AMENDMENT NO. 1 TO SERVICE AGREEMENT

This Amendment No. 1 to Service Agreement No. 23-284 ("Amendment No. 1") is dated November 7, 2023 and is between MENTAL HEALTH SYSTEMS, INC., dba TURN Behavioral Health Services, a private 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 the Contractor entered into County Agreement No. 23-284 ("Agreement"), for a qualified agency to operate a recovery-oriented program for Co-Occurring Disorders Full-Service Partnership services for adults and older adults with active co-occurring disorders and symptoms (severe mental illness and substance use disorders).

B. The Agreement contained the incorrect Scope of Work referenced as Exhibit A in the Agreement.

C. The County and the Contractor now desire to amend the Agreement to replace Exhibit A to reflect the correct Scope of Work as well as replace the rate sheet to include Supplemental/Add On service codes that were previously added by the DBH Director through her authority in Article 25 of the Agreement to accommodate state mandated rate increases.

The parties therefore agree as follows:

1. That effective July 1, 2023, all references to "Exhibit A," shall be deemed references to "Exhibit A1." Exhibit A1 is attached and incorporated by this reference.

2. The effective July 1, 2023, the first page of "Exhibit G" shall be deleted and replaced with "Exhibit G1". References to "Exhibit G" in section 4.1 and section 25.1 of the Agreement shall be deemed references to "Exhibit G and Exhibit G1." References to "Exhibit G" in section 4.6 and section 4.9 of the Agreement shall be deemed references to "Exhibit G1." Exhibit G1 is attached and incorporated by this reference.

3. When both parties have signed this Amendment No. 1, the Service Agreement No. 23-284 and this Amendment No. 1 together constitute the Agreement.

4. 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.

5. 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.

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

7. The Agreement as amended by this Amendment No. 1 is ratified and continued. 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.

Mental Health Systems, Inc., dba TURN Behavioral Health Services	County of Fresno
James C Callaghan Jr James C Callaghan Jr (Oct 20, 2023 16:02 PDT) Chairman of Board or President	Sal Quintero Sal Quintero, Chairman of the Board of Supervisors of the County of Fresno
9465 Farnham Street San Diego, CA 92123	**Attest:** BERNICE E. SEIDEL Clerk of the Board of Supervisors County of Fresno, State of California
	By: Hanam Deputy

For accounting use only:

Org No.: 56304562
Account No.: 7295
Fund No.: 0001
Subclass No. 10000

Mental Health Services Act
Co-Occurring Disorders Program (CDP)
Full-Service Partnership (FSP)
Scope of Work

ORGANIZATION: Mental Health Systems, Inc.

SERVICE ADDRESS: 2550 West Clinton Avenue, Building A, Suite B, Fresno, CA 93705

SERVICES: Co-Occurring integrated, comprehensive, individual-centered mental health services

SCHEDULE OF SERVICES:

Mental Health Systems ("Contractor") staff shall be available to provide services to individuals 24 hours per day, seven (7) days per week, and at least 35% of their time shall be spent on billable activities on behalf of the individual. (NOTE: Billable time/percentage will be re-evaluated periodically and may be adjusted to reflect implementation of the Affordable Care Act (ACA) as its impact is realized.) Target enrollment level for this program is a minimum of 160 unique individuals served at any given time, in addition to residential treatment beds. The Program shall reach and continue to maintain full capacity the remainder of the contract term.

TARGET POPULATION:

Participation for Contractor's Mental Health Services Act (MHSA) Co-Occurring Disorders Full-Service Partnership (FSP) program is on an individual voluntary basis. The target population to be served under this Agreement will be adult and older adult individuals with active co-occurring disorders (COD) of severe mental illness (SMI) and substance use disorder (SUD) who are frequent users of crisis services, emergency rooms, detoxification services, jails, hospitals and as needed. The target population for the ACT services must meet requirements for SMI/severely emotionally disturbed (SED) diagnosis and individuals in the SUD track must have a primary diagnosis of SUD.

PROJECT DESCRIPTION:

The Department of Behavioral Health ("County") MHSA Co-Occurring FSP is a "whatever-it-takes" program to work toward providing a welcoming, recovery oriented, integrated, co-occurring disorder service delivery to adults and older adults with serious mental illness and substance abuse disorders combined with an ACT-like model. Contractor will provide comprehensive, dual diagnosis services through dual program tracks staffed by two Teams, the ACT Team and the SUD Team. Teams will be comprised of qualified, culturally diverse professionals who mirror the cultures of the individuals to be served and who bring a variety of education, experience levels, lived experience, and expertise in the field of mental illness, substance abuse and recovery, and housing to the program. CONTRACTOR will utilize an integrated dual treatment approach through operationalization of a *dual track* design where each disorder receives the appropriately intensive diagnosis-specific treatment. The ACT Track will serve individuals with a primary mental health diagnosis who may have a co-occurring substance use disorder (SUD). The SUD Track will serve individuals with a primary diagnosis of substance use disorder who may or may not have a co-occurring mental health diagnosis.

Contractor staff will provide innovative interventions, comprehensive services, integrated behavioral health and substance abuse treatment services, and housing services to support the individual in recovery and self-sufficiency. In addition, residential treatment beds are provided for individuals at any given time. Services shall be individual-directed and employ psychosocial rehabilitation and recovery principles. Further, it is understood that individuals served will have medical conditions, cognitive and learning difficulties, and that these individuals with complex needs will be welcomed into service and engagement in empathetic, hopeful, integrated, recovery-oriented partnerships to address each and every one of their issues over time in order to achieve a happy, meaningful life.

Contractor's program design will provide community-based and culturally competent outpatient mental health treatment and substance use disorder treatment which increase the likelihood of individuals becoming productive members of society. Contractor will provide the full spectrum of FSP and ACT-like services 24 hours per day, seven days per week. With recovery as the goal for individuals in both tracks, services will include a strong focus on skills building. Contractor staff will meet individuals "where they are" and do "whatever it takes" to move the individuals we serve through the stages of change to empower each individual to achieve their goals. The program's philosophy and values include the belief that every person has the potential for growth, regardless of disability; each individual's Plan of Care will be strength-based focusing on individual and family strengths with the firm belief that all individuals can achieve recovery goals, and gain increased independence, self-sufficiency and community integration with the necessary individualized supports.

Contractor will incorporate a comprehensive array of evidence-based practices and models including the Housing First model, combined with a harm reduction model that ensures individuals face the fewest barriers to service as possible. Contractor will significantly increase the scope of housing services we provide through increased housing staff. Contractor's mantra is "it's not if the client is ready for housing but is the housing ready for our client." To ensure the "housing is ready for our client" speaks to our ability to ensure that the appropriate amount of care is wrapped around each individual which then allows them to successfully live in housing of their choice.

Contractor will ensure that all services are:

- Recovery oriented;
- Client-centered and built upon collaborations between the ACT/SUD Team and the individual that emphasize client ownership of the recovery process;
- Incorporate strengths-based solutions to improve the individual's quality of life utilizing a broad array of integrated services;
- Links individuals to supportive services in the community;
- Includes the participation of family members and community support systems;
- Support peer recovery; and
- Reduce hospitalizations, incarcerations, homelessness and crisis episodes.

The MHSA Co-Occurring FSP program shall be a partnership between Contractor and the Department of Behavioral Health (DBH). Contractor shall provide multi-level services directed to individual needs of the enrollees. Services will include, but are not limited to: personal services coordination, food, clothing, housing, daily living skills, mental and physical health treatment, co-occurring integrated substance abuse services (as well as having capacity for referral to specialized inpatient substance abuse treatment, when indicated, through a subcontract), outpatient substance abuse treatment, supported education and employment, vocational skills assessment and development, transportation, advocacy and peer support. When possible, County staff shall provide vocational services and supported educational services. County will oversee program outcomes, reporting, and contract monitoring.

Co-Occurring Disorders Full-Service Partnership services will provide a staff to individual ratio which shall not exceed 1:15 for those requiring 24/7 'wrap style' services. Contractor shall provide a minimum of 14.22 Full Time Equivalent (FTE) staff, as identified in the Agreement program budget - Exhibit G. Contractor shall also provide for an on-call Psychiatrist for initial and ongoing individual services as needed.

CONTRACTOR'S RESPONSIBILITIES:

Contractor shall:

1. Maintain facilities and equipment, and operate continuously with the number and classification of staff required described under this Agreement and in Exhibit G. If Contractor does not have the positions filled for these services as described in Exhibit G Contractor shall notify County in writing within fifteen (15) days of the vacancy and shall include a plan of action which explains how the Contractor will continue with the contracted level of services. In addition, Contractor shall provide a monthly personnel report to DBH by the 10th of each month.

2. Be required to comply with any requirements of County's Mental Health Managed Care program as related to performance outcomes, quality of life and/or customer satisfaction as a Medi-Cal Organizational Provider, as described in Exhibit F.

3. Maintain its approved service location which is to be accessible by public transportation.

4. Be required to comply with all State regulations regarding State Performance Outcomes measurement requirements and participate in the outcomes measurement process as required by the County.

5. Shall participate in performance outcomes throughout each term of this Agreement. County MHSA staff will notify the Contractor when its participation is required. The performance outcome measurement process will not be limited to survey instruments but will also include, as appropriate, individual and staff interviews, chart reviews, and other methods of obtaining needed information.

6. Collaborate with other community agencies for the provision of non-direct mental health services (Public Guardian, Social Services, physical health, etc.). These services are particularly needed to reach people with co-occurring chronic or medical conditions. Individual's Program Service Plans must include needed mental health services and integrated co-occurring substance abuse services that are recovery oriented. Contractor shall help link individuals to any community services that will provide the most potential benefit for each individual.

7. Develop Provider Program Service Plans that include all safety, emergency and crisis procedures in the field and in the organization's offices.

8. Provide a Program Service Plan that shall contain an outline that will list and describe each multidisciplinary, multicultural and services provided by staff.

   The individual component of the Program Service Plan will describe the Personal Service Plan. In addition, a treatment chart which meets Medi-Cal and Medicare requirements will be maintained for each individual.

9. Develop strategies which include the following components:

A. Individual self-directed care plans (e.g., Wellness Recovery Action Plans or other similar models);

B. Welcoming individuals with co-occurring substance use disorders into care, identifying their needs, and providing appropriately matched integrated services for both mental health and substance issues within a recovery framework;

C. Integrated physical and mental health services in collaboration with primary care physicians;

D. Integrated services with law enforcement, probation and courts;

E. Education for individuals and family or other caregivers as appropriate to maximize individual choice about the nature of medications, the expected benefits and the potential side effects as well as alternatives to medications; and

F. Values-driven, culturally competent, evidence-based or promising clinical services that are integrated with overall service planning and support housing, employment, and/or education goals.

10. Provide the following services to increase cultural competency:

A. Be required to assess and document the demographic make-up and population trends of its service area to identify the cultural and linguistic needs of the eligible beneficiary population. Such studies are critical to designing and planning for providing appropriate and effective behavioral health and substance abuse services.

B. Provide and/or coordinate necessary behavioral health and substance abuse services in a culturally competent manner.

C. Whenever possible will hire racially and ethnically diverse community members and individual/family members to provide or assist with culturally competent, individual and family-driven mental health supportive services. Contractor will collaborate with members of the various ethnic communities to gain cultural perspective. Each ethnic community's perspective on mental illness, co-occurring disorders, and wellness and recovery may include different concepts and practices. By working together to explore these concepts, appropriate approaches can be developed for each ethnic group.

D. Make sure that an assessment of a individual's sexual orientation is included in the bio-psychosocial intake process. Contractor staff will assume that the population served may not be in heterosexual relationships. Gender sensitivity and sexual orientation must be covered during annual training.

E. Utilize existing community supports, referrals to transgender support groups, etc., when appropriate.

F. Required to annually attend the Cultural Competence, Compliance, Billing and Documentation training.

G. Gender appropriate services will be emphasized when working with this population.

11. Maintain compliance with all reporting as required by the State and County.

12. Continuous improvement is a core tenant of the Department and MHSA. Over the past few

years, County DBH participated in a statewide FSP evaluation project. The result of the project required that DBH should add another question to the State required DCR data as follows:
How often do you get the social and emotional support that you need?"
[Response options: always, usually, sometimes, rarely, never]

13. Participate in a Quality Improvement Plan. Contractor is required to have an organized quality improvement process and plan to continually improve care in order to better serve individuals. Quality improvement activities should be aligned with the County vision of services, including making progress toward recovery orientation, cultural competency, and co-occurring disorder.

1. Contractor will provide the following staffing components:

A. Staff work schedules shall be responsive to individual needs. Staff shall be available Monday through Friday from 7:00 a.m. to 7:00 p.m. and on Saturdays and Sundays and from 8:30 a.m. to 6:00 p.m. During off-hours periods, staff shall maintain on-call coverage on a rotating basis and shall be available to respond immediately to individuals by telephone or in person, as dictated by individual needs.

B. Contractor Personal Services Coordinator's (PSC) staff shall be available to provide crisis assessment and intervention twenty-four hours per day, seven days per week throughout the year, including telephone and face-to-face contact as needed. There shall be no barrier to access crisis services based solely on active substance use. Response to crisis shall be rapid and flexible. The Contractor shall collaborate with facilities and designated County staff to provide emergency placement should crisis housing, short-term care and inpatient treatment (voluntary or involuntary) be needed. Contractor's staff shall provide support to the maximum extent possible, including accompanying the individual to the facility, performing a face to face visit if admitted to crisis facility and remaining with the individual during the assessment. As soon as possible Contractor staff shall begin the process of planning for discharge and return to the community.

C. The Contractor shall provide services in the areas of medication prescription, management, administration, monitoring and documentation. The Contractor's psychiatrist(s) shall:

- Assess each individual's mental illness and substance use disorder symptoms and prescribe appropriate medication as necessary. Medication for individuals who do not have a third-party payor will be provided medication by the Contractor.

- Regularly review and document the individual's mental illness and substance use disorder symptoms as well as his/her response to the prescribed medications;

- Educate the individual and individual support system on the purpose of medication and any side effects; and

- Monitor, treat and document any medication side effects.

D. The ratio of staff to individuals will be no less than 1:12 (1 clinical staff member to 12 individuals) and no more than 1:15 (1 clinical staff member to 15 individuals). A primary

goal will be to keep individuals in a stable living environment while reducing interactions with the criminal justice system and reducing inpatient mental health hospitalizations.

E. The Contractor shall evaluate the staff's competency for performance purposes and establish medication policies and procedures which identify processes to administer medications to individuals and train other staff and family members regarding medication education, medication delivery, medication side effects, observation of self administration of medication and medication monitoring. Policies and procedures must indicate how individuals with co-occurring substance use disorders will be engaged and maintained on necessary medications, even when they might still be using substances.

F. Staff shall assess and document the individual's mental health symptoms in response to medication and monitor for medication side-effects during the provision of observed self-administration and during ongoing face-to-face contacts.

G. Contractor shall incorporate individual-directed, psychosocial rehabilitation and recovery principles. Contractor shall utilize a peer-to-peer support network that includes hiring recovering individuals/family members. Staff shall employ harm reduction in philosophy and motivational interviewing techniques and principles.

H. Contractor shall have at least one mental health specialists, e.g. "Mental Health Advocate", "Peer Advocate," "Family Advocate." The mental health specialists shall be a current individual receiving County or County contracted services and/or family member of a current individual. All peer specialists will be expected to have competency working with individuals with co-occurring substance use issues.

   An individual and/or family member will have demonstrated one year of volunteer or paid experience working with individuals with serious and persistent mental illness to meet the requirements of a mental health specialist. A mental health specialist shall be regarded as a full, professional member of the clinical team, function under the same job description as other mental health specialists and receive salary parity.

   The mental health specialists shall not provide services to their respective family members nor serve on a team which provides services to a family member/significant other. Decisions regarding disclosure to individuals, their families and significant others, that a staff person is himself/herself an individual or a family member, shall respect the individual preference of that staff person and be made in consultation with the team director.

2. Contractor will provide specific services as it relates to substance abuse, mental health *and co-occurring substance use disorders:*

A. Contractor shall maintain enrollment capacity at a minimum of 160 individuals at any given time continuing throughout the term of this Agreement. Service capacity will be met by serving individuals in metropolitan and rural Fresno County who present serious and persistent mentally illness residents with a co-occurring disorder and who have frequently accessed crisis, detox services and/or have required law enforcement intervention related to their substance abuse. FSP services are voluntary.

B. Contractor will provide residential treatment beds at any given time. The goal shall be to utilize these residential treatment beds at capacity at any given time.

C. Contractor will utilize the Recovery Model to provide co-occurring services to all enrolled individuals, twenty-four hours a day, seven days a week, during weekend hours, and on call. Wrap-around services will be provided.

D. Contractor will have the flexibility to increase service intensity to individuals in response to individual need. A critical feature of the service delivery shall be the unified team approach, in which multiple staff members with a diversity of skills address each individual's mental health, substance abuse and community life support needs in a comprehensive manner. Staff shall have the capacity to provide as many contacts as needed to individuals experiencing significant problems in daily living.

E. Contractor will operate a multidisciplinary treatment team including licensed/unlicensed mental health professionals, nursing and psychiatric staff, and mental health specialists, peer/family specialists who will assist individuals in developing their Personal Services Plan. The Contractor is encouraged to hire individuals with specific experience in working with co-occurring substance use disorders, but nonetheless, all staff will be required to work on developing co-occurring disorder competency over time.

F. Contractor will be available to provide symptom assessment, personal service coordination and supportive counseling to assist individuals to cope with and gain mastery of symptoms and disabilities due to mental illness and/or substance abuse. These services shall include, but not be limited to, the following:

- Ongoing assessment of the individual's mental illness and substance abuse symptoms and response to treatment;
- Education of the individual regarding his/her mental illness, substance use, and the effects (including side effects) of prescribed medications;
- Symptom management efforts directed to help the individual identify the symptoms and their occurrence patterns and development of methods (internal, behavioral, adaptive) to lessen their effects; and
- Provision, both on a planned and on an "as needed" basis, of such psychological support as is necessary to help individuals accomplish their personal goals and to cope with the stresses of day-today living.
- Developing recognition of the concept of stages of change for each type of problem and working on providing stage matched interventions and outcomes as indicated.

G. Contractor will provide training and instruction, including individual support, problem solving, skill development, modeling and supervision, in home and community settings, to teach the individual to:

- Carry out personal hygiene tasks;
- Perform household chores, including housekeeping, cooking, laundry and shopping;
- Develop or improve money management skills;

- Use community transportation;

- Providing training and assistance to individuals in locating, securing, maintaining and financing safe, clean and affordable housing which is appropriate to their levels of functioning; and

- Providing training and instruction, including individual support, problem solving, skill development, modeling and supervision, in home and community settings, including choices, decisions, and skills regarding substance use.

H. Ensure staff provides appropriate age, culture, gender and language services and accommodations for physical disability (ies) to individuals.

I. Assign a staff within 24 hours of receiving referral and the development of a tentative individual centered Personal Services Plan to meet the individual's identified needs.

J. Ensure that the team members are able to have on hand, in their possession, during regular working hours (and when appropriate during on-call hours) an adequate amount of petty cash with which to make emergency purchases of food, shelter, clothing, prescriptions, transportation, or other items and services as needed for individuals. This may include security deposits, rent subsidy, and other items needed by individuals (Contractor is to provide policies and procedures to MHSA Coordinator or designee as to the handling of petty cash).

K. Ensure and monitor that staff provide frequent contacts, at least three times per week, with individuals where they live or are most comfortable, in order to assist them in accessing behavioral and physical health care, financial, education, vocational, rehabilitative, or other needed community services, especially as these services relate to meeting the individual's mental health and housing needs. At minimum, at least one contact per week will be face-to-face.

L. Link individuals to appropriate social services, legal advocacy and other representation, provide transportation as necessary and serve as a "representative payee" or refer individual to other payee services for individual's SSI/SSD benefits.

M. Develop and support the individual's participation in recreational and social activities and positive social relationships and activities in a community setting. Staff shall provide support and help individual individuals to establish positive social relationships and activities in community settings. Such services shall include, but not to be limited to, assisting individuals in:

- Developing social skills in order to produce meaningful personal relationships;

- Planning appropriate and productive use of leisure time including familiarizing individuals with available social and recreational opportunities and increasing their use of these activities;

- Interacting with landlords, neighbors and others effectively and appropriately;

- Developing assertiveness and self-esteem; and

- Using existing self-help centers, self-help groups and other social, church and recreational groups to combat isolation and withdrawal.

N. Provide alcohol, tobacco and drug abuse services, in accordance with harm reduction principles. This will include, but is not limited to, individual and group interventions to assist individuals in:

- Identifying alcohol, tobacco and drug abuse effects and patterns;
- Recognizing the interactive effects of alcohol, tobacco and drug use, psychiatric symptoms, and psychotropic medications;
- Developing motivation for decreasing alcohol, tobacco and drug use;
- Developing coping skills and alternatives to minimize alcohol, tobacco and drug use;
- Achieving and rewarding periods of improvement and/or periods of abstinence and stability;
- Attending appropriate recovery or self-help meetings; and
- Achieving an alcohol, tobacco, and drug free lifestyle, if consistent with the individual's recovery goal.

O. Provide information, in an educational format, on the use of alcohol, tobacco, prescribed medications, and other drugs of abuse and the impact that chemicals have on the ability to function in major life areas. Information shall also include eating disorders, gambling, overspending, sexual and other addictions, as appropriate.

P. Make appropriate referrals and linkages to addiction inpatient services that are beyond ACT wrap-around/SUD/Co-Occurring outpatient type services to individuals with coexisting alcohol, tobacco and drug abuse and other addictive symptoms that are more severe than what the Co-occurring FSP can be reasonably expected to provide.

Q. Minimize individual involvement with the criminal justice system, with services to include, but not be limited to:

- Helping the individual identify precipitants to the individual's criminal involvement;
- Providing necessary treatment, support and education to help eliminate any unlawful activities or criminal involvement that may be a consequence of the individual's mental illness;
- Collaborating with police, court personnel and jail/prison officials and psychiatric staff to ensure appropriate use of legal and mental health services; and
- Working with County jail psychiatric mental health staff in planning for their release from custody and transition back into the community (staff will pass Sheriff's Department security screening in order to obtain passes to provide outreach linkage and assessment services at the jail).

- Working with the Behavioral Health Court.

R. Provide support to the individual's social network to help them manage the co-occurring mental health and substance use symptoms and illness of the individual and reduce the level of social stress associated with the illness.

S. Assist individual, family and other members of the individual's social network to relate in a positive and supportive manner through such means as:

- Education about the individual's illness and the support person's role in the therapeutic process;
- Supportive counseling;
- Intervention to resolve conflict;
- Referral, as appropriate, to family therapy, self-help and other family support services; and
- Provision to the individual's other support systems with education and information about serious mental illnesses and treatment services and supports.

T. Coordinate services with other community mental health and non-mental health providers, as well as other medical professionals. Methods for service coordination and communication between Contractor and other service providers serving the same individuals shall be developed and implemented consistent with Fresno County confidentiality rules and will include the following:

- Formal and informal affiliations with appropriate mental health, social services, health care, substance abuse, and other human service providers, and inpatient units;
- Involvement of other pertinent agencies, the individual's family, and members of the individual's social network in the coordination of the assessment, and in the development, implementation and revision of service plans;
- Advocacy for and assistance to individuals to obtain needed benefits and services such as Supplemental Security Income (SSI), housing subsidies, food stamps, medical assistance, and legal services. The FSP understands that SSI can be a tremendous long-term benefit to the individual and will give this resource appropriate attention;
- Coordination of meetings of the individual's service providers in the community;
- Maintenance of ongoing communication with all other agencies serving the individual including hospitals, rehabilitation services and housing providers, as needed;
- Maintenance of working relationships with other community services, such as education, law enforcement and social services;
- Coordination with existing community agencies to develop needed community support resources including housing, employment options and income assistance;

and

- Maintenance of an empathic, hopeful, integrated clinical treatment relationship with the individual on a continuing basis whether the individual is in the hospital, community, involved with other agencies or in the criminal justice system.

U. Network with peer support services and appropriate services offered through the Mental Health Services Act (MHSA), as implemented.

V. Provide wrap-around services. Services will be intensive treatment and rehabilitation case management services to promote adaptive functioning in the community and prevent unnecessary admissions to psychiatric hospitals.

Wrap-around services shall include:

- The development of an individual-centered personal service/care plan reflective of behavioral health assessments (including risk assessments);
- The development, location, coordination, and maintenance of independent or other appropriate housing for all individuals within the community;
- The development, maintenance and involvement of all individuals in lower levels of care in a peer-to-peer support network and social engagement activities;
- The development and maintenance of a 24/7 crisis intervention service;
- The 24/7 crisis intervention phone number will be given to all enrolled individuals, the number will be printed on all Contractor business cards, and Contractor will regularly remind individuals that 24/7 crisis intervention services are available.
- The development and maintenance of integrated mental health and substance abuse treatment services for all individuals with co-occurring disorders;
- The development and maintenance of supported employment and/or supported education with involvement of all individuals who can benefit from these services;
- The development and maintenance of "wrap around" fund to provide for the individual's immediate basic needs or to purchase specialized services that are required to reduce the individual's risk factors when no other funding source is available;
- The development and provision of family involvement/support services to all interested families;
- The development and provision of Personal Service Coordinator services that will access all entitlements or make referral to any support services for which a individual is eligible;
- The development and provision of transportation and other support services individuals may need to access heath care, mental health services, education, employment, rehabilitation, peer support, recreational or other services within the

community;

- The development and maintenance of a "representative payee" service for all individuals who would benefit from this service. Contractor may help individuals link to established payee services in the community;

- The provision of integrated medical support services including psychiatric assessments, psychopharmacological treatment, and medication education and monitoring for all individuals;

- The provision of all other mental health services that may be needed or required by individuals;

- The integration of mental health and substance use disorder recovery principles and practices promoting employment; and

- The facilitation of an individual-centered approach in all treatment services.

W. Initiate voluntary commitment should there be a need after every reasonable intervention has been attempted; Contractor's staff shall work with COUNTY staff within the Intensive Services Division. County staff will sign the involuntary commitment papers. Contractor will clearly document and chart all interventions attempted with individual in every potential crisis situation.

X. Contractor will identify and document diversity of said population, along with housing status, identifying gender, ethnicity, date of birth and/or age and other demographics as requested by County and maintain a database of targeted population. Contractor will provide this information to County as requested.

Y. Individualized services may include drug testing on a random basis, as appropriate, as an integral part of the Personal Services Plan. Services will also include linking individual to appropriate substance abuse treatment services.

Z. Ensure staff participate in education and training activities provided by the County, State of California, and/or organizations to strive for the best practices model.

AA. Provide assistance and advocacy in obtaining any available public benefits and accessing needed behavioral health and physical health care for individuals.

BB. Provide whatever direct assistance is reasonable and necessary to ensure that the individual obtains the basic necessities of daily life. Contractor shall have vehicle(s) available to staff to transport individuals to appointments and social group activities. Bus tokens and/or passes will be made available by the Contractor to encourage and empower individual to utilize public transportation to their scheduled appointments.

CC. Enter Information Technology Web Services (ITWS) data via the web-based data collection operated by the State DMH (Contractor is to receive approval from the State prior to entering data). Contractor will complete ITWS data entry in a timely fashion.

DD. Deliver all MHSA required reporting in data collection format that reflects MHSA and

data Infrastructure Grant (DIG) requirements in a timely and accurate manner. DMH has identified domains on which data must be captured by FSP's. Contractor will be required to assign staff to data entry and input; contact the Performance Outcomes and Quality Improvement Division of the California state Department of Mental Health to schedule trainings; and establish procedures to complete the MHSA Full-Service Partnership Outcomes Assessment (FSP) forms.

Reports are to include: Changes to Individual and Services Information (CSI) system reporting, outcome assessments for Full-Service Partnership (FSP) individuals and notification of cost report changes, annual updates and progress reports as outlined in Department Of Mental Health Information Notice 06-02 dated April 18, 2006. County shall provide a timeline on when each report is due to the County. County at its sole discretion may withhold future amounts payable to Contractor, until such time that all reports are satisfactorily received by the County.

Contractor shall maintain an up to date caseload record of all individuals enrolled in services, and provide individual, programmatic, and other demographic information to the County. Reports are to be submitted to the DBH MHSA Staff Analyst, DBH Director, or designee on a monthly basis.

Contractor will work in partnership with DBH in a quality improvement process on improving recognition of the numbers of individuals who have co-occurring substance use issues and disorders and reporting that information routinely and reliably into the county data system.

Contractor will compile quarterly reports indicating the total number of individuals served in a particular Fiscal Year, along with each quarter's target count versus the actual count.

EE. Ensure billable Mental Health Specialty Services meet any/all County, State, Federal regulations including any utilization review and quality assurance standards. Provide all pertinent and appropriate information in a timely manner to County to bill Medi-Cal for services rendered.

FF. Ensure that the County’s Department of Social Services (DSS) are informed of all new and current individuals who qualify for General Relief.

GG. Inform County’s DSS of individuals enrolled through contact with the Contractor staff assigned to the individual and a monthly report provided to MHSA Administration and DSS by Contractor.

HH. Ensure individuals who qualify for General Relief sign the General Relief Cash Aid individual form.

II. Refer individuals who meet the criteria and are eligible for entitlement programs for benefits/services. All individuals currently in the program and any new individuals to be enrolled will go through DSS to qualify for financial resources.

JJ. Ensure that all individuals without financial resources apply for Medi-Cal and complete SSI applications, establish benefits or have developed an alternative plan for eventually assuming their own housing costs.

3. Contractor will provide specific services as it relates to housing:

Success in the community is critically enhanced by obtaining and retaining appropriate housing. MHSA programs are structured to provide housing opportunities and supports for enrollees.

The Contractor will empower individuals to take an active role in the recovery process. The Contractor will provide housing options and maintain individuals in independent living by providing needed services, accessing resources and encouraging individuals to be independent, productive and responsible. The Contractor will be responsible to negotiate and establish relationships with apartment owners/landlords and provide housing to individuals.

Individuals will be assisted to choose the type of housing that they want and will receive assistance to be successful in that housing. As part of this, individuals will be assisted to make choices regarding substance use in their housing, and to develop the skills and supports needed to be successful in deciding what the right amount of substance use for them will be appropriate to maintain the housing of their choice, or in deciding whether they would be more successful making different choices to be in a different type of housing. Individuals will not be excluded from housing solely because of continuing substance use.

A. Contractor's housing staff shall provide whatever direct assistance is reasonable and necessary to ensure that the individual obtains the necessities of daily life, including but not limited to:

   - Safe, clean, affordable housing;
   - Food and clothing;
   - Appropriate financial support, which may include housing deposits, Supplemental Security Income, Social Security Disability Insurance, General Relief, and money management services.

B. The Contractor shall have rapid access to individual assistance funds for purchase of furniture, and other items needed by individuals.

C. Contractor will ensure individuals maintain their respective housing and utilize supportive housing resources by:

   - Providing supportive and independent housing as appropriate for the individual. The goal is to have every individual in supported independent and independent housing, as appropriate, with proper supports, as soon as possible;

D. Provide appropriate number of staff members that will service the maximum capacity of 140 individuals at any time. Contractor shall provide a methodology on the number of Housing Monitors to be assigned for both clustered and scattered site housing.

E. Meet regularly with MHSA staff to discuss and resolve any issues and/or any individual status changes. Status changes include but are not limited to hospitalization, incarceration, crisis calls, housing etc.

F. Staff shall send written notice to landlords of housing facilities that explains the financial responsibility of CONTRACTOR and the individual (tenant) for payment of rent and utilities within three business days.

G. A completed individual rental agreement shall document the amount of rent and the minimum utility expense that an individual is required to pay. Housing Coordinator shall also provide a monthly receipt to individual and staff of the payment received. Contractor will establish and follow clear Policies and Procedures regarding financial issues related to housing.

COUNTY RESPONSIBILITIES:

County shall:

1. Provide oversight, through its MHSA Coordinator or designee, of the Housing and Recovery Expansion services as restored and expanded through MHSA funding and collaborate with Contractor and other County Departments and community agencies to help achieve State program goals and outcomes. In addition to contract monitoring of program(s), oversight includes, but not limited to, coordination with the State Department of Mental Health in regard to program administration and outcomes.

2. County's DBH shall assist Contractor in making linkages with the total mental health and substance abuse system. This will be accomplished through regularly scheduled meetings as well as formal and informal consultation.

3. Participate in evaluating the progress of the overall program and the efficiency of collaboration with the Contractor staff and will be available to Contractor for ongoing consultation.

4. Gather outcome information from target individual groups and Contractor throughout each term of contract. MHSA staff will notify Contractor when its participation is required. The performance outcome measurement process will not be limited to survey instruments but will also include, as appropriate, individual and staff interviews, chart reviews, and other methods of obtaining required information.

5. Assist the individual to determine food stamp eligibility. Upon determination of food stamp eligibility, enrollees shall receive food stamps when they reside in housing that does not include meals.

6. MHSA Administration and DBH recognize that co-occurring is a goal for all programs, and will provide continuing training, consultation, and technical assistance for all programs in order to help them make progress in that goal, as part of their own quality improvement plan. DBH is also supporting the development of a change agent team in the county to support this process and encourages each program to have active representation on this team.

7. MHSA Administration recognizes that cultural competence is a goal toward which professionals, agencies, and systems should strive. Becoming culturally competent is a developmental process and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to

meet culturally unique needs. Offering those services in a manner that fails to achieve its intended result due to cultural and linguistic barriers is not cost effective. To assist the Contractor's efforts towards cultural and linguistic competency, the DBH shall provide the following at no cost to Contractor:

A. Technical assistance regarding cultural competency requirements and sexual orientation training.

B. Mandatory cultural competency training including sexual orientation and sensitivity training for DBH and contactor personnel, at minimum once per year. County will provide mandatory training regarding the special needs of this diverse population and will be included in the cultural competence training(s). Sexual orientation and sensitivity to gender differences is a basic cultural competence principle and shall be included in the cultural competency training. Literature suggests that the mental health needs of lesbian, gay, bisexual, transgender (LGBT) individuals may be at increased risk for mental disorders and mental health problems due to exposure to societal stressors such as stigmatization, prejudice and anti-gay violence. Social support may be critical for this population. Access to care may be limited due to concerns about providers' sensitivity to differences in sexual orientation.

C. Technical assistance for translating behavioral health and substance abuse services information into DBH's threshold languages (Spanish, Laotian, Cambodian and Hmong). Translation services and costs associated will be the responsibility of the Contractor.

PROJECTED OUTCOMES:

The following items listed below represent program goals to be achieved by Contractor. The program's success will be based on the number of goals it can achieve, resulting from performance outcomes. Contractor will utilize a computerized tracking system with which outcome measures and other relevant individual data, such as demographics, will be maintained.

Contractor will meet outcomes in each of the Commission on Accreditation of Rehabilitation Facilities (CARF) domains and has included more than one performance indicator for each of the four domains.

Effectiveness:

1. Individuals served will experience a reduction in recidivism events (incarcerations, homelessness, crisis or inpatient hospitalization admissions) to no more than 6 events with the first six months after admission compared to events prior to admission as evidenced by reports of the KETs completed for each individual whenever a key event takes place.

2. There will be a reduction of key events for recidivism tracked as:

   a. A reduction in engagement in 3 or less key recidivism events (incarcerations, homelessness, crisis or inpatient hospitalization admissions) during *6-12 months* in the program compared to event prior to admissions, as evidenced by reports of the KET 's completed for each individual whenever a key event takes place.

   b. A reduction in engagement in no more than 1 key recidivism events (incarcerations, homelessness, crisis or inpatient hospitalization admissions) during *13-18 months* in the

program compared to events prior to admission, as evidenced by reports of the KET 's completed for each individual whenever a key event takes place.

3. Contractor will show at least 75% reduction in inpatient psychiatric hospitalizations after being admitted to program services compared to inpatient days utilized the year prior to program admissions, as evidenced by the end of year DCR report.

4. Contractor will show at least 75% reduction in incarceration days after being admitted to program services compared to inpatient days utilized the years prior to program admissions, as evidenced by the end of year DCR report.

5. Contractor will show at least 75% reduction in days of homelessness compared to events prior to admission, unless housing assistance is declined, as evidenced by the end of year DCR report.

6. Contractor will show at least 75% reduction in crisis episodes compared to episodes prior to program admission as evidenced by the end of year DCR report.

7. Contractor will demonstrate a significant increase in individual functioning, as evidenced by the above outcomes #3-5.

Regarding Linkages and Referrals:

The Program Manager will ensure that reports are run monthly from the DCR system and will review these reports to ensure that the program is on track to meet overall outcomes.

Efficiency:

1. Contractor direct services productivity rate is expected by MHS to be at a minimum of 60%, thereby exceeding the 35% requirement for Medi-Cal stated in the RFP on page 12 and will be reported in writing by the Program Manager at regularly scheduled meetings with the Department. Productivity is reviewed during the monthly meeting between the Program Manager, Program Supervisors, and Clinical Supervisor.

2. Clients in independent supportive housing and lower levels of care such as Room and Board will develop a plan to provide for their own housing costs. The Team will work with clients on payment issues. Clients will assume responsibility for housing cost, when ready and as appropriate. A report regarding consumer plans for housing costs will be submitted annually.

3. Contractor will conduct a recovery needs level (RNL) assessment tool within 24 hours of initial appointment to assess for appropriate level of care (ACT, Intensive Case Management) for individuals on the ACT *track* and will conduct the ASAM within 72 hours of initial appointment to assess for the appropriate level of care for individuals on the SUD *track*, as evidenced by the RNL's entered into County's Avatar and ASAM's internally monitored by the Program Supervisor.

Access:

1. Within 24 hours of referral receipt, Contractor will make contact to schedule intake and behavioral health assessment for new individuals; Initial appointments will be scheduled within 24 -72 hours from initial contact; If attempts at contact are unsuccessful, Contractor will document accordingly and notify referral source, as evidenced by access logs delivered each month to Fresno County Managed Care.

2. Within 90 days of admission to Contractor, at least 95% of individuals who do not have SSI will have completed an SSI application, as evidenced by progress notes, a receipt in the individual's file, and the tracking log.

3. Within 60 days of admissions to Contractor, at least 95% of individuals will be linked to general relief to establish supplemental income, as evidenced by progress notes, a receipt in the individual's file, and the tracking log.

4. Within 6 months of being admitted to Contractor, at least 95% of individuals served will have linkage to and documentation of a Primary Care Physician, as evidenced by the tracking log.

5. No individuals admitted to Contractor will be referred to or placed on conservatorship while admitted for Contractor services who were not previously in the conservatorship process, as evidenced by lack of a referral for conservatorship in the client file and progress notes.

6. Within 30 days of enrollment, at least 95% of individuals will have participated in forming their individualized personal service care plan, as evidenced by the personal service care plan in the individual's file.

7. Within 120 days of enrollment, at least 95% of individuals will be provided/linked to supported employment activities, if desired, as evidenced by a referral placed in the Team meeting binder and a progress note.

Satisfaction:

1. Contractor will develop a satisfaction survey that is approved by the MHSA Coordinator and will comply with mandated State performance outcomes and quality improvement reports/outcomes. At a minimum, 75% percent of individuals will report their satisfaction with program services through the Contractor twice annual survey and the annual Fresno County surveys of individuals and families, as evidenced by the survey reports.

2. Contractor will provide individuals with the Consumer Recovery Measure (CRM) to assess satisfaction in hope, social, growth, safety and symptom management within 14 days of admissions and administer on a quarterly basis. Contractor will demonstrate an increase in all categories within the first 6 – 12 months of services, as evidenced by the CRM report.

3. Contractor will conduct a Recovery Measure Inventory (RMI) in reference to the individuals served to assess satisfaction in hope, social, growth, safety and symptom management from the provider perspective within 14 days of admissions and repeat on a quarterly basis. Contractor will show an increase in all categories within the first 6 – 12 months of services, as evidenced by the RMI report.

4. Direct services productivity rate is expected to be at a minimum of eighty percent (80%) and reported in writing at regularly scheduled meetings with the Department. Productivity to be reviewed monthly to address projected revenues and outreach activities related to target population requiring benefits assistance.

5. Individuals in independent supportive housing and lower levels of care will develop a plan to provide for their own housing costs. Individuals will assume responsibility for housing cost, when ready and as appropriate. Contractor will work with individuals on payment issues. Within six months of enrollment, all individuals without SSI will have made SSI applications, establish benefits or have developed an alternative plan for eventually assuming their own housing costs. A report regarding individual plans for housing costs will be submitted to County on a semi-annual basis.

Transition Optimization Opportunities

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.

Drug Medi-Cal Transition Optimization funds will be provided through County Realignment.

a. **Funding Allocation Methodology**

i. Each participating contractor is eligible to apply for an allocation of Transition Optimization Funds up to the maximum amounts stated in Article 4 of the 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.

ii. 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.

iii. Payments will be dependent on Contractor demonstrating progress toward meeting deliverables described in this exhibit. 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.

iv. 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**

i. **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 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.

ii. **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 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.

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

1. Q1 Reports: July-Sept:
   a. Letter of Intent: Due July 31, 2023
   b. Fiscal Monitoring Tool, Equity Gap Analysis, and Electronic Health Record Implementation Plans (if applicable): Due September 30, 2023
   c. Fiscal Monitoring Tool Identified Practices and Strategies (if applicable): Due September 30, 2023
2. Q2 Report: Oct-Dec: Due January 15, 2024
3. Q3 Report: Jan-Mar: Due April 15, 2024
4. Q4 Report: Apr-June: Due July 15, 2024

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

c. **Eligible Transition Optimization Activities**

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. Fiscal Monitoring Tools and Implementation Plan: 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.

   a. Identified Practice: Identify at least one process improvement that shall be modified by September 30, 2023.

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

   c. 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 fiscal year 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:
    a. Identify if it serves specific population within its program(s) and identify whom the program(s) currently served based on data.
    b. 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.
    c. Comparison of the county penetration rates to the demographics of persons served by the Contractor and program(s) under agreement with DBH.
    d. 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.
    e. 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:
    a. Contractor shall select three 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 underrepresented
            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
    b. Timeline for each effort shall be included in the plan.

c. 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.

d. 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.

iii. **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

a. 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.

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

c. Total compensation for this Electronic Health Record 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

a. 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.

b. 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.

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	$223.41

Service	Unit	Maximum Units that Can be Billed	Rate per Unit
Interactive Complexity	15 mins per unit	1 per allowed procedure per provider per beneficiary	$16.50
Sign Language or Oral Interpretive Services	15 mins per unit	Variable	$30.00