EXHIBIT C-1

STATEMENT OF WORK 1147

MENTAL HEALTH REHABILITATION CENTER
RESTORATIVE CARE VILLAGE
JUSTICE INVOLVED POPULATION

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STATEMENT OF WORK

MENTAL HEALTH REHABILITATION CENTER SERVICES
RESTORATIVE CARE VILLAGE- JUSTICE INVOLVED POPULATION

1.0 SCOPE OF WORK

Mental Health Rehabilitation Center (MHRC) services shall be designed to provide community care and mental health treatment within a residential setting for clients who would otherwise be placed in a state hospital or other long-term health facility due to lack of other community placements available to meet their needs. Treatment provided to clients at the MHRC must be designed to develop clients' skills to become self-sufficient and capable of increasing levels of independent functioning. Treatment includes adult residential treatment services[1] which provide a therapeutic community, including a range of services 24 hours a day, seven days a week. Services include assessment, plan development, therapy, rehabilitation, and other related services.

1.1 Facility Site and Licensing Contractor shall:

1.1.1 Provide MHRC services.

1.1.2 Be licensed by the California Department of Health Care Services (DHCS) as a provider of services to clients under Welfare and Institutions Code (WIC) Sections 5350 and 6000.

1.1.3 Staff the MHRC facility to provide rehabilitative services in accordance with applicable sections of California Code of Regulations (CCR), Title 9, Chapter 3.5. All clients must be provided a safe environment.

1.1.4 Become Medi-Cal certified.

1.2 Target Population

Contractor shall admit and provide services to ALL clients that are referred by the Los Angeles County (LAC) Department of Mental Health (DMH). Contractor acknowledges that DMH has pre-screened clients as clinically appropriate for MHRC level of care according to generally accepted standards. The population referred to Contractor by DMH includes but is not limited to, adults ages 18 and older who reside in LAC and meet any of the following conditions:

1.2.1 Clients who are in need of MHRC services;

1.2.2 Voluntary and Lanterman-Petris-Short (LPS) conservatees;

1.2.3 Clients who require supervision, re-socialization, rehabilitation, life enrichment, and other care and treatment;

1.2.4 Clients with a history of acute psychiatric hospitalization, evaluation and treatment at an inpatient psychiatric unit;

[1] Title 9 Section 1840.332 (c) Adult Residential Treatment Services must be authorized to operate as a Social Rehab or an MHRC.

1.2.5 Clients diagnosed, using current diagnostic manual nomenclature, as having a disabling psychiatric disorder such as schizophrenia or a major affective disorder; or

1.2.6 Clients as described in WIC Sections 5350 and 6000.

1.2.7 In addition, c that meet any of the criteria in Sections 1.2.1 through 1.2.6, above, may also have any of the following:

a. Present or past history of substance use disorder in the absence of current intoxication or withdrawal;
b. Past history of legal charges, convictions, arrests, or justice involvement status including P3 or P4 client status, as defined below;
c. Difficult client placement issues such as: Fire setter/Registered Arsonist, Registered Sexual Offender, Murphy Conservatee, or Client above the age of 64;
d. The current presence of suicidal ideation in the absence of actual suicidal behavior or intent in the previous week
    1. In the case of disputes between Contractor and DMH regarding whether a client's degree of suicidal risk is appropriate for placement in the facility, suicidal risk assessment will be completed by both DMH and Contractor utilizing the Columbia Suicide Severity Rating Scale (C-SSRS) administered by a licensed clinician with current training in the use of the rating scale.
    2. In the case of continuing dispute, final determination will be made by the DMH Medical Director.
e. Obesity or physical disability – For clients requiring specialized equipment such as a bariatric bed or chair, if the facility is not currently equipped, the equipment will be provided at DMH's expense. Final disposition of the equipment shall be determined on a case by case basis;
f. Orders for medication occurring three or more times a day;
g. Diabetic care requirements including checking glucose levels and administering insulin up to four times a day;
h. Medical need for supplemental oxygen; and
i. Wound care up to twice a day.

1.3 Duration of Client Services and Utilization Review

The initial duration of any client's services hereunder shall not exceed **90** patient days, as defined by DMH. Services beyond **90** days must have prior written approval by DMH and will occur in 30-day increments unless otherwise specified.

DMH will implement utilization review every 30 days, including implementing a standardized decision support tool, InterQual. Authorization and certification of continued stay shall include a review of the client's concrete progress towards

their treatment goals, discharge readiness, and timely documentation of such on a monthly basis. DMH reserves the right to deny authorization and certification for treatment upon failure to receive requisite documentation within 72 hours of monthly due date as indicated on the Certification form (Attachment II).

InterQual shall be administered by DMH staff trained in its usage.

1.3.1 The individualized treatment plan will address any deficits in each of the InterQual dimensions that are currently impairing the person from being able to function at a less intensive/less restrictive level of care.

1.3.2 Contractor shall provide Adult Residential Treatment (ART) services to assist the client in developing a personal community support system to substitute for the program's supportive environment and to minimize the risk of hospitalization and enhance the capability of living independently upon discharge from the program.

Contractor shall provide the following Specialty Mental Health Services (SMHS) as medically necessary, as described in the Short-Doyle/Medi-Cal (SD/MC) Organizational Provider's Manual (https://dmh.lacounty.gov/qa/qama/

Service components include:

1. Assessment;
2. Plan Development;
3. Therapy;
4. Rehabilitation;
5. Collateral; and
6. Crisis Intervention.

Medication support and Life Support may be claimed separately, as appropriate.

ART progress notes must be completed weekly. ART is a bundled service and is not claimed by individual staff. The rendering provider on the claim for ART must have participated in the delivery of service and/or clinically overseen the service. Claimable services require a face-to-face contact.

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 of the Contract - Amendments.

3.0 QUALITY MANAGMENT

3.1 Contractor shall establish and utilize a comprehensive Quality Management Plan to assure the County a consistently high level of service throughout the term of the

Contract. The Plan shall be submitted to DMH upon request for review. The Plan shall include, but may not be limited to the following:

3.1.1 Method of monitoring to ensure that Contract requirements are being met;

3.1.2 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.

3.1.2.1 Record(s) shall be provided to DMH upon request.

3.2 Contractor shall comply with all applicable provisions of WIC, CCR, Code of Federal Regulations, DMH policies and procedures, and DMH quality improvement policies and procedures, to establish and maintain a complete and integrated quality management system. A copy of Contractor's quality management plan shall be submitted to DMH upon request. In conformity with these provisions, Contractor shall establish:

3.2.1 A utilization review process;

3.2.2 An interdisciplinary peer review of the quality of client care; and

3.2.3 Monitoring of medication regimens of clients. Medication monitoring shall be conducted in accordance with DMH policy.

3.3 <u>Data Collection</u>

Contractor shall develop measurement and tracking mechanisms to collect and report data about the MHRC services provided by Contractor that will be requested by DMH on a monthly basis. This data shall be reported no later than the 15th day of the month following the month during which services were provided. Data shall be collected as follows:

3.3.1 Contractor shall measure and track the number and demographics of:

a) Available beds, in real time or at least on a daily basis to DMH;

b) The number of clients who were referred;

c) The number of clients whose admission is delayed beyond seven days or more pending more information;

d) The average length of time to respond to referrals;

e) The number of clients who were accepted and admitted within 7 days of referral;

f) The number of clients discharged; and

g) The number of clients receiving substance use disorder services.

3.3.2 Contractor shall identify and track clients who have mental health and substance use disorders and were provided with a minimum of 12 weeks of treatment targeting dual diagnosis, and the number of clients who were

provided a referral to substance abuse treatment upon discharge to community-based treatment;

3.3.3 Contractor shall track clients who have more than two psychiatric hospitalizations during their admission; and

3.3.4 Contractor acknowledges that DMH is transitioning to a bed management system. Contractor shall provide bed capacity information in real time or at least on a daily basis to the DMH Intensive Care Division (ICD) Director or designee. Contractor also acknowledges that DMH utilizes LANES as a Health Information Exchange network and agrees to provide admission history and physical, recent psychiatric progress notes as applicable and necessary, psychotropic medication information, and discharge/transfer summary when needed.

4.0 QUALITY ASSURANCE PLAN

DMH will evaluate the Contractor's performance under the 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 meetings as requested by DMH.

4.2 Contract Discrepancy Report (SOW - Attachment III)

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

DMH will determine whether a formal Contract Discrepancy Report will be issued. Upon receipt of this document, the Contractor is required to respond in writing to DMH 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 DMH within **five** 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 **Client**: For the purposes of this SOW, a client is an individual with a mental health disorder who requires mental health services in an intensive residential setting and is receiving services from Contractor through the Contract.

5.2 **Conservator:** An adult legally responsible for another adult (conservatee) with a medically diagnosed mental illness.

5.3 **Current Procedural Terminology (CPT) 90805:** Medical and billing code set by the American Medical Association for individual psychotherapy approximately 20 – 30 minutes face to face with medical evaluation and management services.

5.4 **Current Procedural Terminology (CPT) 90807:** Medical and billing code set by the American Medical Association for individual psychotherapy approximately 45 – 50 minutes face to face with medical evaluation and management services.

5.5 **InterQual:** A standardized decision-making tool used to assist with level of care determinations and utilization review.

5.6 **DMH Care Coordination Unit:** Unit responsible for navigation of clients and management of the waitlist.

5.7 **DMH Care Navigator:** DMH staff responsible for care coordination, navigation, and waitlist management.

5.8 **DMH Clinical Reviewer:** DMH staff responsible for making clinical determinations of level of care and utilization review decisions.

5.9 **DMH Intensive Care Division (ICD):** The Los Angeles County Department of Mental Health division which both authorizes the care for and performs utilization review of clients needing treatment for 24-hour residential care due to severe and persistent mental illness in a variety of different levels of care throughout Los Angeles County.

5.10 **DMH ICD Director**: The Director of the Intensive Care Services Division within the Los Angeles County Department of Mental Health.

5.11 **Lanterman-Petris-Short (LPS) Act:** In California, establishes how an individual may be detained in a locked psychiatric facility if the individual is assessed to be a danger to themselves, a danger to others, or gravely disabled.

5.12 **LPS Hold (Short-term holds)**: “5150” holds, also known as 72-hour holds for evaluation and assessment; and “5250” holds, also known as 14-day holds for intensive treatment. Each hold is defined under either WIC section 5150 or 5250.

5.13 **Level of Care Utilization System**: The system through which a client is referred to the various different levels of care offered within the DMH network, which is subject to screening and utilization review.

5.14 **Medically Clear**: For the purposes of this SOW, “Medically Clear” for admission is defined as clients who meet the criteria in Attachment I (Medical Clearance). Contractor shall work with referring institutions to efficiently accept and transfer clients to next levels of care. Any disputes regarding “medical clearance” shall be resolved by doctor-to-doctor consultation between the referring institution and the Contractor.

5.15 **Mental Health Plan (MHP):** In Los Angeles County, DMH, is responsible for the provision of Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries.

5.16 **Mental Health Rehabilitation Center (MHRC):** Long-term care facilities that provide 24-hour, individualized programs for intensive support and rehabilitation

services designed to assist persons with mental disorders who would have been placed in a state hospital or another health facility to develop the skills to become self-sufficient and capable of increasing levels of independent functioning.

5.17 **Murphy Conservatorship** - a mental health conservatorship for adults with a severe mental disorder who have pending criminal charges for violent felonies, are incompetent to stand trial, and have been determined by the court to be a public safety risk as a result of their mental disorder.

5.18 **P3 clients** – justice involved clients with significant impairment. Meets Lanterman-Petris-Short (LPS) criteria under Welfare and Institutions Code section 5150 for danger to self, others, or grave disability as evidenced by:

1. Persistent danger of hurting self in less acute care setting;
2. Recurrent violence due to mental illness;
3. Inability to maintain minimal personal hygiene;
4. Gross impairment in communication; and/or
5. Cannot safely or adequately be treated in a setting that requires independent control of his behavior.

5.19 **P4 clients** – justice involved clients with severe or debilitating symptoms and/or conditions. Meets LPS criteria under Welfare and Institutions Code section 5150 for danger to self, others, or grave disability as evidenced by:

1. Medication refusal and moderate to severe symptomatology;
2. Imminent risk of self-harm or harm to others secondary to mental illness;
3. Impairment in ability to care for self poses health risk;
4. On-going refusal to engage in any form of treatment or intervention;
5. Serious medical illness refusing treatment secondary to untreated mental illness;
6. Severely disorganized thinking and behavior; and/or
7. Displays symptomology that would require inpatient treatment in a community setting.

5.20 **Patient:** This term may be used interchangeably with “client” as defined above.

5.21 **Patient Day:** The number of days of inpatient services based on the most recent full year of hospital discharge data.

5.22 **Service Function Code (SFC)/Service Code:** A code for the purposes of determining the number of units of service provided by Contractor hereunder and established by DMH.

5.23 **Significant Support Person:** A person who, in the opinion of the client/patient, or the person providing services, has or could have a significant role in the successful outcome of treatment.

5.24 **State Hospital Clients:** LPS conserved clients currently residing at the state hospital that may need to move to a lower level of care including subacute/IMD or medical skilled nursing facilities.

6.0 RESPONSIBILITIES

The County’s, and the Contractor’s responsibilities are as follows:

COUNTY

6.1 Personnel

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

6.1.1 Monitoring the Contractor's performance in the daily operation of the 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

CONTRACTOR

6.2 Contract Manager

6.2.1 Contractor shall provide a full-time Contract Manager and a designated alternate. DMH must have access to the Contract Manager or designated alternate during regular business hours. Contractor shall provide a telephone number and electronic mail (e-mail) address where the Contract Manager may be reached on a daily basis.
6.2.2 Contract Manager shall act as a central point of contact with LAC-DMH.
6.2.3 Contract Manager or alternate shall have full authority to act for Contractor on all matters relating to the daily operation of the Contract. Contract Manager/alternate shall be able to effectively communicate in English, both orally and in writing.

6.3 Personnel

6.3.1 Contractor shall assign a sufficient number of employees to perform the required work. Contractor shall also employ bilingual and culturally-appropriate staff to meet the cultural and language needs of consumers.
6.3.2 Contractor shall be required to background check their employees as set forth in sub-paragraph 7.5 of the Contract – Background and Security Investigations.
6.3.3 Contractor's MHRC facility treatment teams shall consist of the client's treating providers, including but not limited to: the psychiatrist, licensed mental health staff, nursing staff, and mental health rehabilitation or recreation therapy staff as well as the client, if he or she so chooses. It may also include members of the DMH staff. If the client chooses not to participate in the treatment team meeting, this shall be reflected in the medical record.

6.3.4 Staffing Ratios

Contractor shall hire and/or retain:

a) Physician services;
b) At a minimum, one licensed nursing staff awake and on duty in the MHRC, at all times, day and night;
c) Dietetic services either full time or part-time. This may be via consultation;
d) Pharmaceutical services including the availability of a 24-HR prescription service;
e) Interdisciplinary staff: minimum of 24 hours per week, two of which may be a Psychologist, Social worker, Marriage, Family and Child Therapist, Occupational Therapist, Mental Health Rehabilitation Specialist; Other type of therapist in related field (art, music, or dance therapy);
f) Program Director full time

6.4 Identification Badges

6.4.1 Contractor shall ensure its employees are appropriately identified as set forth in sub-paragraph 7.4 of the Contract – Contractor's Staff Identification.

6.5 Materials and Equipment

Except for County issued items, or otherwise agreed upon by County and Contractor, 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 employees.

6.6 Training

6.6.1 Contractor shall provide training programs for all new employees and continuing in-service training for all employees. This will include training in proper crisis management, certified restraint training and de-escalation of agitated clients.

6.6.2 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 must wear safety and protective gear according to Occupational Safety and Health Administration (OSHA), Department of Health Care Services (DHCS), Department of Public Health (DPH), Community Care Licensing (CCL), and the Centers for Disease Control and Prevention (CDC) standards, as applicable to their license and certification. Contractor shall supply appropriate personal protective equipment to employees.

6.7 Administrative Office

6.7.1 Contractor shall maintain an administrative 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. When the office is closed, an answering service shall be provided to receive calls and take messages. **The Contractor shall answer calls received by the answering service within 24 hours of receipt of the call.**

7.0 HOURS/DAY OF WORK

MHRC services shall be provided 24 hours per day, seven days per week and 365 days per year (24/7/365).

8.0 WORK SCHEDULES

8.1 Upon DMH's request, Contractor shall submit staff work schedules within **five business** days of request. Said work schedules shall be set on an annual calendar identifying all the required on-going maintenance tasks and task frequencies. The schedules shall list the time frames by day of the week, morning, and afternoon the tasks will be performed.

8.2 Upon DMH's request, Contractor shall submit revised staff work schedules when actual performance differs substantially from planned performance. Said revisions shall be submitted to DMH for review and approval within **five** working days prior to scheduled time for work.

9.0 INTENTIONALLY OMITTED

10.0 SPECIFIC WORK REQUIREMENTS

Contractor shall provide MHRC services to clients in accordance with this SOW and any addenda thereto, as approved in writing by DMH, for the term of the Contract. All MHRC services shall be focused on preparing the client for discharge, which shall begin at the time of admission. Contractor shall provide outstanding results and excellent quality of care where clients are empowered through individualized programs to reach goals of increased independence and ability. Outstanding results shall be defined as achieving 100% compliance as determined by number of clients who increase in level of function and/or privileges per month as documented by Contractor over a six-month period. In addition, Contractor will demonstrate 20% of patients are appropriately discharged and/or deemed discharge ready from facility per month. Contractor will encourage clients' families to participate in therapy sessions, caregiver education, and training.

<u>MHRC services shall include, but are not limited to:</u>

10.1 Admission services 24/7/365;

10.2 Maintain a safe and clean-living environment with adequate lighting, toilet and facilities, toiletries, and a change of laundered bedding at least once a week;

10.3 Three balanced and complete meals each day;

10.4 24-hour supervision of all clients by properly trained personnel. Such supervision shall include, but is not limited to, personal assistance in such matters as eating, personal hygiene, dressing and undressing, and taking of prescribed medications;

10.5 Basic services including nursing, pharmaceutical, and dietary services;

10.6 Structured day and evening services shall consist of, at a minimum, an average of fourteen (14) specific rehabilitation service hours and seven (7) activity program hours per week for each client, and shall be available seven (7) days a week.

10.7 Collaboration with the DMH Care Navigator to ensure an assessment of each client for co-morbid alcohol and drug abuse and provision of appropriate services to those who are dually diagnosed, including development of linkage with appropriate dual diagnosis services in the community to which the client will be returning;

10.8 Collaboration with the DMH Care Navigator to ensure that conservatorship initiations and renewals are appropriately obtained;

10.9 Individual and group counseling or therapy;

10.10 Crisis Intervention;

10.11 Educational services, including diagnostic services and remediation;

10.12 Client advocacy, including assisting clients to develop their own advocacy skills;

10.13 An activity program that encourages socialization within the program and the general community, and that assists linking the client to resources which are available after leaving the program;

10.14 Development of linkages with the general social service system;

10.15 Psychological and neurological services when indicated;

10.16 Physical examinations within 72 hours of admission and referral for further consultation and treatment when medically indicated;

10.17 Utilization of consultative resources, including consumer and family members in the planning and organization of services;

10.18 Discharge planning for both regular and Against Medical Advice (AMA) discharges, as appropriate; and

10.19 Maintenance of a daily attendance log for each client day, as defined by DMH, provided hereunder.

10.20 <u>Individualized Treatment Services (ITS)</u>

10.20.1 ITS will include a program which includes individualized therapy, and will be developed through client assessment, to meet the specific needs of each client.

10.20.2 The treatment planning process shall include level of care assessment utilizing the Level of Care Utilization System.

10.20.3 Contractor shall work on individualized behavioral plans with clients to minimize the use of seclusion and physical/chemical restraints.

10.20.4 Contractor shall optimize both structured and unstructured outdoor activity time for clients.

10.20.5 At time of admission, DMH Clinical Reviewers will specify discharge

readiness criteria for each client. DMH Clinical Reviewers will work closely with Contractors' treatment teams to establish an effective and therapeutic working relationship to ensure that optimum individualized care is provided. Contractor and DMH Clinical Reviewers will focus primarily on development of skills required to allow the client to successfully return to community placement, in the least restrictive, most appropriate environment.

10.20.5.1 Discharge plans and goals will be documented in the client's record at admission and updated quarterly.

10.20.5.2 Continuing re-evaluation of each client's discharge potential will be noted as specified by the Medi-Cal and Medicare regulations.

10.20.5.3 Contractor will provide discharge summaries to the DMH Care Navigator within seven days of discharge.

10.20.5.4 Clients that have been deemed by the DMH Director or designee to have met their treatment goals and their maximum point of medical benefit, and are deemed appropriate for a lower level of care, regardless of whether there are administrative barriers such as private conservator consent or availability of beds at lower level of care, will be reimbursed at 75% of the base rate.

10.21 Training Program for Clients

Contractor shall provide a structured training regimen to assist clients in the development of new skills and in modifying behaviors that prevent them from living in a lower level of care facility. The structured training program shall include, at a minimum, the following special rehabilitation program services:

10.21.1 Self-Help Skills Training

a) Supervision of medications and education regarding medications;
b) Identification and rehabilitation of physical impairment and pain, as well as future injury prevention;
c) Bowel and bladder programs;
d) Money management;
e) Use of community resources;
f) Behavior control and impulse control;
g) Frustration tolerance/stress management;
h) Mental health/substance use disorder education; and
i) Physical education

10.21.2 Behavioral Intervention Training

a) Behavioral modification modalities;
b) Re-motivation therapy;
c) Patient government activities;
d) Group counseling; and

e) Individual counseling

10.21.3 Interpersonal Relationships

a) Social counseling;
b) Educational and recreational therapy; and
c) Social activities such as outings, dances, etc.

10.21.4 Pre-vocational Preparation Services

a) Homemaking;
b) Work activity; and
c) Vocational counseling

10.21.5 Continuing Education to help Clients manage their own self care

a) Good nutrition;
b) Exercise;
c) Use of glucometers to monitor blood glucose; and
d) Both psychiatric and physical health medications

10.21.6 Pre-release Planning

a) Out-of-home planning;
b) Linkage to medical services in the community as needed; and
c) Linkage to benefits and other services as needed in the community

10.21.7 Justice Involved MHRC Special Treatment Programming

Clients admitted to the justice involved population MHRCs will include those that have a history of multiple prior arrests or convictions, Misdemeanor Incompetent to Stand Trial (MIST), Felony Incompetent to Stand Trial (FIST), be enrolled in a diversion programs such as SB 317, and/or may have prior charges (such a Registered Sex Offenders, fire setters/Registered Arsonists, and Murphy Conservatees) that make them difficult placements. Each client will require special treatment programming to address their particular needs and may benefit from structured daily activity including:

(a) Cognitive Behavioral Therapy & retraining;
(b) Impulse Control Training;
(c) Dialectical Behavioral Therapy;
(d) Anger Management;
(e) Trauma-Informed Therapy; and
(f) Substance abuse Treatment.

The Justice Involved population MHRC is meant for either clients that are conserved or clients referred by the court and/or that voluntarily agree to participate in the treatment program.

10.22 Psychiatric Services

Client to psychiatry staffing ratio shall be 75:1 or better. Psychiatric services shall be provided by the treating psychiatrist and shall include, but are not limited to:

10.22.1 Prescribing, administering, dispensing, and monitoring of psychiatric medications, necessary to alleviate the symptoms of mental illness and to return clients to optimal function on a weekly basis;

10.22.2 Evaluating the need for medication, clinical effectiveness, and the side effects of medication;

10.22.3 Obtaining informed consent of the client or his/her conservator;

10.22.4 Providing medication education, including, but not limited to, discussing risks, benefits, and alternatives with clients, conservator, or significant support persons;

10.22.5 Ordering laboratory tests related to the delivery of psychiatric services;

10.22.6 Responding to emergencies 24 hours a day, seven days a week, by telephone consultation either personally or by a specifically designated colleague, and ensuring that this information is available at all times for the clinical staff on duty;

10.22.7 Available for consultation with other social and legal systems;

10.22.8 Available for consultation with care coordinators/ case managers and participate in treatment planning with them;

10.22.9 Testifying, when necessary, in LPS Conservatorship hearings;

10.22.10 Consulting, whenever appropriate, with other general physicians and physician specialists who are providing care to his/her client, and document this in the medical record;

10.22.11 Attending all quarterly multidisciplinary meetings in order to provide medical or clinical input into treatment planning. This may include identifying, documenting, and communicating discharge barriers to DMH designated staff. If the Contractor's psychiatrist disagrees with the assessment of the DMH designated staff that a particular client is ready for discharge, the psychiatrist must document his or her rationale in the chart.

10.22.12 Providing clinical documentation which meets all legal and quality improvement requirements, including:

a) Every entry and subsequent alteration in the medical record is legible, dated and timed (including starting and ending time), includes CPT code, and signature;

b) Document medically necessary criteria that a particular client be kept in a locked facility;

c) Initial assessment is complete and timely;

d) Ready availability of the history of medication usage in the facility; and

e) Clinical progress notes must include, at a minimum, the client's progress, clinical interventions, client response to interventions, reference to treatment plan, including full signature of clinician and their discipline.

10.22.13 Providing at least one face to face treatment session with each client (equivalent to CPT 90805) per week. One of these sessions each month shall be more comprehensive (equivalent to CPT 90807); and

10.22.14 Make (and document) active, and continual efforts to optimize the clients' medication in order to maximize their functional level, minimize both "positive" and "negative" symptoms of psychosis, stabilize mood and behavior, and minimize adverse medication reflect a protocol which is made clear in the medical record. Services provided will be directly related to the client's treatment plan and will be a necessary component to assist the client in reaching the goals set forth in the treatment plan.

10.22.15 Proactively identify patients for discharge. The Contractor will notify the DMH Clinical Reviewer or liaison staff of clients who refuse to leave the facility after clinical determination of readiness to move to a lower level of care.

10.22.16 Document in client's chart the clinical rationale if/when the psychiatrist disagrees with the assessment of the DMH Clinical Reviewer or liaison that a particular client is ready for discharge, the psychiatrist must document his/her clinical rationale in the chart.

10.22.17 Follow the MHP's medication monitoring guidelines.

10.23 Temporary Client Absences

The purpose and plan of each temporary absence, including, but not limited to, specified dates, shall be incorporated in progress notes in the client's case record. Payment for temporary absences must be therapeutically indicated and approved in writing by DMH.

10.23.1 Clients with escalating psychiatric symptoms resulting in a brief stay in an acute psychiatric hospital or who develop serious medical needs resulting in a brief medical hospital stay shall have their beds held for up to a maximum of seven days.

10.23.2 Contractor may be reimbursed for temporary client absences from the facility if they meet the following criteria:

10.23.2.1 Bed hold(s) due to temporary leave of absence for acute hospitalization shall be limited to a maximum of seven calendar days.

10.23.2.2 After the seven calendar days, in order to be reimbursed under the terms of the Contract, a new admission

authorization must be processed for re-entry into the facility.

10.23.2.3 Bed hold(s) due to a temporary leave of absence for acute hospitalization shall be reimbursed at the corresponding rate (facility base rate, minus any treatment patch rate, for a maximum of seven calendar days).

10.23.2.4 DMH payment for bed holds due to a temporary leave of absences must be therapeutically indicated and be part of the client's treatment plan.

10.23.2.5 Payment for bed holds due to temporary leave of absence shall not be claimed or made where the client does not return to the facility or is not expected to return.

10.24 Discharge Criteria and Planning

10.24.1 At time of admission, DMH Clinical Reviewers will specify discharge readiness criteria for each client's service plan.

10.24.2 DMH Clinical Reviewers will review treatment plans of clients for adherence to treatment goals and timeline for estimated length of stay on a regular basis. Clients whose length of stay is beyond average will be reviewed for treatment adjustment and/or level of care adjustment as clinically appropriate.

10.24.3 Clients are generally discharged from the facility only upon the written order of the attending physician or facility medical director, or on-call physician. No medication changes shall be made during the last 30 days prior to discharge that would cause a delay in scheduled discharge unless medically necessary.

10.24.4 If a client is a voluntary admission and wishes to leave the facility without a physician's order, the client must sign a statement acknowledging departure from the facility without a written physician's order.

10.24.5 Assistance with discharges may be obtained from public agencies, including the Public Guardian's Office and State Department of Social Services.

10.24.6 Upon discharge or death of a client, Contractor shall refund the following:

10.24.6.1 Any unused funds received by Contractor for the client's bill to the payor source within 30 days;

10.24.6.2 Any entrusted funds held in an account for the client will be disbursed to the client not conserved or conservator within three banking days.

10.24.7 Any money or valuables entrusted by the client to the care of the

facility will be stored in the facility and returned to the client not conserved or conservator in compliance with existing laws and regulations.

10.24.8 Contractor shall notify DMH's Care Coordinator when a client is discharged from the facility and admitted to another facility within 24 hours. All such discharges and admissions will be authorized by DMH's Care Coordinator and arranged by mutual consent, with family members, DMH, and specified individuals involved with the client's treatment and supports.

10.24.9 Transfer of clients among facilities between contractors will be arranged by mutual consent between Contractor and DMH and with notification to, and appropriate input from, the client's conservator, significant family members, DMH's Care Coordination Unit, and specified individuals involved with the client's treatment and support system. This includes admitting clients who meet criteria for MHRC services and are medically cleared.

10.24.10 The criteria for medical clearance are in Attachment I (Medical Clearance form).

10.24.11 Contractor shall provide the initial aftercare/discharge plan including a list of current medications to all the healthcare providers from whom the patient will receive care after discharge, at least 24 hours prior to discharge. Contractor shall provide the final discharge summary and medication list to the healthcare provider(s) that the patient is receiving care from no later than seven days following discharge.

10.24.12 Contractor shall work with outside institutions to efficiently transfer clients to next levels of care. Any disputes regarding "medical clearance" shall be resolved by doctor-to-doctor consultation between the outside institution and the Contractor.

10.25 **Notices**

10.25.1 Contractor shall immediately notify DMH upon becoming aware of the death of any client provided services hereunder. Notice shall be made by Contractor immediately by telephone and in writing upon learning of such a death. The verbal and written notice shall include the name of the deceased, the date of death, a summary of the circumstances thereof, and the name(s) of all Contractor staff with knowledge of the circumstances.

10.25.2 Contractor shall report by telephone all special incidents to DMH and shall submit a written special incident report within 72 hours. Special incidents include, but are not limited to: suicide or attempt; absence without leave (AWOL); death or serious injury of clients; criminal behavior (including arrests with or without conviction); and any other incident which may result in significant harm to the client or staff or in significant public or media attention to the program.

10.26 Emergency Medical Care

10.26.1 Clients who require emergency medical care for physical illness or accident shall be transported to an appropriate medical facility. The cost of such transportation as well as the cost of any emergency medical care shall not be a charge to nor reimbursable under the Contract.

10.26.2 Contractor shall establish and post written procedures describing appropriate action to be taken in the event of a medical emergency.

10.26.3 Contractor shall also post and maintain a disaster and mass casualty plan of action in accordance with CCR Title 22, Section 80023. Such plan and procedures shall be submitted to LAC-DMH upon request.

11.0 GREEN INITIATIVES

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

11.2 Contractor shall notify DMH, upon request, of Contractor's new green initiatives prior to the Contract commencement.

12.0 MHRC OUTCOMES AND PERFORMANCE MEASURES

12.1 MHRC Outcomes

Contractor **SHALL** ensure that MHRC services produce the following outcomes for individuals served at the MHRC. This list is not exhaustive and may be subject to change:

12.1.1 Reduced utilization of urgent care centers, hospital psychiatric emergency rooms, inpatient units, and a reduction in incarceration;

12.1.2 Reduced law enforcement involvement on mental health crisis calls, contacts, custodies and/or transports for assessment;

12.1.3 Improvement in participation rates in outpatient mental health services, case management services, supportive residential programs, dual diagnosis, and intensive services programs; and

12.1.4 Clients' and their family members' (when appropriate) satisfaction with the crisis intervention received.

12.2 Performance Measures

12.2.1 Contractor **SHALL** maintain processes for systematically involving families, key stakeholders, and direct service staff in defining, selecting, and measuring quality indicators at the program and community levels in the areas of staffing, treatment program, client flow, clientele, and response times. DMH will review the final key performance indicators for approval and these quality indicators shall be measured by Contractor quarterly and reported to DMH. Should there be a change in federal, State and/or County policies/regulations,

DMH will advise the Contractor of the revised Performance-based Criteria with 30-days' notice.

DMH Medical Clearance (All Levels)

Patient Information

Name: _____

DOB:_____

SSN: _____

Core Items (within past year unless otherwise noted)

❑**Medical History & Physical Examination**

❑Unremarkable

❑Allergies: _____

❑Positive Findings:

_____

_____

_____

_____

❑Medicine/Sub-Specialty Consultation & Treatment

❑**Comprehensive Psychiatric Evaluation**

❑DSM-V Diagnosis:

_____

❑**Active Medical & Psychiatric Medication List**

❑Medication Compliant

❑**Labs / Drug Screen (CBC, Chem panel, LFTs, TSH, HgA1C)**

❑Unremarkable

❑Positive Findings:

_____

_____

_____

_____

❑Medicine/Sub-Specialty Consultation & Treatment

❑**RPR-VDRL (if applicable)**

❑Negative

❑Positive

❑Medicine/Sub-Specialty Consultation & Treatment

❑**Pregnancy Test (if applicable)**

❑Negative

❑Positive

❑OB/GYN Consultation

- ❑ **PPD / Chest X-Ray / QuatiFERON-TB Gold (within 30 days)**
  - ❑ Negative
  - ❑ Positive
    - ❑ Medicine/Sub-Specialty Consultation & Treatment
- ❑ **COVID-19 (within 1 week)**
  - ❑ **Vaccinated**
  - ❑ Negative
  - ❑ Positive
    - ❑ Medicine/Sub-Specialty Consultation & Treatment
- ❑ **Forensic History Reviewed**
  - ❑ On Probation
  - ❑ On Parole
  - ❑ Registered Sex Offender
  - ❑ Registered Arsonist
- ❑ **Voluntary**
- ❑ **Lanterman Petris Short (LPS) Act**
  - ❑ Not applicable
  - ❑ LPS Application or LPS Letters
- ❑ **High Elopement Risk**
- ❑ **Assaultive Behavior Risk**

Additional Items (if applicable)

- ❑ **Five (5) Consecutive Inpatient Days of Nursing Progress Notes**
- ❑ **Five (5) Consecutive Acute Inpatient Days of Psychiatry Progress Notes**
- ❑ **One (1) Administrative Inpatient Day of Psychiatry Progress Notes**
  - ❑ **Medication Administration Record (MAR) with PRNs**
    - ❑ No IM PRNs administered in past 5 days
    - ❑ Medication Compliant
  - ❑ **Seclusion & Restraint Record**
    - ❑ No seclusion or restraints applied in past 5 days
- ❑ **Physician's Report Completed**

Comments:

_____

_____

_____

Referring Psychiatrist / Medical Provider Information

Name: _____

Signature: _____ **Date:** _____

Contact Number: _____

Physician / Medical Provider Information (if applicable)

Name: _____

Signature: _____ **Date:** _____

Contact Number: _____

ATTACHMENT II

State of California Health and Welfare *Department of Health Services*

CERTIFICATION FOR SPECIAL TREATMENT PROGRAM: ☐ **CERTIFICATION** ☐ **RECERTIFICATION**

PART 1 - COMPLETED BY FACILITY

CLIENT'S NAME: **DATE HS-231 COMPLETED:**

CLIENT'S - **FACILITY NUMBER:** **LEGAL STATUS:** **ADMISSION DATE:**

FACILITY NAME & ADDRESS: **MEDI-CAL IDENTIFICATION NUMER:**

SOCIAL SECURITY NUMBER:

MIS#

PART III - CERTIFICATION BY

☐ Local Mental Health Director

☐ You are authorized to claim payment for Treatment as recommended by you.

☐ Request Denied

FROM:

TO:

A TOTAL OF ☐ **MONTHS**

PART II - COMPLETED BY DESIGNEE: **BIRTHDATE:** **AGE:** **SEX:** ☐ Male ☐ Female **COUNTY:**

*******THE BELOW IS SUPPORTIVE INFORMATION FOR THIS RECOMMENDATION*******

ADMISSION:

EMOTIONAL STATE:

Reason for Hospitalization:

CURRENT BEHAVIORS/ DISCHARGE BARRIERS REQUIRING SNF - IMD LEVEL OF CARE:

Problem #1:
Manifested By:
Current Average Frequency:

Problem #2:
Manifested By:
Current Average Frequency:

Problem #3:
Manifested By:
Current Average Frequency:

SHORT TERM GOALS (< 90 DAYS)

Goal #1:
Goal Average Frequency: ***By the date of:***

Goal #2:
Goal Average Frequency: ***By the date of:***

Goal #3:
Goal Average Frequency: ***By the date of:***

LONG TERM GOALS (> 90 DAYS)

Goal #1:
Goal Average Frequency: ***By the date of:***

Goal #2:
Goal Average Frequency: ***By the date of:***

Goal #3:
Goal Average Frequency: ***By the date of:***

SPECIAL TREATMENT PROGRAM (STP) GOALS

Problem/Goal Focused Groups/Activities:

Average STP/week Participation/Attendance: ☐ ***Average STP/week Participation Goal:*** ☐ ***By the date of:***

Response to Special Treatment Program:

Response to Incentive Program:

Current Level:
Level Goal:
By the date of:

Designee Signature	**Designee Title**	**Affiliation**	**Date**
Contract Liaison	**Contract Liaison Title**	**County and Department**	**Date**

**DMH reserves the right to deny authorization and certification for treatment upon failure to receive requisite documentation within 72 hours of the quarterly due date

CONTRACT DISCREPANCY REPORT

TO:

FROM:

DATES: **Prepared:** _____

Returned by Contractor: _____

Action Completed: _____

DISCREPANCY / ISSUE:_____

_____

_____

_____ _____

Signature of County Representative Date

CONTRACTOR RESPONSE (Cause and Corrective Action): _____

_____

_____

_____ _____

Signature of Contractor Representative Date

COUNTY EVALUATION OF CONTRACTOR RESPONSE: _____

_____

_____

_____ _____

Signature of Contractor Representative Date

COUNTY ACTIONS:_____

_____

_____

CONTRACTOR NOTIFIED OF ACTION:

County Representative's Signature and Date _____

Contractor Representative's Signature and Date _____