move folks out of inpatient settings and into the community, I think the vision for inpatient outpatient care and community care was big. And I think we could all agree it was never quite fulfilled. So MHSA was really meant to expand that system. And it's been commented that MHSA is kind of the mortar, right, that holds a lot of our program together. But I would argue at this point in time, it really is the steel frame of our mental health system.

Regulations require that the mental health programs, which is us, prepare and submit a three-year program and expenditure plan, followed by an annual plan update for MHSA. So every three years in June, we need to submit to the public and to the state our plan for mental health services. It's our roadmap. So this plan should reflect all of our services for the mental health service, all of our MHSA services. And anything that we want to do has to be there. So we have to go through this process to ensure that any programming is included.

Our plan provides us an opportunity to review existing HSA programs and services and to evaluate effectiveness. This is the outcome I was referring to, and to propose any new programs from what was described in our 3-Year Plan. It's through the Community Planning Process that this feedback is gathered. So this is part of that process here today, and this is why we want to make sure that we have opportunities, too, for the public to make a comment. And the 3-Year Plan that we're working off of this is an Annual Update year. The 3-Year Plan that we're working off of was for fiscal years, '21 through '24 and was submitted to the board in June of 2021.

I'm going to make a quick note because we're going to be starting our new planning process. This is the last Annual Update. Next year, we are going to start our new three-year planning process. I do want to make folks aware that it will actually be a two-year plan. And the reason for this is because during COVID we received one additional year. They gave us kind of a delay in reporting up. And the state would like us to get back on track. So throughout this presentation, there are times where I do refer to a two-year plan. I don't want to confuse folks, but I want to make sure that you're aware of that. I'm talking about the same planning process. Can you go to the next?

So I want to start, and this was a request, too, from our commissioners, from the Executive Committee to start with helping folks see where MHSA fits in our broader system. MHSA is about 26 percent of our full budget for the department. At the last fiscal year, it was at 802 million. And just a note for folks who aren't aware, LA County is about a third of the population of the state. So our allocation is a third of that state funding. We have the largest share by far. And another note, too, for folks who are served, this is just how the funding is broken out, but individuals, most individuals served by MHSA are also served by medical health. That's blended. So these aren't separate populations served. Next slide.

So the MHSA components, they include the Community Services and Supports Plan. This is our largest, and there is a -- we have a mandated allocation for each of these components. So from our full allocation, for example, last year of $802 million, 76 percent of that goes to the Community Services Supports or the CSS plan. This covers Full Service Partnerships. It covers our outpatient services; it covers our urgent care services. We're going to do a little bit of a deeper dive, but I want you to give you -- this is our broad outpatient system.

Secondly, we have Prevention & Early Intervention. That mandated allocation is 19 percent. And that is for our prevention, which is all the community-based work. We do partnerships with parks and libraries, the CBOs we work with, working with families and youth. It also includes early intervention, which are clinic-based services, suicide prevention, and anti-stigma discrimination.

And then 5 percent goes to Innovations. That's our opportunity to try something new. We are always mandated to put away 5 percent for Innovations. And we kind of do, we can do one to five year kind of experiments, so to speak, where we try some sort of new intervention that hasn't been done anywhere else. And then look at those outcomes for sharing and learning and integration into our services if we wish.

We finally have the Workforce Education and Training component and the capital facilities component. There's no mandatory allocation for those. However, if we want to fund those things, it comes out of our CSS pot. So these are two really important areas because it's our infrastructure, right? It's our technology. And right now, workforce and education is particularly important for workforce development. So it's a place where we're looking at some significant -- we've seen some significant increases in funding more recently, but we always have to make that choice to take it out of what services and supports piece to fund those. Next slide.

So our budget for '22, '23, we received an allocation of 879 million. So of that 610 million goes to CSS, 233 to PEI. The Innovations pot was at 10 million. WET, as I noted, is 20 million. And as I noted, that has been an increase for prior years. And CFTN for this year was at 4.1. So next slide.

So let's talk a little bit about the Community Service and Supports component in Fiscal Year '21-'22.. We served under CSS, which includes Full Service Partnership, our outpatient system, Alternative Crisis Services. And that includes urgent care, crisis, residential. It also includes housing. So our housing supports shelter beds. It includes linkage, like, navigation. It includes planning, outreach, and engagement. And that's the funding, for example, that we use with our UsCCs. To work with our stakeholders in that year, we served approximately 147,143 unique clients, 42,000 of which were new. And ethnicity breakout was 30 -- forgive me, I think that's 36 percent Hispanic, 20 percent African American, 17 percent white, 4 percent Asian Pacific Islander, 1 percent Native American with a language breakout of 80 percent English and 13 percent Spanish. These are just the top ones. So of course, there are additional ethnicities and languages. We just wanted to show the major breakouts.

I also want to reflect here that there has been an ask for a further breakout of ethnicity. And that is something that we are offering on our public dashboard. So we understand and recognize the need to break out our API populations, our Latino populations, our Middle Eastern population. So this is a summary. We kind of need to go through this very quickly, but our public dashboard, and we have one up right now that is for all services. Julio, if you don't mind pulling that into the chat box as well if folks want to take a look, and pretty soon, in a couple of weeks, we'll have one for MHSA for folks. But I just want to know that that information will be available.

>> JULIO MIRANDA: It has been posted.

>> KALENE GILBERT: Thank you very much. And thank you, Kenia. So next slide, please.

Here's a breakout of our expenditures and our estimates. What you'll see is a steady increase in funding for nearly all of our programs. And this really has to do -- there's a couple of factors here: one, of course, is we're coming out of COVID. We're coming out of some staffing shortages. But the other thing that we know is happening is our MHSA allocations is increasing, right? So folks are making more money. And when folks make more money, our revenues go up. And so the same thing can happen right as it goes down, those revenues can go back down.

So that is -- those are the maybe, I think, would say the two major factors here. But you can see an intention to really push on outpatient services, particularly Full Service Partnership. We are planning some major expansions and we expect we will need to do those related to the care coordinator and servicing focus. So go ahead. Next slide, please.

So for the Prevention & Early Intervention component or PEI, as I noted, this covers prevention, early intervention, suicide prevention, and stigma and discrimination reduction. It is the second largest component. Let's go ahead and get into some of the details here. Next slide.

So first, we wanted to just give a sampling of prevention services. So prevention services broadly are not like in clinic, claimable services. These are the community-based services that we offer. Here are just some examples of it that include like Nurse Family Partnership, which is a home visiting program, Prevention & Aftercare, which is a partnership, I believe it came from with DCFS to serve at-risk youth and families. VPAN, it was the Peer Access Network for veterans. So what you'll see here, if you go into the Annual Update, you'll see outcomes for these programs. And prevention services, in general, are meant to increase protective factors and reduce risk factors. Those are the primary outcomes that we're looking at with the prevention program. So what we're showing here is just the number of folks served by these programs. So you get a sense of the size, the details, and the outcomes for each of them. Because different tools were used, it's hard to just put a summary up here are available in the Annual Update.

>> COMMISSIONER COOPERBERG: So they're not the number of clients surveyed. It's the number of clients served.

>> KALENE GILBERT: Number of clients surveyed. Thank you. That's correct.

>> COMMISSIONER COOPERBERG: What do you mean by "surveyed"?

>> KALENE GILBERT: So those are the number of clients who participated in the program that responded to a survey.

>> COMMISSIONER COOPERBERG: Oh, okay.

>> KALENE GILBERT: Yes.

>> COMMISSIONER STEVENS: So I have one question. Could you -- could you help me understand why seeds, that number is so low?

>> KALENE GILBERT: So else that is something I'll have to ask and get back to you. You talk to the lead for the program.

>> CHAIR AUSTRIA: Okay. Last question and then we want to proceed with the presentation. Susan?

>> COMMISSIONER FRIEDMAN: Yes. [Inaudible]

>> KALENE GILBERT: So the question is: if I hear you correctly, that the governor wants to change Prevention & Early Intervention. So his proposal actually doesn't say that specifically, but folks anticipate that it will impact Prevention & Early Intervention. If I may, I will be glad to talk a little bit more about that. Do you -- I don't know if you want me to speak on that now?

>> CHAIR AUSTRIA: Finish your presentation, please. And we'll hold questions till the end.

>> KALENE GILBERT: Yeah, it's a much, much -- yeah. It's a large conversation. Can we go to the next slide, please?

So early intervention services, these are clinic-based early intervention services. They are predominantly utilized by children and youth. They're meant to avoid the need for additional mental health services. Treatment is short term, 18 months. This year, we served 35,330 clients. And then of which 17,000 were new. Again, we had a -- this is where if you hear about the evidence-based practices we offer here throughout our services in PEI, this is where the EBPs are. Once again, these are outlined in our Annual Update with outcomes for each of them. So we can go into the next slide.

Another example in PEI services is suicide prevention. I think our biggest examples of our suicide prevention services include the 24/7 suicide prevention crisis line, which this year responded to 145,254 calls on our -- and that was calls, chats, and texts. Our Spanish language crisis hotline responded to 13,000 callers. In addition, we have teams that do suicide prevention training in the community. So not just for providers, but also for community groups, other kinds of service providers and community groups in general. And we had, of all the folks that participated, we received 1,309 surveys for those who completed them as part of the training. We also do an annual conference on suicide prevention. Next slide.

And then finally we have stigma discrimination and reduction. I think our biggest example of this has been the promotores where we have, you know, this is community educating, raising awareness with the community, and providing support and linkage back to services. So for, just for a couple of the samples, the surveys that we do with folks, once they've received kind of whatever training or in-service that they had received or engaged with, one of our promotores, we found that 93 percent agreed that as a direct result of the training, they're more willing to seek support for a mental health professional if needed. And also that 87 percent agreed strongly that anyone can have a mental health condition. So kind of broadening, understanding mental health. These services were often delivered in languages other than English. So I think, again, a breakout of that we can make available. Next slide.

And then, so you have a good idea, too, of our expenditures for last fiscal year, estimated for this fiscal year and moving into next year. You'll see that -- and, again, we anticipate some significant increases in our spending. We do know that I think historically we've seen that low spending. So we have plans now to implement new prevention programming, for example, and expand our services. So, excellent.

So now I'll talk a little bit about our community stakeholder process. I want to acknowledge that there's a lot of text on here. This becomes a public document that we share, so we want it to be referenced. But I'm not going to read them directly, but I will talk through them. So this has been the work of Dr. Darlesh Horn has really taken initiative to revitalize our stakeholder process. And we started with a kickoff in September to re-engage our stakeholders for the past number of years. Under the last administration, our formal stakeholder body has been the community leadership team or CLT, and that's made up of the SALTs, Service Area Leadership co-chairs. So there's broad service area representation, and our UsCC chairs. So we held a two-day retreat in September to kick off the process to hear from folks on what's worked, what hasn't worked, what do I want to see going forward.

In November, we met again with the groups to talk about the timelines and processes, not only for the planning of this year's Annual Update that I'm speaking to now but also what we plan to do for the next year because

we had a short period of time. I think some of you have heard me say, we really took 10 months of planning and put it into four months. So this was a really heavy, tedious process, particularly for those stakeholders. I just -- I can't say how grateful I am to folks that really showed up and participated.

>> COMMISSIONER STEVENS: I have a question. I'm sorry. So I just want to be clear about that particular process. Is it fair to say that it was only the chairs and co-chairs of the community stakeholder groups and not the broader community, or the community at large?

>> KALENE GILBERT: Yeah. For the formal body, CLT, yes. However, I'd like to add that when we got to our stakeholder meetings, the community at large were able to attend. And we also solicited feedback from the community at large as well. So it was not closed after we got through this initial planning process. Once we met in November, I think there was an agreement to maintain the CLT process because we know we have work to do, and we want to do it thoughtfully when we think about that expansion of the stakeholder body. So we would finish out this year with the CLT and then come spring, which is now, our next steps are to kick off a process to expand that route. Next slide.

In December, we met with community stakeholders again to talk a little more about the proposed process and also go through our mid-year adjustment, which is something I've shared here previously. In January is when we kicked off the broader stakeholder planning process. And this was available both to CLT our formal stakeholder body and community. It took us a meeting or two, but we were really proud to be able to pull off some of the first successful fully accessible meetings, hybrid meetings. So we did hold these meetings in-person, but we recognize that, you know, there's an access issue and we now have better tools to allow people to participate. And so we were able to invite folks virtually and still offer sign language and CART services and language translation even within our breakout groups. So some work was that. I say again, a thank you to Julio here, too, because he was a big help in making that happen.

So in January, we spent some time talking about unspent dollars; what's available -- what, you know, what folks had, what the interests were, what were priorities. We talked about some of the proposals that had come forward or had been kind of on the table for a while that we needed to move forward. In February, we talked more about these proposals and we got feedback from folks. We got more specific feedback on comfort level and interest with those proposals. So that information on both scoring not only from our formal stakeholder body, but also from our broader community stakeholders at large is available and was shared. And even I think we'll be including in the final version of our Annual Update the data on the attendance for those meetings. Next slide.

In March 2023, we did an MHSA 101 training. I skipped that part. We also did that with our stakeholders. That is a mandatory piece. We will be doing MHSA 101 training annually. It's kind of like a little bit of what I did earlier here, is just explain to folks about different components and helping educate folks on the services available with MHSA because we want, certainly we want our stakeholders to be educated so they get available to participate in the process.

We also initiated our 30-day public posting which ended on April 24th. And we did solicit some online feedback there, which we'll be sharing a little bit today. And then we conducted a community stakeholder meeting on the 30th with giving folks feedback on what we were moving forward with and what the, what the plan was going forward. So now we are here in April. We've completed that 30-day posting and I'm here today on the 27th with our public hearing. And today is really, again, about more opportunities for the public to provide their feedback. That feedback will be included in the final posting. We do include transcripts and I think for major themes and questions, we'll respond to those as well. Next slide.

Let's see. So stakeholder themes and responses. You'll forgive me now. I think I do need to go to my handout here. So the first one up was commission and stakeholders requested a report on overall system budget recruitment and hiring status. Again, I'm not -- these are kind of here for reference for the future. I'm going to talk through them, not read them off to you our response. But generally, we want to share that. I think when it comes to the overall system budget, we did make the change of adding in the slide and information on where MHSA fits in the budget. We know that that's really, you're asking for a whole lot more than that when we are looking at the broader system. And that is something executive management is aware of and is working on how to respond to that request.

In addition, let's see, the department will -- yeah, we'll look on how we continue to provide budget expenditure reporting. And then finally, when it comes to hiring and recruitment, this is something else that is reported out by our executive management on a regular basis. So they're committed to continuing to provide reports not only here, but also to the board next in our kind of report on accomplishments. But I can note by the way, with hiring, we have seen some significant -- some significant hiring in the past six to nine months, thanks to our leadership. And, you know, I think MHSA has played a role in that with our Workforce Education Training. I noted

that's our opportunity to implement things like stipends, loan repayments offer even additional training to move folks out in the workforce. So that has been a really big contributor to expanding our workforce as intended.

So then the commission requested regular reporting side-by-side comparison of the budget allocations, service utilization and trends, and funding utilization prior to, during, and following the COVID Pandemic. The comparison was requested to be reflected by geographic area.

>> I'm sorry, don't. [Audio fades]

>> KALENE GILBERT: Oh, thank you. The commission requested regular reporting and side-by-side comparison of budget allocations, service utilization and trends, and funding utilization prior to, during, and following the COVID Pandemic. The comparison was requested to be reflected by geographic area, ethnic populations and age group. So this was a request that came from the executive meeting two weeks ago. And it is something we weren't able to turn around so quickly, but we do see this as a valuable report to look at as part of our Community Planning Process going forward. We do recognize really we are coming out of kind of the COVID era of services. So it would be helpful to look at those trends. So we are committed to putting this together, but we'll bring it to our Community Planning Process and certainly can bring it back here. Next slide.

Commission and stakeholders requested updates on data and outcomes reporting. Excuse me while I pull this up on my smaller bike. So I wanted to share with folks that I've already mentioned our countywide public-facing dashboard that will show or reflect clients served. And you can break it out by service area, by Sup district, by ethnicity, age, gender, and even by diagnosis. We are working on an MHSA version of that dashboard. And, again, as I noted, the ethnicities are broken down to sub-communities as well. So we do have that level of detail.

My hope was to have that ready for today, but it's going to be my understanding is another week or two. But as soon as that dashboard is available, it will be up and accessible by anyone 24/7. And we will make sure to share that link for folks. For those that are here, and we can -- I can share this handout with Kenia to send out to those who are online. We did print out a sample of a breakout by Sup district for FSP and for PEI for the last two years since it's not public, but I was able to get the data team to just prepare that for me. So folks got a sense of what we're going to be able to do. This will be available to you.

We're also looking at we have data disparities work group. We're looking forward to working with ARDI to look at and track using the equity mapping pool developed by the CEO and our own internal data to look at disparities and gaps and services.

Let's see, reports and outcomes performance program outcomes. Oh, so we were asked for outcomes and once again, outcomes for programming is available in detail in the Annual Update, or it should be for all of our PEI programs and for FSP. The commission and stakeholders. Next slide.

>> COMMISSIONER STEVENS: I have so many questions.

>> CHAIR AUSTRIA: Okay. Hold them, though, please.

[Laughing]

>> KALENE GILBERT: The commission and stakeholders requested specific responses to items reflected in the draft Annual Update. Let's see. I think we were asked about expansions for programs, which we included in the Annual Update. We did not reflect expansions there. They will be added in the final version and they are discussed here in this presentation.

I think when I spoke here two weeks ago, I paused on a slide and reported it as inaccurate. It was in fact accurate. It was because we were, it was a presentation to our providers on the MHSA 101. I'm looking at the dates that threw me off. But it is accurate and it is definitely accurate in this presentation.

There's a response to the expansion of the Courtland Identification and Early Referral program. This is an early break program. It's one of the proposed expansions. It's a really important program for young folks with first-break psychosis and for families. And the expansion is going to ensure services are available in Service Areas 1, 8, and 6. Right now they're already available in 2, 3, 4, 5, and 7. So we want to make sure that all service areas have access to those services.

And then there was also a question about Innovations proposals and when they'll be reviewed as part of our overall stakeholder process. One thing I noticed, the first thing we're going to start with is an expansion of our stakeholder review. The Innovations proposals are going to fit into that timeline. So we will first bring our new stakeholders. We're hoping to have a new stakeholder group sitting by July 1, or the expanded group sitting by July 1. And then we go through a needs assessment. We look at data, we look at programs data, we look at existing programs we look at, then we're able to look at our priorities and identify gaps. And this is where Innovations and all of the proposals should fit. We should be looking at those proposals through the context of needs identified by the

community once we've had that opportunity to look at both data around services and gaps. So it will be part of our planning process in the coming year. Next slide.

The commission and stakeholders requested responses to when will we be reporting out on the shift from We Rise, which was our campaign last year to take action, which is our May is Mental Health Month campaign. This year, as I noted, the Annual Update reports on outcomes from -- and happenings from the last year. So you'll see a more thorough report on that in next year's program, because that was a shift that happened this year. What you'll see in this Annual Update that has been posted is a report out on We Rise. And if Folks -- We Rise. Thank you.

And for folks who don't know -- sorry, this is one link I did not get -- Julio, take action. We have over 200 events occurring throughout Los Angeles County. Many are funded through CBOs who have proposed to do community events for May is Mental Health Month in our clinics and department as well. There is an online website that shares all of those events and their location. So I want to make sure that everybody will have that and I'll provide that to Kenia to share broadly. It's really exciting. We have a lot going on for me. Very exciting. Next slide.

Let's see. So commission stakeholders requested updates on the Community Planning Process going forward. As I noted, we need to look at expansions. We have our standing stakeholder group, which, of course, stays core to what we're planning to do next, but the regulations do require that we look at broader representation and that includes other community groups. It includes providers, it includes representatives of different systems like schools and fire. So we need to make sure that we have that representation, all the while ensuring we have geographic representation and ensuring we have equity among ethnicity and cultural groups. And then we want to, as in my team, MHSA unit, and the department want to make sure that we maintain that voice and equity, that voice of our consumers and family members. They should always have the spotlight and the core of our feedback. So as we expand -- sorry -- so as we expand, we want to we will be in --as we expand, we will want to make sure that we have avenues and equity for our consumers and family members, because we have heard that as a concern from our stakeholders. Next slide.

And then there was a request for information on the funding request and proposal process. We have talked about the portal here before. And so the portal will continue to be our method by which we take in new proposals at this very moment. We have learned so much from this last process. We are revamping that form to make sure that we're asking the questions that we need to ask upfront.

[Laughing]

So we're taking what we've learned and we're making some changes. So it is down at this very moment, but hold on to those proposals for folks that have them. It is coming back up in a couple of weeks and we'll continue to be open 24/7 for feedback and entry.

And how are folks notified? We do get back to submitters via phone call or email, depending on how they share their contact information. And can the source of proposals be released? Yeah, where we at least let folks know where proposals are from a CBO, Community-Based Organization, a county entity or a community stakeholder. One thing we do want to make clear is, you know, we do have kind of a fair process here in the county. So just because somebody is the proposer does not necessarily mean they're going to be the funded provider. So we're mindful of that when we think about whose information we're sharing. So next slide.

Can the amount requested by proposers be shared? We did share the proposed amounts in our stakeholder meetings. Those it's available in our handouts online. However, once again, with all of the proposals, and I will talk about each one, there was a proposed budget that was included with them, but that does not necessarily mean it is the final budget, right? Some folks absolutely know how to budget a program. Some are, you know, kind of making an estimate. So we want to work with them. And especially where -- and this gets to the next question, where it's going to be served. Some proposers have talked about the communities that they specifically want to serve. For the more general ones we will be using, like, our geographic data, our demographic data, the equity tool to make sure we're applying those services where they're needed most. So we will -- we are committed, and I think we're responsible for reporting that out on a regular basis. I've talked with my team about a dashboard so that we can regularly report progress on each of these programs and those details as we develop them. Next slide.

This is the formal process for requesting MHSA funding. We've presented this here a few times. This has to do with starts. It always starts with a submission to our portal. I mentioned before this kind of this continuum as part of the stakeholder, the CPP planning process of taking some time to look at data, do the needs assessment, identify priorities, identify gaps, looking at existing -- quite looking at existing programming. So again, this proposal review should fit within that process, right? Thus, when we start to look at what proposals we want to bring forth to review with stakeholders, it should be in the context of the priorities that have been identified by the stakeholders. Next slide.

So proposed changes going forward. Again, there's a lot of detail in these boxes, so I'm just going to read the top: the name of the program and the target population. This is a list of all the proposals that we did receive in time by the January 15th cutoff date. And that cutoff date had to do with this whole process, right? That was the latest that we could take something in and still have time to present it and take it through all of these steps. And so some -- most of them are moving forward. I think anything that's not is in here, and I'll explain it's because we have -- we're addressing it in another way.

So starting with the Community Family Resource, this is an expansion. The target population here is for all age groups, especially families. Community Schools Initiative. This is another expansion. And it's looking at middle school and high school. So it's inserted, I think, already when they identify which high schools that they look at a number of risk factors and data presented by vulnerability and then -- excuse me, vulnerability index. So this is about, again, supporting schools.

United Mental Health Promoters Network. This is for underserved cultural populations. This is expanding. This is our promotores, this is our former CANs. We're pulling that all together under one program. We are ensuring that there are multiple cultural languages available. So the Prevention Unit is working on that now. Next slide. One.

Okay. Friends of the Children. This is a mentorship program. Target population is children and youth under 18, starting at four to six years old. Medical Legal Services. This supports for folks to address kind some of the trauma of legal issues that are out there when trying to access services. And it's for all age groups. Home Visitation, which always has to do with supporting new moms. So this is for parents and caregivers with children, zero to five years old. Next slide.

The New Parent Engagement. Welcome to the library and the world. This is for new parents and caregivers. Also, our SPOT Teen Program: Social Places and Opportunities for Teens After School Program. This is another library program for children and youth under 18. We Rise, Parks at Sunset. It's a partnership with the parks and recreation. And We Rise not to be confused with our We Rise but it is for folks who are 24 years old or below. And for families it's about creating safe spaces for families. Next slide.

And then there's a second Parks after Dark at Sunset. I believe this is maybe an eight-week summer program that's more specific. Also, for 24 years and below for families. DPR Safe Passages: Community Engagement and Safe Passages for Youth and Communities for children and youth under 18. Triple P Parent/Caregiver Engagement, this is support and training for new parents. Offered through, again, our library settings. Patient Health Navigation Services. This is available to all age groups. School Readiness; here in the target population is toddlers, two-to-four years old. Creative Wellbeing: Arts Schools and Resilience. Target population here is 24-year-olds and caregivers. The Abundant Birth Project. Next slide.

Oh my goodness. I'm sorry. I need -- let's go back. Yeah. The Abundant Birth Project. Let's see. Slide 32. Okay. So the Abundant Birth Project is adjunct services and supports a stipend program that is offered by another community. We're not offering the stipends; we're just offering the additional support for pregnant people and parents with children 0 to 18 months old. There's the Credible Messenger Mentoring Model for transitional age youth ages 18 to 25, and then Youth Development Regions. And that is for, again, transition age youth, ages 18 to 25. Next slide, please.

A Local Approach to Preventing Homelessness. This is from the City of Long Beach, who also declared a state of emergency around homelessness. They want to focus on young adults exiting foster care and who are at risk for homelessness. There's Laugh Therapy & Gratitude, which is focused on older adults who are Latino. And then there's the older Latino Adults & Caregivers Program, again, focused on older adults for Latino. Next slide, please.

There is the Search to involve Pilipino Americans, SIPA. Target population there is youth. There's the K-Mental Health Awareness and K-hotline. Target population is all age groups for Korean culture. Foster All WPW ReParenting program. This is for children and adults involved with the foster care system. Next slide.

Here's the Cultural Reflections Newsletter. I'm particularly excited about this one. I think this is one where we 're looking to create communication among all of our stakeholder groups. I think there's a real need to make sure everybody is up-to-date. The idea here is that it is developed by peers, for peers. There is Hope & Healing: Mental Health Wellness and Support to Victims and Families and Relatives. And the target population here is African-American families who have suffered loss due to violence. We have the TransPower Project and the target population here is the youth trans population. We're almost there, I promise. Next slide.

There's the Open Arms Community Health & Service Center. Target population here is all age groups. Consumer Empowerment Network. The idea here, again, is to educate, create awareness for our stakeholders and consumers to help them become better advocates and help them learn how to navigate and advocate within the system. Innovation 2/Prevention & Early Intervention. I think this is a request that was related to the CANS

program, which is going to be solicited out very shortly. Which is the Former Innovations Program. Sorry, Innovation/CAN. Next slide, please.

Mental Health Services for Deaf and Hard of Hearing. Think this was an ask for a program for ASL. I think one thing that we're starting with as a department is we are bringing on our own ASL interpreter to be broadly available. There's the Stephen Cohen Military Family Clinic at VVSD Los Angeles. The target population here is veterans and their families.

>> What's VVSD?

>> KALENE GILBERT I don't know, but I can actually get that for you.

>> I think it is --

>> KALENE GILBERT: Sorry, the question was: what is VVSD? I need to get that acronym for you. I don't know it off the top of my head. There's also the DBT expansion. DBT stands for Dialectical Behavioral Therapy. This is a very effective treatment model. It is available at a number of our clinics. The request for us for DBT services at one of our clinics. And this is one where we are already addressing. We have regular trainings on this. We just began a new cohort. We see this as a really valuable intervention and we want to see this more broadly available. Next slide.

>> VVSD is Veterans Village San Diego.

>> KALENE GILBERT: Thank you. Huh. But in Los Angeles. Thank you very much. So if folks didn't hear, it's Veterans Village San Diego. Yeah, thank you. Let's see. Next.

Okay, so now we're going to start to talk about expansion. These are programs that have already been approved by stakeholders. They've been in our plan for quite some time. This is the expansion that we're planning in the next year. Many of them are a response to needs in the community. So I want to talk about where that work is happening because we've had lots of wonderful opportunities with prevention programs, but we know there are some there's a lot happening that we need to be addressing.

So let's start with the Portland Identification and Early Referral Program. I've mentioned this one already. This is that first break program. We recognized a need for services in service areas 1, 6, and 8. So it's an expansion to those service areas. There's the Homeless Outreach and Mobile Engagement expansion. This right now is so critical. I think we were adjusting the state of emergency here. This is an expansion of our street outreach teams. These are the folks who serve the hardest to reach, hardest to engage. Like where you've seen our LA Times articles in our wonderful street teams in street medicine, this is HOME. So we are expanding this program by 94 full-time physicians so that we have 16 teams countywide. And they will be placed where they are needed most, but they will be -- they are available in every single service area. Crisis Residential Treatment Programs, this is additional bets then for folks who are in crisis. They are not necessarily lock settings. So this is just another level of care that we can help folks stay out of the hospital and stay independent. So we're expanding some services and putting them in Downey and Sylmar. Next slide, please.

TAY Drop-in Centers. Another expansion of our TAY Drop-in centers. We recognize, again, this is a high risk population. So we are looking at a total of 10 new sites that will be added countywide service areas 2, 3, 4, 5, 7, and 8. Service areas 1 and 6 will each receive two new sites. TAY Enhanced Emergency Shelter program. This is additional shelter beds. Also for TAY, we're looking at an additional five sites. And I recognize, I think there will probably be an ask where those are. And that is something I can follow up with.

>> Yep.

>> KALENE GILBERT: And then Full Service Partnership. Then we are, of course, looking at an expansion. I've already talked about this, a Full Service Partnership and starting with some of our directly operated where we're adding 66 additional staff to FSP, but expect to see more FSP expansion in the future. Next slide.

Almost there. May. So in terms of next steps and timeline so right now I've noted already, I think we're here in April, right? So the next thing is, I think, we're looking at processing and moving the Annual Update forward so that we can then move on to planning for next year. The end of this month, we're looking at kicking off our process to expand our stakeholder groups. And in May you can anticipate we will continue to work with our stakeholders for that part of that extension. We want that to be a co-created process. In addition, we will be incorporating the feedback that we hear in today's hearing into the Annual Update into the final version that will go forward, will be posted online and will be shared with the board. In June of 2023, we have a reserved board date of June 6th for hearing and approval by the Board of Supervisors, which is required for us to move forward with the plan. And after that, we send it off to the state so that we're able to start services in July. So that is, I believe, we'll go to the next slide.

I believe that is the end of this presentation.

>> CHAIR AUSTRIA: Thank you very much. We appreciate all the hard work that's gone into this and all the meetings with the stakeholders. And we know that you're new to this position and that you're trying to improve it. So we thank you for that. I also have a -- I want to state that we're going to move into the public hearing first and then we'll get feedback from the commissioners because I expect the community stakeholders that are here will inform our thinking and then, you know, ask and improve our questions. I see one quick hand. Brittney?

>> COMMISSIONER WEISSMAN: Yeah, I just want to add to your thanks because I'm not sure that all the commissioners and the public are aware of the process that we've taken to get to today. So I just want to compliment you on, first, the presentation. It was really well organized and all of the questions that you see in the back that you just covered were questions that were raised by the Executive Committee last time we met in person here. And so to see full responses to all the questions written is really helpful. And I just want to commend your overall presentation, give you a chance to catch your breath before we move we move into questions and say thank you for being responsive to what we've desired so far. I think this bodes well for everything ahead here.

>> COMMISSIONER STEVENS: Here. Here.

>> CHAIR AUSTRIA: I have a personal complaint.

[Laughing]

Which does, and I don't want, it's not directed at Kalene, it's directed at DMH executive staff overall. We were -- the commission was asked to sign off on the draft today, you know, before we even hear, we're going to hear a public hearing when they want to sign off. And I just think that there's a point process that is not correct. We need to hear from the community so we can incorporate their comments into our board letter. So I just want to state that. I doubt that we're going to be signing off today, and that will be up to the commission.

The other thing I noted was that it's on the board agenda for this week. And so when I looked at the board agenda last night, I was a little surprised to see that, you know, it ought to be approved this coming Tuesday. So I would, you know, it's there. It's on the agenda. So, you know, I'm going to ask our commissioners to please ask your, you know, board members to please hold until the commission has a chance to incorporate the public comments that, you know, are going to be made today. And also, you know that. So again, and I also know none of the executive staff are in the room today. But thank you, Kalene. Again, this is not directed at you.

>> KALENE GILBERT: May I offer a correction? What is going to be heard on May 2nd is the mid-year adjustment. This Annual Update is on the board agenda for June 6th.

>> CHAIR AUSTRIA: But it's also, if you go look at the agenda, it's there.

[Laughing]

So it has the whole presentation you just made. It's on the board agenda. Okay. So thank you. We'll, and I may follow when seeing things last night when I look at tomorrow's agenda. But I am concerned about that.

>> KALENE GILBERT: Thank you. We'll follow up. Thank you.

>> CHAIR AUSTRIA: So I want to move to the public. I'd like to have the public and just to know we're going to go first -- the person in the room and the person online. And we'll go back and forth to make sure everyone's heard. I want to end public comment at 1:10 so that the commission itself has a chance to ask questions to, you know, internalize what the public has said. And then I have questions because I know they brought up questions. Thank you. And I'm going to turn it over to Kenia Fuentes, our executive assistant, to explain the process. Thank you all. Thank you again, Kalene.

>> KALENE GILBERT: Thank you.

>> KENIA FUENTES: Yeah. So for our online folks, we have AT&T who will handle that. And for our in-person folks, we will need to walk up to where you see Daniel. And we need to speak into the podium so that everyone can hear you and you don't have to project your voice, and it'll be clear to everyone. And so we'll do one person from our hybrid system and then we'll do one person in-person. Okay. So, Julio, we can get at AT&T start with our first caller.

>> DANIEL: Anyone here, who would like to make a public comment, if you'd like to line up on my left-hand side to make a possible comment, you're welcome to come up.

[Public comments]

>> JULIO MIRANDA: I'm sorry, I missed that second part, Kenia, and somebody else spoke.

>> KALENE GILBERT: Oh, it was Daniel giving instructions to me.

>> JULIO MIRANDA: Got it. Don, are you on?

>> AT&T MODERATOR: Yes, I am.

>> JULIO MIRANDA: Thank you, Don. Can you instruct the members who are listening in, if they would like to speak in public comment to queue up with your queuing up instructions?

>> AT&T MODERATOR: Absolutely. Ladies and gentlemen, remember if you want to ask a question, please press "1" then "0" on your telephone keypad. You may withdraw your question at any time by repeating the "1," "0" command.

>> JULIO MIRANDA: Thank you, Don, is there anyone in the queue?

>> AT&T MODERATOR: We do have one in the queue at the moment. Oh, we have a few now. Would you like to begin?

>> JULIO MIRANDA: Yes, please.

>> AT&T MODERATOR: Okay. First we're going to line number 8. Please go ahead.

>> HECTOR RAMIREZ: Hello, can you hear me?

>> JULIO MIRANDA: Yes, you can.

>> HECTOR RAMIREZ: Hello. Good afternoon, commissioners. My name is Hector Ramirez. I am Apache and Mexican, and I am a consumer with the Department of Mental Health at West Valley Mental Health Clinic in Chatsworth, Supervisorial District 3. Supervisor Harvard is my representative. Thank you for this report. I speak here wearing multiple hats but primarily as a consumer. I'm also one of the co-chairs for Access For All. And I call volunteer, which is a state advocacy program funded by MHSA.

And I really want to thank the department for this report. You know, it really, it's absolutely a plus that we've never had as a department. I've been engaged as a consumer since the passage of MHSA. And, you know, we have a lot of first ever first time actually having a stakeholder recommendation. The department has served over 250,000 people in Los Angeles County, and yet one of the things that this report has to highlight is that of all the people that participated, only one consumer submitted proposals. And that was myself.

And the reason for that is multiple reasons. This process out of all the years that I've participated was really inaccessible, particularly because the facilitator and some of the processes and the lack of accommodations that we got were not necessarily the process of good practices, but just constant fighting. It was very difficult, particularly for our Hispanic, Latino communities who really lacked to have access to the same information as anybody else, you know, when they were showing up.

And then, you know, as a consumer, the other thing was very difficult to attend these processes and having to be in competition with DMH staff and, you know, CBOs that were really there, you know, oftentimes replacing us and, you know, making recommendations and shutting us down, and sometimes even retaliating --

>> JULIO MIRANDA: 30 seconds.

>> HECTOR RAMIREZ: -- against us, and he was really, really abusive. And the fact that we have such limited opportunity to really ask for feedback, you know, really highlights the fact that, you know, the disparities, none of that is included in this report. So I really feel gaslighted and it's part of the trauma that this system kind of perpetuates over and over. You know, so I appreciate all the great things but, you know, as well for accountability and, you know, equity and really highlight the struggles that we had. We had people get COVID trying to attend these meetings. We've had people that died while participating in, you know, none of that is really kind of reflected.

>> CHAIR AUSTRIA: Thank you.

>> JULIO MIRANDA: Next caller, please.

>> AT&T MODERATOR: Next, we'll go to line number 11. Please go ahead.

>> KENIA FUENTES: Julio, please go for someone from in person.

>> JULIO MIRANDA: Oh, I'm so sorry. Don, if you can hold that line just for one second longer. We need to have somebody from in-person speak now. Okay. Can you go ahead?

>> KENIA FUENTES: Thank you. And then before we go off to that, Chair Austria, I do want to acknowledge that we do have a representative from our DMH executive team. We have Kimberly Nall with us.

>> KIMBERLY NALL: Hi. Hello. Good to see you.

>> Good to see you, too.

>> KENIA FUENTES: Go ahead.

>> BARBARA WILSON: Yes. Good morning, everyone. This is Barbara Wilson. I'm also from the same service area that Hector is from Service Area 2. I'm here in person and am glad to be able to be heard. I didn't have a lot of love with the technology.

Just wanted to comment. Our favorite -- my favorite passion is about licensed adult residential facilities. We are still losing them. And the concern, of course, is that as we lose licensed facilities, that necessarily means that people, that families that are looking for a placement, when a hospital calls and says, "Come get your loved one over.

We're going to send them to Skid Row." This strikes terror in the hearts of parents and family members. And what we are finding is increasingly facilities are being notified or advised that they should dump the residents that they have currently because they only can pay SSI rates and take in new people because they'll come with a batch or they'll come with an LW on some of these other funding mechanisms.

And so I just need to make you aware of the critical, critical situation that we have for families that don't know how to work the system. They just know that they have a loved one that needs a safe place to be absent of drugs and drug paraphernalia and able to give them medications and meals and an SSI rate. Thank you.

>> CHAIR AUSTRIA: We don't normally have questions, but we do have a question.

>> COMMISSIONER DALGLEISH: I have a follow-up question. Do you have an idea of, you know, a general idea of how many beds have been lost over the last, say, five years and actual facilities that have closed?

>> BARBARA WILSON I don't have that information, but I know people.

>> COMMISSIONER DALGLEISH: Okay. Great.

>> BARBARA WILSON: I can give an estimate.

>> COMMISSIONER DALGLEISH: Thank you. Thank you.

>> CHAIR AUSTRIA: Next comment.

>> JULIO MIRANDA: Don, do we have another caller, please?

>> AT&T MODERATOR: Yep. And we can go on back to line number 11. Please go ahead. 11 took themselves out of the queue. So we're going to line number --

>> MARK KARMATZ: 11.

>> AT&T MODERATOR: Okay. 11, you're on now. Go ahead.

>> MARK KARMATZ: This is Mark Karmatz and I have a -- the consumers have a major, major concern. There's a building for the state legislature having to deal with group disability. And what the bill does is changes the definition and kind of loosens it up in order to get people on involuntary holds. And the person can be detained, conserved, and can -- and unless I have a personal care Medicare provider who can be allowed, taken into custody, usually by police are held in a locked facility for six -- for periods of time. The state would then appoint a conservatorship, which other states called guardians, they can be placed at a locked facility. Significant loss of rights. There would be a -- the bill was passed yesterday at -- not yesterday, it was Tuesday -- it's now either the judiciary committee. It's going to the appropriations.

>> JULIO MIRANDA: 30 seconds.

>> MARK KARMATZ: And so that's very concerning for consumers. So that's basically what my comment is right now.

>> CHAIR AUSTRIA: Thank you.

>> KENIA FUENTES: Thank you. We'll go to in-person attendants.

>> MARK KARMATZ: What was the question?

>> JULIO MIRANDA: Oh, Mark --

>> CHAIR AUSTRIA: Thank you for your comment.

>> MARK KARMATZ: Thank you. We need to take a position on that.

>> CHAIR AUSTRIA: Thank you.

>> JULIO MIRANDA: We're now moving over to an in-room comment. Thank you.

>> JOHN WARDEN: Thank you. My name is John Warden. I'm here today to talk about Life Score: a simple, easy-to-use peer support, full health improvement platform with unique privacy and security to reduce or eliminate stigma, and can build capacity while connecting users to communities and the right resources to the right person at the right time. We have the support of Dr. John Sherin, former LA County Mental Health director, who writes, "I've seen numerous technology tools come and go. I'm hopeful that Life Score gets an opportunity to demonstrate its full potential efficacy and impact, which I believe to be substantial. It's the combination of ongoing self-monitoring to drive self-care objective assessments that prompt external interventions when indicated access to curated resource directories that match evolving patient needs, and the realtime connections with the personal support network set it apart from technology solutions that I've previously seen and tested. I believe that Life score is very worthy of support as a longtime leader of efforts that improve the mental health and wellbeing of individuals and populations suffering from a wide range of illnesses and traumas. I would recommend investing in Life Score and thereby the needs of community by funding a pilot program which will empower technology to scale." Thank you.

>> CHAIR AUSTRIA: Thank you. Next.

>> JULIO MIRANDA: And, AT&T operator, one more on the conference line, please.

>> AT&T MODERATOR: And once again, if you'd like to ask a question or make a comment, may please press "1" then "0". And we are going to line number 3. Please go ahead.

>> OSBEE SANGSTER: Good day. My name is Osbee Sangster, speaking on behalf of the black Los Angeles County Client Coalition, Inc. Today's public comment serves as the counterpoint to the neoliberal apologist who rule in dismissing or denying the reality of the SALT 3 virtual meeting minutes for the months of January and February. And let us take a moment to recapitulate the Black Los Angeles County Client Coalition's public comment delivered on April 13th. The mirrors of truth. SALT 3 minutes edits were demeaning, distorted, broken English, duped, and published. Reflecting rules confined by class in our color, like an unrestrained and deadly virus.

If Dr. King were alive today, he still unflinchingly used his visionary telling voice to declare a deficiency of will to do what's right. In the spirit of Dr. King, we wish to enlist your help as we attempt to unnerve the powers that deny and downplay the rights of people in this county. The month of April is --

>> JULIO MIRANDA: 30 seconds.

>> OSBEE SANGSTER: Los Angeles County Client Coalition's anniversary date, 17 years serving. We take great pride in the needy giveaway, HP Chromebook computers. I ask once again the Mental Health Commission Chair, Kathleen Austria, And the Mental Health Commissioners to please schedule a meeting to discuss and heed this call to care and for the concern ourselves with the plight of this matter. Thank you.

>> CHAIR AUSTRIA: Thank you. Next caller or person.

>> KENIA FUENTES: It'll be a person in person.

>> JULIO MIRANDA: In person. Thank you.

>> PASTOR NAH: Hello, everyone. I am just so glad to meet all of you and the stakeholders and commissioners. And also in particular, I would like to express my gratitude to DMH employees and staff members. I've encountered a lot of all of you during the last 13 meetings or so. I would like to express my gratitude as well. I've learned a great deal through CLT meetings, including what the blind spots are and where they're located. And through the CLT gatherings, I found that we have commonalities and the passions that we share. And then with the passions that we have, I feel that we can do a great deal of work. And through the MHSA Annual Update meetings, I realized that we can do a lot to help the communities after this Pandemic and people who have suffered during the Pandemic.

Okay, so one thing I would like to share with all of you is that there is no such a thing as a perfect way or perfect path. But I feel that things are never going to be perfect, but we do have the choice of going and walking the right path and we can walk that path. Thank you.

>> JULIO MIRANDA: Thank you.

>> CHAIR AUSTRIA: Thank you.

>> JULIO MIRANDA: And do we have an online caller?

>> AT&T MODERATOR: Yes, we do. And once again, if you're making comments, please press "1" then "0". Next, we're going to line number 12. Please go ahead. Hi, can you hear me?

>> JULIO MIRANDA: Yes, we can.

>> CHAIR AUSTRIA: Yes.

>> PAMELA INABA: Yes. Hi, this is Pamela Inaba. I'm an Access ambassador with Access California Cal Voices. I'm in the LA County Client Coalition Inc. The community leadership with the coalition -- I'm in the Community Leadership Team with three UsCCs and the Cultural Competency Committee. I also -- I want to applaud and congratulate the department and the MHSA coordination team for organizing and doing the training and meetings for the CLT. And for other stakeholders of the MHSA, talking about the MHSA process and enhancing the access with creating virtual access. And in addition to the in-person orientations of the MHSA planning process and the proposal review training and meetings. I'm happy that DMH has made a considered effort to explain and show the DMH budget to stakeholders and urge another venue, the Endowment Center for better access to more stakeholders.

I will continue to work with the SALTs and UsCCs and collaborating with consumer-run organizations to increase the stakeholder voice and choice in the Community Planning Process and increase the number of proposals so that programs --

>> JULIO MIRANDA: 30 seconds.

>> PAMELA INABA: -- are more culturally competent with an emphasis on the BIPOC, and especially the AAPI, LGBTQ+, older adults, and the physical disabilities communities as target populations and offer more language access and more recreational opportunities for Fiscal Year '23-'24. One of my jobs as Access ambassador in LA County is to help DMH follow the MHSA guidelines. And I have been proud to be part of --

>> JULIO MIRANDA: Time.

>> PAMELA INABA: -- the planning process and appreciate all the work that the staff and administration has done to work with us, and I really want us to discontinue to do more. Thank you very much.

>> CHAIR AUSTRIA: Thank you. Next person.

>> JULIO MIRANDA: In-person, please.

>> JEAN HARRIS: Good morning. This is Jean Harris. I'm co-chair of the SALT in Service Area 1. I want to address the MHSA presentation on page 41 of Ms. Gilbert's PowerPoint. There is, in June, the adopted final MHSA Annual Update will be presented to the MHSA-OAC for final execution. I believe we have an opportunity to have public comment at the Mental Health Services Oversight and Accountability Commission as well on this final plan. And I'd like to ask -- make sure that that's correct and share that with the community the Innovations process.

Another question: When we were having the January and February meetings, which I did drive down from Antelope Valley and attend all of those in-person, that we were presented with several other Innovations proposals, and I wonder what happened to the Neurofeedback proposal? How does that Innovations process work? I support Neurofeedback and I was pretty excited to see it. I've been telling everybody who listens and now I don't see it anymore.

I would like to address the prudent reserve versus unspent funds. The prudent reserve has apparently been decided to be increased dramatically, and I'd like to have a conversation about that and allow stakeholders to comment on that as well.

On page 165, in the full MHSA report, there is Innovations 3: Hollywood Mental Health co-op $26 million. Is that from one year, the '23-'24? And on page 35, 36 of the urgent care clinics across the county, there are some age levels, and I talked to Ms. Gilbert about this already. But the children in the High Desert Clinic affects Service Area 1, but the clinic there, the urgent care doesn't accept children 13 and under. They also do not accept older adults that are above age 65. And so that also needs to be documented in the statistics. Is there a possibility of requesting a hard copy to review before the final presentation? Because looking at it online, my eyes can't go over almost 200 pages.

>> CHAIR AUSTRIA: Thank you.

>> PAMELA INABA: -- and analyze.

>> CHAIR AUSTRIA: What we'll do is maybe you can Kalene can stay after and we have your questions. They've been documented and so hopefully we can get back to you and feel free to contact me.

>> PAMELA INABA: That's all I have.

>> CHAIR AUSTRIA: Thank you.

>> KALENE GILBERT: Is there anyone online?

>> AT&T MODERATOR: There are no new callers in queue, but line 11 is back; is that okay?

>> KENIA FUENTES: We'll give a person on the floor come in and then Chair Austria wants to give a second two minutes.

>> JULIO MIRANDA: Just to clarify, we are holding for in-person, for everyone to cycle through, and if there is room, Chair Austria will allow time for a repeat caller. Thank you.

>> CHAIR AUSTRIA: Yes.

>> RICHARD KIM: Good afternoon, Madam Chair, Commissioners. It's been a long time. Just want to address the new innovation projects, the Interim Housing Multidisciplinary assessment and training teams and the new IN proposed for this year 2023, 2024 does not address and does not include the number of positions for on-house peer support specialists on this team. This is in February 2022, where I became a participant of the State of California's Project Homekey. After four years of chronic street homelessness as a PHK stakeholder, I've seen many of my peers cycle into a transitional housing setting for the first time in years and cycling back out to the streets.

And unhoused peer support specialists sharing lived experiences that are invaluable to assisting linkages in mental health services and co-occurring SUD services by interim housing residents that can help decrease homelessness. California Mental Health Services Authority is accepting proposals for their peer support specialist training curriculum and certification program for justice-involved training, crisis specialization training, and unhoused peer specialization training, each one due by May 12, 2023, 5:00 PM Pacific Daylight Time.

My question is: why is the new innovation program, Interim Housing and Multidisciplinary Assessment and treatment teams not including peer positions on the team with a five-year proposed budget of $190 Million? Does the Multidisciplinary Assessment also include the role of peers in interim housing who are violent to housing retention, linkages to mental health, co-occurring substance use services and support for recovering wellness of Project Homekey interim housing residents? Moreover, to better serve Project Homekey stakeholders, we must consider creating a peer-driven and led advisory committee that will advise new and existing interim housing policies

in Project Homekey that address the needs of PHK stakeholders and advocate the former current, new, and future PHK stakeholders to the mayor's office, Los Angeles City Council, Los Angeles County Board of Supervisors, the Los Angeles County Department Mental Health, Mental Health Commission, and any oversight commissions of Los Angeles County Departments of Public Health --

>> CHAIR AUSTRIA: Thank you.

>> RICHARD KIM: -- and health services. And if the commission so chooses also the quasi organization called "LAHSA" maybe. Thank you.

>> CHAIR AUSTRIA: Thank you.

>> JULIO MIRANDA: And online, has anyone else joined the conference line?

>> AT&T MODERATOR: Yes, sir. We're going to line number 13, please go ahead.

>> DR. STEPHEN MOUTON: Oh, great. Hi, this is Dr. Stephen Mouton. I'm a psychologist and policy lead liaison for the Seven LA County Regional Centers for Developmental Disabilities. And what I would like to see is the identification of services for people with developmental disabilities, more in the requests for proposals that are done, and then also when services are provided. They're usually broken down by different populations, by different ethnic groups, by different languages.

But you don't often see that a service is available for a person, let's say an intellectual disability or autism, severe or low functioning autism and a variety of those types of services. So I just think it'd be easier for parents and clients of the Regional Center to find mental health services when they have a co-occurring mental health and developmental disability, to be able to look at services and see some kind of identifying code that this service provider would be able to provide services because many times they're not able to get services that they say they do not provide services to people with developmental disabilities, even when they have mental health difficulties. That's it. Thank you.

>> CHAIR AUSTRIA: Thank you.

>> JULIO MIRANDA: Anyone in the room?

>> Yes.

>> LISETTE MARTINEZ: Good morning. My name is Lisette Martinez, and I'm on behalf of the Commission on HIV. So really I come today just to ask for potential collaboration with the Mental Health Commission. Our commission has been reaching out to other commissions to see how we can potentially collaborate to reach our most vulnerable population. So welcome the opportunity to collaborate soon.

>> CHAIR AUSTRIA: Thank you.

>> KENIA FUENTES: And that's all we have for in-person. Julio, is there anyone else online?

>> JULIO MIRANDA: Don, would you be willing to let -- thank you.

>> AT&T MODERATOR: Yes. I'll be going back to line number 11. Please go ahead.

>> MARK KARMATZ: What was I going to say?

>> AT&T MODERATOR: Okay. Line 11, please just speak, don't press the button.

>> MARK KARMATZ: Thank you. This is Mark Karmatz. And I was listening to the -- I'm sorry, to the meeting with the legislature yesterday with regards to the -- I forgot what committee it was. But anyway, they were talking about Senate Bill 403, which has to do with the -- has to do with the caste systems and so that we don't have the same thing going on that they had in India, basically. And it reminded me that we need to have this into the Mental Health Services Act. And having it -- this could be a cultural competency issue with him. So I think we need to -- and we think we need to get that introduced into the Mental Health Services Act meetings here in Los Angeles County. So thank you.

>> CHAIR AUSTRIA: Thank you. Is there any other public comment?

>> KENIA FUENTES: That's all we have in person. I imagine there's no one else behind.

>> CHAIR AUSTRIA: Yes. Go ahead, Jean.

>> JEAN HARRIS: Sorry I ran out of time before.

>> CHAIR AUSTRIA: That's okay.

>> JEAN HARRIS: I'd also like to address the fact that when we're going over these Annual Updates that I'd love to see those budget figures in the service areas getting these proposed services. How are their monies being spent across the county per service area? I see that we were provided with a data sheet as an example of supervisory districts, and that's wonderful. I can't wait to see the statistics.

I also want to commend on the difference from past years with MHSA only being addressed when it's time for the 3-Year Plan. And I am really welcoming DMH's commitment to getting that stakeholder involvement. I would love to see stakeholder meetings in every service area rather than requiring people to travel long distances to attend

in-person meetings. Online is a very much different experience and I want to get all of our communities all across the county involved. Thank you so much for all the effort and all the hard work.

>> CHAIR AUSTRIA: Thank you. I think what I would like to do is maybe, Kalene, you could -- if you can address some of the questions that came up on our public commenters and then we'll go to commission. So I know Jean has some questions and a few others, and I don't know that you can answer them all. Stacy.

>> KALENE GILBERT: So first, first of all, I just -- I want to thank folks for their feedback. I feel like there was a lot of, like, not only positive feedback, but like a lot of helpful feedback that helps us think about how we do not only things in the future, but actually how we communicate in the future. So that was very, very helpful for us.

Just a couple of things that I could say. Well, I think where we saw some, had some direct questions. I do want to start again with the board date. Quite frankly, Ms. Nall shared with me that what is going on to the board calendar on the second is called the Revised Annual Update.

So I had referred to it as the mid-year adjustment, but it's an adjustment to the Annual Update from last fiscal year. So it went onto the board calendar as the revised Annual Update. So it is for fiscal years '22-'23 for this fiscal year. So that helps. Actually, I didn't even recognize it when you had shared it with me, so I appreciate that. So I wanted to make that clarification. It is indeed the mid-year adjustment. It's just referred to as the updated update. So I wanted to share that with folks.

I did hear the ask for the Innovations Neurofeedback. I want to let you know that that is still in progress. Innovations, I kind of see it's on its own timeline.

So one of the things I have shared with stakeholders is that we have two big priority projects with the interim housing and with the CARE Court piece. We're mandated to do CARE Court, and we absolutely insist that we have peers as part of that team and its supporters. But Neurofeedback is next in the queue, so it has not gone away. And, in fact, I'm working with the team now so that we can do the full 30-day post. So that's coming, but it's on its own timeline. I think we just need to get through the big commission meetings, the process with these two first.

>> CHAIR AUSTRIA: And let me just ask a quick question. So on the process then, because we were also asked to sign off on this today, and that we need time to digest the public comment, as well as our own feedback from our, you know, board members. What is the drop-dead date? We can submit a letter to you because we need a little bit of time, at least a week.

>> KALENE GILBERT: I think we need this, and I apologize, I'm going to look to my team. Yeah.

>> Tuesday.

>> CHAIR AUSTRIA: This Tuesday?

>> KALENE GILBERT: Yeah, that's it. It has to do with when we have to submit it to the board so they can go through their process for hearing it by case.

>> CHAIR AUSTRIA: And I -- just, again, in the process, we can't do that and get together. This is difficult to get us all together. We come from all ends of the county. We couldn't talk online, but to actually generate an appropriate letter with appropriate feedback, we need some more time. So we need you to take that back and get back to us.

>> KALENE GILBERT: Yes, absolutely.

>> CHAIR AUSTRIA: Thank you. All right. If you have any other questions that you can respond to from the community? I just want to make sure we're on point in the process. And also, if anybody comes on -- [Clears throat] excuse me, online, Julio, can you let us know and then we'll break and let people comment because I don't want to cut off the hearing too soon.

>> AT&T MODERATOR: We do have -- we do have another person, another repeat if you'd like to open that line now.

>> CHAIR AUSTRIA: Okay.

>> AT&T MODERATOR: Okay. Going back to line number 8. Please go ahead.

> HECTOR RAMIREZ: Can you hear me? Can you hear me? Does anybody hear me?

>> CHAIR AUSTRIA: Yes, we can.

>> JULIO MIRANDA: Yes, we can hear you.

> HECTOR RAMIREZ: Thank you. So I'm Hector Ramirez. So in addition to what I wanted to add, one of the things that I really wanted to recommend, and we have been asking for this over and over is for the department -- the Department of Mental Health MHSA Unit to have additional resources. This is the largest county in the state, and it is nowhere nearly supported or funded to really have the stakeholder process that, you know, we intended and that we need to do this. And so we're kind of functioning at a smaller county-level capacity. We're not even like an

Orange County level but we have great staff, but they're being worked so hard, and that's why we are having all these kinds of big fumbles happening.

You know, and in addition to the lack of Spanish access for our Latino Hispanic population, the other thing that we have been really struggling with is getting information in plain language. And this is a disability accommodation request that we did and request way back in September. And so it's a disability accommodation, and we ask over and over. It makes it very difficult to print, you know, the big over 100-page document and process it. You know, sometimes I have support staff that helps me go through it, but my peers don't. You know, the community does it. And so it really puts our community sometimes, unfortunately, at a disadvantage. If you're not a paid community person or a lobbying person for home, you know, board and care, you really don't have this type of infrastructure to support you.

And so as a result, you know, our both needed partners research, our consumers and our family members are being really oftentimes, you know, supplemented or replaced. And we don't necessarily have that opportunity. And I think our possible solution for that is definitely the stakeholder process suggestions, which I really appreciate and hope that they get funded properly. But then also to have the infrastructure for the department to be able to do this, because right now they don't. And that's why these big, big mistakes are happening --

>> JULIO MIRANDA: Time.

>> HECTOR RAMIREZ: -- and it's not fair for employees that are really trying really hard, not fair for the community. And it's not -- it's something that we -- I would really like to fix.

>> CHAIR AUSTRIA: Thank you

>> COMMISSIONER MOLINA: Thank you for the point of order. Can I just offer a recommendation, then? He's reflecting on Chair Austria's concern and I see frustration a little on the timeline of getting this letter sent to the board office on a timely basis to make your June 6th deadline with the Board of Supervisors. Can we work today to draft the letter so that it reflects the comments and the questions and maybe the concerns of the commission and some of the points that are made in the public hearing today, so that the letter that is drafted really be thoughtful in the discussion that we're having today.

And then if that draft letter could be submitted to us for consideration and for the chair's signature, eventually. I think the point is well made that while the schedule and even the process probably ends up being quick at the very end, as long as that letter reflects some of our comments and some of our thoughts today, I think that may solve a concern that the chair has, that today's meeting somehow is reflected the most comments.

>> COMMISSIONER DALGLEISH: I just would like to agree with that. I think it also provides an opportunity for us to be transparent in our deliberation. So thank you for bringing that out.

>> CHAIR AUSTRIA: Okay. Do you have a last something, a few comments to make and then I want to move to the commission?

>> KALENE GILBERT: Sure. I did want to respond to one other -- actually, two other comments now to the gentleman that asked about the Innovations Project and peers on the team. I do, I think, again, this comes back to how we post and communicate things. There are absolutely -- sorry, there are absolutely peers as part of that program. We would not do outreach novel services without that. We recognize that as so important for engagement, but I also recognize that we didn't share that as part of the details. So that's very helpful feedback for us. But I wanted to assure you that that is most certainly part of the programming there, and I thank you for raising that. So we can share that more publicly.

And then I just, again, I wanted to thank Hector for his final comments, too, on just the infrastructure and support. We are a new unit. It's taken some time, but we are growing very soon. [Laughing] So the team has really worked extraordinarily hard. And I think I've tried to do the work of several people at once. I really want to acknowledge Dr. Horn, who has really worked hard to make sure that these stakeholder processes have gone well. And I think we anticipate seeing that next year. So thank you again for just the acknowledgement of the support.

>> CHAIR AUSTRIA: And we appreciate, again, all of the work and we recognize the changes. Actually, I would like to have the names of your team so we could appropriately thank them.

>> KALENE GILBERT: Absolutely.

>> CHAIR AUSTRIA: And I want to go ahead and move to the commissioner's questions. So yeah, let's go around. We'll start with and just go around. I think that's the easiest. I won't ask.
[Overlapping speakers]
Reba Stevens.

>> COMMISSIONER STEVENS: So my first question is I was curious because through the plan, I didn't find PMRT. So is it included in the plan?

>> KALENE GILBERT: So I believe that right now, PMRT and this is to confirm this, I want to confirm the funding source for PMRT last year versus this year.

>> COMMISSIONER STEVENS: Okay. Got it.

>> KALENE GILBERT: So that's a confirmation I need to make.

>> COMMISSIONER STEVENS: Say that again?

>> KALENE GILBERT: I need to confirm the funding source for PMRT last year versus this year.

>> COMMISSIONER STEVENS: So it's not.

>> KALENE GILBERT: I'm sorry. Let me -- Kim.

>> KIMBERLY NALL: The source of funds is ACS, Alternative Crisis Services, and it is included in the annual. It didn't change. So there was no change to.

>> COMMISSIONER STEVENS: So I'm not going to spend a lot of time, so I'm going to ask for someone to send an email to write me there. And the other question that I have is, you know, and you don't have to answer it now, perhaps you'll send it an email. I'd like to know clearly what is DMH's equity tool and clearly what it is. What is DMH's equity tool?

And then I'll ask just one more question. But I also want to take you to the slide. I believe it's a slide -- I think it's 40.

>> COMMISSIONER FRIEDMAN: Reba, speak up a little bit.

>> COMMISSIONER STEVENS: Really? We never had asked that.

[Laughter]

So slide 40.

>> KENIA FUENTES: So I think what I like to do is, if I interrupt, can I have you go to the podium?

[Overlapping speakers]

>> COMMISSIONER STEVENS: So I'm going to stand up.

>> KENIA FUENTES: Yeah, because it's hard. They also want to hear your beautiful voice.

>> COMMISSIONER STEVENS: So I would like to thank you and everyone who made public comments. I'm going to stand right here. And the question I have on page 40 or slide 40 is you mentioned the TAY drop-in sentence. And it excludes SPA six, but it includes it because then you mentioned that SPA 1 and 6 will receive two, but it's not clear as to where they are and what they look like. And so I would like more information on the SPA 6 needs.

And then the very last thing that I'll say is around Prevention & Early Intervention and suicide prevention. It was mentioned today and reminded us about co-occurring disorders. As we all know, people are dying, literally dying on our streets as a result of fentanyl and other substances. So I would like to know more about what the Department of Mental Health is doing with harm reduction, and what exactly does harm reduction look like in engaging in our community. And I just want to remind us that any of us who are using street drugs have a mental health challenge, because there is something wrong with street substances. And I'll end there for now.

>> CHAIR AUSTRIA: Thank you.

>> KALENE GILBERT: Can I respond?

>> CHAIR AUSTRIA: Yeah, go ahead and respond.

>> KALENE GILBERT: So on the TAY drop-in centers, that is something, the information I can talk with the unit that is rolling those out and get the details for you. Regarding harm reduction, I can tell you that is absolutely the approach of the department. And, in fact, we have also been working really hard to expand not only access to Narcan among all of our teams but also MAT, medication-assisted therapies to make that more broadly accessible. What that looks like, and I think more specifically approach, I would talk to the SMEs, the specialty, the folks who do the programming to give you more information on that. But I can tell you harm reduction is the approach. But what that looks like off the streets and how that's rolled out, I would like to give the program to speak more to that. Yes.

>> CHAIR AUSTRIA: Thank you. I'm going to go to Brittney, and after Brittney, I'm going to go to Imelda, who's online. Go ahead, Brittney.

>> COMMISSIONER WEISSMAN: Thank you. I did -- this is Brittney Weissman. I did represent my questions at the last time we met as an Executive Committee, so they've been mostly addressed. I'll just point out again, in front of, you know, the public hearing that the numbers for PEI just seemed so low in terms of service collective people reached, and I realized that it was a COVID year. And so I'm just hoping for a little bit more context around that because how could LA County possibly serve so few people in PEI.

>> I'm sorry, repeat that.

>> COMMISSIONER WEISSMAN: Possibly serve so few people in PEI over the course of an entire, you know, fiscal year. And then I would say my next point is if you are developing this dashboard for data and it's ready in two

weeks, hallelujah. That is so much work in such a short amount of time. For you and the department to work out something that is public facing that quickly just, I wanted to call out and say congratulations and thank you.

>> KALENE GILBERT: That is a project that has been worked on since I came on board. So there's definitely been, I think we've heard the request long ago. The team has worked very diligently on it. It is done.

>> COMMISSIONER WEISSMAN: I think it's a matter of just final basics. So I'm really excited to share it. So thank you for that. And would we welcome you to do, like, a beta focus group test with us anytime?

>> KALENE GILBERT: Absolutely. We did this with -- actually, I should mention, we did do a preview for our Cultural Competency Committee and got a lot of wonderful feedback. So glad to do that here as well.

>> CHAIR AUSTRIA: Absolutely. Thank you. I want to go to Ms. Frausto, please.

>> COMMISSIONER PADILLA-FRAUSTO: Hi. Thank you. Can everyone hear me?

>> CHAIR AUSTRIA: Yes.

>> JULIO MIRANDA: Yes.

>> COMMISSIONER PADILLA-FRAUSTO: Okay. Thank you. First, I just want to apologize for not being there in person. Many of the issues that we are discussing today have happened in real life or my family. We lost my son-in-law to a fentanyl overdose at the beginning of March. My daughter and my granddaughter have been reeling in devastation from that and has triggered manic and psychotic episodes for my daughter this past month. So we are living this live as we speak. But I do want to say I am here because our mental health system really needs to change. I am living this live in person and it is frustrating. But to this MHSA update in particular, thank you, thank you, thank you so much for all this wonderful information and putting this all together. I'm so happy to hear that there is a dashboard coming together.

I just want to ask a clarifying question. Are these numbers that you presented on slide seven of the client served, is this client served just through MHSA funding, or is it client served through all of DMH? And if you could answer that before I move on to my next question.

>> KALENE GILBERT: Sure. So on slide 7, if folks remember, this is our Community Services and Supports plan slide. This is specific to the Community Services and Supports component. So it's just one part of MHSA, not all of MHSA. So it includes the children, youth, adults, older adults. It's directly operated and contracted services. But once again, it is specific to the programs you see there, which are Full Service Partnership, outpatient care, Alternative Crisis Services, housing linkage, and planning outreach.

>> COMMISSIONER PADILLA-FRAUSTO: Okay. Thank you for that clarification. The second question, and I guess the point that I want to make, and this has come up multiple times because I brought it up, is the need to have the number of people in need. Not just the number of people served, because we, these numbers look great and all, but if we don't know what the need is out in the communities, we don't know if we're actually reaching the people that we need to be serving. And so I did a quick little analysis here based off of the data you provided on slide seven. And these are Community Services and Supports for all ages. And what I did is I compared that to the numbers the estimates of adults in need. It's only adults? No, it's SMI and STD. So it does include kids, my apologies. It includes both.

So I took that number from the Cultural Competency Plan, which is on DMH's website. There, it was from their Table 8. And so I -- they use CHES Data and American Community Survey to provide estimates of mental health need by SPA. They also break it down by race ethnicity, but for now, I just did by SPA and took that number of what, you know, this document identifies as need by SPA and looked at the number of clients served in CSS, which does make sense using CHES Data because data from CHES is a household survey. So these are people who are living in the community, so it doesn't include anybody that's homeless unhoused or institutionalized. And then I used that number of need and subtracted the number of clients served. It kind of overlaps at the same time period. The time periods may be off a little bit and I can adjust that.

But what I'm seeing here is that 75 percent of people in need of all ages in LA County are not getting the services that they need, 75 percent. And this ranges from 66 percent of unmet need in SPA 7, down to 34 percent in SPA 5. And all the other SPAs fall in between there. SPA 7, 2, and 6 and 3 all have more than 50 percent of unmet need. I would highly, highly encourage us to include these numbers in these updates in the dashboard so that we can really start seeing where we need to move the needle, where we really need to start allocating resources and really reaching the people that we really need to reach. Because 75 percent of unmet needs in LA County is not great for us. And I would like for this commission to really work hard with DMH to move that needle so that we are reaching more people.

So to Commissioner Weissman's point about PEI, we should be touching every one of these people who are in need, who are identified as having need, and we're not doing that. So we have worked ahead of us and I am

happy to work with anybody on data to really to really help us address this and really help us start moving this needle and getting people's needs met asap.

>> CHAIR AUSTRIA: Thank you. Can you send your data? And then, Kalene, maybe you could connect personally and have a discussion?

>> KALENE GILBERT: Absolutely. Can I speak to some of the points I want to make?

>> CHAIR AUSTRIA: Sure. Commissioner Frausto, I don't want to interrupt you.

>> COMMISSIONER PADILLA-FRAUSTO: Yeah, no, I'm done. Thank you so much.

>> CHAIR AUSTRIA: Thank you.

>> KALENE GILBERT: So, and then Commissioner Frausto, thank you so much. Just one of the first, what you're really talking about here is doing a proper community needs assessment and really trying to assess what the need is in the community and then how well we're meeting that. I would caution on just using the CSS numbers for a couple of things. I want to -- I would caution against using just the CSS numbers and perhaps the current public facing dashboard that is for all DMH services might give you a better idea of how many people are served across the board. Because it's much larger than here. This is just a subset of MHSA.

A comment. I came -- prior to here, I came from Quality Improvement. So we did look really closely. We do work with them, and it is one of the California Health Information Survey that's done by USC. It's one of the only tools we really have to try to assess what the need is in the community. I think we've struggled a little bit with their questioning. So I would very much love to sit down and talk about how we use it and how we can apply it because, I think, the questions are very general. So I appreciate that, appreciate the attention to detail and I'm really glad to follow up with that. And this -- oh, sorry. Go ahead, please.

>> COMMISSIONER PADILLA-FRAUSTO: Oh, no, I'm just saying that I'm happy to help you with that because the data comes from UCLA. It is housed at the center where I work and we're another house as a researcher. So, you know, please feel free to pick my brain. Let's get this data, let's get it out there. Let's be informed so we know how best to move forward.

>> KALENE GILBERT: Thank you so much. This will be a big part of that community's need. And I also want to speak to the other side of where we apply that data and what population we're applying it to because really what was kind of trying to tell us is the rate of need and, you know, are we applying that to LA County at large? Are we applying into the Medi-Cal population, which is more the population we're serving? Are we applying it to the population of 138 percent poverty, right? Trying to capture folks who maybe don't have Medi-Cal.

So there's a lot of -- I'm so grateful that give -- you're a numbers person, I'd love to work with you. But I think that's one of the things we need to be really clear about, too, when we share statistics is what they really mean and what we use to build those numbers.

I also appreciate the corrections. I think I said USB. I'm a bruin, so that was a huge foe fa. I didn't give credit to the right school. But thank you very much.

>> I will not write you out.

[Laughter]

>> COMMISSIONER PADILLA-FRAUSTO: Thank you. May I just ask to reflect that it's not Brittney Weismann who's continuing to speak. This is Imelda.

>> CHAIR AUSTRIA: Yes, thank you.

>> COMMISSIONER PADILLA-FRAUSTO: Okay, thank you.

>> CHAIR AUSTRIA: Okay. All right. We're -- as we're going to continue to go around I want to move to Larry Schallert. Thank you, Imelda. Going around. Thank you. Go ahead, Larry.

>> COMMISSIONER SCHALLERT: Oh, sorry. Thank you very much, Kalene, for this great report. It's really -- I really appreciate the detail and the amazing thing everyone's doing. Just one issue, I'm kind of taking up on someone else's -- I can't remember who said it -- on the alternative crisis care. Two things. One, the importance of being able to treat, to see adolescence is really crucial. Let alone children under 13. So those two areas are really lacking. And I noticed in the funding, it's actually going down for alternative crisis care, which seems really counterintuitive. Which slide was it? I had it for a second. Yeah, it's slide 8. Do I have that right? That our price Alternative Crisis Services funding is actually decreased at a time when we -- it's been proven how important that services across the board, whether it's a net team or it's an empath center or subversion care we're, obviously, trying to get those in our areas. So can you comment on that? What happened with that?

>> KALENE GILBERT: The change in the funding, I would want to take a closer look before I share that. So I really would like to get back to you with that. I think the other thing that we can do, though, is share all the work that has been done with the alternative crisis because we have seen a significant expansion and I don't know how

publicly we talked about that. And I do appreciate the comment about the age ranges. So this is something, let me, if I can, get more thorough, I want to make sure I'm accurate to that.

>> COMMISSIONER SCHALLERT: Great. And I'm not complaining about everything that's been done because just bringing it all into one department has been amazing. People that are running it's amazing. I mean, everything's great, but we're not -- we're not burying this. Thank you.

>> KALENE GILBERT: And yeah, the trend, and I won't try to explain that. It's a good question.

>> CHAIR AUSTRIA: Judy.

>> COMMISSIONER FRIEDMAN: Susan. I was just going around. Susan?

[Overlapping Speakers]

You're going to defer to Susan, we'll come back. Susan?

>> COMMISSIONER FRIEDMAN: I have two questions. Thank you, Kalene. I'm saying, so I'll just say it up. First of all, if you could tell us more because I do know that the governor has been talking about eliminating Prevention & Early Intervention. The second thing I wanted to ask was about the suicide because are you talking about the 988 line or are you talking about the Didi Hirsch? I was under the impression that DMH is going to use the Didi Hirsch suicide center as that's going to be where the calls; is that correct? So the Didi Hirsch, yes, that is correct with the suicide hotline numbers are specific to a suicide pipeline. Those are the calls that came in last year. Okay. The ones that we reported out on today. But in terms of, are those two points blended together in the future? That's a question I need to ask, but [Speaking away from the mic] is always under the impression that DMH suicide prevention.

>> KALENE GILBERT: Yeah, Didi Hirsch's always been our suicide hotline provider. In terms of the 988, I think I'm wanting to clarify your question, but let me -- again, this is another thing that I want to bring back the folks who are at top to the folks who are doing 988 because again, I want to make sure you have the right answer.

>> COMMISSIONER FRIEDMAN: Can you tell us anything at all?

>> KALENE GILBERT: Sure. And I'll try to write this brief because I do know it is a much, much larger conversation. But just to make sure that if the information out there is correct, and you can go onto the state website and I share that information, too, with Kenia. There will be opportunities for stakeholders to speak. The proposal, as it stands, specifically looks to change those components that I talked about today of CSS, PEI, when from that allocation make up to 30 percent housing and housing services, 35 percent FSP, and 35 percent everything else. And then everything else could be PEI, could be outpatient, right? It doesn't really speak to you. It's like the other things that we prioritize. So that's the proposal as it stands. It also includes services to folks who have substance use disorders and no mental health needs.

Some other things I want to make clear, it is a proposal to put something on the ballot in November of 2024. It'll go back to the voters. So this is not something that's just going to get a railroad, right? There's a lot of conversation that's going to be happening between now and then. We will expect that proposal to morph, but it is something that will be coming to the voters. So at no time did he say we're eliminating PEI but he's proposing that we change those buckets. And if we want to bring that conversation back here, there's a lot we don't know yet. So I want to be very careful about making sure there's accurate information. Does that help?

>> COMMISSIONER FRIEDMAN: Thank you.

>> CHAIR AUSTRIA: Judy.

>> COMMISSIONER COOPERBERG: Yeah. First, I really want to say that I appreciate you including the stakeholder feedback, themes, questions, and responses. This, that's the first time we've ever seen this. And I'm the old lady of the commission, so I know I've never seen this before. So thank you for that. Part of it was the commission's request for data budget allocations, service utilization. I want to encourage that we stay away from any data on Sup districts because there's a big difference between Sup districts. I can't say the whole word.

[Laughter]

Yeah. What he said. And service areas. Service Area 1 goes from Antelope Valley, Santa Clarita Valley, San Fernando Valley, San Gabriel Valley. So they really have nothing to do with one another. And so if you do that one picture in a Sup district, it's way out there in space. So if you stick with the service areas, it really gives you a better picture.

Addressing the current services, that's great. You have the client data by service area, but what is the population of each of those service areas? Because we don't know between ourselves what service areas have what population. And that gives you a better indication of where people aren't being served, where the unmet needs can be focused on. And so if you could include the populations, that would be really helpful. And like what Imelda said, and we brought this up at the Executive Committee meeting, is that we know that this is the MHSA report, but in

terms of us really having a grasp of the department, we need all the funding, all the services, all the data to really be on top of what's actually going on in our county.

>> KALENE GILBERT: If I can, I'll try to start -- and thank you for those comments, Commissioner Cooperberg. I want to start by thanking you for acknowledging the work on responding to those comments. I want to acknowledge your team member, Dr. Horn, again, who spent time to really go through and come over with those attendees and make sure that we do get that information back. So I'm glad that that was helpful. For the data, what I had shared today by Sup district is part of the dashboard. And the dashboard will allow you to cut by district or service area. So that when it comes to our reporting out to the community, we usually broadly go by service area since it's more specific. But we also want to make sure, especially us commissioners and representatives of board members and their constituents can cut either way you need. But we'll continue in that direction.

And then for the total population, there is actually a second report that is available on the department's webpage. And I can share this with Kenia that flyers to the whole department. That's our -- it's our annual needs assessment whereby we do go through, it is by service area, but we do look at not only all the population statistics and demographics, but then we do a cut by, as I was mentioning earlier, we do a cut by Medi-Cal. We do a cut by 138 percent poverty. So I don't want you to have to look at these side by side. So I want to say, I hear the comment that you'd like to see this past. If there's something you're interested in seeing now, it's available. Sure.

>> COMMISSIONER COOPERBERG: It would be helpful to see it side by side.

>> CHAIR AUSTRIA: Right.

>> KALENE GILBERT: Did I miss a question? I just want to make sure I got everything.

>> CHAIR AUSTRIA: No. Thank you. Dr. Barbour.

>> COMMISSIONER BARBOUR: Thank you so much for this comprehensive report. Really quite a lot of detail and I'm looking forward to the dashboard. And I understand that it's a lot of work, but I look forward to seeing how it can be sliced and diced in the way you just described. I think that's going to be very helpful to our community. I just have a few questions and things that I just want to wonder about. And one of them was PMRT. I heard Kimberly said they're seed funded, but in that report there's very little about PMRT. Unless I just missed it going through it. I may have missed it, but maybe I just didn't see it. However, in the LA Times on April 13th, there was quite a lot about PMRT and they gave quite a lot of statistics about PMRT and what's not happening in communities.

And so I'm very concerned about the crisis system and how it can be fortified because I've been a part of it. I'm part of something that's sunsetting and I take great, great risk in talking about that. But I do feel like I have to speak about it because the PMRT is not here. But there are groups, enormous statistics that were in the LA Times, and I just wonder if there's something that we're missing. Is there a problem here? And how it's going to be -- is it always funded by ARC or is it moving to ARC? Is that something new? Is there a lot of flux going on in that area? Because crisis services to people who are experiencing suicidal thoughts, who are experiencing overdoses, who are experiencing domestic violence challenges or who just need access, and we're talking about access to care is really important. And so I just have to bring that up.

I also see what there is a mention in here about FSP wanting to increase it to 51 percent. And I'm really glad that UCLA has been a partner with FSP. It's mentioned in the report what they have done in terms of training, but I'm wondering if there's any training that UCLA or anybody in the department can do that has to do with the sustainability of FSP under CalAIM. We've not talked about CalAIM in this forum as long as I've been, and it's, of course, not in this report because it's retrospective mostly, but it goes a little prospective as well. And I think the absence of that conversation around some of the intensive programs is really kind of noticeable.

I want -- I also want to -- I was very encouraged to see the UsCC recommendations in those meetings. And the LGBTQ+ recommendations serving the Black community, there were at least three and they were well elaborated. I wasn't sure who was implementing it. And I think that would be great because many would like to enjoin that effort to be able to implement. And so those, because these are among the most marginalized people in our community and we experience it in SPA 6 and how can we help that, but we need a little more information and perhaps I can do a little outreach to the UsCC to see where they are so that it's just not words on the paper.

>> CHAIR AUSTRIA: Thank you. Kimberly, can you respond?

>> KALENE GILBERT: Yes. I would like to first respond about -- do you want me to stand up?

>> COMMISSIONER STEVENS: I think before she responds, can I just ask one question that she could maybe include in that in reference to CalAIM? And my question would be: how will wraparound services be impacted by CalAIM?

>> KIMBERLY NALL: You would give me a challenging one, right?

[Laughter]

>> COMMISSIONER STEVENS: Of course.

>> KIMBERLY NALL: So first I would like to speak about PMRT. So this PowerPoint is basically focused on what's changing for next fiscal year. And so that's why you do not see a slide or anything specific on PMRT. So on those pages, you will see that it basically says proposed changes for '23-'24. And so PMRT is already budgeted. It is already in the plan. And I think that what I would like to do is have us come back and share with you more information and details about PMRT and ACR. ACR stands for Alternative Crisis Response, and it involves more than PMRT. And we can give a very wide, you know, range report out on, you know, what that means.

>> COMMISSIONER BARBOUR: I just didn't see it in the updates in the document.

>> KIMBERLY NALL: It's -- right. So basically this update is focused on what is changing. So that's why you didn't see it. It is part of the existing and so we focused on the new stuff that was going in that you guys may not be aware of. Does that make sense?

>> CHAIR AUSTRIA: And we understand that this is just a slice and we just -- it's a big slice, but it's not the whole pie.

>> KIMBERLY NALL: Right.

>> CHAIR AUSTRIA: And we understand that there are many funding streams that come to DMH, which are very complicated.

>> KIMBERLY NALL: Sure.

>> CHAIR AUSTRIA: And so it's sometimes when we're just saying this, of course, it's hard for us to see, it looks like there's gaps when maybe there isn't a gap. So we need to understand that, and that's why we'd ask you in the past to, you know, come and present to us so we stay up on budget, what's coming and all that. So thank you for that. And we would need a report on that, I think.

>> KIMBERLY NALL: Yes.

>> CHAIR AUSTRIA: Okay. Let me go round. Reba. Stacy? Is it something related? Go ahead, Reba.

>> COMMISSIONER STEVENS: Well, actually, you know, it was something that was said, and I believe that it was Commissioner Schallert that had raised a concern around her young people. And so while Kim Nall is still at the podium –

[Laughter]

-- to address something that, you know, I had been watching for quite some time. So in 2018, DMH entered into a grant agreement with the Mental Health Oversight and Accountability Commission. And the grants are ending. So the question is: what is the plan to continue with the services for our --

>> KIMBERLY NALL: The OTTCOTT program?

>> COMMISSIONER STEVENS: The OTTCOTT I think we need to make sure that people understand that OTTCOTT is the outreach triage team --

>> KIMBERLY NALL: And for adults.

>> COMMISSIONER STEVENS: For adults. And that COT is for our Child Outreach Triage chain. So it's important for us to understand these services provided immediate intervention for our TAY to avoid hospitalization. So could you help us to understand, and if you need some support, I have.

>> KIMBERLY NALL: Oh, no. I don't need any support. I got it. So OTTCOTT was a program that we received state funding for, for three years. The OTTCOTT funding source was for personnel only. And we developed a program with outreach teams that took referrals from PMRT if they did not have to put a client on 5150 holds. So basically they had a call, they stabilized the client, right? And the client did not need to go to the hospital. Those referrals were given to the OTTCOTT team. OTTCOTT teams were basically to work with the clients to link them to services. They were not supposed to open cases and do long-term care, but basically to link them, to triage them basically back into mental health services. And so the funding is ending. We have reached out to the state and asked them if they could extend the funding because we have not spent it all, and the state was not able to do so. So the funding will end. We have suspended the referrals to the OTTCOTT teams and our PMRT teams, which we have expanded, and our MCOT teams are picking up these referrals. So I know, you know, it's a lot of PMRT and MCOT. So, you know, PMRT is our --

>> CHAIR AUSTRIA: Right. So I'm going to interrupt. So what happens to the unspent funds?

>> KIMBERLY NALL: Oh, it goes back to the state. So the state has not paid us. We just didn't maximize those funds. So let me explain why. Okay. So I previously stated that the state gave us a personnel grant. It only paid for salaries. That's it. So DMH had to cover the other expenses associated with the OTTCOTT program, which we did because we know that when we put together a program, it's not only for staff.

>> CHAIR AUSTRIA: How much money is going back?

>> KIMBERLY NALL: Oh, I will get that amount for you.

>> CHAIR AUSTRIA: I think that's our concern. If we didn't maximize the funding, we know that it got started two years after the grant. So...

>> KIMBERLY NALL: It was extended. So we did get a full three years to implement the program.

>> COMMISSIONER STEVENS: You know, I really -- I oftentimes wonder about connections, relationships, partnerships.

>> KIMBERLY NALL: Mm-hmm.

>> COMMISSIONER STEVENS: Because, you know, I like, and I can't speak for all of us, but I think we're all advocates. And I would like to be used in a positive light to be able to advocate. But I can't do that if I don't know that these are the challenges in which the department is facing that monies are not being able to be spent for whatever given reason or going back, or the state is not, you know, I want to say cooperating with the department. This is where we could, you know, this would be something new for this body, but we could suit up and show up and support the department because other than that, it's like being a checkbox. And I just need to say that at this moment because I don't like the way that makes me feel when I'm learning that something has been happening and I had no knowledge of it, and now it's too late to help.

>> KIMBERLY NALL: Sure.

>> COMMISSIONER STEVENS: So I'll end. Thank you.

>> KIMBERLY NALL: Okay. You're welcome.

>> CHAIR AUSTRIA: We'd like to know how much money is being returned.

>> KIMBERLY NALL: Sure.

>> CHAIR AUSTRIA: Stacy.

>> COMMISSIONER DALGLEISH: Stacy. Yes. Stacy Dalgleish. So thank you very much. I think that goes without saying, I really appreciate it. I agree that this is the best version of this that I've seen in the time that I've been on the commission, and I appreciate your addition of all stakeholders, consumer's concerns, and advisory capacity for this update. I'd like to start with just a clarification on page 14 of the, you know, Annual Update under Full Mental Health Commission and the qualifications and requirements.

Last year, there was an additional requirement that there be a member of the military on our commissions. Now, if this is just for the previous -- oh, I need to raise my voice. Okay. Sorry. If it's just for the previous year, then I understand. But going forward that is a new requirement and in the legislature right now it looks like they're going to add a youth member, too, so we'll keep our eye on that.

When I was up in Sacramento last month something that kept coming up was the lack of services for older adults and being one. Now I started going through this highlighting all of the issues about older adults and I was really there are places where the numbers aren't there. I don't know if that's just a formatting error, but if we could get those specific numbers, I'm happy to give you the pages where those are located. Also, let me see here. The Incubation Academy, I was really surprised with the number that was on the surveys because I had no idea that there were that many people. I know that there, you mentioned 29 projects but I would love to have more detail on that survey. I know that it appears that that's been a really positive innovation and if we can get more information about it and what we're looking at moving forward I would love to see that in the future. Let me just see here.

In the statistics on -- you have the total numbers served and there's one number that's for, you know, that says you have unique clients served, and then another that is on new. And I'm wondering if those numbers are then combined. Are the new combined in the unique or are those two separate numbers that are then added for a total? So that was something that I was interested in.

And on page 28, reasons for dis-enrollments. There's a category here that I don't see the color combination for. And it looks like it is, it would be a dark orange. And so I'm curious about what that might have been. And if we could see that would be great. I also was curious about getting more information about our investment in faith-based communities because that's something that I really had never thought about, but I see it coming up often in the SALT meetings that I attend and a lot of dollars are being spent in SALT funds in faith-based communities. So I'm curious to know the numbers around that for the department that might be separate from what is being spent in the SALTs. And then I guess we would want to see equity in that, too.

So I'm not going to go over all of the places where I found the issues for older adults. I can provide that separately. I was concerned on 35 and 36 where Starview is missing on 6 36. I don't see Starview or let me just see, unless it's High Desert. Sorry. It is. I apologize. I'm wrong on that one. So I -- and I will not ask the question about UCLA because I could be wrong about that one, too. So on 114, it is an item under the WET or workforce training -- education and training, I believe. There is a comment that says the following training, and I didn't see anything about

what that was referencing. It says "expanded employment," right? And then it says, "The department delivered the following training." And then it says you'll -- the department will continue with new offerings. So I kind of expected that there might be a colon after that to the following, and then it goes straight into Innovations on the next page. So I'd love to know what, you know, more detail on that.

And I do want to thank you for all of your work and for taking into consideration our Underserved Cultural Communities. I see that there's an oral history project for our Cambodian community. I'd love to see that for all of our Underserved Cultural Communities, being able to have, you know, an oral history so that it's not lost. Thank you. And thank you again, and thank you for your time.

>> CHAIR AUSTRIA: Thank you.

>> KALENE GILBERT: So there's a couple things I think I can try to address here, and certainly some things that I'll get back to for you. I do want to comment for older adults. I think you probably are already aware, at least within FSP, I think we eliminated that specific category, but we should still be reporting out where we're serving older adults. We do still have a few practices, so we can do some work to try to highlight that a little bit better.

>> CHAIR AUSTRIA: And I think, I just want to say, I think that was, it was in public comment out there, the planning council. And that was one of the concerns was that once older adults got moved into adults, but, you know, they were different. They were up to, I don't know, 59 or something. So thank you.

>> KALENE GILBERT: The good news is that the providers that have that expertise continue to provide services. So we do continue to have specialty knowledge on serving this conservation. But we can look to see, I think, where we need to do more of a breakout. For the Incubation Academy, the providers, the 29 providers that participate, have funding to deliver their services to the community. So those surveys, right, are connected with the services that are delivered to the community by those participants.

Just for a little more clarification for the faith-based, I don't feel like they have a regular budget. I can tell you one of the big things we invested in this year is a faith-based conference. And we've been working with that committee to roll that conference out. It's going to be May 31st. And, again, Kenia, I can give her some details so that we can email, we've got support to really build bridges, and there is a goal, there's an awareness that there's not equity among the groups. I think we have to do other groups, right? Our SALTs, our UsCC, they all represent different parts of the population in LA County. So we want to do some work to ensure they've got support that's in line with their representation, what they're doing. And so we'll go ahead and look -- take a look at those.

>> COMMISSIONER DALGLEISH: Thank you. Thank you. I do want to mention one other thing. The conversation keeps coming up with combining SUD and mental health.

>> CAPTIONER: Sorry, I can't hear you.

>> COMMISSIONER DALGLEISH: Oh, I'm sorry. The conversation about combining substance use disorder with mental health disorders keeps coming up. I'm always worried when people start looking at the MHSA budget that was specifically for services. And now because there are such needs for housing that potentially can start taking away a lot of money. [Applause] And it's mentioned that it's not just, in some circles it's mentioned that it's not just for people with severe and persistent mental illness, which is referring back to the original intent of MHSA, concerns me. I know it's a big pot of money and everybody wants some of it because there's not enough money in other places. But I feel very protective of that MHSA money. And I think that -- so thank you.

>> CHAIR AUSTRIA: Commissioner Root.

>> COMMISSIONER ROOT: I'd like to thank you for the detailed report. This is much more we've seen before. That's very helpful. As the loss in the details and seeing a lot of trees in this forest. And I think several commissioners have hit on, we seem to have money allocated to various budgets driven by seeds revenues, not needs. And as was pointed out, what's noted here are gaps. And because we can't seek gaps, you can't see priorities or how monies are allocated. Page 8, I think, of the slides are very helpful. Thank you.

I can see that increases year-over-year vary from 50 percent in FSP but 3 percent down in crisis services. Some of the many priorities are here based on something. But this report doesn't require any of that. So we can't give feedback. The community can't give feedback on how priorities are being set and what needs are being addressed. Great step forward, don't misunderstand me, but we can do a better job now of fine tuning details that we have, getting them getting spots where they belong. And I would like to see the supplement of the good work done today with the needs analysis, gap analysis, and how priorities to be set among the various things.

>> CHAIR AUSTRIA: Thank you.

>> KALENE GILBERT: Thank you. I want to start by just acknowledging that need. We've talked about the process that as we see it next year, should absolutely include not only the needs assessment and that data, the gap

analysis, but looking at what we have and what those priorities are. So that should be part of the process every year. And that's the work we're doing to establish. So I appreciate the comment. That is good.

>> COMMISSIONER ROOT: I have to step out early, I apologize.

>> CHAIR AUSTRIA: Thank you. Thank you.

>> COMMISSIONER ROOT: Thank you for letting me give in.

>> COMMISSIONER STEVENS: But before Commissioner Root, and being that there has been discussion -- and thank you, Commissioner Stacy, for raising concern around substance use disorder and then around substance use disorder, but also homelessness under MHSA. So here's the deal: I don't care where money comes from. I'm going to say it again, I don't care where the money comes from.

If we really think about Prevention & Early Intervention, and we can go back maybe 10 or 15 years ago, what could have happened then perhaps would have addressed a lot of where we are today. And today, people are dying unhoused on our streets. People are dying in record numbers. We talk about the county of Los Angeles and MHSA. But the question -- the bigger question for me is: how are we working together with, you know, across the county, partnering with our cities to address the immediate needs in the community?

So the question is also: have you read or are you aware of the state of Black Los Angeles? That's a yes or no?

>> Yes.

>> COMMISSIONER STEVENS: That's a yes or no. Yes or no? Yes or no. It's a no. And here's the thing: because what's happening is the silence. And I think that it's really important for us to even address. And once again, I don't care where the money comes from, the needs of the people that are on our streets, who are dying or either using substances and walking around talking to themselves and not being cared for. We as many people are outside in our community and not only can really speak for Service Area 6, I don't see anyone. Where are the people who are caring for the people who are outreaching to the people to save the people? And the other thing is, how many people did we house this year?

So I think that we need to be understanding what those numbers are. And then you mentioned harm reduction. I want to hear how many people are in treatment? Inside treatment. Where are our treatment facilities? How are we working with the alcohol and other drug commission? We have HIV that came right on up in here and asked, huh, for partnership, right? And we have someone who actually has a seat at that table. So we're going to -- I'm hoping that we will even make better use of you and what you have to offer and bring in connection to what's going on.

So I just -- I want to know how many people were housed. And then I also want to -- there's something else that I have, and I'll be quiet, Madam Chair. In your -- in this document, this handout that you gave today, I found this fascinating. So it says that, "Through the FSP program, the Second District," as I am representing, "those who were served," we almost had, we had over 45, right? But then when you turn over and you look at Prevention & Early Intervention, the numbers is less, which says to me that something is wrong with these numbers.

Something is wrong with where we are actually investing money and how we are addressing, first and foremost, this high need in the Second District to begin with. Then it turns around and it becomes for Prevention & Early Intervention and a whole nother district. And, I mean, I'm okay with everybody getting helped and served, but something is wrong here, Kim Nall. Something is wrong here with this data and these numbers in reference to how dollars or resources are being positioned in our communities that clearly show this is your data, not mine. A need. So I've been hoping that either, not necessarily about addressing it, but fixing it.

>> CHAIR AUSTRIA: Thank you.

>> COMMISSIONER WEISSMAN: I just want to point out that to Kim's point, or there's an aspect here, that these numbers are short three months for the current. They're likely under captive.

>> COMMISSIONER WEISSMAN: She loves you.

[Laughter]

[Overlapping speakers]

>> KIMBERLY NALL: I had the same question, but there must be an under if there's three much shy of data in this.

[Overlapping speakers]

>> CHAIR AUSTRIA: Mike Molina, give him an opportunity.

>> COMMISSIONER MOLINA: Thank you. I just wanted to say to Kalene and to your staff that this is completely your fault. So five years, I've been on this commission, you finally received a quality document. And when we get a quality document, you get an engaged commission. This is the best commission meeting I've been in for five years.

You see passion, engagement, interaction, dialogue, something we've been asking for years, this document is turned. So thank you very much. Thank you for the level of detail. Thank you for responding to a lot of our concerns in previous years. Fantastic document. Now, here's how it can be even better.
[Laughter]

I was happy to come two weeks ago at the invitation of the chair to the Executive Committee to look at this document early on. A lot of us were there. I love the level of detail that begins on page 160 of all these added programs. But I said that day is the same. Same thing. I'm just going to say today, what's missing in those little blue boxes and those little yellow boxes is, and we've heard about this over and over again, and that is, how are these services affecting us by geography? I'm singing out of the Judy Cooperberg and Kim Nall, she wrote the song. We have to look at ways that we can effectively, as Reba said, advocate for these changes among our communities. When we go back to the SALT meetings and they run up and say, "What did we get out of MHSA this year?" I don't know, we got a bunch of green boxes, but I can't tell you what's going to SALT 8 or to SALT 7 or SALT 1. I can't tell you.

So what's missing in these excellent boxes is more description of how this affects our, you know -- we're all rep, we're all here because supervisors appointed. Our supervisors are looking at countywide policies, but they also have their own districts. So we need to be able to respond to our constituents by saying, "Here's the monies that are coming in. Here are the changes that are happening that affect each and every one of our districts," as Judy said, our service areas, which is even better.

So hopefully we can receive, ideally, an appendix to these boxes that give us a chance to advocate among our constituents of where the monies are going, where these projects are best effective. So thank you for that, Kalene.

Just very quickly, I think the stakeholder process description and process itself is far improved. It just looks phenomenal. What I would like to see with the myriad meetings that have taken place is not just the date of the meeting, but how many people attend. I would love to be able to see, "Wow, 300 people showed up to this meeting," or three people showed up to that meeting. So I think it helps me to gauge the effectiveness of the stakeholder process if we know exactly how many people were in attendance at those meetings so that we can see whether or not they were effective processes. That's it.

The last thing is, and maybe this is something for a future meeting, we heard in public comment, and I'm curious on the selection of these programs, the changes: what is the RFP process? How do organizations know there are processes in place that they can apply to programs? I would just love a little 101 on RFPs for the MHSA. So if there's a January 15th deadline, okay, when does it begin? How do people know about it? How is it advertised? We heard that from a couple of our public comments that, you know, there may have been programs that were not fully better, whatever. Let's give us a chance to learn a little bit more so we could advocate among our contacts, among our communities in knowing how that proposal process takes place. And for this year, I'd love to know the total number of proposals that we were funding compared to previous years. Was this a banner a year or was this consistent with previous years the number of proposals. So I think those are my major issues for today. Thank you.

>> CHAIR AUSTRIA: Thank you. Thank you. Susan, do you have a last comment?

>> COMMISSIONER FRIEDMAN: I don't have a last comment. I think Mike covered everything.
[Laughter]

>> CHAIR AUSTRIA: Ditto. Stacy had a comment and then I'll --

>> COMMISSIONER DALGLEISH: Yes. Regarding what you were just speaking about, Michael. One, I'd like to see attendance broken down in categories. And I'm thinking of three: one would be staff, one would be providers, and the other one would be people who I would consider to be a real stakeholder. Hang on one, just one second.

And then in terms of the RFP process, one of the U SCCs I was at this week mentioned that these proposals and please tell me what the situation is on the reporting back that they're sent out to those providers who have signed up in a particular category as opposed to a broader distribution to, you know, so that everybody's included in. So thank you.

>> CHAIR AUSTRIA: I want to make a comment first, please, Reba. Thank you. So I do -- I know there's so much work that you and the team have done and I commend you for, cause obviously people have been here longer than I been made a difference. And I thank you for that. I also appreciate all the people that came today, both online and in person and all the previous meetings to make comments. My comments go, when I need this dis data by district, I need it by SPA. I need it actually by the clinics, whether it's a nonprofit or for profit. We need, like, a position status report because people implement programs and we know that we've made progress in human resources and hiring people, but we don't know about the nonprofit's ability to hire people. And if we don't have the people to

implement, even though we have all these wonderful programs, they, I'm wondering about the implementation of all these programs, right?

>> CHAIR AUSTRIA: Mm-hmm., are they partially implemented? I know that trans transportation was, they couldn't get staff for it. So they're trying to relax the standards. So we've written these things and I think some of the undercounting is not that's for sure, but it's because we don't have, we lack the staff to provide services. It's, so I am requesting from the department, and this goes beyond to say, this goes for the whole department and I want to position a status report. So I know by facility who's got empty, empty has, you know, vacant positions. And then they need to find some way to work with the nonprofits to find out what kind of vacancies they have. And so I'm just very concerned about program implementation and I'm concerned about equity.

So some of these places I know like SALT 6 or SPA 6, where you can see there's a high need for service. We were the last to get transportation. I'm not even sure if we filled it. So they weren't any transportation, which means our patients in that area still had to go by ambulance or police car to, you know, a place where they can be treated. So those are some of my questions. Also capital projects in each district. I know those need to be equitable. And I want to address housing. In the beginning of MHSA, they had a housing fund, which was separate from the rest of the MHSA, which was, I believe spent. But I know I spent a lot of time at that committee making sure that, you know, funds were being spent. Because I will say a couple of districts actually at that time rejected the funding because they didn't want homeless housing built in their district.

>> Sorry, they didn't want what?

>> CHAIR AUSTRIA: They didn't want homeless housing built in their districts. Which, you know, were moved beyond that. But I'm saying there we need to maybe advocate for a housing fund, you know, in addition to that. So that goes beyond MHSA at this point. So those are some of my things. And I also had, in the community stakeholder process, I wanted to see a few -- a whole list of community stakeholders so that we could identify the gaps. I know, like, the police should be at the table. We need other community members. The developmental community disability brought up something. HIV is here. Who is missing from our table that we need to hear from and how do we hear it? Because we are -- there's over 10 million residents in LA County and high needs. So how do we make sure we're being represented? In a previous process on the System Leadership Team, it was identified and we made sure slots were billed so that people, everybody was at the table. And I think that's missing at this point. And so that's my comments.

Again, on the OTT and COTT, again, I'm moving beyond and talking beyond MHSA and looking at the whole budget. You know, we might have a spoken here like PMRT that's, you know, being filled, but we don't know, because right now we're only looking at this piece. So we want to have, you know, unsilo ourselves and make sure that we're looking and programs side-by-side so we can see the whole funding. And, again, whole funding that by district, by SPA, and by location, you know, specific locations to make sure that we're being equitable. And then Reba and then Brittney and then Stacy.

>> COMMISSIONER STEVENS: She can go.

>> COMMISSIONER WEISSMAN: I'm just noticing time and the value of the quality of the comments are sounding to me very similar and aligned. And it feels to me like we might be ready to start crafting whatever the letter you had in mind for the draft discussion conversation if you'd like to get that started. I just thought I would prompt that.

>> CHAIR AUSTRIA: Thank you. Reba.

>> COMMISSIONER WEISSMAN: Whatever you have in mind for that process.

>> COMMISSIONER STEVENS: So I'll just make it real quick based on what is being said and because all of this is deeply associated with MHSA, and that is our stakeholder process, right? And so my question, and I wrote a few things down, is about, you know, composition. So for those of you who remember we had the Systems Leadership Team that no longer exists and as a result of, I don't know, perhaps the department realized that, "Uh-oh," and so what was created was the Service Area Leadership Teams; however, does it have the composition in which you were talking about, Chair Austria? And how do we know that? How are we holding ourselves accountable in all of our service area groups accountable to ensure that we are actually in compliance with MHSA, which is critically important.

And then throughout the stakeholder process, without being if we're not in compliance. And that says that we're really not hearing from the people that we should be hearing, the stakeholders that we should be hearing from prior to this being even approved. I'm just saying we need to really take a look at that. Yeah. So that's all we got.

>> CHAIR AUSTRIA: Thank you. Stacy.

>> COMMISSIONER DALGLEISH: Yeah. Well, just capping off what Commissioner Stevens said, I think this could be in the letter as one of the issues of filling slots on the commission, at least, is the supervisor's court. And we really don't have, I mean, much input to that. We don't even have input to the director's choice. Oh, I'm sorry. I just thought that since we're writing a letter to the Board of Supervisors, we could have this, something about the composition in that because they are the only ones who can make appointments, at least at the commission level. And so if we're -- and in terms of disregarding the commission, as a side note, we weren't included even though it's in the WIC code, in the selection of the director.

>> CHAIR AUSTRIA: Thank you. Thank you. So yeah, I do think a committee, we need a small committee to write this letter. What I would request from the whole commission is if you have something you want included in the letter, if you could, I know that again, short timeline, if you could have it to us, say, by -- today's Thursday -- by Monday, which means you're, I'm spoiling a weekend perhaps [Laughing]. But if you can get that to us, then we can start getting a letter together. And I can't commit to Tuesday.

>> COMMISSIONER DALGLEISH: Are we not going to start now?

We can start now, but I'd like to make sure that people because I know I need to sit down at the computer to write my thoughts.

>> COMMISSIONER FRIEDMAN: How are we doing this?

>> COMMISSIONER STEVENS: We'll just start. Well, I thought there was a small committee that would craft the letter.

>> CHAIR AUSTRIA: Mr. Molina, what was your position?

>> COMMISSIONER MOLINA: Well, my thought would be that it's the staff that would begin drafting the letter and that we would react to something rather than us actually composing the letter. Now, I think we've had a long and engaging discussion today and that this, including the public comment and that the draft of a letter would reflect some of the major issues that have been discussed today. Staff can put that together, send it to us for our review, and then we can make comments from there. I think that's probably a logical way to approach it rather than us getting together with the laptop. Sorry to write something there. There's a template already there. So use the template, let the staff include within that template the major issues that have been discussed today, and then send that letter to us at the beginning of next week for our consideration. That's how I would see it done.

>> CHAIR AUSTRIA: Stacy.

>> COMMISSIONER DALGLEISH: Yes, I would like to add, having written this and Commissioner Weissman also has written one that that is the way it works. The staff writes the letter, and then it comes back. And the important part is that we don't rubber stamp the staff letter, but we make sure that the community and our --

>> COMMISSIONER MOLINA: I agree. I think that, and this whole process is my last comment, this whole process for five years, I've always felt at this moment, all we're here to do is put a check mark, right? You know, and it's been the frustrating part. This is the last -- this is the first year I don't feel as frustrating. I feel like there's some kind of a path and a lot of that is a staff driven improvement in the process. So if the letter -- if the draft truly is not a template and truly is a reflection of today's discussion. I am much, much more comfortable with furthering the letter to the Board of Supervisors.

>> CHAIR AUSTRIA: Mm-hmm. Okay. I do believe, Kenia, you included a draft of last year's letter.

>> KENIA FUENTES: [inaudible]

>> CHAIR AUSTRIA: So everybody has a copy. So I'm going to request that and I will work with you. We can take some of the comments. We need to get the comments for today, download it quickly, and we can start a draft. And actually, I'm babysitting tomorrow all day.

[Laughing]

But I will make myself available, you know, to work on that. And if everybody can get their comments, I think they've been made, and they've been put into the written draft. So unless you have something different, we can work off of that. And if that's okay with the commission.

>> KENIA FUENTES: Yes. I think I'll share the --

>> COMMISSIONER WEISSMAN: And, Kenia, I don't know if you have it, but the letter that went out in 2021 was the really 3-Year Plan, but that's the year that got flummoxed for two years now.

>> CHAIR AUSTRIA: Right. Is that a contract?

>> KENIA FUENTES: I'm happy to send that as an example as well, as long as it's bucketed in themes.

>> COMMISSIONER MOLINA: I remember that.

>> KENIA FUENTES: Okay. Yeah, that was a good line.

>> CHAIR AUSTRIA: No, we had, I think the last couple of times the commission has put more into it and we are taking our role seriously and we want the board and the community to understand that we take our role seriously, that we need to take the community input and feedback to the Board of Supervisors. So we need a little bit more time for DMH to do that. And a comment from the floor. Jean.

>> JEAN HARRIS: Thank you chair. I just wanted to add that since attending the January, beginning of the stakeholder meetings on the MHSA mid-year adjustment and now the annual adjustment that I've been asking repeatedly every chance I get for the geographical information. And so that has actually been months in requesting some information that is apparently unavailable. And I know we're moving into the 3-Year Plan after this. And so I hope that our concerns are addressed. I know the commission itself has asked so many times for different information that is never forthcoming. And so I do not want to have our questions and our comments and concerns ignored.

>> CHAIR AUSTRIA: And we do take them seriously and I did ask for that -- the status report so that we know where, you know, where there's gaps.

>> COMMISSIONER STEVENS: And when is the timeline on receiving that status report?

>> CHAIR AUSTRIA: Again, I would -- Kim, because I know it takes a lot. So we need to be in that process because I know that people will be unhappy with me for asking for that report because I've asked for it in the past.

>> COMMISSIONER STEVENS: But she's going to ask --

>> CHAIR AUSTRIA: Let me finish. So I know it's difficult, but we need it, you know, pretty quickly.

>> KIMBERLY NALL: So may I ask that I work with somebody on this data. So we have a lot of data and we need to be able to provide you exactly what you want or let you know what we have that gives you that or let you know what we have.

>> CHAIR AUSTRIA: And I'm going to refer you back to employee relations because employee relations has been asked for this data in the past by unions.

>> KIMBERLY NALL: Oh, for vacancies you mean?

>> CHAIR AUSTRIA: Yeah. Vacancy.

>> KIMBERLY NALL: Oh, sorry. I thought you meant something else.

>> CHAIR AUSTRIA: Well, both. I want to know -- we want to know, like, how things are budgeted by the facility.

>> KIMBERLY NALL: Yeah. So you want vacancies?

>> CHAIR AUSTRIA: Vacancies by location, not just by SPA. But I would like to know by facility because I know some facilities -- I know traditionally in my past experiences for asking for this, District 5 and District 2 had the most difficulty recruiting and fillings things, one, because again, geographic issues and also because people don't want to work in certain areas or in certain locations like the jail and they have to do certain things to recruit people. So we need that data and we can sit down and, like, really drill down. And I want it quicker than when I asked for the commission data on just for our budget, it took months. So I need that position quicker than it did just to get our commission. So I'm sorry if I'm being harsh.

>> KIMBERLY NALL: Oh, no. It's okay.

>> CHAIR AUSTRIA: Again, I'm very passionate about this too.

>> KIMBERLY NALL: Sure. So if you want vacancies for directly operated --

>> CHAIR AUSTRIA: And nonprofit.

>> KIMBERLY NALL: -- facilities. Okay. So we can give you. Okay. So for our directly operated clinics, that is DMH staff, we have that data. We have it by you. So it is very easy for us to pull up that data. Do you want a specific time period? So I think that that is where --

>> CHAIR AUSTRIA: Well, a present would be nice.
[Laughing]

>> KIMBERLY NALL: As of March 30th.

>> CHAIR AUSTRIA: March 30. That's fine.

>> KIMBERLY NALL: So now for the nonprofits, DMH does not have the data. We will have to reach out to all of our legal entity providers and request that information from them. Yes. Jack Barbour.

>> COMMISSIONER BARBOUR: CMMD reached out to us and asked us about that data. CMMD reached out to us.

>> CHAIR AUSTRIA: What is CMMD?

>> COMMISSIONER BARBOUR: Contracts Management and Monitoring. They reached out to us to ask for that data.

>> KIMBERLY NALL: Sure. A survey.

>> COMMISSIONER BARBOUR: A survey.

>> KIMBERLY NALL: But not to all providers. And we do have that, but it is a subset. So if you want that subset, we do have it available. If you want all the items, we will have to do a broader reach and we can --

>> CHAIR AUSTRIA: Start short-term and long-term.

>> KIMBERLY NALL: Okay.

>> CHAIR AUSTRIA: Okay. I think Brittney and then Stacy, and then we need to move.

>> COMMISSIONER WEISSMAN: I just suggest moving at this point. I think that this conversation is really important, but it's not the purpose of today's meeting. It's in addition to today's meeting. And so I think let us do the good work of closing out what we started off as really rigorous, robust conversation on the MHSA plan and the next steps. And thank you, Brittney. Stacy, and then we'll close it.

>> COMMISSIONER DALGLEISH: We're going against what Commissioner Weissman said.

[Laughing]

I've been asking for two to three months for the additional breakout of people who are out on leave because that is a vacancy. It may be funded, it may even be filled, but if nobody's there, it doesn't help people that we're trying to reach. So that subset is what I'd like. And I'm happy with just directly operated clinics and the department or however that works.

>> KIMBERLY NALL: And so would you like that also by facility?

>> COMMISSIONER DALGLEISH: I meant, you know, eventually that's great. But I have just been asking for it for the department to date.

>> KIMBERLY NALL: Thank you.

>> CHAIR AUSTRIA: All right. I want to conclude the meeting. I want to especially thank the commission for our really valuable input. I want to thank the community again, both online and all the way over here. I want to thank Kalene and her staff and for doing such an excellent group.

[Applause]

[Overlapping speakers]

I want to thank the DMH staff, our Executive Assistant, Kenia, Canetana and Dan -- Kenia, Canetana Daniel and Robert because we are transitioning back to in-person. You know, we're still doing hybrid, but for the commission we do have to come in-person. So thank you for that. I'm going to ask Kenia to stay after so we can talk about the letter and anyone else who wants from the commission, who wants to have a small meeting to talk about the letter, additional input. This concludes our public hearing. And, again, thank you all.

>> Thank you.

>> JULIO MIRANDA: The live event has ended. Thank you, Operator. Can you please close the line?

[End of the meeting]

Appendix E – Acronyms

ACS:	Alternative Crisis Services
ACT:	Assertive Community Treatment
ADLS:	Assisted Daily Living Skills
AF-CBT	Alternatives for Families – Cognitive Behavioral Therapy
AI:	Aging Initiative
AILSP:	American Indian Life Skills Program
APF:	American Psychiatric Foundation
ARF:	Adult Residential Facility
ART:	Aggression Replacement Training
ASD:	Anti-Stigma and Discrimination
ASIST:	Applied Suicide Intervention Skills Training
ASL:	American Sign Language
BSFT:	Brief Strategic Family Therapy
CalSWEC:	CA Social Work Education Center
CAPPS:	Center for the Assessment and Prevention of Prodromal States
CBITS:	Cognitive Behavioral Intervention for Trauma in Schools
CBO:	Community-Based Organizations
CBT:	Cognitive Behavioral Therapy
CDE:	Community Defined Evidence
CDOL:	Center for Distance and Online Learning
CEO:	Chief Executive Office
CF:	Capital Facilities
CFOF:	Caring for our Families
CiMH:	California Institute for Behavioral Health
CMHDA:	California Mental Health Directors' Association
CORS:	Crisis Oriented Recovery Services
COTS:	Commercial-Off-The-Shelf
CPP:	Child Parent Psychotherapy
CSS:	Community Services & Supports
C-SSRS:	Columbia-Suicide Severity Rating Scale
CTF:	Community Treatment Facility
CW:	Countywide
DBT:	Dialectical Behavioral Therapy
DCES:	Diabetes Camping and Educational Services
DCFS:	Department of Children and Family Services
DHS:	Department of Health Services
DPH:	Department of Public Health
DTQI:	Depression Treatment Quality Improvement
EBP(s)	Evidence Based Practice(s)
ECBI:	Eyeberg Child Behavioral Inventory
EESP:	Emergency Shelter Program
EPSDT:	Early Periodic Screening, Diagnosis and Treatment
ER:	Emergency Room
FFP:	Federal Financial Participation
FFT:	Functional Family Therapy
FOCUS:	Families Overcoming Under Stress
FSP(s):	Full Service Partnership(s)
FSS:	Family Support Services
FY:	Fiscal Year
Group CBT:	Group Cognitive Behavioral Therapy
GROW:	General Relief Opportunities for Work
GVRI:	Gang Violence Reduction Initiative
HIPAA:	Health Insurance Portability and Accountability Act
HOME:	Homeless Outreach and Mobile Engagement
HSRC:	Harder-Company Community Research
HWLA:	Healthy Way Los Angeles
IBHIS:	Integrated Behavioral Health System
ICC:	Intensive Care Coordination
ICM:	Integrated Clinic Model
IEP(s):	Individualized Education Program
IFCCS:	Intensive Field Capable Clinical Services
IHBS:	Intensive Home Base Services
ILP:	Independent Living Program
IMD:	Institution for Mental Disease
Ind CBT:	Individual Cognitive Behavioral Therapy
IMHT:	Integrated Mobile Health Team
IMPACT:	Improving Mood-Promoting Access to Collaborative Treatment
IMR:	Illness Management Recovery
INN:	Innovation
IPT:	Interpersonal Psychotherapy for Depression
IS:	Integrated System
ISM:	Integrated Service Management model
ITP:	Interpreter Training Program
IY:	Incredible Years
KEC:	Key Event Change

LGBTQ:	Lesbian/Gay/Bisexual/Transgender/Questioning	PEMR(s):	Probation Electronic Medical Records
LIFE:	Loving Intervention Family Enrichment	PE-PTSD:	Prolonged Exposure therapy for Post-Traumatic Stress Disorder
LIHP:	Low Income Health Plan	PMHS:	Public Mental Health System
LPP:	Licensure Preparation Program	PMRT:	Psychiatric Mobile Response Team
MAP:	Managing and Adapting Practice	PRISM:	Peer-Run Integrated Services Management
MAST:	Mosaic for Assessment of Student Threats	PRRCH:	Peer-Run Respite Care Homes
MDFT:	Multidimensional Family Therapy	PSH:	Permanent Supportive Housing
MDT:	Multidisciplinary Team	PSP:	Partners in Suicide Prevention
MFT:	Masters in Family and Therapy	PST:	Problem Solving Therapy
MH:	Mental Health	PTSD:	Post-Traumatic Stress Disorder
MHC:	Mental Health Commission	PTSD-RI:	Post-Traumatic Stress Disorder – Reaction Index
MHCLP:	Mental Health Court Linkage Program	QPR:	Question, Persuade and Refer
MHFA:	Mental Health First Aide	RFS:	Request For Services
MHIP:	Mental Health Integration Program	RFSQ:	Request for Statement of Qualifications
MHRC:	Mental Health Rehabilitation Center	ROSTCP:	Recovery Oriented Supervision Training and Consultation Program
MHSA:	Mental Health Services Act	RPP:	Reflective Parenting Program
MHSOAC:	Mental Health Services Oversight and Accountability Commission	RRSR:	Recognizing and Responding to Suicide Risk
MMSE:	Mini-Mental State Examination	SA:	Service Area
MORS:	Milestones of Recovery Scale	SAAC:	Service Area Advisory Committee
MOU:	Memorandum of Understanding	SAPC:	Substance Abuse Prevention and Control
MP:	Mindful Parenting	SED:	Severely Emotionally Disturbed
MPAP:	Make Parenting a Pleasure	SF:	Strengthening Families Program
MPG:	Mindful Parenting Groups	SH:	State Hospital
MST:	Multisystemic Therapy	SLT:	System Leadership Team
NACo:	National Association of Counties	SNF:	Skilled Nursing Facility
NFP:	Nurse Family Partnerships	SPC:	Suicide Prevention Center
OA:	Older Adult	SPMI:	Severe and Persistently Mentally Ill
OACT:	Older Adult Care Teams	SS:	Seeking Safety
OASCOC:	Older Adult System of Care	START:	School Threat Assessment and Response Team
OBPP:	Olweus Bullying Prevention Program	TAY:	Transitional Age Youth
OEF:	Operation Enduring Freedom	TF-CBT:	Trauma Focused-Cognitive Behavioral Therapy
OEP:	Outreach and Education Pilot	TN:	Technological Needs
OMA:	Outcome Measures Application	Triple P:	Triple P Positive Parenting Program
OND:	Operation New Dawn	TSV:	Targeted School Violence
OQ:	Outcome Questionnaire	UC:	Usual Care
PATHS:	Providing Alternative Thinking Strategies	UCC(s):	Urgent Care Center(s)
PCIT:	Parent-Child Interaction Therapy	UCLA:	University of California, Los Angeles
PDAT:	Public Defender Advocacy Team	UCLA TTM:	UCLA Ties Transition Model
PE:	Prolonged Exposure	VALOR:	Veterans' and Loved Ones Recovery
PEARLS:	Program to Encourage Active, Rewarding Lives for Seniors	VPAN:	Veteran’s Peer Network
PEI:	Prevention and Early Intervention	WCRSEC:	Women's Community Reintegration Service and

Education Centers

WET:	Workforce Education and Training
YOQ:	Youth Outcome Questionnaire
YOQ-SR:	Youth Outcome Questionnaire – Status Report
YTD:	Year to Date

Adult Age Group: Age range is 26 to 59 years old.
Child Age Group: Age range is 0 to 15 years old.
Older Adult Age Group: Age range is 60+.
Transitional Age Youth Age Group: Age range is 16 to 25 years old.
Total client cost calculation is based on Mode 15 services, inclusive of Federal Financial Participation (FFP) & Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Not inclusive of community outreach services or client supportive services expenditures.
Unique client means a single client claimed in the Integrated Behavioral Health Information System.
New Community Services and Supports clients may have received a non-MHSA mental health service.
New Prevention and Early Intervention clients may have received a non-MHSA mental health service.

MHSA ANNUAL UPDATE

Fiscal Year 2023-24

WELLNESS • RECOVERY • RESILIENCE

LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.

Our mission is to optimize the hope, wellbeing and life trajectory of Los Angeles County's most vulnerable through access to care and resources that promote not only independence and personal recovery, but also connectedness and community reintegration.

MENTAL HEALTH SERVICES ACT AND THE PURPOSE OF THE ANNUAL UPDATE

- In November 2004, California voters supported Proposition 63 and passed the Mental Health Services Act (MHSA) that imposes a 1% income tax on personal income in excess of $1 million.

- The Act provides the significant funding to expand, improve and transform public mental health systems to improve the quality of life for individuals living with a mental illness.

- Welfare and Institutions Code (WIC) Section 5847 requires county mental health programs prepare and submit a Three-Year Program and Expenditure Plan followed by Annual Plan Updates for MHSA programs and expenditures.

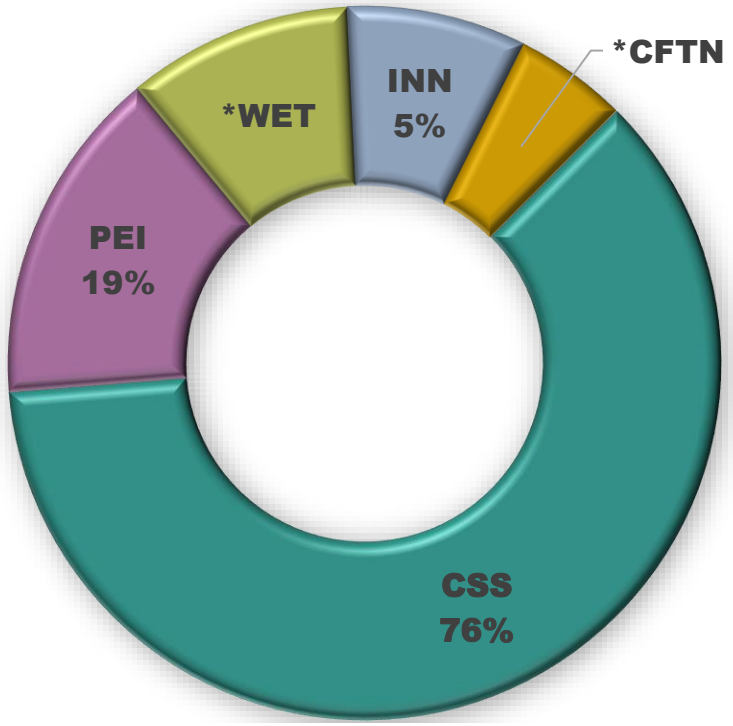
- The Plan provides an opportunity for counties to
  - Review its existing MHSA programs and services to evaluate their effectiveness; and
  - Propose and incorporate any new programs from what was described in the MHSA Three-Year Program and Expenditure Plan

- It is through this Community Planning Process that important feedback is gathered from stakeholders.

- The MHSA Three-Year Plan for Fiscal Years 2021-2024 was adopted by the County Board of Supervisors on June 22, 2021.

MHSA OVERVIEW BY COMPONENTS

- CSS, PEI and INN percent of total annual MHSA allocations shown below
- *WET and CFTN allocations are funded by transfers from CSS



COMMUNITY SERVICES AND SUPPORTS (CSS)

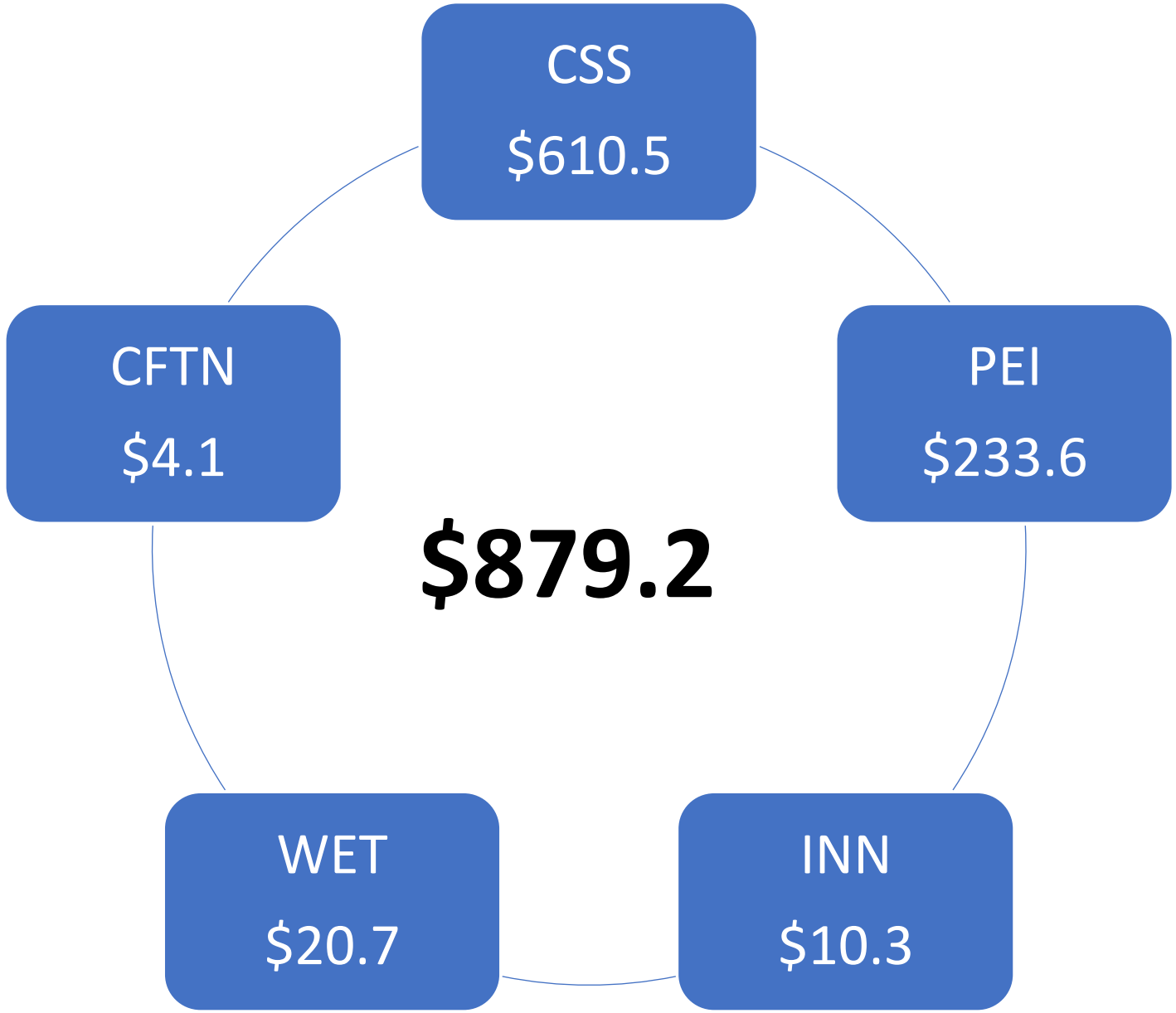
PREVENTION AND EARLY INTERVENTION (PEI)

WORKFORCE EDUCATION AND TRAINING (WET)

INNOVATIONS (INN)

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

MHSA FY 2022-23 BUDGET
(millions)



MHSA CLIENT COUNTS FISCAL YEAR 2021-22

Community Service and Supports (CSS)

- Largest MHSA component with 76% of the total MHSA allocation
- For clients with a diagnosed serious mental illness

CSS PROGRAMS:

- Full Service Partnership
- Outpatient Care Services
- Alternative Services Crisis
- Housing
- Linkage
- Planning, Outreach and Engagement

UNIQUE CLIENTS SERVED

147,143 unique clients received a direct service.

Ethnicity
- 36% Hispanic
- 20% African American
- 17% White
- 4% Asian/Pacific Islander
- 1% Native American

Primary Language
- 80% English
- 13% Spanish

NEW CLIENTS WITH NO PREVIOUS MHSA SERVICE

42,616 new clients were served with no previous MHSA service.

Ethnicity
- 37% Hispanic
- 15% African American
- 15% White
- 3% Asian/Pacific Islander
- 0.38% Native American

Primary Language
- 77% English
- 12% Spanish

CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	10,969	2,852
SA2 – San Fernando Valley	21,809	5,574
SA3 – San Gabriel Valley	20,681	6,945
SA4 – Metro	29,471	8,331
SA5 – West	9,699	2,818
SA6 – South	26,269	6,159
SA7 – East	13,027	2,994
SA8 – South Bay	30,117	8,664

MHSA EXPENDITURES & ESTIMATES – APRIL 2023

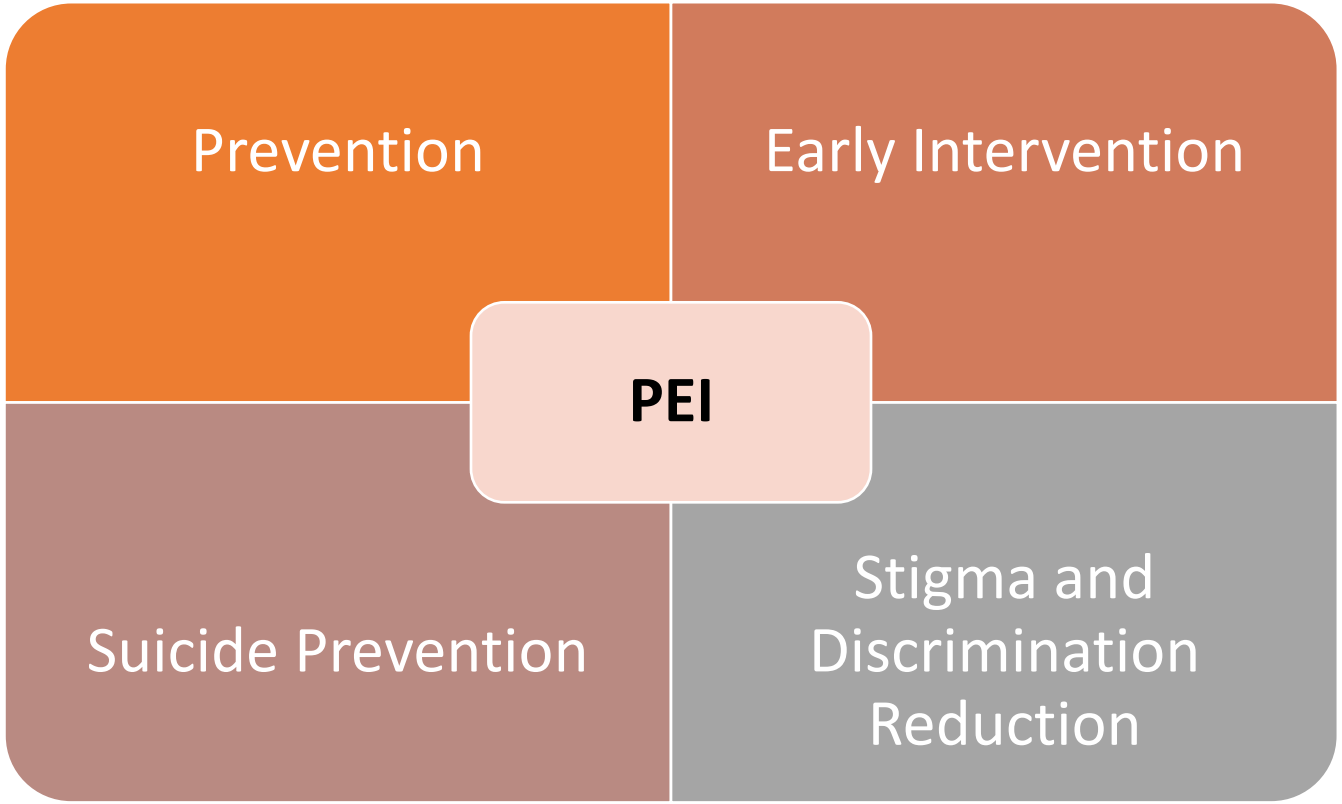
Community Services and Supports (CSS)

Program	FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
Full Service Partnership	$163,545,000	$115,915,000	$95,397,000
Outpatient Care Services	$234,019,000	$192,090,000	$182,950,000
Alternative Crisis Services	$132,177,000	$138,993,000	$132,069,000
Housing	$69,147,000	$45,289,000	$40,593,000
Linkage	$50,878,000	$44,479,000	$34,545,000
Planning, Outreach, and Engagement	$16,970,000	$4,485,000	$6,178,000
Grand Total	**$666,736,000**	**$541,224,000**	**$491,732,000**

PREVENTION AND EARLY INTERVENTION (PEI)

Components

- Second largest MHSA component with 19% of the total MHSA allocation
- Focus on providing preventative and early intervention strategies, education, support and outreach to those at risk of developing mental illness or experiencing early symptoms.



PREVENTION AND EARLY INTERVENTION PROGRAMS

Early Intervention Services

Directed toward individuals and families for whom a short (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve mental health problems and avoid the need for more extensive mental health treatment.

MHSA DIRECT SERVICE CLIENT COUNTS, FISCAL YEAR 2021-22:

UNIQUE CLIENTS SERVED

35,330 unique clients received a direct service.

Ethnicity
- 47% Hispanic
- 8% African American
- 9% White
- 1% Asian/Pacific Islander
- 0.29% Native American

Primary Language
- 76% English
- 21% Spanish

NEW CLIENTS WITH NO PREVIOUS MHSA

17,084 new clients were served with no previous MHSA service

Ethnicity
- 42% Hispanic
- 8% African American
- 9% White
- 2% Asian/Pacific Islander
- 0.64% Native American

Primary Language
- 75% English
- 21% Spanish

CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	2,006	1,203
SA2 – San Fernando Valley	5,565	2,465
SA3 – San Gabriel Valley	5,968	3,225
SA4 – Metro	5,399	2,997
SA5 – West	1,280	739
SA6 – South	3,668	1,964
SA7 – East	4,501	2,303
SA8 – South Bay	6,202	3,078

PREVENTION AND EARLY INTERVENTION PROGRAMS

Prevention Services

Prevention activities and services are geared toward addressing, through awareness, education, training, outreach and/or navigation, the risk factors associated with the onset of mental illness or emotional disturbances, including a focus on enhancing protective factors such as social connectedness and support.

FISCAL YEAR 2021-22 PREVENTION SERVICES:

Community Partnership Programs	Number of Clients Surveyed
Antelope Valley Community Family Resource Centers (AV-CFRC)	83
Friends of the Children LA (FOTC-LA)	48
Incubation Academy	13,836
Los Angeles Unified School District (LAUSD)	32,841
My Health LA Behavioral Health Expansion Program	28,593
Nurse Family Partnership	149
Prevention and Aftercare	1,049
Prevent Homelessness Promote Health (PH^2)	171
Veterans Peer Access Network (VPAN)	15,824
Strategies for Enhancing Early Developmental Success (SEEDS) Trauma-Informed Care for Infants & Toddlers	317

PREVENTION AND EARLY INTERVENTION PROGRAMS

Suicide Prevention

The Suicide Prevention program provides services through multiple strategies by strengthening the capacity of existing community resources and creating new collaborative and comprehensive efforts at the individual, family, and community level.

FISCAL YEAR 2021-22 SUICIDE PREVENTION DATA AND OUTCOMES:

- The 24/7 Suicide Prevention Crisis Line responded to a total of **145,254 calls, chats, and texts** originating from Los Angeles County, including Spanish-language crisis hotline services to **13,087 callers**.
- Los Angeles County received **1,309 surveys** from its Suicide Prevention training and education services.

PREVENTION AND EARLY INTERVENTION PROGRAMS

Stigma and Discrimination Reduction (SDR)

The purpose of SDR is to reduce and eliminate barriers that prevent people from utilizing mental health services by prioritizing information and knowledge on early signs and symptoms of mental illness through client-focused, family support and education and community advocacy strategies. Los Angeles County's Department of Mental Health has implemented Stigma Discrimination Reduction (SDR) programs in the form of training and education.

FISCAL YEAR 2021-22 SDR DATA AND OUTCOMES: **16,572 SURVEYS COLLECTED**

- The majority of participants agreed the training had a positive influence, with a high of 93% agreeing/strongly agreeing with the statement: "As a direct result of this training I am more willing to seek support from a mental health professional if I thought I needed it.
- Results showed the trainings had a positive influence, with a high of 87% agreeing/strongly agreeing with the statement: "anyone can have a mental health condition"
- A high of 97% agreed/strongly agreed with the statement: "The presenters demonstrated knowledge of the subject matter."
- A high of 97% agreed/strongly agreeing with the statement: "The presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.)."

MHSA EXPENDITURES & ESTIMATES – APRIL 2023

Prevention and Early *Intervention* (PEI)

Program	FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
Early Intervention	$106,479,000	$34,218,000	$28,379,000
Prevention	$132,105,000	$85,010,000	$63,021,000
Stigma and Discrimination	$81,836,000	$21,301,000	$6,940,000
Suicide Prevention	$6,146,000	$5,682,000	$5,638,000
Grand Total	**$326,566,000**	**$146,211,000**	**$103,978,000**

COMMUNITY PLANNING PROCESS

Stakeholder Process

September 2022

- LACDMH held a two-day retreat (9/23/22 and 9/30/22) to revitalize its Community Planning Process and strengthen its collaborative relationships with stakeholders from the most vulnerable unserved, underserved, and under-represented populations across the County.
- Participants had an opportunity to examine the past stakeholder engagement processes and outcomes and acknowledge what worked well, what has not worked and identify what is needed in the future to create and sustain a strong collaborative relationship necessary for LACDMH to deliver effective and culturally congruent programs and services under MHSA.

November 2022

- LACDMH met with community stakeholders (11/1/22, 11/17/22, 11/18/22) and presented proposed timelines and processes for meaningful engagement and input on the review of MHSA funding requests for the Mid-Year Adjustment, the upcoming FY 2023-24 MHSA Annual Plan update and the MHSA Two Year Program and Expenditure Plan for FYs 2024-25 through 2025-26.

COMMUNITY PLANNING PROCESS

Stakeholder Process

December 2022

- LACDMH met with community stakeholders (12/22/22) and presented proposed timelines and processes for meaningful engagement and input on the review of MHSA funding requests for the Mid-Year Adjustment

January 2023

- LACDMH conducted an annual MHSA foundational training (1/2/23) to LACDMH staff, provider network staff, and community stakeholders on MHSA policies, the Department's MHSA funding request procedure, the MHSA Three Year Program and Expenditure and Annual Update development and submission process and timeline, and the client resolution process.
- LACDMH conducted two community stakeholder meetings (1/23/23, 1/31/23) focused on education participants on MHSA funding components, requirements and spending regulations.

February 2023

- LACDMH conducted two community stakeholder meetings (2/17/23, 2/21/23) focused on reviewing DMH and stakeholder proposals to be considered for inclusion in the FY 2023-24 MHSA Annual Update and building consensus on which proposals presented in January and February meetings would receive final stakeholder recommendation for inclusion in the Plan.

COMMUNITY PLANNING PROCESS

Stakeholder Process

March 2023

- LACDMH delivered a Provider MHSA 101 Training (3/23/23).
- LACDMH initiated a 30-day public review and comment period for its FY 2023-24 MHSA Annual Update(3/24/23).
- LACDMH conducted a community stakeholder meeting (3/30/23)with the objective of reviewing the draft FY 2023-24 MHSA Annual Update. Stakeholders received a presentation about all items included in the Update.

April 2023

- LACDMH 4/24/23-Completion of the 30-day public posting and comment period and collection of submitted feedback for inclusion in the draft Annual Update
- 4/27/23 -The Mental Health Commission held a public hearing to provide feedback and recommendations for revisions, if any.

EXPANSION
FISCAL YEAR 2023-24

Programs below are existing MHSA programs previously approved by Stakeholders set to expand in Fiscal Year 2023-24.

Portland Identification and Early Referral Program (PIER)

PEI: Early Intervention

This will expand the number of sites and areas of availability of the program to SA 1 and 8, and expand services in SA 6. PIER is a Coordinated Specialty Care program for adolescents and young adults, ages 12-25 who are either at Clinical High Risk for psychosis or have had their first psychotic episode. Currently, referrals from ELAC STAND (UCLA) , NAMI Urban LA, schools and various outpatient programs are exceeding the capacity of the current service level.

Homeless Outreach and Mobile Engagement (HOME)

CSS: Planning Outreach and Engagement

The HOME program provides field-based outreach, engagement, support, and treatment to individuals with severe and persistent mental illness who are experiencing unsheltered homelessness.

The expansion will include a total of 94 full time positions, (6 new multidisciplinary teams and 1 Service Area Navigation team) will be added between FY 2022-23 and FY 2023-24. The expansion will bring a total number of 16 multidisciplinary teams Countywide and 1 Service Navigation team.

Crisis Residential Treatment Programs (CRTP)

CSS: Alternative Crisis Services

CRTPs are designed to provide short-term, intensive, and supportive services in a home-like environment through an active social rehabilitation program that is certified by the California Department of Health Services and licensed by the California Department of Social Services, Community Care Licensing Division.

Awarded a new legal entity contract to Bel Aire Health Services to provide services at 2 locations: Downey and Sylmar.

EXPANSION (continued)

FISCAL YEAR 2023-24

Programs below are existing MHSA programs previously approved by Stakeholders set to expand in Fiscal Year 2023-24.

TAY Drop-In Centers

PEI: Prevention
CSS: Outpatient Care Services

TAY Drop-In Centers are intended as entry points to the mental health system for homeless youth or youth in unstable living situations.
A total of 10 new sites will be added Countywide. Service Areas 2, 3, 4, 5, 7 and 8 will each receive one new site. Service Areas 1 and 6 will each receive two.

TAY Enhanced Emergency Shelter Program

CSS: Housing

The Enhanced Emergency Shelter Program (EESP) serves the urgent housing needs of the TAY population, ages 18-25, who are unhoused or at immediate risk with no alternative place to stay, no significant resources or income to pay for shelter, are experiencing mental health concerns, and are willing to accept the treatment we offer.

Additional funding was added to 5 sites.

Full Service Partnership (FSP)

CSS: Full Service Partnership

The expansion will add a total of 66 additional staff to FSP directly operated programs. Some of these additional items will staff two new half teams at Edelman Child and Youth and Valley Coordinated Child Services. Additional staff will help to form FSP teams at Santa Clarita Mental Health, Antelope Valley Mental Health and Arcadia Mental Health. Six FSP teams will also receive additional staff.

NEXT STEPS/TIMELINE

The following timeline outlines next steps to Board adoption of the FY 2023-24 MHSA Annual Update.

May 2023

- LACDMH received the Public Hearing feedback and recommendation on the FY 2023-24 Annual Update for inclusion in the final draft to be heard and adopted by the Board of Supervisors.
- LACDMH will initiate a Community Needs Assessment and Recommendation process to inform the Community Planning Process for the upcoming MHSA Two Year Program and Expenditure Plan for FYs 2024-25 through 2025-26.

June 2023

- LACDMH will present the draft FY 2023-24 MHSA Annual Update, including all stakeholder and Mental Health Commission's feedback and responses to the Board of Supervisors review, hearing, and adoption. (6/6/23)
- Adopted FY 2023-24 MHSA Annual Update will be presented to the Mental Health Oversight and Accountability Commission for approval and final execution to continue existing or begin implementation of programs and services within the Update. (6/30/23)

THANK YOU

BOARD LETTER/MEMO
CLUSTER FACT SHEET

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	05/24/2023
BOARD MEETING DATE	06/06/2023
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
DEPARTMENT(S)	Department of Health Services
SUBJECT	Request approval of an ordinance to amend County Code, Title 7 – Business Licenses, Los Angeles County Code Chapter 7.16, Ambulances, Sections 7.16.280 – Rate Schedule for Ambulances, 7.16.310 – Special Charges, and 7.16.340 – Modification of Rates.
PROGRAM	Emergency Medical Services
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☐Yes ☒ No
SOLE SOURCE CONTRACT	☐ Yes ☒ No
DEADLINES/ TIME CONSTRAINTS	Effective date for the rate increase per the ordinance is July 1st. Board approval of the Ordinance is critical no later than June, 2023. This rate increase will make LA County's rates competitive with our surrounding Counties.
COST & FUNDING	Total cost: $ N/A / Funding source: N/A
	TERMS (if applicable): N/A
	Explanation: The ambulance rate increase only affects non-LA County ambulance transportation contracts. There is no fiscal impact to the County. The proposed changes to County Code Section 7.16.280 -- Rate Schedule for Ambulances, Section 7.16.310 -- Special Charges, and 7.16.340 -- Modification of Rates, will allow the County to make a one-time adjustment and annual adjustments to the maximum allowable rates to the general public for ambulance transportation to mitigate the substantial increase in cost to operate an ambulance company sustained from the COVID-19 pandemic and future inflationary forces. The proposed changes to the County Code will not have an effect on ambulance transportation contracts between ambulance operators and the County.
PURPOSE OF REQUEST	The COVID-19 pandemic has significantly increased the cost to ambulance company operations, both in employee salaries and benefits, medical equipment, supplies, and most significantly the cost of fuel, as determined by evaluating information of a sampling of current ambulance companies and in discussions with the Los Angeles County Ambulance Association, which represents private ambulance companies operating in Los Angeles County. Approval of the recommendation will amend the County Code to: 1) increase the base ambulance rate for emergency and non-emergency transports; 2) increase the rates for special ancillary services; and 3) change how rates are modified to allow for an annual increase in ambulance rate based on current methodology or by two percent, whichever is higher.
BACKGROUND (include internal/external issues that may exist	On May 24, 2016, the Board approved the Department of Health Services' recommendation to amend the methodology utilized to calculate the maximum rates chargeable by ambulance company operations to address the increased cost to ambulance company operations from the substantial minimum wage

including any related motions)	increases between years 2017 through 2019. The rate changes served to mitigate the impact of the minimum wage. The EMS Agency currently modifies rates based on an annual adjustment of the average in the percentage changes in Minimum Wage and the Transportation line item and the Medical Care line item of the Consumer Price Index (CPI) for All Urban Consumers, Western Region. This is in alignment with current medical billing and insurance reimbursement practices.
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: Richard Tadeo, Director, (562) 378-1610 rtadeo@dhs.lacounty.gov

June 6, 2023 **DRAFT**

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 OF ORDINANCE AMENDMENT TO THE COUNTY CODE, TITLE 7 – BUSINESS LICENSES, CHAPTER 7.16, AMBULANCES
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request approval of an ordinance to amend Los Angeles County (LA County) Code, Title 7 – Business Licenses, LA County Code Chapter 7.16, Ambulances, Sections 7.16.280 – Rate Schedule for Ambulances, 7.16.310 – Special Charges, and 7.16.340 – Modification of Rates.

IT IS RECOMMENDED THAT THE BOARD:

Approve and adopt the attached Ordinance (Exhibit I) to Title 7 – Business Licenses, Chapter 7.16, Ambulances, to: i) amend the provisions relating to Section 7.16.280 – Rate Schedule for Ambulances, Section 7.16.310 – Special Charges, and Section 7.16.340 – Modification of Rates, to amend the rate schedule for ground ambulance transportation and charges for special ancillary services, and the methodology utilized for calculating and annually adjusting these rates.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

On May 24, 2016, the Board of Supervisors (Board) approved the Department of Health Services' recommendation to amend the methodology utilized to calculate the maximum rates chargeable by an ambulance company to address the increased cost of ambulance company operations, and implement corresponding fees adjustments effective July 1, 2017, and every July 1st thereafter.

The Emergency Medical Services (EMS) Agency currently modifies rates based on an annual adjustment of the average in the percentage changes in minimum wage, the transportation line item, and the medical care line item of the Consumer Price Index (CPI) for All Urban Consumers, Western Region. This is in alignment with current medical billing and insurance reimbursement practices.

The COVID-19 pandemic has significantly increased the cost to ambulance company operations, both in employee salaries and benefits, medical equipment, supplies, and most significantly the cost of fuel, as determined by evaluating information of a sampling of current ambulance companies and in discussions with the LA County Ambulance Association, which represents private ambulance companies operating in LA County.

The proposed changes to LA County Code Section 7.16.280 -- Rate Schedule for Ambulances, Section 7.16.310 -- Special Charges, and 7.16.340 -- Modification of Rates, will allow LA County to make a one-time adjustment and annual adjustments to the maximum allowable rates to the general public for ambulance transportation to mitigate the substantial increase in cost to operate an ambulance company sustained from the COVID-19 pandemic and future inflationary forces.

The proposed changes to the LA County Code will not have an effect on ambulance transportation contracts between ambulance operators and LA County.

Approval of the recommendation will amend the LA County Code to: 1) increase the base ambulance rate for emergency and non-emergency transports; 2) increase the rates for special ancillary services; and 3) change how rates are modified to allow for an annual increase in ambulance rate based on current methodology or by 2%, whichever is higher.

IMPLEMENTATION OF STRATEGIC PLAN GOALS

The recommended actions support Strategy II.2, "Supporting the Wellness of Our Communities" and III.3, "Striving for Operational Effectiveness, Fiscal Responsibility and Accountability," of LA County's Strategic Plan.

FISCAL IMPACT/FINANCING

The ambulance rate increase only affects non-LA County ambulance transportation contracts. There is no fiscal impact to LA County.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

State law, including the EMS System and the Prehospital Emergency Medical Care Personnel Act, found under California Health and Safety Code Section 1797, et. seq., provides LA County with the necessary legal authority for the proposed amendments.

A local agency is required to hold a public hearing at which oral or written presentations can be made pursuant to the California Government Code (Government Code), Section 66018. The Executive Office of the Board, in accordance with Government Code Section 6062 (a), published an official notice of the time and place of stated meeting, including a general explanation of the fees to be established or revised.

County Counsel has reviewed and approved Exhibit I.

CONTRACTING PROCESS

Not applicable.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

The Ordinance will amend LA County Code provisions for setting and modifying ambulance rates and special charges and will be enacted upon the Board's approval with new rates effective July 1, 2023.

Respectfully Submitted,

Christina R. Ghaly, M.D.
Director

CRG:am

Attachment

c:
Chief Executive Office
County Counsel
Executive Office of the Board of Supervisors
Auditor-Controller

ANALYSIS

An ordinance amending Title 7 – Business Licenses of the Los Angeles County Code, by revising the maximum charge that a ground ambulance operator may charge for its services and revising the methodology for the annual adjustment of these rates.

DAWYN R. HARRISON
County Counsel

BRIAN T. CHU
Principal Deputy County Counsel
Health Services Division

BTC:jj

Requested: 12/8/2022
Revised 3/1/2023
5/17/2023

ORDINANCE NO._____

An ordinance amending Title 7 – Business Licenses of the Los Angeles County Code, by revising the maximum charge that a ground ambulance operator may charge for its services and revising the methodology for the annual adjustment of these rates.

The Board of Supervisors of the County of Los Angeles ordains as follows:

SECTION 1. Section 7.16.280 is hereby amended to read as follows:

7.16.280 Rate Schedule for Ambulances.

A. A ground ambulance operator shall charge no more than the following rates for one patient:

Rates Effective July ~~2022~~2023		
1.	Response to a non-emergency call with equipment and personnel at an advanced life support (ALS) level	$~~2,532.00~~3,038.00
2.	Response to an emergency ~~9-1-1~~ call with equipment and personnel at an advanced life support (ALS) level	$~~2,710.00~~3,252.00
3.	Response to a non-emergency call with equipment and personnel at a basic life support (BLS) level	$~~1,687.00~~2,024.00
4.	Response to an emergency ~~9-1-1~~ call with equipment and personnel at a basic life support (BLS) level	$~~1,809.00~~2,171.00
5.	Mileage Rate. Each mile or fraction thereof	$~~23.00~~28.00
6.	Waiting Time. For each 30-minute period or fraction thereof after the first 30 minutes of waiting time at the request of the person hiring the ambulance	$~~143.00~~172.00

7.	Standby Time. The base rate for the prescribed level of service and, in addition, for each 30-minute period or fraction thereof after the first 30 minutes of standby time	~~$137.00~~164.00

B. This section does not apply to a contract between the ambulance operator and the County where different rates or payment mechanisms are specified.

*** Editor's note:** Fee changes in this section include changes made by the Director of Emergency Medical Services Agency in accordance with County Code Section 7.16.340 - Modification of Rates and are effective July 1, ~~2022~~2023, and every July 1 thereafter.

SECTION 2. Section 7.16.310 is hereby amended to read as follows:

7.16.310 Special Charges.*

A. A ground ambulance operator shall charge no more than the following rates for special ancillary services:

1.	Request for service after 7:00 p.m. and before 7:00 a.m. of the next day will be subject to an additional maximum charge of	~~$29.00~~30.00
2.	Persons requiring oxygen, shall be subject to an additional maximum charge per tank or fraction thereof, and oxygen delivery equipment to include nasal cannula and/or oxygen mask, of	~~$108.00~~114.00
3.	Neonatal transport	~~$271.00~~288.00

4.	Registered Nurse or Respiratory Therapist Specialty Care Transport with equipment and personnel for up to 3 hours of transportation time	~~$3,049.00~~3,659.00
5.	Registered Nurse and Respiratory Therapist Specialty Care Transport with equipment and personnel for up to 3 hours of transportation time	~~$3,445.00~~4,134.00
6.	Registered Nurse and/or Respiratory Therapist per hour after the first 3 hours	~~$172.00~~206.00
7.	Volume ventilator	~~$209.00~~221.00
8.	Disposable Medical Supplies	~~$31.00~~33.00

…

SECTION 3. Section 7.16.340 is hereby amended to read as follows:

7.16.340 Modification of Rates.

The maximum rates chargeable to the general public as set forth in Sections 7.16.280 and 7.16.310 of this chapter shall be adjusted effective July 1, 1992, and on July 1st of each year thereafter, to reflect changes in the value of the dollar. For each of the one-year periods respectively beginning July 1, 1992 and July 1, 1993, such adjustments shall be made by multiplying the base amounts by the percentage change in the transportation portion of the Consumer Price Index for All Urban Consumers, Western Region, as compiled and reported by the Bureau of Labor Statistics for the 12-month period ending with the last day of the prior month of February. Beginning July 1, 1994, and on each July 1 thereafter, such adjustments shall be determined by

multiplying the base amounts by the average of the percentage changes of the transportation portion and of the medical portion of the Consumer Price Index for All Urban Consumers, Western Region, as compiled and reported by the Bureau of Labor Statistics for the 12-month period ending with the last day of the prior month of February. Beginning July 1, 2017, and on every July 1 thereafter, such adjustments shall be determined by multiplying seventy-five (75) percent of the base amounts by the percentage change of the minimum wage change in Los Angeles County as defined in County Code Section 8.100.040 - Minimum Wage and by multiplying twenty-five (25) percent of the base amounts by the percentage change of the Medical Care line item of the Consumer Price Index for all Urban Customers, Western Region, as compiled and reported by the Bureau of Labor Statistics for the 12-month period ending with the last day of the prior month of February, except for the following changes: Registered Nurse/Respiratory Therapist per hour after the first three (3) hours adjustment shall be determined by multiplying the current charge by the percentage change of the minimum wage change in Los Angeles County as defined in County Code Section 8.100.040 - Minimum Wage: mileage adjustment shall be determined by multiplying the current charge for the percentage change of the transportation line item of the Consumer Price Index for All Urban Customers, Western Region, as compiled and reported by the Bureau of Labor Statistics for the 12-month period ending with the last day of the prior month of February: and Oxygen, Disposable Medical Supplies, and a Ventilator adjustment shall be determined by multiplying the current charges by the percentage change of the Medical Care line item of the Consumer Price Index for all of the Customers, Western Region, as compiled and reported by the Bureau of Labor

Statistics for the 12-month period ending with the last day of the prior month of February. Beginning July 1, 2024, and on every July 1 thereafter, such adjustments shall be determined by multiplying seventy-five (75) percent of the base amounts by the percentage change of the minimum wage change in Los Angeles County as defined in County Code Section 8.100.040 – Minimum Wage, or by two percent, whichever is higher, and by multiplying twenty-five (25) percent of the base amounts by the percentage change of the Medical Care line item of the Consumer Price Index for all Urban Consumers, Western Region, as compiled and reported by the Bureau of Labor Statistics for the 12-month period ending with the last day of the prior month of February. The result so determined shall be rounded to the nearest whole number and added or subtracted, as appropriate, to the rate. ~~The result so determined shall be rounded to the nearest whole number and added or subtracted, as appropriate, to the rate.~~ The Director of the Department of Health Services, or authorized designee, shall initiate implementation of these rate changes by notifying in writing each licensed private ambulance operator in Los Angeles County thereof, and any other individual or agency requesting such notification from the Director. Such notice shall be sent by first class mail no later than June 15 of the prior period.

[716280BCCC]

BOARD LETTER/MEMO
CLUSTER FACT SHEET

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/24/2023	
BOARD MEETING DATE	6/6/2023	
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th	
DEPARTMENT(S)	Department of Health Services (DHS)	
SUBJECT	Approve acceptance of an award from the California Department of State Hospitals and approve related actions to further implement the Felony Incompetent to Stand Trial Community-Based Restoration Program and the Pre-Trial Felony Mental Health Diversion Program.	
PROGRAM	Office of Diversion and Reentry's (ODR) Felony Incompetent to Stand Trial Community-Base Restoration (FIST CBR) and Pre-Trial Felony Mental Health Diversion (Diversion) Programs	
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No	
SOLE SOURCE CONTRACT	☐ Yes ☒ No	
	If Yes, please explain why:	
DEADLINES/ TIME CONSTRAINTS		
COST & FUNDING	Total cost: $ TBD	Funding source: The DSH award will fund the entire FIST CBR and Diversion Program expansion up to $629,677,190
	TERMS (if applicable):	
	Explanation: There is no impact to net County cost.	
PURPOSE OF REQUEST	1. Delegate authority to the Director of Health Services (Director), or designee, to accept an anticipated award from the California Department of State Hospitals (DSH) in the amount of $629,677,190 effective November 1, 2022 through June 30, 2027, and sign an agreement with DSH (Agreement No. 22-79016-000), and all other related documents, to further implement the County of Los Angeles' (County) Office of Diversion and Reentry (ODR) Felony Incompetent to Stand Trial Community-Based Restoration (FIST CBR) Program and Pre-Trial Felony Mental Health Diversion (Diversion) Program, subject to prior review and approval as to form by County Counsel. 2. Delegate authority to the Director, or designee, to negotiate and sign future no-cost amendments to Agreement No. 22-79016-000, on the condition that the amendments and related documents do not materially alter the legal obligations of the County under the base Agreement No. 22-79016-000, subject to prior review and approval as to form by County Counsel. 3. Delegate authority to the Director, or designee, to negotiate and execute new agreements and/or amendments to agreements with qualified Mental Health providers to provide acute and Institute of Mental Disease (IMD) hospital transitional beds that are necessary to provide care to eligible Incompetent to Stand Trial (IST) clients, including revisions to statements of work, extension to agreement terms and/or increase contract sums, provided such actions do not exceed Board approved funding to deliver such services, subject to review and approval as to form by County Counsel with notification to the Board and Chief	

	Executive Office (CEO). The foregoing delegated authority includes negotiating on a case-by-case basis appropriate changes to the standard County insurance and indemnification provisions, and other standard County contract terms, subject to review and approval of CEO Risk Management and County Counsel with notification to the Board. 4. Delegate authority to the Director, or designee, to execute new Supportive and/or Housing Services Master Agreement (SHSMA) Work Orders with qualified community-based organizations and amendments to existing SHSMA Work Orders that are necessary to implement FIST CBR and Diversion Programs, subject to prior review and approval as to form by County Counsel.
BACKGROUND (include internal/external issues that may exist including any related motions)	On June 19, 2018, the Board of Supervisors delegated authority to the Director to execute DSH Agreement No. 18-78002-000 to accept the initial award of $44,213,875 from DSH to implement the FIST CBR Program to provide community-based competency restoration for individuals charged with felony offenses and found by the courts IST under Penal Code section 1370. On November 2, 2021, the Board approved Amendment No. 4 to DSH Agreement 18-78002-000 to increase the award to a total of $110,941,497 and expand the program to a total of 515 beds. On February 5, 2019, the Board of Supervisors delegated authority to the Director to execute DSH Agreement No. 18-79901-000 to accept the initial award of $25,864,100 from DSH to implement the Diversion Program for the provision of housing and services for up to 200 clients with serious mental health needs who have been diverted from the criminal justice system by the court pursuant to Penal Code Section 1001.36 et seq. On August 9, 2022, the Board approved Amendment No. 2 to DSH Agreement 18-79901-000 to increase the award to a total of $59,576,100 and provide services for up to 336 total clients. To streamline the management of the agreements and delivery of services, DSH is proposing to combine Agreements 18-78002-000 and 18-79901-000. The newly combined Agreement No. 22-79016-000 will increase funding and authorize the expansion of the FIST CBR and Diversion Programs to up to 1,344 beds and admit up to 840 IST clients per year. This will align the delivery of FIST community-based services in accordance with the legislative authority pending final approval as part of the 2022-23 State budget. The retroactive effective date will allow DHS to submit claims for related costs prior to execution of Agreement No. 22-79016-000.
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: The expansion of the Diversion Program supports Priority 3: Care First, Jails Last as it allows those with serious mental health needs in jail to be receive care in the community, rather than jail.
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: DHS – Clemens Hong, MD, Director, Community Programs, Chong@dhs.lacounty.gov County Counsel – Lynette Clyde, Deputy County Counsel, LClyde@counsel.lacounty.gov

DRAFT
DHS Letterhead

June 6, 2023

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:

APPROVE ACCEPTANCE OF AN AWARD FROM THE CALIFORNIA DEPARTMENT OF STATE HOSPITALS AND APPROVE RELATED ACTIONS TO FURTHER IMPLEMENT THE FELONY INCOMPETENT TO STAND TRIAL COMMUNITY-BASED RESTORATION PROGRAM AND THE PRE-TRIAL FELONY MENTAL HEALTH DIVERSION PROGRAM
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Approve acceptance of an award from the California Department of State Hospitals (DSH) in the amount of $629,677,190 and approve related actions to further implement the Felony Incompetent to Stand Trial Community-Based Restoration Program and the Pre-Trial Felony Mental Health Diversion Program.

IT IS RECOMMENDED THAT THE BOARD:

1. Delegate authority to the Director of Health Services (Director), or designee, to accept an anticipated award from the DSH in the amount of $629,677,190, effective November 1, 2022 through June 30, 2027, and sign an agreement with DSH (Agreement No. 22-79016-000), and all other related documents, to further implement the County of Los Angeles' (County) Office of Diversion and Reentry (ODR) Felony Incompetent to Stand Trial Community-Based Restoration (FIST CBR) Program and Pre-Trial Felony Mental Health Diversion (Diversion) Program, subject to prior review and approval as to form by County Counsel.

2. Delegate authority to the Director, or designee, to execute future no-cost amendments to Agreement No. 22-79016-000, on the condition that the amendments do not materially alter the legal obligations of the County under the base Agreement No. 22-79016-000, subject to prior review and approval as to form by County Counsel.

3. Delegate authority to the Director, or designee, to negotiate and execute new agreements and/or amendments to agreements with qualified Mental Health providers to provide acute and Institute of Mental Disease (IMD) hospital transitional beds that are necessary to provide care to eligible Incompetent to Stand Trial (IST) clients, including revisions to statements of work, extension to agreement terms, and/or increase contract sums, provided such actions do not exceed Board of Supervisors (Board) approved funding to deliver such services, subject to review and approval as to form by County Counsel with notification to the Board and Chief Executive Office (CEO). The foregoing delegated authority includes negotiating on a case-by-case basis appropriate changes to the standard County insurance and indemnification provisions, and other standard County contract terms, subject to review and approval of CEO Risk Management and County Counsel with notification to the Board.

4. Delegate authority to the Director, or designee, to execute new Supportive and/or Housing Services Master Agreement (SHSMA) Work Orders with qualified community-based organizations and amendments to existing SHSMA Work Orders that are necessary to implement FIST CBR and Diversion Programs, subject to prior review and approval as to form by County Counsel.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Background

On June 19, 2018, the Board delegated authority to the Director to execute DSH Agreement No. 18-78002-000 to accept the initial award of $44,213,875 from DSH to implement the FIST CBR Program to provide community-based competency restoration for individuals charged with felony offenses and found by the courts IST under Penal Code section 1370. On November 2, 2021, the Board approved Amendment No. 4 to DSH Agreement 18-78002-000 to increase the award to a total of $110,941,497 and expand the program to a total of 515 beds.

On February 5, 2019, the Board of Supervisors delegated authority to the Director to execute DSH Agreement No. 18-79901-000 to accept the initial award of $25,864,100 from DSH to implement the Diversion Program for the provision of housing and services for up to 200 clients with serious mental health needs who have been diverted from the criminal justice system by the court pursuant to Penal Code Section 1001.36 et seq. On August 9, 2022, the Board approved Amendment No. 2 to DSH Agreement 18-79901-000 to increase the award to a total of $59,576,100 and provide services for up to 336 total clients.

To streamline the management of the agreements and delivery of services, DSH is proposing to combine Agreements 18-78002-000 and 18-79901-000. The newly combined Agreement No. 22-79016-000 will increase funding and authorize the expansion of the FIST CBR and Diversion Programs to up to 1,344 beds and admit up to 840 IST clients per year. This will align the delivery of FIST community-based services in

accordance with the legislative authority pending final approval as part of the 2022-23 State budget.

The terms and conditions of Agreement 18-79002-000 will remain in full force and effect until such time as the new combined Agreement is fully executed and contingent upon enactment of the 2022-23 State budget. A Notice of Cancellation will be issued for Agreement 18-79002-000 upon execution of the new combined Agreement No. 22-79016-000. The terms and conditions of Agreement 18-79901-000 will remain in full force and effect until all contracted clients have been served at which point a Notice of Cancellation will be issued, if necessary, and the ongoing program funding will be paid through the new Agreement No. 22-79016-000.

Recommendations

Approval of the first recommendation will allow the Director, or designee, to accept an award of $629,677,190 for the FIST CBR and Diversion Programs, and sign Agreement No. 22-79016-000with DSH effective November 1, 2022, and expiring on June 30, 2027. This award will authorize the expansion of the FIST CBR and Diversion Programs to up to 1,344 beds. The retroactive effective date will allow the Department of Health Services to submit claims for related costs prior to execution of Agreement No. 22-79016-000.

Approval of the second recommendation will allow the Director, or designee, to execute future amendments to Agreement No. 22-79016-000 without interruption to the provision of services in a timely manner.

Approval of the third recommendation will allow the Director, or designee, to execute new agreements and/or amendments to agreements with qualified Mental Health providers to provide acute and IMD hospital transitional beds that are necessary to provide care to eligible IST clients.

Approval of the fourth recommendation will allow the Director, or designee, to execute new SHSMA Work Orders with qualified community-based organizations and amendments to existing SHSMA Work Orders that are necessary to implement FIST CBR and Diversion Programs.

IMPLEMENTATION OF STRATEGIC PLAN GOALS

The recommended actions support “Strategy I.3 Reform Service Delivery within Our Justice Systems” and “Strategy III.3 Pursue Operational Effectiveness, Fiscal Responsibility, and Accountability” of the County’s Strategic Plan.”

FISCAL IMPACT/FINANCING

The total FIST CBR and Diversion Program expansion costs are estimated at $629,677,190 and the DSH award will fully fund the entire expansion. There will be no impact to net County cost.

$34,407,000 of the total $629,677,190 estimated costs is already included in the FY 2022-23 Final Budget.

Remaining appropriation will be requested in Fiscal Year 2023-24 Supplemental Budget Resolution (SBR) Request and future fiscal years, as needed.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Despite the decrease in the number of people in the general population of the County jails, the number of people with mental health needs in jail has increased to 5,500 individuals, comprising over 40% of the total jail population. Of those, approximately 1,620 have acute mental health needs (approximately 12% of the total jail population). As of May 3, 2023, there are 357 people awaiting transfer to a State hospital who are deemed IST, many of whom have been waiting for several months. Many people with serious mental health needs, including those who are deemed IST, remain in jail because they do not have access to other facilities for their care. Agreement No. 22-79016-000 will continue and expand community treatment services pursuant to Penal Code section 1001.36 (Diversion), Welfare & Institutions Code section 4361 (Diversion), and Penal Code section 1370 (CBR) for IST individuals charged with felonies who would otherwise remain in jail or receive care in other State hospital facilities. This contract furthers the County's efforts to come into compliance with provisions of the federal settlement agreement with the United States Department of Justice and its Care First, Jails Last priorities by ramping up additional community treatment capacity for those who would otherwise remain longer in County Jails.

Agreement No. 22-79016-000and/or related documents, will be reviewed and approved as to form by County Counsel before execution.

CONTRACTING PROCESS

ODR was selected by DSH to administer the FIST CBR and Diversion Programs based on programmatic need in the County.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommendations will enable ODR to expand the FIST CBR and Diversion Programs to up to 1,344 beds.

Respectfully submitted,

Christina R. Ghaly, M.D.
Director

CRG:ch

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

OFFICE OF DIVERSION AND REENTRY

IST Solutions Award
May 24, 2023

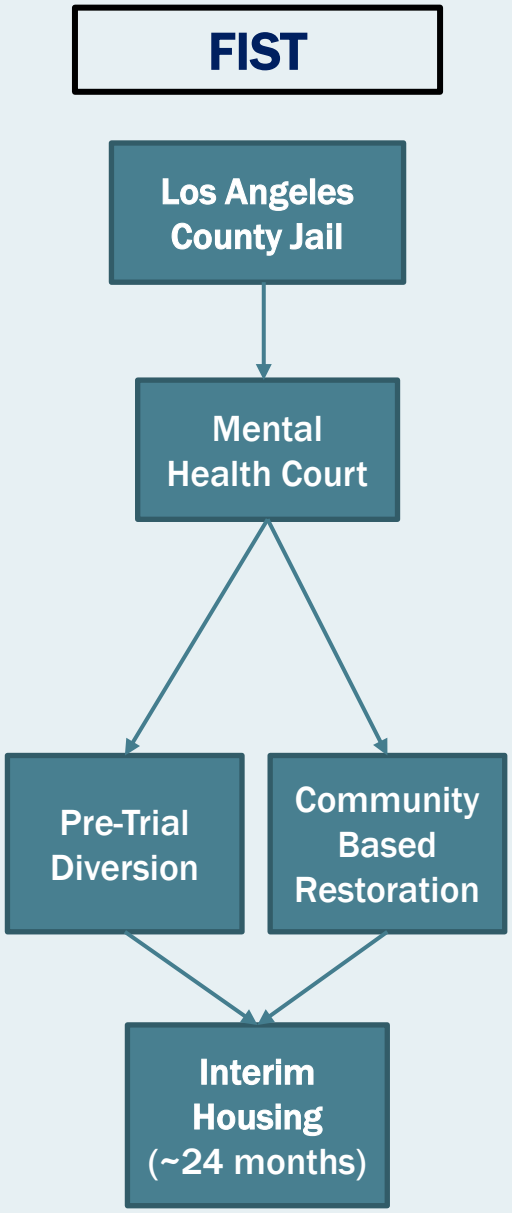
Health Services
LOS ANGELES COUNTY

IST SOLUTIONS AWARD

- ODR has been awarded approximately $630M, over 5 years, from the California Department of State Hospitals (DHS) to continue and expand the FIST (Felony Incompetent to Stand Trial) program.
  - We anticipate the award will be renewed at the end of the agreement term.
- If approved by the LA County Board of Supervisors, the award will be effective November 1, 2022 and expire on June 30, 2027.
- The retroactive effective date will allow the Department of Health Services to submit claims for related costs prior to execution
- This award will authorize the expansion of the FIST CBR and Diversion Programs to up to 1,344 beds.
- The DSH award will fully fund the entire expansion. There will be no impact to net County cost.

Felony Incompetent to Stand Trial

- The FIST program diverts individuals facing felony charges who are found incompetent to stand trial into community-based settings, reducing the jail mental health population.
- Community-based placements are tailored to the client and range from inpatient treatment to care in open residential settings.



FIST BED EXPANSION

Bed Type	IST Beds prior to expansion (Oct 2022)	Current IST Beds (May 2023)	Total IST Beds After Expansion (June 2027)
Acute/Subacute	38	38	200
Specialty Interim Housing	477	736	1144
Total	515	774	1344

THANK YOU

QUESTIONS?