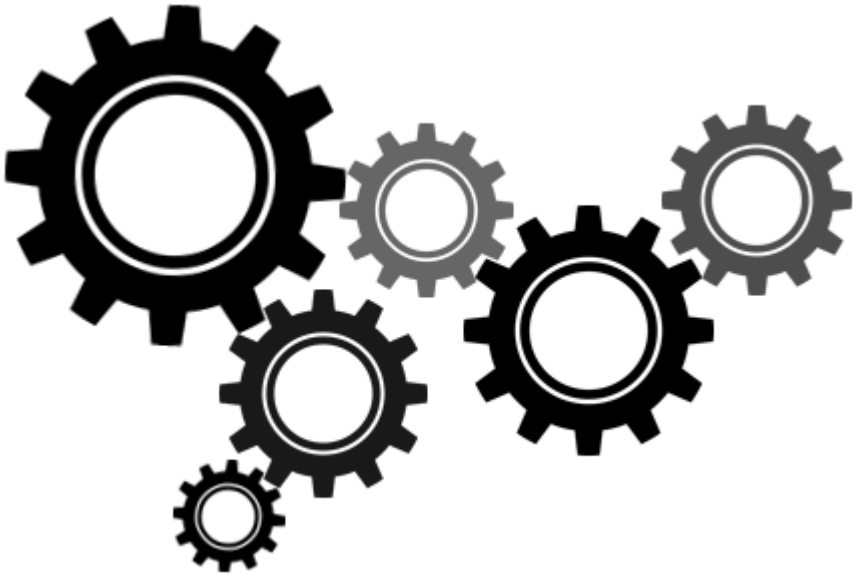
County of San Diego Health and Human Services
Agency, Behavioral Health Services

Mental Health Plan Implementation Plan for Medi-Cal Specialty Mental Health Services



FY 2018-19

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

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County of San Diego Mental Health Plan (MHP) Implementation Plan

COUNTY OF SAN DIEGO MENTAL HEALTH PLAN OVERVIEW

Mental Health Plan Principles

The County of San Diego Mental Health Plan (MHP) is built on the principle that all people, regardless of physical and mental abilities have dignity and worth, dreams and aspirations, and are part of the communities in which they live. Biopsychosocial treatment programs provided by the County and contracted mental health providers will make available mental health and rehabilitation treatment services without stigma or discrimination and with respect for the personal privacy, diversity, and dignity of persons with mental illness.

Mental Health Plan Philosophy

The MHP philosophy is that mental health care is consumer- and family-centered, safe, clinically effective, rehabilitation and recovery focused, trauma informed, outcomes driven, and culturally competent. It is our intent to provide our clients and families with comprehensive, preventive, rehabilitative, and therapeutic mental health care delivered in the least restrictive environment and in the most effective mode. This will be accomplished in a manner that ensures access to and satisfaction with services (consumer-centered), appropriateness of services (trauma informed, clinically effective, and culturally competent), and desirable outcomes (outcomes driven). The MHP's philosophy further appreciates and understands that trauma and complex stress are pervasive among those we serve and those we work with. This approach helps understand all people served and seen, and all staff. We must also accept that everyone does not respond to the same experiences in the same way—it is not a "one size fits all" approach. The quality of the MHP's care and services delivery system will be ensured by continually assessing important aspects of care and services, using reliable and valid measures.

Mental Health Plan Program Goal and Objectives

The MHP's goal is two-fold: to improve the health and well-being of our clients, and to provide the highest quality and most cost effective managed, recovery-oriented and trauma informed mental health care and administrative services available. Accordingly, the MHP is designed to promote the continuous improvement of specialty mental health and supportive services provided to clients; increase the effectiveness of care management and coordination of care with providers and referral sources; and advance the scope and efficiency of administrative services provided to stakeholders. The MHP is committed to becoming and remaining a Trauma Informed System, which draws upon and reflects the diversity in the experiences and needs of our community as seen in our clients, staff and provider networks.

System Scope of Services and Activities

The MHP utilizes a multidisciplinary network of providers to deliver a comprehensive continuum of mental health services that are trauma informed. These include, but are not limited to:

- Access and Crisis Line
- Assertive Community Treatment (ACT)
- Behavioral Health Court Services
- Case Management
- Clubhouses
- Crisis Residential Programs

- Day Treatment Services
- Emergency Services
- Forensic Services
- Full Service Partnership (FSP) Programs
- Homeless Services
- Housing Services
- Innovation (INN) Programs
- Inpatient Services
- Jail Services
- Long-Term Care
- Outpatient Services
- Prevention and Early Intervention (PEI) Programs
- Rehabilitation and Recovery Services
- Residential Treatment Programs
- Supporting Housing
- Therapeutic Behavioral Services
- Wraparound Services

History and Background

Between 1995 and 1998, the State consolidated Fee-for-Service (FFS) and Short-Doyle/Medi-Cal programs into one specialty mental health managed care program, and under the system all Medi-Cal specialty mental health services were "carved out" of Medi-Cal and became the Counties' responsibility. Medi-Cal beneficiary access to specialty mental health services became available through County Mental Health Plans. One of the Agency's departmental excellence goals is to become a trauma informed system of care. This effort is to build a better service delivery system that aligns with all three components of *Live Well San Diego*.

Additionally, the County of San Diego Behavioral Health Services (SDCBHS) Division has supported the County in the implementation of the Affordable Care Act (ACA) that has expanded coverage to a large number of individuals. The County administration has been working hand-in-hand with seven current Medi-Cal approved Health Plans (Aetna Better Health, Care 1st Health Plan, Community Health Group, Health Net, Kaiser Permanente, Molina Healthcare, and UnitedHealthcare) to develop communication and strategies around the ACA, and access to services under coverage expansion. In addition to the ACA and Medi-Cal expansion, California Medi-Cal program and the federal Medicare program partnered to launch a three-year project, Cal MediConnect, to promote coordinated health care delivery to seniors and people with disabilities who are dually eligible for both of the public health insurance programs, or "dual eligible beneficiaries." The program was implemented in 2014 and had a significant impact on care coordination and quality of care for dual eligible beneficiaries. SDCBHS worked closely with the participating Health Plans to coordinate Cal MediConnect planning and implementation. The California Governor's 2017-18 budget proposal aims to continue Cal MediConnect until 2020 in an effort to further improve the coordination of care for dual-eligible individuals and the administration's commitment to the principles of the Coordinated Care Initiative (CCI). Local coordination of care activities will continue under Cal MediConnect in alignment with CCI.

SDCBHS provides a continuum of trauma informed mental health and substance use disorder services to children, youth, families, adults, and older adults. The SDCBHS Division promotes recovery and well-being through prevention, treatment, and intervention, as well as integrated services for clients experiencing co-occurring mental illness and substance use issues. It employs an administrative services

organization (ASO) to fulfill specific management functions using managed care technology and expertise.

Please Note: MHP addresses service delivery for Children, Youth and Families (CYF), and Adults and Older Adults (A/OA). Some of the following sections will have program sub-headings indicating differences in the programs. If no sub-headings are identified, the processes are the same for both Systems of Care.

A. PLANNING, COORDINATION, OUTREACH AND NOTIFICATION

A1. PUBLIC PLANNING PROCESS

A1. Describe the public planning process utilized for the consolidation of MHP services and how members of the local mental health community were involved.

The County of San Diego's Mental Health Board, was originally established in the 1960s. In 1994 (for Phase I Managed Care Consolidation) and 1998 (for Phase II Managed Care Consolidation), the Mental Health Director (now Behavioral Health Services Director) apprised the Board of the steps leading toward consolidation. The membership of the Mental Health Board has historically been drawn from members of the local mental health community, including clients, family members, a County supervisor, mental health professionals, and members of the public.

Board Consolidation
SDCBHS previously had two Boards that advised the Behavioral Health Services Director, the Alcohol and Drug Services Advisory Board (ADAB) and the Mental Health Board (MHB). They had shared commonalities, but differ in composition and structure. In 2015, the two Boards consolidated into a Behavioral Health Advisory Board (BHAB) that resulted in an efficient and streamlined process, and key communication and oversight link between the client and family community and the local behavioral health service system. The Board meets monthly and provides advice on the public behavioral health system to the County Board of Supervisors and the Behavioral Health Services Director. The Board continues with defined duties and responsibilities by reviewing a broad range of performance and outcome reports, reviewing and taking action on all BHS-related Board Letters going before the Board of Supervisors, participating in the public/stakeholder input process in service planning, reviewing and analyzing budget priorities, reviewing critical incidents for process improvement, taking direct citizen comment/complaints/requests under consideration, and throughout these activities making recommendations to the Behavioral Health Services Director and to the Board of Supervisors. Additionally, BHAB serves as a one-stop forum for hearing public input on issues of concern to mental health and substance use disorder programs, while communicating information of significance regarding behavioral health to the community at large. In addition to the membership, the Board meetings are open to the public and are generally well attended by clients, advocates, and other interested individuals.

Mental Health Services Act (MHSA)
During a three-month period in 2016, the SDCBHS Division conducted a dynamic Community Planning Process (CPP) for the MHSA Three-Year Program and Expenditure Plan: Fiscal Years 2017-18 through 2019-20. The County engaged in discussions and received input from stakeholders, System of Care Councils, community organizations, and individuals starting on August 29, with public comment ending on November 7, 2016. . More than 550 people participated in 12 community forums and more than 100 individuals joined six specialty focus groups. The San Diego BHAB accepted the CPP report in January, 2017. The report was included in the MHSA Three-Year Plan, referenced above. The MHSA Three-Year Plan was approved by the San Diego Board of Supervisors in October, 2017, following a 30-day public comment period and BHAB approval. The MHSA Three-Year Plan included new and revised Innovation programs, also reviewed during the community forums and approved in a separate Board of Supervisors action in April, 2017, following a 30-day public comment period and BHAB approval.

BHS continues to gather input through a seasonal series of regional CPP forums and focus groups, including input on MHSA-funded programs. The most recent Community Engagement forums took place in August and September of 2017 and included five focus groups with homeless individuals, clubhouse participants, justice-involved individuals, service providers, and justice partners (law enforcement, Probation Department, and judges). One forum and one focus group were conducted via teleconference to provide greater access for participants. The next round of Community Engagement activities is scheduled for August, 2018. The draft FY 2018-19 MHSA Annual Update to the Three-Year Plan is expected to be ready for public review in August, 2018.

CPP provides a structured process that the County uses in partnership with stakeholders in determining how best to utilize funds that become available for the MHSA components. Due to the success of the model, SDCBHS also utilizes input to assist with planning for all BHS related funds and has developed a 10-year roadmap to identify funding priorities based on that input. CPP includes participation from BHAB and System of Care Councils, as well as individuals, stakeholders, and community organizations. Comments are submitted at Council meetings or through the MHSA comments/question line. The CPP is ongoing, and the County encourages open dialogue to provide everyone with opportunities to have input of future planning. Stakeholders are encouraged to participate in BHAB and Council meetings and to contact SDCBHS by visiting the MHSA page on the Network of Care site at http://sandiego.camhsa.org/.

System of Care Integration (Children's and Adult Services)

In its original design in 1998, the MHP was comprised of three separate systems of care: Children's Mental Health Services, Adult/Older Adult (A/OA) Mental Health Services, and Alcohol and Drug Services (ADS). As of 2005, the three systems have been integrated under one Behavioral Health Services Director. The Children's system has been renamed to Children, Youth, and Families (CYF), but the philosophy of each system has been largely retained. The ADS system has been integrated within CYF and A/OA Systems of Care (SOC). Additionally, all services provided by the CYF and A/OA SOCs are oriented to meet the unique linguistic and cultural needs of the persons served. The systems strive to ensure that the County residents have access to quality trauma informed services as guided by the Behavioral Health Services mission, principles and goals. The mental health services are directly provided through County-operated and County-contracted facilities, as well as through contracts with community-based providers and individual FFS providers. The Behavioral Health Services SOCs ensure that certain State-mandated functions, such as quality improvement, grievance and appeal procedures, and billing and claiming procedures are in place, and are accurate and effective. Additional administrative functions include direction and coordination of medical record services and contract administration.

The SOCs offer a wide variety of services, from prevention and early intervention to residential services with a wide variety of treatment, rehabilitation and recovery services. Additional departments within the SDCBHS are the Clinical Director's Office (CDO) and the Prevention and Planning Unit (PPU).

- The CDO develops and monitors various workforce and integrated care programs. In addition, CDO also oversees hospital services as well as long-term care coordination, and interfaces with the Health Plans.

- The PPU is the outward face in the community for BHS and provides oversight, coordination and leadership around prevention and early intervention activities and initiatives, including the integration of the *Live Well San Diego* Vision. BHS has integrated community outreach; Mental

Health Services Act coordination; suicide prevention and stigma reduction planning; primary, secondary and environmental prevention activities for Substance Use Disorder and Mental Health contracts and initiatives; and all strategic planning, advisory board coordination, legislation tracking and media activities under the PPU.

The SDCBHS Division is composed of Mental Health Services and Substance Use Disorder Services which are both integrated in the CYF and A/OA SOCs.

CHILDREN, YOUTH, AND FAMILIES SYSTEM OF CARE (CYF SOC)

On December 12, 1995, the Board of Supervisors (BOS) directed the Chief Administrative Officer for a preliminary plan for a consolidated system of care for emotionally disturbed children and youth. A "Heartbeat" System of Care of Emotionally Disturbed Children and Youth plan was presented to the Board of Supervisors on July 23, 1996. Between April 11 and 13, 1997, more than 200 San Diego County citizens met to design a new system of care for children and youth with emotional disturbances. This event, the Heartbeat Charrette, was organized by the San Diego County Bar Association's "Project Heartbeat" working with HHSA/MHS staff. A management team was created to develop a Children's Mental Health System of Care plan. The Mental Health Board created a Children's sub-committee to advise the team. The draft implementation plan was approved the Board of Supervisors on June 15, 1999. Final plan was approved on August 10, 1999.

Additionally, the Children's Mental Health Services were enhanced as the Early Periodic Screening, Diagnosis and Treatment (EPSDT) expansion was approved November 9, 1999, which allowed for CMHS expanded services for eligible clients through these system changes and, on October 17, 2000, the BOS approved the Children's Mental Health Initiative which incorporates wraparound principles.

The cornerstone of the CMHS was the philosophy and practice of the partnership among family representatives, public agencies, and private providers. The Children's Mental Health Initiative Advisory Group was composed of individuals representing the three-sector participation. The ongoing oversight group was the "System of Care Steering Committee", which functioned as a subcommittee of the BHAB (then, Mental Health Board). Membership consisted of the Education sector, family/parents/caregivers, youth, providers, clinicians, County of San Diego Health and Human Services, Regional Centers, Probation department, Juvenile Court Judge, and at-large stakeholders.

In 2004, this committee evolved into the Children's Mental Health Services System of Care Council, a four sector partnership: Public, Private, and Education sectors, and Family/Youth. The Council serves in an advisory capacity to the Behavioral Health Services Director, and operates according to its by-laws adopted March of 2006 and last revised July 11, 2016.

The values and principles developed and implemented through the CSOC have been instrumental in setting forth new practices and approaches to the County of San Diego children's mental health delivery system.

In 2010, the Children's System of Care Council recommended that the principles be reviewed to ensure that they are contemporary with current practice as driven by the needs of the community. In the CSOC workgroup review process, it was concluded that the initial core principles remain relevant. Refinements

have been made to reflect current direction which complements the *Live Well San Diego* Vision. This evolution:

- Integrates mental health and substance use into a behavioral health system, which resulted in a name change from Children Mental Health Services to Children, Youth and Families (CYF);
- Integrates physical health for the overall advancement of health and wellness;
- Underscores the importance of natural community resources;
- Values the complexity of cultural diversity;
- Recognizes the influence of trauma and chronic stress on coping strategies and behavior*; and
- Strengthens commitment to youth and families.

**Added as part of the 2016 review of the core CYF SOC principles which were approved in May, 2018.*

These refinements re-affirm the system of care principles, the advancements made, and the pathway for future direction.

ADULT/OLDER ADULT SYSTEM OF CARE (A/OA SOC)

In spring 1995, under the direction of the Board of Supervisors, the HHSA launched a system redesign effort for the A/OA Mental Health Services. Lasting several months, this community-based process resulted in the *Plan for Mental Health System Redesign*, endorsed by the County of San Diego Board of Supervisors in January 1996.

In February 1997, the Board approved a major re-engineering of A/OA SOC's business functions and elements of the service delivery system. One of the proposed changes was to develop a regionalized and integrated system of care and services. In planning for this new system, A/OA SOC convened four Regional Planning Groups to identify and prioritize mental health needs, develop outcomes criteria, and define the services that could be shared across regions. The groups, comprised of 151 stakeholders, including 29 clients and family members, held public meetings from August to December 1997. Part of the process included administering a client-generated survey in which clients identified their service priorities and provided input to the planning process. More than 1,700 surveys were completed.

The final piece of the system redesign effort was the completion and endorsement by the County of San Diego Board of Supervisors, of the *System Redesign Implementation Plan* (SRI Plan) in August 1999. The plan presented the sequence of events, the activities, and the proposed schedule for re-procuring and/or re-engineering regional mental health services toward the establishment of the integrated regional service systems, with an integration of Biopsychosocial principles and practices throughout the system. While the Guiding Principles have been refined over the years, they continue to guide the A/OA SOC in its approach to relationship building; cultural competence and diversity; commitment to the clients; and resource utilization.

A Managed Care Advisory Group (MCAG) was established in 1997 to review, advise, and comment on the implementation of the A/OA managed care initiative. The group membership includes clients, family members, providers and a representative from the BHAB. Currently, monthly meetings are held with the

San Diego County Medi-Cal Health Plans. These meetings bring together the Health Plans, County administration, and providers to discuss current issues and address and concerns around access and quality of care. The other stakeholder groups include but aren't limited to: Adult Council, Older Adult Council, Housing Council, and Transition Age Youth (TAY) Council. These groups are composed of community organizations; SDCBHS and other County staff; and clients and family members.

A2. LOCAL MENTAL HEALTH BOARD LETTER

A2. Include a letter from the local mental health board or commission advising that they have reviewed the Implementation Plan.

At its regular meeting on February 25, 1998, the County of San Diego Mental Health Board reviewed and approved the implementation plan for the consolidation of specialty mental health services. *MHB letter was included in the original Implementation Plan.*

A3. PROCESSES FOR SCREENING AND REFERRAL

A3. Describe the process the MHP will use for screening and when appropriate, referral and coordination with other services, including, but not limited to, substance abuse services, education, housing, social services, probation, employment, and vocational rehabilitation. Indicate if there are differences in the screening, referral and coordination of services for special populations.

"NO WRONG DOOR" POLICY

The County of San Diego MHP has a policy of "No Wrong Door" regionalized outpatient screening and treatment. Consumers are able to access care by calling the statewide toll-free Access and Crisis Line (ACL) at 1-888-724-7240 or by self-referral to system providers in the community. The following scenarios illustrate screening protocols:

Screening Processes
Person calls 1-888-724-7240 the ACL number.

- Caller is prompted to choose number 2 for Spanish, number 8 for Crisis or to remain on the line for English (default).
- The call is routed to the next available counselor through CentreVu, which has three separate queues for English, Spanish, or Crisis.
- Call is answered and a determination is made if an interpreter is needed. The caller has the right to request an interpreter at any time.
- Language assistance is available for all Limited English Proficiency (LEP) callers through bi-lingual counselors and LanguageLine services.
- Calls to the LanguageLine, the contracted agency that provides interpreter services, by the ACL have the same top priority as 911 calls.

ACL clinician appraises presenting situation, screens for clinical risk potential, applies clinical interventions, and then provides:

- Immediate referral to emergency services for emergent condition, and/or initiates active rescue services, or
- Immediate referral to MHP provider network and authorization for face-to-face assessment within 72 hours for urgent condition, or
- Referral to appropriate provider and authorization for face-to-face assessment for routine care.

Person self-refers to MHP system of care provider.

- Provider staff completes screening process by telephone or face-to-face assessment, and then provides:

- Immediate referral to emergency or crisis services if necessary, or
- Appointment or referral for urgent care and face-to-face evaluation within 72 hours, or
- Appointment or referral for routine MHP services.
- Referral to services in the community if it is determined after a face-to-face assessment that Title 9 medical necessity criteria are not met.

Referral and Coordination Processes

MHP providers make appropriate referrals to other County and community services, and Memoranda of Understanding (MOU) are negotiated with other County departments and community resources when appropriate (e.g., education and housing).

- Referrals to Substance Use Services

  The ACL is also the San Diego number to call for referrals to Substance Use Disorder services. Typically, a high percentage of mental health services' consumers report substance use as a current or historical problem. The MHP and its providers work in partnership with Substance Use Disorder programs to expand and improve the integration, coordination and efficacy of services for those qualifying as dually diagnosed. The integrated services model focuses on the provision of integrated screening, assessment, treatment services, and appropriate referrals to clients and their families. Care plans reflect the integration of both mental health and substance use services when appropriate. Care coordinators (and consumer support coordinators when appropriate) determine with the client the level of peer or professional support needed, necessity for modification of care plan, and outcomes. Almost all BHS programs are expected to achieve Dual Diagnosis Capable (DDC) status; a smaller number of programs may achieve Dual Diagnosis Enhanced (DDE) status. DDC programs routinely accept individuals who have co-occurring mental and substance use disorders, and address each patient's needs as long as their psychiatric disorders are sufficiently stabilized and their mental health symptom acuity does not seriously interfere with substance abuse treatment. DDE programs can accommodate individuals with dual or multiple diagnoses who may be unstable or disabled to such an extent that specific psychiatric and mental health support, monitoring and accommodation are necessary in order for the individual to participate in addiction treatment.

  In 2012, efforts to further refine the SDCBHS administrative structure were made. Key leadership positions were streamlined, and a training plan was implemented to ensure all BHS staff were well acquainted with the work of all units. Concurrently, BHS administration began planning for the integration of the stakeholder community with a goal to fully integrate all board meetings and stakeholder groups by 2015. In an effort to achieve full integration, BHS continues to review data surrounding the co-occurrence of mental health disorders and addiction.

  A number of contracted mental health programs provide substance use services in conjunction with their mental health services. This is especially true in programs that serve Juvenile Probation. When services are not directly available through a mental health program, referrals are made to the network of substance use programs, including programs that are specifically designed for pregnant and parenting women, programs that serve adolescents, and general adult programs.

- Referrals to Veteran Services

  Courage to Call is a veteran-staffed 24/7 Helpline that provides free confidential information, self-screening tools and appropriate resources, guidance, and referrals to individuals who have served in the military and their families. The program also provides training to improve cultural awareness

and understanding for community organizations and providers serving those with a military or military family background. Providers also refer to Veterans Affairs as needed. It is the responsibility of staff to ensure that all veterans who present for mental health services at a San Diego County program are appropriately assessed and assisted with accessing their eligible benefits provided through the Department of Veterans Affairs (USDVA) or other federal health care program or are referred and provided services through a San Diego County program. A/OA staff ask the client if he/she is receiving veterans' services benefits. If the client is receiving benefits or claims to have services in the military, the staff completes the following procedure:

- Complete "Request for Verification of Veterans Eligibility for Counseling and Guidance Services Fax Form".
- Fax the form to the Veterans Office for verification.
- If an urgent response is required, it is noted in the Comment Section of the Request Form and the Veterans Office is contacted by phone after the Form has been faxed. All individuals who present for emergency mental health services receive appropriate emergency assessment and crisis stabilization services, including processing for inpatient admission, if necessary.
- If the client meets the eligibility criteria for seriously mentally ill persons and is receiving veterans' benefits, but needs mental health services not offered by the USDVA, the client can be offered mental health services.
- If the client meets eligibility criteria for seriously mentally ill persons and eligibility for veterans' services is pending, the client can be offered mental health services until the veterans services benefit determination is completed.

- Referrals to Services for Deaf and Hard of Hearing

  Outpatient Services for Deaf and Hard of Hearing, a program of Deaf Community Services, provides specialized, culturally, linguistically and developmentally appropriate outpatient Bio-Psychosocial Rehabilitation (BPSR) services for Medi-Cal and unfunded deaf and hard of hearing persons of all ages with serious mental illness, as well as those who may also have a co-occurring substance use disorder. Providers are fluent in American Sign Language (ASL) and are members of the deaf community. As of July 1, 2010, services have been expanded to provide substance use counseling with the addition of an experienced and certified Alcohol and Drug counselor who is ASL-fluent. Additionally, Deaf Community Services Clubhouse, which opened in November 2012 and now has more than 32 active members, is a day-based recovery and activity center which provides educational, vocational, and social activities to Deaf and Hard of Hearing clients located throughout San Diego County. Services are provided by staff fluent in ASL and knowledgeable about Deaf culture and the implications of deafness on a person's well-being.

- Referrals to Employment and Vocational Rehabilitation Services

  The MHP provider network includes programs currently delivering vocational rehabilitation components. The Employment Services Program (ESP), in partnership with the California Department of Vocational Rehabilitation, is a comprehensive employment-readiness program accessible to all beneficiaries of the MHP. Programs without vocational rehabilitation components are encouraged to send interested consumers to the ESP. Some programs currently have ESP personnel on site to facilitate the involvement of interested consumers, have job support groups, and provide volunteer or paid employment for self-identified consumers. Additionally, Peer-run Clubhouses have specific staff who provide vocational rehabilitation assistance. Dependents of the Juvenile Court are assisted in job preparation by Independent Living Services providers. ACT teams have Education and Employment Specialists on staff.

- Referrals to Housing
  BHS provides short-term, transitional, and permanent supported housing to persons who are enrolled in the MHP and are homeless or at risk of homelessness. Programs such as Full Service Partnerships (FSP) for homeless clients provide housing and support services for TAY, Adults and Older Adults with a psychiatric disability. Linkage to housing is provided by the program in coordination with numerous partners to include housing entities, landlords, board and care facilities, and Independent Living Homes (ILH). Other resources utilized include the ILH Association website and community warm lines. Approved and affordable housing lists are available at the San Diego County Housing Authority. All applications and processing for Section 8 housing must be done by mail, although the applications themselves are available at various programs and agencies. Consumers are educated about the extensive length of federal housing waiting lists and the need to keep applications updated. The County contracts with Assertive Community Treatment (ACT) programs that provide housing services with a full range of subsidies. Additionally, as part of the Project One for All (POFA) effort to provide intensive wraparound services to homeless individuals with serious mental illness (SMI) who are eligible for supportive housing, behavioral health contracts were expanded in February 2016 to provide 300 outreach and engagement slots through a variety of mechanisms to assist people in accessing housing and services. Furthermore, to facilitate the implementation of POFA, the County integrated the Department of Housing and Community Development into the Health and Human Services Agency in July 2016. The goal of POFA is to reach and house 1,250 homeless individuals with SMI by the end of 2018.

- Referrals to Physical Health Services
  In addition to collecting medical history information, clinicians also document clients' primary care provider information and make referrals when needed. All mental health clinics have referral relationships established with community clinics located in their geographic area. A Coordination of Care Form (*see section C for more information*) has been developed that is used widely to refer individuals to primary care. Some sites have also developed additional protocols to effectively transition stable individuals with SMI to primary care, when appropriate.

- Referrals to Older Adult Services
  BHS has implemented an Older Adult initiative to expand services to older adults with mental health issues. Older adults may be referred to the Aging and Independent Services Senior Service teams, outpatient clinics, or emergency psychiatric units (EPU) for assessment and treatment. Appropriate referrals for older adult case management will continue to be made to Adult Protective Services, Inc., as long as the county continues to contract with this organization. Once an older adult is enrolled in the MHP, his/her care coordinator may facilitate necessary referrals and follow-up. Additionally, many outpatient programs have added Geriatric Specialists in effort to increase access for and outreach to this population.

- Referrals to Social Services
  Children and youth receiving mental health services may also require social services intervention. Referrals for child protective services are made directly to the Child Abuse Hotline when indicated. Referrals for eligibility for CalWORKS and Medi-Cal are made through the Family Resource Centers. Mental Health program staff actively assist the beneficiary by providing information and facilitating the referral.

- Referrals to Education Services
  Children and youth enrolled in general or special education may receive mental health services directly through the school district which as of July 1, 2012 oversees the Educationally Related Mental Health Services (ERMHS) previously known as AB 2726 (AB 3632) program which was managed by the County mental health system. In addition to ERMHS provided through the school, beneficiaries may elect to receive services through the MHP which collaborates closely with the school to offer coordinated services. Through the EPSDT expansion of 1999, the MHP has made a commitment to offer school-based services in schools with high enrollment of Medi-Cal beneficiaries. The MHSA furthered this commitment through expanding services to underserved children and youth. School-based services allow for increased direct access to care.

- Referrals/Coordination with Other County Services
  For children and youth, a significant array of services is provided in collaboration with the Child Welfare Services (CWS) program. Services, ranging from outpatient to day services are provided for the shelter care settings by mental health staff. Consultation is provided to CWS staff on a regular basis. BHS also provides oversight through the ASO of the Treatment and Evaluation Resource Management (TERM) Team for CWS and Probation clients in need of outpatient mental health services provided in the FFS network. Most recently, coordination efforts have been enhanced through the Continuum of Care reform, as BHS and CWS representatives have worked closely together to plan for and implement this important effort.

- Referrals to Law Enforcement
  The Psychiatric Emergency Response Team (PERT) is a partnership between BHS, the San Diego Police Department (PD), and the County Sheriff's Department. There are 10 law enforcement agencies: Oceanside PD, National City PD, Carlsbad PD, Escondido PD, Chula Vista PD, Coronado PD, La Mesa PD, El Cajon PD, San Diego PD, and San Diego Sheriff. PERT was expanded in phases with the ultimate goal of providing countywide coverage, and new teams were added in FY 2017-18. Originally created to fill the need for more training in recognizing and responding to mental health issues, PERT has evolved as a law enforcement-based mental health crisis intervention team that pairs a licensed mental health professional with a law enforcement officer/deputy. It is designed to improve the response to community incidents where law enforcement intervenes and mental health issues are identified as a primary concern. SDCBHS has continued expansion efforts and there are currently 50 licensed mental health clinicians who are teamed with PERT-trained law enforcement officers/deputies throughout San Diego County. PERT conducts eight full-day "PERT Academy" trainings for law enforcement partner agencies throughout the year. In addition, PERT provides mental health crisis intervention trainings in various community settings throughout San Diego County. In FY 2016-17: PERT conducted 7,852 crisis intervention contacts and 10,655 community service contacts for a total of 18,507 contacts. The San Diego Sheriff's Department reported 6,454 PERT-related calls in calendar year 2017. The Sheriff's Department saw a jurisdiction-wide average increase of 88 percent for PERT-related calls from 2009 to 2017. Eleven Sheriffs' jurisdictions saw an increase of 78 percent or more over the same time period. The San Diego Police Department (SDPD) reported 19,026 PERT-related calls in calendar year 2016, which is the largest overall volume of PERT-related calls by jurisdiction. SDPD also saw an increase of 97 percent of calls from 2009 to 2016.

  Brief assessments are completed in the field and are intended to provide the most appropriate level of care available. The assessed individual is generally referred to a community-based mental health facility that can provide crisis intervention, outpatient care, and case management services.

Sometimes, involuntary hospitalizations are necessary to ensure safety. In this case, the individual in crisis is transported to the nearest LPS designated facility and may be held for up to 72 hours. The PERT team stays with the individual until the hospital's social worker accepts the individual for further assessment by hospital staff.

Additional Resources and Services

- Emergency Services

  The County of San Diego contracts with an Emergency Screening Unit (ESU) program that provides evaluation for hospital placement and crisis stabilization services to defer children and youth from hospital placement. Another function of ESU is to support the local residential facilities in stabilizing youth who are experiencing difficulty in their group home placement. Additionally, ESU provides crisis-orientated interventions including emergency medication refills, referrals for outpatient and substance use services, as well as follow-up case management services. There has been a significant collaboration and effort, across numerous County departments, to renovate a County building and relocate the ESU. The new and expanded centralized location with 12 dedicated beds opened in December 2017. Walk-in emergency mental health services are also available for adults and older adults who are experiencing a mental health emergency or crisis at the County-operated EPU which provides screening and crisis stabilization services. In FY 2016-17, adult crisis stabilization services were established in the North Inland and North Coastal regions of San Diego County. The new crisis stabilization units are located within two FFS hospitals and have a total of 14 recliner chairs.

  San Diego is fortunate to hold a contract for an inpatient acute psychiatric hospital unit which facilitates access to acute care. In addition, the County has 14 FFS hospitals that accept Medi-Cal beneficiaries: one children's hospital, 10 adult hospitals, and two hospitals with adult and children's units. There are a total of 65 acute children's beds and 710 adult beds (including the County-operated hospital) in the County that serve Medi-Cal, indigent and private pay clients.

- Stabilization Treatment and Transition (STAT) Team

  County staff provides a variety of mental health services to children and youth who are involved with the Probation Department. The STAT team provides mental health services to children and youth detained in the different County Juvenile Probation detention facilities.

  A wide array of services is provided by the Juvenile Forensic Services (JFS) division that includes mental health assessment, crisis intervention, consultation, individual therapy, and treatment services to children and adolescents who are involved in the Juvenile Court and who are either dependents or delinquents. JFS provides services throughout the County at sites including Juvenile Hall, Girls' Rehabilitation Facility, Polinsky Children's Center, Juvenile Ranch Facilities, and Camp Barrett. Some of the services are provided by contract agencies, such as intensive case management and outpatient services, transition services for wards leaving Juvenile Hall, and parent peer support counseling for families of children in Juvenile Hall.

- AB 109 Services for Clients 18 Years of Age and Older

  Due to the Public Safety Realignment Act of 2011 (also known as AB 109), there was a shift in many basic responsibilities in the California criminal justice system from the State to the counties. Individuals who have committed non-violent, non-serious or non-sex crimes serve their time in county jails and are offered mental health services while in jail and after release. The services provided to the individuals include substance use and mental health treatment, housing and other

services that are designed to reduce recidivism. The County established a centralized screening and referral unit, and has worked with Probation to fund substance use and mental health programs to provide services to this population. One of the programs that specifically serves clients who are in the Post Release Offender Program through San Diego Probation is Exodus Recovery Center. The AB 109 program at Exodus Recovery serves clients who meet criteria for the specialty mental health services through SDCBHS and are in need of psychiatric medication management. It provides assessment and treatment planning to identify the type of services and the level of care for each individual. In addition to Exodus Recovery, clients are referred to 15 other programs that serve AB 109 clients through San Diego Probation and the centralized screening and referral unit after release from jail.

- Crisis, Action and Connection (CAC)
  Intensive in-home services are offered to children and youth who are experiencing a psychiatric emergency and require stabilization services. The focus is on children and youth and their families who are assessed through an Emergency Services Unit and with the CAC program support are diverted from inpatient care and maintained safely in the community. Additionally, in-home support and care coordination services are offered to children and youth and their families who are being discharged from an inpatient psychiatric unit, with the goal of stabilizing and connecting them to appropriate services. An emphasis on short-term, intensive, rehabilitation, in-home care coordination for children/youth experiencing a psychiatric crisis is the foundation of this contracted service.

- Wraparound Services
  The County currently provides wraparound services to two distinct groups of children and youth through County contracts. Wraparound services are intensive, non-traditional mental health services to support children and their families and that offer a full range of treatment and resource options. One focus is on children/youth transitioning from a group home setting to a lower level of care or from other high levels of care to lower levels (stepping down). A second focus is on children and youth who are at imminent risk of high level residential placement, or psychiatric hospitalization. Wraparound services are also offered to children and youth to prevent higher levels of care other than group homes.

- Extended Foster Care (EFC)
  The vast majority of youth who are still in foster care at age 18 opt to remain under the jurisdiction of the Juvenile Court as a non-minor dependent in the Extended Foster Care Program (EFC). EFC offers housing support and case management to assist these youth with achieving goals related to self-efficacy (education and employment) and to maintaining permanent connections. EFC has been in operation since 2012 and the number of non-minor dependents now remains fairly constant at 450 youth. This includes youth from both CWS and Juvenile Probation. Youth in EFC participate in their planning via Child and Family Teams (Pathways to Well-Being), Independence Mappings (based on Safety-Organized Practice) and their Transitional Independent Living Plan (TILP). BHS supports this population via the resources identified in the TAY Workgroup, by contracts related to housing and therapeutic services specific to TAY, and by joint governance in the Pathways to Well-Being program.

- Treatment and Evaluation Resource Management (TERM)
  Private practice therapists paneled under Treatment and Evaluation Resource Management (TERM) network provide outpatient therapy to CWS and Probation children, youth, and parent group

treatment. SDCBHS contracts with an Administrative Services Organization (ASO) to provide independent oversight of treatment, service authorization, and quality review of work products for TERM providers. Additionally, SDCBHS has an extensive network of FFS providers through the ASO.

- Pathways to Well-Being
  Pathways to Well-Being was developed in response to a 2002 lawsuit brought forth by foster youth and their advocates against Los Angeles County and the State of California alleging violations of federal laws related to unmet mental health and support needs. The lawsuit sought to improve the provision of mental health and support services for youth in, or at imminent risk of placement in, foster care in California. In 2011, the State of California settled its portion of the lawsuit which led to the development of the Core Practice Model in 2013. The Core Practice Model promotes shared governance between BHS and CWS, in collaboration with family/youth partners and Probation. The MHP works very closely with CWS through joint governance to provide integrated service delivery to children and youth involved with CWS who require enhanced mental health services. As of July 1, 2016, services provided to CWS Enhanced youth became available through the EPSDT benefit to all children and youth under the age of 21 who are eligible for full scope Medi-Cal services and meet medical necessity criteria for these services.

- Multidimensional Treatment Foster Care (MTFC)
  BHS CYF augments Therapeutic Foster Homes with a clinical component utilizing the evidence based practice of MTFC. This intensive and prescriptive model is used to support children with complex mental health needs. Therapy, care coordination, case management and rehabilitative services are the cornerstone of this model and are done in partnership with the child's caregivers with a home based approach. The County of San Diego offers MTFC to children from preschool to adolescence.

- Comprehensive Assessment and Stabilization Services (CASS)
  A short-term contracted program supports CWS children and youth who are at risk of losing their placement. On average, a three-month treatment episode of intensive in-home stabilization services is offered post a comprehensive assessment. A team approach is utilized and a strong collaboration is in place between the CASS program and CWS. Services are offered 24/7 in the child and youth placement, school, and other venues within the child's natural environment. A therapist and a behavior specialist provide mental health, rehabilitative and case management/care coordination services.

- Foster Family Agency Stabilization and Treatment (FFAST)
  A contracted provider serves CWS children and youth with mental health needs that are placed in Foster Family Agency homes throughout the County. Services are offered with a specialization and recognition of the particular needs of children and youth in foster placements. Program utilizes evidence based and best practices to serve the population. A Care Coordinator/Case Manager and Family Partner in conjunction with the family (foster and biological when available), as well as youth and therapist, are an integral part of the treatment team. Services are offered in the foster home when appropriate, recognizing that working collaboratively with the foster and biological parents leads to positive outcomes for the child/youth and family unit.

- Therapeutic Behavioral Services (TBS)
  TBS is an intensive, individualized, one-to-one behavioral coaching program that is offered through a County contract. A multi-disciplinary team headed by the Specialty Mental Health Provider (SMHP) is convened with the child/youth and family as the core drivers for treatment plan development. All

direct services are offered in the home or child's/youth's natural environment, such as school. A TBS Case Manager acts as the care coordinator.

- Peer-Supported Recovery and Rehabilitation Services
  The SDCBHS recognizes the value of mutual support and peer counseling and encourages programs to employ qualified people who bring consumer experience to their jobs. SDCBHS supports the provision of consumer-provided services throughout the system of care, including, but not limited to: outpatient clinics, case management programs, and clubhouses. Volunteers also offer peer recovery services, and SDCBHS supports programs such as NAMI's Peer to Peer and Warm Line, which offers volunteers the opportunity to use their consumer experiences to help educate and support others.

- Crisis Residential Services
  Crisis residential services are considered a "step down" or diversion from inpatient services, and are provided to both Medi-Cal and non-Medi-Cal clients who meet medical necessity and admission criteria. There are seven facilities in San Diego County that provide crisis residential services. Built around a bio-psychosocial approach, the programs offer a multi-disciplinary team whose members address each aspect of every client's unique situation. The programs seek to ensure that each resident is connected to a variety of social service supports within the community, to aid in transition into successful living beyond the crisis residential facility.

- Long Term Care
  The SDCBHS works with several County-funded long-term care facilities to provide care to individuals who experience serious psychiatric disabilities and require a secure, safe, and structured environment.

Screening and Referral Processes for Special Populations

- Transition Age Youth (TAY)
  BHS has developed and implemented services and programs that target the specialized needs of TAY. These include: an intensive ACT FSP program with integrated services and supported housing for persons 16-25 years of age; a member-run, age appropriate Clubhouse providing peer education and support, skill development, employment and educational support services; and a creation of specific age and developmentally appropriate enhanced outpatient mental health services for persons 18-25 years of age in multiple outpatient mental health clinics throughout the County. In addition, specialized programs have also been initiated to focus on prevention and early intervention efforts. One program educates community members to help identify TAY (in this program, individuals ages 12-25) who are experiencing at-risk or high risk behaviors or features of a first psychotic episode. Other programs include support and assistance for families in: maintaining a safe home for children and reducing the effects of trauma exposure; preventing re-traumatization related to exposure to domestic and/or community violence; and assessing and evaluating short-term interventions in rural community clinics for CYF and TAY in an integrated Behavioral Health and Primary Care Services program.

  These SOC models, initiatives, and programs support the desired comprehensive transition services for TAY individuals that are in need of continued age appropriate mental health services. Over time and with the benefit of additional resources through the MHSA, the County has been working steadily to ensure services are developmentally and culturally appropriate, trauma informed,

individualized, accessible, coordinated, community based, and integrated with other public and private initiatives. A TAY Council meets regularly to provide feedback and recommendations to SDCBHS, and is comprised of: community organizations, County representatives, service providers, clients and family members, and others.

- Infants and Preschool Children
  BHS has created and strengthened contracts that focus on serving children less than six years of age. These programs are available in all regions and use evidence based practices for young children. For example:
  - Developmental Evaluation Clinic (DEC) provides comprehensive developmental and psychological assessments to primarily CWS dependents to rule out autism and developmental delays. Through early identification and intervention, a young child's trajectory is positively impacted.
  - KidSTART is a program designed in partnership with CWS and First 5 to enhance developmental services for children with complex needs by also attending to their mental health needs. Work is done within a multidisciplinary team, working with biological parents in conjunction with a current caregiver.
  - Positive Parenting Program uses the Triple P evidence based practice to offer parenting support and education in Head Start Programs and to military families.
  - Additionally, CYF has programs designated to provide the Incredible Years curriculum and a program that provides services using the Incredible Families model.
  - The Pediatric Symptom Checklist (PSC-35) has replaced the Eyberg Childhood Behavior Inventory (ECBI) assessment tool and will be implemented on July 1, 2018. It will be completed by parents/caregivers of youth 3-18 years at intake, at utilization management/review (UM/UR), and at discharge. The DHCS has mandated the implementation of this measure for all counties in FY 2018-19.

- Older Adults
  BHS has a number of programs that focus on serving older adults. One Strength-Based Case Management FSP program focuses on care coordination and rehabilitation services for adults ages 60 and older with a serious mental illness who may be on LPS Conservatorship or who have needs that cannot be adequately met by a lower level of care. Additionally, some programs have Geriatric Specialists who assist with senior outreach services:
  - Senior IMPACT is an ACT FSP program specifically focused on serving older adults. Their goal is to increase timely access to services and supports in effort to assist older adults and family/caregivers in managing independent living, reducing isolation, improving mental health, and remaining safely in their homes.
  - Elder Multicultural Access & Support Services (EMASS) program provides outreach and support to older adults in effort to reduce ethic disparities in service access and care. The program specifically focuses on multicultural seniors, refugees, and asylees.

- Homeless
  BHS has a strong relationship with community organizations and a number of contracts to focus on homelessness in San Diego County. FSP ACT programs provide comprehensive wraparound mental health services for those adults who are most severely ill and are in most in need due to severe functional impairments. An adult residential transitional housing program provides supportive services for those who are homeless and have a serious mental illness. Additionally, outpatient programs offer homeless outreach services. In September of 2015, the County Board of Supervisors

approved the allocation of up to 10 million dollars in one-time MHSA funding to leverage the development of permanent supportive housing for homeless persons with SMI who are enrolled in FSP ACT programs. The MHSA funding is an addition to 33 million dollars the County has leveraged to create 241 supportive housing units for the homeless. The new funds have enhanced the County's efforts to increase housing stock in the County of San Diego and help create approximately 70 new permanent supportive housing units. To facilitate the implementation of POFA, the County integrated the Department of Housing and Community Development into the Health and Human Services Agency in July 2016. The goal of POFA is to reach and house 1,250 homeless individuals with SMI by the end of 2018. Furthermore, in FY 2016-17, the San Diego Housing Commission (SDHC) collaborated with Housing Development Partners (HDP) to renovate the historic Hotel Churchill in downtown San Diego to create a total of 72 affordable housing units for homeless individuals.

- Persons with Developmental Disabilities

  There is an existing MOU with the San Diego Regional Center for Persons with Developmental Disabilities. There are a number of programs that serve clients with both a developmental delay and behavioral problems throughout San Diego. The SDCBHS Division is engaged in continuous efforts to coordinate care for this population and develop additional resources to ensure access to services. San Diego Regional Center representatives work closely with BHS providers and Administration to ensure communication and collaboration.

- Culturally Diverse Populations

  The Cultural Competence Resource Team (CCRT) comprised of community stakeholders, program representatives, and County staff, serves as the "eyes, ears and conscience" of SDCBHS regarding the development of cultural competence in the delivery of behavioral health services to culturally diverse populations and system-wide adherence to the local Cultural Competence Plan. Mental Health Services staff chairs and actively participates in the CCRT on a monthly basis. The CCRT is a formal mechanism for providing input and feedback on cultural competence to both organizational and contracted individual providers. Members provide such input collectively and conversely bring the message of the CCRT to the community organizations, committees, councils, and advisory boards to which they belong. The CCRT team participated in the planning, formulation and review of the first Disparities Report "Progress toward Reducing Disparities" in FY 2001-02. The most recent report deals with changes in cultural disparities in the behavioral health system over a seven-year period, and the CCRT team continues to be engaged in its review. This report is used to guide SDCBHS in identifying target populations and developing strategies to reduce and eliminate health disparities. Additionally, in Fiscal Year 2013-14, with the support of the Cultural Competence Resource Team (CCRT), the Quality Improvement Unit updated the Cultural Competence Handbook and replaced the *Cultural Competence Clinical Practice Standards* with the Culturally and Linguistically Appropriate Services (CLAS) Standards. CLAS Standards were developed by the Health and Human Services Office of Minority Health and are a comprehensive series of guidelines that inform, guide, and facilitate practices related to culturally and linguistically appropriate health services. They are intended to advance health equity, improve quality, and help eliminate health care disparities. In addition to CLAS Standards, the revised Handbook has been enhanced with the language on trauma-informed systems of care and its infusion into the Cultural Competence Plan development guidelines and most program, staff, and client evaluations. In addition, CLAS Standards provide resources to assist staff in understanding and effectively leveraging the available tools. Additionally, the CCRT Education and Training committee actively participated in the review of the annual and biennial assessments to replace the current cultural competence tools. The Handbook

was further revised in 2017 to include the new cultural competence assessments—The Cultural and Linguistic Competence Policy Assessment (CLCPA) and the Promoting Cultural Diversity Self-Assessment (PCDSA). The revised Handbook was disseminated at the end of 2017 to all providers to assist them with ensuring their adherence to the County and State requirements, and with enhancing their services. Lastly, the CCRT has also participated in ongoing input and review of the development and implementation of all phases of the MHSA Plans. The CCRT also works with QI on performance outcomes and standards for assessing the behavioral health system's cultural competence in servicing culturally diverse populations and recommending data collection strategies. The CCRT also provides annual feedback on and the review of the Cultural Competence Plan, and provided input on the development of the Three-year Strategic Plan in FY 2016-17.

Clients are offered an initial choice of provider including cultural and linguistic alternatives and options. All clients have access to free language assistance. The MHP has policies in place that prohibit the expectation that families will provide interpreter services. Providers' assessment documentation is monitored to ensure that the needs of special populations are being addressed in screening and referral activities. Clients also have the right to request a change of provider, based on cultural and linguistic needs.

The Center for Multicultural Development (CMD) at the California Institute for Behavioral Health Solutions (CIBHS) and the California Department of Health Care Services (DHCS) formed a collaborative with the objectives of: 1) fostering successful partnerships between counties and ethnically and culturally focused community based organizations (CBO) in the implementation of MHSA activities; and 2) providing strategies, training, and tools for developing organizational capacity of ethnically and culturally focused CBOs. In 2010, the County of San Diego identified two agencies, Chaldean Middle Eastern Social Services (CMSS) and Survivors of Torture, International (SOTI) to participate in trainings.

- CMSS' Behavioral Health Program is a community-based, comprehensive outpatient program that addresses the mental health needs of the Chaldean and Middle-Eastern communities in San Diego County with a host of services for individuals, couples, families, and refugees.

- SOTI provides outpatient mental health services to adult and older adult victims of trauma and torture who are seriously mentally ill and to children who suffer from a serious emotional disturbance. SOTI utilizes a comprehensive and integrated approach to provide bio-psychosocial rehabilitation services in the community which are recovery and strength-based, client and family driven, trauma informed, and culturally competent.

These providers continue to deliver culturally specific services and consult on curriculum development as needed when topics pertain to the specific cultures they serve.

In addition, National Alliance on Mental Illness (NAMI San Diego) has helped address the county's current relationship with, engagement with, and involvement in racial, ethnically, culturally, and linguistically diverse groups (e.g., clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the mental health system's planning process for services) through the provision of multiple culturally competent activities. Representatives sit in multiple BHS meetings, workgroups and advisory councils.

The Breaking Down Barriers (BDB) Prevention and Early Intervention (PEI) program uses a Cultural Broker outreach model to create effective collaborations with various agencies, community groups,

participant and family member organizations, and other stakeholders to reduce mental health stigma and increase access to behavioral health services by unserved and underserved culturally diverse communities. The program provides PEI services through the efforts of Cultural Brokers who are individuals known in the local community who provide outreach and engagement support. Some of the services/programs include, but are not limited to: mental health outreach, engagement and education to persons in the Latino, Native American (rural and urban), Lesbian, Gay, Bisexual, Transgender, Intersex, Questioning (LGBTIQ), African, and African American communities; the implementation and evaluation of strategies to reduce mental health stigma; and effective collaborations with other agencies, community groups, participants, and family member organizations. BDB is one of many programs implemented as a result of the MHSA.

A4. INTERAGENCY AGREEMENTS

A4. For clients who require a system of care approach, provide a list of agencies with which the MHP has interagency agreements. Briefly describe the nature of those agreements. As an alternative, the MHP may include copies of any existing interagency agreements and describe any additional interagency agreements planned or in process.

Memoranda of Understanding/Memoranda of Agreement

SDCBHS has Memoranda of Understanding (MOU) and Memoranda of Agreement (MOA) with more than 50 entities and agencies (see Attachment A4 for the complete list).

A5. MEMBER SERVICES HANDBOOK BROCHURE

A5. Provide statement assuring that at least thirty (30) days prior to implementation, the MHP will provide a copy of proposed draft of the MHP's Member Services Handbook/Brochure. The minimum components are: (a) information about accessing services; (b) description of services available; and (c) beneficiary problem resolution processes.

CYF and A/OA Mental Health Services

The MHP provided a draft of the Client and Family Handbook (now called the *State Guide*) to the Department of Health Care Services prior to Phase II implementation. Consumers and family members participated in designing and reviewing the handbook and the finished product. The original handbook included definitions of terms, explanation and location of MHP services, explanation of consumers' rights and beneficiary resolution procedures, access telephone numbers, and addresses and telephone numbers of client and family member organizations.

The handbook is updated as needed and is now being published as *the State Guide.* The handbook is available in San Diego County's six threshold languages: English, Spanish, Vietnamese, Tagalog, Farsi, and Arabic. It is also available in a large print, and the English version is available in an audio format. All beneficiaries receiving MHP services are provided with a copy of the handbook upon entering the system and/or upon discharge from contracted hospitals or residential centers. Providers are required to share the guide information regarding client rights and the client problem resolution process with clients. In addition, the *State Guide* is available in an electronic version on the ASO's website and in hard copy at client-run Clubhouses, all County and County-contracted agencies, and NAMI San Diego.

A6. PROVIDER HANDBOOK

A6. Provide a statement assuring that at least thirty (30) days prior to implementation, the MHP will provide a copy or proposed draft of the MHP's Provider Handbook/Brochure, which will be distributed to providers of the MHP. The minimum components are:
(a) procedures for requesting authorization of services:
(b) procedures for submitting claims for payments;
(c) beneficiary problem resolution processes; and
(d) provider problem resolution processes.

The MHP provided a draft of the *Organizational Provider Operations Handbook* (OPOH) to the Department of Health Care Services prior to Phase II Implementation. The OPOH is revised and distributed as needed, and is available online on the ASO's website and the Technical Resource Library at http://www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html (Section 1). The OPOH contains but isn't limited to: procedures for requesting authorization of services; procedures for submitting claims for payments; beneficiary problem resolution processes; and provider problem resolution processes.

A7. 24-HOUR ACCESS AND CRISIS LINE

A7. Describe how the MHP will provide for 24-hour phone access, including a statewide, toll-free phone line with linguistic capacity.

The MHP provides 24-hour screening, information, and referrals through the Access and Crisis Line (ACL). The ACL (1-888-724-7240) is a statewide, toll-free telephone service, staffed by licensed and specially trained mental health counselors 24 hours/day, 7 days/week. The ACL facilitates access to the mental health system by providing culturally and linguistically appropriate information, referrals, and crisis intervention for children/youth, their families, adults, and older adults who are seeking behavioral health services. It also provides authorization for outpatient and inpatient services. The ACL phone system routes crisis calls to a Crisis Queue for immediate response, while non-crisis calls are routed to the next available ACL staff member. The ACL has a Telecommunications Device for the Deaf (TDD) phone line and a Telecommunications Typewriter (TTY) capability for hearing-impaired clients. The TDD phone number (711) is available 24 hours/day, 7 days/week and is answered by ACL staff. The ASO transitioned from a 10-digit number to the new 3-digit number in effort to enhance accessibility to and availability of services.

The ACL also provides access to the licensed staff and counselors via a Live Chat that is available Monday through Friday from 4pm until 10pm. The Live Chat feature provides emotional support in a time of crisis. If the Crisis Chat specialist determines that the individual is a danger to him/herself or others and the crisis intervention is necessary, the specialist will ask the client to provide a phone number.

To meet the language needs of a significant portion of the San Diego County community, the ACL employs staff who speaks San Diego County's threshold languages as they can, and also uses LanguageLine Solutions for immediate translation services in 150 languages.

B. CONTINUITY OF CARE

B1. PROCEDURES FOR TRANSITION OF SERVICES

B1. For beneficiaries receiving Fee-for-Service/Medi-Cal (FFS/MC) outpatient professional MHP services prior to Phase II consolidation, describe the procedures the MHP will use for the transition of services to protect the continuity of care for beneficiaries. Include procedures:

a) When the existing provider will continue as a member of the plan.

b) When a provider will not continue as a member of the plan.

c) A description of how the individuals and providers who are receiving or providing MHP services prior to Phase II consolidation will be notified of the MHP policies and procedures

a) WHEN THE EXISTING PROVIDER WILL CONTINUE AS MEMBER OF THE MHP

During the initial implementation in June 1998, CYF MHS established the criteria for authorization of outpatient services for beneficiaries that were designed by representatives from the public, private, and family sectors. All providers who continued as members of the MHP received training on the criteria for outpatient authorization. Providers from San Diego County designed the criteria for payment authorization of A/OA Mental Health outpatient services for beneficiaries. The providers, along with representatives of A/OA MHS, clients, family members and advocates, met as part of a Care Management Design Process. All providers who continued as members of the MHP received training on the criteria for outpatient services.

Since the initial implementation, all providers who contract as members of the MHP receive training on the criteria for outpatient services. The detailed process and additional information are available in Attachment F3.

b) WHEN A PROVIDER WILL NOT CONTINUE AS MEMBER OF THE MHP

Providers who elect to not be members of the MHP or are no longer eligible to participate as a contracted provider are requested to identify which of their clients require ongoing outpatient therapy. The MHP contacts those clients offering a choice of MHP providers. If the client chooses to remain with his or her current provider, and the provider is not interested in continuing as an MHP provider, the MHP may extend a limited provider status accommodation to the provider for a specific individual client, as possible. In all instances, SDCBHS works diligently to ensure client continuity of care and to facilitate smooth transitions. In all cases, the providers must meet the MHP credentialing criteria.

c) NOTIFICATION OF MHP POLICIES AND PROCEDURES

When Phase II of mental health managed care was implemented, measures were taken to ensure that beneficiaries currently in treatment who met medical necessity guidelines would not experience delays or disruptions in their care. In FY 1998-99, the MHP contracted with all willing and eligible current Medi-Cal practitioners and organizational providers (defined as any provider who submitted a claim for services within the prior two years).

All MHP practitioners who had submitted claims for FFS Medi-Cal in the two years prior to 1998-99 were sent an application packet. Between February 10 and March 6, 1998, credentialing applications were mailed using the State-provided list of Medi-Cal practitioners. In addition, organizational and group providers were contacted for names of their providers who would need to be credentialed. Finally, health maintenance organizations were contacted to offer their practitioners the opportunity to be credentialed and to continue providing mental health services to Medi-Cal clients within the HMO. Professional psychiatric and psychological discipline associations were also contacted. Fliers were posted and notices published in newsletters about the need for providers to be credentialed in order to continue to provide reimbursable mental health services to Medi-Cal beneficiaries.

The application packet included:

- An application form.
- A letter outlining the basic requirements for inclusion in the MHP network of providers and procedures for submitting the application.
- Medical necessity criteria for reimbursement of MHP services.
- The *Clinical Assessment and Update Report* for listing current Medi-Cal client names and information.
- Information fliers to be given to current clients explaining the transition policy and procedures.

Approximately 350 applications were initially returned, processed, and forwarded for verification. The list of providers who returned applications was cross-referenced to the lists that had been used by the DHCS to determine who did not respond to the initial mailing. Particular attention was paid to those who had shown large billings (in excess of $20,000) to Medi-Cal in the prior two-year period. The providers were contacted to determine why they had not responded. Providers who chose not to continue to provide Medi-Cal services were offered assistance in transitioning current clients to other credentialed Medi-Cal providers.

In addition, the list of returned applications was sorted geographically to determine response by region. When a particular region appeared to be low in number of overall providers, all available mailing lists were examined to recruit providers who had not responded in the potentially underserved areas. The providers were contacted to determine if they would be interested in providing services or if there were particular reasons that might be negotiated. When there was limited response within a region, the MHP actively sought provider participation through contact with local groups, at provider meetings, and through publications. A limited number of licensed LCSWs and MFTs were added to the network because of their expertise in child protection cases and/or unique linguistic or cultural abilities.

Information to beneficiaries regarding the possibility of transitioning to another provider was included in the *Managed Care Handbook* and other communications to consumers. The handbook was distributed to organizational providers, individual providers, socialization and self-help centers, and the MHP ASO staff to be distributed directly to beneficiaries. The MHP

ASO provided question and answer sessions for beneficiaries regarding the changes under Phase II consolidation.

All beneficiaries were offered a copy of the *State Guide*.

Today, the ASO manages a panel of more than 650 FFS providers and regularly conducts recruiting activities. All applicants are required to submit an application and supporting documentation, including, but not limited to: State license, resume, and appropriate provider numbers. The ASO's staff confirms receipt of the application within three business days and reviews for completeness. The completed applications are then submitted to the County's Credentialing Committee, which meets monthly. The applicants are notified within 10 business days of the committee's decision. Additionally, all beneficiaries have access to information on the ASO's website at www.optumsandiego.com.

C. INTERFACE WITH PHYSICAL HEALTH CARE

C1. HOW MHP WILL INTERFACE

C1. Describe how the MHP will interface with physical health care providers and provide clinical consultation and training when a beneficiary belongs to a physical health managed care plan and/or when the beneficiary has a FFS/MC primary health care provider.

a) Referral protocols between plans, including how the MHP will provide a referral to physical health care-based treatment.

b) The availability of clinical consultation, including medications, between plans.

c) Exchange of critical medical records information within agreed upon confidentiality guidelines.

d) A process for resolving disputes between plans.

MHP INTERFACE WITH PHYSICAL HEALTH PROVIDERS

In an effort to strengthen coordination of care between providers, BHS convened three Learning Community cohorts in FY 2010-11. Each cohort had representatives from substance abuse, mental health and primary care who went through change management training and were then grouped by geographic region into triads. The goal of the triads was to facilitate substance use, mental health and primary care providers' understanding of the services offered in their areas and to provide a strengthened referral process. After the initial meetings, many of the triads continue to meet regularly to discuss referral protocols and better care coordination, and to learn more about the services that each member of the group provides. Some triads have created referral/transfer forms that are tailored to their needs and assist in providing necessary information to best serve their shared clients.

In March 2014, a Learning Community focused on serving the needs of children was also convened and continues to meet to streamline services and provide a more integrated experience for children and their families. Additionally, the Learning Community hosts an annual Primary Care and Behavioral Health Integration Summit, with the first one held in 2010.

a) Referral Protocols

When medical consultation is determined to be needed, the MHP provider or the MHP Medical Director (or designee) refers beneficiaries to their primary care physician, if known, or their physical health care provider plan. The physical health plan physician is given information about reasons for, or observations of, medical need.

SDCBHS has developed a Coordination of Care Form—a protocol for coordination of care with primary care physicians and behavioral health providers—and all County and County-contracted programs are required to utilize the form. It is available in all six threshold languages. The Coordination of Care Form in English can be found in the Attachment C1.

b) Availability of Clinical Consultation

The MHP Medical Director is available to physical Health Care Plan physicians/providers for consultation regarding coordination of beneficiary care between physical and mental health care, treatment of mental health conditions by primary care providers, and medication issues.

The MHP will offer clinical consultation to the health plan providers, including the providers at Indian Health Clinics and Federally Qualified Health Centers (FQHC), regarding various mental health conditions and diagnoses which primary care physicians may be treating or for which they might require referral to the MHP for diagnosis and treatment. Other efforts may include collaboration on clients and issues regarding psychotropic medications. Furthermore, SmartCare Behavioral Health Consultation Service (BHCS) offers real time access to psychiatric and behavioral health treatment consultation, in conjunction with the MHP, to FQHC, Indian Health Clinics and Centers, and primary care physicians. SmartCare BHCS services are funded by SDCBHS.

All consultation activities are within State and Federal regulations.

c) Exchange of Medical Records

The MHP requires that each mental health provider obtain a release of information from the beneficiary. Using a standardized form and following all state and federal confidentiality guidelines, the providers communicate with physical Health Care Plan physicians regarding treatment and medication rendered to the beneficiaries.

d) Resolving Disputes

The MHP notifies the physical Health Plans of the appropriate MHP person to contact for dispute resolution. If the MHP has a dispute with a physical Health Plan:

The MHP:

- Documents specifics and suggests acceptable solutions, and
- Forwards the document to the contact person at the physical Health Care Plan.

The physical Health Care Plan:

- Sends a response within 15 calendar days, and
- Consults with appropriate administrative and clinical personnel to determine if the response is acceptable.

If the response is not acceptable, the MHP contact person and/or other appropriate personnel meets with physical Health Care Plan contact personnel at the physical Health Care Plan to negotiate a solution.

While the dispute is being resolved, the client will continue to receive medically necessary services, including specialty mental health services and prescription drugs.

Both the Plans and the MHP agree to follow the dispute resolution process in accordance to Title 9, Section 1850.505, and the contract between the Plans, DHCS and Centers for Medicare & Medicaid Services (CMS).

D. ACCESS, CULTURAL COMPETENCE, AGE APPROPRIATENESS

Under a 1915(b) waiver from the Health Care Financing Administration (HCFA), access to Medi-Cal MHP services must be maintained or enhanced under the waivered program. Section 14684 W&I Code requires the delivery of culturally competent and age appropriate services to the extent feasible.

D1. LEVEL OF ACCESS

D1. Describe the level of access to Phase II FFS/MC MHP services, which existed prior to consolidation.

To date, SDCBHS has more than 650 FFS providers. In the Fiscal Year 2016-17, 15,242 CYF clients received outpatient services, out of which 90 percent (13,782) of clients had Medi-Cal. A total of 2,663 CYF clients received outpatient FFS mental health services. Additionally, 16,535 A/OA clients received outpatient services, out of which 82 percent (13,632) of clients had Medi-Cal. A total of 11,738 A/OA clients received outpatient FFS mental health services.

In FY 2016-17, the CYF SOC delivered behavioral health services to 15,839 clients, 49 percent of whom were adolescents ages 12-17, 34 percent were school-age clients ages 6-11, and 12 percent were children ages 0-5. Furthermore, access to services among Hispanic children and youth has increased from 2.8 to 5.1 percent from FY 2001-02.

In FY 2016-17, the A/OA SOC delivered behavioral health services to 42,767 clients. The majority of the clients (69 percent) were ages 26-59. Access to services has increased from 3.5 to 4.3 percent among Hispanic A/OA clients, from 17.9 to 18.1 percent among African American A/OA clients, and from 3.6 to 4.1 percent among Native American A/OA clients since FY 2001-02.

In the first quarter of FY 2017-18, the interpreter services provided interpretation in five of six threshold languages in San Diego County (not including English): 14,844 services in Spanish, 1,510 services in Arabic, 941 services in Vietnamese, 75 services in Farsi, and 108 services in Tagalog.

D2. GEOGRAPHIC ACCESS, SPECIAL POPULATIONS, UNDER 21 YEARS

D2. Describe:

a) How access to Medi-Cal MHP services will be maintained under Phase II consolidation, including a geographical access to services.

b) How the MHP will maintain access for special populations.

c) How the MHP will assure adequate service capacity for full-scope Medi-Cal beneficiaries under age 21.

ACCESS TO SERVICES

a) How Access will be Maintained Under Phase II Consolidation

Access to MHP services has been maintained and improved under Phase II consolidation by ensuring that beneficiaries are informed of the availability of services and how to access them, and by ensuring that appropriate types of specialty mental health services are available within each region of San Diego County.

The plan to ensure public knowledge about how to access MHP services includes several information and education opportunities, such as:

- Distributing the *State Guide,* the *Quick Guides* and the brochure on the beneficiary problem resolution process in five threshold languages.
- ACL informational flyers distributed to MHP programs and other community resources.
- Speaking engagements at community meetings attended by clients.
- Outreach at community health and resource fairs.

Goals have been established for the appropriate number, type and geographical distribution of providers. The SDCBHS is tracking progress towards the goals. In addition, the SDCBHS is analyzing possible gaps in the accessibility of services by tracking wait times for routine and urgent mental health assessments, client grievances and appeals, and results of client satisfaction surveys.

The San Diego County's Prevention and Early Intervention (PEI) funding has allowed for the addition of Health Promotion Specialists (HPS) who are located throughout the regions and have their own established networks wherein they deliver health promotion messages. The HPS' goal is to work with Mental Health Services and their contractors to: enhance suicide prevention efforts; reduce stigma and discrimination; and increase the number of individuals/families from underserved populations who receive prevention programs and early intervention services.

b) Access and Special Populations

San Diego County special populations include, but are not limited to: Transition Age Youth (TAY), older adults, homeless, deaf and hard-of-hearing, non-English-speaking clients, and those with co-occurring diagnoses of mental illness and substance use. Consideration of special populations is included in all current and future service planning when possible augmentation of funding is occurring to expand program capability to provide services to identified special need populations.

Key points about access include:

- The *State Guide (previously, Client and Family Handbook)* is available in six threshold languages: English, Spanish, Vietnamese, Tagalog, Farsi, and Arabic. Clients also have access to the *Quick Guides* in all six languages.
- ACL information distribution and language interpretation availability.
- LanguageLine Solutions is used to translate for callers or others who are monolingual non-English speakers. Funding is available for interpreter services for the hearing impaired. Information about the ACL has been distributed to MHP programs and other community resources.
- For the hearing impaired, the ACL maintains a TDD (Telecommunications Device for the Deaf) on a separate number and has Telecommunications Typewriter (TTY) available.
- County-operated and Country-contracted programs employ staff who speak San Diego's threshold languages, and ensure that an interpreter is available to clients who request a specific language.

c) Full Scope Medi-Cal Beneficiaries under Age 21

On January 1, 2010, the CYF SOC outpatient treatment system transitioned from a time-based to predominately a session based short-term model. All service providers were trained on the system, with written procedures outlined in the OPOH. The utilization management system was designed to allow for episodic services when needed with an emphasis on allowing children and youth to experience success and practice resiliency and discovery.

With the transition of the Healthy Families program to Medi-Cal in 2013 and implementation of the Affordable Care Act (ACA) on January 1, 2014, the CYF SOC implemented a more comprehensive screening system. Closer coordination with Care 1st Health Plan, Community Health Group, Health Net, Kaiser Permanente, Aetna, UnitedHealthcare, and Molina Healthcare—the seven current local Medi-Cal Health Plans—is instrumental in getting children and youth to the right level of care.

Additionally, the MHP assures adequate service capacity for full scope Medi-Cal beneficiaries under 21 years of age by:

- Supporting FFS practitioners in all geographic areas who wish to contract with the MHP to be credentialed when they meet requirements.

- Providing training and encouraging system of care participants to utilize evidence-based and evidence informed practices which allow for focused and timely treatment.

- Providing community based services through numerous providers countywide which closely monitor their access time to meet the County goal of an average of up to five business days.

- Providing services in over 412 schools, serving over 52 percent of the schools in the County of San Diego.

- Working closely with CWS to offer Pathways to Well-Being services in a coordinated manner while monitoring capacity.

- Assuring access to ACT programs for a full range of services such as: routine outreach and engagement; crisis intervention; intensive case management; mental health services; care coordination; short-term, transitional and permanent supported housing services; supported education/employment services and skill development; and rehabilitation and recovery services.

D3. PROCEDURES FOR 24-HOUR AVAILABILITY OF SERVICES

D3. Describe procedures the MHP will use to provide for 24-hour availability of services to address urgent conditions for beneficiaries who need services when: a) in County; or b) out of County. Describe how back up will be provided: c) if a single practitioner is not available or on call.

AVAILABILITY OF 24-HOUR SERVICES

A. In County

In San Diego County, beneficiaries may call the statewide toll-free ACL 24 hours/day, 7 days/week. A specially trained mental health professional answers the call in the crisis queue within 45 seconds and the call in all other queues within 60 seconds, and provides crisis counseling, mental health risk screening, problem solving, education, and referrals. In urgent, emergent or routine situations ACL staff provides referrals and authorizations to the most appropriate MHP or community resource.

In addition to the ACL, MHP specialty mental health services that are available 24/7 include inpatient services, crisis residential programs, PERT, EPU, and ESU. EPU and ESU also provide crisis stabilization services. Additional crisis stabilization services are provided at two FFS hospitals in North Inland and North Coastal Regions.

B. Out of County

San Diego County's Medi-Cal beneficiaries who need assessment and treatment due to an urgent condition when they are outside of the County may call the County of San Diego MHP statewide toll-free ACL at 1-888-724-7240.

- The ACL authorizes both inpatient and outpatient services for CYF and A/OA Medi-Cal beneficiaries experiencing urgent or emergent conditions when they are out of San Diego County, including San Diego County residents who are unable to return to the County for treatment.

- The ACL authorizes outpatient services for children and youth Medi-Cal beneficiaries who are in a Kinship Guardianship Assistance Program (KinGAP). Aid to Adoptive Parents (AAP), or Foster Care as specified by SB 785 when they are out of San Diego County.

- Requests for authorization for children and adolescents in out-of-county placements, such as foster care or residential placement are referred to the ASO.

- The County manages requests for TBS for San Diego youth residing out of County through the administration division of the CYF System of Care.

SDCBHS is aware of the upcoming implementation of Assembly Bill 1299 and will ensure that foster children who are placed outside of their county of original jurisdiction are able to access mental health services in a timely manner consistent with their individualized strengths and needs as well as the requirements of EPSDT program standards and requirements.

C. Availability of MHP Providers

MHP providers are required to be available for clients' urgent needs on a 24-hour basis, using one or more of the following methods:

- 24-hour availability by pager.
- A crisis plan which indicates what after-hours providers and services are available to the client.
- A plan for back-up coverage when the MHP provider is unavailable.

The MHP Provider Agreement specifies the requirement to be available for urgent needs on a 24-hour basis. Providers are also asked to update their back-up plans in the course of providing clinical treatment, for use when they are not available.

D4. OUT-OF-COUNTY ACCESS

D4. Describe how access will be ensured for beneficiaries living out of County when there may or may not be an in-plan provider available. This includes children in foster care placements and adults in residential placements, as well as other individuals who may seek mental health services in another county.

Out-of-county beneficiaries wishing to seek mental health services may contact the ACL at 1-888-724-7240 for authorization or information.

For San Diego County adults in residential placement, and adults and children who are temporarily out-of-county, or who have recently moved out of San Diego County, the MHP refers the clients to a currently contracted individual or group provider if there is one available or administers a Letter of Agreement for an out-of-network Provider. See Attachment F3 for more details on the authorization process.

SDCBHS is aware of the upcoming implementation of Assembly Bill 1299 and will work with other counties to ensure that foster children who are placed outside of their county of original jurisdiction are able to access mental health services in a timely manner consistent with their individualized strengths and needs as well as the requirements of EPSDT program standards and requirements.

D5. LANGUAGES, VISUAL/HEARING INFORMATION

D5. Describe: (a) the languages in which MHP information will be available; (b) the standards for making these determinations; and (c) how the MHP will provide information for persons with visual and hearing impairments.

a) LANGUAGES

MHP information that has been translated from English into the other five identified threshold languages (Spanish, Vietnamese, Tagalog, Farsi, and Arabic) includes: the *State Guide, G*rievance and Appeal posters and brochures, Advanced Directives brochures, Notice of Privacy Practices, ACL flyers, and other documents, as needed per the target population.

b) STANDARDS

State guidelines define English, Spanish, Vietnamese, Arabic, Farsi, and Tagalog as the threshold languages for San Diego County. The guidelines are based upon the percent of the beneficiary population who speak a given language (>5% indicates a threshold language) and upon the number of persons in the beneficiary population who speak a given language (>3,000 indicates a threshold language).

c) VISUAL AND HEARING IMPAIRED

The ACL includes Telephonic Device for the Deaf (TDD) and the Telecommunications Typewriter (TTY) capability for hearing-impaired clients 24 hours/day, 7 days/week. The TDD number is free locally. Many of the organizational providers also have TDD capability, but those who don't, have been informed by the MHP about the availability of the California Relay Service for hearing-impaired consumers. The MHP contracts with a community-based agency to provide specialty mental health services for the deaf and hard of hearing, as well.

A large print version of the *State Guide* is available on the ASO's website. The *Quick Guide* has been produced as a fourfold brochure in English, Spanish, Vietnamese, Tagalog, Farsi, and Arabic, and is updated regularly. The *Quick Guide* is also available in hard copy, and the English version is available in an audio format.

D6. PROVIDER CHOICE, SECOND OPINIONS

D6. Describe the process for ensuring that the beneficiary will: (a) have a choice of practitioner whenever feasible; and (b) availability of second opinions when there is a dispute regarding medical necessity and the MHP denies services.

a) CHOICE OF PROVIDER

Every attempt is made to match beneficiaries to a provider whose culture, language, geographic location, and specialty credentials fit the client's service needs and stated preferences.

A choice of approximately three providers is offered during the initial ACL referral process. A beneficiary may choose a provider at that time or may be given the telephone numbers for each of the three providers so that the caller can choose after learning more about each provider directly. If the beneficiary is not satisfied with any of the choices, other MHP providers may be offered by the ACL until the beneficiary is matched with an appropriate provider.

Beneficiaries may also request the following by phone or in writing:

- A list of all providers by region that includes available information on culture and language.
- Referral to another provider in the event that during the initial assessment the beneficiary decides that the original provider does not meet his/her needs.
- Referral to another provider due to a change of address for either the provider or the beneficiary; a change in the diagnosis or focus of treatment; an irreparable breach in the therapeutic alliance; and/or any issues which would impede the beneficiary's successful completion of treatment.

Additionally, the San Diego County providers, clients, and the community have access to the Network of Care for Mental/Behavioral Health that is accessible at http://sandiego.networkofcare.org/mh/. It is an online information portal for individuals, families and social service agencies concerned with community mental health services, substance use treatment programs, and help for people with developmental disabilities. The website ensures the "No Wrong Door" for those navigating the system of behavioral health resources, those working to avoid the need for format services, and those ready to transition out of the behavioral health system. The website and the documents are accessible in 14 human-translated languages and in over 80 languages through Google translation. The visitors can select a preferred language by selecting the "Change Language" option on the left side of the home screen, selecting "Service Directory" once the preferred language has been chosen, and browsing the categories to access service providers.

Beneficiaries can also provide feedback to their provider. Providers then submit this information quarterly to the MHP to track. This is referred to as the Suggestion and Transfer Log. Providers are required to report transfer requests on the Suggestion and Transfer Log which is part of the required Quarterly Status Report, as stated in the *Organizational Provider Operations Handbook* (OPOH).

In FY 2016-17, a total of 127 transfer requests were received (53 CYF and 74 A/OA). The top three reasons for transfer requests in the CYF and A/OA SOCs were:

- Preference: Client does not like provider (31 and 43, respectively).
- Gender/Sexual Orientation: Client requests provider with a specified gender or sexual orientation (7 and 14, respectively).
- Availability: Provider not available during hours client can make appointments or client cannot wait until next available appointment (5 and 10, respectively).

b) SECOND OPINION

The *State Guide* and the *Quick Guide* inform clients that they have the right to request a second opinion for the purpose of assessment or clarification of a diagnosis and/or treatment intervention or in the event that the MHP denies, reduces, or terminates services. In addition, callers to the ACL are informed of the right to a second opinion.

The MHP arranges for a second opinion by an individual or group provider who is part of a panel of contracted providers available for second opinions through the ASO. The MHP may gather additional information from the beneficiary regarding their request in order to match the beneficiary with an appropriate provider.

D7. WRITTEN LOG OF INITIAL CONTACT

D7. Describe procedures the MHP will use to maintain a written log of initial contact (telephone, written, or in person) by beneficiaries requesting MHP services from the MHP.

ACCESS AND CRISIS LINE

All initial ACL contacts with beneficiaries, providers, family members, and others regarding a beneficiary, are documented in the Daily Log that includes name, date, and the reason for the call. Such contacts include:

- Calls to the ACL: requiring crisis intervention
- Requests for provider referral
- Questions about authorizations
- Beneficiary problems
- Appeals of authorization decisions
- Questions from providers regarding reimbursement
- Contacts for the purpose of care coordination and case management

ORGANIZATIONAL, INDIVIDUAL AND GROUP PROVIDERS

All contracted MHP providers are instructed to maintain a Request for Services Log with the following information: date and type of inquiry, disposition, client's preferred language, client's race/ethnicity, dates of first appointment offered and appointment chosen, and referral information. The Request for Services Logs are submitted to QI monthly. The QI Unit has been working to develop the Access to Services Journal and integrate it into the Electronic Health Record (EHR). The Journal will be implemented in FY 2018-19.

E. CONFIDENTIALITY

E1. POLICIES AND PROCEDURES REGARDING CONFIDENTIALITY

E1. Describe any changes in current or planned policies and procedures to continue to assure compliance with all applicable state and federal laws and regulations to protect beneficiary confidentiality.

The County of San Diego MHP abides by and complies with all applicable state and federal laws and regulations regarding confidentiality. In order to safeguard against intentional or unintentional destruction, modification, or disclosure of information, access to client data is restricted to individuals who have a need, reason, purpose, and permission to receive or review the information.

The MHP has developed and implemented policies and procedures that include safeguards for confidentiality and prevent unauthorized access to all patient information, including electronically stored patient data.

The policies and procedures require that each person accessing the Management Information Services (MIS) use a valid password and log-on identification, which is then mapped to a security-level profile defining and controlling the individual's level of access to data and documenting usage. Staff security levels are assigned and monitored jointly by provider and MHP management.

The disclosure of statistical or summary data in which a beneficiary cannot be identified meets regulatory compliance regarding confidentiality. The disclosure of information for research purposes is reviewed and approved through appropriate institutional review boards and is also approved by the MHP Research Committee.

MHP policy, referencing applicable Welfare and Institutions Code sections, clearly informs staff of their responsibilities regarding the confidentiality of patient information and delineates sanctions if trust is breached.

F. QUALITY IMPROVEMENT, UTILIZATION MANAGEMENT PROGRAMS

F1. QUALITY IMPROVEMENT PROGRAM

F1. Describe the MHP's Quality Improvement (QI) Program. MHPs may attach supportive documentation such as organizational charts, process descriptions, and policies and procedures to satisfy any of the following required elements of this section. The description must include the QI program description of structure and process, including the following:

a) The role, structure, function, and meeting frequency of the QI Committee and other relevant committees.

b) How practitioners, providers, consumers, and family members will describe how the relationships meet DMH standards.

c) *If the MHP delegates any QI activities to a separate entity, the MHP will describe how the relationship meets DMH standards.*

QUALITY IMPROVEMENT PROGRAM

The purpose of the SDCBHS QI Program is to ensure that all clients and families receive the highest quality and most cost-effective mental health, substance use, and administrative services available.

The QI Program delineates the structures and processes that will be used to monitor and evaluate the quality of mental health and substance use services provided. The QI Program encompasses the efforts of clients, family members, clinicians, mental health advocates, substance use disorder services, quality improvement staff, and other stakeholders.

The QI Program and QI Work Plan (QIWP) are based on the following values:

- Development of QI Program and QIWP objectives is completed in collaboration with clients and stakeholders.
- Client feedback is incorporated into the QI Program and QIWP objectives.
- QI Program and QIWP are mindful of those whom data represent and, therefore, integrate client feedback to improve systems and services.

The scope of the MHP QI Program is comprehensive. The QI Unit monitors the services provided for safety, effectiveness, responsiveness to clients, timeliness, efficiency, and equity. Key variables related to practices and processes performed or delivered by service providers that affect the outcome of services to client and family members are measured and analyzed on a weekly, quarterly, and annual basis. QI staff performs medical record reviews and tri-annual site reviews/Medi-Cal Certification reviews. Access times, serious incidents, results of medication monitoring, and grievances and appeals are tracked and trended. Surveys are conducted to monitor client and provider satisfaction.

The following are components of the QI Program structure:

- Executive Quality Improvement Team (EQIT)
  The EQIT is responsible for implementing the QI Program, responding to recommendations from the Quality Review Council (QRC), and identifying and initiating quality improvement activities, as indicated. The EQIT consists of BHS Director, BHS Clinical Director, Deputy Directors, and QI Chief.

- Quality Review Council (QRC)
  The QI Program includes the QRC, which is a standing body charged with the responsibility to provide recommendations regarding the quality improvement activities for mental health and the QIWP. The QRC meets every two months, and the members are clients or family members, as well as stakeholders, from the behavioral health and substance use health communities across all regions. The QRC provides advice and guidance to SDCBHS on developing the annual QIWP, including identification of additional methods for including clients in quality improvement activities; collection, review, interpretation, and evaluation of quality improvement activities; consideration of options for improvement based upon the report data; and recommendations for system improvement and policy changes.

- Quality Improvement Performance Improvement Team (QI PIT)
  The QI Program includes the SDCBHS QI PIT, which monitors targeted aspects of care on an on-going basis and produces reports monthly, quarterly, or annually. High-volume, high-frequency, and high-risk areas of client care are given priority. So opportunities for improvement can be identified, the QI PIT collects data which are analyzed over time and used to measure against goals and objectives. Reports in each of these areas are periodically brought to the EQIT and QRC for input.

- Quality Management (QM) Team
  The QM team is another component of the QI program and is comprised of Quality Improvement Specialists—licensed therapists and clinicians—who conduct a variety of reviews, audits, trainings, and other quality improvement functions for both County-operated and County-contracted programs.

- Management Information Services (MIS) Team
  The MIS team, another component of the QI Program, provides data management and systems support to BHS client management system users, including but not limited to service providers, administrative and support staff, and BHS staff.

- Quality Improvement Committees (QICs)
  The QICs are subcommittees of the QRC composed of QRC members and QI staff. Subcommittee minutes and activities are monitored by the QRC. The current QRC Subcommittees are:
  - QRC Membership Committee
  - Serious Incidents (ad hoc committee)
  - Peer and Family Employment Subcommittee

The goals of the Quality Improvement Program are to:

1. Identify important practices and processes where improvement is needed to achieve excellence and conformance to standards.
2. Monitor these functions accurately.
3. Draw meaningful conclusions from the data collected using valid and reliable methods.
4. Implement useful changes to improve quality.
5. Evaluate the effectiveness of changes.
6. Communicate findings to the appropriate people.
7. Document the outcomes.

All indicators of quality, along with acceptable standards, are based on nationally and regionally established standards (when available), State, Federal, and County regulations, and/or the specific needs of client, family members, providers, and stakeholders.

The QIWP is monitored and revised on an on-going basis. Additional QI activities may be added during the year based on requirements from the County or the State, recommendations by the QI Committee or other stakeholder group, or may be based on observed patterns, trends, or single occurrences.

A formal evaluation of the QIWP is conducted annually. The evaluation includes a summary of completed and in-process quality improvement activities, results and interventions planned that would impact the process, and the need for process revisions, and modifications. Evaluation findings are used to revise the QIWP as needed.

a) Role, Structure and Function of the QRC

The role and function of the QRC is to ensure stakeholder input to the MHP's QI Program. Through participation in the QRC, San Diego County clients, family members, and providers actively contribute in the planning design and execution of the QI Program. The QRC reviews the planned QI activities, evaluates the results of QI activities, recommends policy changes, institutes needed QI actions, and ensures follow-up of QI processes.

The QRC membership includes licensed mental health professionals, consumers, and family members. New members are added as needed, and submit an application to the QRC membership committee. Culture is considered during the member selection process. The QRC meets every two months. Minutes are kept of each meeting including the general discussion, topic findings, policy recommendations, actions proposed/taken, rationale for each decision and follow-up.

See Attachment F1 for details on the purpose, composition, charges, and procedures of the QRC.

b) Relationship with Practitioners, Providers, Consumers, and Family Members

Stakeholders' and family members' concerns are actively solicited and valued as part of the QI Program. Clients, family members, and providers continue to participate in the QRC, BHAB, and the SOC advisory councils. The results of QI activities are also reported in various venues, including but not limited to: regional monthly organizational provider meetings, quarterly Leadership meetings, QI trainings, the Clinical Standards Committee, the Mental Health Contractor's Association Executive meetings, and Quality Improvement Partners (QIP) meetings.

c) Delegation of QI Activities to a Separate Entity

From October 1997 through June 30, 2000, the MHP contracted with an ASO to provide Quality Improvement services. On July 1, 2000, quality improvement activities became the responsibility of the QI Unit of SDCBHS and continue to date.

F2. ANNUAL WORK PLAN

F2. Provide an assurance that within ninety (90) days after implementation, the MHP will have completed an annual work plan to include the requirements in Attachment 2, Section 2.

Within ninety (90) days after Managed Care Phase II Implementation, an annual work plan was completed and submitted to the DHCS for approval.

The QIWP is revised annually, and the FY 2017-18 QIWP has been included in Attachment F2.

F3. UTILIZATION MANAGEMENT PROGRAM

F3. Describe the MHP's Utilization Management (UM) Program. MHPs may attach supportive documentation such as organizational charts, process descriptions, and policies and procedures to satisfy any of the following required elements of this section. The description must include the UM program description of structure and process, including the following:

a) The authorization process used by the MHP, including the process by which the MHP obtains relevant information to support its authorization decisions.

b) If the MHP delegates any UM activities to a separate entity, the MHP will describe how the relationship meets DMH standards.

The MHP has policies in place for all county and contracted organizational providers regarding managing service utilization for all outpatient and case management services. The MHP has contracted with the ASO, to provide utilization management functions for all FFS outpatient services, day treatment services and inpatient services. The role and responsibilities for the ASO monitoring utilization management activities are included in the contract between the MHP and the ASO. The MHP will continue to have oversight of utilization management activities and review them at least annually to monitor consistency of the authorization for payment procedure. SDCBHS is currently in the process of reviewing systems to ensure compliance with Parity Requirements under the Medicaid Managed Care Final Rule regulations. If the current utilization management process is changed, it will be reviewed by the following stakeholder groups prior to implementation:

- San Diego County MH Contractors' Association
- County of San Diego Behavioral Health Advisory Board
- System of Care Advisory Councils

For complete details on the current Utilization Management Process, see Attachment F3.

G. PROBLEM RESOLUTION PROCESSES

G1. BENEFICIARY PROBLEM RESOLUTION PROCESS

G1. Beneficiary Problem Resolution Processes: Describe how the MHP will respond to beneficiary concerns regarding service-related issues in compliance with statewide requirements specified in Attachment 4.

The MHP's Beneficiary Problem Resolution Process was developed through a public planning process and is in accordance with Title 9 regulations. Written information regarding the resolution process for grievances, appeals, and State Fair Hearings is available to Medi-Cal beneficiaries at all provider sites. Providers are required to share information regarding the problem resolution process with all new clients, and annually with each continuing client. The information is posted in prominent locations at provider sites and includes the telephone numbers of the agencies contracted by the MHP to provide a problem resolution process. The beneficiaries are also encouraged to speak directly with the provider or with program management regarding dissatisfaction with treatment or medication. SDCBHS is currently reviewing the Beneficiary Problem Resolution Process and stated timelines to align with Medicaid Final Rule regulations. See Attachment G1 for detailed information on current processes.

G2. PROVIDER PROBLEM RESOLUTION PROCESS

G2. Provider Resolution Process: Describe how the MHP will respond to concerns from providers on any issue, including denial of payment authorization and claims processing delays, in compliance with statewide requirements specified in Attachment 5.

Providers have access to both informal problem resolution and formal appeals procedures.

INFORMAL PROBLEM RESOLUTION PROCEDURES

- **Service and Authorization-Related Problems**
  Problems may arise when there are disagreements about medical necessity, level of care placement, the intensity and frequency of treatment, and other issues related to authorizations or the care of the client. The ASO staff are responsible for authorization decisions (Care Managers, ACL staff, and the ASO medical director), and work to resolve disagreements with providers as expeditiously as possible. Important elements of informal problem resolution include a collaborative approach to communicating with providers along with flexible and individualized application of policies and procedures.

  The informal procedures include:

  - Negotiated resolution by authorization staff.
  - Pending authorizations while awaiting more information.
  - Mediation by supervising managers.
  - Expedited review by medical director or other physician advisor available immediately by phone.

  Negotiations may involve a mutually agreed upon level of care or a trial of an alternate level of care.

- **Claims Payment Problems**
  Claims-related problems and questions are handled by the ASO's Claims Unit, which processes claims and makes payments to providers. Claims Services Representatives are available for phone consultation about the status of the claims. Most questions can be answered immediately. Those that cannot be handled immediately usually require investigation of service authorization or further information from the provider for clarification of the claim.

PROVIDER APPEALS PROCESS: LEVELS I AND II

Should the outcome of the appropriate informal resolution procedures result in a decision that is unsatisfactory to the provider, the provider is informed about the available appeal procedures. The Title 9 appeals procedure is followed for processing provider appeals. See Attachment F3 for a description of the formal denial procedures.

- **Level I Clinical Appeal**
  Should the outcome of the review with the ASO medical director result in a decision that is not satisfactory to the provider, the provider may submit a formal appeal, known as a Level I appeal, by:

  - Submitting a written request for a review of the denial; and
  - Submitting in writing all relevant data, documents or comments that support the medical necessity of the services requested.

  This information must be filed within ninety (90) days of the date of the denial of payment letter and is reviewed by an ASO psychiatrist not involved in the original decision. A written response is sent to the provider within sixty (60) days of receipt of the appeal.

- **Level II Clinical Appeal**
  If a Level I Appeal is upheld, and the provider chooses to appeal that decision, the provider may initiate a Level II appeal. The provider is required to send a letter and documentation to support the appeal to the DHCS within thirty (30) days of receipt of the Level I appeal decision.

- **Expedited Appeal**
  In accordance with Title 9, Providers may request an expedited appeal when it has been determined by the MHP or the beneficiary's provider that taking the time for the standard appeal resolution could seriously jeopardize the beneficiary's life, health or ability to attain, maintain or regain maximum function.

  SDCBHS follows all timelines outlined and is currently reviewing the Beneficiary Problem Resolution Process and stated timelines to align with Medicaid Managed Care Final Rule regulations.

H. ADMINISTRATION

H1. PROVIDER SELECTION CRITERIA

H1. Specify any practitioner provider and organizational provider selection criteria the MHP will utilize that exceed minimum state and federal criteria specified in Attachment 6.

INDIVIDUAL AND GROUP PROVIDERS

The MHP requires all individual and group practitioners to meet MHP credentialing requirements and provide verification of the required credentialing information. The MHP requires all practitioners and providers to be in good standing with the Medi-Cal program. The ASO, subject to approval by the Board of Supervisors and with oversight by the MHP, negotiates and contracts with the individual practitioners.

Individual providers must complete a credentialing application, which requires:

- A current valid license to practice as an independent mental health practitioner.
- A valid Drug Enforcement Agency certificate for physicians.
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline, and licensure of the mental health practitioner.
- Verification of board certification, if appropriate.
- Work history.
- Current, adequate malpractice insurance, according to MHP policy.
- History of professional liability claims which resulted in settlements or judgments paid by or on behalf of the practitioner.
- Information from recognized monitoring organizations if the applicant has sanctions or limitations on licensure from:
  - State Board of Licensure or Certification and/or the National Practitioner Data Bank, and
  - State Board of Medical Examiners, the Federation of State Medical Boards, or appropriate state agency.
  - Regional Medicare and Medi-Cal offices.

The information collected beyond licensing and Medi-Cal status is entered into the provider database that is used for provider network development and when matching a client's service needs to an appropriate provider.

Licensed independent practitioners who wish to contract with the MHP must go through the MHP credentialing process. Individually credentialed practitioners will not require a formal site certification. However, the site must meet medical record requirements, records maintenance, and medication

storage must conform to County standards. The ASO conducts periodic audits or reviews, including onsite audits or reviews, and evaluates: level and quality of care, necessity, appropriateness, and timeliness of the services provided; internal procedures for assuring quality of care, efficiency and economy; and financial records when determined necessary. Independent practitioners will be exempt from filing year-end cost reports.

The MHP actively recruits licensed practitioners who provide culturally competent services in a location and manner that meet the needs of the San Diego County Medi-Cal population.

ORGANIZATIONAL PROVIDERS

The MHP requires all organizational providers to maintain a safe facility meeting ADA requirements. Providers must store and dispense medications according to state and federal requirements, and store medical records according to state and federal requirements. Medication storage and prescribing are monitored by the County pharmacy for County-operated programs. For contracted organizational providers, the medication storage review is conducted at Medi-Cal certification and re-certification site visits. Medication monitoring activities are conducted by legal entities and submitted quarterly for the MHP review.

All providers must comply with the MHP quality management standards. Providers shall meet the MHP requirements, which include cultural competence standards, staff training requirements, patients' rights procedures according to the Patients' Rights Manual and other contractual requirements. MHP agencies are encouraged to have beneficiaries and representatives from the geographic areas served by the agency on their boards of directors and/or advisory boards.

Providers are required to have accounting and fiscal practices that meet the DHCS standards and have a head of service that meets Title 9 requirements.

Inpatient psychiatric facilities must be currently licensed by the State of California as a hospital and accredited by the Joint Commission Accreditation of Health Care Organizations.

Skilled nursing facilities must be currently licensed in alignment with the California Department of Public Health (CDPH).

The organizational providers are required to adhere to background check requirements, license status verifications, and sanctions for employee violations of any of the requirements and/or protection of confidentiality/security. The organizational providers will not be permitted to work at any HHSA funded program or to interact with any clients if found to be on any of the California Medi-Cal Suspended and Ineligible Providers Lists.

Staffing requirements meet or exceed Title 9 standards. SDCBHS is currently reviewing Medicaid Final Managed Care Rule regulations to ensure compliance with all provider requirements outlined.

H2. SAMPLE BOILERPLATE

H2. Provide a statement assuring that at least thirty (30) days prior to implementation, the MHP will submit a sample boilerplate contract for each type of provider with whom the MHP intends to contract--organizational and practitioner provider(s).

The MHP contracts with organizational providers, group providers, and individual providers. A boilerplate contract for each type of service was submitted to the State Department of Mental Health (now known as DHCS) prior to implementation in 1998. See Attachment H2 for the current service template.

H3. CLAIMS METHOD AND TIMEFRAMES

H3. Describe the method and time frames to be used by the MHP to process claims and payments for: (a) practitioner, and (b) organizational providers.

METHOD: (a) and (b)

a) FFS Individual and Group Providers may submit their claims to the MHP on an original CMS1500 Forms or via electronic claiming.

Providers send claims to the ASO's Claims Unit. The following procedures are followed by claims processing staff:

- Claims are scanned and logged for inventory control/accountability and compliance to billing limitation (discussed below).
- Claims are checked against the State MEDS Eligibility files via the electronic health record for verification of eligibility, county of beneficiary, and appropriate AID Code.
- Claims that are found to be prepared accurately are processed by the computer system and checked against authorizations and computer edits. Edits include verification of County Code and Aid Code.
- Claims that do not meet authorization and/or computer edits are placed on hold. Providers are notified of the pending status and are required to submit requested information within 60 calendar days for inpatient services and 30 days for outpatient services. If the claim is received after the deadline, the claim is denied and the explanation of benefits is sent to the provider. The provider is required to submit corrected claims within 45 days from the receipt of the explanation of benefits but no later than six months from the date of service.
- Claims that meet all necessary criteria are processed for payment. Payment is made within 30 calendar days from date of receipt for 95% of all claims that meet the necessary criteria.
- A Medi-Cal Denied Claims Report is generated and reviewed on a weekly basis to determine if the claims can be resubmitted to Medi-Cal or if claims payments need to be recouped from the provider. If it is determined that Medi-Cal denied the claim in error, a Replace Request Form is completed and submitted.

<u>Out of County Medi-Cal Claims</u>

- In general, when claims are received for services rendered to Medi-Cal beneficiaries from counties other than San Diego are denied, providers are instructed to bill the responsible county. If there is a valid authorization in place, the claim is processed for payment. If a claim is received for an out-of-county Medi-Cal beneficiary who has an adoption assistance program, kinship guardianship assistance program or foster care related aid code, the claim is processed.

TIMEFRAMES:

Individual and Group Providers are required to submit their claims to the MHP within 60 days of the date of rendered service.

b) Language as stated in the OPOH, section J.4:

Contractor Payments
Contractors will be paid in arrears. After the month for which service has been given, the MHS CAU will process claims (invoice) in accordance with the contract terms.

Budgets, Cost Reports and Supplemental Data Sheets and Claims (Invoices)

- Budgets, cost reports, supplemental data sheets, and claims (invoices) must comply with the established DHCS procedures outlined in the Fiscal Year 2015-16 Mental Health Plan Cost Reporting Instruction Manual.

- Quarterly Cost Reports are due 45 days after the quarter end on November 15, February 15, May 15, and August 15.

- Year-end cost report is due December 31, following the end of the previous fiscal year.

- Reconciled cost report is due 18 months after the end of the fiscal year.

- All cost reports must be submitted in a zipped file via the DHCS Information Technology Web Server (ITWS).

Overpayment
In the event of overpayments, excess funds must be returned or offset against future claim payments.

Certification on Disbarment or Exclusion
Beginning April 1, 2003, all claims for reimbursement submitted must contain a certification about staff freedom from federal disbarment or exclusion from services. The details of this new procedure are laid out in the February 21, 2003, Letter from HHSA Contract Support and Compliance directed to all HHSA contractors.

SDCBHS is currently reviewing Medicaid Managed Care Final Rule regulations to ensure all related processes are in compliance.

H4. CONTACT PERSON

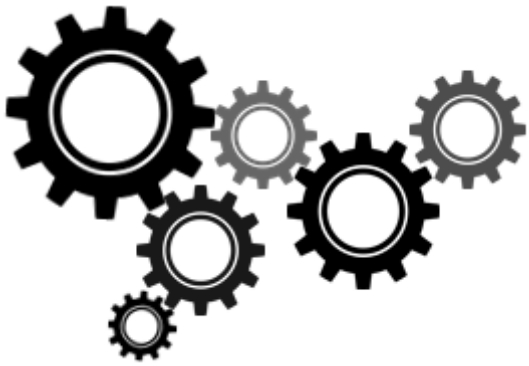
H4. Identify a contact person who can be reached regarding any questions with this Implementation Plan.

Tabatha Lang, LMFT
Chief, Agency Operations
Behavioral Health Services, Quality Improvement Unit
County of San Diego Health and Human Services Agency
(619) 563-2741

Alfredo Aguirre, LCSW
Director, Behavioral Health Services
P.O. Box 85524
San Diego, CA 92186-5524
(619) 563-2765 | Fax: (619) 563-2775

Attachment A4

Interagency Agreements



COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

ATTACHMENT A4
INTERAGENCY AGREEMENTS

The current Memoranda of Understanding (MOU), Memoranda of Agreement (MOA), and other agreements with other organizations are:

Entity/Organization	Service Provided
15th and Commercial; S.V.D.P. Management, Inc.; Mental Health Systems, Inc.; Heritage Clinic; CRF	To provide high quality, safe, and affordable permanent supportive housing to MHSA-Eligible Households and to offer MHSA-Eligible Households supportive services to maintain their housing and meet personal goals.
34th Street Project LLC; Townspeople; Community Research Foundation	To provide high quality, safe, and affordable permanent supportive housing to MHSA-Eligible Households and to offer the MHSA-Eligible Households supportive services that enables them to maintain their housing and meet personal goals.
Cedar Gateway; FPI Management, Inc.; Community Research Foundation, Heritage Clinic	To provide high quality, safe, and affordable permanent supportive housing to MHSA-Eligible Households and to offer MHSA-Eligible Households supportive services to maintain their housing and meet personal goals.
Connections Housing Downtown LP; Solari MHS	Parties are collaboratively engaging in the Development to offer housing and supportive service to households that include at least one Adult with a severe mental illness and who is also homeless or at risk of homelessness at time applied for MHSA Unit.
HDP Mason Housing Corporation; Solari Enterprises; Community Research Foundation; Hyder	Development and implementation of supportive services for The Mason housing project at 1337-1345 Fifth Ave, San Diego.
Tavarua Senior Apartment, LP; Western Senior Housing; CRF	For the Development and Implementation of Supportive Services for Tavarua Senior Apartments.
Probation Department	Provide probation integrated services to persons with serious mental illness receiving services funded through MHSA.
Probation Department	Provide mental health and substance abuse treatment services for offenders referred per Assembly Bill 109 (AB 109).
Family Health Centers of San Diego	Mutual client referrals between East County Mental Health Center (ECMHC) and Grossmont Spring Valley Family Health Center (GSVFHC) to provide comprehensive health services to adults.
San Diego State University	SDSU Graduate School of Public Health to place students in approved internships with COSD Behavioral Health Services.
San Diego State University	Provide placement of students in approved internships within divisions of the Agency.
Regents of the University of California, UCSD	Allow School access to Affiliate's clinic facilities in which trainees can obtain broader clinical learning experiences pursuant to the requirements of the Liaison Committee on Medical Education/ Accreditation Council for Graduate Medical Education.
CCWS	Allow CWS staff access to certain ADS Management Information Systems (SanWITS and SSRS) and to set the parameters and responsibilities of that access.

Dependency Legal Group of San Diego (DLGSD)	Allows DLGSD staff access to ADS Management Information Systems (SanWITS) and sets parameters and responsibilities of that access. The access is granted by the County to the DLGSD as part of providing services to the Court's clients.
Fresenius Medical Care/San Diego Dialysis Services, Inc.	Availability of dialysis treatment.
Kaplan College	Providing training in the field of Associate Degree in Nursing as "Sponsoring Institution" for medical education programs.
Parkside Special Care Center	Transferring patients between the two facilities.
RAI Care Centers of California II, LLC	Availability of dialysis treatment.
San Diego Skilled Nursing and/or Long Term Care Facilities	Provide mutual aid at the time of a disaster.
Stanford Court Nursing Center	In Event of Disaster or emergency, transferring patients between facilities.
Prime Healthcare Paradise Valley LLC	Transferring patients between the two facilities.
Superior Court of California	Establish provisions of services and payments of costs of services and related matters as defined in GC sections 77003, 77212(d)(1), and Rule 10.810 of the CA Rules of Court effective 7/1/96.
San Diego Association of Governments	Access to the Criminal Offender Information Database (BHS database) Contract is with Probation.
Aetna Better Health	Medi-Cal Managed Care Plans for Implementation of the Duals Demonstration Project to Medicare - Medi-Cal Beneficiaries.
Care 1st Health Plan	
UnitedHealthcare	
Kaiser Permanente	
Community Health Group	
Health Net of California	
Molina Healthcare of California	
Concorde Career Colleges	Concorde College to place students in approved externships with HHSA to learn front office skills, and provide education and training in the health field to Edgemoor clients.
National University	National University to place students in approved internships with COSD Behavioral Health Services.
Newbridge College	Newbridge College to place students in approved externships with HHSA to learn front office skills.
Pacifica Graduate Institute	Pacifica Graduate students receive training and supervision while volunteering at COSD MH facilities.
UEI College	UEI to place students in approved externships with the HHSA to learn front office skills.
University of Kansas School of Nursing	School to place students in approved internships with County/East County Mental Health to learn clinical skills.
University of San Diego, Hahn School of Nursing and Health Science	The County is not funded for providing a clinical training site to students from the University of San Diego Hahn School of Nursing and Health Science. The parties agree placing students in approved internships with BHS to learn clinical skills.
University of Southern California	USC School of Work to place students in approved internships with the County of San Diego BHS.
San Diego Community College	SDCCD to place students in approved internships with COSD

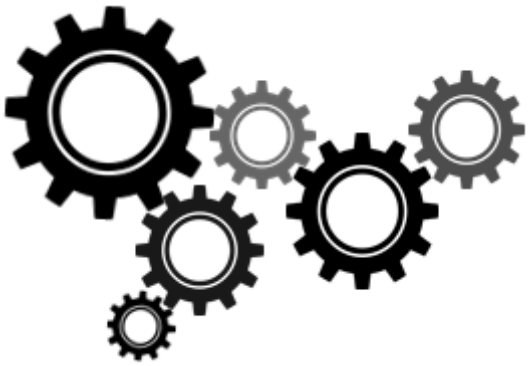
District	Behavioral Health Services
CSU San Marcos	Clinical experiences at San Diego County Psychiatric Hospital to students enrolled in Nursing Programs at California State University San Marcos.
CCWS	Administer and process payments for Community Treatment Facility contract.
Fred Finch Youth Center; San Diego County Child Welfare Services, San Diego Regional Center	Parties will work collaboratively to serve clients who have both a developmental disability and a DSM IV Axis I diagnosis.
Probation Department	Breaking Cycles and Juvenile Drug Court.
Probation Department	Provide support and services to the Multi-Systemic Therapy (MST) and Assertive Community Training (AST) CMHS Program.
Probation Department	Services provided by CMH Juvenile Forensic Program to Probation for Dual Diagnosis Services for Probation Institutions and Field Services.
Probation Department; CWS; Fiscal Services Section	Clarify roles and responsibilities of each division in relation to the Wraparound programs.
SD County Superior Court, Probation Dept., DA Office, SD County Dept. of the Primary Public Defender	Forensic Assistance for Stabilization and Treatment of Juvenile Offenders Program (JFAST) is made up of all partners to this MOU. The mission is to promote rehabilitation, public safety and reduce recidivism.
Home Start Inc.	Provide maximum available assistance for crime victims residing in the County of San Diego.
San Diego Regional Center	Assure that the highest quality services are available for residents of San Diego County who may have mental disability and/or developmental disability.
Probation Department	Adolescent referrals from the Probation Dept. to the Breaking Cycles program.
Probation Department	Adolescent referrals from the Juvenile Court and the Probation Dept. to the Juvenile Drug Court (JDC) program.
Grossmont Health Occupations Center	Provide health and comprehensive skilled nursing facility related services for student placement from Grossmont Health Occupations Center.
Regents of the University of California, San Diego	Provide Nursing Trainees from UCSD with experience at the Edgemoor Hospital District Part Skilled Nursing Facility (DPSNF).
Department of General Services	Routine maintenance and repair of Edgemoor.
Eastern Michigan University Dietetics and Human Nutrition	Provide education and training.
County of Riverside	To share creative works produced for the It's Up to Us stigma and discrimination reduction and suicide prevention campaigns.
Sheriff's Department	Provide Mental Health Services at Detention Facilities.
San Diego State University Research Foundation	Authorizes SDSURF to access data and reports from BHS/ADS SD DUI Program Participant Data System.
Citronica Two	Develop and implement supportive services.
Parkview	Develop and implement supportive services.
PATH San Diego	To provide eligible County clients with the use of 25 Sponsor-Based Subsidies funded by the San Diego Housing Commission in order to provide valuable housing options to clients enrolled in the above programs in the City of San Diego.

Attachment A4

Iowa State University (ISU)	Edgemoor DPSNF to provide Supervised Practice and Field Experience and for ISU students that have earned a satisfactory record and met with minimum requirements established by ISU.
VA San Diego Healthcare System	Ecological Momentary Assessment of Functioning in Schizophrenia.

Attachment C1

Coordination of Care Form



COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Coordination with Primary Care Physicians and Behavioral Health Services

Coordination of care between behavioral health care providers and health care providers is necessary to optimize the overall health of a client. Behavioral Health Services (BHS) values and expects coordination of care with health care providers, linkage of clients to medical homes, acquisition of primary care provider (PCP) information and the entry of all information into the client's behavioral health record. With healthcare reform, BHS providers shall further strengthen integration efforts by improving care coordination with primary care providers. Requesting client/guardian authorization to exchange information with primary care providers is mandatory, and upon authorization, communicating with primary care providers is required. County providers shall utilize the *Coordination and/or Referral of Physical & Behavioral Health Form & Update Form*, while contracted providers may obtain legal counsel to determine the format to exchange the required information. *This requirement is effective immediately and County QI staff and/or COTR will audit to this standard beginning FY 13-14*.

For all clients:

Coordination and/or Referral of Physical & Behavioral Health Form:

- Obtain written consent from the client/guardian on the *Coordination and/or Referral of Physical & Behavioral Health Form*/ contractor identified form at intake, but no later than 30 days of episode opening.

- For clients that do not have a PCP, provider shall connect them to a medical home. Contractor will initiate the process by completing the *Coordination and/or Referral of Physical & Behavioral Health Form* /contractor form and sending it to the PCP within 30 days of episode opening. It is critical to have the specific name of the treating physician.

- Users of the form shall check the appropriate box at the top of the *Coordination and/or Referral of Physical & Behavioral Health Form* /contractor form noting if this is a referral for physical healthcare, a referral for physical healthcare and medication management, a referral for total healthcare, or coordination of care notification only. If it is a referral for physical healthcare, or physical healthcare and medication management, type in your program name in the blank, and select appropriate program type.

Coordination of Physical and Behavioral Health Update Form:

- Update and send the *Coordination of Physical and Behavioral Health Update Form* /contractor form if there are significant changes like an addition, change or discontinuation of a medication.

- Notify the PCP when the client is discharged from services by sending the *Coordination of Physical and Behavioral Health Update Form* /contractor form. The form shall be completed prior to completion of a discharge summary.

Tracking Reminders:

- Users of the form shall have a system in place to track the expiration date of the authorization to release/exchange information.

- Users of the form shall have a system in place to track and adhere to any written revocation for authorization to release/exchange information.

- Users of the form shall have a system in place to track and discontinue release/exchange of information upon termination of treatment relationship. Upon termination of treatment the provider may only communicate the conclusion of treatment, but not the reason for termination.

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Coordination and/or Referral of Physical & Behavioral Health Form

☐ Referral for *physical* healthcare – [Program Name] will continue to provide specialty behavioral health services
☐ Mental Health ☐ Alcohol and Drug

☐ Referral for *physical* healthcare & Medication Management – [Program Name] will continue to provide limited specialty behavioral health services
☐ Mental Health ☐ Alcohol and Drug

☐ Referral for *total* healthcare – [Program Name] is no longer providing specialty behavioral health services. Available for psychiatric consult.

☐ Coordination of care notification only.

Section A: CLIENT INFORMATION

Client Name: Last First Middle Initial	AKA	◯ Male ◯ Female
Street Address	Date of Birth	
City	Telephone #	
Zip	Alternate Telephone #	

Section B: BEHAVIORAL HEALTH PROVIDER INFORMATION

Name of Treatment Provider:	Name of Treating Psychiatrist (If applicable)
Agency/Program	
Street Address	City, State, Zip
Telephone #	Specific provider secure fax # or secure email address:
Date of Initial Assessment:	
Focus of Treatment (*Use Additional Progress Note if Needed*)	
Case Manager/ Mental Health Clinician/ Alcohol and Drug Counselor/ Program Manager:	Behavioral Health Nurse: Phone #:

Date Last Seen	Mental Health Diagnoses: Alcohol and Drug Related Diagnoses:

Current Mental and Physical Health Symptoms (*Use Additional Progress Note if Needed*)

Current Mental Health and Non-Psychiatric Medication and Doses
(*Use Additional Medication/Progress Note if Needed*)

Last Psychiatric Hospitalization
○ Date: ○ None

Section C: PRIMARY CARE PHYSICIAN INFORMATION

Provider's Name

Organization OR Medical Group

Street Address

City, State, Zip

Telephone #:	Specific provider secure fax # or secure email address:

Section D: FOR PRIMARY CARE PHYSICIAN COMPLETION ACCEPTED FOR TREATMENT OR REFERRED BACK TO SDCBHS PROGRAM (PLEASE COMPLETE THE FOLLOWING INFORMATION AND RETURN TO BEHAVIORAL HEALTH PROVIDER WITHIN TWO WEEKS OF RECEIPT)

☐ Coordination of Care notification received.
If this is a primary care referral, please indicate appropriate response below:

1. ☐ Patient accepted for physical health treatment only
2. ☐ Patient accepted for physical healthcare and psychotropic medication treatment while additional services continue with behavioral health program
3. ☐ Patient accepted for total healthcare including psychotropic medication treatment
4. ☐ Patient not accepted for psychotropic medication treatment and referred back due to:

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax:
I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE:

Client Name (*Please type or print clearly*)
Last: First: Middle:

IF SIGNED BY LEGAL REPRESENTATIVE, PRINT NAME:	RELATIONSHIP OF INDIVIDUAL:

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.

☐ Information Contained on this form	☐ Discharge Reports/Summaries
☐ Current Medication & Treatment Plan	☐ Laboratory/Diagnostics Test Results
☐ Substance Dependence Assessments	☐ Medical History
☐ Assessment /Evaluation Report	☐ Other _____

The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the medical records and Information/updates concerning the patient. The purpose of such a release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.

I would like a copy of this authorization ◯Yes ◯No
Clients/Guardians Initials

➔Please place a copy of this Form in your client's chart

TO REACH A PLAN REPRESENTATIVE

Care1st Health Plan	Community Health Group	Health Net	Kaiser Permanente	Molina Healthcare	Access &Crisis Line
(800) 605-2556	(800) 404-3332	(800) 675-6110	(800) 464-4000	(888) 665-4621	(888) 724-7240

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Date Release of Information Signed:

COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH UPDATE FORM

CLIENT NAME

Last	First	Middle
Date of Birth	☐ Male	☐ Female

BEHAVIORAL HEALTH UPDATE

Date:

Treating Provider Name	Phone	FAX
Treating Psychiatrist Name (If applicable)	Phone	FAX

☐ Medications prescribed on _____ Date ☐ Medications changed on _____ Date ☐ Medications discontinued on _____ Date	Name/Dosage:_____ Name/Dosage:_____ Name/Dosage:_____
☐ Medications prescribed on _____ Date ☐ Medications changed on _____ Date ☐ Medications discontinued on _____ Date	Name/Dosage:_____ Name/Dosage:_____ Name/Dosage:_____

☐ Diagnosis Update :

☐ Key Information Update:

☐ Discharge from Treatment Date:

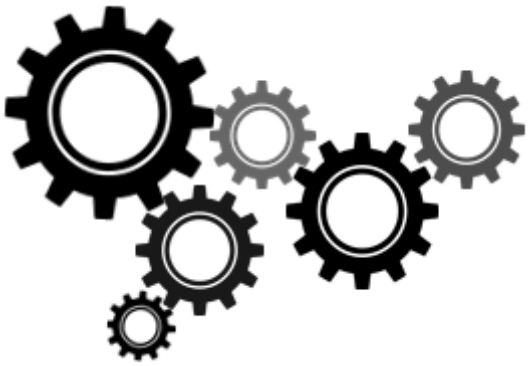
☐ Follow-up Recommendations:

PRIMARY CARE PHYSICIAN UPDATE

Please provide any relevant Update/Change to Patient's Physical Health Status.

Attachment F1

Quality Improvement Program



COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

ATTACHMENT F1
QUALITY IMPROVEMENT PROGRAM

The purpose of the San Diego County Health and Human Services Agency, Behavioral Health Services (BHS) Quality Improvement (QI) Program is to ensure that all recipients of services and their families receive the highest quality and most cost-effective mental health, substance use, and administrative services available.

The QI Program delineates the structures and processes that will be used to monitor and evaluate the quality of mental health and substance use services provided. The QI Program encompasses the efforts of clients, family members, clinicians, mental health advocates, substance use treatment programs, QI personnel, and other stakeholders.

The QI Program and Work Plan (QIWP) are based on the following values:

- Development of QI Program and QIWP objectives is completed in collaboration with clients and stakeholders.

- Client feedback is incorporated into the QI Program and QIWP objectives.

- QI Program and QIWP are mindful of those whom data represent and, therefore, integrate client feedback to improve systems and services.

QI Committees - Structure and Responsibilities
The QI Program structure consists of the following components:

- Executive Quality Improvement Team (EQIT)
  The EQIT is responsible for implementing the QI Program, responding to recommendations from the Quality Review Council (QRC), and identifying and initiating quality improvement activities. The EQIT consists of BHS Director, BHS Clinical Director, Assistant Deputy Directors, and QI Chief.

- Quality Improvement Performance Improvement Team (QI PIT)
  The QI Program includes the BHS QI PIT, which monitors targeted aspects of care on an ongoing basis and produces reports monthly, quarterly, and annually. High-volume, high-frequency, and high-risk areas of client care are given priority. So opportunities for improvement can be identified, the QI PIT collects data which are analyzed over time and used to measure against goals and objectives. Reports in each of these areas are periodically brought to the EQIT and QRC for input.

- Quality Management (QM) Team
  The QM team is another component of the QI Program and is composed of QI Specialists—licensed therapists and clinicians—who conduct a variety of reviews, audits, trainings, and other quality improvement functions for both County-operated and County-contracted programs.

- Management Information Services (MIS) Team
  The MIS team—another component of the QI Program—provides support services to BHS programs through internal security management of user accounts, development of electronic forms, troubleshooting system issues, implementation of new functionality within CCBH, user acceptance testing of releases for CCBH, and the coordination of IT support for BHS Administration.

- Quality Review Council (QRC)
  The QI Program includes the QRC, which is a standing body charged with the responsibility to provide recommendations regarding the quality improvement activities for mental health and the QIWP. The QRC meets at least quarterly, and the members are clients or family members, as well as stakeholders, from the behavioral health communities across all regions. The QRC provides advice and guidance to BHS on developing the annual QIWP, including identification of additional methods for including clients in quality improvement activities; collection, review, interpretation, and evaluation of quality improvement activities; consideration of options for improvement based on the report data; and recommendations for system improvement and policy changes.

- Quality Improvement Committees (QICs)
  The QICs are subcommittees of the QRC composed of QRC members and QI staff. Subcommittee minutes and activities are monitored by the QRC. The current QRC Subcommittees are:
  - QRC Membership Committee
  - Serious Incidents (ad hoc committee)

Confidentiality

All QI activities are covered by MHP policies on confidentiality. Additionally, the proceedings as well as derivative documents and minutes of the internal and external quality improvement committees and their ad hoc and subcommittees are confidential and protected from discoverability under Sections 1156 and 1157 of the California Evidence Code. All reports, committee minutes, audits, focused studies, and documentation of quality improvement activities shall be considered confidential and kept in a locked file cabinet or the equivalent. Committee members have a duty to preserve this confidentiality. They sign a statement at each meeting acknowledging the confidentiality of information presented at said meetings.

The confidentiality policy extends to all medical records reviewed by the quality improvement committees. When possible, identifying client information is excluded from any data presented.

QUALITY IMPROVEMENT PROCESS

BHS has adopted a continuous quality improvement model for producing improvement in key service and clinical areas. This model encompasses a systematic series of activities, organization-wide, which focus on improving the quality of identified key treatment, service and administrative functions.

The overall objective of the quality improvement process is to ensure that quality is built into the performance of the BHS functions. This objective is met through a commitment to quality from the administration, QI staff, clients, family members, and providers. The quality improvement process is incorporated internally into all service areas of BHS. It is applied when examining the care and services delivered by the BHS network of fee-for-service providers, County-operated and County-contracted agencies, and the administrative services organization (ASO).

Client and Family Involvement in Quality Improvement

Consistent with our values of involving clients and family members in the quality improvement process, many of the quality improvement activities are based on input from clients and family members.

This goal is to involve clients, family members, providers, and stakeholders in the planning, operations, and monitoring of our quality improvement efforts. Their input comes from a broad variety of sources including the Behavioral Health Advisory Board (BHAB), community coalitions, planning councils, client and family contracted liaisons, youth and Transition Age Youth (TAY) representatives, Program Advisory Groups, client satisfaction surveys, client advocacy programs, complaints, grievances, and input received on the County BHS website.

Annual Quality Improvement Work Plan

The Quality Improvement Work Plan (QIWP) describes elements by functional area and the aspects of care or service for which the MHP will measure quality. The work plan defines:

1) Indicators – the objective data elements that will be measured to know how well the standard is being met;
2) Goals – how this measure is being utilized to assess this aspect of care;
3) Data collection method/frequency/source – how necessary data will be collected to measure this indicator and how often this indicator is measured; and
4) Reporting frequency/responsible party/collaborator(s) – the frequency with which data will be reported, the source of the data and who will be responsible.

The QIWP is monitored and updated annually on the previous year's objectives. A formal evaluation is conducted annually. Key findings of the performance goals are presented to the appropriate quality improvement committee(s) and key MHP staff for recommended action, if needed.

Annual Evaluation of Program Effectiveness

The MHP shall evaluate the QI Program at least annually in order to ensure that it is effective and remains current with overall goals and objectives. The assessment will include a summary of completed and in-process quality improvement activities, results and intervention, the impact the process has had, and the need for process revisions and modifications. Evaluation findings are used to develop the following year's QIWP.

QUALITY REVIEW COUNCIL

Purpose:

The Quality Review Council (QRC) is a standing, countywide body charged with the responsibility to implement the QI Program and QIWP.

Composition:

The QRC shall include members from across the behavioral health community.

Recommendations for the QRC membership are requested from several stakeholder organizations. Ethnicity/culture is considered during selection, whenever possible. The Chair of the QRC will be designated by the BHS Director annually.

The committee may consist of representation from: clients, family members, veteran representatives, Peer Support Specialists, Family Support Partners, organizational providers; BHS QI Unit, other County representatives, ASO representatives, advocacy group representatives, and Substance Use Disorder (SUD) services representatives.

Specific charges:

1. Recommend quality improvement policies.
2. Review and evaluate results of quality improvement activities.
3. Recommend remedial actions.
4. Monitor follow-up.
5. Provide advice and guidance on the identification of methods for including clients in management of quality improvement activities.
6. Provide advice and guidance on the collection and review of quality measures.
7. Identify any other measures and data that should be collected.
8. Consider options for improvements based upon the data.
9. Make recommendations to the County and provider network for system improvements and change.
10. Participate in preparation of annual quality improvement reports to County and community.
11. Consider and recommend annual updates of the QIWP.
12. Solicit input from County QI Unit staff, the System of Care Councils, and regional advisory groups.
13. Propose mechanisms for quality improvement feedback to the organization and to service providers.

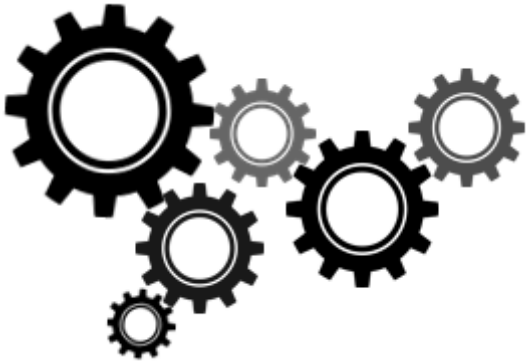
Procedures:

1. Applications for new members are reviewed by the QRC Membership committee, and recommendations are taken to the QRC. The QRC votes on members presented by the QRC Membership committee.

2. The QRC meets at least once every quarter. There shall be no alternates and members may not designate attendance to any other representative.

Attachment F2

Quality Improvement Work Plan, FY 2017-18



COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

Quality Improvement Program and Work Plan

2017-2018

Fiscal Year July 1, 2017-June 30, 2018

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INTRODUCTION

In accordance with the California Department of Health Care Services (DHCS) requirements in Title 9, Section 1810.440, the County of San Diego Behavioral Health Services (BHS) has a Quality Improvement (QI) Unit and an Annual Quality Improvement Work Plan (QIWP).

The goals of the BHS QI Unit are based on the healthcare quality improvement aims identified by the Institute of Medicine's (IOM) report: "*Crossing the Quality Chasm*." The targeted quality improvement aims for all health care services are to be *safe, client centered, effective, timely, efficient, and equitable*. These IOM aims are interwoven throughout the QI Unit and QIWP. In addition, both are guided by BHS' mission statement and guiding principles.

SDCBHS Guiding Principles:

- To foster continuous improvement to maximize efficiency and effectiveness of services.
- To support activities designed to reduce stigma and raise awareness surrounding mental health, alcohol and other drug problems.
- To maintain fiscal integrity.
- To ensure services are:
  - Outcome driven
  - Culturally competent
  - Recovery and client/family centered
  - Innovative and creative
  - Trauma-informed
- To assist County employees to reach their full potential.

County of San Diego
Behavioral Health Services

Mission Statement:

To help ensure safe, mentally healthy, addiction-free communities.
In partnership with our communities, work to make people's lives safe, healthy and self-sufficient by providing quality behavioral health services.

Quality Improvement Unit, FY 2017-18

Quality Improvement Unit Purpose

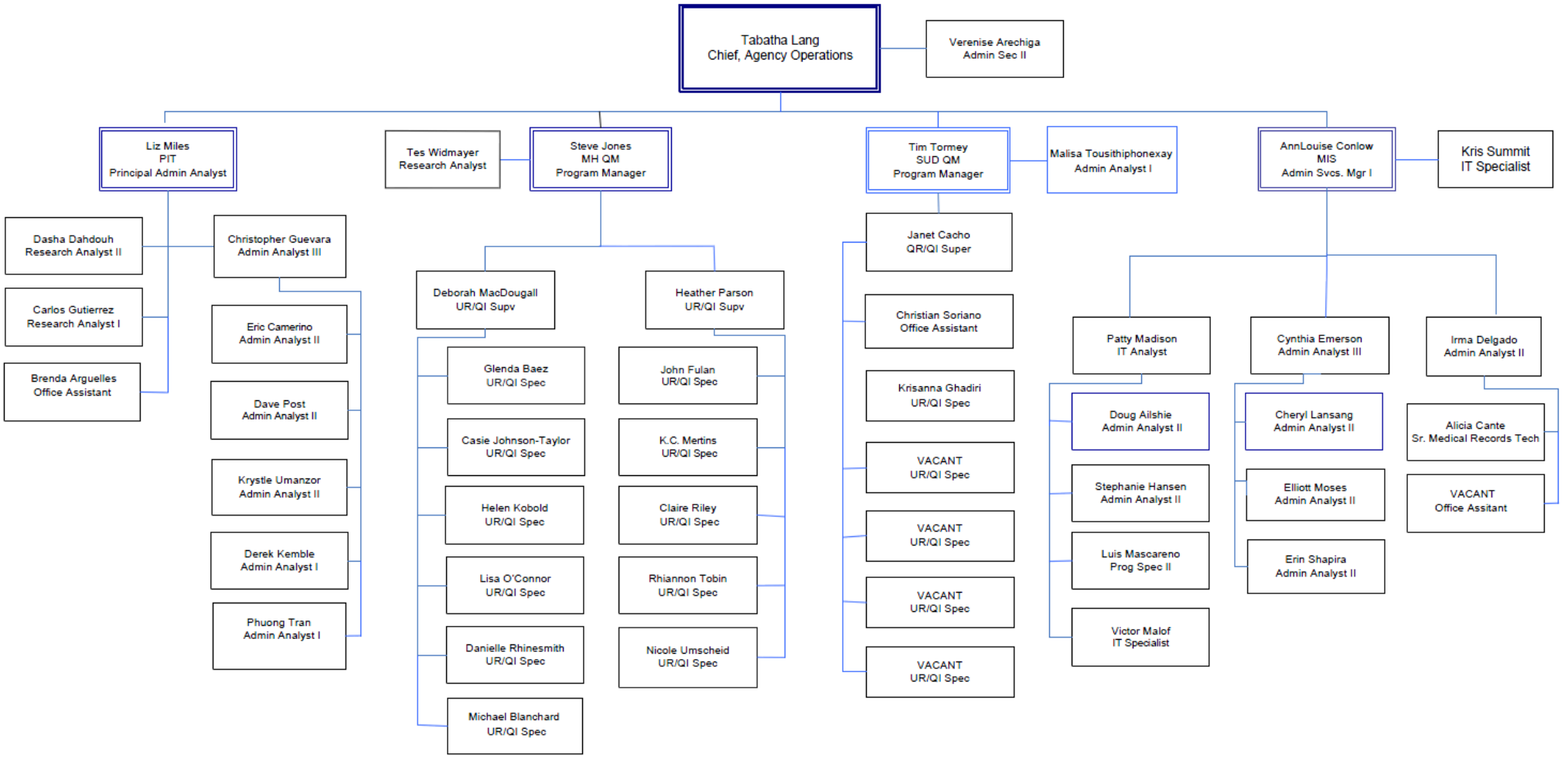
The purpose of the BHS QI Unit is to ensure that all clients and families receive the highest quality and most cost-effective mental health, substance use, and administrative services available.

The QI Unit delineates the structures and processes that will be used to monitor and evaluate the quality of mental health and substance abuse services provided. The QI Unit encompasses the efforts of clients, family members, clinicians, mental health advocates, substance abuse treatment programs, quality improvement personnel, and other stakeholders.

The QI Unit and QIWP are based on the following values:

- Development of QI Unit and QIWP objectives is completed in collaboration with clients and stakeholders.
- Client feedback is incorporated into the QI Unit and QIWP objectives.
- QI Unit and QIWP are mindful of those whom data represent and, therefore, integrate client feedback to improve systems and services.

Quality Improvement Unit Organizational Chart



Quality Improvement Unit Structure

The following are components of the QI Unit structure:

- Executive Quality Improvement Team (EQIT)
  The EQIT is responsible for implementing the QI Unit, responding to recommendations from the Quality Review Council (QRC), and identifying and initiating quality improvement activities. The EQIT consists of BHS Director, BHS Clinical Director, Assistant Deputy Directors, and QI Chief. The EQIT reviews Serious Incidents and Grievances routinely.

- Quality Improvement Performance Improvement Team (QI PIT)
  The QI Unit includes the BHS QI PIT, which monitors targeted aspects of care on an ongoing basis and produces reports monthly, quarterly, or annually. High-volume, high-frequency, and high-risk areas of client care are given priority. So opportunities for improvement can be identified, the QI PIT collects data which are analyzed over time and used to measure against goals and objectives. Reports in each of these areas are periodically brought to the EQIT and QRC for input.

- Quality Management (QM) Team
  The QM team is another component of the QI Unit and is comprised of Quality Improvement Specialists—licensed therapists and clinicians—who conduct a variety of reviews, audits, trainings, and other quality improvement functions for both County-operated and County-contracted programs.

- Management Information Services (MIS) Team
  The MIS Unit provides support services to BHS programs through internal security management of user accounts, development of electronic forms, troubleshooting system issues, implementation of new functionality within CCBH, user acceptance testing of releases for CCBH and SanWITS, and the coordination of IT support for BHS Administration. Staff serve in a variety of advisory capacities including committees on interoperability and other system functionality. Staff also collaborate with other BHS departments, the County's outsourced IT Vendor, and Cerner, the software vendor for CCBH to design, test, and implement new functionality and hardware.

- Quality Review Council (QRC)
  The QI Unit includes the QRC, which is a standing body charged with the responsibility to provide recommendations regarding the quality improvement activities for mental health and the QIWP. The QRC meets at least quarterly, and the members are clients or family members, as well as stakeholders, from the behavioral health communities across all regions. The QRC provides advice and guidance to SDCBHS on developing the annual QIWP, including identification of additional methods for including clients in quality improvement activities; collection, review, interpretation, and evaluation of quality improvement activities; consideration of options for improvement based upon the report data; and recommendations for system improvement and policy changes.

- Quality Improvement Committees (QICs)

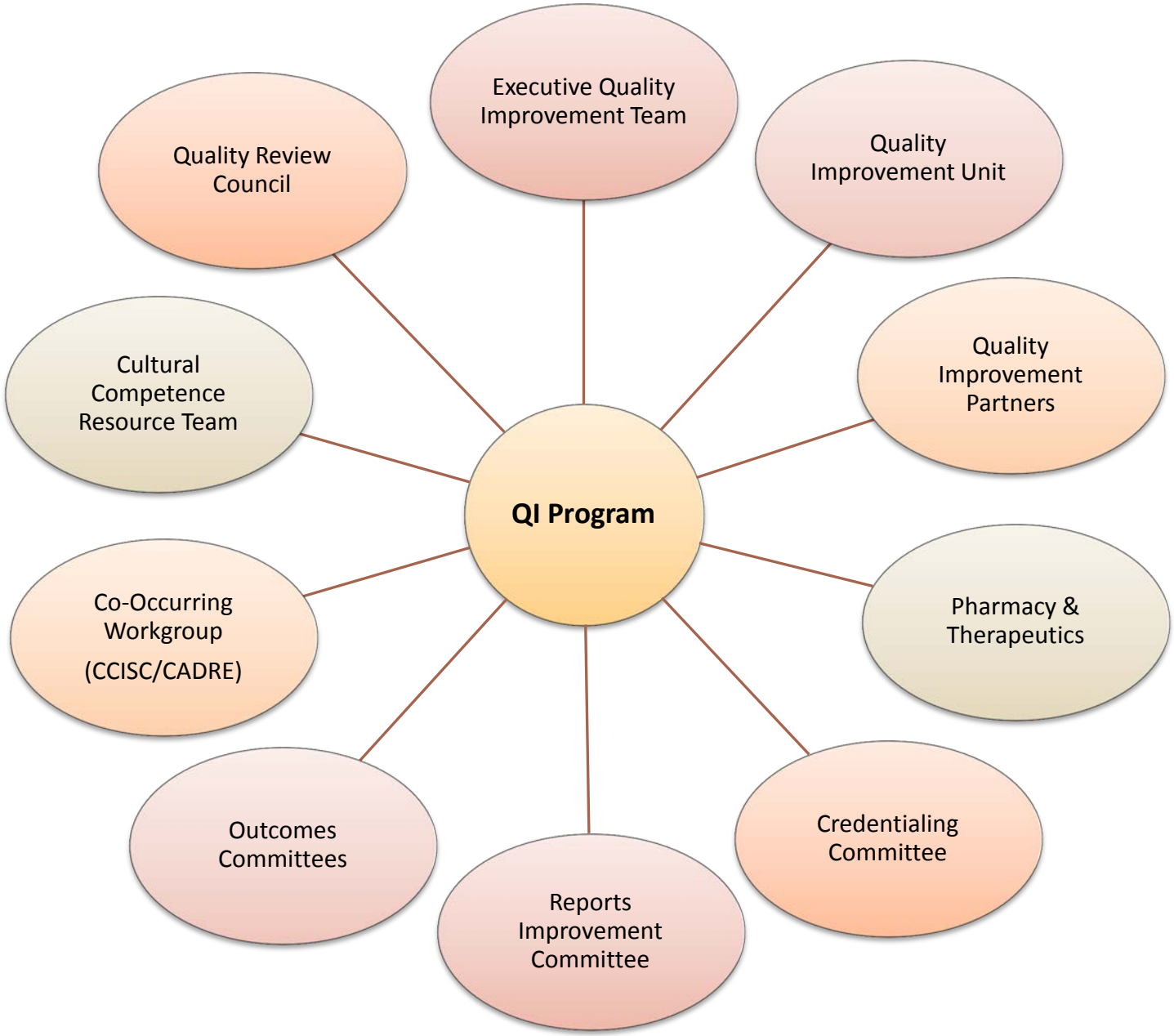
  The QICs are subcommittees of the QRC composed of QRC members and QI staff. Subcommittee minutes and activities are monitored by the QRC. The current QRC Subcommittees are:

  - QRC Membership Committee
  - Serious Incidents (ad hoc committee)

The QI Unit's recent accomplishments have included, but weren't limited to:

- Revising and testing multiple forms in Cerner Community Behavioral Health (CCBH) Client Management System
- Collaborating with other teams and stakeholders on the Project One for All (POFA) Agency Initiative
- Implementing Prevention and Early Intervention (PEI) program regulations
- Completing inter-rater reliability procedures and standards to improve consistency of Medical Record Reviews
- Completing and submitting the 2017 Cultural Competence and 3-Year Strategic Plan to DHCS
- Updating the 2017 Mental Health Implementation Plan
- Developing a new Pathways to Well-being Dashboard
- Collaborating on Hepatitis A reporting to assist with efforts to increase vaccinations within BHS programs
- Implementing client attachments and progress note template updates in CCBH
- Developing and updating an electronic database for tracking AB 109 clients
- Developing paperless process for processing and filing Access Request Forms

The following diagram depicts the committees and workgroups that make up the structure of the QI Program:



Quality Improvement Process

BHS has adopted a continuous quality improvement model for producing improvement in key service and clinical areas. This model encompasses a systematic series of activities, organization-wide, which focus on improving the quality of identified key systems, service and administrative functions.

The overall objective of the quality improvement process is to ensure that quality is built, measure consistently, interpreted, and articulated into the performance of the BHS functions. This objective is met through a commitment to quality from the administration, QI staff, clients, family members, and providers. The quality improvement process is incorporated internally into all service areas of BHS. It is applied when examining the care and services delivered by the BHS network of providers, programs, facilities, and the Administrative Service Organization.

Goals of Quality Improvement

The goals of the quality improvement process are to:

1) Identify important practices and processes where improvement is needed to achieve excellence and conformance to standards
2) Monitor these functions accurately
3) Draw meaningful conclusions from the data collected using valid and reliable methods
4) Implement useful changes to improve quality
5) Evaluate the effectiveness of changes
6) Communicate findings to the appropriate people
7) Document the outcomes

Client and Family Involvement in Quality Improvement

Consistent with our goals of involving clients and family members in the quality improvement process, many of the QI activities are based on input from clients and family members.

Clients, family members, providers and stakeholders are involved in the planning, operations, and monitoring of our quality improvement efforts. Their input comes from a broad variety of sources including the Behavioral Health Advisory Board, community coalitions, planning councils, community engagement forums, client and family focus groups, client- and family-contracted liaisons, youth and Transition Age Youth (TAY) representatives, Program Advisory Groups, client satisfaction surveys, client advocacy programs, complaints, grievances, and input from the County Behavioral Health website.

Quality Review Council Focus

QRC has identified the following potential focus topics for FY 2017-18:

- *Client-centered services:* client grievances, client interaction with the Support Specialists, customer service, and monitoring of requests for Appeals and State Fair Hearings.
- *Safety:* reducing serious incidents, medication monitoring standards, and Psychiatric Emergency Response Team (PERT) expansion.
- *Effective services:* continuity of care, Project One for All (POFA) housing efforts, reducing readmissions, and continued collaboration with stakeholders and hospital partners.
- *Efficient and accessible services:* focus on the AB 109 client population and expanding crisis stabilization services.
- *Equitable services:* client and family access to information in their preferred language, and continuity of care and connection to services for the jail population.
- *Timely services:* timely access to crisis and non-crisis Access and Crisis Line options, access time for mental health assessments, and access time between assessment and initial treatment.

Performance Improvement Projects

To be responsive and transformative, the QI Unit will continue its work on two Performance Improvement Projects (PIPs) that began in the fourth quarter of FY 2015-16, focused on:

1) Homework Utilization in Outpatient CYF Programs (Clinical)
   The clinical PIP began in FY 2015-16 and focused on increasing use of therapeutic homework in mental health treatment as an intervention to potentially improve client outcomes. In FY 2016-17, interventions included supervisor training on the use of homework, dissemination of suggested mobile homework apps, administration of the survey on homework use, and the addition of the required field in the electronic health record to track use of therapeutic homework among CYF clinicians.

   Since the beginning of the PIP, mental health outcomes improved between 11.5% and 13.5% in behavioral and emotional problems at follow-up assessment, and the length of treatment went down slightly (by 2%). Additionally, a follow-up survey administered to pilot program clinicians showed that homework was assigned more frequently and discussed during supervision more frequently.

2) Connection to Services after Discharge from the San Diego County Psychiatric Hospital (Non-Clinical)

The non-clinical PIP began in FY 2015-16 and focused on engaging new clients with services after a psychiatric hospital discharge from the San Diego County Psychiatric Hospital (SDCPH) specifically. A committee continued to meet in FY 2017-18 and included the BHS Clinical Director and representatives from: SDCPH, three County-operated clinics, Next Steps, Health Services Research Center (HSRC), and several BHS staff. A number of interventions were implemented at SDCPH, the clinics, and Next Steps to connect clients to services.

Since the beginning of the PIP, 85 new clients were discharged and had a post-discharge appointment scheduled at one of three participating clinics. As of fall 2017, 42% of those clients engaged in post-discharge services with a provider they were referred to. This compares with 28% of new clients at the beginning of the PIP in FY 2015-16.

The PIP will be finalized in Quarter 3, FY 2017-18, and the findings will be presented at the Hospital Partners, Clinical Standards, and the Ad Hoc Program Manager meetings.

Targeted Aspects of Care Monitored by QI Unit

Appropriateness of Services
- Assessment
- Level of Care
- Treatment Plans
- Discharge Planning
- Education Outcomes
- Employment Outcomes
- Utilization Management
- Crisis Stabilization Services

Access to Routine, Urgent and Emergency Services
- Crisis Stabilization Services
- Access Times for Assessments
- Access to Inpatient Hospital Beds
- Access to Crisis Residential Services
- Access to Residential Treatment Services
- Call Volume for the Access and Crisis Line (ACL)

Utilization of Services
- Retention Rate
- Completion Rate
- Readmission Rate
- Patterns of Utilization
- Average Length of Stay (ALOS) for Hospitals

Client Satisfaction
- Grievances
- Satisfaction Surveys
- Provider Transfer Requests

Cultural Competence
- Trauma-Informed
- Staff Cultural Competence
- Analysis of Gaps in Services
- Provider Language Capacity
- Penetration Rate of Populations
- Training Provided and Evaluated for Feedback

Client Rights
- LPS Facility Reviews
- Patient Advocate Findings
- Quarterly Client Rights Reports
- Conservatorship Trend Reports

Effectiveness of Managed Care Practices
- Provider Satisfaction
- Provider Denials and Appeals
- Credentialing Committee Actions
- Client Appeals and State Fair Hearings

Coordination with Physical Health and Other Community Services
- MOAs with Healthy San Diego
- Integration with Physical Health Providers
- Outcomes Resulting from Improved Integration

Safety of Services
- Serious Incidents
- Medication Monitoring
- On-Site Review of Safety

Quality Improvement Work Plan, FY 2017-18

Developing the Quality Improvement Work Plan

The purpose of the SDCBHS QIWP is to establish the framework for evaluating how the QI Unit contributed to meaningful improvement in trauma-informed care and administrative services. The QIWP defines the specific areas of quality of services, both clinical and administrative, that SDCBHS will evaluate for FY 2017-18.

The QIWP defines the 1) objectives, 2) goals, 3) indicators and/or measures, 4) planned interventions, 5) data collection and interpretation, and 6) planned reports. The QIWP includes plans for monitoring previously identified issues, sustaining improvement from previous years, and tracking of issues over time.

The QIWP will be monitored and revised throughout the year, as needed. The QIWP is reviewed by the QRC and approved by the EQIT. A formal evaluation will be completed annually.

Annual Evaluation of the Quality Improvement Work Plan

SDCBHS shall evaluate the QIWP annually in order to ensure that it is effective and remains current with overall goals and objectives. This evaluation will be the Annual QIWP Evaluation. The assessment will include a summary of completed and in-process quality improvement activities, the impact of these processes, and the identified need for any process revisions and modifications.

Quality Improvement Work Plan Goals

The QIWP Goals define targeted measures by which Behavioral Health Services can objectively evaluate the quality of services, both clinical and administrative, provided to clients and families. Some of the goals are process goals while others are measurable objectives. The target areas for improvement have been identified in the following ways:

1) Client and family feedback about areas that need improvement

2) Systemwide enhancement identified through data and analysis

Target Objectives for the Quality Improvement Work Plan

The targeted objectives of the QIWP are based on the IOM aims and address QRC recommendations. It ensures high-quality trauma-informed systems and services are being engaged by clients and family members in San Diego County.

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed Intervention or Previous Next Steps:
QIWP Target Area: Services Are Client Centered					
1	State Requirement Ongoing	Decrease the number of Quality of Care related grievances by 5%.	Number of grievances related to quality of care.	Quarterly Grievances and Appeals report. Annual Medi-Cal Beneficiary Grievance and Appeal Report (ABGAR).	Advocacy contractors to report on trends of incomplete grievances.
2	EQRO Feedback 1st Year	Evaluate changes from FY 2013-14 baseline in satisfaction, engagement, and career opportunities among Support Specialists in the BHS System.	Peer Support Specialist (PSS), Family Support Partner (FSP), and Youth Support Partner (YSP) surveys administered in 2014 and 2017.	2014 and 2017 Reports on Exploring Support Specialist Services.	Administer the 2017 survey to PSSs, FSPs, and YSPs. Analyze, present, and discuss the findings at the QRC and various Council meetings.
3	State Requirement 1st Year	Implement new Outcome Tools in the CYF System of Care—Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC-35)—and determine baseline data.	Successfully implemented tools per the State requirements. Analyze reports to determine baseline data for measures.	Availability of tools to providers.	Collaborate with University of California, San Diego on incorporating tools into Mental Health Outcomes Management System (mHOMS). Provide training on the use of the tools. Collaborate with Behavioral Health Education and Training Academy (BHETA) and the Praed Foundation on the training of the tools.

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed Intervention or Previous Next Steps:
QIWP Target Area: Services Are Safe					
4	Systemwide Enhancement Ongoing	Decrease the number of completed suicides in the Behavioral Health System of Care by 5% from the previous Fiscal Year.	Number of suicides.	Suicide report based on data from the Medical Examiner's Office.	Identify risk factors and work with the Systems of Care to ensure appropriate assessment and intervention for high risk clients.
5	State Requirement 1st Year	100% of programs meet the medication monitoring review requirement (1% each quarter).	At least 1% of active medication caseload monitored each year. Completion and submission of medication monitoring activities.	Quarterly Medication Monitoring Reports.	Follow up with providers to ensure goals are met.
6	Systemwide Enhancement 1st Year	Increase Psychiatric Emergency Response Team (PERT) clinicians from 40 to 50.	Number of PERT clinicians in San Diego County.	PERT Statement of Work. PERT Quarterly Status Report (QSR). Optum CO-26 Report.	A/OA SOC to collaborate with PERT on contract/program and staffing enhancements.

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed Intervention or Previous Next Steps:
QIWP Target Area: Services Are Effective					
7	Systemwide Enhancement 2nd Year	Ensure that 60% of Full Service Partnership (FSP) Project One for All (POFA) clients are in permanent housing at the latest assessment compared to intake.	At least 60% of FSP POFA clients are in permanent housing at the latest assessment compared to intake.	POFA specific indicators and data. FSP Quarterly Reports.	Continue to meet the 1,250 new treatment slots as part of the POFA outreach effort.
8	Systemwide Enhancement Ongoing	Increase the number of clients discharged from a psychiatric hospital who connect to services within 7 and within 30 days after discharge by 5% from last Fiscal Year to provide effective continuity of care.	Connection to services within 7 and within 30 days after psychiatric inpatient discharge.	BHS Electronic Health Record ASO report and dashboard on client services 7 and 30 days following psychiatric hospital discharge.	Enhance case management and care coordination efforts to increase connection to services after discharge.

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed Intervention or Previous Next Steps:
QIWP Target Area: Services Are Efficient and Accessible					
9	State Requirement Ongoing	Provide specialty mental health services to 2% (12,923 clients) of county uninsured or Medi-Cal under 200% Federal Poverty Level (FPL) eligible population.*	Number of Specialty Mental Health Services clients in ratio to number San Diego County residents who are uninsured or Medi-Cal under 200% FPL. Percent of uninsured or Medi-Cal under 200% FPL.	Quarterly reports and Databook. Penetration rates. Triennial Disparities Report.	Continue outreach efforts to unserved and underserved communities.
10	Systemwide Enhancement 2nd Year	Relocate youth crisis stabilization beds to Central region and expand from 4 to 12 beds.	The relocation of youth crisis stabilization beds to Central region. Expansion of youth crisis stabilization beds from 4 to 12 beds.	Information, updates and data from CYF SOC.	Utilize funding to upgrade facilities in Central region and work with the contracted provider to ensure a smooth transition.

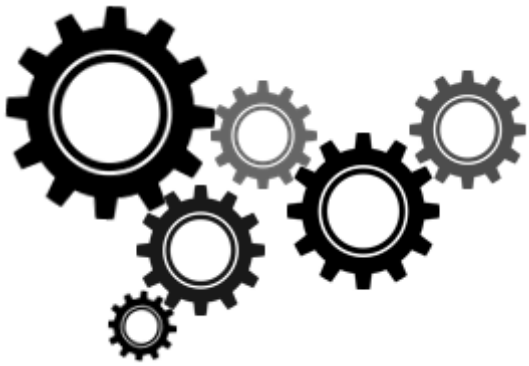
**The new methodology is based on the population eligible for county Specialty Mental Health Services vs the total San Diego County population.*

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed Intervention or Previous Next Steps:
QIWP Target Area: Services Are Equitable					
11	State Requirement Ongoing	100% of clients and families indicating in the State-required Consumer Perception Surveys that they had access to written info in their primary language and/or received services in the language they prefer.	Mental Health Statistics Improvement Program (MHSIP) and Youth Services Survey (YSS) responses to items focused on the availability of materials and services in the clients' preferred language.	Semi-annual client satisfaction survey, including threshold languages from MHSIP and YSS.	Administer the YSS and MHSIP surveys. Continue to provide all beneficiary packet materials in all threshold languages. Continue to regularly evaluate and update translated documents.
12	Systemwide Enhancement	100% of requests from all races/ethnicities meet the systemwide access time standard of 5 days for CYF clients and 8 days for A/OA clients.	Average access times among clients of different races/ethnicities compared to the overall average penetration rates.	Request for Services Logs.	Ensure diverse workforce recruitment. Enhance outreach efforts.
13	Systemwide Enhancement	100% of requests in all preferred languages meet the systemwide access time standard of 5 days for CYF clients and 8 days for A/OA clients.	Average access times among clients speaking different languages compared to the overall average penetration rates.	Request for Services Logs.	Ensure diverse workforce recruitment. Enhance outreach efforts. Educate providers on the use of interpreter services.

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed Intervention or Previous Next Steps:
QIWP Target Area: Services Are Timely					
14	State Requirement Ongoing	o 95% of calls answered by the Access and Crisis Line (ACL) crisis queue are within 45 seconds. o Average speed to answer all other (non-crisis) calls is within 60 seconds.	Number of crisis and non-crisis ACL calls received. Response rates for crisis and non-crisis ACL calls.	Report on ACL access times and types of calls received. Quarterly ACL Performance Standards Report.	Continue to track trends to ensure goals are met.
15	State Requirement Ongoing	o 100% of CYF programs meet the mental health assessment timeliness standard (5 days). o 100% of A/OA programs meet the mental health assessment timeliness standard (8 days). o 100% of CYF and A/OA programs meet the timeliness standard for mental health assessment requests deemed as urgent (72 hours).	Percent of CYF and A/OA providers who provide face-to-face clinical contact within timeliness standards.	Data from Request for Services Logs on routine and urgent mental health services requests.	Implement Cerner system capabilities to develop a report that is able to document access times from assessment to initial treatment service.

Attachment F3

Utilization Management Program



COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

ATTACHMENT F3
UTILIZATION MANAGEMENT PROGRAM

The County of San Diego Mental Health Plan (MHP) has delegated responsibility to the MHP's administrative services organization (ASO), to authorize fee-for-service (FFS) inpatient, day rehabilitation services, day school services, and FFS outpatient services.

The MHP has delegated responsibility to County-operated and County-contracted organizational providers to perform utilization management for specialty mental health Short-Doyle/Medi-Cal services, including crisis residential services, outpatient services, and case management services. Each delegated entity shall be accountable to the Behavioral Health Services (BHS) Director and shall follow the MHP's *Utilization Management* (UM) plan as noted in the Organizational Provider Operations Handbook (OPOH).

Authorization and utilization management decisions are based on medical necessity criteria delineated in Title 9 of the California Code of Regulations.

Utilization Management Activities Delegated to the ASO
Under the contract with the County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS), the ASO authorizes payment for Medi-Cal FFS inpatient care, day treatment, day school services, and services delivered through the individual and group provider FFS network. Referrals for FFS inpatient care and FFS outpatient services are performed by the UM staff or the staff at the Access and Crisis Line (ACL), which is a statewide toll-free access line operated 24 hours per day, 7 days per week. Licensed care managers obtain relevant clinical information and make authorizations. Statewide Medi-Cal medical necessity criteria are used for authorization decisions. Clients may also be referred to community support services, psycho-educational groups, and self-help groups, as appropriate.

Inpatient FFS
Licensed clinicians at the ACL as well as UM care managers are responsible for completing authorizations and concurrent review of Medi-Cal acute inpatient services. Clinical information obtained during the review process contains, at a minimum, information that justifies care based on the statewide Medical Necessity Guidelines. Emergency services do not require pre-authorization; however, providers are required to notify the ASO within 24 hours of admission. Requests for referral and/or authorization for reimbursement of services for urgent conditions are prioritized so that the turnaround time for authorization meets the statewide timeline of within one hour of the request.

Authorizations for administrative days are based on Title 9 criteria and shall include clients being placed in: 1) a County-funded long term care facility; 2) a skilled nursing facility; or 3) an adult residential treatment facility.

The ASO submits completed Treatment Authorization Requests (TAR) to the State's fiscal agent, in accordance with Title 9 requirements.

Day Treatment
Day Treatment services are administered by the ASO in accordance with Title 9 Regulations.

Outpatient FFS Individual and Group Providers
Initial requests for services may come from clients and family, community mental health providers, County staff, primary care providers, human service agencies and others. Once a request for services is received, the ACL staff obtains relevant intake information for basic clinical risk screening. The Title 9 medical necessity criteria are used

to determine appropriate referrals. The ACL staff then search for an appropriate provider based on the clinical and cultural needs identified by the caller. The electronic Client Management System allows for a search for a provider based on location, linguistic capability, and other clinical specialties. Based on the current presenting problems and clinical risk potential, the client may be referred directly to crisis response services, organizational providers, County-contracted programs, or an FFS provider for a thorough behavioral health assessment. If the client is referred to an FFS provider, the network provider may conduct an assessment session. To request additional sessions beyond the assessment, the provider must submit an Initial Outpatient Authorization Request (IOAR) form.

Utilization Management Activities Delegated to Organizational Providers

Initial Assessment

At the time of admission to a program, clinicians shall perform a face-to-face assessment to ensure that each new client meets medical necessity criteria for specialty mental health services. The assessment shall be completed within 30 days of the client's first visit. The clinician shall complete the behavioral health assessment and ensure that, at a minimum, the following domains are completed:

- Presenting problem
- Relevant psychosocial factors or conditions affecting physical and mental health
- Mental Health History
- Medical History
- Medications
- Substance Exposure/Substance Use
- Client Strengths
- Risks
- Mental Status Examination
- Current DSM/ICD Diagnosis Code
- Additional clarifying formulation information, as needed

If, after completing the assessment, the clinician determines that medical necessity criteria for specialty mental health services are met, a client plan must be developed with the client within 30 days of admission to the program. If, after completing the assessment, the clinician determines that medical necessity criteria for specialty mental health services are not met and the client is a Medi-Cal beneficiary, the client will be issued a Notice of Adverse Benefit Determination (NOABD) and his or her beneficiary rights shall be explained.

Continuing Services

For services provided to a beneficiary at an organizational provider site, providers are required to follow the UM activities as outlined in the OPOH. The UM activities are reviewed by the Quality Improvement (QI) Unit on an annual basis, at minimum.

Crisis Residential

Individuals may access crisis residential services by being referred from another program, or the client may walk in or self-refer. If the client is referred by another mental health program, the referring program/facility shall ensure that the following information is up to date in the client's electronic health record: the client's presenting problem; current medications; current substance use; mental status exam; DSM diagnosis; and current potential for harm. Once the client arrives at the crisis residential facility, a face-to-face assessment is completed. If the client is admitted, the Utilization Review Committee (URC) of the crisis residential services shall review the case for continuing treatment. If the client is not admitted and the client is not currently receiving specialty mental health services, and is a Medi-Cal beneficiary, the crisis residential facility shall issue an NOA-A to the client.

Case Management

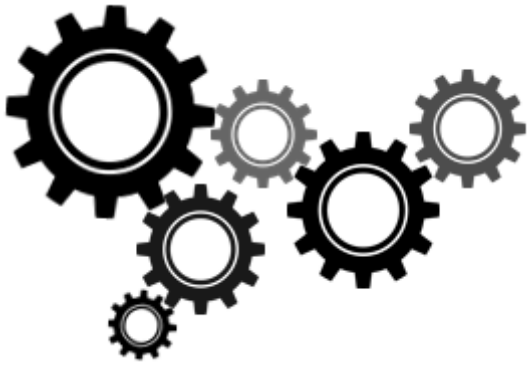
Prior to admission to the program, each client must have a face-to-face assessment to establish medical necessity. The assessment shall be completed within 30 days of the client's first visit. If the client is admitted, the Client Plan is due within 30 days. The URC shall review all cases of clients who have received more than two years of services, and other cases identified by the QI Unit. The URC may authorize up to one year of services.

NOABD (NOA)

Each delegated entity shall maintain an NOABD Log and document actions as applicable. All actions shall be documented in the NOABD Log.

Attachment G1

Beneficiary Problem Resolution Process



COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

ATTACHMENT G1
BENEFICIARY PROBLEM RESOLUTION PROCESS

Overview of Grievance and Appeal Procedures

Consistent with the principle of a consumer driven system of care, the grievance process has been developed through a collaborative process with consumers, family members, the contracted patient advocacy programs, and the County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS) staff.

Consumers stress that these procedures are as important as all other behavioral health services, and that they deserve equal priority in the health care system. Consequently, the number of grievances received through this consumer friendly process can be viewed as a reflection of the provider efficiency and integrity, and a genuine commitment to improve quality services.

The Code of Federal Regulations (42 CFR 438.400 through 42 CFR 438.424) and The California Code of Regulations (Title 9, Section 1850.205) are the basic authority for the grievance and appeal process. This process covers Medi-Cal beneficiaries and persons without Medi-Cal funds receiving Mental Health Plan (MHP) mental health services. According to the Welfare and Institution (WI) Code 19950, the State Fair Hearing process is only available to Medi-Cal beneficiaries.

Objectives of the Grievance and Appeal Policy

- To assist individuals in accessing medically necessary, high quality, trauma informed, consumer centered mental health services and education.
- To provide a formal process for independent resolution of grievances and appeals.
- To respond to consumer concerns in a linguistically appropriate, culturally competent, trauma informed, and timely manner.
- To be carried out in the appropriate language, with translators available.
- To protect the rights of consumers during grievance and appeal processes.
- To provide education regarding, and easy access to, the grievance and appeal process through widely available informational brochures, posters, and self-addressed grievance and appeal forms located at all provider sites.
- To educate clients, consumers, families, and staff about the grievance and appeal process.

Definitions

Adverse Benefit Determination: Any of the following actions taken by a Plan:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in a whole or in part, of payment for a service;
4. The failure to provide services in a timely manner;
5. The failure to act within the required timeframes for standard resolution of grievances and appeals; or

6. The denial of a beneficiary's request to dispute financial liability.

ASO: Administrative services organization contracted by the Health and Human Services Agency (HHSA) to provide Managed Care Administrative functions.

Beneficiary: A client who is currently requesting or receiving specialty mental health services paid for under the County's Medi-Cal Managed Care Plan.

Client: Any individual currently receiving mental health services from the County Mental Health Services (MHS) system, regardless of funding source.

Complaint: An oral or written expression of dissatisfaction or concern regarding mental health services by the consumer directly with a provider or with program management.

Consumer: Any individual who is currently requesting or receiving specialty mental health services regardless of the individual's funding source and/or has received such services in the past and/or the persons authorized to act on his/her behalf. (This includes family members and any other person(s) designated by the client as his/her support system.)

Grievance: A written or oral expression of dissatisfaction by the consumer about any matter (other than an adverse benefit determination) regarding mental health services in cases where a resolution of a complaint filed with the provider or with program management was not satisfactory. (See Grievance Process below.)

Grievance Advocate: An advocate who is available to help consumers through the grievance process.

Grievance Process: A formal process for the purpose of hearing and attempting to resolve consumer concerns regarding specialty mental health services.

Medical/ Clinical Review Panel: A panel of mental health professionals qualified to provide second opinions regarding denial, reduction, or termination of services. Said professionals shall not be employed by the same party providing the first opinion, or have any financial interest other than for purposes of providing these specific services.

Mental Health Plan (MHP): The County of San Diego, HHSA, Behavioral Health Services.

Notice of Adverse Benefit Determination (NOABD): Beneficiaries must receive a written NOABD when the MHP takes any of the actions described in the Adverse Benefit Determination. The MHP must give beneficiaries timely and adequate NOABD in writing, consistent with the requirements in 42 CFR 438.10, and must explain all of the following:

1. The adverse benefit determination the MHP has made or intends to make.
2. A clear and concise explanation of the reason(s) for the decision. For determinations based on medical necessity criteria, the notice must include the clinical reasons for the decision. The MHP shall explicitly state why the beneficiary's condition does not meet specialty mental health services.
3. A description of the criteria used. This includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations.

4. The beneficiary's right to be provided, upon request and free of charge; reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination.

Patient Advocacy Organizations: Community based programs that provide education, information, and advocacy services, including investigation of patients' rights, grievances to consumers receiving outpatient and inpatient services, consumers in residential facilities, and consumers in incarceration.

Patients' Rights Advocate: The persons designated under Welfare and Institutions Code, Section 5500 et seq. to protect the rights of all recipients of specialty mental health services. The Patients' Rights Advocate shall have no direct or indirect clinical or administrative responsibility for any recipient of Medi-Cal Managed Care Services, and shall have no other responsibilities that would otherwise compromise his or her ability to advocate on behalf of specialty mental health beneficiaries.

QI Unit: The Quality Improvement (QI) Unit, within SDCBHS that provides monitoring and oversight of the grievance and appeal process.

Second Opinion: A medical clinical panel review providing a re-assessment when other specialty mental health services have been denied, reduced, or terminated.

State Fair Hearing: A formal hearing conducted by the California Department of Social Services as described in Welfare and Institutions Code, Section 19950 and Federal Regulations Subpart E, Section 431.200 et. Seq. This process is available to Medi-Cal beneficiaries any time within 120 days of completion of the grievance and appeal process. Beneficiaries do not need to use the County process to request a State Fair Hearing.

Grievance Policy

The Mental Health Plan (MHP) shall establish a procedure for addressing and resolving grievances regarding specialty mental health services. Grievances registered by the direct recipient of such services and/or persons acting on his/her behalf shall be responded to in accordance with these procedures. Clients and/or their representatives may submit a grievance, file an appeal, or request a State Fair Hearing (upon the completion of the County grievance and appeal process) at any time.

- Consumer concerns shall be responded to in a linguistically appropriate, culturally competent and timely manner.
- Clients' rights and confidentiality shall be protected at all stages of the grievance process by all providers, advocates, and level II committee members involved.
- Consumers of the MHP and persons seeking services shall be informed annually of their rights to contact the patient advocacy programs at any time, for assistance in resolving a grievance at County level, or for assistance in obtaining a second opinion at no cost or requesting a State Fair Hearing.
- Consumers of the MHP and persons seeking services shall be informed annually of the procedure for resolution of grievances. This will include information about the availability of the patient advocacy programs.

- At the client's request, a support person chosen by the client, such as family, friend or other advocate may accompany them to any meetings or hearings regarding a grievance.
- Consumers shall not be subject to any discrimination, penalty, sanction, or restriction for filing a grievance. The consumer shall not be discouraged, hindered, or otherwise interfered with in seeking or attempting to register a grievance.
- The client may authorize another person or persons to act on his/her behalf.
- Issues identified as a result of the unsatisfactory complaint resolution with the provider or grievance process shall be reviewed by the MHP for implementation of system changes when appropriate.

Grievance Procedures

Notification of Grievance Procedures

- Consumers of the MHP shall be informed annually in a clear and concise way of the process for reporting and resolving grievances and appeals. This includes information on how to contact the patient advocacy programs. The information shall be available in the threshold languages and shall be given to the client at the point of intake to a program and annually during the provision of services. Clients with limited English proficiency have the right to free language assistance services if so requested. The consumers are encouraged to express dissatisfaction about any matter directly with a provider or with program management. If the reason for dissatisfaction is treatment or medication, the consumers are encouraged to obtain a second opinion from another clinician on the provider's staff or through the Access and Crisis Line at (888) 724-7240.
- Notices describing mental health rights, as well as the grievance and appeal procedures shall be posted in prominent locations in public and staff areas, including waiting areas of the provider location. Brochures with this information will also be available in these areas in the threshold languages.
- Materials received from or required by The California Department of Health Care Services (DHCS), including pamphlets, posters and brochures will be printed and made available by BHS. Grievance and Appeal forms and self-addressed envelopes must be available for consumers at all provider sites in a visible location, without the consumer having to make a written or verbal request to anyone. This includes common areas of all programs including both locked and unlocked inpatient behavioral health units.
- When the MHP denies any authorization for payment request from a provider to continue specialty mental health services to a beneficiary, the MHP must provide a Medi-Cal beneficiary with a Notice of Adverse Benefit Determination (NOABD), which informs the beneficiary of his or her right to a State Fair Hearing, and the right to call a patient advocate. The consumers are not required to wait for the NOA before requesting a State Fair Hearing.

Grievance Procedures

The County contracts with the Patient Advocacy Organizations to handle grievances about client services. Any client of mental health services may express dissatisfaction with mental health services or their administration by filing a grievance through one of the Patient Advocacy Organizations. If the resolution of the expression of dissatisfaction brought up with the provider or program management is unsatisfactory, the clients may choose to use the grievance process available through these contractors, for outpatient or inpatient services, as appropriate. A client's designated representative may use the

grievance process on behalf of the client. Grievances may be submitted orally or in writing; if necessary, the Patient Advocacy Organizations or other representatives of the client may provide assistance in filing the grievance. The nature of the problem may be an expression of dissatisfaction about any matter other than an adverse benefit determination.

A written acknowledgement of receipt of grievance is provided to the beneficiary by the MHP, and includes the date of receipt, as well as the name, telephone number, and address of the representative whom the beneficiary may contact about the grievance. The acknowledgement must be postmarked within five (5) calendar days of grievance receipt. Both programs will have designated personnel to provide information on the status of a client's grievance during the process. Both contractors track and monitor all grievances and send monthly logs to the BHS Quality Improvement Unit. The client may inquire about the status of the grievance at any time by calling the involved contractor.

Grievance Review

- Response to a grievance must be linguistically appropriate, culturally competent, and completed in a timely manner.
- The Patient Advocacy Organization will log the grievance within one working day of receipt and will acknowledge receipt of the grievance to beneficiary in writing. The log is to be maintained in a confidential location at the Patient Advocacy Organizations. The log content pertaining to the client shall be summarized in writing if the client requests it. The log will include the name of the client and his/her designated representative, if any, date of receipt of grievance, and nature of the problem, and the resolution. The QI Unit of the MHP shall be notified monthly of any grievance filed.
- The provider involved will be informed in writing within three (3) working days and shall be required to cooperate with the investigation by the contractor.
- The advocate will make every effort to resolve the grievance within 90 calendar days of receipt, in accordance with Title 9 requirements. This timeline may only be extended for good cause and cannot exceed 14 calendar days. Consumer agreement to any good cause extension must also be documented.
- If the timeline will be extended beyond 60 days not at the request of the enrollee, the MHP will give the enrollee an applicable Notice of Adverse Benefit Determination (NOABD) and include the status of the grievance and the estimated date of resolution, which shall not exceed 14 calendar days. If the MHP extends the timeframe, it must: a) give the beneficiary prompt oral notice of the delay; b) within two (2) calendar days of making the decision, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he/she disagrees with that decision; and c) resolve the grievance no later than the date of the extension expires.
- The contractor shall document all efforts made on behalf of the consumer in the client record.
- The contractor's Grievance Log will also record the final disposition of the grievance, including the date the decision is sent to the beneficiary or documentation of the reason(s) that there was not a final disposition.
- The client shall be notified in writing of the determination and his/her right to an appeal. Medi-Cal beneficiaries shall also be notified of the right to a State Fair Hearing. If any providers were cited or otherwise involved in the grievance, they should be notified of the final disposition of that grievance.

- The affected provider must all be notified of the decision within 24 hours of the determination.

Appeal Procedures

The appeal procedure begins when the client contacts one of the Patient Advocacy Organizations to file an appeal to review an adverse benefit determination regarding provision of services through an authorization process, including: denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; reduction, suspension, or termination of a previously authorized service; denial of, in whole or in part, of payment for a service; failure to provide services in a timely manner; failure to act within the required timeframes of a standard resolution of grievances and appeals; or denial of a beneficiary's request to dispute financial liability.

- Federal regulations require clients to file an appeal within 60 calendar days from the date of the NOABD.
- The client may file the appeal orally or in writing. Oral appeals (excluding expedited appeals) must be followed by with a written, signed appeal. Appeals filed by the provider on behalf of the client require a written consent. The client will be provided with assistance in completing the written appeal, if requested. The date of the oral appeal begins the appeal resolution timeframe, regardless of when the follow-up, written appeal was signed.
- The Patient Advocacy Organizations, as appropriate, determine whether the appeal meets the criteria for expedited appeal and, if so, follow the expedited appeal process.
- The appeals are entered in the tracking log within one working day of receipt. The log is maintained in a confidential location at the Patient Advocacy Organizations. If the client requests to see the log, the content pertaining to the client will be summarized in writing.
- The client and the Quality Improvement Unit will be notified of the receipt of the appeal within three working days.
- The appeals must be resolved within 30 calendar days from the date of the receipt of the appeal. If the extension is required, the Patient Advocacy Organizations will contact the client to discuss the extension that shall not exceed 14 days.
- A written acknowledgment of the appeal receipt must be provided to the client and must be postmarked within five (5) calendar days of receipt.

Expedited Appeal Procedures

- Expedited appeals can be requested if a client or the provider certifies that the standard appeal timeline could seriously jeopardize the client's life, health or ability to attain, maintain or regain maximum function.
- When a Medi-Cal client, or his/her designated representative, files an expedited appeal against the MHP or a provider, the appeal shall be handled expeditiously. The client may file the expedited appeal orally or in writing. Oral expedited appeals do not have to be followed up in writing. The Patient Advocacy Organizations shall acknowledge the receipt of the oral or written expedited appeal within one working day.

- When the expedited appeal has been received by the Patient Advocacy Organizations before the beneficiaries' discharge from the services, the beneficiary has the right to continue to receive services until the decision on the appeal is rendered.
- The MHP shall continue payment for the services until the MHP responds to the expedited appeal through Aid Paid pending. The provider or MHP may then take action, as appropriate, based on the appeal decision.
- Expedited appeals are resolved and the client is notified orally and in writing no later than 72 hours from the date of receipt of the expedited appeal. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days if the client requests an extension.
- If the MHP requests an extension of the expedited appeal, the MHP will give the client written notice of the reason for delay within two (2) calendar days and inform the client of the right to file a grievance if he/she disagrees with that decision.
- A Medi-Cal beneficiary has the right to request a State Fair Hearing after receiving notice that the adverse benefit determination is upheld, and Aid Paid pending shall apply when appropriate.
- If the MHP fails to adhere to the notice and timing requirements, the client is deemed to have exhausted the MHP's appeals process and may initiate a State Fair Hearing.

State Fair Hearing

In addition to the County grievance and appeal resolution process, Medi-Cal beneficiaries may request a State Fair Hearing. A client may request a hearing any time within 120 days of completing the County's Appeal Process and only after receiving a notice that the MHP is upholding an adverse benefit determination. Clients must exhaust the MHP's appeal process prior to requesting a State hearing.

For Standard Hearings, the MHP will notify the clients that the State must reach its decision on the hearing within 90 calendar days of the date of the request for the hearing. For Expedited Hearings, the MHP will notify the clients that the State must reach its decision on the State Fair Hearing within three (3) working days of the date of the request for the hearing. For overturned decisions, the MHP will authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires, but no later than 72 hours from the date it receives notice reversing the MHP's adverse benefit determination.

A claimant may obtain an impartial review of any County mental health action at a State Fair Hearing. Hearings are conducted before an administrative law judge. The client or his/her representative may request a State Fair Hearing by calling The State Fair Hearings Division of the California Department of Social Services at (855) 795-0634 or by contacting the Patient Advocacy Organization for assistance. If TDD is required, the client may call (800) 952-8349. The client may be self-represented or represented by an authorized third party such as legal counsel, relative, friend, or any other person.

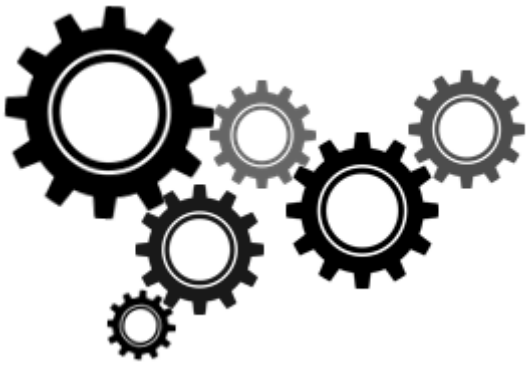
The BHS QI Unit has a civil responsibility to represent the County. In cases where the County's ASO has denied, modified, or terminated authorization for requested services, the ASO's Medical Director will assist the BHS QI Unit in representing the County's position at a State Fair Hearing.

Process for Monitoring Grievances and Appeals

- The BHS QI Unit shall be responsible for monitoring grievances and appeals, identifying issues and making recommendations for needed system improvement.
- On a monthly basis, by the 20th of each month, the patient advocacy programs shall submit copies of their Grievance and Appeal Logs to BHS QI Unit for the previous month.
- The BHS QI Unit will keep centralized records regarding all grievance procedures. Records shall include: the nature of the grievances; timelines for grievance or appeal receipt and resolution; and disposition details. The records shall also include a mechanism for tracking outcomes of grievances and State Fair Hearings which were referred to other entities. An Annual Medi-Cal Beneficiary Grievance and Appeal Report (ABGAR) shall be submitted to DHCS on the 1st of October of every year.

Attachment H2

Sample Boilerplate Contract



COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

[# Template Instructions: (1) Use Times New Roman 10; (2) # indicates instructions, notes, or where text needs to be revised. Instructions and notes are set apart from template text with [ ]. Search document for all # and change or delete text as needed. Remove all instructions, notes, and #. (3) _ indicates where text should be inserted. Search document for all _ and replace with text.]

This agreement ("Agreement") is made and entered into on the date shown on the signature page ("Effective Date") by and between the County of San Diego, a political subdivision of the State of California ("County") and Contractor **[# *enter full corporate title, describe company, located at (complete address)]*** *("* Contractor"), with reference to the following facts:

RECITALS

A. The County, by action of the Board of Supervisors Minute Order No**. [# *Enter date and minute item number, if applicable]*** authorized the Director of Purchasing and Contracting ***[#where applicable, insert the Clerk of the Board if other than Purchasing and Contracting]***, to award a contract for **[#*insert purpose.]* *[# This option is used where the Board is granting the authority to award the contract; if used, delete alternative paragraph A below.]***

Pursuant to Administrative Code section 401, the County's Director of the Department of Purchasing and Contracting is authorized to award a contract for **[#*insert purpose.]* *[# This option is used where the authority of the Director of Purchasing and Contracting to award the contract is derived from Administrative Code section 401; if used, delete alternative paragraph A above.]***

B. Contractor is specially trained and possesses certain skills, experience, education and competency to perform these services.

C. The Chief Administrative Officer made a determination that Contractor can perform the services more economically and efficiently than the County, pursuant to Section 703.10 of the County Charter**.**

D. County entered into an interim contract with Contractor, effective **[insert date]** to initiate this critical work, while the Agreement was being negotiated. County and Contractor finalized negotiations, resulting in this Agreement, which supersedes the interim contract. ***[# INCLUDE ONLY IF AN INTERIM CONTRACT WAS USED.]***

E. The Agreement shall consist of this document, Exhibit A Statement of Work, **[# *include Contractor's offer including final revisions as Exhibit A-1 where applicable],*** Exhibit B Insurance Requirements and Exhibit C, Payment [# ***Schedule*** or ***Contractor's Budget]*.** In the event that any provision of the Agreement or its Exhibits, A, A-1, B or C, conflicts with any other term or condition, precedence shall be: First (1st) the Agreement; Second (2nd) Exhibit B; Third (3rd) Exhibit A; Fourth (4th) Exhibit C; and fifth (5^{th}) Exhibit A-1.

NOW THEREFORE, for valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

ARTICLE 1
PERFORMANCE OF WORK

1.1 Standard of Performance. Contractor shall, in good and workmanlike manner and in accordance with the highest professional standards, at its own cost and expense, furnish all of the labor, technical, administrative, professional and all other personnel, all supplies and materials, equipment, printing, transportation, training, facilities, and all other means whatsoever, except as herein otherwise expressly specified to be furnished by County, necessary or proper to perform and complete the work and provide the services required of Contractor by this Agreement.

1.2 Contractor's Representative. The person identified on the signature page ("Contractor's Representative") shall ensure that Contractor's duties under this Agreement shall be performed on behalf of the Contractor by qualified personnel; Contractor represents and warrants that (1) Contractor has fulfilled all applicable requirements of the laws of the State of California to perform the services under this Agreement and (2) Contractor's Representative has full authority to act for Contractor hereunder. Contractor and County recognize that the services to be provided by Contractor's Representative pursuant to this Agreement are unique: accordingly, Contractor's Representative shall not be changed during the Term of the Agreement without County's written consent. County reserves the right to terminate this Agreement pursuant to Clause 7.1 "Termination for Default", if Contractor's Representative should leave Contractor's employ, or if, in County's judgment, the work hereunder is not being performed by Contractor's Representative.

1.3 Contractor as Independent Contractor. Contractor is, for all purposes of this Agreement, an independent contractor, and neither Contractor nor Contractor's employees or subcontractors shall be deemed to be employees of the County. Contractor shall perform its obligations under this Agreement according to the Contractor's own means and methods of work, which shall be in the exclusive charge and under the control of the Contractor, and which shall not be subject to control or supervision by County except as to the results of the work. County hereby delegates to Contractor any and all responsibility for the safety of Contractor's employees, which shall include inspection of property to identify potential hazards. Neither Contractor nor Contractor's employees or subcontractors shall be entitled to any benefits to which County

employees are entitled, including without limitation, overtime, retirement benefits, workers' compensation benefits and injury leave.

1.4 Contractor's Agents and Employees or Subcontractors. Contractor shall obtain, at Contractor's expense, all agents, employees and subcontractors required for Contractor to perform its duties under this Agreement, and all such services shall be performed by Contractor's Representative, or under Contractor's Representatives' supervision, by persons authorized by law to perform such services. Retention by Contractor of any agent, employee or subcontractor shall be at Contractor's sole cost and expense, and County shall have no obligation to pay Contractor's agents, employees or subcontractors; to support any such person's or entity's claim against the Contractor; or to defend Contractor against any such claim.

Any subcontract or consultant agreement that is in excess of fifty thousand dollars ($50,000) or twenty five percent (25%) of the value of the contract, whichever is less, or a combination of subcontracts or consultant agreements to the same individual or firm for the agreement period, or any subcontract or consultant agreement for professional medical or mental health services, regardless of value, must have prior concurrence of the Contracting Officer's Representative ("COR"). Contractor shall provide Contracting Officer Representative with copies of all other subcontracts relating to this Agreement entered into by Contractor within 30 days after the effective date of the subcontract. Such subcontractors of Contractor shall be notified of Contractor's relationship to County. "Subcontractor" means any entity, other than County, that furnishes to Contractor services or supplies relevant to this Agreement other than standard commercial supplies, office space, and printing services.

1.4.1 Contractor Responsibility. In the event any subcontractor is utilized by Contractor for any portion of the project, Contractor retains the prime responsibility for carrying out all the terms of this Agreement, including the responsibility for performance and insuring the availability and retention of records of subcontractors in accordance with this Agreement. No subcontract utilizing funds from this Agreement shall be entered into if it has a term extending beyond the ending date of this Agreement.

1.4.2 Mandated Clause. All subcontracts shall include the Standard Terms and Conditions required of Contractor Articles 3, 7, 8, 9, 10, 11, 12, 13, 14 and 16 herein.

1.4.3 County Approval. As identified above, all subcontracts under this Agreement shall have prior written approval of the Contracting Officer Representative.

1.5 Off Shore Prohibition. Except where Contractor obtains the County's prior written approval, Contractor shall perform the work of this Agreement only from or at locations within the United States. Any County approval for the performance of work outside of the United States shall be limited to the specific instance and scope of such written approval, including the types of work and locations involved. Notwithstanding the foregoing, this Section shall not restrict the country or countries of origin of any assets purchased to provide the work hereunder; provided that when such assets are used to provide the work, such assets shall be used only from or at locations within the geographic boundaries of the United States.

ARTICLE 2
SCOPE OF WORK

2.1 Statement of Work. Contractor shall perform the work described in the "Statement of Work" attached as Exhibit "A" to this Agreement, and by this reference incorporated herein, except for any work therein designated to be performed by County.

2.2 Right to Acquire Equipment and Services. Nothing in this Agreement shall prohibit the County from acquiring the same type or equivalent equipment and/or service from other sources, when deemed by the County to be in its best interest.

2.3 Responsibility for Equipment. For cost reimbursement agreements, County shall not be responsible nor be held liable for any damage to persons or property consequent upon the use, misuse, or failure of any equipment used by Contractor or any of Contractor's employees, even though such equipment may be furnished, rented, or loaned to Contractor by County. The acceptance or use of any such equipment by Contractor or Contractor's employees shall be construed to mean that Contractor accepts full responsibility for and agrees to exonerate, indemnify and hold harmless County from and against any and all claims for any damage whatsoever resulting from the use, misuse, or failure of such equipment, whether such damage be to the employee or property of Contractor, other Contractors, County, or other persons. Equipment includes, but is not limited to material, computer hardware and software, tools, or other things.

2.3.1 Contractor shall repair or replace, at Contractor's expense, all County equipment or fixed assets that are damaged or lost as a result of Contractor negligence.

2.4 Non-Expendable Property Acquisition. County retains title to all non-expendable property provided to Contractor by County, or which Contractor may acquire with funds from this Agreement if payment is on a cost reimbursement basis, including property acquired by lease purchase Agreement. Contractor may not expend funds under this Agreement for the acquisition of non-expendable property having a unit cost of $5,000 or more and a normal life expectancy of more than one year without the prior written approval of Contracting Officer Representative. Contractor shall maintain an inventory of

non-expendable equipment, including dates of purchase and disposition of the property. Inventory records on non-expendable equipment shall be retained, and shall be made available to the County upon request, for at least three years following date of disposition. Non-expendable property that has value at the end of the Agreement (e.g. has not been depreciated so that its value is zero), and to which the County may retain title under this paragraph, shall be disposed of at the end of the Agreement as follows: At County's option, it may: 1) have Contractor deliver to another County contractor or have another County contractor pick up the non-expendable property; 2) allow the contractor to retain the non-expendable property provided that the contractor submits to the County a written statement in the format directed by the County of how the non-expendable property will be used for the public good; or 3) direct the Contractor to return to the County the non-expendable property.

ARTICLE 3
DISENTANGLEMENT

3.1 General Obligations

At County's discretion, Contractor shall accomplish a complete transition of the services as set forth in Exhibit A to this Agreement (for purposes of this Article 3.1, these shall be referred to as the "Disentangled Services") being terminated from Contractor and the Subcontractors to County, or to any replacement provider designated by County, without any interruption of or adverse impact on the Disentangled Services or any other services provided by third parties. This process shall be referred to as the Disentanglement. Contractor shall fully cooperate with County and any new service provider and otherwise promptly take all steps, including, but not limited to providing to County or any new service provider all requested information or documentation, required to assist County in effecting a complete Disentanglement. Contractor shall provide all information or documentation regarding the Disentangled Services or as otherwise needed for Disentanglement, including, but not limited to, data conversion, client files, interface specifications, training staff assuming responsibility, and related professional services. Contractor shall provide for the prompt and orderly conclusion of all work required under the Agreement, as County may direct, including completion or partial completion of projects, documentation of work in process, and other measures to assure an orderly transition to County or the County's designee of the Disentangled Services. All Contractor work done as part of the Disentanglement shall be performed by Contractor and will be reimbursed by the County at no more than Contractor's costs, up to the total amount of this Agreement. Contractor shall not receive any additional or different compensation for the work otherwise required by the Agreement. Contractor's obligation to provide the Services shall not cease until the earlier of the following: 1) The Disentanglement is satisfactory to County, including the performance by Contractor of all asset-transfers and other obligations of Contractor provided in this Paragraph, has been completed to the County's reasonable satisfaction or 2) twelve (12) months after the Expiration Date of the Agreement.

3.2 Disentanglement Process

The Disentanglement process shall begin on any of the following dates: (i) the date County notifies Contractor that no funds or insufficient funds have been appropriated so that the Term shall be terminated pursuant to the Agreement, Article 7; (ii) the date designated by County not earlier than sixty (60) days prior to the end of any initial or extended term that County has not elected to extend pursuant to the Agreement's, Signature Page, Agreement Term; or (iii) the date any Termination Notice is delivered, if County elects to terminate any or all of the Services pursuant to the Agreement, Article 7. Subject to Exhibit A Contractor's obligation to perform Disentangled Services, and County's obligation to pay for Disentangled Services, shall expire: (A) when funds appropriated for payment under this Agreement are exhausted, as provided in this Agreement, Article 7; (B) at the end of the initial or extended term set forth in this Agreement's, Signature Page, Agreement Term; or (C) on the Termination Date, pursuant to this Agreement, Article 7 (with the applicable date on which Contractor's obligation to perform the Services expires being referred to herein as the "Expiration Date"). Contractor and County shall discuss in good faith a plan for determining the nature and extent of Contractor's Disentanglement obligations and for the transfer of the Disentangled Services in process provided, however, that Contractor's obligation under this Agreement to provide all Disentangled Services shall not be lessened in any respect.

3.3 Specific Obligations

The Disentanglement shall include the performance of the following specific obligations:

3.3.1 No Interruption or Adverse Impact

Contractor shall cooperate with County and all of the County's other service providers to ensure a smooth transition at the time of Disentanglement, with no interruption of Disentangled Services or other work required under the Agreement, no adverse impact on the provision of Disentangled Services or other work required under the Agreement or County's activities, no interruption of any services provided by third parties, and no adverse impact on the provision of services provided by third parties.

3.3.2 Third-Party Authorizations

Without limiting the obligations of Contractor pursuant to any other clause in Exhibit A herein, Contractor shall, subject to the terms of any third-party agreements, procure at no charge to County any third-party authorizations necessary to grant County the use and benefit of any third-party agreements between Contractor and third-party contractors used to provide the Disentangled Services, pending their assignment to County. Similarly, at County's direction, Contractor shall obtain all legally necessary client consents or authorizations legally necessary to transfer client data to County or any new service provider.

3.3.3 Licenses to Proprietary Software ***[# only include this paragraph in software agreements.]***

For any software programs developed for use under this Agreement, Contractor shall provide a nonexclusive, nontransferable, fully-paid, perpetual, irrevocable, royalty-free worldwide license to the County (or other service provider, as the case may be), at no charge to County, to use, copy, and modify, all Contractor Underlying Works and Contractor Derivatives that would be needed in order to allow County to continue to perform for itself, or obtain from other providers, the Services as the same might exist at the time of Disentanglement. Contractor shall also provide County with a copy of each such program, in such media as requested by County, together with object code, source code, and appropriate documentation. Contractor shall also offer to County the right to receive maintenance (including all enhancements and upgrades) and support with respect to such Contractor Underlying Works and Contractor Derivatives for so long as County requires, at the best rates Contractor is offering to other major customers for services of a similar nature and scope.

3.3.4 Return, Transfer and Removal of Assets

3.3.4.1 Contractor shall return to County all County assets in Contractor's possession, pursuant to Paragraph 2.4 of the Agreement.

3.3.4.2 County shall be entitled to purchase at net book value those Contractor assets used for the provision of Disentangled Services to or for County, other than those assets expressly identified by the Parties as not being subject to this provision. Contractor shall promptly remove from County's premises, or the site of the work being performed by Contractor for County, any Contractor assets that County, or its designee, chooses not to purchase under this provision.

3.3.5 Transfer of Leases, Licenses, and Agreements

Contractor, at its expense, shall convey or assign to County or its designee such fully-paid leases, licenses, and other agreements used by Contractor, County, or any other Person in connection with the Disentangled Services, as County may select**,** when such leases, licenses, and other agreements have no other use by Contractor**.** Contractor's obligation described herein, shall include Contractor's performance of all obligations under such leases, licenses, and other agreements to be performed by it with respect to periods prior to the date of conveyance or assignment and Contractor shall reimburse County for any losses resulting from any claim that Contractor did not perform any such obligations.

3.3.6 Delivery of Documentation

Contractor shall deliver to County or its designee, at County's request, all documentation and data related to County, including, but not limited to, the County Data and client files, held by Contractor, and Contractor shall destroy all copies thereof not turned over to County, all at no charge to County. Notwithstanding the foregoing, Contractor may retain one (1) copy of the documentation and data, excluding County Data, for archival purposes or warranty support.

3.4 Findings Confidential. Any reports, information, data, etc., given to or prepared or assembled by Contractor under this Agreement that the County requests to be kept as confidential shall not be made available to any individual or organization by the Contractor without the prior written approval of the County.

3.5 Publication, Reproduction or Use of Materials. No material produced, in whole or in part, under this Agreement shall be subject to copyright in the United States or in any other country. The County shall have unrestricted authority to publish, disclose, distribute and otherwise use, in whole or in part, any reports, data or other materials prepared under this Agreement. All reports, data and other materials prepared under this Agreement shall be the property of the County upon completion of this Agreement.

ARTICLE 4
COMPENSATION

[# Insert the appropriate Article 4 here]

ARTICLE 5
AGREEMENT ADMINISTRATION

5.1 County's Agreement Administrator. The Director of Purchasing and Contracting is designated as the Contracting officer ("Contracting Officer") and is the only County official authorized to make any Changes to this Agreement. The County has designated the individual identified on the signature page as the Contracting Officer's Representative ("COR")

5.1.1 County's COR will chair Contractor progress meetings and will coordinate County's Agreement administrative functions. The COR is designated to receive and approve Contractor invoices for payment, audit and inspect records, inspect Contractor services, and provide other technical guidance as required. The COR is not authorized to change any terms and conditions of this Agreement. Only the Contracting Officer, by issuing a properly executed amendment to this Agreement, may make changes to the scope of work or total price.

5.1.2 Notwithstanding any provision of this Agreement to the contrary, County's COR may make Administrative Adjustments ("AA") to the Agreement, such as line item budget changes or adjustments to the service requirements that do not change the purpose or intent of the Statement of Work, the Terms and Conditions, the Agreement Term or the total Agreement price. Each AA shall be in writing and signed by COR and Contractor. All inquiries about such AA will be referred directly to the COR.

5.2 Agreement Progress Meeting. The COR and other County personnel, as appropriate, will meet periodically with the Contractor to review the Agreement performance. At these meetings the COR will apprise the Contractor of how the County views the Contractor's performance and the Contractor will apprise the County of problems, if any, being experienced. The Contractor shall also notify the Contracting Officer (in writing) of any work being performed, if any, that the Contractor considers being over and above the requirements of the Agreement. Appropriate action shall be taken to resolve outstanding issues. The minutes of these meetings will be reduced to writing and signed by the COR and the Contractor. Should the Contractor not concur with the minutes, the Contractor shall set out in writing any area of disagreement. Appropriate action will be taken to resolve any areas of disagreement.

ARTICLE 6
CHANGES

6.1 Contracting Officer. The Contracting Officer may at any time, by a written order, make changes ("Changes"), within the general scope of this Agreement, in the definition of services to be performed, and the time (i.e.) hours of the day, days of the week, etc. and place of performance thereof. If any such Change causes an increase or decrease in the cost of, or the time required for, the performance of any part of the work under this Agreement, whether changed or not changed by such an order, an equitable adjustment shall be made in the Agreement price or delivery schedule, or both, and the Agreement shall be modified in writing accordingly. Such changes may require Board of Supervisors approval.

6.2 Claims. Contractor must assert any claim for adjustment under this clause within thirty (30) days from the date of receipt by the Contractor of the notification of Change; provided, however, that the Contracting Officer, if he decides that the facts justify such action, may receive and act upon any such claim asserted at any time prior to final payment under this Agreement. Where the cost of property made obsolete or excess as a result of a change is included in the Contractor's claim for adjustment, the Contracting Officer shall have the right to prescribe the manner of disposition of such property. Failure to agree to any adjustment shall be a dispute concerning a question of fact within the meaning of the clause of this Agreement entitled "Disputes" (Article 15). However, nothing in this clause shall excuse the Contractor from proceeding with this Agreement as changed.

ARTICLE 7
SUSPENSION, DELAY AND TERMINATION

7.1 Termination for Default. Upon Contractor's breach of this Agreement, County shall have the right to terminate this Agreement, in whole or part. Prior to termination for default, County will send Contractor written notice specifying the cause. The notice will give Contractor ten (10) days from the date the notice is issued to cure the default or make progress satisfactory to County in curing the default, unless a different time is given in the notice. If County determines that the default contributes to the curtailment of an essential service or poses an immediate threat to life, health or property, County may terminate this Agreement immediately upon issuing oral or written notice to the Contractor without any prior notice or opportunity to cure. In the event of termination under this Article, all finished or unfinished documents, and other materials, prepared by Contractor under this Agreement shall become the sole and exclusive property of County.

In the event of such termination, the County may purchase or obtain the supplies or services elsewhere, and Contractor shall be liable for the difference between the prices set forth in the terminated order and the actual cost thereof to the County. The prevailing market price shall be considered the fair repurchase price. Notwithstanding the above, Contractor shall not be relieved of liability to County for damages sustained by County by virtue of any breach of this Agreement by

Contractor, and County may withhold any reimbursement to Contractor for the purpose of off-setting until such time as the exact amount of damages due County from Contractor is determined.

If, after notice of termination of this Agreement under the provisions of this clause, it is determined for any reason that the Contractor was not in default under the provisions of this clause, the rights and obligations of the parties shall, if this Agreement contains a clause providing for termination for convenience of the County, be the same as if the notice of termination had been issued pursuant to such clause.

7.2 Damages for Delay. If Contractor refuses or fails to prosecute the work, or any separable part thereof, with such diligence as shall ensure its completion within the time specified in this Agreement, or any extension thereof, or fails to complete said work within such time, County will be entitled to the resulting damages caused by the delay. Damages will be the cost to County incurred as a result of continuing the current level and type of service over that cost that would be incurred had the Agreement segments been completed by the time frame stipulated and any other damages suffered by County.

7.3 County Exemption from Liability. In the event there is a reduction of funds made available by County to Contractor under this or subsequent agreements, the County of San Diego and its Departments, officers and employees shall incur no liability to Contractor and shall be held harmless from any and all claims, demands, losses, damages, injuries, or liabilities arising directly or from such action.

7.4 Full Cost Recovery Of Investigation And Audit Costs. Contractor shall reimburse County of San Diego for all direct and indirect expenditures incurred in conducting an audit/investigation when Contractor is found in violation (material breach) of the terms of the Agreement.

At the sole discretion of the County, and subject to funding source restrictions and federal and State law, County may (1) withhold reimbursement for such costs from any amounts due to Contractor pursuant to the payment terms of the Agreement, (2) withhold reimbursement for such costs from any other amounts due to Contractor from County, and/or (3) require Contractor to remit a check for the total amount due (or a lesser amount specified by the County) to County within thirty (30) days of request by County. Alternatively, at the County's sole discretion, County and Contractor may enter into a written repayment plan for the reimbursement of the audit/investigation costs.

7.5 Termination for Convenience. The County may, by written notice stating the extent and effective date terminate this Agreement for convenience in whole or in part, at any time. The County shall pay the Contractor as full compensation for work performed in accordance with the terms of this Agreement until such termination:

7.5.1 The unit or pro rata price for any delivered and accepted portion of the work.

7.5.2 A reasonable amount, as costs of termination, not otherwise recoverable from other sources by the Contractor as approved by the County, with respect to the undelivered or unaccepted portion of the order, provided compensation hereunder shall in no event exceed the total price.

7.5.3 In no event shall the County be liable for any loss of profits on the resulting order or portion thereof so terminated.

7.5.4 County's termination of this Agreement for convenience shall not preclude County from taking any action in law or equity against Contractor for:

7.5.4.1 Fraud, waste or abuse of Agreement funds, or

7.5.4.2 Improperly submitted claims, or

7.5.4.3 Any failure to perform the work in accordance with the Statement of Work, or

7.5.4.4 Any breach of any term or condition of the Agreement, or

7.5.4.5 Any actions under any warranty, express or implied, or

7.5.4.6 Any claim of professional negligence, or

7.5.4.7 Any other matter arising from or related to this Agreement, whether known, knowable or unknown before, during or after the date of termination.

7.6 Suspension of Work. The Contracting Officer may order the Contractor, in writing, to suspend, delay, or interrupt all or any part of the work of this Agreement for the period of time that the Contracting Officer determines appropriate for the convenience of the Government. County reserves the right to prohibit, without prior notice, contractor or contractor's employees, directors, officers, agents, subcontractors, vendors, consultants or volunteers from 1) accessing County data systems and County owned software applications, including websites, domain names, platforms, physical files, 2) treating County's patients, clients, or facility residents, or 3) providing any other services under this Agreement.

7.7 Remedies Not Exclusive. The rights and remedies of County provided in this article shall not be exclusive and are in addition to any other rights and remedies provided by law, equity, or under resulting order.

ARTICLE 8
COMPLIANCE WITH LAWS AND REGULATIONS

8.1 Compliance with Laws and Regulations. Contractor shall at all times perform its obligations hereunder in compliance with all applicable federal, State, County, and local laws, rules, and regulations, current and hereinafter enacted, including facility and professional licensing and/or certification laws and keep in effect any and all licenses, permits, notices and certificates as are required. Contractor shall further comply with all laws applicable to wages and hours of employment, occupational safety, and to fire safety, health and sanitation.

8.2 Contractor Permits and License. Contractor certifies that it possesses and shall continue to maintain or shall cause to be obtained and maintained, at no cost to the County, all approvals, permissions, permits, licenses, and other forms of documentation required for it and its employees to comply with all existing foreign or domestic statutes, ordinances, and regulations, or other laws, that may be applicable to performance of services hereunder. The County reserves the right to reasonably request and review all such applications, permits, and licenses prior to the commencement of any services hereunder.

8.3 Equal Opportunity. Contractor shall comply with the provisions of Title VII of the Civil Rights Act of 1964 in that it will not discriminate against any individual with respect to his or her compensation, terms, conditions, or privileges of employment nor shall Contractor discriminate in any way that would deprive or intend to deprive any individual of employment opportunities or otherwise adversely affect his or her status as an employee because of such individual's race, color, religion, sex, national origin, age, handicap, medical condition, sexual orientation or marital status.

8.4 Affirmative Action. Each Contractor of services and supplies employing fifteen (15) or more full-time permanent employees, shall comply with the Affirmative Action Program for Vendors as set forth in Article IIIk (commencing at Section 84) of the San Diego County Administrative Code, which program is incorporated herein by reference. A copy of this Affirmative Action Program will be furnished upon request by COR or from the County of San Diego Internet web-site (www.co.san-diego.ca.us).

8.5 Non Discrimination. Contractor shall ensure that services and facilities are provided without regard to ethnic group identification, race, color, nation origin, creed, religion, age, sex, physical or mental disability, political affiliation or marital status in accordance with applicable laws, including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C 200-d), Section 162 (a) of the Federal-Aid Highway Act of 1973 (23 U.S.C 324), Section 504 of the Rehabilitation Act of 1973, The Civil Rights Restoration Act of 1987 (P.L. 100-209), Executive Order 12898 (February 11, 1994), Executive Order 13166 (August 16, 2000), Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000-d), the Age Discrimination of 1975 (42 U.S.C. 6101), Article 9.5, Chapter 1, Part 1, Division 2, Title 2 (Section 11135, et seq) of the California Government Code, Title 9, Chapter 4, Subchapter 6 (Section 10800, et seq) of the CCR and California Dept of Social Services Manual of Policies and Procedures (CDSS MPP) Division 21.

8.6 AIDS Discrimination. Contractor shall not deny any person the full and equal enjoyment of, or impose less advantageous terms, or restrict the availability of, the use of any County facility or participation in any County funded or supported service or program on the grounds that such person has Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) as those terms are defined in Title 3, Division 2, Chapter 8, Section 32.803, of the San Diego County Code of Regulatory Ordinances.

8.7 American with Disabilities Act (ADA) 1990. Contractor shall not discriminate against qualified people with disabilities in employment, public services, transportation, public accommodations and telecommunications services in compliance with the Americans with Disabilities Act (ADA) and California Administrative Code Title 24.

8.8 Political Activities Prohibited. None of the funds, provided directly or indirectly, under this Agreement shall be used for any political activities or to further the election or defeat of any candidate for public office. Contractor shall not utilize or allow its name to be utilized in any endorsement of any candidate for elected office. Neither this Agreement nor any funds provided hereunder shall be utilized in support of any partisan political activities, or activities for or against the election of a candidate for an elected office.

8.9 Lobbying. Contractor agrees to comply with the lobbying ordinances of the County and to assure that its officers and employees comply before any appearance before the County Board of Supervisors. Except as required by this Agreement, none of the funds provided under this Agreement shall be used for publicity or propaganda purposes designed to support or defeat any legislation pending before State and federal Legislatures, the Board of Supervisors of the County, or before any other local governmental entity. This provision shall not preclude Contractor from seeking necessary permits, licenses and the like necessary for it to comply with the terms of this Agreement.

8.10 Religious Activity Prohibited. There shall be no religious worship, instructions or proselytization as part of or in connection with the performance of this Agreement.

8.11 Drug and Alcohol-Free Workplace. The County of San Diego, in recognition of individual rights to work in a safe, healthful and productive work place, has adopted a requirement for a drug and alcohol free work place, County of San

Diego Drug and Alcohol Use Policy C-25. This policy provides that all County-employed Contractors and Contractor employees shall assist in meeting this requirement.

8.11.1 As a material condition of this Agreement, the Contractor agrees that the Contractor and the Contractor employees, while performing service for the County, on County property, or while using County equipment:

8.11.1.1 Shall not be in any way impaired because of being under the influence of alcohol or a drug.

8.11.1.2 Shall not possess an open container of alcohol or consume alcohol or possess or be under the influence of an illegal drug.

8.11.1.3 Shall not sell, offer, or provide alcohol or an illegal drug to another person; provided, however, that the foregoing restriction shall not be applicable to a Contractor or Contractor employee who as part of the performance of normal job duties and responsibilities prescribes or administers medically prescribed drugs.

8.11.2 Contractor shall inform all employees who are performing service for the County on County property or using County equipment of the County objective of a safe, healthful and productive work place and the prohibition of drug or alcohol use or impairment from same while performing such service for the County.

8.11.3 The County may terminate for default or breach this Agreement, and any other agreement the Contractor has with the County, if the Contractor, or Contractor employees are determined by the Contracting Officer not to be in compliance with the conditions listed herein.

8.12 Board of Supervisors' Policies. Contractor represents that it is familiar, and shall use its best efforts to comply, with the following policies of the Board of Supervisors: **[#** ***Add Other Policies That May Apply for Certain Types of Services]***

8.12.1 Board Policy B-67, which encourages the County's Contractors to offer products made with recycled materials, reusable products, and products designed to be recycled to the County in response to the County's requirements; and

8.12.2 Board Policies B-53 and B-39a, which encourage the participation of small and disabled veterans' business enterprises in County procurements; and

8.12.3 Zero Tolerance for Fraudulent Conduct in County Services. Contractor shall comply with County of San Diego Board of Supervisors Policy A-120 "Zero Tolerance for Fraudulent Conduct in County Services." There shall be "Zero Tolerance" for fraud committed by contractors in the administration of County programs and the provision of County services. Upon proven instances of fraud committed by independent contractors in connection with their performance under the Agreement, said contractor shall be subject to corrective action up to and including termination of the Agreement; and

8.12.4 Interlocking Directorate. In recognition of County Policy A-79, not-for-profit Contractors shall not subcontract with related for-profit subcontractors for which an interlocking relationship exist unless specifically authorized in writing by the Board of Supervisors; and

8.12.5 Zero Tolerance in Coaching Medi-Cal or Welfare Clients (Including Undocumented Immigrants). The County of San Diego in recognition of its unique geographical location and the utilization of the Welfare and Medi-Cal systems by foreign nationals who are not legal residents of this county or country, has adopted a Zero Tolerance policy and shall aggressively prosecute employees and Contractors who coach Medi-Cal or Welfare clients (including undocumented immigrants), to obtain services for which they are not otherwise entitled.

As a material condition of this Agreement, Contractor agrees that the Contractor and Contractor's employees, while performing service for the County, on County property or while using County equipment shall not:

(a) in any way coach, instruct, advise, or guide any Medi-Cal or Welfare clients or prospective clients who are undocumented immigrants on ways to obtain or qualify for Medi-Cal assistance, for which they are not otherwise entitled.

(b) support or provide funds to any organization engaged directly or indirectly in advising undocumented immigrants on ways to obtain or qualify for Medi-Cal assistance, for which they are not otherwise entitled.

Contractor shall inform all employees that are performing service for the County on County property or using County equipment of County's Zero Tolerance Policy as referenced herein.

County may terminate for default or breach this Agreement and any other agreement Contractor has with County, if Contractor or Contractor employees are determined not to be in compliance with the conditions stated herein.

8.13 Cartwright Act. Following receipt of final payment under the Agreement, Contractor assigns to the County all rights, title and interest in and to all causes of action it may have under Section 4 of the Clayton Act (15 U.S.C. Sec. 15) or under the

Cartwright act (Chapter 1) (commencing with Section 16700) of Part 2 of Division 7 of the Business and Professions Code), arising from purchases of goods, materials, or services by the Contractor for sale to the County under this Agreement.

8.14 Hazardous Materials. Contractor shall comply with all Environmental Laws and all other laws, rules, regulations, and requirements regarding Hazardous Materials, health and safety, notices, and training. Contractor agrees that it will not store any Hazardous Materials at any County facility for periods in excess of ninety (90) days or in violation of the applicable site storage limitations imposed by Environmental Law. Contractor agrees to take, at its expense, all actions necessary to protect third parties, including, without limitation, employees and agents of the County, from any exposure to Hazardous Materials generated or utilized in its performance under this Agreement. Contractor agrees to report to the appropriate governmental agencies all discharges, releases, and spills of Hazardous Materials that are required to be reported by any Environmental Law and to immediately notify the County of it. Contractor shall not be liable to the County for the County's failure to comply with, or violation of, any Environmental Law. As used in this section, the term "Environmental Laws" means any and all federal, state or local laws or ordinances, rules, decrees, orders, regulations or court decisions (including the so-called "common law"), including, but not limited to, the Resource Conservation and Recovery Act, relating to hazardous substances, hazardous materials, hazardous waste, toxic substances, environmental conditions or other similar substances or conditions. As used in this section the term "Hazardous Materials" means any chemical, compound, material, substance or other matter that: (a) is a flammable, explosive, asbestos, radioactive nuclear medicine, vaccine, bacteria, virus, hazardous waste, toxic, overtly injurious or potentially injurious material, whether injurious or potentially injurious by itself or in combination with other materials; (b) is controlled, referred to, designated in or governed by any Environmental Laws; (c) gives rise to any reporting, notice or publication requirements under any Environmental Laws, or (d) is any other material or substance giving rise to any liability, responsibility or duty upon the County or Lessee with respect to any third person under any Environmental Laws.

8.15 Clean Air Act and Federal Water Pollution Control Act.

8.15.1 Contractor agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, as amended, 42 U.S.C. §§ 7401 et seq. Contractor agrees to report each violation to the USDA and the appropriate EPA Regional Office.

8.15.2 Contractor agrees to comply with all applicable standards, orders or regulations issued pursuant to the Federal Water Pollution Control Act as amended (33 U.S.C. §§ 1251 et seq.). Contractor agrees to report each violation to the USDA and the appropriate EPA Regional Office.

8.16 Debarment, Exclusion, Suspension, and Ineligibility.

8.16.1 Contractor certifies that, except as disclosed to County and acknowledged in writing by County prior to the execution of this Agreement, Contractor, its employees, directors, officers, agents, subcontractors, vendors, consultants, and volunteers:

8.16.1.1 Are not presently debarred, excluded, suspended, declared ineligible, voluntarily excluded, or proposed for debarment, exclusion, suspension or ineligibility by any federal, state, or local department or agency; and

8.16.1.2 Have not within a 3-year period preceding this Agreement been convicted of, or had a civil or administrative judgment rendered against them for, the commission of fraud or a criminal offense or civil action in connection with obtaining, attempting to obtain, or performing a public (federal, State, or local) transaction; violation of federal or State anti-trust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, receiving stolen property; physical, financial or sexual abuse or misconduct with a patient or client, or medical negligence or malpractice;

8.16.1.3 Are not presently indicted or otherwise criminally, civilly or administratively charged by a government entity (federal, State, or local) with commission of any of the offenses enumerated in the paragraph above; and

8.16.1.4 Have not within a 3-year period preceding this Agreement had one or more public transaction (federal, State, or local) terminated for cause or default.

8.16.2 Contractor shall have an ongoing duty during the term of this Agreement to disclose to the County any occurrence that would prevent Contractor from making the certifications contained in this Section 8.16 on an ongoing basis. Such disclosure shall be made in writing to the COR and the County Office of Ethics and Compliance within five (5) business days of when Contractor discovers or reasonably believes there is a likelihood of such occurrence.

8.16.3 Contractor invoices shall include the following language:

I certify that the above deliverables and/or services were delivered and/or performed specifically for this Agreement in accordance with the terms and conditions set forth herein.

[# This paragraph may be removed if no federal or State funds are used] I further certify, under penalty of perjury under the laws of the State of California, that no employee or entity providing services under the terms and conditions of this Agreement is currently listed as debarred, excluded, suspended, or ineligible on the Federal System for Award Management (SAM: http://SAM.gov), the Federal Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (LEIE: http://exclusions.oig.hhs.gov), or the State of California Medi-Cal Suspended and Ineligible list (www.medi-cal.ca.gov).

8.17 Display of Fraud Hotline Poster(s). As a material term and condition of this Agreement, Contractor shall:

8.17.1 Prominently display in common work areas within all business segments performing work under this Agreement County of San Diego Office of Ethics and Compliance Ethics Hotline posters;

8.17.2 Posters may be downloaded from the County Office of Ethics and Compliance website at: http://www.sandiegocounty.gov/content/sdc/cao/oec.html. Additionally, if Contractor maintains a company website as a method of providing information to employees, the Contractor shall display an electronic version of the poster(s) at the website;

8.17.3 If Contractor has implemented a business ethics and conduct awareness program, including a reporting mechanism, the Contractor need not display the County poster;

8.17.4 In the event Contractor subcontracts any of the work performed under this Agreement, Contractor include this clause in the subcontract(s) and shall take appropriate steps to ensure compliance by the subcontractor(s).

8.18 False Claims Act Training. Contractor shall, not less than annually, provide training on the Federal False Claims Act (31 USC 3729-3730) and State False Claims Act (California Government Code 12650-12653) to all employees, directors, officers, agents, subcontractors, consultants or volunteers providing services under this Agreement. Contractor shall maintain verification of this training. Contractor shall retain these forms, or an electronic version, in accordance with the Agreement requirement for retention of records. For the purposes of this section, "Subcontractor" shall include any entity, other than County, that furnishes to Contractor services or supplies relevant to this Agreement other than standard commercial supplies, office space, and printing services.

8.19 Code of Ethics. As a material term and condition of this Agreement, Contractor shall develop and implement a Code of Ethics or similar document and maintain it during the term of this Agreement. Additionally, Contractor shall train all employees and volunteers on the Code of Ethics, and all employees, volunteers, directors, officers, and agents shall certify that they have received training and have been provided an opportunity to ask questions of their employer regarding the Code of Ethics. Contractor shall retain these certifications in accordance with the Agreement's provision regarding retention of records. Contractor shall pass this requirement down to its subcontractors in its entirety. For purposes of this section, "Subcontractor" shall mean any entity, other than County, that furnishes to Contractor services or supplies relevant to this Agreement other than standard commercial supplies, office space, and printing services.

8.20 Compliance Program. Contractors with an agreement that exceeds more than $250,000 in value annually shall establish, and maintain for the duration of this Agreement, a compliance program that meets the standards of Federal Sentencing Guidelines section 8B2.1 and 42 CFR 438.608 (b)(1) – (b) (7) regardless of funding source or services.

8.21 Investigations. Unless prohibited by an investigating government authority, Contractor shall cooperate and participate fully in any investigation initiated by County relative to this Agreement. Upon County's request, Contractor shall promptly provide to County any and all documents, including any and all communications or information stored digitally, and make available for interviews any employee(s) of Contractor identified by County. Contractor further agrees to immediately notify County if any employee, director, officer, agent, subcontractor, vendor, consultant or volunteer of Contractor comes under investigation by any federal, State or local government entity with law enforcement or oversight authority over the Agreement or its funding for conduct arising out of, or related to, performance under this Agreement.

Contractor shall promptly make available to County all internal investigative results, findings, conclusions, recommendations and corrective action plans pertaining to the investigation in its possession as requested by the County, unless otherwise protected by applicable law or privilege.

8.22 Contracting with Small and Minority Businesses, Women's Business Enterprises, and Labor Surplus Area Firms. ***[#Remove this clause unless federal funds are being used]*** Contractor shall, in accordance with 2 CFR 200.321 - Contracting with small and minority businesses, women's business enterprises, and labor surplus area firms, take affirmative steps to include minority business, women's business enterprises, and labor surplus area firm by:

8.22.1 Placing qualified small and minority businesses and women's business enterprises on solicitation lists;

8.22.2 Assuring that small and minority businesses, and women's business enterprises are solicited whenever they are potential sources;

8.22.3 Dividing total requirements, when economically feasible, into smaller tasks or quantities to permit maximum participation by small and minority businesses, and women's business enterprises;

8.22.4 Establishing delivery schedules, where the requirement permits, which encourage participation by small and minority businesses, and women's business enterprises; and

8.22.5 Using the services and assistance, as appropriate, of such organizations as the Small Business Administration and the Minority Business Development Agency of the Department of Commerce.

ARTICLE 9
CONFLICTS OF INTEREST; CONTRACTOR'S CONDUCT

9.1 Conflicts of Interest. Contractor presently has no interest, including but not limited to other projects or independent agreements, and shall not acquire any such interest, direct or indirect, which would conflict in any manner or degree with the performance of services required to be performed under this Agreement. The Contractor shall not employ any person having any such interest in the performance of this Agreement. Contractor shall not hire County's employees to perform any portion of the work or services provided for herein including secretarial, clerical and similar incidental services except upon the written approval of County. Without such written approval, performance of services under this Agreement by associates or employees of County shall not relieve Contractor from any responsibility under this Agreement.

9.1.1 California Political Reform Act and Government Code Section 1090 Et Seq. Contractor acknowledges that the California Political Reform Act ("Act"), Government Code section 81000 et seq., provides that Contractors hired by a public agency, such as County, may be deemed to be a "public official" subject to the Act if the Contractor advises the agency on decisions or actions to be taken by the agency. The Act requires such public officials to disqualify themselves from participating in any way in such decisions if they have any one of several specified "conflicts of interest" relating to the decision. To the extent the Act applies to Contractor, Contractor shall abide by the Act. In addition, Contractor acknowledges and shall abide by the conflict of interest restrictions imposed on public officials by Government Code section 1090 et seq.

9.2 Conduct of Contractor.

9.2.1 Contractor shall inform the County of all Contractor's interests, if any, that are, or that Contractor believes to be, incompatible with any interests of the County.

9.2.2 Contractor shall not, under circumstances that might reasonably be interpreted as an attempt to influence the recipient in the conduct of his duties, accept any gratuity or special favor from individuals or organizations with whom the Contractor is doing business or proposing to do business, in accomplishing the work under this Agreement.

9.2.3 Contractor shall not use for personal gain or make other improper use of confidential information, which is acquired in connection with his employment. In this connection, the term "confidential information" includes, but is not limited to, unpublished information relating to technological and scientific development; medical, personnel, or security records of the individuals; anticipated materials requirements or pricing actions; and knowledge of selections of Contractors or subcontractors in advance of official announcement.

9.2.4 Contractor, its employees, directors, officers, agents, subcontractors, vendors, consultants, and volunteers shall not offer, directly or indirectly, any unlawful gift, gratuity, favor, entertainment, or other item(s) of monetary value to an employee or official of the County.

9.2.5 Referrals. Contractor further covenants that no referrals of clients through Contractor's intake or referral process shall be made to the private practice of any person(s) employed by the Contractor.

9.3 Prohibited Agreements. As required by Section 67 of the San Diego County Administrative Code, Contractor certifies that it is not in violation of the provisions of Section 67, and that Contractor is not, and will not subcontract with, any of the following:

9.3.1. Persons employed by County or of public agencies for which the Board of Supervisors is the governing body;

9.3.2. Profit-making firms or businesses in which employees described in sub-section 9.3.1, above, serve as officers, principals, partners, or major shareholders;

9.3.3. Persons who, within the immediately preceding twelve (12) months came within the provisions of the above sub-sections and who (1) were employed in positions of substantial responsibility in the area of service to be performed by the Agreement, or (2) participated in any way in developing the Agreement or its service specifications; and

9.3.4. Profit-making firms or businesses, in which the former employees described in sub-section 9.3.3 above, serve as officers, principals, partners, or major shareholders.

9.4 Limitation of Future Agreements or Grants. It is agreed by the parties to the Agreement that Contractor shall be restricted in its future contracting with the County to the manner described below. Except as specifically provided in this clause, Contractor shall be free to compete for business on an equal basis with other companies.

9.4.1 If Contractor, under the terms of the Agreement, or through the performance of tasks pursuant to this Agreement, is required to develop specifications or statements of work and such specifications or statements of work are to be incorporated into a solicitation, Contractor shall be ineligible to perform the work described within that solicitation as a prime or subcontractor under an ensuing County agreement. It is further agreed, however, that County will not, as additional work, unilaterally require Contractor to prepare such specifications or statements of work under this Agreement.

9.4.2 Contractor may not apply for nor accept additional payments for the same services contained in the Statement of Work.

ARTICLE 10
INDEMNITY AND INSURANCE

10.1 Indemnity. County shall not be liable for, and Contractor shall defend and indemnify County and the employees and agents of County (collectively "County Parties"), against any and all claims, demands, liability, judgments, awards, fines, mechanics' liens or other liens, labor disputes, losses, damages, expenses, charges or costs of any kind or character, including attorneys' fees and court costs (hereinafter collectively referred to as "Claims"), related to this Agreement or the work covered by this Agreement and arising either directly or indirectly from any act, error, omission or negligence of Contractor or its Contractors, licensees, agents, servants or employees, including, without limitation, Claims caused by the sole passive negligent act or the concurrent negligent act, error or omission, whether active or passive, of County Parties. Contractor shall have no obligation, however, to defend or indemnify County Parties from a Claim if it is determined by a court of competent jurisdiction that such Claim was caused by the sole negligence or willful misconduct of County Parties.

10.2 Insurance. Prior to execution of this Agreement, Contractor must obtain at its own cost and expense, and keep in force and effect during the term of this Agreement, including all extensions, the insurance specified in Exhibit "B," "Insurance Requirements," attached hereto.

ARTICLE 11
AUDIT AND INSPECTION OF RECORDS

The County shall have the audit and inspection rights described in this section.

11.1 Audit and Inspection. Contractor agrees to maintain and/or make available within San Diego County accurate books and accounting records relative to all its activities under this Agreement. Authorized federal, State or County representatives shall have the right to monitor, assess, or evaluate Contractor's performance pursuant to this Agreement, said monitoring, assessments, or evaluations to include but not limited to audits, inspection of premises, reports, and interviews of project staff and participants. Contractor assertions of confidentiality shall not be a bar to full access to the records.

At any time during normal business hours and as often as County may deem necessary, Contractor shall make available to County, State or federal officials for examination all of its records with respect to all matters covered by this Agreement and will permit County, State or federal officials to audit, examine and make excerpts or transcripts from such records, and to make audits of all invoices, materials, payrolls, records of personnel, information regarding clients receiving services, and other data relating to all matters covered by this Agreement. If an audit is conducted, it will be done in accordance with generally accepted government auditing standards as described in "Government Auditing Standards," published for the United States General Accountability Office or the institute of Internal Auditors International Standards for the Professional Practice of Internal Auditing.

If any services performed hereunder are not in conformity with the specifications and requirements of this Agreement, County shall have the right to require the Contractor to perform the services in conformity with said specifications and requirements at no additional increase in total Agreement amount. When the services to be performed are of such nature that the difference cannot be corrected, County shall have the right to (1) require Contractor immediately to take all necessary steps to ensure future performance of the services in conformity with requirements of the Agreement, and (2) reduce the Agreement price to reflect the reduced value of the services performed. In the event Contractor fails to perform the services promptly or to take necessary steps to ensure future performance of the service in conformity with the specifications and requirements of the Agreement, County shall have the right to either (1) by agreement or to otherwise have the services performed in conformity with the Agreement specifications and charge to Contractor any cost occasioned to County that is directly related to the performance of such services, or (2) terminate this Agreement for default as provided in the Termination clause.

11.2 External Audits. [Note: Health and Human Services Agency (HHSA) Contractors shall advise and provide the electronic audit copies to Agency Contract Support (ACS) at ACS.HHSA@sdcounty.ca.gov.] All other contractors will provide the following to their COR:

11.2.1 Contractor shall provide COR a copy of all notifications of audits or pending audits by federal or State representatives regarding contracted services identified in this Agreement no later than three (3) business days of Contractor receiving notice of the audit.

11.2.2 Contractor shall provide COR with a copy of the draft and final State or federal audit reports within twenty four (24) hours of receiving them.

11.2.3 Contractor shall provide COR a copy of the contractor's response to the draft and final State or federal audit reports at the same time as response provided to the State or federal representatives.

11.2.4 Unless prohibited by the government agency conducting the audit, Contractor shall provide COR a copy of all responses made by the federal or State audit representative to the contractors' audit response no later than three (3) business days of receiving it. This will continue until the federal or State auditors have accepted and closed the audit.

11.3 Cost or Pricing Data. If the Contractor submitted cost or pricing data in connection with the pricing of this Agreement or any change or modification thereto, unless such pricing was based on adequate price competition, established catalog or market prices of commercial items sold in substantial quantities of the general public, or prices set by law or regulation, the Contracting Officer or his representatives who are employees of the County or its agent shall have the right to examine all books, records, documents and other data of the Contractor related to the negotiation pricing or performance of such Agreement, change or modification, for the purpose of evaluating the accuracy, completeness and currency of the cost or pricing data submitted.

11.4 Availability. The materials described above shall be made available at the office of the Contractor, at all reasonable times, for inspection, audit or reproduction, until the expiration of three (3) years from the date of final payment under this Agreement, or by section 11.4.1 and 11.4.2, below:

11.4.1 If this Agreement is completely or partially terminated, the records relating to the work terminated shall be made available for a period of three (3) years from the date of any resulting final settlement.

11.4.2 Record that relate to appeals under the "Disputes" clause of this Agreement, or litigation or the settlement of claims arising out of the performance of this Agreement, shall be made available until such appeals, litigation, or claims have been disposed of, or three years after Agreement completion, whichever is longer. County shall keep the materials described above confidential unless otherwise required by law.

11.5 Subcontract. The Contractor shall insert a clause containing all the provisions of this Article 11 in all subcontracts hereunder except altered as necessary for proper identification of the contracting parties and the contracting officer.

ARTICLE 12
INSPECTION OF SERVICE

12.1 Subject to Inspection. All performance (including services, materials, supplies and equipment furnished or utilized in the performance of this Agreement, and workmanship in the performance of services) shall be subject to inspection and test by the County at all times during the term of this Agreement. Contractor shall cooperate with any inspector assigned by the County to permit the inspector to determine whether Contractor's performance conforms to the requirements of this Agreement. County shall perform such inspection in a manner as not to unduly interfere with Contractor's performance.

12.2 Specification and Requirements. If any services performed by Contractor do not conform to the specifications and requirements of this Agreement, County may require Contractor to re-perform the services until they conform to said specifications and requirements, at no additional cost, and County may withhold payment for such services until Contractor correctly performs them. When the services to be performed are of such a nature that Contractor's cannot correct its performance, the County shall have the right to (1) require the Contractor to immediately take all necessary steps to ensure future performance of services conforms to the requirements of this Agreement, and (2) reduce the Agreement price to reflect the reduced value of the services received by County. In the event Contractor fails to promptly re-perform the services or to take necessary steps to ensure that future performance of the service conforms to the specifications and requirements of this Agreement, the County shall have the right to either (1) without terminating this Agreement, have the services performed, by agreement or otherwise, in conformance with the specifications of this Agreement, and charge Contractor, and/or withhold from payments due to Contractor, any costs incurred by County that are directly related to the performance of such services, or (2) terminate this Agreement for default.

ARTICLE 13
USE OF DOCUMENTS AND REPORTS

13.2 Findings Confidential. Any reports, information, data, etc., given to or prepared or assembled by Contractor under this Agreement that the County requests to be kept as confidential shall not be made available to any individual or organization by the Contractor without the prior written approval of the County.

13.3 Ownership, Publication, Reproduction and Use of Material. All reports, studies, information, data, statistics, forms, designs, plans, procedures, systems, and any other material or properties produced under this Agreement shall be the sole and exclusive property of County. No such materials or properties produced in whole or in part under this Agreement shall be subject to private use, copyright or patent right by Contractor in the United States or in any other country without the express written consent of County. County shall have unrestricted authority to publish, disclose, distribute and otherwise use, copyright or patent, in whole or in part, any such reports, studies, data, statistics, forms or other materials or properties produced under this Agreement.

13.4 Confidentiality. Contractor agrees to maintain the confidentiality of and take industry appropriate and legally required measures to prevent the unlawful disclosure of any information that is legally required to be kept confidential. Except as otherwise allowed by local, State or federal law or regulation and pursuant to this Section 13.3, Contractor agrees to only disclose confidential records where the holder of the privilege, whether the County, or a third party, provides written permission authorizing the disclosure.

13.5 Public Records Act. The California Public Records Act ("CPRA") requires County to disclose "public records" in its actual or constructive possession unless a statutory exemption applies. This generally includes contracts and related documents. If County receives a CPRA request for records relating to the Agreement, County may, at its sole discretion, either determine its response to the request without notifying Contractor or notify Contractor of the request. If County determines its response to the request without notifying Contractor, Contractor shall hold County harmless for such determination. If County notifies Contractor of the request, Contractor may request that County withhold or redact records responsive to the request by submitting to County a written request within five (5) business days after receipt of the County's notice. Contractor's request must identify specific records to be withheld or redacted and applicable exemptions. Upon timely receipt of Contractor's request, County will review the request and at its sole discretion withhold and/or redact the records identified by Contractor. Contractor shall hold County harmless for County's decision whether to withhold and/or redact pursuant to Contractor's written request. Contractor further agrees that its defense and indemnification obligations set forth in Section 10.1 of this Agreement extend to any Claim (as defined in Section 10.1) against the County Parties (as defined in Section 10.1) arising out of County's withholding and/or redacting of records pursuant to Contractor's request. Nothing in this section shall preclude Contractor from bringing a "reverse CPRA action" to prevent disclosure of records. Nothing in this section shall prevent the County or its agents or any other governmental entity from accessing any records for the purpose of audits or program reviews if that access is legally permissible under the applicable local, State or federal laws or regulations. Similarly, County or its agent or designee may take possession of the record(s) where legally authorized to do so.

13.6 Maintenance of Records. Contractor shall maintain all records relating to its performance under this Agreement, including all records of costs charged to this Agreement, and shall make them available within San Diego County for a minimum of five (5) years from the ending date of this Agreement, or longer where required by funding source or while under dispute under the terms of this Agreement, unless County agrees in writing to an earlier disposition. Contractor shall provide any requested records to County within two (2) business days of request.

13.7 Custody of Records. County, at its option, may take custody of Contractor's client records upon Agreement, termination, expiration, or at such other time as County may deem necessary. County agrees that such custody will conform to applicable confidentiality provisions of State and federal law. Said records shall be kept by County in an accessible location within San Diego County and shall be available to Contractor for examination and inspection.

13.8 Audit Requirement.

(a) Contractor shall annually engage a Licensed Certified Public Accountant licensed to perform audits and attests in the State of California to conduct an annual audit of its operations. Contractors that expend $750,000 or more of federal grant funds per year shall also have an audit conducted in compliance with Government Auditing Standards, which includes Single Audit Act Amendments, Public Law 104-156, and the Compliance Supplement (2CFR part 200 App. XI). Contractors that are commercial organizations (for-profit) are required to have a non-federal audit if, during its fiscal year, it expended a total of $750,000 or more under one or more HHS awards. 45 CFR part 74.26(d) incorporates the threshold and deadlines of the Compliance Supplement but provides for-profit organizations two options regarding the type of audit that will satisfy the audit requirements. Contractor shall include a clause in any agreement entered into with an audit firm, or notify the audit firm in writing prior to the audit firm commencing its work for Contractor, that the audit firm shall, pursuant to 31 U.S.C. 7503, and to the extent otherwise required by law, provide access by the federal government or other legally required entity to the independent auditor's working papers that were part of the independent auditor's audit of Contractor. Contractor shall submit two (2) copies of the annual audit report, the audit performed in accordance with the

Compliance Supplement, and the management letter to the County fifteen (15) days after receipt from the independent Certified Public Accountant but no later than nine (9) months after the Contractor's fiscal year end.

(b) Contractor shall immediately notify County upon learning that Contractor's independent Certified Public Accountant may or will issue a disclaimer of opinion due to substantial doubt of Contractor's ability to continue as a going concern.

13.9 Reports. Contractor shall submit reports required in Exhibit A and additional reports as may be requested by the COR and agreed to by the Contractor. Format for the content of such reports may be developed by County. The timely submission of these reports is a necessary and material term and condition of this Agreement and Contractor agrees that failure to meet specified deadlines will be sufficient cause to withhold payment. Contractor shall submit to County within thirty (30) days of the termination of this Agreement a report detailing all work done pursuant to this Agreement by Contractor.

13.10 Evaluation Studies. Contractor shall participate as requested by the County in research and/or evaluative studies designed to show the effectiveness and/or efficiency of Contractor services or to provide information about Contractor's project.

ARTICLE 14
(RESERVED)

ARTICLE 15
DISPUTES

Notwithstanding any provision of this Agreement to the contrary, the Contracting Officer shall decide any dispute concerning a question of fact arising out of this Agreement that is not otherwise disposed of by the parties within a reasonable period of time. The decision of the Contracting Officer shall be final and conclusive unless determined by a court of competent jurisdiction to have been fraudulent, capricious, arbitrary or so grossly erroneous as necessarily to imply bad faith. Contractor shall proceed diligently with its performance hereunder pending resolution by the Contracting Officer of any such dispute. Nothing herein shall be construed as granting the Contracting Officer or any other administrative official, representative or board authority to decide questions of law**,** or issues regarding the medical necessity of treatment or to pre-empt any medical practitioners' judgment regarding the medical necessity of treatment of patients in their care. The foregoing does not change the County's ability to refuse to pay for services rendered if County disputes the medical necessity of care.

ARTICLE 16
GENERAL PROVISIONS

16.1 Assignment and Subcontracting. Contractor shall not assign any interest in this Agreement, and shall not transfer any interest in the same (whether by assignment or novation), without the prior written consent of the County; County's consent shall not be unreasonably withheld. The Contractor shall make no agreement with any party for furnishing any of the work or services herein contained without the prior written consent of the COR, pursuant to Paragraph 1.4.

16.2 Contingency. This Agreement shall bind the County only following its approval by the Board of Supervisors or when signed by the Purchasing and Contracting Director.

16.3 Entire Agreement. This Agreement, together with all Exhibits attached hereto and other agreements expressly referred to herein, constitute the entire agreement between the parties with respect to the subject matter contained herein. All prior or contemporaneous agreements, understandings, representations, warranties and statements, oral or written, including any proposals from Contractor and requests for proposals from County, are superseded.

16.4 Sections and Exhibits. All sections and exhibits referred to herein are attached hereto and incorporated by reference.

16.5 Further Assurances. Parties agree to perform such further acts and to execute and deliver such additional documents and instruments as may be reasonably required in order to carry out the provisions of this Agreement and the intentions of the parties.

16.6 Governing Law. This Agreement shall be governed, interpreted, construed and enforced in accordance with the laws of the State of California.

16.7 Headings. The Article captions, Clause and Section headings used in this Agreement are inserted for convenience of reference only and are not intended to define, limit or affect the construction or interpretation of any term or provision hereof.

16.8 Modification Waiver. Except as otherwise provided in Article 6, "Changes," above, no modification, waiver, amendment or discharge of this Agreement shall be valid unless the same is in writing and signed by both parties.

16.9 Neither Party Considered Drafter. Despite the possibility that one party may have prepared the initial draft of this Agreement or played the greater role in the physical preparation of subsequent drafts, neither party shall be deemed the drafter of this Agreement and that, in construing this Agreement in case of any claim that any provision hereof may be

ambiguous, no such provision shall be construed in favor of one party on the ground that such provision was drafted by the other.

16.10 No Other Inducement. The making, execution and delivery of this Agreement by the parties hereto has been induced by no representations, statements, warranties or agreements other than those expressed herein.

16.11 Notices. Notice to either party shall be in writing and personally delivered; sent by certified mail, postage prepaid, return receipt requested; or emailed to the County's or Contractor's designated representative (or such party's authorized representative). Any such notice shall be deemed received by the party (or such party's authorized representative) on the earliest of the date of personal delivery, three (3) business days after deposit in the U.S. Mail, or upon sending of an email from which an acknowledgement of receipt has been received other than an out of office, unavailable, or undeliverable reply.

16.12 Severability. If any term, provision, covenant or condition of this Agreement is held to be invalid, void or otherwise unenforceable, to any extent, by any court of competent jurisdiction, the remainder of this Agreement shall not be affected thereby, and each term, provision, covenant or condition of this Agreement shall be valid and enforceable to the fullest extent permitted by law.

16.13 Successors. Subject to the limitations on assignment set forth in Clause 16.1 above, all terms of this Agreement shall be binding upon, inure to the benefit of, and be enforceable by the parties hereto and their respective heirs, legal representatives, successors, and assigns.

16.14 Time. Time is of the essence for each provision of this Agreement.

16.15 Time Period Computation. All periods of time referred to in this Agreement shall be calendar days, unless the period of time specifies business days. Calendar days shall include all days of the week, including holidays. Business days shall be Monday through Friday, excluding County observed holidays.

16.16 Waiver. The waiver by one party of the performance of any term, provision, covenant or condition shall not invalidate this Agreement, nor shall it be considered as a waiver by such party of any other term, provision, covenant or condition. Delay by any party in pursuing any remedy or in insisting upon full performance for any breach or failure of any term, provision, covenant or condition shall not prevent such party from later pursuing remedies or insisting upon full performance for the same or any similar breach or failure.

16.17 Third Party Beneficiaries Excluded. This Agreement is intended solely for the benefit of the County and its Contractor. Any benefit to any third party is incidental and does not confer on any third party to this Agreement any rights whatsoever regarding the performance of this Agreement. Any attempt to enforce provisions of this Agreement by third parties is specifically prohibited.

16.18 Publicity Announcements and Materials. All public announcements, including those issued on Contractor letterhead, and materials distributed to the community shall identify the County of San Diego as the funding source for contracted programs identified in this Agreement. Copies of publicity materials related to contracted programs identified in this Agreement shall be filed with the COR. County shall be advised at least twenty four (24) hours in advance of all locally generated press releases and media events regarding contracted services identified in this Agreement. Alcohol and Drug Prevention Services Contractors shall notify COR or designee at least five (5) business days in advance of all Contractor generated media releases and media events regarding contracted services identified in this Agreement.

16.19 Critical Incidents. Contractor shall have written plans or protocols and provide employee training for handling critical incidents involving: external or internal instances of violence or threat of violence directed toward staff or clients; loss, theft or unlawful accessing of confidential client, patient or facility resident Personal Information (PI), Personally Identifiable Information (PII) and/or Personal Health Information (PHI); fraud, waste and/or abuse of Agreement funds; unethical conduct; or violation of any portion of San Diego County Board of Supervisors Policy C-25 "Drug & Alcohol Use" while performing under this Agreement. Contractor shall report all such incidents to the COR within one business day of their occurrence. However, if this Agreement includes Article 14, Contractor must adhere to the timelines and processes contained in Article 14.

16.20 Responsiveness to Community Concerns. Unless prohibited by applicable State or federal law, Contractor shall notify County within one business day of receipt of any material complaints including but not limited to complaints referring to issues of abuse or quality of care**,** submitted to Contractor orally or in writing, regarding the operation of Contractor's program or facility under this Agreement. Contractor shall take appropriate steps to acknowledge receipt of said complaint(s) from individuals or organizations. Contractor shall take appropriate steps to utilize appropriate forums to address or resolve any such complaints received. Nothing in this provision shall be interpreted to preclude Contractor from engaging in any legally authorized use of its facility, property or business as approved, permitted or licensed by the applicable authority.

16.21 Criminal Background Check Requirements. Contractor shall ensure that criminal background checks are required and completed prior to employment or placement of any employee, director, officer, agent, subcontractor, consultant or

volunteer in compliance with any licensing, certification, funding, or Agreement requirements, including the Statement of Work, which may be higher than the minimum standards described herein. At a minimum, background checks shall be in compliance with Board of Supervisors policy C-28 and are required for any individuals identified above who will be providing services under this Agreement or who will be assigned to sensitive positions funded by this Agreement. Sensitive positions are those that: (1) physically supervise minors or vulnerable adults; (2) have unsupervised physical contact with minors or vulnerable adults; and/or (3) have a fiduciary responsibility to any County client, or direct access to, or control over, bank accounts or accounts with financial institutions of any client. If this Agreement includes Article 14, Contractor must also adhere to requirements contained in Article 14.

Contractor shall have a documented process for reviewing the information and determine if criminal history demonstrates behavior that could create an increased risk of harm to clients. Contractor shall document review of criminal background findings and consideration of criminal history in the selection of such persons listed above in this section

16.21.1 Contractor shall utilize a subsequent arrest notification service during the term of this Agreement for any individual required to undergo the Criminal Background Check process described in 16.21.

16.21.2 Contractor shall keep the documentation of their review and consideration of the individual's criminal history on file in accordance with paragraph 13.4 "Maintenance of Records."

16.21.3 Definitions

A. Activities of Daily Living: The basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring.

B. Minor: Individuals under the age of eighteen (18) years old.

C. Sensitive Position: A job with responsibilities that can be criminally abused at great harm to the Agreement or the clients served. All positions that (1) physically supervise minors or vulnerable adults, (2) have unsupervised physical contact with minors or vulnerable adults, or (3) have fiduciary responsibility to a County client or direct access to, or control over client bank accounts, or serve in a financial capacity to the County client.

D. Vulnerable Adult: (1) Individuals age eighteen (18) years or older, who require assistance with activities of daily living and who may be put at risk of abuse during service provision; (2) Individuals age eighteen (18) years or older who have a permanent or temporary limited physical and/or mental capacity that may put them at risk of abuse during service provision because it renders them: unable to make decisions for themselves, unable to physically defend themselves, or unaware of physical abuse or other harm that could be perpetrated against them.

E. Volunteer: A person who performs a service willingly and without pay.

16.22 Health Insurance. Contractors providing direct services to the public shall ask if the client and any minor(s) for whom they are responsible have health insurance coverage. If the response is "no" for client or minor(s) the Contractor shall refer the client to Covered California at https://www.coveredca.com/ or to 1-800-300-1506. [#***Remove if not applicable]***

16.23 Survival. The following sections or articles of this Agreement shall survive the expiration or earlier termination of this Agreement: Sections 8.1, 8.13, 8.14, 8.15, 8.21, 10.1, 11.1, 11.2, and 11.4, and Articles 7 and 13.

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SIGNATURE PAGE

AGREEMENT TERM. This Agreement shall be effective this ____day of _____ 20__ ("Effective Date") and end on ____ __ 20__ ("Initial Term") for a total Agreement period of ___years.

[#Optional language for one time deliverables*]*: This Agreement shall be effective this ____day of _____ 20__ ("Effective Date") and end upon completion and County acceptance of all *deliverables under this Agreement.*

OPTION TO EXTEND. ***[#Optional]*** The County's option to extend is for ____ increments of ___ year(s) each for a total of ___ years beyond the expiration of the Initial Term, not to exceed _____ __, 20__, pursuant to Exhibit C Payment Schedule ***or adjustment factor identified*****.** Unless County notifies Contractor in writing, not less than thirty (30) days prior to the expiration date that they do not intend to renew the Agreement; the Agreement will be automatically renewed for another year.

Options to Extend For One To Six Additional Months at End of Agreement. County shall also have the option to extend the term of this Agreement in one or more increments for a total of no less than one (1) and no more than six (6) calendar months at the discretion of the County Purchasing and Contracting Director. Each extension shall be effected by written notice delivered to Contractor no less than fifteen (15) calendar days prior to expiration of any Agreement term.

The rates set forth in Article 4, Exhibit C, or other pricing section of this Agreement shall apply to any option exercised pursuant to this option clause unless provision for appropriate price adjustment has been made elsewhere in this Agreement or by Agreement amendment. All payments are subject to "Availability of Funds."

COMPENSATION: Pursuant to Exhibit C, County agrees to pay Contractor a sum not to exceed _____ ($######) for the initial term of this Agreement and _____ ($######) for each of the # one-year option periods, for a maximum Agreement amount of _____ ($######), in accordance with the method of payment stipulated in Article 4. It is understood that the parties will meet and confer on the Agreement price if adjustments are made to the scope of work for an extension of the term or terms. These discussions shall not obligate either party to make a requested adjustment to the scope of work or price except as otherwise set forth in this Agreement, nor shall it relieve either party of its obligations under the Agreement.

COR. The County has designated the following individual as the Contracting Officer's Representative ("COR")

#Name and Title
#Address
#Address
#Phone, FAX and email

CONTRACTOR'S REPRESENTATIVE. The Contractor has designated the following individual as the Contractor's Representative.

#Name and Title
#Address
#Address
#Phone, FAX and email

IN WITNESS WHEREOF, County and Contractor have executed this Agreement effective as of the date first set forth above

COUNTY OF SAN DIEGO

By: _____
JOHN M. PELLEGRINO, Director
Department of Purchasing and Contracting

Date: _____

[#CONTRACTOR NAME]

By: _____
[*#Name and Title]*

Date: _____