**FIRST AMENDMENT TO AGREEMENT
BETWEEN THE COUNTY OF SAN MATEO AND
CAMINAR**

THIS FIRST AMENDMENT TO THE AGREEMENT, entered into this _____ day of _______________, 20_____, by and between the COUNTY OF SAN MATEO, hereinafter called "County," and CAMINAR, hereinafter called "Contractor";

W I T N E S S E T H:

WHEREAS, pursuant to Government Code, Section 31000, County may contract with independent contractors for the furnishing of such services to or for County or any Department thereof;

WHEREAS, the parties entered into an Agreement on January 6, 2014 for Full service Partnership Mental Health Service programs (FSP) and Housing support program, for the term July 1, 2014 through June 30, 2017, for a maximum obligation of $3,026,865; and

WHEREAS, the parties wish to amend the Agreement to include 3% cost of living adjustment for FY 2015-16, 2% cost of living for FY 2016-17, and Assisted Outpatient Treatment for Laura's Law Full Service Partnership (AOT Laura's Law FSP), effective July 1, 2016, increasing the maximum obligation to $4,723,505, with no change to the term of the agreement.

NOW, THEREFORE, IT IS HEREBY AGREED BY THE PARTIES HERETO AS FOLLOWS:

1. Exhibit A is hereby deleted and replaced with Exhibit A1 attached hereto.

2. Exhibit B is hereby deleted and replaced with Exhibit B1 attached hereto.

3. All other terms and conditions of the agreement dated January 6, 2014, between the County and Contractor shall remain in full force and effect.

SIGNATURE PAGE TO FOLLOW

IN WITNESS WHEREOF, the parties hereto, by their duly authorized representatives, have affixed their hands.

COUNTY OF SAN MATEO

By:______________________________
President, Board of Supervisors, San Mateo County

Date:______________________________

ATTEST:

By:______________________________
Clerk of Said Board

CAMINAR

____
Contractor's Signature

Date: 6/13/16

CAMINAR
Full Service Partnership Services
FY 2014-17
Exhibit A-1

In consideration of the payments set forth in Exhibit B-1, Contractor shall provide the following services:

I. Description of Services to be Performed by Contractor

Contractor shall provide full service partnership ("Full Service Partnership" or "FSP") mental health service programs for the highest risk adults ("Adults") and highest risk older adults ("Older Adults" or "OA") / medically fragile adults ("Medically Fragile" or "MF") in San Mateo County and housing services for these FSP enrollees. The purpose of these programs is to assist consumer/members to enroll and once enrolled, to achieve independence, stability and wellness within the context of their cultures, and communities. Contractor shall work with San Mateo County Behavioral Health & Recovery Services (BHRS) staff ("County") to implement these services in accordance with requirements of the California Behavioral Health & Recovery Services Act (MHSA) requirements.

II. Full Service Partnership Scope of Service

A. Program Goals

1. Divert from the criminal justice system and/or acute and long term institutional levels of care (locked facilities) seriously mentally ill (SMI) and complex individuals with multiple co-morbid conditions that can succeed in the community with sufficient structure and support.

2. Offer "whatever it takes" to engage complex adults and older adults with SMI in a partnership to achieve their individual wellness and recovery goals, using alternative models of care which offer greater benefits to them, increasing the likelihood that they will experience positive outcomes.

3. Maximize use of community resources as opposed to costly crisis, emergency, and institutional care.

4. Use strategies relating to housing, employment, education, recreation, peer support and self-help that will engender increased collaboration with those systems and sectors.

B. Target Population

The program will be open to adults and older adults meeting the population criteria described below, however special consideration is directed towards historically underserved populations including but not limited to Asian/Pacific Islander, Latino and African American populations. Both Medi-Cal and non Medi-Cal eligible consumers will be offered the opportunity to participate.

Most of the adults with SMI served by the FSP will have histories of hospitalization, institutionalization, substance use, not engaged in medication treatment, and difficulty in participating in structured activities and living independently. Some individuals may have histories of assaultive behavior. It is possible that many consumers will have resided in long term care facilities for extended periods. For some of these individuals, patterns of service have relied almost exclusively on emergency and institutional care. Others have bounced in and out of every type of service without improved outcomes.

Older adults with SMI will likely have cognitive difficulties and medical co-morbidities. Some SMI adults and older adults will be medically fragile. This group of consumers may have resided in long term care facilities for extended periods or be at risk of placement. The program will serve as a step down program for acute care, locked placements, and skilled nursing facilities in order to avoid prolonged institutional placements that often hasten the loss of an individual's sense of wellness, independence, and overall quality of life.

Populations to be served by the program are:

1. Individuals whose SMI and the complex nature of their diagnoses and medical or other concerns result in frequent emergency room visits, hospitalizations, and homelessness that puts them at risk of criminal justice or institutional placement.

2. Adults with SMI, and possibly substance use issues and current incarceration, and for whom early discharge planning and post-release partnership structure and support may prevent recidivism and/or re-hospitalization.

3. Adults with SMI, often co-occurring substance use, currently placed in locked MH facilities; the FSP will explicitly target individuals living in sub-acute locked facilities located outside the county as a step-down, enabling them to return to their community. Many of these individuals will have behavioral problems that have caused them to be viewed as "difficult" IMD residents.

4. Older adults with SMI who are medically fragile and may have additional complex issues including: dementia; are at risk of institutionalization or currently institutionalized; and who, with more intensive supports, could live in a community setting.

C. Values and Principle

1. Service Values

a. Community-based services are those that foster the greatest independence in the least restrictive, most accessible, familiar setting. Community-based services are also those which are offered to consumers where they live, work, or recreate.

b. Consumer participation is voluntary. This does not preclude intensive outreach to potential consumers.

c. Services are to be recovery based and guided by an individualized plan developed between consumer and staff and signed off by the consumer. Staff will employ a variety of supportive and recovery techniques to encourage consumers to assume responsibility for their own wellness and recovery.

d. Services will integrate consumer's family members or other supportive people into treatment whenever possible via consumer consent. Consumers will be given ongoing opportunities to choose what family members or other supportive people, if any, they would like to be involved.

e. Advisory Board: Consumers will be encouraged to have an active role in making decisions about program operations through an advisory board or similar structure. Substantive changes in program structure and service operations will be communicated back to consumers via the governing board or other communication method.

f. Lived Experience: Consumers are actively recruited for staff positions so as to incorporate the consumer perspective throughout the agency.

g. Consumers are provided self-help and peer support opportunities.

2. Operational principles and practices

This program is grounded in research and evaluation findings of California's Mentally Ill Criminally Ill Crime Reduction (MIOCR) program and national effectiveness research through the federal GAINS/TAPA Center. These demonstrate that diversion and post incarceration services reduce incarceration, jail time and re-offense rates for offenders whose untreated mental illness has been a factor in their criminal behaviors.

Research has also demonstrated that the models using team-based services have been effective in reducing hospitalization and costs. The following are key elements of that model:

a. High staffing ratio of staff to consumers; research shows that programs are most effective with a ratio of one to ten or fewer.

b. Team staff all work with and share responsibility for each consumer.

c. There are frequent team meetings to discuss all team consumers.

d. There is contact each week between staff and each consumer.

e. A psychiatrist is assigned to each team and participates in team discussions and decisions as well as prescribing medication.

f. A licensed professional who can administer medications in the field is assigned (at least part time) to each team in the field.

g. There is full continuity of care including medication access at any time, and staff involvement with all stages of hospitalization.

h. Comprehensive, culturally competent assessment of each enrolled consumer's service needs and objectives, including, but not limited to, needs for MH services, rehabilitation, housing, employment, education, social and recreational activities, and health care.

i. Development and implementation of a Plan of Care for each enrolled consumer, which incorporates the treatment goals and objectives in accordance with principles outlined in the Short-Doyle/Medi-Cal Manual and serves as the authorization document for all services.

j. Case management or treatment teams organized to respond to fluctuations in service intensity and able to assure integration of services and continuity of care.

k. Treatment of psychiatric conditions in appropriate settings, including but not limited to emergency care, acute inpatient services, long term care, residential treatment and residential care.

l. Medication treatment as appropriate and medication management.

In general, these programs have successfully improved rehabilitation outcomes by using their own staff specialists who are closely integrated into the team. However, successful rehabilitation programs have been demonstrated using other models. Regardless of the model, the following recovery based program elements should be available via direct provision, purchase of service, interagency agreements, or other means.

m. Consumer self-help and peer support services.

n. A program for assisting consumers to become involved in paid work and/or education. This includes direct services or referral to vocational assessment, job development, supported employment, competitive employment, and other employment services.

o. Money management, including serving as representative payee where appropriate, income maintenance services and assisting consumers with budgeting.

p. A program for assisting consumers to develop social, recreational and relationship skills.

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q. Substance use treatment programming; preferably integrated with team or case management services.

r. A program that will be used to support consumers in independent housing choices.

s. Transportation as needed to implement each consumer's Plan of Care.

t. Consumer education programs.

u. Information, counseling and other appropriate individualized services for enrolled consumers' family members.

v. Twenty-four hour, seven day a week crisis response capability, including in-home support services and services at other consumer locations as appropriate.

w. Plan for linkage to and coordination with primary care services, with the intent of strengthening the consumer's ability to access healthcare services and ensuring follow up with detailed care plans.

3. Culturally Competent Elements

The ethnic/linguistic populations that are emphasized for FSP enrollment are those that have experienced the greatest disparities in access and services utilization in San Mateo County's mental health services system. Services should be linguistically and culturally competent and provided to a substantial degree by staff from the same ethnic/linguistic groups as consumers. To successfully address the targeted populations the program must incorporate culturally competent elements:

a. A culturally competent service provider or system acknowledges diversity and recognizes its value, is knowledgeable about cultural differences and can provide high quality services adapted to meet unique cultural needs.

b. Culturally competent services are designed to reach and engage diverse communities and are sensitive to the consumer's cultural identity, use culturally appropriate strategies, are available in the consumer's primary language and use the natural supports provided by the consumer's culture and community.

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c. Goal setting and planning processes are culturally sensitive, individualized and build on an individual's cultural community resources and context. Services plans reflect and respect the alternative therapies or healing traditions and healers of each individual consumer.

d. Services design will respect and engage each individual's family, community and other support systems contingent on his/her wishes.

e. Team members are trained in culturally competent practices. Services are delivered by bilingual, culturally competent staff.

f. Staff will consider consumers spirituality during assessment and treatment. Staff should have the skills to understand the spiritual interests, beliefs and worldviews of consumers and families in order to integrate these into treatment goals whenever appropriate.

g. Contractor shall develop and provide to BHRS policies for hiring consumer staff who have their own experiences in facing the challenges of mental illness and/or alcohol and other drug addiction. These policies should indicate how the Contractor will recruit individuals with these skill sets or life experiences.

h. Contractor will use staff who self-identify as LGBTQ, or who are very experienced and comfortable working with consumers who self-identify as LGBTQ, in the delivery of services.

D. FSP Services

1. FSP services are delivered by multidisciplinary teams; this is not a brokering model. Staff will be available to consumers 24/7 and service plans will be designed to utilize community relationships that are already well developed and in place. The inclusion of a behavioral health nurse on the team along with dedicated psychiatric staff will allow consistent medication evaluation and rapid linkage to physical health providers. Within each team, a personal services coordinator is identified for each enrolled consumer. There is a 1:10 staff to consumer ratio for the intensive level of services.

2. The FSP team will operate under policies and procedures that ensure:

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a. 24-hour, 7-day a week availability of program staff, including access to medication support services. Night and weekend treatment and support or wellness and recovery activities should be assumed as a part of program services. Consumers will have access to an emergency number to call during off hours where their situation can be assessed and responded to 24/7, including face-to-face visits.

b. Interventions with consumers are mostly face-to-face visits. Contact with each consumer will occur as often as clinically needed, which may be daily.

c. Consumer treatment will include a variety of modalities based on consumer need including, but not limited to, case management, individual or group therapy, psychiatric medication prescription, and general medication support and monitoring.

3. Continuity of care will be emphasized and will include:

a. Engagement during inpatient episodes includes face-to-face visits when allowed by the facility with the consumer at local hospitals and other locked facilities. For San Mateo Medical Center PES and 3AB (the SMMC in-patient psychiatric unit), FSP program staff will make phone contact with the medical facility within 4 hours of knowledge of consumer arrival and make an initial visit with the consumer within 24 hours of consumer entry.

b. Regular contact will occur with the consumer and with inpatient treatment staff while the consumer is hospitalized. During these episodes, the FSP will work with inpatient staff to make discharge recommendations and facilitate the consumer's return to the community.

c. Engagement during criminal justice contacts. FSP program staff will be quickly responsive to and maintain contact with criminal justice clinical Navigators at Maguire jail when a consumer becomes incarcerated. Program staff will visit consumers when possible and work with criminal justice clinical Navigators to devise and implement a discharge plan.

d. Coordination including but not limited to the consumer's medical provider and assistance in following through on detailed care plans which includes transportation to and from related appointments.

4. FSP teams have final accountability for assuring the delivery of services and are responsible for service outcomes. FSP staff will generally deliver the services identified in the individualized plan, and most consumers will not be served by other parts of the behavioral health service delivery system unless stepping-down to a lower level of services. However, in some instances it may work best for a consumer to continue some services in another part of the behavioral health system (e.g., employment services). The FSP team will work in collaboration with the other service providers to assure implementation of the individualized plan.

5. FSP services will be supported by existing BHRS relationships with all aspects of the criminal justice community including Probation, Parole, Sheriff's Department and municipal Police Departments.

   a. FSP staff will collaborate within the Community Service Area (CSA) where individual consumers reside and participate in current and future collaborative meetings which address consumers at risk in the community, communication barriers between treatment providers or within the CSA, collaborative structures and approaches to make treatment more accessible and residential placement or incarceration less likely.

   b. FSP program staff will also participate in twice monthly case conference meetings with BHRS and an annual review panel to assist in the management of the consumer level of care needs.

   c. The FSP staff and the BHRS Criminal Justice navigator staff and Service Connect staff will build a collaborative relationship to coordinate and communicate with one another regarding consumers, and in particular, transition planning for consumers being released from jail.

   d. FSP program staff will also communicate substantive changes in a consumers, health, behavioral health, or criminal justice status immediately to BHRS, and/or the Conservator's office and will collaborate to assist the consumer to resolve those issues.

6. FSP staff will have access to flexible funds so that resources can be provided that assist the consumer in achieving recovery plans.

7. Medication services will include psychiatry and nursing support for ongoing dialogues with consumers about their psychiatric medication choices, symptoms, limiting side effects, and individualizing dosage schedules. FSP team members will work with individual consumers to arrange for delivery/prompts/reminders that will support regular scheduled medications.

8. Should psychiatric inpatient care be necessary and appropriate, it will be provided as it is now, through current processes.

9. The FSP teams will provide co-occurring mental health and drug and alcohol services and supports such as individual and/or group therapy, Motivational Interviewing and harm reduction approaches. FSP programs are strongly encouraged to become certified as a Drug Medi-Cal provider. Staff will be trained in co-occurring treatment modalities and will develop commensurate programming, including groups. Drug/alcohol use will not be used as a reason for program termination.

10. At intake, a housing stability assessment will be conducted with the consumer to assess the extent to which housing subsidies, or the level of housing supports, are needed to sustain the consumer in housing. However, it is recognized that it will be important to provide temporary housing for some consumers as rapidly as possible, to avert incarceration or to shorten or prevent a sub-acute inpatient stay.

    a. The goal is to provide permanent independent housing throughout the community.

    b. Significant housing resources will be available to consumers in this program in the form of rental subsidies for adults and older adults.

    c. The FSP housing resources for all age groups and will include a variety of levels of housing including independent, Board and Care, and supported housing.

11. The FSP will foster and promote the values of recovery/resiliency through its emphasis upon a strength-based approach to services and individual service planning. Service plans will be used to help consumers identify, cultivate and sustain relationships with peers, family members, neighbors, landlords, employers, and others to create a network of support that will build the resiliency of consumers.

12. While services provided through this initiative will address the individual's underlying mental health, substance use and behavioral problems that may have contributed to involvement in the criminal justice system and institutionalization, a wide range of strategies and supports beyond behavioral health services will be essential. Substantial time and resources will be devoted to the process of engaging individuals, including outreach to those in institutions and locked settings. Services will be provided in the field, in natural settings where people conduct their lives as opposed to a clinic setting. Staff members of this program will be creative in their approach to identifying what approach or resource will make a difference to a particular individual in engaging them in treatment.

13. The Peer Partner will play a critical role, modeling personal recovery, helping consumers establish a network of peer, family, and cultural supports including, peer run self-help centers. One of the primary roles to be performed by the FSP team Peer Partners will be to establish peer relationships among FSP consumers and promote peer involvement in wellness and recovery, social, recreation, and entertainment activities. Peer support groups will be developed to further foster healthy peer relationships and to build consumer capacity to address challenges to their recovery as well as celebrate their accomplishments on the journey to recovery. This peer and resource linkage will also help maintain the consumer in the least restrictive environment.

14. Consumers will work with FSP team members to develop their own individual service and Wellness and Recovery Action Plans (WRAP) which will specify individual action steps in relation to employment, education, housing, medication, peer relations, social activities, and education.. All services will be voluntary, guided by individual choice, and the delivery of all services will be guided by the principles of cultural competence, recovery and resiliency with an emphasis on building consumer strengths and natural resources in the community, with family, and with their peer/social network. The program will be designed to allow a greater or lesser degree of support and structure, depending on the needs and goals of the consumer at any given time.

15. FSP program will assess the vocational needs for each consumer upon enrollment and annually and assist consumers in accessing vocational counseling services.to identify, obtain, and retain employment opportunities and reach their vocational goals as identified in their care plan.

16. Supported education is another resource for FSP consumers. The FSP team should link with community colleges and the existing contractor for adult supported education services in San Mateo County, developing action steps in the recovery plan related to educational opportunities for consumers.

17. Consistent with the principles of wellness and recovery, the consumer will be primarily responsible for establishing the specific goals that define his/her desired quality of life including healthcare and end of life decisions. The licensed clinicians will oversee the completion of the multidisciplinary assessment and the development and implementation of a comprehensive service plan that involves all members of the team, the consumer and the family contingent on the consumer's wishes. This plan will define the roles and responsibilities of the team, as well as those of the consumer, the family, and peers.

18. The role of the nurse will be to enable the team to more effectively collaborate with primary care providers, assist consumers in both their communications with their primary care doctors and in their follow-up on medical care, including medical treatment regimes, and lifestyle changes due to medical complications and provide adherence to treatment protocols. The role of the nurse in providing education and monitoring of and adherence to medical treatment will increase medical and medication engagement and enable the consumer to maintain their community placement.

19. The FSP program staff will assess and arrange for services and supports as appropriate for each consumer based on a range of supports including:

    a. Transportation and escorted services to assist at medical appointments and with other transportation needs.

    b. Monitoring and/or arranging for home-based support with routine tasks and personal care needs (e.g. meal preparation, house cleaning, laundry, shopping, bathing and other hygiene needs), and coordinating with involved agencies such as In-Home Supportive Services.

    c. Providing social supports and facilitating access to supports to address isolation and loneliness.

20. The FSP program will collaborate when necessary with the Human Services Agency, the Health Department (Aging and Adult Services), San Mateo Medical Center (Primary Care) and a variety of contract agencies that provide board and care, acute care and other supportive services. The FSP will engage and empower natural community supports that will extend the impact of the FSP staff.

E. Admission, Discharge and Length of Stay

1. The BHRS FSP Review Committee oversees the referral and authorization process and the process of consumers transitioning to a different level of care in collaboration with the FSP provider.

2. Disagreements regarding referrals will ultimately be resolved by BHRS Deputy Director of Adult and Older Adult Services and Contractor's regional Executive Director.

3. The FSP will admit individuals referred to the FSP by BHRS. Consumers will be referred for FSP services based on acuity and need for intensive level services based on the following criteria:

   LOCUS level 4 or higher AND at least one of the following:

   a. Three PES/ED visits in last 60 days; AND/OR

   b. Two inpatient psychiatric hospitalizations in last 6 months with most recent hospitalization in past 30 days; AND/OR

c. Transitioning out of a locked/secure facility (i.e. MHRC, Secured SNF, Jail, or Out of County Placement); AND/OR

d. Loss of current support system that would potentially result in hospitalization, incarceration or other form of locked placement without FSP level services based on past history.

4. The FSP Review Committee will be convened as needed to ensure FSP slots are filled when they become available.

5. Transition planning begins at assessment, with step down planning as a part of the overall service plan. The FSP Review Committee will conduct an annual review to discuss consumer level of care needs and potential transition plans to another level of care within the FSP program or discharge out of the FSP program. Cases will also be discussed regarding consumer level of care needs within each month at the partnering meetings between BHRS and the FSP program..

6. Indicators related to transition include but are not limited to stable housing, no PES or inpatient utilization, participation in meaningful activities, symptom management, and overall improved quality of life.

7. If a consumer enrolled in a FSP is consistently unsuccessful in the program or requires short term or long term placement (after other alternatives have been fully explored) the FSP program may present this case for consultation at the BHRS/Caminar case management meeting to determine how best to proceed. If short term placement is agreed upon and authorized, the FSP will maintain contact with the consumer and plan for return to the FSP program.

8. The FSP will also present to the case management meeting cases in which consumers choose to dis-enroll from the program or are otherwise no longer appropriate for FSP level of care. Every opportunity will be given in advance for the consumer to be re-engaged before disenrollment, during which time the program will be responsible for continued outreach/engagement as well as linking the consumer to alternative services.

9. Length of stay in the FSP program is determined by consumer level of care needs which will be assessed regularly by the FSP provider and formally discussed on an annual basis with at the case management meeting. FSP providers will develop and implement an internal system of review of consumer level of care needs to assess when consumers may be ready to graduate from FSP services.

10. Housing subsidies for FSP consumers may be managed as part of a separate contract for management of housing subsidy resources.

11. A collaborative active utilization review process will be maintained. This process will ensure that consumers are seen at an appropriate level of service that matches their service needs and LOCUS level.

12. A list of consumers that are maintained in a locked setting (including SMMC, 3AB or other psychiatric facility, jail and/or prison) for more than 60 days will be submitted to BHRS on a monthly basis. In addition, Contractor will provide on a monthly basis a list of consumers that have had no contact with the FSP program (for any reason) for more than 45 days.

F. Staffing

1. See the Budget and FTE summaries that follow for a summary of the staffing assumptions that went into the MHSA Plan and budget.

2. Staff should reflect the ethnic/cultural/linguistically diverse populations that are identified in *2. Population to be Served.*

3. Desirable staff skills include CBT, motivational interviewing, and experience working with trauma, personality disorders, co-occurring disorders, and co-morbid medical conditions.

4. The Peer Partners must have personal knowledge and experience as a recovering user of behavioral health services.

Peers:	Have been or are currently served in the Behavioral Health (BH) system—peers are a source of support in both informal and formal locations in the BH system.
Peer Partners are:	Peers as defined above that are employed by the BH system to provide support to consumers, peer counseling, benefits counseling, assistance navigating the system and co-lead groups

Parent/Caregiver Partners are:	Parents that have had services from the behavioral health system for their families—they are peers to other parents of adults now receiving services and formally employed by the behavioral health system to focus on engagement, education and support for family members. This may include other family members as well.

5. A quarterly updated staff roster and phone list will be provided to BHRS and to SMMC PES and 3AB.

G. Training

1. There will be system wide training for staff in County and contract programs that includes cultural competence, sexual orientation and gender differences, and consumer culture. Budget and staffing assumptions should align with County identified FSP needs as well as projected number of consumers.

2. Another component of training will be training for all county and contract staff in co-occurring disorder assessment and treatment skills.

3. County and contract staff serving will be trained in cognitive behavioral approaches, such as Trauma Focused CBT.

H. Funding

Full Service Partnership Funds, are funds to provide "whatever it takes" for enrolled populations.

1. The 30 slots will be funded with MHSA FSP and Medi-Caid and/or Medicare funds.

2. The FSP budget includes funding for transportation and for flex funds.

3. Housing subsidies will be funded with MHSA FSP funds and managed through a separate contract. San Mateo County will work with the contractor to establish a small portion of the housing funds to be allocated to the FSP as flex funds specific to managing housing crises.

4. It is expected that all consumers will be assessed for insurance status and potential eligibility for third party coverage, and that assistance in obtaining coverage will be provided by the FSP team.

5. Provider is required to submit all necessary documentation in order for Medi-Cal and Medicare reimbursement.

6. There will be a three-year contract period.

   a. Contracts will be based on units and unit costs, with a cost settlement (note that the budget assumes two hours per consumer per week, and a minimum of 100 hours per year per consumer). Unit costs must not exceed the State Short-Doyle/Medi-Cal Maximum Reimbursement rates.

   b. The method of payment for FSP services is explained in Exhibit B of this agreement. The method for reconciling Medi-Cal, Medicare and other 3rd party payments recouped by the contractor will be negotiated.

7. See the Budget and FTE summaries that follow for a summary of the financing assumptions that went into the MHSA Plan and budget.

I. Quality and Outcomes

1. A specific component of the San Mateo County Quality Plan will be developed to track FSP programs.

2. The key outcomes include:

   a. Residential / Hospital / Incarceration Status;

   b. Justice System Involvement Status;

   c. Emergency Intervention;

   d. Education;

   e. Employment;

   f. Benefits;

   g. Conservatorship / Payee Status.

3. These domains, as well as the method of data collection, Key Event Tracking (KET) and Quarterly Assessment Form (3M), are consistent with the measurement strategy developed by the AB2034 program - which has been successful in demonstrating that program's effectiveness. It is crucial that the vendor maintain accurate, timely reporting of outcome data.

4. The indicators/domains to be collected by the KET method are *those which are best measured as the changes are occurring*. These would be domains such as residential status. Residential status is a domain for which all changes are relevant. For example, it is important to know when and to what type of residence a person moved, in order to count the days in different types of residences, as well as the progression toward more independent living over time. If residential status is only collected on an interim basis, e.g., annually, the resulting data are not very meaningful, nor useful.

5. Other indicators/domains will be measured using the 3M tool. This measure will produce quarterly summaries of the consumer's progress in important areas such as, education, financial support, legal status and issues, health status, substance use, and activities of daily living. Other indicators/domains will be measured using the 3M tool. This measure will produce quarterly summaries of the consumer's progress in important areas such as, education, financial support, legal status and issues, health status, substance use, and activities of daily living.

6. The FSP contractor will be required to provide, via San Mateo County, Consumer and Service Information (CSI) to meet State DHCS requirements.

J. Service Model

1. Contractor shall provide whatever might be necessary to perform the following:

   a. Twenty-four (24) hours per day, seven (7) days per week availability of program staff services including:
      i. medication and medication support services.
      ii. continuity of care during inpatient episodes including visits with local hospitals and locked facilities that allow program staff to have regular contact with the enrollee and with inpatient treatment staff while the consumer is hospitalized.
      iii. continuity of care during criminal justice contacts.
      iv. coordinate with enrollee's primary care physician and assist enrollee in following through on detailed care plans.

v. Contractor will contact each enrollee as often as clinically necessary, which might be daily. Minimum contact is two (2) times per week for intensive service level.

b. Average service time per enrollee

Contractor will provide an average service time of four and one half (4.5) hours per week per enrollee. Each week enrollee will be seen no less than two (2) hours face-to-face. This average service time refers in the intensive (1-10) level of treatment.

c. Crisis Response

Contractor will develop and/or maintain policy and protocol that includes the following:

i. Staff will assist consumers to complete a safety plan within 30 days of intake. This plan will be reviewed minimally on an annual basis or more frequently as needed with the consumer and will include the following elements:
   (1) Signs and symptoms of distress or decline in mental health status;
   (2) Emergency numbers to call;
   (3) Family members and/or other consumer supporters, including contact information and a signed verbal release of information form detailing what information may be shared;
   (4) Historically effective coping strategies and healthy ways to relieve stress in non-emergency situations.

ii. Identified family members and loved ones of the consumer will be given information with consumer consent, upon consumer's intake into the program and annually, about effective ways to respond to the consumer if/when consumer is experiencing a psychiatric crisis. The program staff will encourage family members and/or other identified consumer supports to inform staff when noticing signs of decompensation. Family members and/or other identified consumer supporters will be given a script to use with police or other emergency personnel when encountering their family member in crisis. They will also be given suggestions regarding what resources to call in different types of situations. Those resources may include:
    (1) The FSP provider and team emergency or regular contact lines;
    (2) Toll free crisis line;
    (3) 911 and local police department with the potential aide of CIT trained police officers and/or the SMART team.

d. Medication/Medication Support

    i. Contractor will provide necessary and required individualized medication services in a collaborative manner with enrollees.
    ii. Physician and licensed nursing staff will meet in vivo as indicated with enrollees to ensure appropriate education and medications as aligned with culture and lifestyle.
    iii. FSP teams work with individual enrollees to arrange for delivery and prompts that supports enrollees taking medications as prescribed.
    iv. Medication assessment and management shall consist of at least one (1) face-to-face visit conducted by a licensed physician (psychiatrist).
    v. Dispensing medication, or assisting consumers to dispense their own medication, shall be done by either a licensed physician (psychiatrist) or a licensed/registered nurse.
    vi. Medication support performed by peer staff consists of observing consumers taking their medications, and encouraging communication with their psychiatrist regarding any non-urgent side effects or medication concerns.

e. Consumer and Family Participation

i. A consumer council and a family support group will provide a formal mechanism for enrollees/families to provide input into program management and direction.

ii. Contractor will employ at least one (1.0) FTE consumer/family member.

iii. Contractor will utilize paid consumer consultants to participate in the provision of wellness and recovery action plans ("Wellness and Recovery Action Plans" or "WRAP") services.

iv. Contractor will establish a "warm line" utilizing consumers.

v. Contractor will utilize peers to provide medication support, assistance with activities of daily living, transportation and accompaniment to service plan related appointments, conflict resolution with housemates, assistance with access to benefits, and crisis prevention.

vi. Contractor will develop a written policy and implement a process whereby peer staff (or family partner) will assist with orientation of new consumers, assist new consumers in the development of a support system, and help family members understand the FSP program and services available. Written orientation materials will be provided that include information on HIPAA, the National Alliance for the Mentally Ill (NAMI), and the BHRS Office of Consumer and Family Affairs.

vii. The family partner shall assist caregivers in facilitation and active engagement of the Family Team goals by:

(1) Supporting caregivers in identifying, creating and working with resources to sustain tasks and goals set by the consumer, caregivers and treatment team;

(2) Working in cooperation with the consumer, caregivers, and treatment team;

(3) Participating in family team meetings and treatment meetings.

viii. The family/caregiver support group shall provide a venue for caregivers to gather and share their experiences and to:

(1) Increase knowledge of mental illness, symptoms, causes, treatments and management;

(2) Increase knowledge of practical management skills;

(3) Increase family/caregiver communication skills;

(4) Provide opportunities for family/caregivers to expand support networks.

f. Illness Management/Medical Treatment Support

i. Contractor will ensure enrollee physical and dental health needs are identified. Contractor's staff will collaborate with primary care providers and assist enrollees in both their communications with their primary care providers and in their follow-up on medical care, including medical treatment regimes, and lifestyle changes necessitated because of medical conditions. The role of the team nurse is to ensure the provision of education and monitoring of medications which will increase medication engagement and enable the enrollee to maintain their community placement.

ii. Contractor will develop and maintain relationships with other health care providers to facilitate enrollee being maintained in community.

iii. Contractor will provide access to the Bridges to Wellness Program. This is a program within the Medication Clinic that integrates primary care with behavioral health and tracks health outcomes. Participants are to receive healthcare education groups, health screenings and linkages to primary care. The program is grant funded, it is understood that ongoing funding is not guaranteed.

g. Housing and Housing Supports

Contractor will provide continual support to enrollees to ensure success in attaining and maintaining housing of their choice.

h. Evidence Based and Promising Practices

Contractor will provide clinical staff with training and skills in the following areas:

i. Wellness management and recovery
ii. Cognitive Behavioral Therapy
iii. Motivational Interviewing
iv. Life skills training
v. Dual Diagnosis (Mental Health/Substance Abuse))
vi. Harm Reduction
vii. WRAP Plans

j. Benefits

i. Contractor will ensure all enrollees are assisted in maximizing financial/health benefits.
ii. Contractor will make best efforts to ensure enrollees develop independent banking and fiscal responsibilities.
iii. Contractor will work towards providing representative payee services to all enrollees who require such assistance.

k. Vocational & Educational Services

Contractor will provide services necessary to identify and attain employment and educational opportunities.

l. Individualized Service Plans

i. Contractor will ensure that all plans are completed in collaboration with enrollees and are consistent with enrollees stated goals.
ii. Contractor will facilitate all enrollees developing Wellness and Recovery Action Plans.

m. Specific to Older Medically Fragile Adults

i. Contractor will work with enrollees to maximize social and daily living skills and assist in formalizing contacts with community programs and agencies.
ii. Contractor will facilitate the use of in-home supportive services i.e., health aides and home care nursing agencies.

iii. Contractor will develop and maintain relationships with other health care providers specific to this population i.e., Ron Robinson Senior Care Center.

n. Flexible Funds

Contractor will ensure a system to access flexible funds easily allowing resources to be used to assist enrollee in achieving rehabilitation goals and to maintain stability. Policies are to be developed to ensure accountability of funds. Where possible funds are to be treated as loans that will be repaid by enrollees.

o. Representative Payee Services

Contractor will research and develop a representative payee services program for those FSP consumers and REACH participants that require fiscal management in order to meet their day-to-day needs and remain stable in their current living situation.

Services will include, but not be limited to, the following guidelines:

i. All income and benefits must come from government sources such as Social Security (SSI), Railroad Pensions, and Medi-Cal/Medicare.
ii. The need for money management services shall be demonstrated through documented examples of skill deficits that prevent successful self-management of funds.
iii. Consumers, who are competitively employed, own and maintain cars and/or own and maintain homes may not be candidates for Representative Payee services.
iv. Contractor will establish and utilize the following documents: a "Representative Payee Agreement", a "Representative Payee Consent Form", and an initial and ongoing budget plan or spreadsheet.
v. Separate records will be maintained for each consumer receiving payee services. Contractor shall keep all records for at least 2 years.
vi. A surety bond will be obtained to cover the funds managed.
vii. Contractor will observe state guidelines for representative payees. Guidelines are available at: http://www.socialsecurity.gov/payee.

viii. Contractor will develop an agreement template for payee services that informs the consumer of the duties the Contractor shall perform on the consumer's behalf and any obligations the consumer may have.

ix. Contractor shall pay rent and utilities (or Room and Board) and other bills directly to the service provider.

x. Contractor shall not charge consumers a fee for representative payee services.

Contractor will submit a proposal for the delivery of representative payee services to the BHRS Deputy Director of Adult/Older Adult Services by January 31, 2015. The proposal shall include estimated number of consumers to be served and costs associated with providing the service.

K. Projected Capacity: Thirty (30) slots.

L. Caminar Staffing

FSP services are delivered by multidisciplinary teams; this is not a brokering model. Staff will be available to consumers 24/7 and service plans will be designed to utilize community relationships that are already well developed and in place. The inclusion of a behavioral health nurse on the team along with dedicated psychiatric staff will allow consistent medication evaluation and rapid linkage to physical health providers.

Within each team, a personal services coordinator is identified for each enrolled consumer. There is a 1:10 staff to consumer ratio for the intensive level of services.

Caminar FSP Team (Services and Housing Support) staffing shall include the following:

Director	0.31 FTE
Assistant Director	0.74 FTE
Nurse RN	0.60 FTE
Nurse LVN	0.20 FTE
Personal Service Coordinator / Case Manager	2.50 FTE
Administrative Assistants	0.45 FTE
Director – Supportive Housing	0.10 FTE
Rep. – Payee / Outcome Asst.	0.35 FTE
Peer / Family Partner	1.00 FTE
"Warm Line" / Emergency Line	0.60 FTE

Psychiatrist (Contracted)	0.35 FTE
Total FTE's	7.20 FTE

F. Volume of Services:

Contractor will provide the minimum volumes of services per contract period as established below. The services to be provided are defined in the San Mateo County BHRS Documentation Manual. The minimum number of eligible units are as follows:

Year 1 (FY 2014-15)	
Minutes of Service	300,000
Year 2 (FY 2015-16)	
Minutes of service	300,000
Year 3 (FY 2016-17)	
Minutes of service	300,000
Program Total	900,000

III. MHS Act Funded Housing Support Program

A. Description of Services

The contractor shall provide FSP enrollees with clean, safe, and affordable housing which is maintained in a good state of repair. Housing shall be located in areas that are readily accessible to required services such as transportation, shopping, recreation and places of worship. The contractor understands that there is a scarcity of such housing and securing housing at any level shall be done collaboratively with the needs of all of those being served by the mental health community in mind.

The contractor shall ensure the individual has a housing component to their personal service plan, and that progress in skill acquisition and the individual's living experience is reviewed and discussed with the individual on a regular basis no less than four (4) times per year. It is expected that such reviews shall lead to a revision of the housing component of the individual's service plan. These reviews may take place in individual sessions or group sessions as is appropriate.

The contractor shall be responsible for providing at least sixty percent (60%) of enrollment with housing units of mixed types including augmented board and care, congregate and supervised living, S.R.O, shelter and independent living. Each type of housing unit shall provide a specific set of community living experiences, shall be supervised at rates determined by the individual's needs, and shall be financially subsidized at predetermined rates appropriate to the individual's needs and abilities. The contractor is responsible for locating niche placements, negotiating rates, paying supplemental costs over and above the consumer's ability to pay, and ensuring that consumers meet their financial obligations. The living experiences and housing goals could include the following:

1. Supplemented/Augmented Board and Care

   This housing experience shall focus on developing a permanent living arrangement for the medically frail/elderly individual or an enrollee who needs on site supervision. The purpose of the supervision is to insure that the individual is provided with medication management, and to the degree needed, is provided with assistance in securing both medical as well as psychiatric management. The services could include reminding the individual of medical and psychiatric appointments, providing transportation or escort to appointments and general observation of the individual's condition to insure whenever possible interventions to treat problems that may arise occur as early as possible.

   Supplemented/Augmented Board and Care services shall be above and beyond those of regular licensed board and care programs. The contractor shall be responsible to insure the Board and care provider has the necessary skills to provide these services and that they are maintained on a regular basis. These skills may be secured through attending appropriate classes offered in the community, by the Health System or by the contractor.

2. Supervised Living

   Contractor will develop a supervised living program defined as congregate living with on-site support.

3. Transitional Social Rehabilitation Services for TAY and Adults

Contractor shall provide Transitional Social Rehabilitation services for transitional aged youth (TAY) at the Eucalyptus House Residential Transitional Program and at Hawthorne House. The program shall provide services to San Mateo County mental health consumers aged 18 to 65, with a focus on serving TAY who are young adults between the ages of 18 and 30.

Contractor shall provide transitional residential services for adults at Hawthorne House to assist consumers to prepare for independent living.

4.. S.R.O. (Single Room Occupancy)

Contractor shall provide a more permanent housing situation for those individuals who choose to live in more manageable living situations with modest supports. The contractor is responsible to insure that the rent is paid in a timely manner and that the living unit is maintained in a safe, clean and secure manner. The contractor shall make monthly room inspections or more often as is required to maintain the room in a clean and safe order.

5. Shelter Services

Contractor shall provide temporary living situations while the individual and program staff are locating more appropriate housing. The contractor shall insure that these temporary living situations are safe and meet minimal housing standards. The contractor shall strive to limit the use of shelters to a minimum and whenever a shelter is use, the individual with the program staff either develop, or in process of utilizing a new housing plan as part of the overall service plan.

6. Other Housing

There are a variety of housing resources available through San Mateo County Mental Health Services that may be both available and appropriate for FSP enrollees, and could include half-way houses, room and board, etc. This category of housing shall be considered a temporary or transitional placement while an individual develops additional community living skills. The contractor shall be the primary case manager and be responsible for finding permanent living for consumers upon program completion. Contractor will provide consultation to program staff to ensure enrollee's success in the program, and to include in the individual's service plan, specific housing goals.

The contractor shall also ensure that any individual placed in this type of housing follow any specific rules that may exist about living at that center, and that a component of the individual's service plan outline these housing goals.

7. Alcohol and Other Drug (AOD) Treatment Residential Programs

   This housing experience shall be limited to those individuals who require a residential alcohol or drug treatment program. This category of housing should be considered temporary for the purpose of achieving a drug or alcohol treatment goal.

   Contractor will work with AOD providers to subsidize (spin-off) after care permanent housing.

8. Independent Apartment or House Living

   This housing experience shall focus on providing permanent safe and affordable housing where the individual has maximum control of their environment. The contractor shall ensure the property is rented and maintained in good repair, and that rent and utility payments are made in a timely manner. The contractor shall inspect the independent units on a regular basis and ensure when necessary, that all repairs are made as soon as possible. When living problems are identified, the contractor will ensure the treating team is notified and that the team takes immediate action to address any concern. The mechanics of the identification, leasing, and ongoing maintenance of independent housing are described in Section III.A.7.

   a. Property Management

      i. Contractor property management assists consumers in locating and acquiring safe, affordable housing. They help consumers negotiate rental agreements, mediate landlord-tenant issues and establish and maintain utilities. Contractor leases, subleases, and/or acts as a rental guarantor for apartments to consumers, enabling consumers to establish a positive rental history.

ii. Contractor property management staff shall collect and pay consumers' rent. Staff shall work closely with the Housing Authority to acquire, manage and maintain all housing contracts. When appropriate, staff shall help consumers acquire and maintain Section 8 Housing and Shelter Plus vouchers, ensure basic household maintenance, rental unit inspections and when necessary, pursue a legal eviction.

iii. Contractor shall provide and maintain property liability insurance on all units.

iv. Contractor property management staff shall work closely with contractor case managers and peer counselors to provide integrated support services with independent living skills training and access to community resources to enable consumers to maintain and retain their housing.

b. Placement of Individuals into Housing Units

i. The type of housing will be determined by consumer's previous rental history and housing problems, history of violence, history of drug or alcohol abuse and a criminal justice report. The following criteria shall be considered in determining the type of placement in housing: individuals who are registered sex offenders, individuals with a history of the manufacture or sale of methamphetamine, alcohol and drug abuse, history of residential fire setting, or people with significant histories of random violence with no information about a mitigating intervention or treatment.

ii. Contractor shall hold personal meetings with the tenant (consumer) to complete the screening process. Contractor shall focus on assessing the likelihood that any tenant applicant will be able to meet the essential requirements of tenancy as expressed in the lease as follows:

1) To pay rent and any other charges in a timely manner.

2) To care for and avoid damaging the unit and common areas, use the facilities and equipment in a reasonable way, to not create health or safety hazards, and to report significant maintenance needs in a timely manner.
3) To respect the personal and property rights of others
4) To not engage in criminal activity that threatens the health and/or safety of other residents or staff
5) To comply with health and safety codes and necessary and reasonable rules and program guidelines.

9. Rental Procedures

The contractor will meet the following objectives relating to rent collection and general tenant relations:

a. Contractor will ensure that 24/7 staff coverage is available to respond to housing landlord for any type of housing emergency.

b. Contractor staff will be available during regular business hours to assist tenants with a broad range of issues related to housing stability.

c. Contractor will establish a clear and consistent method for tenants to pay rent, including standard practices for providing notice to tenants regarding late payment.

d. When appropriate, Contractor will establish 3rd party rent payment mechanism for tenants.

e. Contractor will develop and administer a consumer satisfaction survey that assesses tenant satisfaction with housing and property management services.

f. Should it be necessary to begin the eviction process, Contractor will proceed according to legal statute and requirements.

10. Eviction Prevention

Individuals who are deemed continuously disruptive will become the subject of a meeting to identify possible intervention to alleviate the problem. The participants in such meeting shall be the Property Manager as applicable, the Program Supervisor, the FSP Provider staff and when possible, the individual tenant. Efforts will be made to determine if the disruption is the result of symptoms of illness, or if the resident is under the influence of alcohol or drugs when the disruption occurs. Meeting participants will seek to determine if there is a cause that can be ameliorated, reduced or eliminated to avoid eviction and will develop a plan of action based on complete, accurate and factual documentation of the activity. In cases where the disruptive behavior is a coping mechanism for symptoms which are never completely eliminated, participants will seek to identify housing that reduces interaction with others, while maintaining the necessary supports to keep the individual successfully housed.

11. Unit Maintenance and Habitation

a. One hundred percent (100%) of the units will meet local building and health codes at the time of initial rent-up.

b. One hundred percent (100%) of the units will be monitored by the contractor for proper functioning of safety issues including smoke detectors, plumbing, gas, electricity and heating systems and any issues or concerns will be reported immediately to the owner or the owner's designee.

c. Any hazards or other unsafe or unhealthy conditions that are reported by tenant, landlord, or program personnel will be investigated by contractor within twenty-four (24) hours. Life/Safety issues (including, but not limited to heating, plumbing, and electrical systems) will be corrected within forty-eight (48) hours, or consumer will be relocated to temporary housing until hazard or unsafe condition is repaired Non-emergency repairs will be corrected within fifteen (15) working days.

d. One hundred percent (100%) of consumers needing accessibility modifications will receive them prior to move-in.

e. After thirty (30) days of trying to resolve a unit habitability issue, if the suitable resolution has not occurred, Contractor will report such occurrence to BHRS Deputy Director for Adult and Older Adult Services.

IV. Assisted Outpatient Treatment Full Service Partnership

Assisted Out Patient Treatment Full Service Partnership (AOT FSP) provides services to individuals with serious mental illness who currently are not receiving treatment and may or may not require court intervention to receive treatment. AOT FSP services are based on the Assertive Community Treatment model (ACT). All information and requirements in section II and III of this contract apply to AOT FSP as well the additional requirements and distinctions in the following sections.

A. Assisted Outpatient Treatment provides for adult San Mateo County residents living with serious mental illness who meet the eligibility criteria listed below as specified in Assembly Bill 1421:

1. Unable to "survive safely" in the community without "supervision;"

2. History of "lack of compliance with treatment" as evidenced by at least one of the following:

   a. Hospitalized/incarcerated two or more times in the last 36 months due to a mental illness; or

   b. Violent behavior towards self or others in the last 48 months.

3. Previously offered treatment on a voluntary basis and refused it; and

4. Is "deteriorating."

B. Assisted Outpatient Treatment Full Service Partnership Scope of Service

1. Program Goals

   a. Engage individuals who have not had a successful and lasting connection to treatment and recovery services.

   b. Divert from the criminal justice system and/or acute and long term institutional levels of care (locked facilities) seriously mentally ill (SMI) and complex individuals with multiple co-morbid conditions that can succeed in the community with sufficient structure and support.

c. Offer "whatever it takes" to engage complex adults and older adults with SMI in a partnership to achieve their individual wellness and recovery goals, using alternative models of care which offer greater benefits to them, increasing the likelihood that they will experience positive outcomes.

d. Maximize use of community resources as opposed to costly crisis, emergency, and institutional care.

e. Use strategies relating to housing, employment, education, recreation, peer support and self-help that will engender increased collaboration with those systems and sectors.

2. Referrals from BHRS

a. All referrals will come exclusively from the BHRS AOT Team

b. All BHRS AOT Team referrals will be accepted for enrollment into the AOT FSP.

c. The provider's AOT FSP staff will comply with the following:

i. Participate in weekly BHRS AOT FSP meeting with SMMC.

ii. Attend treatment planning conferences for prospective and current clients of at the request of the treatment teams involved with clients.

iii. Attend routine treatment/discharge meetings at San Mateo Medical Center when AOT FSP clients or prospective clients are in SMMC.

iv. Have the AOT FSP Manager or designee available to BHRS AOT Team 24/7.

v. AOT FSP staff will respond to BHRS AOT FSP team within 1 hour of call or email during business hours for any issue identified as urgent or emergent.

3. Court Process, the provider AOT FSP will:

   a. Participate in collaborative meetings with the Court, Private Defenders Office, County Counsel and BHRS AOT Team for the purposes of coordinating treatment planning. These meetings may be as frequently as once a week.

   b. Be present in Court when a potential new referral is being considered by the Court for inclusion in AOT FSP services.

   c. Submit all Court requested documents and reports within 60 days.

   d. Be present in Court and ensure the AOT FSP client is also present in Court unless the Court, Private Defender's Office, County Counsel, AOT FSP and BHRS AOT have mutually agreed that it would be in the best interests of the client to not have to appear in Court.

4. Intake/Outreach

   a. Upon receipt of referral start engagement with client within 1 business day.

   b. Inform client of scope and availability of services (e.g., a full description of the AOT FSP services as outlined in this contract).

   c. Use Evidence Based Practices (e.g., Motivational Interviewing).

   d. Deliver immediate practical supports to clients as soon as possible such as case management services around acquisition of food, shelter and medical needs.

   e. Based on information from referral and initial client contact, establish initial needs of client, start on appropriate referrals: housing, residential/outpatient treatment programs for mental health, substance abuse, other co-occurring issues.

   f. Engage and support family members and other caregivers.

   g. Link and work closely with rep payee, conservator, etc.

h. Link client to Caminar Psychiatry as soon as possible and no later than 5 business days. Medication evaluation will be conducted by the psychiatrist and/or Medical Clinic medical staff during this 5 day period.

5. Assessment

   a. Within 60 days of receiving the referral complete and submit to BHRS AOT, a comprehensive assessment. The assessment will include but not limited to an evaluation of: high risk behaviors, substance use, history/current trauma, harm to self/others, social/emotional isolation, medical needs, spirituality, ability to manage basic needs.

   b. Continue to identify and engage natural supports.

6. Client Non-Compliance with Treatment

   a. If client is non-compliant with treatment plan including but not limited to taking medications as prescribed, AOT FSP staff will make appropriate efforts to solicit adherence. If client is still not compliant, AOT FSP will arrange for transport to hospital for mental health evaluation and accompany client to the hospital. Once in the hospital, the AOT FSP case manager will work in collaboration with the client to provide information to the hospital treatment team regarding the circumstances leading up to the admission and what is needed in order to be discharged/released back to the community. The AOT FSP treatment team will work with the hospital around case planning including discharge planning.

   b. If a client court appearance is required the AOT FSP case manager will accompany client and will be prepared to provide the Court with an update on how the client is doing in regard to his/her current treatment plan.

7. Treatment Planning

   a. Upon completion of the assessment, a treatment plan will be completed within 30 days.

b. The treatment planning process will consist of the following elements:

   i. Client centered team approach including but not limited to: the consumer, previous treatment provider, family member and/or significant others, conservator, etc.

   ii. A strength based approach

   iii. Engagement of natural supports (sponsors, church, self-help, groups, etc.) and articulate roles to provide support.

   iv. Medication management.

   v. Wellness Recovery and Action Plan (WRAP), that includes and advanced directive.

8. Client Hospitalizations

   a. When an AOT FSP client is transported to Psychiatric Emergency Services or to an Emergency Department, AOT FSP staff will provide full report within 24 hours to the BHRS AOT. The AOT FSP case manager will accompany client to PES and will work collaboratively with the PES staff and client.

9. Treatment

   Treatment consists of the following menu of services. The treatment team will select from this menu based on the results of the clinical assessment

   a. Service frequency will depend on the assessment of the client's needs and will vary as those needs change. The frequency will never be less than the minimum established by FSP guidelines.

   b. Substance use counseling, education, referrals as needed/requested.

   c. Motivational Interviewing techniques and approach.

   d. Groups: WRAP, Seeking Safety, mindfulness, expressive art therapies.

e. Linkage to recreational social activities, 12 steps, NAMI, religious organizations if indicated by client, LGBTQ support groups.

f. Self-awareness and self-management building by way of individual and group therapy.

g. Safety Plan development, increasing "tools in the toolbox" (coping skills, additional community supports, etc.).

h. Benefit linkage (e.g. SSI) when possible.

i. Medication evaluation, prescribing and monitoring.

j. Engagement of clients based on individualized strengths, interest, hobbies. This may include Bridges to Wellness and Art Therapy. If client indicates, assist in identifying and practicing additional forms of self-care, such as yoga, meditation, spiritual awareness, giving back to the community.

k. Assist client in creating a circle of support: health friends and family members, pet therapy, spiritual community, etc.

10. Step Down from the AOT FSP when clinically indicated will adhere to the following guidelines and must be reviewed and approved by the BHRS AOT Clinical Manager:

a. Prepare client for step-down/transition to independent living in the community that may focus, but not be limited to maintaining housing, pursuing vocational or educational endeavors, reengage and/or develop peer and family support, connect with recovery supports, and/or spiritual support.

b. Decrease intensity of services

c. WRAP and Safety Planning.

d. Client has increased insight into client's own ability to manage mental health needs, treatment, and learned better self-regulation.

e. Client demonstrates ability to manage medication solo or with limited support.

f. Client can acknowledge their milestones, accomplishments, internalized growth.

g. Engage (or re-engage) with social connections to peers and pro-social.

h. Establish and solidify linkages to medical, health care coverage, psychiatric, case management, social services, and income benefits.

11. Client Grievances

Should an AOT FSP client file a grievance, the AOT FSP Manager will notify the AOT FSP Clinical Services Manager by email of grievance within 2 working days, and will work closely with Office of Consumer and Family Affairs for resolution.

C. Projected Capacity – 50 Clients

D. Staffing

Contractor will assign a total of 13.30 FTE employees including:

Management staff:
- Executive Director, San Mateo Region (0.1 FTE)
- Director of Case Management (0.2 FTE)
- AOT FSP Program Director (1.0 FTE)

Direct service medical staff*:
- Medical Director/Psychiatrist (0.1 FTE)
- Psychiatric Nurse Practitioner (0.4 FTE)
- Registered Nurse (RN) (1.0 FTE)
- Clinic Coordinator/Licensed Vocational Nurse (LVN) (0.25 FTE)

Direct service staff:
- Case Managers (5.0 FTE)
- Assistant Case Managers (2.0 FTE) preferred with lived experience
- Community Support Worker (1.0 FTE)
- Peer Support Worker (0.5 FTE)
- Family Support Worker (0.5 FTE)

Administrative support:
- Client Finance and Housing Specialist (0.5 FTE)
- Administrative Assistant/File Clerk (0.5 FTE)
- Director of Quality Improvement (0.15 FTE)
- Clinical Supervisor (0.1 FTE)

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E. Training

All AOT/FSP direct service staff and direct medical staff will be trained in the following areas no later than 90 days:

- Assertive Community Treatment(ACT), Motivational Interviewing, Cognitive Behavioral Therapy (CBT) Harm Reduction, Seeking Safety, Trauma Informed Services, Stages of Change, Crisis intervention and management, Medication benefits, rep payee financial management, WRAP, recovery based treatment.
- Contractor will develop a plan for team orientation and development that incorporates team members hired over time. Contractor will review such plan with BHRS AOT Manager for approval.

F. *Medication Support:

1. All medical positions are to be part of the contractors Medication clinic.
2. Contractor will apportion funds from this contract to secure and maintain the level of medical staff for the AOT FSP clientele.
3. The direct medical services staff are essential components of the AOT FSP and will participate in team client planning and review and AOT team trainings.
4. When appropriate a member of the medical direct service staff will provide field based services along with another AOT team member
5. Teams will meet on a weekly basis for the purpose of discussion and planning regarding their members. A medical member of the AOT FSP team will be present or available for each of these meetings for consultation.

G. Funding

1. The 50 slots will be funded with Measure A funds.
2. All previous elements of funding described in original body of contract apply.

H. Time Frame

Contractor will form a startup team of existing direct service management staff who will develop job descriptions, conduct hiring, secure work space, oversee orientation, team development and participate in initial planning with BHRS staff during the months of June 2016 through August 2016.

Contractor will hire direct service staff on a flow basis as the client caseload evolves, starting in July 2016. Contractor will maintain sufficient staffing at all times in order to ensure caseloads will not exceed a 1 to 10 ratio.

I. Data Outcome

Contractor will work with BHRS to develop and track the following outcomes that are included in the California Welfare and Institutions Code (WIC) §5348. Such data may include, but not limited to, the following for enrolled clients:

1. The number served
2. The number who are able to maintain housing
3. The number of contacts with law enforcement
4. The number participating in employment services programs
5. Psychiatric hospitalization days
6. Days incarcerated
7. Adherence to prescribed treatment
8. Victimization of persons in the program.
9. Violent behavior of persons in the program.
10. Substance abuse by persons in the program.
11. Type, intensity, and frequency of treatment of persons in the program.
12. Satisfaction with program services both by those receiving them and by their families, when relevant.

V. Administrative Requirements (For all service components)

A. Paragraph 15 of the Agreement and Paragraph I.S.4. of Exhibit B notwithstanding, Contractor shall maintain medical records required by the California Code of Regulations. Notwithstanding the foregoing, Contractor shall maintain beneficiary medical and/or clinical records for a period of seven (7) years, except that the records of persons under age eighteen (18) at the time of treatment shall be maintained: a) until one (1) year beyond the person's eighteenth (18th) birthday or b) for a period of seven (7) years beyond the date of discharge, whichever is later.

B. Administering Satisfaction Surveys

Contractor agrees to administer/utilize any and all survey instruments as directed by BHRS, including outcomes and satisfaction measurement instruments.

C. Cultural Competency

Implementations of these guidelines are based on the National Culturally and Linguistically Accessible Services (CLAS) Standards issued by the Department of Health and Human Services. For more information about these standards, please contact the Health Equity Initiatives Manager (HEIM) at 650-573-2714 or jafrica@smcgov.org .

1. Contractor will submit an annual cultural competence plan that details on-going and future efforts to address the diverse needs of consumers, families and the workforce. This plan will be submitted to the BHRS Program Manager and the Health Equity Initiatives Manager (HEIM) by September of the fiscal year

The annual cultural competence plan will include, but is not limited to the following:

a. Implementation of policies and practices that are related to promoting diversity and cultural competence.

b. Contractor forum for discussing relevant and appropriate cultural competence-related issues (such as a cultural competence committee).

c. Collection of consumer cultural demographic information, including race, ethnicity, primary language, gender and sexual orientation.

d. Staffing objectives that reflect the cultural and linguistic diversity of the consumers. (Contractor will recruit, hire and retain clinical staff members who can provide services in a culturally and linguistically appropriate manner.)

e. Staff training plan related to cultural competency. Contractor will ensure that all program staff receive at least 8 hours of external training per year (i.e. sponsored by BHRS or other agencies) on how to provide culturally and linguistically appropriate services.

2. Contractor will actively participate in at least one cultural competence effort within BHRS and/or to send a representative to attend the Cultural Competence Council for the term of the Agreement. Contractor shall submit to BHRS ODE by March 31st, a list of staff who have participated in these efforts. For more information about the Cultural Competence Council (CCC), and other cultural competence efforts within BHRS, contact HEIM.

3. Contractor will establish the appropriate infrastructure to provide services in County identified threshold languages. Currently the threshold languages are: Spanish, Tagalog and Chinese (Mandarin and Cantonese). If contractor is unable to provide services in those languages, the contractor is expected to contact Access Call Center or their BHRS Program Manager for consultation. If additional language resources are needed, please contact HEIM.

4. Contractor will translate relevant and appropriate behavioral health-related materials (such as forms, signage, etc.) in County identified threshold languages in a culturally and linguistically appropriate manner. BHRS strongly encourages its contractors to use BHRS-sponsored forms in an effort to create uniformity within the system of care. Contractor shall submit to HEIM by March 31st, copies of Contractor's health-related materials in English and as translated.

5. Should Contractor be unable to comply with the cultural competence requirements, Contractor will meet with the Program Manager and HEIM (jafrica@smcgov.org) to plan for appropriate technical assistance.

D. Contractor shall submit a copy of any licensing report issued by a licensing agency to BHRS, Deputy Director of Adult and Older Adult Services within ten (10) business days of Contractor's receipt of any such licensing report.

E. Contractor shall provide all pertinent documentation required for federal Medi-Cal reimbursement. Documentation shall be completed in compliance with the San Mateo County BHRS Documentation Manual, which is incorporated into this Agreement by reference herein.

F. Contractor shall maintain certification through San Mateo County to provide Short-Doyle Medi-Cal and Medicare reimbursable services.

G. Drug Medi-Cal Certification: Contractor shall submit a Drug Medi-Cal (DMC) certification application to the Department of Healthcare Services by March 1, 2015. Once the DMC certification has been approved and a copy submitted to BHRS, Contractor may submit invoices to BHRS for DMC service reimbursement.

H. Ineligible Employees

BHRS requires that contractors identify the eligibility status of employees, interns or volunteers prior to hiring and on an annual basis thereafter. Results of the eligibility screenings are to be maintained in the employee files. This process is meant to ensure that any person delivering services to consumers of BHRS are not currently excluded, suspended, debarred or have been convicted of a criminal offense as described below. The Contractor must notify BHRS Quality Management (by completing the BHRS Critical Incident Reporting form, Policy #93-11) should a current employee, intern or volunteer be identified as ineligible. Contractors are required to screen for ineligible employees, interns and volunteers by using the following websites:

1. Office of Inspector General

   Contractor may not employ any persons deemed an Ineligible Person by the Office of the Inspector General in the provision of services for the County through this agreement. Any employee(s) of contractor determined to be an Ineligible Person will be removed from responsibility for, or involvement with County consumers or operations. An "Ineligible Person" is an individual who (1) is currently excluded, suspended, debarred or otherwise ineligible to participate in Federal health care programs, or (2) has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in the Federal health care programs after a period of exclusion, suspension, debarment or ineligibility. Ineligibility may be verified by checking: http://www.exclusions.oig.hhs.gov/.

2. California Department of Healthcare Services (DHCS)

Contractors providing state funded health services may not employ any persons deemed an Ineligible Person by the California Department of Health Services (CDHS) in the provision of services for the County through this agreement. Any employee(s) of contractor determined to be an Ineligible Person will be removed from responsibility for, or involvement with County consumers or operations. An "Ineligible Person" is an individual who has been (1) convicted of a crime involving fraud or abuse of the Medi-Cal program, or (2) suspended from the federal Medicare program for any reason. Ineligibility may be verified by checking: http://files.medi-cal.ca.gov, once there, type in "medi-cal suspended and ineligible provider list" in the search box.

3. Fingerprinting of Staff

Any contractor staff that have on-the-job contact with children or other vulnerable clients whose safety may be compromised by an individual's criminal history (i.e. sex offenses, abuse of dependent adults, etc.) should be fingerprinted, including administrative staff who routinely interact with clients, case managers, peer support workers, etc. Staff or potential staff found to hold such a criminal history would not be eligible for hire or retention in a position involving a vulnerable population.

I. Advance Directives

Contractor will comply with County policies and procedures relating to advance directives.

J. Beneficiary Rights

Contractor will comply with County policies and procedures relating to beneficiary's rights and responsibilities.

K. Physician Incentive Plans

Contractor shall obtain approval from County prior to implementing a Physician Incentive Plan as described by Title 42, CFR, Section 438.6(h). The County will submit the Physician Incentive Plan to the State for approval. The State shall approve the Contractor's request for a Physician Incentive Plan only if the proposed Physician Plan complies with all applicable federal and state regulations.

L. Availability and Accessibility of Service

Contractor shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees, if the Contractor also serves enrollees of a commercial plan, or that are comparable to the hours the Contractor makes available for Medi-Cal services that are not covered by the County or another Mental Health Plan, if the Contractor serves only Medi-Cal consumers.

M. Compliance Plan and Code of Conduct

Contractor shall read and be knowledgeable of the compliance principles contained in the BHRS Compliance Plan and Code of Conduct. In addition, Contractor shall assure that Contractor's workforce is aware of compliance mandates, and are informed of the existence and how to use the Compliance Improvement Hotline Telephone Number (650) 573-2695. The compliance Plan is accessible at sanmateo.networkofcare.org/mh by following the ling "Newsletters, Announcements, and Other Resources", then the link "Information for Providers".

N. Beneficiary Brochure and Provider Lists

Contractor agrees to provide Medi-Cal consumers who are new to the BHRS System with a brochure (an original of which shall be provided by County) when a consumer first receives a specialty mental health service from the Contractor. Such brochure shall contain a description of County services available; a description of the process for obtaining County services, including the County's state-wide toll-free telephone number; a list of the County's providers; a description of the County's beneficiary problem resolution process, including the complaint resolution and grievance processes; and a description of the beneficiary's right to request a fair hearing at any time before, during or within 90 days after the completion of the beneficiary problem resolution process.

V. GOALS AND OBJECTIVES / REPORTING

A. Program

Goal One: Contractor shall implement wellness and recovery action plans (WRAP)

Objective One: Fifty percent (50%) of FSP enrollees will have WRAP within 12 months of enrollment.

Data to be collected by Contractor.

Goal Two:	Decrease incarceration of consumers needing mental health services. (FSP)
Objective One:	Enrolled program consumers shall reduce total days of incarceration by seventy percent (70%) in comparison to total days for twelve (12) months prior to enrollment.

Data to be collected by Contractor.

Goal Three	Decrease hospitalization of consumers needing mental health services (FSP)
Objective One	Enrolled program consumers shall reduce total days of hospitalization by seventy percent (70%) in comparison to total days for twelve (12) months prior to enrollment. Data to be collected by Contractor.
Goal Four:	Consumers shall be maintained in stable housing. (Housing)
Objective One:	Sixty percent (60%) of consumers who live in supported housing will remain in stable housing at least one (1) year.

Data to be collected by Contractor.

Objective Two:	Ninety Percent (90%) of consumers satisfied with property management services. (Housing).

Data to be collected by Contractor.

B. Reporting

Contractor shall comply with all State Department of Health Care Services reporting requirements for Mental Health Services Act Full Service Partnerships including collections using State instruments, maintenance according to State guidelines, and reporting using State processes. Data collected will include but are not to be limited to:

1. Consumer's Satisfaction
2. Medical/Psychiatric Hospitalization
3. Residential Status
4. Employment
5. Incarceration
6. Emergency Room Contacts
7. Financial Status
8. Legal Events
9. Monthly status reports including enrollments, disenrollments, jail, locked and twenty-four (24) hour placements.

End of Exhibit A-1

LS

CAMINAR
Full Service Partnerships for Adults and Older Adults
FY 2014 – 2017
Exhibit B-1

County and Contractor hereby agree to amend this agreement to incorporate necessary language to meet Federal and State requirements during the term of this agreement.

In consideration of the services provided by Contractor in Exhibit A-1, County shall pay Contractor based on the following fee schedule:

I. Payments

A. Notwithstanding the method of payment set forth herein, in no event shall the maximum obligation that County shall pay or be obligated to pay Contractor for Full Service Partnership Services (FSP) and Housing Support Programs provided under this Agreement exceed the sum of FOUR MILLION SEVEN THOUSAND TWENTY-THREE HUNDRED FIVE HUNDRED FIVE DOLLARS ($4,723,505) for the period of July 1, 2014 through June 30, 2017.

B. In consideration of the services to be provided by Contractor, payment by County to Contractor shall be subject to the annual Cost Settlement process defined in Paragraph I.K. of this Exhibit B.

C. Payment for the period of July 1, 2014 – June 30, 2015 (Year 1)

For the period July 1, 2014 through June 30, 2015, the maximum payment shall not exceed ONE MILLION EIGHT THOUSAND NINE HUNDRED FORTY-FIVE DOLLARS ($1,008,945).

1. FSP Services Payment

The maximum payment for FSP services for the period July 1, 2014 through June 30, 2015, shall not exceed EIGHT HUNDRED THIRTY-FIVE THOUSAND SIX HUNDRED FIVE DOLLARS ($835,605).

a. FSP Services Payment

1) The FSP will cover service costs for thirty (30) enrollees. The FSP for this period of the Agreement includes: 1) MHSA funding of FIVE HUNDRED EIGHTY-FOUR THOUSAND NINE HUNDRED

TWENTY-FOUR DOLLARS ($584,924), and 2) the revenues expected to be generated by third-party billings: Medi-Cal Federal Financial Participation (FFP), Medicare and other applicable third-party payors for FSP services provided to enrollees (i.e. "Revenue Component"). The projected Revenue Component for FY 2014-15 is TWO HUNDRED FIFTY THOUSAND SIX HUNDRED EIGHTY-ONE DOLLARS ($250,681). In no event shall the total obligation of the County for FSP payments for this period exceed EIGHT HUNDRED THIRTY-FIVE THOUSAND SIX HUNDRED FIVE DOLLARS ($835,605).

2) County and Contractor agree that in the event that the actual revenues collected for Contractor's services for this period are less than the Revenue Component and that difference is shown to have been generated by failure to bill and/or disallowances by third party payors based on Contractor's failure: 1) to use Medicare-eligible providers; 2) to provide documentation adequate to support Contractor's services per County BHRS Documentation Manual (incorporated by reference herein); 3) to provide services at a per unit cost that is equal to or below the State Maximum Allowance; or 4) to submit the billing information required by this Agreement to the County in a timely manner (collectively, "Third Party Disallowances"), the FSP may be reduced by the amount of that difference. In determining the amount of such reduction, the Third Party Disallowances shall be subtracted from the amount of gross revenues collected by County for Contractor's services under this Agreement. The County shall determine the actual revenue generation. Any such reduction will result in a corresponding one-twelfth (1/12) payment reduction based upon the revised Revenue Component estimate of actual revenues available at that time.

3) FSP Services Monthly Rate

Unless otherwise authorized by the Chief of the Health System or designee, and/or as adjusted subject to Paragraph I.D.1.a.2) of this Exhibit B, the monthly rate of payment by County to Contractor

shall be one-twelfth (1/12) of the FSP. Payments will be made in the amount of SIXTY-NINE THOUSAND SIX HUNDRED THIRTY-FOUR DOLLARS ($69,634) per month for this period of the Agreement. The amount of the monthly payment is subject to reduction as described in Paragraph I.D.1.a.2). The FSP maximum for this period shall not exceed EIGHT HUNDRED THIRTY-FIVE THOUSAND SIX HUNDRED FIVE DOLLARS ($835,605).

b. Revenue Component reductions as described in I.D.1.a.2) of this Exhibit B shall not relieve Contractor of the obligation to provide the volume of services as described in Paragraph I.F. of Exhibit A.

2. Payment for Housing Support Program

The total Housing Support Program costs for the period beginning July 1, 2014 through June 30, 2015, is ONE HUNDRED SEVENTY-THREE THOUSAND THREE HUNDRED FORTY DOLLARS ($173,340). Program administration and related expenses for this period will be limited to a maximum of TWENTY THOUSAND FOUR HUNDRED FIFTY-FIVE DOLLARS ($20,455). For this period the monthly payment for housing will be for actual costs upon receipt of invoice from Contractor. Contractor shall be responsible for collecting tenant payments to cover portions of the program costs.

D. Payment for the period of July 1, 2015 – June 30, 2016 (Year 2)

For the period July 1, 2015 through June 30, 2016, the maximum payment shall not exceed ONE MILLION THIRTY NINE THOUSAND TWO HUNDRED THIRTEEN DOLLARS ($1,039,213).

1. FSP Services Payment

The maximum payment for FSP services for the period July 1, 2015 through June 30, 2016, shall not exceed EIGHT HUNDRED SIXTY THOUSAND SIX HUNDRED SEVENTY-THREE DOLLARS ($860,673).

a. FSP Services Payment

1) The FSP will cover service costs for thirty (30) enrollees. The FSP for this period of the Agreement includes: 1) MHSA funding of SIX HUNDRED TWENTY-SEVEN THOUSAND TWO HUNDRED FIVE DOLLARS ($627,205), and 2) the revenues expected to be generated by third-party billings: Medi-Cal Federal Financial Participation (FFP), Medicare and other applicable third-party payors for FSP services provided to enrollees (i.e. "Revenue Component"). The projected Revenue Component for FY 2015-16 is TWO HUNDRED FIFTY THOUSAND SIX HUNDRED EIGHTY-ONE DOLLARS ($250,681). In no event shall the total obligation of the County for FSP payments for this period exceed EIGHT HUNDRED SIXTY THOUSAND SIX HUNDRED SEVENTY-THREE DOLLARS ($860,673).

2) County and Contractor agree that in the event that the actual revenues collected for Contractor's services for this period are less than the Revenue Component and that difference is shown to have been generated by failure to bill and/or disallowances by third party payors based on Contractor's failure: 1) to use Medicare-eligible providers; 2) to provide documentation adequate to support Contractor's services per County BHRS Documentation Manual (incorporated by reference herein); 3) to provide services at a per unit cost that is equal to or below the State Maximum Allowance; /or 4) to submit the billing information required by this Agreement to the County in a timely manner (collectively, "Third Party Disallowances"), the FSP may be reduced by the amount of that difference. In determining the amount of such reduction, the Third Party Disallowances shall be subtracted from the amount of gross revenues collected by County for Contractor's services under this Agreement. . The County shall determine the actual revenue generation. Any such reduction will result in a corresponding one-twelfth (1/12) payment reduction based upon the revised Revenue Component estimate of actual revenues available at that time.

3) FSP Services Monthly Rate

Unless otherwise authorized by the Chief of the Health System or designee, and/or as adjusted subject to Paragraph I.D.1.a.2) of this Exhibit B, the monthly rate of payment by County to Contractor shall be one-twelfth (1/12) of the FSP. Payments will be made in the amount of SEVENTY-ONE THOUSAND SEVEN HUNDRED TWENTY-THREE DOLLARS ($71,723) per month for this period of the Agreement. The amount of the monthly payment is subject to reduction as described in Paragraph I.D.1.a.2). The FSP maximum for this period shall not exceed EIGHT HUNDRED SIXTY THOUSAND SIX HUNDRED SEVENTY-THREE DOLLARS ($860,673).

b. Revenue Component reductions as described in I.E.1.a.2). of this Exhibit B shall not relieve Contractor of the obligation to provide the volume of services as described in Paragraph I.F. of Exhibit A.

2. Payment for Housing Support Program

The total Housing Support Program costs for the period beginning July 1, 2014 through June 30, 2015, is ONE HUNDRED SEVENTY-EIGHT THOUSAND FIVE HUNDRED FORTY DOLLARS ($178,540). Program administration and related expenses for this period will be limited to a maximum of TWENTY THOUSAND FOUR HUNDRED FIFTY-FIVE DOLLARS ($20,455). For this period the monthly payment for housing will be for actual costs upon receipt of invoice from Contractor. Contractor shall be responsible for collecting tenant payments to cover portions of the program costs.

E. Payment for the period of July 1, 2016 – June 30, 2017 (Year 3)

For the period July 1, 2016 through June 30, 2017, the maximum payment shall not exceed TWO MILLION SIX THOUSAND SEVENTY FIVE HUNDRED THREE HUNDRED FORTY-SEVEN DOLLARS ($2,675,347).

1. FSP Services Payment

The maximum payment for FSP services for the period of July 1, 2016 through June 30, 2017 shall not exceed EIGHT HUNDRED SEVENTY-SEVEN THOUSAND EIGHT HUNDRED EIGHTY-SIX DOLLARS ($877,886).

qw

a. FSP Services Payment

1) The FSP will cover service costs for thirty (30) enrollees. The FSP for this period of the Agreement includes: 1) MHSA funding of SIX HUNDRED TWENTY-SEVEN THOUSAND TWO HUNDRED FIVE DOLLARS ($627,205), and 2) the revenues expected to be generated by third-party billings: Medi-Cal Federal Financial Participation (FFP), Medicare and other applicable third-party payors for FSP services provided to enrollees (i.e. "Revenue Component"). The projected Revenue Component for FY 2016-17 is TWO HUNDRED FIFTY THOUSAND SIX HUNDRED EIGHTY-ONE DOLLARS ($250,681). In no event shall the total obligation of the County for FSP payments for this period exceed EIGHT HUNDRED SEVENTY-SEVEN THOUSAND EIGHT HUNDRED EIGHTY-SIX DOLLARS ($877,886).

2) County and Contractor agree that in the event that the actual revenues collected for Contractor's services for this period are less than the Revenue Component and that difference is shown to have been generated by failure to bill and/or disallowances by third party payors based on Contractor's failure: 1) to use Medicare-eligible providers; 2) to provide documentation adequate to support Contractor's services per County BHRS Documentation Manual (incorporated by reference herein); 3) to provide services at a per unit cost that is equal to or below the State Maximum Allowance; or 4) to submit the billing information required by this Agreement to the County in a timely manner (collectively, "Third Party Disallowances"), the FSP may be reduced by the amount of that difference. In determining the amount of such reduction, the Third Party Disallowances shall be subtracted from the amount of gross revenues collected by County for Contractor's services under this Agreement. . The County shall determine the actual revenue generation. Any such reduction will result in a corresponding one-twelfth (1/12) payment reduction based upon the revised Revenue Component estimate of actual revenues available at that time.

3) FSP Services Monthly Rate

Unless otherwise authorized by the Chief of the Health System or designee, and/or as adjusted subject to Paragraph I.D.1.a.2) of this Exhibit B, the monthly rate of payment by County to Contractor shall be one-twelfth (1/12) of the FSP. Payments will be made in the amount of SEVENTY-THREE THOUSAND ONE HUNDRED FIFTY-SEVEN DOLLARS ($73,157) per month for this period of the Agreement. The amount of the monthly payment is subject to reduction as described in Paragraph I.D.1.a.2). The FSP maximum for this period shall not exceed EIGHT HUNDRED SEVENTY-SEVEN THOUSAND EIGHT HUNDRED EIGHTY-SIX DOLLARS ($877,886).

b. Revenue Component reductions as described in I.E.1.a.2). of this Exhibit B shall not relieve Contractor of the obligation to provide the volume of services as described in Paragraph I.F. of Exhibit A.

2. Payment for Housing Support Program

The total Housing Support Program costs for the period beginning July 1, 2014 through June 30, 2015, is ONE HUNDRED EIGHTY-TWO THOUSAND ONE HUNDRED ELEVEN DOLLARS ($182,111). Program administration and related expenses for this period will be limited to a maximum of TWENTY THOUSAND FOUR HUNDRED FIFTY-FIVE DOLLARS ($20,455). For this period the monthly payment for housing will be for actual costs upon receipt of invoice from Contractor. Contractor shall be responsible for collecting tenant payments to cover portions of the program costs.

3. AOT FSP from July 1, 2016 through June 30, 2017

a. Start-Up Costs

Contractor shall be reimbursed up to EIGHTY FIVE THOUSAND DOLLARS ($85,000) for AOT FSP actual start-up expenditures. $30,000 will be provided in advance of actual expenditures. Contractor shall then submit invoices for reimbursement of actual start-up costs in arrears. Invoices shall include an itemized list of expenses, and are subject to approval by the BHRS Manager. Arrears payments for reimbursement of start-up expenditures will be made until a total of $55,000 has been paid notwithstanding the $30,000 advance.

Contractor shall provide a final reconciliation of total start-up expenditures within 15 days of the contract year-end. Contractor shall return all unexpended funds with the reconciliation. Start-up funds will not roll over nor may be used for any other expense within the program.

b. Ongoing Services

Unless otherwise authorized by the Chief of the Health System or designee, and/or as adjusted subject to Paragraph I.D.1.a.2) of this Exhibit B, the monthly rate of payment by County to Contractor shall be one-twelfth (1/12) of the FSP. Payments will be made in the amount of ONE HUNDRED TWO THOUSAND FIVE HUNDRED DOLLARS ($102,500) per month for this period of the Agreement. The amount of the monthly payment is subject to reduction as described in Paragraph I.D.1.a.2). The FSP maximum for this period shall not exceed ONE MILLION TWO HUNDRED THIRTY THOUSAND DOLLARS ($1,230,000).

c. Housing Support

The total Housing Support Program costs for the period beginning July 1, 2016 through June 30, 2017 is THREE HUNDRED THOUSAND THREE HUNDRED FIFTY DOLLARS ($300,350). For this period the monthly payment for housing will be for actual costs upon receipt of invoice from Contractor. Contractor shall be responsible for collecting tenant payments to cover portions of the program costs.

d. Federal Financial Participation

For Medi-Cal beneficiaries the provider is expected to claim for all eligible services.

F. County Revenue Component Estimates

Contractor shall provide the minimum Medi-Cal and Medicare reimbursable services which shall generate the amounts of revenue for FSP Services as established below. These services shall be reported to County through the Monthly Reporting process as described in paragraph I.L. of this Exhibit B.

	July 1, 2014 - June 30, 2015 (Year 1)	July 1, 2015 - June 30, 2016 (Year 2)	July 1, 2016 - June 30, 2017 (Year 3)
FSP	$250,681	$250,681	$250,681

G. Contractor's Budget

1. Contractor's annual budget for these services for Fiscal Years 2014-2017 is incorporated into this Agreement as Exhibit C.

2. Contractor shall be responsible for all expenses incurred during the performance of services rendered under this Agreement that are not included in Exhibit C.

H. Budget modifications may be approved by the Chief of the Health System or designee, subject to the maximum amount set forth in Paragraph 3.

I. The Chief of the Health System or designee is authorized to execute contract amendments which modify the County's maximum fiscal obligation by no more than TWENTY-FIVE THOUSAND DOLLARS ($25,000) (in aggregate), and/or modify the contract term and/or services so long as the modified term or services is/are within the current or revised fiscal provisions.

J. Contractor shall maintain all program fiscal records to maintain current and future requirements for MHSA funded FSP services as determined by the State DMH, and as requested by the County.

K. Contractor shall submit to County a year-end cost report no later than ninety (90) days after the end of each applicable fiscal year (June 30th). Cost reports shall include accounting for all services provided through the Agreement for each applicable period, and separate accountings for 1) FSP services, 2) one-time expenditures, and 3) flexible funds. Cost reports shall be in accordance with the principles and format outlined in the Cost Reporting/Data Collection (CR/DC) Manual. Contractor shall annually have its books of accounts audited by a Certified Public Accountant and a copy of said audit report shall be submitted along with the Cost Report.

1. For any annual Cost Report provided to County that shows that total payments to Contractor exceed the total actual costs for these services rendered by Contractor during the annual reporting period, following any and all adjustments made under Paragraphs I.C.1.a.2), I.D.1.a.2) and/or I.E.1.a.2) of this Exhibit B, a single payment in the amount of the contract savings shall be made to County by Contractor, unless otherwise authorized by the Chief of the Health System or designee. This cost settlement reimbursement shall be made within ninety (90) days of the end of each fiscal year.

2. Where discrepancies between reported service units and/or actual costs, and payments are found on the Cost Reports to County, Contractor shall make a single payment to County when the total charges exceed the total actual costs for all of the services rendered during the reporting period.

3. Accounting records and supporting documents shall be retained for a three-year (3) period from the date the year-end cost settlement report was approved by State for interim settlement. Should an audit be started before the expiration of the three-year (3) period, the records shall be retained until completion of the audit and final resolution of all issues that arise in the audit. Final settlement shall be made at the end of the audit and appeal process. If an audit has not begun within three (3) years, the interim settlement shall be considered as the final settlement.

4. Subsequent audits by the State may result in additional cost settlement.

5. Notwithstanding other provisions of this agreement, final settlement shall include an amount for Administrative Services equal to the amount listed in contractor's Budget, Exhibit C.

L. Reporting

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1. Payment by County to Contractor shall be monthly. Contractor shall bill County on or before the tenth (10th) working day of each month for the prior month. The invoice shall include a summary of services and charges for the month of service. In addition contractor shall provide back-up to the invoice. Such back-up shall be in the form of:

   a. County provided service reporting form(s) ("Service Reporting Form(s)") completed by Contractor according to the instructions accompanying the Service Reporting Form(s), or
   b. County approved form(s) which provide detailed description of services provided including but not limited to: consumer name, mental health ID#, service date, type of service provided (Ex: TBS, Intensive Day Treatment, etc.), and duration of service (hour/minute format).

2. County reserves the right to change the Service Report Forms, instructions, and/or require the Contractor to modify their description of services as the County deems necessary.

M. County anticipates revenues from various sources to be used to fund services provided by Contractor through this Agreement. Should actual revenues be less than the amounts anticipated for any period of this Agreement, the maximum obligation and/or payment obligations for specific services may be reduced at the discretion of the Chief of the Health System or designee.

N. If County or Contractor finds that performance is inadequate, at the County's discretion, a meeting may be called to discuss the causes for the performance problem, and this Agreement may either be renegotiated, allowed to continue to end of term, or terminated pursuant to Paragraph 4 of this Agreement. Any unspent monies due to performance failure may reduce the following year's agreement, if any.

O. In the event Contractor claims or receives payment from County for a service, reimbursement for which is later disallowed by County or the State of California, or the United States Government, then Contractor shall promptly refund the disallowed amount to County upon request, or, at its option, County may offset the amount disallowed from any payment due or become due to Contractor under this Agreement or any other Agreement.

P. Contractor shall provide all pertinent documentation required for federal Medi-Cal reimbursement (including initial and quarterly notices, assessment and service plans, and progress notes). The County may withhold payment for any and all services for which the required documentation is not provided, or if the documentation provided does not meet professional standards as determined by the Quality Improvement Manager of San Mateo County BHRS. Contractor shall meet quarterly with County contract monitor, as designated by the BHRS Deputy Director of Adult and Older Adult Services, to review documentation and billing reports, and to take appropriate corrective action, as needed, to resolve any identified discrepancies.

Q. In the event this Agreement is terminated prior to June 30, 2017, the Contractor shall be paid for services already provided pursuant to this Agreement.

R. Beneficiary Billing

Contractor shall not submit a claim to, demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this contract. The Contractor shall not hold beneficiaries liable for debts in the event that the County becomes insolvent, for costs of covered services for which the State does not pay the County, for costs of covered services for which the State or the County does not pay the Contractor, for costs of covered services provided under this or other contracts, referral or other arrangement rather than from the County, or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary with an emergency psychiatric condition.

S. Claims Certification and Program Integrity

1. Contractor shall comply with all state and federal statutory and regulatory requirements for certification of claims, including Title 42, Code of Federal Regulations (CFR) Part 438, Sections 438.604, 438.606, and, as effective August 13, 2003, Section 438.608, as published in the June 14, 2002 Federal Register (Vol. 67, No. 115, Page 41112), which are hereby incorporated by reference.

2. Anytime Contractor submits a claim to the County for reimbursement for services provided under Exhibit A of this Agreement, Contractor shall certify by signature that the claim is true and accurate by stating the claim is submitted under the penalty of perjury under the laws of the State of California.

The claim must include the following language and signature line at the bottom of the form(s) and/or cover letter used to report the claim.

"Under the penalty of perjury under the laws of the State of California, I hereby certify that this claim for services complies with all terms and conditions referenced in the Agreement with San Mateo County.

Executed at ____________California, on__________, 20___

Signed _______________Title_______________________

Agency _______________"

3. The certification shall attest to the following for each beneficiary with services included in the claim:

   a. An assessment of the beneficiary was conducted in compliance with the requirements established in this agreement.

   b. The beneficiary was eligible to receive services described in Exhibit A of this Agreement at the time the services were provided to the beneficiary.

   c. The services included in the claim were actually provided to the beneficiary.

   d. Medical necessity was established for the beneficiary as defined under California Code of Regulations, Title 9, Division 1, Chapter 11, for the service or services provided, for the timeframe in which the services were provided.

   e. A consumer plan was developed and maintained for the beneficiary that met all consumer plan requirements established in this agreement.

   f. For each beneficiary with specialty mental health services included in the claim, all requirements for Contractor payment authorization for specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in this agreement.

g. Services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

4. Except as provided in Paragraph IV.A. of Exhibit A relative to medical records, Contractor agrees to keep for a minimum period of three (3) years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the consumer. Contractor agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Mental Health; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, Managed Risk Medical Insurance Board or their duly authorized representatives, and/or the County.

T. Unspent Funds

Contractor may rollover unspent one-time and flexible funding only according to the following procedures. In the event this Agreement is renewed beyond the term of this Agreement, the Contractor may also rollover unspent funding to a subsequent agreement according to the following procedures. By mutual agreement of County and Contractor, contractual savings or "rollover" of flexible funds as defined in this Exhibit B1 may be retained by Contractor and expended the following year, provided that these funds are expended for mental health services and/or FSP Program-related services approved by County and are retained in accordance with the terms of this Paragraph I.V. No other funds provided through this Agreement may be rolled over.

1. Contractor shall submit a projected calculation of any savings no later than ninety (90) days before end of the fiscal year. The projected calculation will be a separate report from the year-end cost report. With the projected calculation Contractor shall return the amount of the savings.

2. At the time of the submission of the projected calculation Contractor may request to rollover some or all of any savings. The request must be made in writing to the Director of BHRS or designee. The request shall identify specifically how the rollover funds will be spent, including a detailed budget. Savings shall not be spent until Contractor receives a written approval of the request. Approved rollover funds shall be spent only for the succeeding fiscal year and only for the specific purpose(s) requested and approved.

3. Contractor shall submit an accounting report of the rollover savings. This report shall include copies of the detailed expenses. The report is due ninety (90) days after the specific purpose has been completed, or ninety (90) days after the end of the fiscal year, whichever comes first. Any unspent rollover funds shall be returned to the County with the accounting report.

4. If the specific purpose is not yet complete as of the end of the succeeding fiscal year, contractor may request to rollover the unspent funds to the succeeding second (2nd) fiscal year by submitting a written request with the accounting report. The unspent rollover funds shall not be spent until the request is approved by the Director of BHRS or designee.

5. A final accounting of the rollover funds shall be submitted ninety (90) days after the specific purpose has been completed, or ninety (90) days after the end of the second (2nd) fiscal year, whichever comes first. Any unspent rollover funds shall be returned to the County with the accounting report.

U. Election of Third Party Billing Process

Contractor shall select an option for participating in serial billing of third-party payors for services provided through this Agreement through the completion of Attachment C – Election of Third Party Billing Process. The completed Attachment C shall be returned to the County with the signed Agreement. Based upon the option selected by the Contractor the appropriate following language shall be in effect for this Agreement.

1. Option One

3. Contractor shall submit an accounting report of the rollover savings. This report shall include copies of the detailed expenses. The report is due ninety (90) days after the specific purpose has been completed, or ninety (90) days after the end of the fiscal year, whichever comes first. Any unspent rollover funds shall be returned to the County with the accounting report.

4. If the specific purpose is not yet complete as of the end of the succeeding fiscal year, contractor may request to rollover the unspent funds to the succeeding second (2nd) fiscal year by submitting a written request with the accounting report. The unspent rollover funds shall not be spent until the request is approved by the Director of BHRS or designee.

5. A final accounting of the rollover funds shall be submitted ninety (90) days after the specific purpose has been completed, or ninety (90) days after the end of the second (2nd) fiscal year, whichever comes first. Any unspent rollover funds shall be returned to the County with the accounting report.

U. Election of Third Party Billing Process

Contractor shall select an option for participating in serial billing of third-party payors for services provided through this Agreement through the completion of Attachment C – Election of Third Party Billing Process. The completed Attachment C shall be returned to the County with the signed Agreement. Based upon the option selected by the Contractor the appropriate following language shall be in effect for this Agreement.

1. Option One

a. Contractor shall bill all eligible third-party payors financially responsible for a beneficiary's health care services that Contractor provides through this Agreement. Within ten (10) days of the end of each month, Contractor shall provide to County copies of the Explanation of Benefits or other remittance advice for every third-party payment and/or denial of such third-party payments for services provided by Contractor during such month. The amount of any such third-party payment shall be deducted from the total actual costs for all services rendered by Contractor as reflected on the Cost Report as defined in Paragraph M. of this Exhibit B1. County accepts no financial responsibility for services provided to beneficiaries where there is a responsible third-party payor, and to the extent that County inadvertently makes payments to Contractor for such services rendered, County shall be entitled to recoup such reimbursement, through the Cost Report reconciliation.

b. Contractor shall provide a copy of each completed Payor Financial Form (Attachment D) and subsequent annual updates for all consumers who receive services through this Agreement. For consumers who begin to receive services during the term of this Agreement, completed Payor Financial Forms shall be provided to the County with consumer registration forms. For consumers who were receiving services prior to the start date of this Agreement and who continue to receive services through this Agreement, completed Payor Financial Forms are due within ten (10) days of the end of the first month of the Agreement.

2. Option Two

a. Contractor shall provide information to County so that County may bill applicable other third-parties for services provided by Contractor through this Agreement. County shall retain these revenues and shall not offset these revenues against payments to Contractor.

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b. Contractor shall provide a copy of the completed Payor Financial Form (Attachment D) and subsequent annual updates for all consumers who receive services through this agreement. For consumers who begin to receive services during the term of this Agreement, completed Payor Financial Forms shall be provided to the County with consumer registration forms. For consumers who were receiving services prior to the start date of this Agreement and who continue to receive services through this Agreement, completed Payor Financial Forms are due within ten (10) days of the end of the first month of the Agreement.

End of Exhibit B-1