AMENDMENT NO. 1 TO SERVICE AGREEMENT

This Amendment No. 1 to Service Agreement No. 23-280 is dated the 20th day of February, 2024 and is between Pacific Clinics, a California Non-Profit, 501 (c)(3) Corporation ("Contractor"), and the County of Fresno, a political subdivision of the State of California ("County").

Recitals

A. On June 20, 2023, the County and Contractor entered into County Agreement No. 23-280 ("Agreement"), also referred to as the Adolescent Community Treatment program, for the operation of a Mental Health Services Act (MHSA) funded Children's Services Program which currently provides Full-Service Partnership services for underserved or unserved high-risk children between the ages of 10 to 18 years with Serious Emotional Disturbance (SED) and their families.

B. The County and the Contractor now desire to amend the Agreement to fill a community need for Outpatient (OP) and Intensive Case Management (ICM) level of care services for youth ages 10 to 18 years old.

The parties therefore agree as follows:

1. Page 1 of Exhibit G is deleted in its entirety. References in the Agreement to Exhibit G in section 4.6 on line 24, page 9; in section 25.1 on line 23, page 12; and in section 4.9, on line 24, page 51 shall be deemed references to Exhibit G1 and Exhibit G2. Reference to Exhibit G in section 4.1, line 11, page 8 shall be deemed references to Exhibit G, Exhibit G1, and Exhibit G2. Exhibit G1 and Exhibit G2 are attached and incorporated by this reference.

2. All references in the Agreement to "Exhibit A" shall be deemed references to Revised Exhibit A. Revised Exhibit A is attached and incorporated by this reference.

3. All references in the Agreement to "Assertive Community Treatment" shall be deemed references to "Adolescent Community Treatment".

4. When both parties have signed this Amendment No. 1, the Agreement and this Amendment No. 1 together constitute the Agreement.

5. The Contractor represents and warrants to the County that:

a. The Contractor is duly authorized and empowered to sign and perform its obligations under this Amendment.

b. The individual signing this Amendment on behalf of the Contractor is duly authorized to do so and his or her signature on this Amendment legally binds the Contractor to the terms of this Amendment.

6. The parties agree that this Amendment may be executed by electronic signature as provided in this section.

a. An "electronic signature" means any symbol or process intended by an individual signing this Amendment to represent their signature, including but not limited to (1) a digital signature; (2) a faxed version of an original handwritten signature; or (3) an electronically scanned and transmitted (for example by PDF document) version of an original handwritten signature.

b. Each electronic signature affixed or attached to this Amendment (1) is deemed equivalent to a valid original handwritten signature of the person signing this Amendment for all purposes, including but not limited to evidentiary proof in any administrative or judicial proceeding, and (2) has the same force and effect as the valid original handwritten signature of that person.

c. The provisions of this section satisfy the requirements of Civil Code section 1633.5, subdivision (b), in the Uniform Electronic Transaction Act (Civil Code, Division 3, Part 2, Title 2.5, beginning with section 1633.1).

d. Each party using a digital signature represents that it has undertaken and satisfied the requirements of Government Code section 16.5, subdivision (a), paragraphs (1) through (5), and agrees that each other party may rely upon that representation.

e. This Amendment is not conditioned upon the parties conducting the transactions under it by electronic means and either party may sign this Amendment with an original handwritten signature.

7. This Amendment may be signed in counterparts, each of which is an original, and all of which together constitute this Amendment.

8. The Agreement as amended by this Amendment No. 1 is ratified and continued, effective upon execution. All provisions of the Agreement and not amended by this Amendment No. 1 remain in full force and effect.

[*SIGNATURE PAGE FOLLOWS*]

The parties are signing this Amendment No. 1 on the date stated in the introductory clause.

PACIFIC CLINICS

DocuSigned by:
CA06E8E4E66D401...
(Authorized Signature)

Kim M. Wells Chief Legal Officer
Print Name & Title

251 Llewellyn Avenue
Campbell, CA 95008
Mailing Address

COUNTY OF FRESNO

Nathan Magsig, Chairman of the Board of Supervisors of the County of Fresno

Attest:
Bernice E. Seidel
Clerk of the Board of Supervisors
County of Fresno, State of California

By: Alexandria Vieira
Deputy

For accounting use only:

Org No.: 56304323
Account No.: 7295
Fund No.: 0001
Subclass No.: 10000

Adolescent Community Treatment Program for Children Ages 10 to 18 years

SCOPE OF SERVICES

I. BACKGROUND

The Adolescent Community Treatment (ACT) program brings together the knowledge, skills, expertise, and resources of an established community-based provider. The program builds upon evidence-based services and activities to offer an expanded continuum of unduplicated services. Integrated services maximize the use of resources to broaden the scope, intensity, and accessibility of services and supports to children and families in rural and metropolitan areas who might otherwise not receive the services they need.

The Contractor's experience with serving culturally and linguistically diverse families has supported outreach, access and appropriate service delivery to populations that may not be adequately served by traditional mental health and other support systems. The resulting service delivery system has proven to be effective in assisting targeted populations with achieving and maintaining wellness and promoting recovery and resiliency for their young children. Over time, this program has evolved into a best-practice model of child, adolescent, and family treatment that has the potential to be duplicated in other areas and has increased capacity to reach out to and engage unserved and underserved populations throughout Fresno County.

The program includes three (3) distinct levels of care – 1) Outpatient (OP) services, 2) Intensive Case Management (ICM), and 3) Full-Service Partnership (FSP).

II. TARGET POPULATION

The ACT program is designed to provide services to youth ages 10-18 with mental health symptoms/needs that meet medical necessity for specialty mental health services. The target population will include youth who present with moderate to severe impairment and a diagnosable Serious Emotional Disturbance (SED). In addition, identified youths' siblings, other relatives, caregivers, and other significant support person may participate and receive specialty mental health services from this program, to optimize the youth's ability to reach wellness and recovery. The program will provide a range of services that will be tailored to each youth's needs for service type, intensity, and duration. Children will therefore be assigned to one (1) of three (3) levels of care upon completion of the intake/assessment: Outpatient, Intensive Case Management, or Full-Service Partnership. For children who have mild-to-moderate impairment or need medications only and do not require specialty mental health services, the Contractor will work with other programs such as the appropriate Fresno County Department of Behavioral Health (DBH) Wellness Centers, managed care health plans or other like agencies to develop a collaborative agreement for the provision or transition of needed services.

III. LOCATION OF SERVICES

Services will be provided at the Contractor's clinic site, in the community, at home and education locations, whichever is most comfortable for the child and family. The Contractor must also be capable of offering services through telehealth-phone and telehealth-video should the need arise.

IV. DESCRIPTION OF SERVICES

The intended benefit of creating a program such as the ACT program with multiple levels of care is for maximum flexibility to move children seamlessly between levels, as clinically indicated. The Contractor shall provide a level of service and support that will reflect each child's unique and individual needs.

A. Behavioral Health

1. Contractor shall provide these services to all children in the program. Services will include but are not limited to the following:
    i. Provide support to the child's family and other members of the child's social network to help them manage the symptoms and illness of the child and reduce the level of family and social stress associated with the illness.
    ii. Make appropriate referrals and linkages to services that are beyond that of the Contractor's services under this Agreement or as appropriate when discharging/transitioning a child from the program.
    iii. Coordinate services with any other community mental health and non-mental health providers as well as other medical professionals.
    iv. Assist child/family with accessing all entitlements or benefits for which they are eligible (i.e., Medi-Cal, SSI, Section 8 vouchers, etc.).
    v. Develop family support and involvement whenever possible.
    vi. Refer child/family to supported education and employment opportunities, as appropriate.
    vii. Provide or link to transportation services when it is critical to initially access a support service or gain entitlements or benefits.
    viii. Provide or refer to peer support activities, as appropriate.
    ix. Ensure that clinically appropriate Evidence-Based Practices are utilized in service delivery at all levels of care – see the table below.
2. Contractor shall deliver a comprehensive specialty mental health program. Behavioral health services include but are not limited to:
    i. Assessment
    ii. Treatment or Care planning/Goal setting
    iii. Pediatric Symptom Checklist (PSC) 35 and the clinically appropriate version of the Child and Adolescent Needs and Strengths (CANS) assessment
    iv. Individual therapy
    v. Group therapy
    vi. Family therapy
    vii. Case management
    viii. Consultation
    ix. Collateral

x. Linkage to additional services and supports including medication services.

xi. Hospitalization/Post Hospitalization Support

3. Contractor will ensure that all services:

   i. Be values-driven, strengths based, individual-driven, and co-occurring capable.

   ii. Be culturally and linguistically competent.

   iii. Be age, culture, gender, and language appropriate.

   iv. Include accommodations for children with physical disability(ies)

4. Methods for service coordination and communication between program and other service providers shall be developed and implemented consistent with Fresno County Mental Health Plan (MHP) confidentiality rules.

5. Contractor shall maintain up-to-date caseload records of all children enrolled in services, and provide individual, programmatic, and other demographic information to DBH as requested.

6. Contractor shall ensure billable specialty mental health services meet any/all County, State, Federal regulations including any utilization review and quality assurance standards and provide all pertinent and appropriate information in a timely manner to DBH to bill Medi-Cal services rendered.

7. Staffing should be appropriate for services needed at each level of care, which should include case managers, therapists, peer support specialists, psychiatrists, and nurses.

B. Evidence-Based Practices

Evidence-based practices (EBP) utilized in the ACT program include Dialectic Behavioral Therapy (DBT), Managing and Adapting Practices (MAP), Eye Movement Desensitization and Reprocessing (EMDR), Motivational Interviewing (MI), and Trauma Focused Cognitive Behavioral Therapy (TF CBT). Some EBPs may be more appropriate for specific populations, based on age, gender, and/or diagnostic considerations.

The table below clarifies the EBP, description, and target person served sub-group.

Evidence Based Treatment	Description	Target Age

Dialectic Behavioral Therapy (DBT)	A cognitive behavioral treatment that has been shown to be effective in treating a wide range of disorders such as depression, eating disorders, PTSD, and substance dependence.	Parents of children 0-18 years
Managing and Adapting Practices (MAP)	Coordinates and supplements the use of evidence-based programs for children's mental health. The system is not a single treatment program; rather, it involves several decision and practice support tools to assist in the selection, review, adaptation, or construction of empirically derived common treatment elements to match particular child characteristics. The three main features of the MAP system are: • The PracticeWise Evidence-Based Services Database • The Clinical Dashboard • The Practitioner Guides	0-18 years
EMDR	• EMDR is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories (Shapiro, 1989a, 1989b). During EMDR therapy the client attends to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus. Therapist directed lateral eye movements are the most commonly used external stimulus but a variety of other stimuli including hand-tapping and audio stimulation are often used (Shapiro, 1991). Shapiro (1995, 2001) hypothesizes that EMDR therapy facilitates the accessing of the traumatic memory network, so that information processing is enhanced, with new associations forged between the traumatic memory and more adaptive memories or information. These new associations are thought to result in complete information processing, new learning, elimination of emotional distress, and development of cognitive insights. EMDR therapy uses a three pronged protocol: (1) the past events that have laid the groundwork for dysfunction are processed, forging new associative links with adaptive information; (2) the current circumstances that elicit distress	Birth to adult

	are targeted, and internal and external triggers are desensitized; (3) imaginal templates of future events are incorporated, to assist the client in acquiring the skills needed for adaptive functioning.	
Trauma Focused Cognitive Behavioral Therapy	TF-CBT is an evidence-based psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children (0-5 [early childhood] and 6-12 [childhood]), adolescents [13-17 years] and their caregivers. Initially developed to address the psychological trauma associated with child sexual abuse, the model has been adapted for use with children who have a wide array of traumatic experiences, including domestic violence, traumatic loss, and the often multiple psychological traumas experienced by children prior to foster care placement. The treatment model is designed to be delivered by trained therapists who initially provide parallel individual sessions with children and their parents (or guardians), with conjoint parent-child sessions increasingly incorporated over the course of treatment.	Birth- 17 years
Motivational Interviewing	Motivational Interviewing (MI) is an evidence-based treatment that addresses ambivalence to change. MI is a conversational approach designed to help people discover their own interest in considering and/or making a change in their life (e.g., diet, exercise, managing symptoms of physical or mental illness, reducing and eliminating the use of alcohol, tobacco, and other drugs). It also helps people express in their own words their desire for change (i.e., "change-talk"), examine their ambivalence about the change, and plan for and begin the process of change. Additional aspects of the treatment include eliciting and strengthening change-talk, enhancing people's confidence in taking action and noticing that even small, incremental changes are important, and strengthening their commitment to change.	

C. Levels of Treatment

1. Outpatient (OP)

i. The OP level of care focuses primarily on therapeutic appointments for individual and group treatment as well as case management and medication services, as needed. Children at this level receive a minimum of one (1) contact per week with at least one (1) of those contacts being face-to-face per month.

ii. Caseload

Maximum caseload: 1:40

iii. Length of Stay

Suggested length of stay is twelve (12) to eighteen (18) months, with Contractor evaluating the needs of each enrolled child on an ongoing basis to ensure that the level of care is clinically appropriate.

2. Intensive Case Management (ICM)

i. Children at this ICM level of care would benefit from regularly scheduled case management, individual rehabilitation and/or individual therapy. Children at this level receive a minimum of one (1) to two (2) mental health contacts per week with one of those contacts being face-to-face. These mental health contacts can include but are not limited to individual therapy, family therapy, group therapy, case management, peer support services and/or medication management.

ii. Caseload

Maximum caseload: 1:30

iii. Length of Stay

Suggested length of stay is twelve (12) to twenty-four (24) months, with Contractor evaluating the needs of each enrolled child on an ongoing basis to ensure that the level of care is clinically appropriate.

3. Full-Service Partnership (FSP)

i. This FSP level of care employs the concept of “whatever it takes”, which focuses on innovative approaches to “no fail” services. Children at this level meet the State-defined FSP criteria and require higher intensity services to meet their needs. FSP has an increased focus on engagement, collaboration with the youth/family and stabilization to achieve mutually agreed upon treatment goals. Services at this level of care shall be accessible 24/7. Children at the FSP level shall receive a minimum of three (3) face-to-face contacts per week.

ii. Caseload

Maximum caseload: 1:8

iii. Length of Stay

Suggested length of stay is eighteen (18) to twenty-four (24) months, with Contractor evaluating the needs of each enrolled child on an ongoing basis to ensure that the level of care is clinically appropriate.

D. <u>Admission, Termination and Discharge</u>

1. Entry Criteria

   Child must meet at least one (1) of the following criteria for FSP Level services:

   i. Have a substantial impairment in at least two (2) of the following categories as a result of a SED: self-care, school functioning, family relationships, and ability to function in the community. The child must be at risk of, or already removed from, the home; or the mental disorder and impairments have been present for more than six (6) months or are likely to continue for more than one year without treatment.
   ii. Displays psychotic features, is at risk of suicide, and/or is at risk of violence due to a mental disorder.
   iii. Meets special education eligibility requirements under Chapter 26.5 of the Government Code.

   Child must meet one (1) of the following criteria for the OP and ICM services:

   i. Has a condition placing them at high-risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by DBH, involvement in the Child Welfare system, juvenile justice involvement, or experiencing homelessness.
   ii. Meets both of the following requirements:
      a. Has at least one (1) of the following: a significant impairment, a reasonable probability of significant deterioration in an important area of life functioning, a reasonable probability of not progressing developmentally as appropriate, a need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.
      b. The youth's condition as described above is due to one (1) of the following: a diagnosed mental health disorder, a suspected mental health disorder that has not yet been diagnosed or significant trauma placing the youth at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

2. Intake and Initial Assessment

   The OP and ICM services are considered access points; therefore, children can be referred directly to enter the ACT program based on meeting medical necessity for specialty mental health services. Children may be referred to the program for OP or ICM services through various sources including, but not limited to DBH, schools, individuals, or other agencies.

   Children will be referred to the ACT program for FSP services through DBH's Youth Wellness Center. Contractors will contact the family of the referred child within twenty-four (24) hours of receipt of the referral. A face-to-face meeting will be scheduled within three (3) business days to begin the intake process.

   For all levels of care, Contractor shall adhere to the timeliness standards set forth by the state and County's DBH. An initial mental health assessment will be completed within a clinically appropriate timeframe. If the timeframe exceeds thirty (30) days, justification for this delay should be clearly represented in the clinical documentation.

3. Termination and Discharge

Children referred to the ACT program may be denied services if the child does not meet medical necessity for specialty mental health services, meets medical necessity for a mental health diagnosis that is not covered by the County's MHP, and/or the child is under the age of 10 at the time of referral. Children who are determined to be ineligible for ACT services will be linked to other appropriate services and resources.

Discharge is determined on a case-by-case basis depending on the child's progress toward individualized treatment goals. Reasons for discharge include the child or caregiver refuses or terminates services; the child is transferred to another program mutually agreed upon by the child, parent/caregiver, and ACT; mutual agreement that the treatment goals have been met; and/or the child is 18 years old or older.

V. STAFFING

A. Contractor shall provide the following staffing components, at minimum:

1. Staffing shall be appropriate for services needed at each level of care, which would include any combination of the following classifications: licensed or license-eligible therapists, personal service coordinators, and family specialists.

2. Licensed or license-eligible therapists:

    a. Provide evidenced-based clinical treatment. At least one (1) of the therapist positions will be occupied by a former person served or family member with comparable experience to the child and family receiving services. This position shall be recruited based on linguistic and cultural needs of the targeted population (e.g., Latino, Southeast Asian, African American, Native American).

    b. Provide linkages and therapeutic services to enrolled children and their caregivers as identified in the Individual Services and Supports Plan (ISSP), as applicable.

3. Family Partners (or equivalent): Shall be occupied by a former person served or family member with comparable experience to the child and family receiving services.

4. Personal Service Coordinators (PSC): At least one (1) of the PSC positions shall be occupied by a former person served or family member with comparable experience to the child and family receiving services. This position shall be recruited based on linguistic and cultural needs of the targeted population (e.g., Latino, Southeast Asian, African American, Native American). A bachelor's degree level is preferred for the requirements of the PSC positions; however, 12 college units (including psychology, counseling, etc.) with mental health experience can act as a substitute for the bachelor's degree requirement.

    a. Ensure the following is provided by the PSC:

        1. Assign a primary PSC to each child served at the FSP level of care. The primary PSC will work with each child, and family member when appropriate, to develop the child's ISSP. The ISSP is used to identify the child's goals and describe the array of services and supports necessary to advance these goals based on the child's needs and preferences and, when appropriate, the needs and preferences of the child's family. ISSPs are reviewed by DBH's MHP Managed Care during chart audits.

        2. The PSC will act as a single point of responsibility and contact for the delivery of personal service coordination for each child, as assigned. Personal service

coordination is the assistance provided to the child, and the child's family when appropriate, to access medical, educational, social, vocational, rehabilitative, crisis intervention, or other community services, when needed.

3. Ensure all children and families that receive personal service coordination services also receive mental health treatment services when a determination is made by qualified staff using clinically proven assessment tools that a child and/or family would benefit from mental health treatment. Contractors shall institute mental health treatment models to meet the mental health treatment needs of the children/families engaged in services offered in this Agreement.

VI. HOURS OF OPERATION

The standard hours of operation will be Monday through Friday 8:00 AM until 5:00 PM; additional services will be provided after 5:00 PM and on weekends, as needed, to address child or family concerns and/or provide services for children and families who are unavailable for services during standard business hours.

Additionally, Contractors shall provide operational and clinical services in the field, as needed, and temporarily extend office hours to accommodate and increase timeliness of services.

FSP services will be available to children and their families twenty-four (24) hours a day, seven (7) days a week.

VII. GOALS/OUTCOMES

Contractor will gather, collect, and submit Mental Health Services Act (MHSA) Full-Service Partnership data as required by the State Data Collection Reporting system and other data reports as requested by County, such as the Annual Mental Health Advisory Board Data Report. These data will be submitted as required and entered into a local database for internal reporting purposes.

Service satisfaction data will be collected for all cross-sectional mental health programs, as required by the California Department of Health Care Services, at two time periods across the agency for each twelve (12) month period of the Agreement term. Additionally, the Youth Satisfaction Survey (YSS) is collected for each child/youth six months post-entry to provide more detailed and relevant information regarding service satisfaction over time.

Contractor will also participate in the Performance Outcomes and Quality Improvement (POQI) satisfaction survey.

Contractor will have a unit dedicated to providing outcome and evaluation information pertaining to the services provided and youths served. Contractor will implement a core set of outcome measures, permitting comparative and other analyses that add depth and value to the outcomes obtained by specific programs. Measurement tools used will include

the Child and Adolescent Needs and Strengths (CANS) and the Pediatric Symptom Checklist (PSC-35) as primary outcome measures for clinical outcomes, in addition to standard ascertainment of sociodemographic information related to social determinants of health (e.g., living situation, criminal justice involvement, etc.). Such indicators will be used to track and report each enrolled child/youth's progress. In addition, these measurement tools allow Contractor and County to assess treatment efficacy at person served and systemic levels.

Contractor's electronic health record (EHR) will be used to collect basic system level indicators, upon program entry and discharge, including standard demographic information, sexual orientation, gender identity, and ethnicity. Outcome indicators allow the following factors to be assessed in 12-month time spans: frequency of incarceration (probation involvement), frequency of hospitalizations, frequency of contacts with the County's Children's Crisis Stabilization Center; school attendance, school grades and performance, employment, and living situations. Data will be routinely reported to program staff and agency leadership as a part of ongoing continuous quality improvement, and to County on a fixed or variable schedule according to County requirements.

The tables below summarize outcome measures used by Contractor. System Level Measures are somewhat dependent on cross systems collaboration; whereas Practice Level Measures capture data that are often most directly linked to the work of the practitioner.

A. System Level Measures and Outcomes:

WHAT	SOURCE	WHEN
1. Living Situation: a. Restrictiveness b. Stability c. Permanence	Recorded by Clinician/Case Manager	Upon entry, at three month intervals, and upon discharge.
2. Educational Performance: a. School Attendance 2. School Performance	Recorded by Clinician/Case Manager	Upon entry, at three month intervals, and upon discharge.
3. Employment (when relevant): a. Hours Worked b. Length of Employment	Recorded by Clinician/Case Manager	Upon entry, at three month intervals, and upon discharge.
4. Juvenile Justice: a. Recidivism: arrests and citations by type of offense	Recorded by Clinician/Case Manager	Upon entry, at three month intervals, and upon discharge.

B. Practice Level Measures and Outcomes:

WHAT	SOURCE	WHEN
1. Functioning, competence, and impairment from caregiver, child/youth, and clinician perspectives; Child and Adolescent Needs and Strengths	Caregiver Child/youth Clinician	Upon entry, at three month intervals, and upon discharge. At six month cross-

(CANS)		sections and six months post intake.
2. Satisfaction with Services (YSS)	Child/youth	Bi-annual sample, at six month intervals, and upon discharge.

C. Program Outcomes

At minimum, one performance indicator will be identified for each of the four CARF domains listed below.

a. *Access to care*: The ability of youths to receive the right service at the right time. Examples include:
   1. Timeliness of bridging prescriptions
   2. Timeliness of identifying youths with a serious mental illness
   3. Timeliness between youth referral for assessment and completion of assessment; assessment to first treatment service; and, first treatment service to next follow-up
   4. Timeliness of subsequent follow-up visits
   5. Timeliness of response to sick call/health service requests

b. Effectiveness: Objective results achieved through health care services. Examples include:
   1. Effectiveness of crisis interventions
   2. Effectiveness of treatment interventions (medical and behavioral health indicators)
   3. Effectiveness of discharge planning (such as percentage of youths successfully linked to County programs, community providers, and/or other community resources after release)
   4. Timely continuity of verified community prescriptions for medication(s), upon youth's release
   5. Effectiveness of transportation coordination, upon release

c. Efficiency: The demonstration of the relationship between results and the resources used to achieve them.

   Examples include:

   1. Cost per youth
   2. Number of units of services per FTE by discipline
   3. Number of youths served per general population
   4. Comparison of numbers served against industry standards

d. Satisfaction and Compliance: The degree to which youths, County, and other stakeholders are satisfied with the services.

   Examples include:

   1. Audits and other performance and utilization reviews of health care services and compliance with agreement terms and conditions

Surveys of persons served, family members, other health care providers, and other stakeholders

VIII. TRANSITION OPTIMIZATION FUNDS

One-time Transition Optimization Funds will be available to specialty mental health providers and Drug Medi-Cal providers within FY 2023-24 to encourage Contractors to identify and implement organization changes during the first year of CalAIM Payment Reform to improve outcomes for persons served and create operational efficiencies. Contractor is expected to utilize the strategies, tools and knowledge learned to their programming and continue to improve services for the population served.

A. Funding Allocation Methodology

1. Each participating contractor is eligible to apply for an allocation of Transition Optimization Funds up to the maximum amounts stated in Article 4 of this Agreement and further described below. Transition Optimization Funds will only be available from July 1, 2023 through June 30, 2024 and payments shall be on a quarterly basis.

2. Payments will be disbursed upon review and approval by DBH of each deliverable described below. Quarterly progress reports shall be submitted to DBH in order to show progress as outlined in the submitted plans and deliverables.

3. Payments will be dependent on Contractor demonstrating progress toward meeting deliverables described in this Revised Exhibit B. Contractors who fail to submit progress reports by stated deadlines, or who do not demonstrate adequate progress made, may be determined ineligible for that quarter's payment at the sole discretion of the County.

4. All invoices will be submitted on a quarterly basis within fifteen (15) days following the end of the quarter. Invoices submitted thereafter may not be eligible for payment.

B. Responsibilities

1. Letter of Intent

Contractor shall submit a letter of intent to DBH by July 31, 2023 identifying the selected Transition Optimization Activity(ies) and commitment to meet the deliverable deadlines as described below. The letter shall include all current Medi-Cal billable specialty mental health and substance use disorder services agreements the Contractor has with the County.

The County shall respond to the Contractor's letter of intent within thirty (30) days. The County's response shall include a breakdown of anticipated payments, as determined by the County, depending on the Transition Optimization Activity(ies) chosen and depending on the number of current Medi-Cal billable specialty mental health and substance use disorder services agreements the Contractor has with the County.

2. Quarterly Reports

Contractor shall submit quarterly progress reports and invoices. Reports shall be submitted on the dates indicated in the Schedule of Deliverables below. Invoices are due fifteen (15) days after the end of each quarter. All activities shall be completed by June 30, 2024. The report shall

include updated plans/tools and progress Contractor has made toward the Transition Optimization Activity(ies) described in each Contractors' letter of intent.

3. Schedule of Deliverables: Equity Gap Analysis, Fiscal Monitoring Tool, and Electronic Health Record

    i. Q1 Reports: July-Sept:

        1. Letter of Intent: Due July 31, 2023

        2. Fiscal Monitoring Tool, Equity Gap Analysis, and Electronic Health Record Implementation Plans (if applicable): Due September 30, 2023

        3. Fiscal Monitoring Tool Identified Practices and Strategies (if applicable): Due September 30, 2023

    ii. Q2 Report: Oct-Dec: Due January 15, 2024

    iii. Q3 Report: Jan-Mar: Due April 15, 2024

    iv. Q4 Report: Apr-June: Due July 15, 2024

    v. All deliverables will be reviewed and approved by DBH prior to payment.

4. <u>Eligible Transition Optimization Activities</u>

    i. Fiscal Monitoring Tools: Contractor shall submit to DBH a draft of their fiscal monitoring tool that shall be used monthly on an ongoing basis to evaluate fiscal health of the organization. Tools shall, at a minimum, monitor costs, productivity targets and identify one or more practice pattern(s) the organization is employing to increase direct care time to the Medi-Cal population.

        1. <u>Fiscal Monitoring Tools and Implementation Plan</u>: Contractor shall develop fiscal monitoring tools that will be used monthly to ensure their organizational fiscal health and implementation plan. Fiscal monitoring tools drafts and implementation plan shall be submitted to DBH by September 30, 2023.

            i. <u>Identified Practice</u>: Identify at least one process improvement that shall be modified by September 30, 2023.

            ii. <u>Quarterly Progress Reports</u>: Quarterly progress reports shall be submitted including but not limited to a narrative of progress, obstacles, alternative solutions and outcomes.

            iii. Funding for this activity shall be available up to $25,000 for the initial agreement with Contractor and up to another $10,000 for each additional agreement. County shall provide further details on deliverables and payment schedule in County's response to the Contractor's letter of intent.

ii. Equity Gap Analysis: Contractor shall produce a report identifying the race/ethnicity of population served in FY 2022-23 compared to the County's population as provided by the County. Contractor shall identify key disparities in both persons served and amount of services and frequency of transitions to other levels of care received. Contractor shall identify three (3) strategies they shall employ during FY 2023-24 to reduce the disparities among underserved population.

1. Report on Underserved Population: Contractor shall submit an Equity Gap Report to the Department containing including, but not limited to, the following:

    i. Identify if it serves specific population within its program(s) and identify whom the program(s) currently served based on data.

    ii. Staffing/workforce information and demographics. Report the staffing/workforce supporting the different programs and populations served by the provider in Fresno County. This data is to evaluate how the staffing reflects the populations it is serving.

    iii. Comparison of the County penetration rates to the demographics of persons served by the Contractor and program(s) under agreement with DBH.

    iv. Data on retention of persons served by demographics. Total persons served and the average length of stay by demographics of the persons served in programs.

        i. Which populations are remaining in the programs by demographics, which ones are having the shortest stays.

        ii. How long is the average length of stay by the demographics.

    v. Identify what data points the Contractor is missing at this time that challenges its ability to thoroughly assess its equity gap analysis. Examples: data is not collected, data that is missing or under reported, data not captured in its processes, etc.

2. Equity Improvement Implementation Plan: Contractor shall submit an Equity Improvement Implementation Plan related to improving health equity by September 30, 2023. The plan shall include the following items at a minimum:

    i. Contractor shall select three (3) strategies from below:

        i. Plan shall include specific efforts including, but not limited to, the following and timelines to increase access to underserved groups.

1. Outreach/Engagement with underserved communities
2. Active attendance/participation in DBH's Diversity Equity and Inclusion (DEI) workgroup
3. Plan for retention of persons served in programs who are under represented
4. Improvement of demographic data collection including Sexual Orientation Gender Identity (SOGI)/LGBTQ data.

ii. Plan shall address workforce capacity to render services to more underserved populations, through:

1. Development of bilingual personnel
2. Recruitment plan for more diverse workforce to reflect populations served.
3. Training for workforce to increase capacity to be culturally responsive
4. Development workforce pool for the future that can be bilingual and bicultural

ii. Timeline for each effort shall be included in the plan.

iii. Contractor shall identify the measurement to be used to demonstrate successful implementation of plan. Measure may be identified by the Contractor to best support their plan and goals.

iv. Contractor shall develop and submit policies and procedures to formally support equity effort.

3. Quarterly Progress Reports: Use available data including but not limited to, External Quality Review Organization (EQRO) and EHR data to evaluate the strategies deployed. Quarterly progress reports shall be submitted including but not limited to a narrative of the progress, obstacles, alternative solutions and outcomes. The final quarter shall include a comprehensive final report on the outcomes.

4. Funding for this activity shall be available up to $25,000 for the initial agreement with Contractor and up to another $10,000 for each additional agreement. County shall provide further details on deliverables and payment schedule in County's response to the Contractor's letter of intent.

C. Electronic Health Record (EHR): The implementation and expansion of the SmartCare EHR is an essential component of improving oversight with the implementation of payment reform. Furthermore, a standardized EHR will improve continuity of care, create transparency across the

system, remove obstacles for individuals accessing services and improve the overall outcomes for persons served. For Contractors who plan to opt in to use SmartCare or have previously opted into DBH's former EHR and intend to transition to SmartCare, user fees and costs shall be waived during FY 2023-2024 and FY 2024-2025.

1. Option One: Current EHR Users

    i. Strategic Plan: Contractors utilizing DBH's EHR as their current EHR, and who will continue to utilize SmartCare beginning July 1, 2023, shall provide a plan, including, but not limited to, how they will optimize Medi-Cal billing, illustrate how they will utilize the information in the EHR to improve care for persons served, and a training plan for their organization by September 30, 2023.

        i. Quarterly Progress Reports**:** Quarterly progress reports shall be submitted, including, but not limited to, a narrative on the progress, obstacles, alternative solutions and outcomes.

        ii. Total compensation for this EHR activity, Option 1, shall not exceed $50,000.00 split among all current agreements between the Contractor and the County for Medi-Cal billable specialty mental health and substance use disorder services. County shall provide further details on deliverables and payment schedule in County's response to the Contractor's letter of intent.

2. Option Two: Non-EHR Users

    i. Contractor shall submit an implementation plan by September 30, 2023 regarding how they will transition to utilizing the SmartCare EHR by June 30, 2024. The plan shall include, at a minimum, an identified Go Live Date, plan on how the current record system will be maintained and utilized, training plan including number of individuals, and additional supports. The Go Live Date must occur by June 30, 2024 to receive final payment. Contractor shall work closely with DBH to identify needs, assignments, collaboration opportunities to transition.

    ii. For Option 2, the Contractor shall not be reimbursed more than $200,000 split among all current agreements between the Contractor and the County for Medi-Cal billable specialty mental health and substance use disorder services. The total maximum compensation available for this option, shall include costs for maintaining current electronic health record/record system and additional supports and training costs per user. Contractor shall transition both specialty mental health and Drug Medi-Cal programming to the County's EHR and shall be required to use the County's EHR for future eligibility agreements with DBH. County shall provide further details on deliverables and payment schedule in County's response to the Contractor's letter of intent.

IX. REPORTS

A. Contractor shall prepare an evaluation report annually, which will be submitted to County's DBH and

made available to partnering and interested local agencies and organizations (e.g., project collaborators, other community agencies, and mental health treatment providers). Annual evaluation reports will include the following information: demographics of the target population served, services provided to each participant, number of hospitalizations, enrollment in school, results of data analysis compared to planned process, output and outcome measures, barriers to program implementation and measures taken to overcome those barriers, accomplishments of program participants, lessons learned, and the final result of any and all satisfaction survey(s).

B. Contractor shall comply with all contract monitoring and compliance protocols, procedures, data collection methods, and reporting requirements conducted by County.

C. Additional reports and outcome information may be requested by County at a later date, as needed.

D. Additional Reporting Requirements

Contractors will be responsible for meeting with DBH on a monthly basis, or more often as agreed upon between DBH and Contractors, for contract and performance monitoring.

Contractors will be required to submit monthly reports to the County that will include, but not be limited to: the number of persons served served/anticipated to be served; utilization of services by persons served; and staff composition. These reports will be due within thirty (30) days after the last day of the previous month or payments may be delayed.

Additional reporting is required for FSPs by DHCS. DHCS uses the FSP Data Collection and Reporting (DCR) system to ensure adequate research and evaluation, regarding the effectiveness of services being provided and the achievement of the outcome measures. Contractors will need to report individual/partner information and outcomes of the FSP program directly into the DCR system. Data will be submitted through an online interface using specific forms. The Partnership Assessment Form gathers baseline information about the partner and is completed once the partnership is established. Key Event Tracking provides a snapshot of changes in key quality of life areas and is tracked on a continuous basis throughout the course of the FSP. The Quarterly Assessment collects updated information about changes in quality of life areas and is completed every three (3) months from the date the partnership is established.

Continuous improvement is a core tenant of the Department and the Mental Health Services Act (MHSA). As a result of a multi-year statewide FSP evaluation project that the County DBH participated in, another question has been added to the State required DCR data as follows:

"How often do you get the social and emotional support that you need?" Response options will be: “always, usually, sometimes, rarely, or never”.

X. COUNTY RESPONSIBILITIES:

COUNTY shall:

A. Assist Contractor’s efforts to evaluate the needs of each enrolled child on an ongoing basis to ensure that the level of care each child is receiving is clinically appropriate.

B. Provide oversight and collaborate with contractors and other County Departments and community agencies to help achieve State program goals and outcomes. Oversight includes, but is not limited to, contract monitoring and coordination with the State Department of Health Care Services in regard to program administration and outcomes.

C. Assist Contractors in making linkages with the total mental health system of care. This will be accomplished through regularly scheduled meetings as well as formal and informal consultation.

D. Participate in evaluating overall program progress and efficiency and be available to contractors for ongoing consultation.

E. Gather outcome information from target person served groups and Contractors throughout each term of this Agreement. County shall notify contractor when their participation is required. The performance outcome measurement process will not be limited to survey instruments but will also include, as appropriate, person served and staff interviews, chart reviews, and other methods of obtaining required information.

F. Assist Contractor's efforts toward cultural and linguistic competency by providing the following to contractors:

    1. Technical assistance and training regarding cultural competency requirements at no cost to contractor.

    2. Mandatory cultural competency training for contractor's personnel, on an annual basis, at minimum.

    3. Technical assistance for translating information into County's threshold languages (Spanish and Hmong). Translation services and costs associated will be the responsibility of contractors.

Fresno County Department of Behavioral Health
Specialty Mental Health Services Outpatient Rates

FSP and AOT	
Provider Type	**Provider Rate Per Hour**
Psychiatrist/ Contracted Psychiatrist	$1,140.98
Physicians Assistant	$511.73
Nurse Practitioner	$567.38
RN	$463.45
Certified Nurse Specialist	$567.38
LVN	$243.47
Pharmacist	$546.16
Licensed Psychiatric Technician	$208.72
Psychologist/Pre-licensed Psychologist	$458.87
LPHA (MFT LCSW LPCC)/ Intern or Waivered LPHA (MFT LCSW LPCC)	$296.95
Occupational Therapist	$395.28
Mental Health Rehab Specialist	$223.41
Peer Recovery Specialist	$234.58
Other Qualified Providers - Other Designated MH staff that bill medical	$223.41

Fresno County Department of Behavioral Health
Specialty Mental Health Services Outpatient Rates

Field Based (at least 50% of services are provided in the field)	
Provider Type	**Provider Rate Per Hour**
Psychiatrist/ Contracted Psychiatrist	$988.85
Physicians Assistant	$443.50
Nurse Practitioner	$491.73
RN	$401.65
Certified Nurse Specialist	$491.73
LVN	$211.00
Pharmacist	$473.34
Licensed Psychiatric Technician	$180.89
Psychologist/Pre-licensed Psychologist	$397.68
LPHA (MFT LCSW LPCC)/ Intern or Waivered LPHA (MFT LCSW LPCC)	$257.35
Occupational Therapist	$342.58
Mental Health Rehab Specialist	$193.62
Peer Recovery Specialist	$203.30
Other Qualified Providers - Other Designated MH staff that bill medical	$193.62

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