



**County of Sacramento
Department of Health Services**

REQUEST FOR APPLICATIONS (RFA) No. MHSA/075

Adult Full Service Partnership Program

MANDATORY APPLICANTS' CONFERENCE

June 8, 2022, 2:00 pm – 3:00 pm (PDT)

- Organizations must meet all minimum requirements as stated in this document
- Organizations must have representation at the Mandatory Applicants' Conference, held virtually, to submit an application
- Organizations must register for the Mandatory Applicants' Conference through the on-line link shown in the RFA timeline. The registration deadline is shown in the RFA timeline.
- Each organization may register a maximum of three (3) representatives per organization. Organizations may only register one time.

Applications due no later than 5:00 pm (PDT), June 30, 2022

- LATE APPLICATIONS WILL NOT BE ACCEPTED
- The application packet must be sent via email to ApplicationsMHSA075@SacCounty.gov as a PDF file attachment or as a zipped file containing multiple documents.
- Mailed or hand delivered hard copies, or faxed submissions will not be accepted. Applications sent to any other email address will not be accepted.

Review all sections carefully and follow all instructions.

Release Date: May 20, 2022

RFA Timeline

May 20, 2022	Request for Applications (RFA) released
June 6, 2022 5:00 pm (PDT)	<p>Mandatory Applicants' Conference Registration Deadline</p> <p>REGISTRATION IS REQUIRED TO ATTEND THE MANDATORY APPLICANTS' CONFERENCE</p> <p>Register here: https://www.surveymonkey.com/r/ZYWTTXK</p>
June 8, 2022 2:00 – 3:00 pm (PDT)	<p>Mandatory Applicants' Conference</p> <p>ATTENDANCE IS REQUIRED TO APPLY FOR FUNDING</p> <p>Conference will be held virtually with listen-only access</p>
June 10, 2022 5:00 pm (PDT)	<p>Exhibit O: Applicant Questions Form submission deadline</p> <p>(see Exhibit O for submission instructions)</p>
June 30, 2022 5:00 pm (PDT)	<p>APPLICATION DEADLINE</p> <p>The application packet must be sent via email to ApplicationsMHSA075@SacCounty.gov as a PDF file attachment or as a zipped file containing multiple documents</p>
By July 5, 2022	Initial screening of Applications
By July 7, 2022	Notice of insurance deficiencies emailed to Applicants
July 13, 2022 5:00 pm (PDT)	Final date for Applicants to submit corrections of all insurance deficiencies
By July 18, 2022	Notice of disqualification emailed to Applicants
July 25-26, 2022	Applicants Virtual Briefing Sessions
July 27-29, 2022	Applicants Virtual Presentations
By August 8, 2022	Evaluation of Applications completed
By August 12, 2022	Awards recommendation emailed to applicants
August 18, 2022 5:00 pm (PDT)	<p>Final date to submit written protest to Department of Health Services Director by email: DHS-Director@SacCounty.net</p>
August 29, 2022 5:00 pm (PDT)	Response to protest

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SECTION I. OVERVIEW

A. **BACKGROUND**

Introduction to Sacramento County

Sacramento County is one of eighteen counties located in the Central Mental Health Region of the State of California. The State of California, Department of Finance estimates the 2019 population of Sacramento County to be approximately 1.5 million. With more than a half million residents living in unincorporated Sacramento County, it makes our unincorporated county population the fifth largest in the state. As such, Sacramento is considered a large county, especially in comparison with the populations of surrounding counties.

Sacramento is one of the most ethnically and racially diverse communities in California. While the Wilton Rancheria Tribe is the only Federally Recognized Tribe in Sacramento County, Native Americans from local and out of state tribes currently reside in Sacramento. Historically, Sacramento County has been one of three counties with the highest number of newly arriving refugees in California. However, in recent years, Sacramento County has resettled the most Refugees and Special Immigrant Visa holders (SIVs) as compared to any other county in California. With the addition of Arabic as a threshold language in 2017 and Farsi in 2020, Sacramento County now has a total of seven threshold languages (Arabic, Cantonese, Farsi, Hmong, Russian, Spanish, and Vietnamese).

Specialty Mental Health Services

Since 1998, Sacramento County, through the Department of Health Services, Behavioral Health Services (BHS), is the Mental Health Plan (MHP) responsible for the provision of specialty mental health services to Medi-Cal eligible Sacramento County residents. In 2019, 342,202 adult Medi-Cal eligible beneficiaries resided in Sacramento. Of those, 14,638 unduplicated adults received services through the MHP.

Specialty mental health services are provided in accordance with California's 1915(b) Medi-Cal waiver. These services may be provided through the County or through contracted providers. Outpatient specialty mental health services include treatment of co-occurring substance use disorders and are not limited to: assessment, plan development, individual and group therapy, individual and group rehabilitation, collateral services (inclusion of family members or significant support persons in services provided to individuals), case management, intensive care coordination, intensive home based services, medication support services, crisis intervention and crisis stabilization. Medi-Cal beneficiaries may receive specialty mental health services if it is medically necessary in order to address a particular mental health condition (diagnosis). A service is medically necessary if the interventions focus on addressing functional impairment resulting from a diagnosed mental disorder.

The adult outpatient services system provides community-based mental health services for individuals (age 18 and older) being released from acute care settings or who are at risk for entering acute care settings and are not linked to on-going mental health services.

Mental Health Services Act

The passage of Proposition 63, now known as the Mental Health Services Act or MHSA, in November 2004 provided the first opportunity in many years for the California Department of Health Care Services (DHCS) to provide increased funding, personnel, and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults, and families. MHSA addresses a broad continuum of prevention, early intervention, and

service needs, as well as the necessary infrastructure, technology, and training elements that will effectively support this system. MHSA imposes a 1% income tax on personal income in excess of \$1 million. Much of the funding is provided to county mental health programs to fund programs consistent with their local plans resulting from community and stakeholder planning processes. All MHSA plans are approved by the local Board of Supervisors (BOS).

MHSA General Standards must be embedded and continuously addressed in all MHSA funded programs and projects:

- Community Collaboration
- Cultural Competence
- Client/Family driven mental health system
- Wellness focus, which includes the concepts of recovery and resilience
- Integrated service experiences for clients and their families throughout their interactions with the mental health system

The MHSA specifies five major components:

- Community Services and Supports (CSS) – programs, services, and strategies that serve clients and families
- Workforce Education and Training (WET) – targets workforce development programs
- Capital Facilities and Technological Needs (CFTN) – addresses the capital infrastructure and technology systems needed to support implementation of MHSA
- Prevention and Early Intervention (PEI) – supports the design of programs to prevent mental illnesses from becoming severe and disabling
- Innovation (INN) – component goal is to develop new mental health approaches, increase access to services, and increase the quality of services

The CSS component consists of three service categories:

- Full Service Partnerships (FSPs) programs utilize the “whatever it takes” approach in meeting service goals that include a broad array of coordinated and intensive services for clients and families
- General System Development (GSD) programs aim to improve services and supports for clients and families
- Outreach and Engagement activities are aimed at reaching unserved and underserved populations

The primary goal of all MHSA programs is to reduce the negative outcomes resulting from untreated mental illness, including suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness, and the removal of children from their family home.

Sacramento County Behavioral Health Services’ Adult Mental Health System

In Sacramento County, there is an array of services and supports that encompass BHS’ Adult Mental Health System. This continuum is offered by county operated programs and community-based organizations that deliver mental health services in a culturally and linguistically responsive manner in order to help individuals function better at home, in the community, and throughout life. Services are provided along a continuum of prevention and early intervention services, outpatient, intensive outpatient and acute residential services.

Sacramento County Assisted Outpatient Treatment

Assisted Outpatient Treatment (AOT), also known as Laura’s Law was passed by the California Legislature in 2002 as Assembly Bill 1421. This law allows for court ordered outpatient treatment for individuals, ages 18 and older, who meet limited legal criteria as indicated in the California Welfare and Institution Code (W&I) Code Section 5346. Outpatient treatment would prevent deterioration in their condition that would likely result in grave disability or to self and others. On September 25, 2020, Assembly Bill 1976 was signed into law requiring counties to implement AOT or opt out by July 1, 2021. With wide community support, on January 11, 2022, the Sacramento County Board of Supervisors (BOS) approved BHS’ implementation of an AOT program funded with Realignment revenue.

AOT is civil court ordered mental health treatment for individuals suffering from a serious mental illness when treatment would prevent a deterioration in their condition that would likely result in grave disability or harm to self or others. These criteria includes, in part, that the individual must be 18 years of age or older, have a history of psychiatric hospitalizations, incarcerations or acts, threats or attempts of serious violent behavior towards themselves or others and have been offered the opportunity to participate in treatment voluntarily but failed to engage on multiple occasions.

Counties that have implemented AOT programs use the FSP model with elements of Assertive Community Treatment (ACT). These models provide community-based services delivered by a multi-disciplinary team who provide 24/7 on-call outreach and support, comprehensive array of mental health services, coordination of care, and referral and linkage to physical health, social services, and housing resources. AOT services are recovery-focused, strengths-based, and anchored in biopsychosocial rehabilitation and recovery principles.

Sacramento County Behavioral Health Services’ Vision, Mission and Values

The following vision and mission statements and core values define BHS’ mental health system of care objectives. They also provide direction and guiding principles for how all services are delivered through the mental health system of care:

BHS Vision - We envision a community where persons from diverse backgrounds across the life continuum have the opportunity to experience optimum wellness.

BHS Mission - To provide a culturally competent system of care that promotes holistic recovery, optimum health, and resiliency.

BHS Values:

- Respect, Compassion, Integrity
- Client and/or Family Driven
- Equal Access for Diverse Populations
- Cultural Competence, Adaptive, Responsive and Meaningful
- Prevention and Early Intervention
- Full Community Integration and Collaboration
- Coordinated Near Home and Natural Settings
- Strength-Based Integrated and Evidence-Based Practices
- Innovation and Outcome-Driven Practices and Systems
- Wellness, Recovery and Resilience Focus

This RFA specifically relates to MHSA CSS component FSP service category and AOT programming combined with Specialty Mental Health Services serving Medi-Cal beneficiaries. It braids MHSA, Realignment and Federal Financial Participation (FFP) funds. FFP is the funding mechanism under which Title XIX (Medi-Cal) dollars are accessed (via matching funds) to reimburse the MHP. AOT program services will be funded with Realignment and Federal Funding. FSP services and MHSA flex funds, including housing supports, will be funded with MHSA and FFP.

B. **PURPOSE**

In Fiscal Year (FY) 2020-21, BHS was awarded No Place Like Home (NPLH) grant funds to develop permanent supportive housing for individuals living with a serious mental illness, are in need of mental health services, are experiencing homelessness, chronic homelessness, or who are at risk of chronic homelessness. Permanent supportive housing (PSH) is a highly effective strategy that combines affordable housing with intensive coordinated services to assist individuals struggling with mental health issues maintain stable housing and receive needed services. Under the NPLH Program, counties are required provide mental health services and help coordinate access to other supportive services to the individuals housed in NPLH-funded PSH to ensure they are stably housed, improve mental health and wellness, and to live and work in their community.

Many of Sacramento County Behavioral Health Services' MHSA CSS FSP programs utilize an integrated supported housing and team-based treatment approach to do "whatever it takes" to improve housing stability and mental health outcomes for individuals living with a serious mental illness at risk of or experiencing homelessness. These FSPs provide the intensive coordinated support and mental health services to clients residing in Sacramento County's MHSA Program units.

At the October 21, 2021 MHSA Steering Committee meeting, BHS put forth a recommendation to increase FSP capacity, both new and expanded, to support the additional housing capacity resulting from the NPLH award. The MHSA Steering Committee supported this recommendation.

In March 2021, BHS facilitated several Laura's Law/Assisted Outpatient Treatment (AOT) community input sessions. Many community members support the County's implementation of AOT. On January 11, 2022, the Sacramento County Board of Supervisors (BOS) approved BHS' implementation of an AOT program funded with Realignment revenue.

AOT is court ordered outpatient mental health treatment for adults, ages 18 years and older, living with a serious mental illness with the goal of preventing deterioration in their condition that would likely result in grave disability or harm to self or others. Counties that have implemented AOT programs use FSP and Assertive Community Treatment models (see Attachment 1).

Sacramento County BHS' purpose in issuing this RFA is to implement a new Adult FSP that will increase FSP capacity for individuals age 18 years and older, living with a serious mental illness, who may be at risk of or experiencing homelessness, have a co-occurring substance use disorder, have multi-system involvement and/or at risk of incarceration and/or involuntary psychiatric hospitalization or institutionalization. This increased capacity will provide the full spectrum of FSP services and supports for clients who will reside in the new NPLH units and those referred through the County operated AOT Engagement Team. The additional FSP capacity will accommodate Sacramento County's implementation of AOT by providing treatment and supports to court referred or mandated clients. Clients receiving AOT services may be uninsured or insured by Medi-Cal or private insurance.

This new program will support and promote the recovery of their clients. Recovery as defined by Substance Abuse Mental Health Services Administration (SAMHSA) is a process of change through which clients improve their health and wellness, live a self-directed life, and strive to reach their full potential by way of the four major dimensions that support a life in recovery:

- Health – overcoming or managing one’s symptoms and making informed, healthy choices that support physical and emotional well-being.
- Housing – having a stable and safe place to live.
- Purpose – engaging in meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society.
- Community – having relationships and social networks that provide support, friendship, love, interconnectedness, and hope.

This Adult FSP will employ MHSA Steering Committee’s recommendation for FSP:

- Easy access to services, such as sustained engagement of clients in the field, reaching out to clients as they are discharging or being released from other services or systems, and offering services outside standard business hours.
- Mental health treatment includes providing services in the community, coordination of care with system partners, skills building, benefits acquisition, and transportation.
- Develop and maintain collaborations and partnerships with housing partners to better serve clients that are at risk of or experiencing homelessness.

The new FSP will:

- Outreach to clients and successfully engage them in services;
- Provide recovery-oriented, culturally appropriate, gender appropriate, age appropriate, and trauma informed specialty mental health services and peer support services;
- Provide full spectrum of community services and supports that includes a full array of mental health and non-mental health services and supports; and
- Provide housing supports/assistance; provide on-site support services to FSP clients in approximately 105 NPLH funded PSH units and in other community housing.

FSPs use the “whatever it takes” philosophy to service delivery which means finding the methods and means to engage the client, determine their needs for recovery and create collaborative services and supports to meet those needs. These services are provided by a team 24/7.

FSP tenets emphasize that the MHSA General Standards are integrated into the FSP model. These tenets include: client and family-driven FSP services within the context of a partnership between the client and provider; accessible, individualized services and supports tailored to a client’s readiness for change that leverage community partnerships; delivery of culturally and linguistically responsive services with a focus for wellness, outcomes and accountability. (See Attachment 2).

Sacramento County is seeking applications from organizations that have experience in providing 24/7 comprehensive mental health services and supports that address the needs of adults living with serious mental illness who may be at risk of or experiencing homelessness, have a co-occurring substance use disorder, have multi-system involvement and/or at risk of incarceration and/or involuntary psychiatric hospitalization or institutionalization. This includes experience with outreach and engagement to clients who may also be engaged with the criminal justice system and at risk of involuntary psychiatric hospitalization or institutionalization.

C. **SCOPE OF WORK**

1. **Program Description:** *The Adult Full Service Partnership (FSP) Program* will provide comprehensive, flexible, client-driven recovery-oriented, strength-based, trauma informed,

culturally and linguistically responsive, community-based specialty mental health services, and FSP supports to adult beneficiaries who meet target population and medical necessity criteria as defined by the Sacramento County BHS. The successful applicant will provide intensive outpatient services to adults over 18 years old who require frequent contact and support to maintain in the community due to the severity of their mental illness. This FSP will support their clients in qualifying, preparing for and living in PSH with supportive services that will ensure safety and stability in the community. Clients in the new FSP may be experiencing one or more of the following: homelessness, involvement with the criminal justice system, a co-occurring substance use disorder, frequent psychiatric hospitalizations, frequent incarcerations, and court-ordered mental health treatment. FSP Services should be provided in accordance with the California Institute for Mental Health Full Service Partnership Tool Kit, the Adult version (see Attachment 2). Services are comprehensive, and are provided in the home, community, or office depending on client need – using a harm reduction “whatever it takes” approach – in order to assist clients in maintaining stability in the community, including PSH units. The Adult FSP will utilize the service delivery approaches defined in this scope of work (see Section I, C. 8) to provide FSP full spectrum of community services to assist clients in recovery and transitioning to a lower level of care.

- a. Full spectrum of community services and mental health supports include but are not limited to:
 - i. Individual rehabilitation utilizing evidence-based practices (EBP), for example Motivational Interviewing, Cognitive Behavioral Therapy, and other EBPs that build skills, promote wellness and recovery, etc.;
 - ii. Peer support;
 - iii. Supportive services to assist the client, and when appropriate the client’s family, in obtaining and maintaining employment, housing and/or education;
 - iv. Personal service coordination/case management to assist the client and when appropriate the client’s family, to access needed medical, educational, social, vocational rehabilitative and /or other community services;
 - v. Needs assessment;
 - vi. Individual services and supports plan;
 - vii. Crisis intervention/stabilization services; and
 - viii. Family education services.
- b. Non-mental health services and supports include:
 - i. Food;
 - ii. Clothing;
 - iii. Housing, including but not limited to rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and support in temporary, transitional or permanent housing, or PSH;
 - iv. Cost and/or coordination of health care treatment;
 - v. Cost of treatment and/or care coordination of co-occurring conditions, such as substance abuse; and,
 - vi. Respite care.

2. Program Objectives:

- a. Promote recovery and optimize community functioning through the provision of mental health services and supports at the appropriate level of care;

- b. Elevate and improve client driven recovery-oriented, trauma informed and culturally responsive approaches that address mental illness and co-occurring substance use disorders;
 - c. Advance and increase timely access to appropriate linkages and coordination with key services and benefits impacting clients health and well-being (e.g. Primary Health, Supplemental Security Income, Medi-Cal, etc.);
 - d. Further client self-determination in the least restrictive setting and transition to lower level of service intensity and community integration as appropriate;
 - e. Reduce emergency room visits, psychiatric hospitalizations, admissions to long term facilities, arrests, incarceration and homelessness; and,
 - f. Promote stability in the community housing units by providing services including but not limited to: supporting qualified clients in application and lease up process, coordinating care with housing management, and crisis and stabilization interventions to secure housing placement.
3. **Clients Served:** All eligible adults age 18 years and older, as defined by the Sacramento County BHS, Quality Management (QM) “Determination for Medical Necessity and Target Population” Policy and Procedure (see Attachment 3). Individuals must also meet the following criteria:
- a. Unserved or underserved
 - b. Frequently in or being discharged from psychiatric acute care settings
 - c. Severe level of impairment, which requires frequent contact and support from a mental health provider
 - d. May be at risk of or experiencing one or more of the following:
 - i. Homelessness or risk of homelessness
 - ii. Involved in the criminal justice system
 - iii. Court ordered mental health treatment
 - iv. At risk of involuntary psychiatric hospitalization or institutionalization
 - e. May be referred by AOT, including those who may be uninsured, insured by Medi-Cal or have private insurance.
4. **Capacity:** Capacity is defined as the number of clients with a direct service within a 30 day period.
- a. The Adult FSP will serve a capacity of at least 200 individuals.
 - b. The Adult FSP will serve an additional capacity of 40 AOT referred individuals.
5. **Service Location:** The service location(s) will be negotiated between the successful applicant and BHS during contract development. Service location(s) must be sited to allow for maximum use of Regional Transit Bus and Light Rail routes. The successful applicants' negotiated service location(s) must be in compliance with Sacramento County’s Good Neighbor policy and have written approval by BHS prior to executing the property lease agreement(s) or purchase.
6. **Hours of Operation:** The successful applicant shall have extended business hours that include late evening and/or weekend hours. Additionally, the successful applicant shall provide responsive crisis intervention services twenty-four (24) hours per day, seven (7) days per week, including holidays.
7. **Service requirements for the Adult Full Service Partnership Program:**
The successful applicant shall:

- a. Maintain two separate client records, one for FSP and the other for AOT services for clients receiving both FSP and AOT services.
- b. Provide intensive outpatient community-based specialty mental health services that includes assessment, plan development, individual therapy, group therapy, rehabilitation, collateral services, intensive case management, medication support services, and crisis intervention within the service delivery approaches as defined in Section I, C. 8.
 - i. **Assessment** is the clinical evaluation of the client's current status and history of the individual's mental, emotional, or behavioral health including co-occurring substance abuse or significant medical conditions. Relevant cultural issues and history should be included where appropriate. Assessment charting may include self-report, collateral reports, diagnostic impressions and/or information gathering from a variety of screening tools. The use of psychological testing, within staff scope of practice, when appropriate or authorized, is considered assessment activity.
 - ii. **Case Management/Brokerage** services are activities provided by program staff to help an individual access needed medical, educational, social, prevocational, vocational, rehabilitative, or other necessary community services. The service activities may include communication, consultation, coordination, linkage and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development. A case management/brokerage intervention may be with family/caregiver, teacher, social worker, probation officer, and/or volunteers (i.e., Big Brother/Sister, and Coaches).
 - iii. **Collateral services** are contact with a significant support person in the life of the client with the intent of improving or maintaining the mental health status and achieving the goals of the client's service plan / goals. A significant support person(s) means persons, in the opinion of the client or the person providing services, who have or could have a significant role in the successful outcome of treatment, including but not limited to the parents or caregivers of a beneficiary, the legal representative of a client who is not a minor, living in the same household as the client, the client's spouse, and relatives of the client.
 - iv. **Crisis Intervention** is provided when a client requires an immediate response or intervention to help him/her stabilize and maintain in a community setting. A crisis intervention is an unplanned service to or on behalf of an individual. Crisis intervention services are responses where a regularly scheduled visit will not meet the urgent or emergency nature of an individual crisis. An immediate assessment of risk and a time sensitive plan is developed and executed by service staff. Crisis intervention is utilized to stabilize an individual with psychiatric illness, prevent deterioration in individual functioning that may lead to a high level of care hospitalization or involuntary treatment. It typically requires face-to-face contact in addition to multiple other time sensitive service activities. Service activities are not limited to any single treatment modality and may include assessment, treatment or other appropriate collateral services that are clinically determined to be needed to resolve the crisis.
 - v. **Medication Support Services** include prescribing, administering, dispensing and/or monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness. Medication Support activities may include:
 - a) Evaluation of the need for medication, including a brief mental status exam;
 - b) Evaluation of clinical effectiveness and side effects of medication;

- c) Reviewing and obtaining informed consent;
 - d) Medication education, individual or group (including discussing risks, benefits and alternatives with the individual, family or significant support persons); and,
 - e) Plan development related to the delivery of this service.
- vi. **Plan Development** consists of development of client service plans, approval of plans, and/or monitoring of a client's progress or lack of progress. Individualized treatment plans include information of a client's natural support systems including, but not limited to family members, caregivers, peers, employers, or teachers.
- vii. **Rehabilitation** is defined as a service activity that includes, but is not limited to:
- a) Assistance in improving, restoring or maintaining the functional life skills, daily living skills, social skills, grooming and personal hygiene skills, obtaining support resources, obtaining medication education, medication adherence;
 - b) Age-appropriate counseling of the client and/or family, support systems and involved others;
 - c) Training in leisure activities needed to achieve the client's goals/desired results/personal milestones;
 - d) Coaching of clients and caregivers to help improve parenting skills;
 - e) Assistance with education, vocational and employment goals; and,
 - f) Rehabilitative or skill building groups provided by staff (both licensed and unlicensed).
- viii. **Therapy** is a service activity that may be delivered to a client or group of clients and may include family therapy (when the client is present). Therapeutic interventions are consistent with the client's goals, desired results, and personal milestones and focus primarily on symptom reduction as the means to improve functional impairments.
- c. Deliver mental health services within a recovery framework. Services must be individually tailored to a client's unique needs based on a comprehensive assessment. The overarching goals of psychiatric rehabilitation are to be fully integrated into the community, and to function as independently as possible. For optimal functioning, treatment must eliminate or diminish the impact on daily activities and increase those skills that promote self-efficacy.
 - d. Ensure implementation of any EBP that may be selected and adopted by the County MHP and in compliance with BHS EBP registration requirements.
 - e. Implement the Supplemental Security Income (SSI) / Social Security Disability Insurance (SSDI) Outreach, Access and Recovery (SOAR) initiative within 6 months of contract execution to a high fidelity as a foundation of benefit acquisition support and assistance per SAMHSA at <https://soarworks.samhsa.gov/article/starting-your-soar-initiative>.
 - f. Offer enrolled clients who express desire for medication support, or assessed that client is exhibiting behaviors, risk factors, or symptoms which could be addressed through medication management, an appointment for medication management services within 15 days for Initial Psychiatric Assessment.
 - g. Provide culturally responsive services that will increase the likelihood of equitable and just outcomes, including integrated services for co-occurring conditions and substance use disorders.

- h. Adhere to Admission and Authorization guidelines defined per Quality Management (QM) County Policy. Ongoing services must be based on annual completion of the Client Plan, with medical necessity clearly documented in the client's Electronic Health Record (EHR). A Level of Care Utilization System (LOCUS) will be completed for all high intensity service requests. Successful applicant shall accept all admissions from the County. Services to Sacramento County residents with other available benefits from another payor such as Kaiser, Veteran's Administration, Parole, or other health plans with mental health benefits in accordance with the MHP may only be served with an exception, granted in writing by County.
- i. Assess level of service needs by completing a Child and Adolescent Needs and Strengths Assessment (CANS) for clients age 18 and up to 21 years or Adult Needs and Strengths Assessment (ANSA) for clients age 21 years and older within 60 days of beginning services but prior to the treatment plan completion date, every six (6) months from the admit date or more often if clinically indicated, and at discharge.
- j. Ensure newly referred clients are seen face-to-face individually same day or within 24 hours of notification by County, including but not limited to, clients within a secured setting.
- k. Facilitate community placement for clients in secured settings. Develop a community re-entry plan with the client that specifies barriers to community placement with the planned actions and timeframes to address the barriers.
- l. Ensure newly referred clients who are in acute inpatient settings, out of county, are seen face-to-face individually as soon as possible and no later than 5 business days from notification by County.
- m. Ensure that newly referred clients who are incarcerated at the Sacramento County Jail are seen face-to-face individually within five business days after designated provider staff is cleared for admission to the facility.
- n. Newly referred clients in sub-acute settings shall have a target discharge from the sub-acute setting of no more than 10 business days from initial face-to-face.
- o. Newly referred clients in acute settings shall have a target discharge from the acute setting of no more than 3 business days from initial face-to-face.
- p. Enrolled clients in a secured setting determined ready for discharge shall have a target discharge from the secured setting of no more than 3 business days from notification of readiness for discharge.
- q. Ensure staff will respond in person, within 2 hours of notification, to enrolled clients hospitalized (acute psychiatric hospitalization, emergency department or inpatient medical hospitalization) within Sacramento County. Staff will actively participate in ameliorating the crisis when possible and/or assisting in assessment, treatment and discharge planning.
- r. Contact newly referred clients who are in acute inpatient settings more than one county over, within one business day by phone. Coordination efforts on care coordination and/or discharge planning, including transportation back to Sacramento County shall be made with the client and inpatient provider.
- s. Identify appropriate alternative services if a client does not meet Medical Necessity for specialty mental health services, as determined by the evaluating Licensed Practitioner of the Healing Arts (LPHA). Within 30 business days successful applicant will make referrals to appropriate resources, assist client in accessing those services and note services provided in client's chart. Services will not be terminated until medication needs have been secured.

- t. Submit supportive written documentation to the County on disputes regarding the appropriateness of an authorized referral that includes the specific rationale and behavioral conditions of concern. Unresolved disputes will be reviewed by County for disposition per QM policy regarding Problem Resolution.
- u. Provide integrated treatment and recovery-oriented support that:
 - i. Leverages educational services and supports;
 - ii. Provides co-occurring substance use services;
 - iii. Collaborates with community partners and other systems;
 - iv. Collaborates with physical health care systems;
 - v. Partners with the justice system, law enforcement, welfare and probation;
 - vi. Includes services and supports that will allow the client to access and maintain BHS housing and community based housing resources;
 - vii. Includes natural supports in all aspects of treatment; and,
 - viii. Compliments, not supplants, necessary Alta Regional Services.
- v. Provide client **advocacy** which is defined as a process that provides clients with information to make informed decisions; communicating, educating, interceding on behalf of a person to acquire needed services, benefit entitlements, managed care resources or housing supports.
- w. Include client voice and choice and **Peer/Advocate/Partner/Cultural Broker Support Services**. These services shall include client voice and choice provided in collaboration with those individuals and agencies involved with the client. Clients will have a high level of decision-making power. Successful applicant shall involve significant others/family/parents/caregivers/guardians, as appropriate, in all treatment planning and decision-making regarding the client's services as documented in the client plan. Peer staff will utilize their lived experience to provide peer support, engagement, wellness services and navigation supports within the Mental Health Plan (MHP), as well as other health systems and community supports.
- x. Provide linkages for resources and services that address housing stability, financial stability, vocational stability, substance abuse issues and relapse prevention, immigration and legal issues.
- y. Provide **Housing Subsidies and Support Services** to clients at risk of or experiencing homelessness allowable by funding and consistent with County policies, as well as requirements outlined by the local housing authority related to vouchers and certificates, in order to reduce impact to the client's mental health condition.
 - i. Disseminate Housing Subsidies and Support Services consistent with the client housing plan including and not limited to housing subsidies for permanent, transitional and temporary housing, master leases, rental security deposits, first and last month rental payments, closing rent gaps, short term emergency hotel/motel payments, utility hook ups, credit repair support, application fees, damage repair, landlord development.
 - ii. Provide relevant case management and support including but not limited to supporting clients with required homeless continuum documentation, referring clients to eligible homeless resources, utilizing the County provided rental calculator when appropriate, conducting screenings for homelessness prevention funds eligibility and supporting with housing search and housing readiness consistent with County policy.

- iii. Update Homeless Management Information System (HMIS) consistent with County policy.
 - iv. Provide supportive services on site at approximately 105 NPLH PSH units. Services may include support to qualified clients in application and lease up process, coordination of care with housing management, crisis and stabilization interventions to secure housing placement, etc.
 - z. Partner and collaborate with homeless outreach teams that provide outreach, engagement and linkage services by meeting clients in encampments, shelters or any location they are experiencing homelessness, supporting rapport building, supporting linkages, and providing or assisting with transportation and other types of supports.
 - aa. Assess and determine client stepdown and transition readiness by considering indicators such as: engagement in new habits and patterns of behavior; no recent hospitalizations; housing stability; access to adequate resources; decreased or no need for case management; improvement in quality of life; client's choice and desire; access adequate social support network; lowered acuity; and treatment goals met.
 - i. Transition all services and facilitate an appropriate discharge and linkages when the client is able to function more independently as demonstrated by their ability to implement new interventions and new skills and that reduce the risks of mental health crisis or psychiatric hospitalization.
8. **Service Delivery Approaches:** Successful applicant shall utilize the following approaches/practices in providing services as defined in Section I, C. 7.
- a. Trauma informed care, based on the Center of Health Care Strategies' core principles and key ingredients of trauma-informed care (see Attachment 4). Core principles of a trauma-informed approach include program participant empowerment and choice, collaboration among service providers and systems, ensuring physical and emotional safety and trustworthiness for program participants. Key ingredients of providing comprehensive trauma informed care involve both organizational and clinical practices. Successful applicant will develop and maintain organization-wide policies and practices that recognize the impact of trauma both on clients and staff.
 - b. Implement the SOAR program to fidelity that is sustainable and which promotes recovery and wellness through increased access to Social Security disability benefits for eligible individuals who are experiencing or at risk of homelessness and have serious mental illness, medical impairment, and/or co-occurring substance use disorder, per SAMHSA (see Attachment 5). SAMHSA developed the SOAR model to address this critical need. FSP SOAR trained case managers submit complete and quality applications that are approved quickly, described in SSI/SSDI Outreach, Access, and Recovery: An Overview (see Attachment 5 and SOAR Online Course Catalog).
 - c. FSP full spectrum of community services and FSP tenets, described in the Adult FSP Tool Kit (see Attachment 2). This includes the provision of moderate to high intensity level of service:
 - i. High intensity level of service includes a contact expectation of three to seven days per week, multiple times per day, as needed for stabilization. Service mode of contact shall be face-to-face and service delivery shall be primarily in the client's home or community, and at the successful applicant's office as appropriate. All new program enrollees shall receive high intensity level of services until stable. At minimum, high intensity services include assessment, plan development, crisis intervention, safety planning, and safety plan monitoring. Decisions to increase or decrease services shall be made in agreement with

the client and rationale documented in the client's EHR. The Client Plan shall be updated to reflect the change in contact frequency.

- ii. Moderate intensity level of service includes a contact expectation of weekly face-to-face service delivery for the purpose of stabilization and recovery. At minimum, moderate intensity services include social rehabilitation for skills building, enhancing relationships and community connections (i.e. work, school, volunteer, faith-based groups, community centers, etc.), case management, safety plan monitoring, and any other service that aids in wellness and recovery. Service intensity may increase for stabilization as necessary. Decisions to increase or decrease services shall be made in agreement with the client and rationale documented in the client's EHR. The Client Plan shall be updated to reflect the change in contact frequency.
 - d. Assertive Community Treatment (ACT) is a service delivery model that promotes recovery through community treatment and rehabilitation. ACT is characterized by a team approach, in vivo services, smaller caseloads, a shared caseload, flexible service delivery, a fixed point of responsibility and 24/7 crisis availability and a basis for FSP programming. (see Attachment 1)
 - e. Develop and implement an internal model that effectively supports clients participating in collaborative courts (i.e., Mental Health Court) for the purpose of assisting clients in successfully completing their respective court programs. Client's participation shall be included in the Client Plan and progress, or lack thereof, must be documented in the client's EHR. Program staff will attend all meetings related to collaborative courts and will meet guidelines for court reporting as applicable.
 - f. Identify and use evidence based interventions and practice(s), community defined practice(s), and/or promising practice(s) and will register the practice with BHS QM. Services shall be provided within standard theoretical frameworks that meet the needs of the individual served.
9. **Program Staffing:** The successful applicant is expected to develop and maintain a staffing composition necessary to provide FSP services as defined in this RFA's scope of work to FSP clients, including FSP clients in assigned Permanent Supportive Housing (PSH) Units, and AOT referred clients. The staffing array may include a combination of education and experience, ranging from paraprofessionals to licensed clinicians. Program staff will be reflective of the cultural, racial, ethnic and linguistic diversity of Sacramento County.
- a. For the purpose of this RFA, one full time equivalent (FTE 1.0) is equal to 40 hours per work week.
 - b. Staff to client ratios:
 - i. For FSP clients the staffing ratio is one (1) FTE staff to 10 to 15 clients.
 - ii. For AOT referred clients, the staffing ratio is one (1) FTE staff to 8 clients.
 - c. The following list is a suggested representation of staff for this program:
 - i. Licensed Practitioner of the Healing Arts (LPHA) staff conducts assessments and treatment planning, provides oversight and direction to the treatment team, provides individual and family therapy, crisis intervention services, and family intervention and support. The LPHA or LPHA Waived staff assists with developing interventions and coordinating the services delivered by team members.
 - ii. Mental Health Rehabilitation Specialist (MHRS) performs a wide variety of duties including intensive care coordination services and social rehabilitation services with a wellness and recovery focus; assists and supports team members and adults. MHRS's

- have broad knowledge of co-occurring disorders supports, employment resources, benefits and entitlements, community supports, etc.
- iii. Mental Health Assistant (MHA) I, II, III provides social rehabilitation, models behaviors and teaches/demonstrates skills to client and family, provides feedback on interventions to the team, as well as crisis intervention and support.
 - iv. Peer Staff/Wellness Coach is an individual who has been successful in the recovery process and helps others experiencing similar situations. Peer Staff/Wellness Coach provides peer support, engagement, wellness services and navigation supports within the MHP, as well as other health systems and community supports.
 - v. Resource Specialist provides assistance to locate, secure, and maintain community resources including but not limited to housing, benefits, education, etc. This position provides recovery based services which may include but are not limited to: education, community outreach, skills training, and group facilitation.
 - vi. Housing Specialist is responsible for assisting program clients to locate, secure, and maintain permanent housing. This work includes tenant education, land lord outreach, and relationship building, removing barriers to community based housing options, housing search activities and assisting program clients with creating an individual housing plan. This position provides recovery based services which may include but are not limited to: housing coordination and education, community outreach, mentoring, independent living skills training, group facilitation and crisis intervention.
 - vii. Physician's Assistant or Nurse Practitioner provides psychiatric assessments, health screenings and evaluation, develops medication plan, prescribes medication and coordinates follow up care and works under the supervision of a Psychiatrist.
 - viii. Licensed Vocational Nurse (LVN) / Licensed Psychiatric Technician (LPT) provides medical/medication training for staff, conducts health screenings, develops medication plan, provides medication education, and administers medications as prescribed.
 - ix. Psychiatrist provides initial psychiatric assessment and evaluation, develops medication plan, prescribes medication, coordinates follow-up care, and provides oversight to medical staff.
- d. The successful applicant will ensure that MHRS and/or MHA staff receive clinical supervision on identifying risk, safety planning, plan development and implementation of interventions. The LPHA/LPHA Waived staff will provide clinical oversight and guide the direction of services.
 - e. In addition to staff identified above, the applicant's proposed budget may include specialized staff relevant to program implementation and practices. All proposed staff must meet the definition of the BHS QM "Staff Registration" Policy and Procedure (see Attachment 6).
10. **Key Program Outcomes and Plans for Measuring:** BHS collects data and measures outcomes throughout the continuum of care. BHS will work with the successful applicant to develop and implement program evaluation of the FSP supported by MHSA and DHCS outcomes.
- Data will be used to inform program planning decisions as well as to report progress towards desired outcomes and program effectiveness. Data will be reported on a quarterly and annual basis and will include outcome data, program analysis of data to determine significance of changes, and an evaluation of whether goals, objectives, and outcomes have been attained, as well as the effectiveness of funded services.

- a. The successful applicant will be required to utilize and collect data on a standard set of outcome assessment forms as developed by the DHCS: Partnership Assessment Form (PAF) that collects baseline and current data when clients first enter FSP services; Quarterly assessment form (3M) that updates the data from the PAF and is done every three months for each client as long as they are receiving FSP services; and the Key Event Tracking form (KET) that is done each time a key event (i.e. crisis visit, arrest, incarceration, hospitalization) occurs. These forms track client progress/improvements in the following areas:
 - i. Residential status, including hospitalization or incarceration;
 - ii. Educational status;
 - iii. Employment status;
 - iv. Legal issues/designation;
 - v. Sources of financial support;
 - vi. Health status;
 - vii. Substance abuse issues;
 - viii. Assessment of daily living functions; and,
 - ix. Emergency interventions.
- b. The successful applicant will also be required to track performance measures related to PSH supportive services provision which includes:
 - i. Vacancy rates;
 - ii. Unit turnover time from exit to new move in;
 - iii. Application acceptance and denials;
 - iv. Voluntary versus involuntary move-outs;
 - v. Exit destination, e.g., stably housed versus homeless;
 - vi. Retention and length of tenancy; and,
 - vii. Timeliness to reporting data and vacancies to the County.
- c. Outcomes for this program align with MHSA goals and performance improvement activities outlined in BHS QM Program Annual Work Plan – Fiscal Year 18/19 (see Attachment 7). These outcomes include, but are not limited to:
 - i. Increase timely access to services defined as a face-to-face appointment within ten (10) business days of being admitted into program;
 - ii. Reduce unnecessary hospitalizations and incarcerations;
 - iii. Promote housing stability;
 - iv. Improve positive behaviors and quality of life;
 - v. Increase ongoing meaningful activity;
 - vi. Decrease in overall behaviors that contribute to law enforcement and judicial contacts, crisis residential treatment, mental health rehabilitation center treatment, and state hospitalizations;
 - vii. Improve care coordination with primary care physician (PCP);

- viii. Improve care coordination with other system partners (i.e. Adult Protective Services, Child Protective Services, probation, Public Guardian’s Office, and collaborative justice courts);
- ix. Increase successful discharges defined as meeting treatment goals and sustained stability in functioning to prevent recidivism or transition to a higher level of services;
- x. Increase successful linkage to primary care or geographic managed care provider if ongoing services are needed;
- xi. Increase effectiveness of evidence based practices, community defined practices, and promising practices; and
- xii. Other outcomes measures as defined by BHS.

The successful applicant must review performance data, assess progress, and use this information to inform and improve the management and delivery of services. There should be clear and convincing evidence, through carefully collected data, that the delivered services and interventions are responsible for client and caregiver satisfaction and placement stability.

11. Additional Provisions:

- a. Successful applicants unable to implement the program within a six (6) month time frame upon contract execution with Sacramento County BHS as described in the successful applicant’s Start-Up Work Plan may be at risk of contract termination.
- b. Follow all requirements consistent with California Advancing and Innovating Medi-Cal (CalAIM) – including Enhanced Care Management (ECM) implemented January 2022. ECM provides a whole-person approach to care, addressing the clinical and non-clinical needs of the client. ECM Core service components include: i. comprehensive assessment and care management plan, ii. enhanced coordination of care, iii. health promotion, iv. comprehensive traditional care, v. member and family supports, vi. coordination of referral to community and social support services. See DHCS CalAIM Executive Summary and Key Changes <https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx>

D. FUNDING

1. Annual Program Funding:

a. FSP Services

Fund Source	Allocation	Available Annual Funding*
Non-Federal Funding	Services	\$ 2,024,883
	Flexible Supports	\$400,000
Federal Funding	Services	\$1,861,000
ECM	Services	\$300,000
TOTAL		\$4,585,883**

* Approximate amounts

** The available funds are subject to change.

b. AOT Supports

Fund Source	Allocation	Available Annual Funding*
Non-Federal Funding (Realignment)	Services	\$ 696,000
	Flexible Supports	\$150,000
Federal Funding	Services	\$603,000
TOTAL		\$1,449,000**

* Approximate amounts

** The available funds are subject to change.

c. **Total Available Annual Funding: \$6,034,883**

2. Indirect and allocated costs may not exceed 15% of actual direct expense.
3. The term of this RFA is five (5) years.
4. The successful applicant will serve a capacity of 200 unduplicated clients with moderate to high intensity levels of service need and a capacity of 40 AOT referred participants with high intensity level of service need. Capacity is defined as the number of clients served within a 30 day period. Served is defined as one service provided directly to the client within a 30 day period.
5. Funding for the term of this RFA does not guarantee cost of living adjustment (COLA) / maintenance of effort (MOE) increases. COLA/MOE requests are subject to Board of Supervisors approval.
6. The service contract may be negotiated and renewed annually, at the discretion of the County.
7. County does not guarantee (implied or otherwise) referral rate or volume. The successful applicant is responsible to adapt/adjust to client volume and client service needs.
8. Unit volumes are averages based on specific client needs. The successful applicant must deliver annual service volume total to ensure 100% reimbursement at cost settlement.
9. **The applicant understands that this will be a Net 30 day agreement; payment due in full 30 days** after receipt of an appropriate and correct invoice. The successful applicant will certify they have and will maintain adequate working capital to cover costs during this period. Reimbursement is based on a Medi-Cal unit-driven system and the successful applicant will be reimbursed on a provisional unit rate value not to exceed the contract maximum.
10. Cost settlement: At the point of contract execution, funds due or owed will not occur until the State of California accepts the County annual cost report. At which point the County and successful applicant has 30 days to issue reimbursement. Adjustments to cost settlement processes may be made due to CalAIM payment reform efforts.
 - a. The successful applicant will reimburse County for services at the cost settled rate found to be not reimbursable by State and/or Federal funds. The successful applicant will be responsible for the costs associated with denied Medi-Cal claims. The successful applicant is responsible to make the appropriate corrections to Medi-Cal denials and for services that do not successfully claim out.
 - b. If total approved unit volume is not achieved, then the percent difference between actual approved units and the unit volume specified in the contract will be the factor used to reduce

contract maximum, and to determine the adjusted maximum reimbursement value to the successful applicant.

- c. Provisional rates are determined based on a contract maximum, contracted unit volume, and the relative value of each service function code.
 - i. Provisional unit rates serve as the basis for the payment, for monthly cash flow, and are subject to cost settlement to the lesser of actual and allowable costs or published charges of DHCS approved Mental Health Services. Rates are inclusive of all costs.
 - ii. County reserves the right to make annual adjustments to contract maximum, based on data showing inadequate service utilization.

11. For the purpose of this RFA, one full time equivalent (FTE 1.0) is equal to 40 hours per work week.

E. ELIGIBILITY TO APPLY/MINIMUM REQUIREMENTS

Those organizations meeting all of the following criteria are eligible to submit an application in response to this RFA. Organizations must:

1. Submit single agency applications only. No collaborations, partnerships, multi-organization, or fiscal sponsorships applications will be accepted.
2. Obtain County approval in writing at the time of contract negotiation for subcontracting any portion of the work. Successful applicants will have the opportunity to subcontract for peer support services as described in this RFA's scope of work.
3. Be represented at the Mandatory Applicants' Conference.
4. Have five (5) or more years' experience providing mental health services and or co-occurring mental health and substance use disorder services, and crisis intervention services 24/7 to adults living with a serious mental illness who are at risk of or experiencing homelessness, and/or involved with the criminal justice system.
5. Have five (5) or more years' experience collaborating with all of the following systems: mental health system of care/Mental Health Plans (MHP), law enforcement, court systems, welfare, housing resources, and health care systems.
6. Have five (5) or more years' experience utilizing culturally informed care, trauma informed care, wellness and recovery action planning, and wellness and recovery principles related to the provision of mental health treatment and support for adults and their families/caregivers.
7. Have at least three (3) consecutive years within the past ten (10) years utilizing the same evidenced based practice (EBP), promising practice (PP), and/or community defined practice (CDP). EBP, PP and CDP are defined in Attachment 8, "Review Process for Implementation of New Clinical Practices Policy", of this RFA.
8. Must state the ability to comply with BHS EBP registration requirements and provide and sustain any EBP selected and adopted by the County MHP.
9. Have the ability to submit, meet, and abide by any applicable state, federal, and county laws, statutes, regulations and certifications pertinent and necessary to the operations of an outpatient mental health program at the time of contract execution.
10. Comply with rigorous data collection, reporting, and audits, as required by the County or its funders, with the capability to implement program changes based on findings.
11. Have the ability to comply with the approved Start-Up Work Plan (Exhibit N) taking into consideration available expertise and any existing business commitments.

12. Possess 45 days of working capital.
13. Have the understanding that funds due or owed will not occur until the State of California accepts the County annual cost report. At that point, the County and successful applicant have 30 days to issue reimbursement. Furthermore, the successful applicant must have adequate working capital to cover costs during the cost reporting period.
14. Be in compliance with any outstanding corrective action plan.
15. Be a responsive applicant whose application complies with all requirements of the RFA.

F. MANDATORY APPLICANTS' CONFERENCE

1. A Mandatory Applicants' Conference will be held virtually to discuss the RFA and requirements. Organizations interested in submitting an application must have representation at this conference or their application will be rejected as non-responsive (disqualified) without review and eliminated from further consideration.
2. The date/time of the virtual Mandatory Applicants' Conference is shown in the RFA timeline.
3. Organizations must register to attend the Mandatory Applicants' Conference through the on-line link shown in the RFA timeline. The registration deadline is shown in the RFA timeline.
 - a. Each organization may register a maximum of three (3) representatives per organization.
 - i. Organizations should designate one (1) representative as their principal Point of Contact (POC). Any necessary Sacramento County BHS communication regarding this RFA process will be made through this POC.
 - ii. **Organizations should register all representatives simultaneously (using the same form).**
 - b. After registering, organization representatives will receive a confirmation email containing the virtual meeting link and password for the Mandatory Applicants' Conference.
4. Because there will be listen-only access to the Mandatory Applicants' Conference, applicant questions about the RFA, its scope of work, and related processes **will not be accepted** during the Conference. See Section I, G. Applicants' Questions for instructions on submitting written applicant questions.

G. APPLICANTS' QUESTIONS

1. Organization representatives registered for the Mandatory Applicants' Conference will be emailed the Exhibit O: RFA No. MHSA/075 Applicants Questions Form.
2. Applicant questions must be submitted on the Exhibit O: RFA No. MHSA/075 Applicants Questions Form. The completed form must be attached to the sender's email and emailed to QuestionsMHSA075@SacCounty.gov by the date shown in the RFA timeline. Email's subject line must read, "RFA MHSA/075 Questions Form".
3. Questions in any other form (either written or oral) about the RFA, its scope of work, or related processes **will not be accepted**.
4. **Applicant questions will not be accepted or answered after the Questions Form submission deadline as shown in the RFA timeline.**
5. Following the deadline for questions submission, answers to all substantive questions will be provided in the form of a question and answer document that will be emailed to organization representatives who attended the Mandatory Applicants' Conference. At the sole discretion of

Sacramento County BHS, questions may be paraphrased for clarity. Questions and answers will be provided without identifying the submitters. Similar questions will be combined into one representative question with its relevant answer.

SECTION II. REQUEST FOR APPLICATION PROCESS

A. RULES GOVERNING COMPETITIVE APPLICATIONS

1. Costs for developing and submitting application packages are the responsibility of the applicant and shall not be chargeable in any way to the County of Sacramento.
2. If the County determines that revisions or additional data to the RFA are necessary, the County will provide addenda or supplements.
3. All applications submitted become property of the County and will not be returned.
4. Issuance of this RFA in no way constitutes a commitment by the County to award a contract. News releases pertaining to this RFA and its award shall not be made without prior written approval of the County.
5. All applications shall remain confidential and are not subject to the California Public Records Act until contract execution.

B. RIGHTS OF THE COUNTY

The County reserves the right to:

1. Make a contract award to one or more applicants.
2. Make awards of contracts for all the services offered in an application or for any portion thereof.
3. Reject any or all applications received in response to this RFA, or to cancel and/or re-issue this RFA if it is deemed in the best interest of the County to do so.
4. Negotiate, make changes, or terminate awards due to budgetary or funding changes or constraints.
5. Negotiate changes to application submissions.
6. Enter into negotiations with the applicant who submitted the next highest-rated application, or issue a new RFA, if a competitor that is selected through this RFA fails to accept the terms of the County contract.
7. Authorize renewal of contracts annually based on availability of funds and the success of the contractor in meeting the measurable outcomes stated in the contract.
8. Determine the amount of resources allocated to successful applicants.
9. Require information in addition to the application for further evaluation, if necessary.
10. Check with references and share any information it may receive with the evaluation committee.
11. Require successful applicants to sign a County contract.
12. Make the final determination of the requirement for the report of internal controls to be included with the financial statements.
13. Conduct an evaluation(s) and as a result make changes to various aspects of the program.

C. SCREENING CRITERIA

1. Organizations' application packets received by the deadline (from organizations with a representative at the mandatory applicants' conference) will be screened for RFA requirements.
2. All applications shall be screened to determine whether they meet the (a) formatting (see Section III for formatting requirements), (b) content (see Section III for content requirements), (c) Staffing Detail, Budget Template, and Budget Narrative (Exhibit K) screening requirements (d) financial stability (Exhibit J), (e) insurance requirements (Exhibit C), (f) criteria as stated in Section I, E. Eligibility to Apply/Minimum Requirements.
3. Applications meeting all the screening requirements shall be submitted to an Evaluation Committee. The Committee will evaluate the applications based on the RFA evaluation criteria. Portions of responses, including attachments that exceed the maximum page allowance will not be reviewed by the Committee.
4. Failure to furnish all information required in this RFA or to substantially follow the application format requested shall disqualify the application. Applicants will be notified of disqualification **by the date shown in the RFA timeline**. An applicant may protest screening disqualification by following the rules found in the Section II, Request for Application Process, E. Opportunity to Protest.

D. RATING PROCESS: GENERAL

1. Those applications meeting all minimum requirements as noted above will be included in an evaluation and selection process. The applications will be reviewed and evaluated by an Evaluation Committee, which may consist of County Staff, representatives from other public agencies, and/or individuals from the community at large. The Evaluation Committee will recommend the highest rated application to the Department of Health Services (DHS) Director. The DHS Director will make final recommendation for the applicant selection to the Sacramento County BOS. The DHS Director may recommend an applicant that is not the highest rated and provide justification for his/her recommendation to the Sacramento County BOS.
2. Recommendation for the awards is contingent on successful resolution of any protests, which would otherwise restrict or limit such award.
3. A notice of the recommendation for the award will be emailed to all applicants by **the date shown in the RFA timeline**.
4. A minimum score of 70% is required to pass the evaluation. If the minimum score is not met, the application will be rejected. Scoring will be as follows:

ELEMENT	POINTS POSSIBLE
Financial Statement	Pass/Fail
Application Narrative	115
Start-Up Work Plan	10
Presentation	30
Total	155

E. OPPORTUNITY TO PROTEST

1. Any applicant wishing to protest disqualification in the screening process or the proposed award recommendation must submit a written letter of protest. Submit such a letter by the date shown in the RFA timeline. Any protest shall be limited to the following grounds:
 - a. The County failed to include in the RFA a clear, precise description of the format which applications shall follow and elements they shall contain, the standards to be used in screening and evaluating applications, the date on which applications are due, and the timetable the County will follow in reviewing and evaluating them, and/or
 - b. Applications were not evaluated and/or recommendation for awards were not made in the following manner:
 - i. All applications, received by the deadline and at the address specified in this RFA, were reviewed to determine which ones met the screening requirements specified in the RFA; and/or
 - ii. All applicants meeting the screening requirements were submitted to an Evaluation Committee which evaluated applications using the criteria specified in the RFA; and/or
 - iii. Applicant(s) judged best qualified by the Evaluation Committee was recommended to the Director of DHS for award; and/or
 - iv. The County correctly applied the standards for screening for eligibility requirements or evaluating the applications as specified in the RFA.
2. The written letter of protest of the proposed awards must reference the title of this RFA and be submitted by email to DHS-Director@SacCounty.net . Email subject line must read, "Protest, RFA No. MHSA/075".

Protest letters must be received at the above email address **by the date shown in the RFA timeline**. Mailed or hand delivered hard copy letters, or faxed letters will not be accepted. Letters received by any other office or any other email address will not be accepted. Oral protests will not be accepted. It is the applicant's responsibility to request an email delivery receipt to ensure receipt of delivery at the above email address by the date, time and place specified above and in the timetable. Protests will not be accepted after the deadline specified. Protest letter/email must clearly explain the failure of the County to follow the rules of the RFA as discussed above in Section II, E.

3. All written protests shall be investigated by the Director of DHS, or their designee, who shall make a finding regarding any protest by the date shown in the RFA timeline.

F. COMMENCEMENT OF WORK

1. Contract shall not be executed until after DHS has obtained Sacramento County BOS approval for the contract.
2. The successful applicant shall be required to sign a Sacramento County contract. The successful applicant must agree to all terms and conditions of any resultant contract with Sacramento County, which includes providing proof of required insurance coverage. Failure to conform to insurance requirements shall constitute grounds for termination of contract negotiations and the County may enter into negotiations with the next highest scoring applicant or reissue the RFA.
3. The successful applicant will not be allowed to begin work under any successfully negotiated contract until such time as the contract has been signed by the proposed contractor and Sacramento County.

SECTION III. APPLICATION SUBMISSION

A. APPLICATION PACKAGE

Applications must include the following Exhibits A. through N. in the order specified below:
(See referenced exhibits for complete instructions.)

1. **Exhibit A. Application Package Checklist:** All items included in the Application package must be submitted in the order listed on the Application Package Checklist. The Checklist must be submitted as part of the Application package and will be provided electronically.
2. **Exhibit B. Application/Certification of Intent to Meet RFA Requirements:**
The Application/Certification of Intent must be completed with authorized signature and submitted as part of the Application package. Electronic or scanned authorized signature will be accepted. The Application form will be provided electronically.
3. **Exhibit C. Sample of Insurance Requirements:** Successful Applicants shall be required to obtain and maintain insurance according to Sacramento County Insurance requirements. Application packets must include the applicant's standard certificate of insurance showing current coverages and/or written evidence that the applicant will be able to have the required insurance in place before a contract is signed and services commence.
4. **Exhibit D. Resolution by the organization's Board of Directors:** Resolutions from the applicant's Board of Directors, allowing submission of the Application, must be submitted with authorized signature(s). Electronic or scanned authorized signature(s) will be accepted.
5. **Exhibit E. County of Sacramento Contractor Certification of Compliance Form (Child, Family and Spousal Support):** When Applicants submit a bid, application or other offer to provide goods or perform services for or on the behalf of the County, Applicants must complete and submit Certification with an authorized signature as part of the Application package. Electronic or scanned authorized signature will be accepted. The Certification of Compliance Form will be provided electronically.
6. **Exhibit F. Certification Regarding Debarment and Suspension:** Applicants agree to comply with 45 CFR Part 76.100 (Code of Federal Regulations), which provides that Federal funds may not be used for any contracted services, if CONTRACTOR is debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or organization. Applicants must submit Certification with an authorized signature as part of the Application package. Electronic or scanned authorized signature will be accepted. The Certification Regarding Debarment will be provided electronically.
7. **Exhibit G. Statement of Compliance with Sacramento County Good Neighbor Policy:** Applicants are required to comply with the Statement of Compliance with Sacramento County Good Neighbor Policy. Applicants must complete and include the Statement of Compliance with Sacramento County Good Neighbor Policy. Electronic or scanned authorized signature will be accepted. The Good Neighbor Policy Statement of Compliance will be provided electronically.
8. **Exhibit H. Assurance of Cultural Competence Compliance:** Applicants are required to comply with the Assurance of Cultural Competence Compliance requirements. The applicant must complete and submit a signed certification as part of the Application package. Electronic or scanned authorized signatures will be accepted. The Assurance of Cultural Competence Compliance will be provided electronically.

9. **Exhibit I. Statement of Compliance: Quality Management and Compliance:** Applicants agree to comply with Quality Management regulations and develop a Policy and Procedure to ensure compliance. Applicants must complete and submit Statement of Compliance with an authorized signature as part of the Application package. Electronic or scanned authorized signatures will be accepted. The Quality Management and Compliance will be provided electronically.
10. **Exhibit J. Independent Audited Financial Statement:** Applicants must submit their latest complete audited financial statement with accompanying notes, completed by an independent Certified Public Accountant, for a fiscal period not more than 24 months old at the time of submission.
11. **Exhibit K. Budget:** Applicants must submit a Budget as described in the RFA as part of the Application package. The Budget forms will be provided electronically.
12. **Exhibit L. Application Narrative and Presentation:** The application narrative must be submitted as part of the Application package. It must enable an evaluation committee to determine whether the written application narrative meets the requirements of this RFA. Thus, it should be clearly written and concise but also explicit and complete. Also, applicants whose applications meet eligibility and screening criteria as specified in this RFA will be expected to give a presentation to the evaluation committee.
13. **Exhibit M. Organizational Chart:** Applicants must submit a current organizational chart that includes the projected placement of the program described in this RFA.
14. **Exhibit N. Start-Up Work Plan:** Start-up Work Plan template must be completed as part of the Application package. Start-Up Work Plan template will be provided electronically.
15. **Exhibit O. Applicant Questions Form:** Applicant questions must be submitted on this RFA MHSA/075 Applicants Questions Form.

B. APPLICATION SUBMISSION REQUIREMENTS

1. All Exhibits in the application should be given file names containing the Applicant's organization name or initials, followed by the RFA designation of MHSA075, followed by the Exhibit letter or letters. *Sample file names:* Smithsonian MHSA075 Exhibit C (*single exhibit file*) or Smithsonian MHSA075 Exhibits A-J (*multiple exhibit files*).
2. Exhibits A. through J. in the Application package must be submitted in the following format:
 - a. Document type: Portable Document Format (PDF)
 - b. Page size: letter (8 ½ inches by 11 inches)
 - c. Page orientation: portrait
3. Budget (Exhibit K) must be submitted in the following format:
 - a. Document type: Excel or PDF
 - b. Page size: letter (8 ½ inches by 11 inches)
 - c. Page orientation: portrait
4. Application Narrative (Exhibit L) must be submitted in the following format:
 - a. Document type: Word or PDF
 - b. Page size: letter (8 ½ inches by 11 inches)
 - c. Page orientation: portrait

- d. Pagination: pages should be clearly and consecutively numbered.
- e. Question/area and response format:
 - i. Each question/area in the narrative should begin on a new page.
 - ii. State the question/area prior to providing a response
 - iii. Questions/areas should be **single spaced**, with 1 inch margins, using 12 point Arial or Times New Roman font.
 - iv. Narrative responses should be **double spaced**, with 1 inch margins, using 12 point Arial or Times New Roman font.
 - v. The maximum page requirements per question shown in Exhibit L include both the statement of the question/area and Applicant's response to that question/area. Portions of question/area responses exceeding the maximum page allowance will not be reviewed by the Evaluation Committee.
5. Exhibits M. and N. in the Application package must be submitted in the following format:
 - a. Document type: PDF
 - b. Page size: letter (8 ½ inches by 11 inches)
 - c. Page orientation: portrait or landscape
6. The inclusion of elaborate artwork, expensive visuals, embedded web links or other presentations as part of the application package are neither necessary nor desired and will not be rated or scored.
7. All applications must be submitted in the order specified in the Application Package Checklist (see Exhibit A).
8. The application must be submitted in the legal entity name of the organization and that legal entity shall be party to the contract. Applications submitted by a corporation must include the signature of an individual authorized by the organization's board of directors. Electronic or scanned authorized signature will be accepted.
9. This RFA requests no more than one (1) application per applying organization.
10. The application packet must be sent via email to ApplicationsMHSA075@SacCounty.gov as a PDF file attachment or as a zipped file containing multiple documents. If size constraints require sending the application packet across multiple emails, all emails must be sent on the same calendar day. Email subject line should include organization name, RFA number, and whether the email contains all or parts of an application packet (examples: *Smithsonian, RFA MHSA075 Application – Complete Packet* or *Smithsonian, RFA MHSA075 Application – Part 1 of 3*). Email box ApplicationsMHSA075@SacCounty.gov will send an Automatic Reply email notifying applicants that their email(s) have been sent to the correct email address. An emailed receipt of delivery will be sent in response to all emails containing application packets or parts thereof.
11. **Applications not received by 5:00 pm (PDT) on the application submission date shown in the RFA timeline will be rejected.** It is the responsibility of the applicant to submit the application package by email by the time and date shown in the RFA timeline.
12. **Mailed or hand delivered hard copies or faxed submissions will not be accepted.** Applications received by any other office will not be accepted. Applications emailed to other email addresses will not be accepted.
13. **DHS/BHS will reject any application not meeting ALL RFA requirements.**

EXHIBIT A: APPLICATION PACKAGE CHECKLIST

The Application Package Checklist must be completed and submitted with your application package. All items must be submitted electronically in the order listed. Please utilize this checklist to ensure that your application package is complete.

CHECKBOX ITEMS

- 1. Application Package Checklist (see Exhibit A)
- 2. Application/Certification of Intent to Meet RFA Requirements (see Exhibit B)
- 3. Certificate(s) of Insurance, documenting current coverage (see Exhibit C)
 - General Liability: \$2,000,000
 - Automobile Liability: \$1,000,000
 - Worker’s Compensation/Employers Liability: Statutory/\$1,000,000
 - Professional Liability or Errors and Omissions Liability: \$1,000,000
 - Cyber Liability including Identity Theft, Information Security and Privacy Injury: \$1,000,000 per claim or incident and \$1,000,000 aggregate
- OR--
- Insurance Broker’s Letter Demonstrating Ability to Meet County Requirements
- 4. Resolution by the organization’s Board of Directors (see Exhibit D)
- 5. County of Sacramento Contractor Certification of Compliance with Child, Family and Spousal Support Form (See Exhibit E)
- 6. Certification Regarding Debarment and Suspension (see Exhibit F)
- 7. Statement of Compliance with Sacramento County Good Neighbor Policy (see Exhibit G)
- 8. Assurance of Cultural Competence Compliance (see Exhibit H)
- 9. Statement of Compliance with Quality Management and Compliance (see Exhibit I)
- 10. Independently Audited Financial Statement (see Exhibit J)
- 11. Budget (see Exhibit K)
- 12. Application Narrative (see Exhibit L)
- 13. Organizational Chart (see Exhibit M)
- 14. Start-Up Work Plan (see Exhibit N)

SUBMISSION STANDARDS

Use this list to check your Application for compliance with screening requirements

- Authorized signatures on ALL documents in application package (electronic or scanned authorized signature will be accepted)
- Application package submitted electronically by 5:00pm (PDT) on date shown in RFA timeline
- All documents meet format and content requirements
- Independently Audited Financial Statement not more than 24 months old
- Insurance requirements met
- Attended Mandatory Applicants’ Conference

**EXHIBIT B: ADULT FULL SERVICE PARTNERSHIP
REQUEST FOR APPLICATION No. MHSA/075
APPLICATION/CERTIFICATION OF INTENT
TO MEET RFA REQUIREMENTS**

Applicants are required to complete Exhibit B, RFA No. MHSA/075 Application/Certification of Intent to Meet RFA Requirements. The application is a Portable Document Format (PDF) with fillable fields; the Exhibit B will be included in an email sent to Mandatory Applicants' Conference attendees.

For the purposes of this document, the applicant is defined as the organization.

Instructions: Applicants must: A) Respond to all sections of this Exhibit; B) Concisely include applicable, essential, and specific information; attach supplementary sheets as necessary; C) Not alter, delete, or otherwise change any section in the form; D) Include this Exhibit in your organization's application packet with authorized signature. Electronic or scanned authorized signature will be accepted.

A. ORGANIZATION'S INFORMATION

1. Organization Name		2. Federal Tax ID#		
3. Organization Address				
4. Parent Corporation Name				
5. Parent Corporation Address				
6. Contact Person & Title		Phone	Email	
7. Person/Title Authorized (per Board Resolution) to sign on organization's behalf		Phone	Email	
8. Number of years organization has been in business under present business name:				
9. List contracts, for outpatient mental health programs serving adults, ages 18 and older, that were successfully completed in the past three (3) years:				
Contract Term(s) (ex: 2020-2021)	Legal Contract Name	Service Description	Fund Source(s)	Contract Value

10. List contracts that were terminated prior to end of term in the past three (3) years. Attach supplementary sheets if necessary.

Contract Term	Legal Contract Name	Service Description	Fund Source(s)	Contract Value	Reason for Termination

11. List active contracts or other commitments (e.g. consulting arrangements). Attach supplementary sheets if necessary.

Contract Term	Legal Contract Name	Service Description	Fund Source(s)	Contract Value

12. Describe any litigation involving the organization and/or principal officers thereof. Please include details about resolution/conclusion.

13. Does the organization hold financial interest in any other business?		
If yes, list business(es):		
14. Does the organization hold a controlling interest in any other organization?		
If yes, list organization(s):		
15. Is the organization owned or controlled by any other person or organization?		
If yes, list person(s) or organization(s):		
16. List name of persons with whom the prospective organization has been associated in business as partners or business associates within the past three (3) years:		

B. ORGANIZATION’S ELIGIBILITY TO APPLY/MINIMUM REQUIREMENTS

- 1. Organization is submitting a single agency application only. (NOTE: No collaborations, partnerships, multi-organization, or fiscal sponsorships applications will be accepted.)
- 2. Organization will obtain County approval at the time of contract negotiation for subcontracting any portion of the work? (Successful applicants will have the opportunity to subcontract for peer support services as described in this RFA’s scope of work.)
- 3. Organization representative(s) was represented at the RFA No. MHSA/075 Mandatory Applicants’ Conference?

Name(s) of Organization Representative(s) in attendance

- 4. Organization has five (5) or more years’ experience providing mental health services and or co-occurring mental health and substance use disorder services, and crisis intervention services 24/7 to adults living with a serious mental illness who are at risk of or experiencing homelessness, and/or involved with the criminal justice system.

How many years?

- 5. Organization has five (5) or more years’ experience collaborating with all of the following systems: mental health system of care/Mental Health Plans (MHP), law enforcement, court systems, welfare, housing resources, and health care systems.

List experiences of collaboration.

Duration of Collaboration (ex: June 2020-June 2021)	List the Agency/Organization

- 6. Organization has five (5) or more years’ experience utilizing culturally informed care, trauma informed care, wellness and recovery action planning, and wellness and recovery principles related to the provision of mental health treatment and support for adults and their families/caregivers.

- 7. Organization has at least three (3) consecutive years within the past ten (10) years utilizing the same evidenced based practice (EBP), promising practice (PP), and/or community defined practice (CDP). EBP, PP and CDP are defined in Attachment 8, “Review Process for Implementation of New Clinical Practices Policy”, of this RFA.

If yes, provide the following details below. Attach supplementary sheets if necessary.

Year Range Utilized (ex: 2018-2021)	Evidence Based Practice, Promising Practice, Community Defined Practice

8. Organization has the ability to comply with BHS EBP registration requirements and provide and sustain any EBP selected and adopted by the County MHP.	
9. Organization has ability to submit, meet, and abide by any applicable state, federal, and county laws, statutes, regulations and certifications pertinent and necessary to the operations of an outpatient mental health program at the time of contract execution?	
10. Organization will comply with rigorous data collection, reporting, and audits, as required by the County or its funders, with the capability to implement program changes based on findings?	
11. Organization will comply with the approved Start-Up Work Plan (Exhibit N) taking into consideration available expertise and any existing business commitments?	
12. Organization possesses 45 days of working capital?	
13. Organization has the understanding that funds due or owed will not occur until the State of California accepts the County annual cost report. At that point, the County and successful applicant have 30 days to issue reimbursement. Furthermore, the successful applicant must have adequate working capital to cover costs during the cost reporting period.	
14. Organization is in compliance with any outstanding corrective action plan?	
15. Organization is a responsive applicant whose application complies with all requirements of the RFA?	

Certification:

I certify that all statements in this Adult Full Service Partnership Program RFA No. MHSA/075 Application are true and that all eligibility to apply/minimum requirements in this RFA are satisfied. This certification constitutes a warranty, the falsity of which shall entitle Sacramento County Department of Health Services to pursue any remedy authorized by law, which shall include the right, at the option of the County, of declaring any contract made as a result thereof to be void.

I agree to provide the County with any other information the County determines is necessary for the accurate determination of the organization’s qualification to provide services.

I certify that (_____) will comply with all requirements specified in the RFA. I agree to the right of the County, state, and federal government to audit (_____)’s financial and other records.

Electronic or Scanned Signature of Organization’s Authorized Agent

Date

Print Name/Title

EXHIBIT C: SAMPLE OF INSURANCE REQUIREMENTS

Following this page is a sample of the insurance exhibit included in Sacramento County agreements. The types of insurance and minimum limits required for any agreement resulting from this RFA are specified in the sample insurance exhibit. A contract negotiated following this RFA will include the attached insurance exhibit.

Your organization's application package should include a standard certificate of insurance showing current coverages. If your organization's current insurance coverage does not conform to the requirements of the attached insurance exhibit, do not obtain additional insurance until a contract is offered. You must, however, provide written evidence, which must be in the form of a letter from your insurance broker or agent that you will be able to have the required insurance in place before a contract is signed and services commence.

If during the application screening for this RFA, the County finds a problem with the applicants' insurance submission, the applicant will have until the date shown in the RFA timeline to submit any required documentation to the County. Applicants will be notified via e-mail regarding any deficiencies in the insurance submission.

Certificate holder or additional insured proof is not required as part of this RFA.

If your organization receives a formal contract offer at the completion of this RFA process, and your organization's current insurance coverage does not meet the insurance requirements of the contract, you must provide proof of the required coverage at the time required by the County or the County has the right to enter into negotiations with the applicant who submitted the next highest-rated application, or issue a new RFA.

In general, the best course is to provide the sample exhibit to your organization's insurance agent or broker and direct him or her to provide a standard certificate of insurance to certify the coverage currently in force.

**EXHIBIT B to Agreement
between the COUNTY OF SACRAMENTO,
hereinafter referred to as "COUNTY," and
«CONTRACTORNAME», hereinafter referred
to as "CONTRACTOR"**

**COUNTY OF SACRAMENTO
INSURANCE REQUIREMENTS**

1.0. INSURANCE REQUIREMENTS

1.1. CONTRACTOR shall procure, maintain, and keep in force at all times during the term of the Contract, at CONTRACTOR's sole expense, the following minimum required insurance policies and limits which are intended for the protection of COUNTY and the public. CONTRACTOR's obligations for loss or damage arising out of CONTRACTOR's work or services are in no way limited by the types or amounts of insurance set forth herein. In specifying minimum insurance requirements herein, COUNTY does not assert that the required minimum insurance is adequate to protect CONTRACTOR. CONTRACTOR is solely responsible to inform itself of the types and amounts of insurance it may need beyond these requirements to protect itself from loss, damage or liability. It is the sole responsibility of CONTRACTOR to notify its insurance advisor or insurance carrier(s) regarding coverage, limits and forms specified in this Insurance Requirements Exhibit.

1.2. COUNTY reserves the right to modify the required minimum insurance coverages and limits depending on the scope and hazards of the work or services to be provided. COUNTY's requirements shall be reasonable but shall be imposed to assure protection from and against the kind and extent of risks that exist at the time a change in insurance is required. Any claim by CONTRACTOR that COUNTY's insurance changes result in higher costs will be subject to review and approval by COUNTY, whose approval will not be unreasonably withheld.

1.3. Where a specific Insurance Services Office (ISO) form is referenced in these Requirements or the CONTRACTOR utilizes "a form or policy language as broad in scope and coverage" to satisfy the insurance requirements required herein, CONTRACTOR shall use the most recently approved State edition or revision of the form(s) or policy language to satisfy the insurance requirements.

2.0. Verification of Coverage

2.1. CONTRACTOR shall furnish COUNTY with original certificates and copies of required endorsements, or original certificates and copies of the applicable insurance policy language effecting coverage required by this Exhibit; or a combination thereof.

2.2. COUNTY reserves the right to require that CONTRACTOR also provide a copy of the declarations page and a copy of the schedule of forms and endorsements of each policy of insurance required herein. COUNTY further reserves the right to require that CONTRACTOR, through its broker, provide explanatory memoranda regarding coverages, endorsements, policy language, or limits as required herein. All required verifications of coverage are to be received and accepted by COUNTY before work or services commence. However, failure to obtain the required documents prior to the work beginning shall not waive CONTRACTOR's obligation to provide them.

2.3. COUNTY reserves the right to require complete copies of all required insurance policies, including endorsements, required by this Exhibit, at any time and with reasonable notice.

2.4. If CONTRACTOR utilizes proprietary coverage forms or endorsements, CONTRACTOR has the option of having its broker provide explanatory memoranda confirming coverage and limits as required herein.

3.0. Minimum Scope of Insurance and Limits

CONTRACTOR's coverage shall include the following:

3.1. GENERAL LIABILITY: Commercial General Liability insurance including, but not limited to, protection for claims of bodily injury and property damage, personal and advertising injury, contractual, and products and completed operations. Coverage shall be at least as broad as "Insurance Services Office (ISO) Commercial General Liability Coverage Form CG 0001" (Occurrence Form) or a form as broad in scope and coverage. The limits of liability shall be not less than:

Each Occurrence	Two Million Dollars (\$2,000,000)
Personal & Advertising Injury	Two Million Dollars (\$2,000,000)
Products and Completed Operations Aggregate	Two Million Dollars (\$2,000,000)
General Aggregate	Two Million Dollars (\$2,000,000)

3.2. AUTOMOBILE LIABILITY: Automobile Liability insurance providing protection for bodily injury and property damage arising out of ownership, operation, maintenance, or use of owned, hired, and non-owned automobiles. Coverage shall be at least as broad as ISO Business Auto Coverage Form CA 0001 (or a form or policy language as broad in scope and coverage), symbol 1 (any auto), if commercially available. Use of any symbols other than symbol 1 for liability for corporate/business owned vehicles must be declared to and accepted by COUNTY in writing. If there are no owned or leased vehicles, symbols 8 and 9 for non-owned and hired autos shall apply. The minimum limits of liability shall not be less than the following for each accident:

Corporate/Business Owned	One Million Dollars (\$1,000,000)
Private Passenger Vehicles	
Commercial Vehicles	One Million Dollars (\$1,000,000)

3.2.1. If there are no corporate/business owned vehicles covered by a Commercial Auto Policy, then personal automobile insurance requirements apply to any individually owned personal vehicles used by CONTRACTOR for work or services being provided.

3.2.2. The personal automobile liability limits shall not be less than:
\$300,000 Combined Single Limit or, if split limits are used, \$100,000 per person, \$300,000 each accident, \$100,000 property damage.

3.3. WORKERS' COMPENSATION: Workers' Compensation insurance, with coverage as required by the State of California (unless the CONTRACTOR is a qualified self-insurer with the State of California), and Employers' Liability coverage. The limits of Employers' Liability shall not be less than:

Each Accident	One Million Dollars (\$1,000,000)
Disease Each Employee	One Million Dollars (\$1,000,000)
Disease Policy Limit	One Million Dollars (\$1,000,000)

3.3.1. The Workers' Compensation policy required herein shall be endorsed to state that the Workers' Compensation carrier waives its right of subrogation against COUNTY, its governing Board, officers, directors, officials, employees, and authorized agents and volunteers. In the event CONTRACTOR is self-insured, CONTRACTOR shall furnish a Certificate of Permission to Self-Insure by the Department of Industrial Relations Administration of Self-Insurance, Sacramento. CONTRACTOR hereby agrees that it waives its right of subrogation against COUNTY, its governing Board, officers, directors, officials, employees, and authorized agents and volunteers in the event a Workers' Compensation claim is filed by CONTRACTOR under any self-insured program.

3.3.2. OMITTED

3.4. UMBRELLA or EXCESS LIABILITY policies: CONTRACTOR is granted the option of arranging the required coverages and limits under a single policy or by a combination of underlying policies with the balance provided by an Excess or Umbrella liability policy equal to the total Per Occurrence and Aggregate limits required on the Commercial General Liability policy and the Combined Single Limit on the Commercial Automobile Liability policy.

3.5. CYBER LIABILITY INCLUDING ERRORS AND OMISSIONS, IDENTITY THEFT, INFORMATION SECURITY and PRIVACY INJURY LIABILITY

3.5.1. The minimum limits shall be not less than \$1,000,000 per claim or incident and \$1,000,000 aggregate. Coverage shall include but is not limited to:

3.5.2. Third party injury or damage (including loss or corruption of data) arising from a negligent act, error or omission or a data breach.

3.5.3. Defense, indemnity and legal costs associated with regulatory breach (including HIPAA), negligence or breach of contract.

3.5.4. Administrative expenses for forensic expenses and legal services.

3.5.5. Crisis management expenses for printing, advertising, mailing of materials and travel costs of crisis management firm, including notification expenses.

3.5.6. Identity event service expenses for identity theft education, assistance, credit file monitoring to mitigate effects of personal identity event, post event services.

3.6. PROFESSIONAL LIABILITY with TECHNOLOGY ERRORS AND OMISSIONS: OMITTED

3.7. PROFESSIONAL LIABILITY: Errors and Omissions (E&O) Liability insurance appropriate to the CONTRACTOR's profession or services.

3.7.1. The minimum limits shall be not less than \$1,000,000 per claim and aggregate.

3.8. If Professional Liability with Technology Errors and Omissions or Professional Liability coverage is written on a Claims Made form:

3.8.1. The "Retro Date" must be shown, and must be on or before the date of the Agreement or the beginning of Agreement performance by CONTRACTOR.

3.8.2. Insurance must be maintained and evidence of insurance must be provided for at least one (1) year after completion of the Agreement.

3.8.3. If coverage is cancelled or non-renewed, and not replaced with another claims made policy form with a "Retro Date" prior to the contract effective date, the CONTRACTOR must purchase "extended reporting" coverage for a minimum of one (1) year after completion of the Agreement.

3.9. ABUSE or MOLESTATION: OMITTED

4.0. Specific Insurance Requirements Related to Commercial General Liability Policies

CONTRACTOR's Commercial General Liability policy shall contain the following provisions:

4.1. COUNTY, its governing Board, officers, directors, officials, employees, and authorized agents and volunteers (collectively, "COUNTY ADDITIONAL INSUREDS") shall be included as Additional Insureds as respects liability caused, in whole or in part, by the acts or omissions of CONTRACTOR, or the acts or omissions of those acting on behalf of CONTRACTOR; or premises owned, occupied or used by CONTRACTOR in conjunction with work or services provided by CONTRACTOR.

4.2. The required additional insured status of COUNTY ADDITIONAL INSUREDS may be satisfied by any of the following methods:

4.2.1. Use of a commercially available ISO Additional Insured form or other comparable insurance company form as broad in scope and coverage that provides "automatic" or "blanket" additional insured coverage as required by written contract or agreement.

4.2.2. Use of policy language as broad in scope and coverage that provides "automatic" or "blanket" additional insured coverage as required by written contract or agreement.

4.2.3. Use of a commercially available ISO Additional Insured endorsement form or other comparable insurance company form as broad in scope and coverage that specifically names COUNTY ADDITIONAL INSUREDS as Additional Insureds.

4.3. COUNTY ADDITIONAL INSUREDS shall be included under CONTRACTOR's Completed Operations coverage as required by written contract or agreement or as specifically endorsed as applicable.

4.4. CONTRACTOR's Commercial General Liability policy shall include a waiver of subrogation in favor of the COUNTY ADDITIONAL INSUREDS as required by written contract or agreement or as specifically endorsed as applicable.

4.5. CONTRACTOR's Commercial General Liability policy shall provide that for any claims related to the Agreement, CONTRACTOR's insurance coverage shall be primary and non-contributory, as required by written contract or agreement, or as specifically endorsed as applicable, as respects COUNTY ADDITIONAL INSUREDS. Any insurance or self-insurance maintained by COUNTY ADDITIONAL INSUREDS shall be excess of CONTRACTOR's insurance, whether CONTRACTOR's insurance is self-insurance, a primary Commercial General Liability policy, excess or umbrella policy, or a combination thereof, and any insurance or self-insurance maintained by COUNTY ADDITIONAL INSUREDS shall not contribute with it.

4.6. CONTRACTOR's Commercial General Liability policy shall apply separately to each insured against whom claim is made or suit is brought, except with respect to the limits of the insurer's liability.

4.7. If CONTRACTOR maintains higher limits than the minimums shown above, whether on a primary or excess basis, COUNTY requires and shall be entitled to coverage with the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverages shall be available to COUNTY.

4.8. CONTRACTOR shall maintain the required Commercial General Liability policy, including Completed Operations, at not less than the required minimum limits, for not less than two (2) years after completion of the work or services; or termination or expiration of the contract. CONTRACTOR shall furnish COUNTY with original certificates and copies of required amendatory endorsements, or original certificates and copies of the applicable insurance policy language effecting coverage required by this Contract; or a combination thereof, for the required two (2) years.

4.9. If CONTRACTOR will utilize subcontractors or subconsultants to perform work or services, CONTRACTOR shall require each of its subcontractors or subconsultants, at every tier, to include COUNTY ADDITIONAL INSUREDS as Additional Insureds, including Completed Operations, as required by written contract or agreement, or specifically endorsed as applicable.

4.10. CONTRACTOR shall also have each of its subcontractors or subconsultants, at every tier, to include primary language and waivers of subrogation on their Commercial General Liability policies and Workers' Compensation policies in favor of COUNTY ADDITIONAL INSUREDS, as required by written contract or agreement, or specifically endorsed as applicable.

4.11. It is the express duty of CONTRACTOR that it verifies that its subcontractors, at every tier, have met the requirements stated in 4.9. through 4.11.

4.12. Failure of CONTRACTOR to obtain additional insured status, primary and non-contributory language, and waivers of subrogation for COUNTY ADDITIONAL INSUREDS, by CONTRACTOR and its subcontractors or subconsultants, at every tier, shall be considered a material breach of the Agreement.

5.0. Specific Insurance Requirements Related to Commercial Automobile Liability Policies

5.1. CONTRACTOR's Commercial Automobile Liability policy shall include COUNTY ADDITIONAL INSUREDS as indemnitees and additional (designated) insureds as required by written contract or agreement, or specifically endorsed as applicable.

5.2. CONTRACTOR's Commercial Automobile policy shall include a waiver of subrogation in favor of the COUNTY ADDITIONAL INSUREDS, as required by written contract or agreement, or specifically endorsed as applicable.

6.0. Deductibles and Self-Insured Retention

6.1. Any deductible or self-insured retention that applies to Commercial General Liability, Commercial Automobile Liability or Professional (E&O), must be declared to COUNTY. Any deductibles or self-insured retention in excess of \$100,000 must be declared to and accepted by COUNTY in writing. CONTRACTOR has the option to provide by separate letter the amount of its General Liability, Automobile Liability, Professional (E&O) and, if applicable, other coverage deductibles or self-insured retentions to COUNTY's Risk Management Office for a confidential review and acceptance prior to the execution of the Agreement. COUNTY reserves the right to require CONTRACTOR to substantiate its ability to maintain a deductible or self-insured retention in excess of \$100,000 through furnishing appropriate financial reports. All deductibles or self-insured retentions shall be borne solely by CONTRACTOR, and COUNTY shall not be responsible to pay any deductible or self-insured retention, in whole or in part.

7.0. (Reserved for future use.)

8.0. (Reserved for future use.)

9.0. (Reserved for future use.)

10.0. Other Insurance Provisions – All Policies

The insurance policies required in this Exhibit are to meet the following provisions:

10.1. ACCEPTABILITY OF INSURERS: All of CONTRACTOR's insurance coverage, except as noted below, shall be placed with insurance companies with a current A.M. Best rating of at least A-:VII and admitted to write insurance in California. Any use of a non-admitted insurer shall be disclosed and shall require COUNTY approval in writing, which approval shall not be unreasonably withheld.

10.1.1. Exceptions:

10.1.1.1. Underwriters at Lloyd's of London, which are not rated by A.M. Best.

10.1.1.2. Workers' Compensation which is provided through a State Compensation Insurance Fund or a qualified self-insurer for Workers' Compensation under California law.

10.2. MAINTENANCE OF INSURANCE COVERAGE: CONTRACTOR shall maintain all insurance coverages in place at all times and provide COUNTY with evidence of each policy's renewal within ten (10) days after its anniversary date. CONTRACTOR is expressly required by this Exhibit to immediately notify COUNTY if it receives a communication from its insurance carrier(s) or agent that any required insurance is to be canceled, non-renewed, reduced in scope or limits (excepting reduction of limits due to claims) or otherwise materially changed that would reasonably adversely impact the required insurance coverages, limits or related requirements as required herein. CONTRACTOR shall provide evidence that such cancelled or non-renewed or otherwise materially changed insurance has been replaced or its cancellation notice withdrawn without any interruption in coverage, scope or limits. If commercially available, each insurance policy required herein shall state that coverage shall not be cancelled by CONTRACTOR or its insurer(s), reduced in scope of coverage or limits (excepting reduction by claims), non-renewed, or otherwise materially changed unless the insurer(s) provide thirty (30) days written notice to COUNTY prior to such change. Ten (10) days prior written notice shall be given to COUNTY in the event of cancellation due to nonpayment of premium. Failure to maintain required insurance in force shall be considered a material breach of the Agreement.

10.2.1. If CONTRACTOR fails to procure or maintain insurance as required herein, or fails to furnish COUNTY with proof of such insurance, COUNTY, at its discretion, may consider such failure to be a material breach of the Agreement.

10.2.2. It is understood and agreed that COUNTY shall not pay any sum to CONTRACTOR under this Agreement unless and until COUNTY is satisfied that all insurance required by this Agreement is in force at the time services hereunder are rendered. Failure to maintain insurance as required in this Agreement may be grounds for material breach of contract.

10.2.3. The failure of COUNTY to enforce in a timely manner any of the provisions of this Exhibit shall not act as a waiver to enforcement of any of these provisions at any time during the term of the Agreement.

11.0. Notification of Claim

11.1. If any claim for damages or injury is filed with CONTRACTOR or if any lawsuit is instituted against CONTRACTOR, that arise out of or are in any way connected with CONTRACTOR's performance under this Agreement and that in any way, directly or indirectly, contingently or otherwise, affect or might reasonably affect COUNTY, CONTRACTOR shall give prompt and timely notice thereof to COUNTY. Notice shall not be considered prompt and timely if not given within thirty (30) days following the date of receipt of a claim or ten (10) days following the date of service of process of a lawsuit.

EXHIBIT D: RESOLUTION NO. _____
BY THE BOARD OF DIRECTORS
****SAMPLE****

WHEREAS, an application to request funding for a program of services to be submitted to Sacramento County has been determined to be in the best interest of (NAME OF ORGANIZATION) by its duly constituted Board of Directors.

NOW, THEREFORE, BE IT RESOLVED that the persons named below are authorized to submit such an application and to negotiate and execute, on behalf of this corporation, any resulting Agreement and any and all documents pertaining to such Agreement, and to submit claims for reimbursement of other financial reports required by said Agreement.

AND FURTHERMORE, that the signatures recorded below are the true and correct signatures of the designated individuals.

AUTHORIZED TO EXECUTE AGREEMENT

AUTHORIZED TO SUBMIT CLAIMS

TITLE

TITLE

PRINT NAME

PRINT NAME

ELECTRONIC or SCANNED SIGNATURE

ELECTRONIC or SCANNED SIGNATURE

CERTIFICATION

I certify that I am the duly qualified and acting Secretary of (NAME OF ORGANIZATION), a duly organized and existing (NATURE OF BUSINESS). The foregoing is a true copy of a resolution adopted by the Board of Directors of said corporation, at a meeting legally held on (DATE) and entered into the minutes of such meeting, and is now in full force and effect.

DATE

PRINT NAME

ELECTRONIC or SCANNED SIGNATURE

**EXHIBIT E: COUNTY OF SACRAMENTO
CONTRACTOR CERTIFICATION OF COMPLIANCE WITH
CHILD, FAMILY AND SPOUSAL SUPPORT**

WHEREAS it is in the best interest of Sacramento County that those entities with whom the County does business demonstrate financial responsibility, integrity and lawfulness, it is inequitable for those entities with whom the County does business to receive County funds while failing to pay court-ordered child, family and spousal support which shifts the support of their dependents onto the public treasury.

Therefore, in order to assist the Sacramento County Department of Child Support Services in its efforts to collect unpaid court-ordered child, family and spousal support orders, the following certification must be provided by all entities with whom the County does business:

CONTRACTOR hereby certifies that either:

- _____ (a) the CONTRACTOR is a government or non-profit entity (exempt), or
- _____ (b) the CONTRACTOR has no Principal Owners (25% or more) (exempt), or
- _____ (c) each Principal Owner (25% or more), does not have any existing child support orders, or
- _____ (d) CONTRACTOR'S Principal Owners are currently in substantial compliance with any court-ordered child, family and spousal support order, including orders to provide current residence address, employment information, and whether dependent health insurance coverage is available. If not in compliance, Principal Owner has become current or has arranged a payment schedule with the Department of Child Support Services or the court.

New CONTRACTOR shall certify that each of the following statements is true:

- a. CONTRACTOR has fully complied with all applicable state and federal reporting requirements relating to employment reporting for its employees; and
- b. CONTRACTOR has fully complied with all lawfully served wage and earnings assignment orders and notices of assignment and will continue to maintain compliance.

NOTE: Failure to comply with state and federal reporting requirements regarding a contractor's employees or failure to implement lawfully served wage and earnings assignment orders or notices of assignment constitutes a default under the contract; and failure to cure the default within 90 days of notice by the County shall be grounds for termination of the contract. Principal Owners can contact the Sacramento Department of Child Support Services at 1-866-901-3212, by writing to P.O. Box 269112, Sacramento, 95826-9112, or via the Customer Connect website at www.childsup.ca.gov .

CONTRACTOR NAME

Date

Printed Name of person authorized to sign

Signature

EXHIBIT F: CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

CONTRACTOR agrees to comply with 45 CFR Part 76.100 (Code of Federal Regulations), which provides that federal funds may not be used for any contracted services, if CONTRACTOR is debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or agency.

I (We) certify to the best of my (our) knowledge and belief, that CONTRACTOR named below and its principals:

1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or agency;
2. Have not within a three (3)-year period preceding this application been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
3. Are not presently indicted or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses enumerated in paragraph (2) of this certification; and
4. Have not within a three (3)-year period preceding this Application/agreement had one or more public transactions (Federal, State, or local) terminated for cause or default.
5. Shall notify COUNTY within ten (10) days of receipt of notification that CONTRACTOR is subject to any proposed or pending debarment, suspension, indictments or termination of a public transaction.
6. Shall obtain a certification regarding debarment and suspension from all its subcontractors that will be funded through this Agreement.
7. Hereby agree to terminate immediately, any subcontractor's services that will be/are funded through this Agreement, upon discovery that the subcontractor is ineligible or voluntarily excluded from covered transactions by any federal department or agency.

ORGANIZATION'S NAME

Printed Name of person authorized to sign

Electronic or Scanned Signature

Date

EXHIBIT G: STATEMENT OF COMPLIANCE WITH SACRAMENTO COUNTY GOOD NEIGHBOR POLICY

- A. CONTRACTOR shall comply with COUNTY’s Good Neighbor Policy. CONTRACTOR shall establish good neighbor practices for its facilities that include, but are not limited to, the following:
 - 1. Provision of parking adequate for the needs of its employees and service population;
 - 2. Provision of adequate waiting and visiting areas;
 - 3. Provision of adequate restroom facilities located inside the facility;
 - 4. Implementation of litter control services;
 - 5. Removal of graffiti within seventy-two (72) hours;
 - 6. Provision for control of loitering and management of crowds;
 - 7. Maintenance of facility grounds, including landscaping, in a manner that is consistent with the neighborhood in which the facility is located;
 - 8. Participation in area crime prevention and nuisance abatement efforts; and
 - 9. Undertake such other good neighbor practices as determined appropriate by COUNTY, based on COUNTY’s individualized assessment of CONTRACTOR’s facility, services, and actual impacts on the neighborhood in which such facility is located.
- B. CONTRACTOR shall identify, either by sign or other method as approved by DIRECTOR, a named representative who shall be responsible for responding to any complaints relating to CONTRACTOR’s compliance with the required good neighbor practices specified in this Section. CONTRACTOR shall post the name and telephone number of such contact person on the outside of the facility, unless otherwise advised by DIRECTOR.
- C. CONTRACTOR shall comply with all applicable public nuisance ordinances.
- D. CONTRACTOR shall establish an ongoing relationship with the surrounding businesses, law enforcement, and neighborhood groups and shall be an active member of the neighborhood in which CONTRACTOR’s site is located.
- E. If COUNTY finds that CONTRACTOR has failed to comply with the Good Neighbor Policy, COUNTY shall notify CONTRACTOR in writing that corrective action must be taken by CONTRACTOR within a specified time frame. If CONTRACTOR fails to take such corrective action, COUNTY shall take such actions as are necessary to implement the necessary corrective action. COUNTY shall deduct any actual costs incurred by COUNTY when implementing such corrective action from any amounts payable to CONTRACTOR under this Agreement.

Contractor’s continued non-compliance with the Good Neighbor Policy shall be grounds for termination of this Agreement and may also result in ineligibility for additional or future contracts with COUNTY.

ORGANIZATION’S NAME

Printed Name of the person authorized to sign

ELECTRONIC OR SCANNED SIGNATURE

DATE

EXHIBIT H: ASSURANCE OF CULTURAL COMPETENCE COMPLIANCE



DIVISION OF BEHAVIORAL HEALTH SERVICES

ASSURANCE OF CULTURAL COMPETENCE COMPLIANCE

This document assures compliance with various federal, state and local regulations, laws, statutes and policies related to culturally and linguistically competent services to diverse populations as outlined in the Sacramento County Division of Behavioral Health Services (DBHS) Cultural Competence Plan Objectives and the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

In a culturally and linguistically competent system, each provider organization shows respect for and responds to individual differences and special needs of the community. Services are provided in the appropriate cultural context and without discrimination related to, but not limited to race, ethnicity, national origin, income level, religion, gender identity, gender expression, sexual orientation, age, or physical disability. Culturally competent providers are aware of the impact of their own culture on their relationships with consumers and know about and respect cultural and ethnic differences. They adapt their skills to meet each family's values and customs. Cultural competence is a developmental and dynamic process – one that occurs over time.

Cultural Competence Definition

Cultural Competence is defined as a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family members, and professionals that enables that system, agency, or those professionals and consumers, and family member providers to work effectively in cross-cultural situations. (Adapted from Cross, et al., 1989)

Cultural Competence Guiding Principles

Cultural Competence is an ongoing process that is critical to eliminating cultural, racial and ethnic disparities in the delivery of quality mental health and substance use disorder services. Cultural Competence enhances the ability of the whole system to incorporate the languages, cultures, beliefs and practices of its clients into the service and should be incorporated into all aspects of policy-making, program design, administration, service delivery, data collection and outcome measurement. The County Behavioral Health Directors Association of California developed the

following guiding principles and corresponding strategies for counties to use in operating a culturally and linguistically competent system of care to eliminate disparities.

- Commitment to Cultural Competence and Health Equity
 - Address cultural competence at all levels of the system including policy, programs, operations, treatment, research and investigation, training and quality improvement. (CLAS Standard 1)
 - Demonstrate commitment to cultural and linguistic competence in all agency policy and practice documents, including the mission statement, statement of values, strategic plans, and policy and procedural manuals. (CLAS Standard 2)
 - Provide easy to understand print and multimedia materials and signage in languages commonly used by the population in the service area to inform them of the availability of language assistance services offered at no cost to them. (CLAS Standards 8 & 6)
- Identification of Disparities and Assessment of Needs and Assets
 - Collect, compile and analyze population statistics across language, ethnicity, age, gender, sexual orientation, socio-economic status markers and evaluate the impact of County Client Services Information data across same statistical areas. (CLAS Standard 11)
 - Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. (CLAS Standard 12)
- Implementation of Strategies to Reduce Identified Disparities
 - Develop, implement, and monitor strategies for elimination of identified disparities (including upstream approaches that address the social determinants of health) and track impact of those strategies on disparities. (CLAS Standard 9)
 - Utilize a quality improvement framework to monitor and evaluate Cultural Competence Plans and disparity elimination activities, and share improvement targets and progress with stakeholders. (CLAS Standards 10 & 15)
- Community Driven Care
 - Develop formal and informal relationships with community members, community organizations, and other partners to maximize the delivery of effective culturally, ethnically and linguistically appropriate care, and monitor the outcomes of these partnerships. (CLAS Standard 13)
 - Ensure representation of consumers, individuals with lived mental health/behavioral health experience; family members of a consumer; children; youth; parent/caregivers of youth with serious emotional disturbance; and representatives from unserved/under-served/inappropriately served communities including Limited English Proficient (LEP) individuals on their advisory/governance body/committee to develop service delivery and evaluation (with a recommended minimum of 50%).
 - Establish and implement a transparent and inclusive process for obtaining client, community, and staff input related to cultural competence planning, implementation, monitoring and evaluation. Create and utilize culturally and linguistically appropriate conflict grievance resolution processes. (CLAS Standard 14)

- Workforce Development
 - Establish workforce recruitment strategies that ensure adequate levels of consumer/peer (persons with lived experience), community (navigators, community health workers), administrative, support, and professional staff, reflective of the diversity of the populations served. Emphasize professional development opportunities, self-care strategies to address stress and micro-aggressions, and other retention efforts. Develop corrective measures to address severe shortages impacting ability to serve county populations (WIC 4341, CLAS Standard 3).
 - Provide ongoing cultural competence and quality improvement training to consumer/peer (persons with lived experience), community (navigators, community health workers), administrative, support and professional personnel (trained behavioral health interpreters, bilingual staff) in order to effectively address the needs of cultural, racial and ethnic populations, including linguistic capability. (CCR Title 9 Section 1810.410, CLAS Standards 4 & 7)
- Provision of Culturally and Linguistically Appropriate Services
 - Ensure access to culturally and linguistically appropriate services (treatment interventions, engagement strategies, outreach services, assessment approaches, community defined practices) and offer language assistance at no cost to them, for all diverse unserved, underserved and inappropriately served populations by making them: available, accessible, acceptable, accommodating, and sensitive to historical, cultural, spiritual and/or religious experiences, values, and traditional healing practices and ceremonies. (CLAS Standards 1 & 5)
 - Make available behavioral health services that are responsive to the numerous stressors and social determinants of health experienced by cultural, racial and ethnic populations which have a negative impact on the emotional and psychological state of individuals and make every attempt to provide greater access to services, e.g. evenings/weekend hours and in less stigmatizing settings (primary care, faith-based organizations, community organizations, etc).

“While culturally competent service delivery systems will continue to have primary goals around ongoing elimination of inequities for specific racial, ethnic, and cultural communities, culturally competent systems must be sufficiently flexible in order to promote improved quality and effectiveness of services for all community members...” (County Behavioral Health Directors Association of California Framework for Advancing Cultural, Linguistic, Racial and Ethnic Behavioral Health Equity, Updated 2016, page 2).

CONTRACTOR hereby agrees that it shall comply with the principles and guidelines set forth as outlined above, and shall:

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with clients and each other in a culturally diverse work environment. Support evidence-based, community defined, promising and emerging practices that are congruent with ethnic/racial/linguistic/cultural group belief systems, cultural values, traditional healing practices, and help-seeking behaviors. Support the

county's goal to reduce disparities to care by increasing access, decreasing barriers, and improving services for unserved, underserved, and inappropriately served communities.

- Provide an emotional environment that ensures people of all cultures, ages, sexual orientation, gender identity, and gender expression feel welcome and cared for. This shall include: respect for individual preferences for traditional healing practices, alternative, spiritual and/or holistic approaches to health; a reception staff that is proficient in the different languages spoken by clients; bilingual and/or bicultural clinical staff that is knowledgeable of cultural and ethnic differences, needs, and culturally accepted social interactions and healthy behaviors within the client's family constellation or other natural support system and is able and willing to respond to clients and their natural support system in an appropriate and respectful manner.
2. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, outcomes, evaluation, policies, procedures, and designated staff responsible for implementation.
 - As outlined in the Sacramento County Division of Behavioral Health Services Cultural Competence Plan Objectives:

Ensure progress in the delivery of culturally competent services through the biennial completion and analysis of a system-wide Agency Self-Assessment of Cultural Competence.
 3. Develop and implement a strategy to recruit, retain and promote qualified, diverse culturally and linguistically competent administrative, clinical, and support staff, reflective of the community, that are trained and qualified to address the needs of the racial and ethnic communities being served.
 - As outlined in the Sacramento County Division of Behavioral Health Services Cultural Competence Plan Objectives:

Increase the percentage of direct service staff by 5% annually to reflect the racial, cultural and linguistic makeup of the county until the makeup of direct services staff is proportionate to the makeup of Medi-Cal beneficiaries plus 200% of poverty population.
 4. Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery. In addition to ensuring that staff members participate in required cultural competence trainings offered by Sacramento County Division of Behavioral Health Services, CONTRACTOR shall provide cultural competence training to all employees.
 - As outlined in the Sacramento County Division of Behavioral Health Services Cultural Competence Plan Objectives:

75% of direct service (including ADS) staff and supervisors will have completed the California Brief Multicultural Competence Scale (CBMCS) and/or equivalent cultural competence training approved by DBHS.

5. Provide all clients with limited English proficiency access to bilingual staff or interpretation services at no cost to the client.
6. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services.
7. Translate and make available signage and commonly-used written client educational material and other materials for members of the predominant language groups in the service area.
 - Create a physical environment that ensures people of all cultures, ages, sexual orientation, gender identity and gender expression feel welcome and cared for. This shall include: decorating waiting and treatment areas with pictures that reflect the diverse cultures of Sacramento County; providing reading materials, resources, and magazines in varied languages that are at appropriate reading levels and are suitable for different age groups, including children and youth; considering cultural differences and preferences when offering refreshments; ensuring that any pictures, symbols or materials on display are not unintentionally disrespectful to another culture.
8. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or nonclinical encounters.
 - As outlined in the Sacramento County Division of Behavioral Health Services Cultural Competence Plan Objectives:

Maintain the standard that 98% of staff identified as interpreters complete the approved mental health/behavioral health interpreter training and receive certification. Include system partners in training to expand pool of trained interpreters in emerging language populations.
9. Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the provider's management information system as well as any client records used by provider staff.
10. Promote equity in behavioral health service utilization by actively engaging and sustaining meaningful participation of representatives from unserved, underserved and inappropriately served communities at every step of program planning, implementation, outcome measurement and evaluation. Collaborate with diverse cultural, racial, ethnic, LGBTQ, and emerging refugee communities to learn more about how they define and view culturally and linguistically competent outreach, engagement, and behavioral health wellness and recovery services.

Dissemination of these Provisions: CONTRACTOR shall inform all its officers, employees, agents, and subcontractors providing services hereunder of these provisions.

By my signature below, as the authorized representative of the CONTRACTOR named below, I certify acceptance and understanding for myself and the CONTRACTOR of the above provisions.

Contractor (Organization Name)

Electronic or Scanned Signature of
Authorized Representative

Name of Authorized Representative (Printed)

Date

Title of Authorized Representative

EXHIBIT I: STATEMENT OF COMPLIANCE WITH QUALITY MANAGEMENT AND COMPLIANCE

IF AWARDED THE CONTRACT, the applicant will be required to comply with all applicable items below in conformity with the program being implemented:

Quality Management and Compliance policies and procedures and internal administrative controls are critical to prevent fraud, abuse and ensure appropriate quality of care, billing accuracy and fiscal integrity.

QUALITY MANAGEMENT:

Demonstrate ability to:

1. Meet site certification standards for State/County and funding sources for delivering services.
2. Analyze, resolve and respond to consumer grievances and complaints and County time sensitive requests for corrective actions.
3. Establish and track selected benchmarks and work plans meaningful to County Quality Management, agency and program quality improvement goals.
4. Conduct internal utilization review and participate in County utilization review/peer review processes.
5. Participate in system wide or community Quality Improvement Committees and other quality improvement studies and system-wide activities.
6. Monitor quality or client care in all elements of program design.
7. Establish internal protocols for reporting and responding to critical incidents, conducting appropriate follow-up investigations and plans of correction.
8. Designate qualified individuals to manage and prepare internal and external clinical reviews, audits and follow-up actions.

COMPLIANCE:

1. Demonstrate evidence of a Compliance Program to meet federal, state or regulatory requirements depending on the funding source.
2. Designate qualified individuals to manage key elements of agency Compliance Program and interface with County Compliance Program and complete follow-up actions.
3. Initiate and conduct agency level reporting, training, and education plan to meet federal, State and County Compliance Program requirements.
4. Develop and oversight procedures to monitor clinical documentation and billing accuracy.
5. Delineate designated internal controls to validate, crosscheck and correct staff billing and clinical privileges and service authorization accuracy.
6. Develop administrative systems and controls to monitor staff qualifications, enroll and disenroll staff in accordance with privileges and professional regulatory bodies (Office of the Inspector General (OIG), National Practitioners Database (NPDB).
7. Ensure site certification standards are continuously maintained in accordance with State / County and funding source requirements.

By my signature I certify that my agency is able to comply with Quality Management and Compliance reference listed above.

ORGANIZATION'S NAME

DATE

Printed Name of the person authorized to sign

ELECTRONIC OR SCANNED SIGNATURE

EXHIBIT J: INDEPENDENT AUDITED FINANCIAL STATEMENT

1. Independent Audited Financial Statement Instructions: Applicants must submit their latest complete audited financial statement with accompanying notes, completed by an independent Certified Public Accountant (CPA), for a fiscal period not more than 24 months old at the time of submission. Use of generally accepted accounting principles (GAAP) is required. The demonstration of the organization's financial stability will be screened. If the audit is of a parent firm, the parent firm shall be party to the contract.

If the total budget amount of the application, plus the total of all the organization's existing contracts with DHS is less than \$150,000, a reviewed financial statement may be provided in place of the audited financial statement. The reviewed financial statement shall be prepared by an independent CPA in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants (AICPA), and must be for a fiscal period of not more than 24 months old at the time of submission.

2. Independent Audited Financial Statement (Exhibit J) that is not more than 24 months old at time of submission will be screened by the Department's Accounting Manager for:
 - a. No adverse auditor opinion
 - b. No disclaimer of auditor opinion
 - c. No going concerns/issues

The RFA allows for communication between the applicant, the CPA who prepared the financial statement, and the Department's Accounting Manager. This communication includes additional documentation and reports to be provided to the Department's Accounting Manager and for those documents and explanations to be considered as part of the demonstration of financial stability.

3. Once screened, the Independent Audited Financial Statement will receive a Pass or Fail mark based on:
 - a. Liquidity ratios
 - i. Current (current assets divided by current liability)
 - ii. Quick (equal to cash plus government securities plus accounts receivable divided by total current liabilities)
 - b. Leverage ratio: Debt ratio (total liability divided total assets)
 - c. Working capital: Total current assets minus total current liabilities

EXHIBIT K: BUDGET

Exhibit K, Excel spreadsheet, will be included in an email sent to the Mandatory Applicants' Conference attendees.

1. Instructions for completing Staffing Detail, Budget Template and Budget Narrative:
 - a. Applicants are required to complete a 12 month budget (Exhibit K) that includes the Staffing Detail, Budget Template, and Budget Narrative. Exhibit K must be completed and submitted in your organization's application package. The budget is an Excel spreadsheet; the spreadsheet will include tabs for the Staffing Detail, Budget Template, and Budget Narrative. Exhibit K, Excel spreadsheet, will be included in an email sent to the Mandatory Applicants' Conference attendees.
 - b. The amounts identified in the Staffing Detail sheet automatically calculate and carry over to the Budget Template.
 - c. Round all expenditures to the nearest whole dollar.
 - d. Provide detailed information for each line item in the budget and justification of expenses listed in each major category in the Budget Narrative. Identify one-time expenditures.
2. Budget Screening: Budget will be screened to verify that:
 - a. Instructions listed above have been followed.
 - b. Total proposed budget for services does not exceed total available funds.
 - c. Proposed indirect/allocated costs for services do not exceed 15% of proposed salary/benefits, and operating costs.

EXHIBIT K STAFFING DETAIL

Organization Name:

Fiscal Year:

2021-22

Agency Position Classifications	QM Classification	No. of FTEs	Budgeted Compensation per FTE	Budgeted Compensation - County Funding
PROGRAM SERVICE STAFF -- EMPLOYEES				
		0.00	\$ -	\$ -
		0.00	\$ -	\$ -
		0.00	\$ -	\$ -
		0.00	\$ -	\$ -
		0.00	\$ -	\$ -
		0.00	\$ -	\$ -
		0.00	\$ -	\$ -
		0.00	\$ -	\$ -
		0.00	\$ -	\$ -
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		0.00	\$ -	\$ -
		0.00	\$ -	\$ -
		0.00	\$ -	\$ -
		0.00	\$ -	\$ -
		0.00	\$ -	\$ -
		0.00	\$ -	\$ -
Total Program Service Staff - Employees		0.00		\$ -
PROGRAM SERVICE STAFF -- CONTRACTORS				
		0.00	\$ -	\$ -
		0.00	\$ -	\$ -
		0.00	\$ -	\$ -
Total Program Service Staff - Contractors		0.00	\$ -	\$ -
TOTAL PROGRAM SERVICE STAFF COMPENSATION		0.00		\$ -

ADMINISTRATIVE PERSONNEL COSTS			
Administrative Personnel Support Positions: (Non-Allocated Positions) Example: Clerical, Data Entry exclusive to this program.	No. of FTEs	Budgeted Compensation per FTE	Budgeted Compensation - County Funding
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
Total Administrative Personnel Support	0.00		\$ -
Allocated Positions: Those Shared With Other Programs. Examples include CEO, Fiscal, Legal, IT and HR staff. INCLUDE benefits and payroll taxes for these positons in the budgeted compensation.	No. of FTEs	Budgeted Compensation per FTE	Budgeted Compensation - County Funding
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
	0.00	\$ -	\$ -
Total Allocated Positions	0.00		\$ -
TOTAL ADMINISTRATIVE PERSONNEL COSTS			\$ -

Exhibit K Budget Narrative

Organization Name:	Fiscal Year: 2021-22
PROGRAM SERVICE PERSONNEL EXPENSES	
a. Personnel Expenses	
b. Payroll Taxes	
c. Employee Benefits	
d. Program Services Contracted Staff	
PROGRAM SERVICE OPERATING EXPENSES	
Use your General Ledger if available. List major categories and include brief explanations of expenses listed in each major category.	
a. Rent and security for program site	
b. Office expenses including supplies needed for program operation, paper, pens, ink cartridges, medical file folders, file storage and maintenance, office equipment, paper shredding, etc.	
c. Equipment leases for copier and scanner	
d. IT support and maintenance including repair and replacement of servers, computers and laptops, costs for offsite storage of servers in a secure location	
e. Phone and internet services for landlines, cellphones and WiFi	
f. Travel, Transportation, and Mileage; All clinical program staff are reimbursed for mileage to provide community-based services.	
g. Professional services for annual independent audit required for contract compliance.	
h. Medical waste disposal, injection supplies and related medical supplies.	
i. Insurance coverage for general liability, auto, professional liability, worker's compensation, sexual misconduct, cyber security	
j. Training plan includes costs for training programs, workshops, partial funding for licensure exams and resources.	
k. Utilities include electricity and gas.	

ALLOCATED COSTS
a. Allocated Administrative Salaries
b. Payroll Taxes and Benefits - Allocated Administrative Salaries
c. Other allocated expenses - Provide explanation of allocation methodology.
d. Other indirect expenses. Provide explanation.
HOUSING AND OTHER FLEXIBLE SUPPORTS
a.
b.
c.
d.
e.
f.
g.
h.
i.

EXHIBIT L: APPLICATION NARRATIVE AND PRESENTATION

A. Narrative formatting instructions may be found in Section III. B. of this RFA.

MHSA General Standards should be incorporated in all aspects of the narrative			
Areas to be addressed:	Applicants will be rated on:	Maximum Pages	Maximum Points
<p>I. Knowledge & Vision</p> <p>A. Describe your vision for how the Adult Full Service Partnership (FSP) model will be ramped up and implemented that demonstrates understanding of the FSP model, including any anticipated barriers and how you will address them.</p> <p>B. Describe your organization’s plan for embedding the “Service Delivery Approaches” as outlined in RFA’s scope of work, Section I, C. 8, into your organization’s culture, structure, and staffing model.</p> <p style="padding-left: 20px;">a. Describe how your organization will implement and incorporate these service delivery approaches in all aspects of service delivery.</p> <p style="padding-left: 20px;">b. Include a proposed evidence based practice(s) (EBPs), community defined practice(s) (CDP), and/or promising practice(s) (PPs) and how it will be used and helpful for population being served.</p> <p>C. Describe your organization’s harm reduction, stages of change and “whatever it takes” strategies to engage clients in recovery and maintain stability in the community.</p>	<p>Clarity and completeness of response; and:</p> <p>A. Quality and relevance of organization’s understanding and vision for program implementation that includes realistic challenges and opportunities.</p> <p>B. Demonstrated understanding of all key elements and principles of all service delivery approaches as defined in the RFA’s scope of work Section I, C. 8 and the plan for implementing and incorporating into services as defined in the RFA’s scope of work and for the population to be served.</p> <p>C. Quality and relevance of strategies for harm reduction, stages of change and “whatever it takes” to engage clients in recovery and maintain stability in the community.</p>	4	20

**MHSA General Standards
should be incorporated in all aspects of the narrative**

Areas to be addressed:	Applicants will be rated on:	Maximum Pages	Maximum Points
<p>II. Crisis Response Protocols</p> <p>A. Describe your organization’s crisis response staff trainings and policies and procedures for the population defined in the RFA that includes:</p> <ul style="list-style-type: none"> a. Responding safely twenty-four (24) hours a day, seven (7) days a week, b. Triaging the crisis, c. Providing face-to-face crisis intervention services, d. Your organization’s crisis response Triaging Tool and the Policy and Procedure(s) that outline how crisis intervention services will be triaged and delivered and how managing crises will be included in treatment planning and follow up care. <p>B. Describe how your program would respond from first call to action when a system partner, such as emergency room or the Mental Health Urgent Care Clinic calls about a client in crisis after regular business hours. Include how the response protocols are designed prevent negative outcomes.</p> <p>C. Outline how your program will identify, assess, manage and support clients that need urgent medication services and supports.</p>	<p>Clarity and completeness of response, and;</p> <ul style="list-style-type: none"> A. Inclusion of organizational trainings and policies and procedures that address triaging and crisis response protocols, impact and effect on treatment planning and follow up care as it relates to the population described in this RFA that will help prevent negative outcomes FSPs are designed to address. B. Identification of effective care coordination and crisis response protocols that demonstrates understanding of the need to respond and coordinate with system partners at any time, including after hours to prevent negative outcomes. C. A copy of your organization’s crisis response Triaging Tool and the Policy and Procedure(s) that outline how crisis intervention services will be triaged and delivered and how managing crises will be included in treatment planning and follow up care. <p>*Please note inclusion of your organization’s crisis response Policy and Procedure and Triaging Tool does not count towards page limit.</p>	3*	15
<p>III. Knowledge of Population & Programming Needs</p> <p>A. Describe your organization’s understanding of the characteristics and complex needs of adults with serious mental illness to be served as defined in this RFA.</p> <p>B. Describe strategies your organization will use to effectively engage the target population defined in the RFA.</p>	<p>Clarity and completeness of response, and:</p> <ul style="list-style-type: none"> A. Demonstrated knowledge and understanding of the characteristics and complex needs of adults with serious mentally illness as defined in the RFA. B. Demonstrated knowledge and understanding of effective engagement strategies for the target population as described in the RFA. 	3	15

**MHSA General Standards
should be incorporated in all aspects of the narrative**

Areas to be addressed:	Applicants will be rated on:	Maximum Pages	Maximum Points
C. Describe how your program will attract staff that is representative of the cultural, sexual orientation, gender identity and expression, ethnic and linguistic diversity of the community.	C. Comprehensive plan and strategies to attract staff that is representative of the cultural, sexual orientation, gender identity and expression, ethnic and linguistic diversity of the community.		
IV. Treatment Effectiveness, Outcomes and Recovery Advancement A. How will your organization identify and measure the client’s recovery progress through treatment, readiness for step-down to a lower level of care, and community integration? B. How will your organization measure the effective utilization of interventions and strategies? Include how your organization will use information gathered from these measures: a. To ensure treatment effectiveness with clients and in supervision and b. To provide staff supervision. C. How will your organization obtain client and family feedback to improve a client’s services and outcomes, and to define client-driven recovery goals?	Clarity and completeness of response, and: A. Plan or strategies to identify and measure the client’s recovery progress through treatment, readiness for step-down to a lower level of care, and community integration. B. Plan or strategy to measure the effective utilization of interventions and strategies. Include how your organization will use information gathered from these measures to ensure treatment effectiveness with clients and in supervision. C. Demonstrated knowledge of effective strategies for soliciting meaningful feedback from clients and their families for improvement of services, outcomes, and development of client-driven recovery goals.	3	15
V. Collaboration A. Identify the relevant Sacramento County system and community partners with whom your organization will collaborate and the rationale for how these collaborations will enhance service delivery. B. Describe your organization’s strategies for establishing and maintaining effective collaborations with relevant system and community partners, providers, organizations, and other local resources.	Clarity and completeness of response, and: A. Demonstrated knowledge of relevant Sacramento County system and community partners and demonstrated rationale for the importance of the collaboration. B. Demonstrated knowledge of strategies for establishing and maintaining effective collaborations with relevant system and community partners, providers, organizations, and other local resources.	2	10

**MHSA General Standards
should be incorporated in all aspects of the narrative**

Areas to be addressed:	Applicants will be rated on:	Maximum Pages	Maximum Points
C. Attach at least one Letter of Intent to Collaborate from an Emergency Department program. No page limit for attached letters of Intent to Collaborate.	C. Letter of Intent to Collaborate is included and relevant to the services offered.		
<p>VI. Housing Services and Supports</p> <p>A. Describe the steps your organization will take to meet the housing needs of the Behavioral Health Program clients who are:</p> <ul style="list-style-type: none"> • At risk of imminent homelessness or • Experiencing literal homelessness. <p>B. Describe how your organization will create a constantly renewing array of Sacramento market housing resources and options and how the organization would help FSP clients sustain themselves in their own housing into the future.</p> <p>C. Describe how your organization will support clients with subsidized housing (Shelter Plus Care Voucher, Housing Choice Voucher/Section 8, low income housing, etc.).</p> <p>D. Describe how your organization will support clients in Permanent Supportive Housing (PSH).</p> <p>E. Describe how you will collaborate with system partners and housing providers or programs including landlords, property managers, residential services providers, housing navigators, etc.</p> <p>F. Describe how you will plan and implement a staffing composition to support clients in permanent supportive built units including how your organization will coordinate with onsite resident services and property management.</p>	<p>Clarity and completeness of response, and:</p> <p>A. Demonstrated knowledge and understanding of steps required to constantly build market housing resources that meet the unique housing needs of FSP clients and shows understanding of how to help clients self-sustain in their own housing.</p> <p>B. Quality of plan to constantly build open market housing resources and options that benefit the Behavioral Health Program clients. Interventions include client self-sustainability plans.</p> <p>C. Demonstrated knowledge and understanding of supports that will benefit clients in subsidized housing.</p> <p>D. Demonstrated knowledge and understanding of supports that will benefit clients' needs in Permanent Supportive Housing (PSH).</p> <p>E. Quality of plan for collaboration with system partners and housing providers or programs.</p> <p>F. Demonstrated understanding of an effective plan and staffing composition to support clients in permanent supportive housing (built units) including how your organization will coordinate with onsite resident services and property management.</p>	3	15

MHSA General Standards should be incorporated in all aspects of the narrative			
Areas to be addressed:	Applicants will be rated on:	Maximum Pages	Maximum Points
<p>VII. Staffing & Training</p> <p>A. Describe your organization’s plan for recruiting and hiring quality staff for this program.</p> <p>B. Describe a staffing composition essential to the scope of work defined in the RFA. Include description of Full Time Equivalent (FTE), summary of job descriptions, necessary skill set, qualifications, and desired characteristics of each staff position.</p> <p>C. Describe your organization’s supervisory and training plan for program staff that include professional development and necessary training to deliver services defined in the RFA’s scope of work for clinical, paraprofessional and peer staff who deliver services defined in this RFA.</p>	<p>Clarity and completeness of response, and:</p> <p>A. Demonstrated understanding of an effective and successful hiring and recruiting plan for selecting staff experienced in providing behavioral health services.</p> <p>B. Demonstrated comprehensive understanding of staff positions, composition, structure and coverage essential to delivering services defined in this RFA’s scope of work.</p> <p>C. Demonstrated knowledge of supervisory, staff professional development training methods and tool that address staff morale and retention, and provides guidance to clinical, paraprofessional and peer staff who deliver services defined in this RFA.</p>	3	15
<p>VIII. Program Siting and Compliance with Sacramento County’s Good Neighbor Policy</p> <p>A. Describe how the principles of wellness and recovery, trauma-informed care, and culturally responsive care informs how your organization sites a behavioral health/mental health program that serves the adult behavioral health population.</p> <p>B. Describe common issues and neighborhood concerns regarding clients accessing on-site services.</p> <p>C. Describe how your organization will address common issues and concerns that ensure good neighbor practices and compliance with Sacramento County’s Good Neighbor Policy (see Exhibit G and Attachment 12).</p>	<p>Clarity and completeness of response, and:</p> <p>A. Demonstrated understanding of how the principles of wellness and recovery, trauma-informed care, and culturally responsive care informs siting a mental health program.</p> <p>B. Demonstrated knowledge of common issues and concerns regarding clients accessing on-site services.</p> <p>C. Demonstrated knowledge of effective protocols and practices that address common issues and concerns and that ensure good neighbor practices and compliance with Sacramento County’s Good Neighbor Policy.</p>	3	10
TOTAL PAGES MAXIMUM FOR NARRATIVE/ MAXIMUM POSSIBLE POINTS FOR NARRATIVE		24	115

B. PRESENTATION INSTRUCTIONS:

1. Organizations that submit applications meeting eligibility and screening criteria as specified in this RFA will be contacted by Sacramento County BHS and assigned a specific date and time for a virtual briefing session and their virtual presentation.
2. The pre-scheduled 30-minute virtual briefing session will provide applicants an opportunity to test their operating system, browser, microphone and camera and to familiarize themselves with the platform prior to their virtual presentation.
3. Each organization may have no more than five (5) representatives presenting.
4. BHS will audio-visual record all organizations' presentations to be used by the County for RFA process and evaluation purposes only. All recordings become property of the County and are not subject to the California Public Records Act until contract execution.
5. All organization presenters will be required to sign a Consent Form for Video/Audio Recording before presentations commence.
6. Organizations may **not** use any handouts, visual presentations, audio equipment or software programs during the presentation.
7. At the scheduled virtual presentation date and time, the organization will be provided:
 - a. One (1) question and two (2) vignettes
 - b. Thirty (30) minutes to prepare oral responses to the question and vignettes
 - c. Thirty (30) minutes to respond to the question and vignettes
8. Applicant (organization) responses will be rated on:
 - a. Question: Clarity, quality and completeness of response and;
 - i. Energy and enthusiasm that embody the understanding of the principles of wellness and recovery;
 - ii. Creativity and use of effective approaches resulting in positive outcomes for the population served defined in this RFA's scope of work;
 - iii. Incorporation of MHSA General Standards, FSP tenets, and creative utilization of service delivery approaches defined in this RFA's scope of work;
 - iv. Effective collaborations with local relevant organizations, system partners, community partners that enhance service delivery and knowledge of effective strategies for maintaining collaborations with those partners; and
 - v. Effective solutions to delivering services during the COVID-19 pandemic.
 - b. Vignettes: Clarity and completeness of response and;
 - i. Demonstrated understanding of the scope of work defined in this RFA;
 - ii. Demonstrated understanding and incorporation of the Service Delivery Approaches defined in this RFA, culturally responsive care, and MHSA General Standards in all aspects of service delivery;
 - iii. Demonstrated understanding of the appropriate utilization of relevant evidenced based practice(s), promising practice(s), or community defined practice(s) for the population defined in this RFA;

- iv. Demonstrated understanding of strategies and interventions that engage clients into services, promote their ongoing participation in services, and support them in achieving goals aligned with program outcomes;
- v. Creative utilization of effective approaches that result in positive outcomes for program clients;
- vi. Demonstrated understanding of effective collaborations with local relevant organizations, system partners, community partners, natural supports including clients;
- vii. Demonstrated ability to use and link clients to appropriate resources; and
- viii. Demonstrated knowledge of effective utilization of staff and understanding of the value of lived experience and advocacy.

Maximum 10 points per question and 10 points per vignette for a total maximum possible points of 30 for the Presentation.

EXHIBIT M: ORGANIZATIONAL CHART

Applicants are required to submit a current organizational chart that includes the placement of the new program as described in this RFA. Include this Exhibit M in your organization's application packet. The organizational chart will not be scored, but should complement your organization's narrative.

EXHIBIT N: START-UP WORK PLAN

The Exhibit N: Start-Up Work Plan is a formatted Word document and will be included in an email sent to the Mandatory Applicants' Conference attendees. Applicants are required to complete and include the Exhibit N: Start-Up Work Plan in your application packet.

Instructions for completing: **Identify the action steps for the development and implementation of the Adult Full Service Partnership Program.** Applicants will be rated on clarity, quality, comprehensiveness, organization, completeness and feasibility of the Start-Up Work Plan; understanding of principles of wellness and recovery, trauma informed and culturally responsive care as it relates to all aspects of organization culture and program siting and implementation; understanding of program operations, creative hiring strategies, and community/neighbor collaborations as it relates to good neighbor practices and Sacramento County's Good Neighbor Policy; demonstrates the ability to deliver services within a six (6) month time frame upon contract execution; and demonstrates understanding of potential barriers to all implementation steps, including the potential of being awarded and starting up multiple contracts/programs at one time, and effectiveness of solutions to address barriers. **Maximum possible points for the Start-Up Work Plan: 10 points.**

Start-Up Work Plan						
Step	Action Steps What will be done to ensure that the organization can deliver services by January 1, 2023	Responsibilities Who will complete the action step?	Resources A. Resources available B. Resources Needed (financial, human, political & other)	Timeline By When? (Day/Month) <i>(for the purpose of this application, use July 1, 2022 start date)</i>	Potential Barriers	Solution
1.						
2.						
3.						
4.						
5.						

**EXHIBIT O:
REQUEST FOR APPLICATION No. MHSA/075
APPLICANT QUESTIONS FORM**

Instructions for completion and submission:

1. Exhibit O: RFA No. MHSA/075 Applicant Questions Form is a Portable Document Format (PDF) document with fillable fields. Organization representatives registered for the Mandatory Applicants’ Conference will be emailed the Exhibit O: RFA No. MHSA/075 Questions Form.
2. Applicant questions must be submitted on this RFA MHSA/075 Applicant Questions Form. The completed form must be attached to the sender’s email and emailed to QuestionsMHSA75@SacCounty.gov by the date shown in the RFA timeline. Emails subject line must read, “RFA MHSA/075 Questions Form”.
3. Questions in any other form (either written or oral) about the RFA, its scope of work, or related processes will not be accepted.
4. Applicant questions will not be accepted after the Questions Form submission deadline as shown in the RFA timeline.
5. Following the deadline for questions submission, answers to all substantive questions will be provided in the form of a question and answer document that will be emailed to organization representatives who attended the Mandatory Applicants’ Conference. At the sole discretion of Sacramento County BHS, questions may be paraphrased for clarity. Questions and answers will be provided without identifying the submitters.

Date	
Organization: (insert name)	
Submitted By: (insert name and title)	
E-Mail Address:	

RFA Section Number	RFA Page Number	Concisely describe your Question. Use a separate row for each question.

RFA Section Number	RFA Page Number	Concisely describe your Question. Use a separate row for each question.



EVIDENCE-BASED
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Building Your Program

Assertive Community Treatment



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Center for Mental Health Services
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Building Your Program

Assertive Community Treatment

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

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Disclaimer

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Building Your Program

Building Your Program is intended to help mental health authorities, agency administrators, and ACT leaders think through and develop the structure of ACT programs. Although you will work closely together to build ACT programs, for ease, we created two separate sections of tips that target your specific needs:

- Tips for Mental Health Authorities
- Tips for Agency Administrators and ACT Leaders

In preparing this information, we could think of no one better to advise you than people who have worked successfully with ACT programs. Therefore, we based the information in this booklet on the experience of veteran ACT leaders and administrators, and the booklet ends with their words of advice.

For references see the booklet, *The Evidence*.

Assertive Community Treatment

This KIT is part of a series of Evidence-Based Practices KITs created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

This booklet is part of the Assertive Community Treatment KIT that includes a DVD, CD-ROM, and seven booklets:

How to Use the Evidence-Based Practices KITs

Getting Started with Evidence-Based Practices

Building Your Program

Training Front-Line Staff

Evaluating Your Program

The Evidence

Using Multimedia to Introduce Your EBP



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Assertive Community Treatment

Building Your Program

How Assertive Community Treatment Began

Assertive Community Treatment (ACT) started when a group of mental health professionals at the Mendota Mental Health Institute in Wisconsin—Arnold Marx, M.D.; Leonard Stein, M.D.; and Mary Ann Test, Ph.D.— recognized that many consumers were discharged from inpatient care in stable condition, only to be readmitted relatively soon afterward. Practitioners and consumers were frustrated.

This group looked at how the mental health system worked and tried to figure out what could be done so that consumers could remain in their communities and have a life that was not driven by their illness.

They recognized that the type and intensity of services available to consumers immediately decreased after they left the hospital. The group also realized that, even when hospital staff spent

Finally, staff looked at the unit leaders, Dr. Marx and me, and declared, “We don’t want to do another one of these programs where we try to get patients ready for life in the community. Even though they appear ‘ready’ when we discharge them, they come right back. What good are we doing?”

Test, M.A. The Origins of PACT, *The Journal*, Volume 9, Issue 1, 1998, Sacramento, California

considerable time teaching consumers skills that they needed to live in the community, consumers were often unable to apply these skills once they actually lived in the community.

Our patients work very hard at getting better and getting ready to live in the community, and we work hard to help them. They leave B-2 (the hospital) in pretty good shape, but they always return. Their efforts and ours seem in vain.

Test, M.A. The Origins of PACT, *The Journal*, Volume 9, Issue 1, 1998, Sacramento, California

Adjusting to a community setting was worsened by the fact that consumers who experience serious psychiatric symptoms may be particularly vulnerable to the stress associated with change. Consumers often had difficulty getting the services and support they needed to prevent relapse because the mental health system was complex and services were fragmented.

Many programs were available only for a limited time. Once consumers were discharged, assistance ended. Sometimes consumers were denied services or they were unable to apply for services because of problems caused by the symptoms of their mental illness. Sometimes the service consumers needed did not even exist, and no one was responsible for making sure consumers got the help they needed to stay out of the hospital.

Eventually, one of the paraprofessionals commented, “You know, the patients that Barb Lontz works with intensively don’t come back. Maybe we should all go out and do what Barb does.”

Test, M.A. The Origins of PACT, *The Journal*, Volume 9, Issue 1, 1998, Sacramento, California

What the originators did

The group learned from the actions of a social worker, Barb Lontz. They moved inpatient staff into the community to work with consumers in the settings where they lived and worked. They created multidisciplinary teams which gave consumers the support, treatment, and rehabilitation services they needed to continue living in the community.

The types of services that were provided and how long those services were provided depended on consumers’ needs. Team members pooled their experience and knowledge and worked together to ensure that consumers had the help they needed and that the treatment they received was effective.

Every day, ACT team members met to discuss how each consumer was doing; they quickly adjusted services, when necessary. When consumers needed more support, team members met with them more frequently.

Team members responded to consumers in the community 24 hours a day, 7 days a week. As consumers improved, team members decreased their interactions with them, but remained available to give additional support any time it was needed. After 30 years, the principles of this model remain the same.

Principles of ACT

- ACT is a service-delivery model, not a case management program.
- The primary goal of ACT is recovery through community treatment and habilitation.
- ACT is characterized by:
 - D **a team approach** — Practitioners with various professional training and general life skills work closely together to blend their knowledge and skills.
 - D **in vivo services**—Services are delivered in the places and contexts where they are needed.
 - D **a small caseload** — An ACT team consists of 10 to 12 staff members who serve about 100 consumers, resulting in a staff-to-consumer ratio of approximately 1 to 10.
 - D **time-unlimited services** — A service is provided as long as needed,
 - D **a shared caseload** — Practitioners do not have individual caseloads; rather, the team as a whole is responsible for ensuring that consumers receive the services they need to live in the community and reach their personal goals.
- D **a flexible service delivery** — The ACT team meets daily to discuss how each consumer is doing. The team members can quickly adjust their services to respond to changes in consumers' needs.
- D **a fixed point of responsibility** — Rather than sending consumers to various providers for services, the ACT team provides the services that consumers need. If using another provider cannot be avoided (e.g., medical care), the team makes certain that consumers receive the services they need.
- D **24/7 crisis availability** — Services are available 24 hours a day, 7 days a week. However, team members often find that they can anticipate and avoid crises.
- ACT is for consumers with the most challenging and persistent problems.
- Programs that adhere most closely to the ACT model are more likely to get the best outcomes.

What ACT Is

ACT is a way of delivering comprehensive and effective services to consumers who have needs that have not been well met by traditional approaches to delivering services. At the heart of ACT is a transdisciplinary team of 10 to 12 practitioners who provide services to about 100 people.

ACT teams directly deliver services to consumers instead of brokering services from other agencies or providers. For the most part, to ensure that services are highly integrated, team members are cross-trained in one another's areas of expertise.

ACT team members collaborate on assessments, treatment planning, and day-to-day interventions. Instead of practitioners having individual caseloads, team members are jointly responsible for making sure that each consumer receives the services needed to support recovery from mental illness.

The course of recovery from serious mental illness, and what it means to have a life that is not defined by a serious mental illness, differ among consumers. Consequently, ACT services are highly individualized. No arbitrary time limits dictate the length of time consumers receive services.

Most services are provided *in vivo*, that is, in the community settings where problems may occur and where support is needed rather than in staff offices or clinics. By providing services in this way, consumers receive the treatment and support they need to address the complex, real-world problems that can hinder their recovery.

Every day, ACT teams review each consumer's status so that the ACT team can quickly adjust the nature and intensity of services as needs change. At times, team members may meet with consumers several times a day but, as consumers' needs and goals change, the nature and frequency of contacts with them also change.

How we know that ACT is effective

Since the original ACT program began in Madison, Wisconsin nearly 30 years ago, programs have been implemented in 35 States and in Canada, England, Sweden, Australia, and the Netherlands. As ACT spread, researchers carefully studied its effectiveness. Reviews of ACT research consistently conclude that, compared with other treatments (e.g., brokered or clinical case management programs), when faithfully implemented, ACT greatly reduces psychiatric hospitalization and leads to a higher level of housing stability.

Research also shows that, compared to other treatments, ACT has the same or a better effect on consumers' quality of life, symptoms, and social functioning. In addition, consumers and family members report greater satisfaction.

While studies consistently show that ACT is associated with many beneficial outcomes, the Patient Outcomes Research Team (PORT), consisting of researchers from the University of Maryland and Johns Hopkins University, found that people who might benefit from ACT often did not receive this intervention (Phillips, et. al., 2001). Those findings ultimately led to creating this KIT.

In a growing trend, governmental and professional organizations see ACT as a fundamental element in a mental health service system. The Centers for Medicare and Medicaid Services (CMS) authorized ACT as a Medicaid-reimbursable treatment and ACT has been endorsed as an essential treatment for serious mental illness in the Surgeon General's Report on Mental Health (U.S. Department of Health and Human Services, 1999).

In the federal performance indicator system that the Substance Abuse and Mental Health Services Administration (SAMHSA) developed, accessibility to ACT services was one of three best-practice measures of the quality of a state's mental health system. Disseminating the ACT model has also been a top priority for the National Alliance on Mental Illness. For more information about the effectiveness of the ACT model, see *The Evidence* section of this KIT.

Core ACT services

- crisis assessment and intervention;
- comprehensive assessment;
- illness management and recovery skills;
- individual supportive therapy;
- substance-abuse treatment;
- employment-support services;
- side-by-side assistance with activities of daily living;
- intervention with support networks (family, friends, landlords, neighbors, etc.);
- support services, such as medical care, housing, benefits, transportation;
- case management; and
- medication prescription, administration, and monitoring.

Building Your Program

Tips for Mental Health Authorities

Why should mental health authorities be interested in ACT?

ACT is for a relatively small group of consumers who are diagnosed with serious mental illness, experience the most intractable symptoms, and, consequently, have the most serious problems living independently in the community. Because of the severe and recalcitrant nature of their symptoms, these consumers are more likely to:

- frequently use emergency and inpatient medical and psychiatric services,
- be homeless or live in substandard housing,
- be involved in the criminal justice system, or
- use illegal substances.

From a purely fiscal perspective, these consumers are the heaviest users of the most expensive resources. More importantly, they personally suffer the most extreme and devastating consequences of having a serious mental illness.

Traditionally, the mental health system has not been successful in engaging these consumers in effective treatment. However, ACT teams can successfully help consumers who have extensive needs to live safely and autonomously in the community.



Can ACT make a difference?

Whenever new programs come along, administrators have to ask whether reorganizing resources is worth the effort: **Is the new program really going to make a difference?**

When it comes to ACT, extensive research shows that the answer is “Yes.” Most impressive is the extent to which ACT has been subjected to rigorous research and the consistency of favorable findings.

Briefly stated, extensive research (Phillips et al., 2001) shows that ACT:

- reduces the use of inpatient services,
- increases housing stability,
- leads to better substance-abuse outcomes (when programs include a substance-abuse treatment component),
- yields higher rates of competitive employment (when programs included a supported employment component), and
- is more satisfying to consumers and family members.

As an administrator who must balance competing fiscal demands, you will be particularly interested in knowing that rigorous economic analyses have found that ACT is cost-effective when programs adhere closely to the model in serving high-risk consumers. Studies have found that reduced hospitalization offset the costs of ACT (Bond et al., 2001; Essock et al., 1998).

For more information, see *The Evidence* section of this KIT.

Aren't we already doing this?

Your mental health system may already provide crisis services, community-based programs, or even case management programs which operate in teams. While these services share some characteristics of ACT, important distinctions exist.

First, **ACT is not a case management program; it is a self-contained service delivery system.** Case management is only one of many services that ACT teams provide. Rather than sending consumers to different providers for different services as case management programs might, ACT teams provide the vast majority of treatments and services that consumers need.

This approach results in services that are carefully coordinated and integrated. Because team members with a wide range of skills and experience work closely together in ACT teams, they can quickly increase or decrease any number of services and supports as consumers' needs and preferences dictate.

Consider this example

A consumer has a serious medical problem and experiences psychotic symptoms, lives on the streets, and abuses drugs. In the traditional approach to services, that consumer would most likely be referred to a different provider for each need. Of course, the consumer may not meet a particular program's eligibility requirements or a waiting list may exist for a service that the consumer needs.

Assuming that the consumer is admitted to multiple programs, various providers may or may not communicate with one another. They may be unaware of one another's interventions.

If the consumer's needs drastically increase, a new provider may have to be found. If the consumer has a crisis, yet another provider may become involved. At other times, a service may be discontinued simply because an arbitrary time limit has arisen; that time limit may have nothing to do with the consumer's need for the service.

Rather than referring the consumer in this example to different providers, an ACT team would provide the full array of services the consumer needs. For instance, the team would help the consumer find safe affordable housing and provide side-by-side support to help maintain that housing.

The team would assess the consumer's symptoms and teach the person strategies to minimize and manage those symptoms. Team members would see the consumer as often as necessary to help plan and carry out activities of daily living and other constructive activities.

At the same time, the consumer would receive integrated substance-abuse treatment from the team. ACT team members would also work with the consumer to help find paid employment and develop strategies to effectively deal with problems that may arise in the work place.

The team psychiatrist and nurses would carefully monitor the consumer's medical condition and communicate with medical providers to ensure that the consumer receives appropriate treatment. If a need arises that the team cannot meet, such as inpatient medical care, the team would make certain that the consumer receives that care.

Will ACT work in your mental health system?

The ACT model has been adapted to a wide range of mental health systems and to the needs of severely ill consumers.

Some teams target their programs to serve homeless consumers. Others focus on veterans diagnosed with a serious mental illness or consumers with dual diagnoses. Some have had the goal of increasing competitive employment. Still others have included consumers and family members as active members of ACT teams.

ACT programs have been implemented throughout the United States as well as in Canada, England, Sweden, Australia, and the Netherlands, and they operate in both urban and rural settings.

How can mental health authorities support ACT?

As you read about ACT, you may think that it sounds great but unaffordable. We want to challenge that notion — mental health systems with the same access to resources as your system are in the process of implementing ACT programs system-wide.

These systems have visionaries who recognized the benefits of providing this evidence-based practice and who persisted in overcoming challenges.

We hope you are that visionary for your system.

For ACT initiatives to be successful, mental health authorities must lead and be involved in developing ACT programs in local communities.

Be involved in implementing ACT

- Help create a vision of how ACT programs can be integrated into the service delivery system.
- Develop administrative rules that support ACT.
- Create program standards to sustain high-fidelity ACT programs.
- Share this information with those in your mental health system whose expertise you'll need in setting appropriate rules and financial structures.

Create a vision

Agencies commonly set out to implement one program, but end up with something entirely different. Sometimes these variations are intentional, but often they occur because:

- one administration starts an initiative and another with a different vision and priorities subsequently assumes leadership,
- the model wasn't clearly understood to begin with, or
- the staff drifted back to doing things in a way that was more familiar and comfortable.

Articulating the vision and developing momentum for that vision are essential if you are to successfully implement an ACT program. You can help ensure that the ACT model is implemented appropriately if you contractually mandate that stakeholder advisory groups guide the implementation initiative.

Form advisory groups

Consider forming groups on the State and agency levels. State-level advisory groups may include:

- stakeholders from different State agencies (housing, employment, substance abuse, criminal justice departments) that would be invested in the initiative,
- leadership from implementing agencies, and
- representatives from consumer and family State advocacy organizations.

Local advisory groups can serve as a liaison between the community and participating mental health agencies. Community stakeholders with an interest in the success of ACT programs include representatives of:

- local homeless services,
- the criminal justice agencies,
- community colleges,
- landlords, employers, and
- local consumer and family organizations.

From the beginning, you need to lead your advisory groups in understanding and articulating what ACT is and how it is going to be developed in your mental health service system. For training materials that you can use to help stakeholders develop a basic understanding of ACT, see *Using Multimedia to Introduce Your EBPs* in this KIT. For additional information about advisory groups, go to www.nami.org.

With a vision firmly in place, the process of unfolding ACT programs across the service system can begin. Carefully planning this process will help ensure a successful outcome.

Implementing ACT programs first in pilot or demonstration sites may be useful, both in managing problems that will inevitably arise and in giving constituents the opportunity to see that ACT works. Multiple pilot sites are preferable to just one. When only one site is used, idiosyncratic things can happen that misrepresent the model.

On the other hand, when systems do a system-wide "rollout," it is difficult to adequately train all of the teams. In that case, system problems that may have been resolved easily on a smaller scale with a few teams can cause havoc.

Establish program standards

Studies of agencies that have tried to replicate ACT have found that, if agencies do not achieve outcomes comparable to those of the original program, it was often because they failed to implement all of ACT's components. Mental health authorities have the capacity to ensure that the incentives in the system will help implement ACT. Attention to aligning these incentives in a positive way is vital to successfully implementing ACT.

States have the authority to adopt regulations that govern services to consumers. These regulations set standards for the quality and adequacy of programs, including criteria that govern:

- admission and discharge,
- staffing and credentials,
- service intensity and capacity,
- program organization and communication,
- assessment and treatment planning,
- required services,
- consumer medical records, and
- consumer rights and grievance procedures.

According to two originators of the model (Deborah Allness and Bill Knoedler), the Rhode Island Division of Mental Health’s initiative represents an excellent system-wide dissemination of ACT. The originators attribute this success, in part, to the fact that Rhode Island’s mental health authority developed program standards or administrative rules that closely follow the ACT model.

For more examples of State initiatives to implement ACT, see *The Evidence* in this KIT.

Develop administrative rules for admissions

One of the early decisions that a mental health system must make is how to define the specific population that the ACT program will target. ACT studies have demonstrated positive outcomes in programs where the most common diagnoses were schizophrenia, schizoaffective disorder, and bipolar disorder or when consumers showed substantial functional impairment (Calsyn, et al., 1998; Chandler, et al., 1996; Dixon, et al., 1998; Hadley, et al., 1997).

Other studies have documented benefits for consumers with co-occurring substance abuse disorders (Drake, et al., 1998; Teague, Drake & Anderson, 1995). ACT’s effectiveness has been documented in programs with consumers from diverse ethnic backgrounds, both males and females, and from wide-ranging age groups (Bond, et al., 1991).

For this reason, admission guidelines for ACT programs should target consumers with mental illnesses that seriously impair their functioning in community living. Give priority to consumers with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), or bipolar disorder because these illnesses more often cause long-term psychiatric disability. Consumers with a primary diagnosis of a substance-use disorder or mental retardation are not considered appropriate.

Significant functional impairments include at least one of the following:

- Consistent inability to perform practical daily tasks needed to function in the community:
 - maintaining personal hygiene;
 - meeting nutritional needs;
 - caring for personal business affairs;
 - obtaining medical, legal, and housing services; and
 - recognizing and avoiding common dangers or hazards to one’s self and one’s possessions.
- Persistent or recurrent failure to perform daily living tasks, except with significant support or help from others, such as friends, family, or relatives;
- Consistent inability to be employed at a self-sustaining level or to carry out homemaker roles; and
- Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing).

Consumers with one or more of the following indicators of continuous high-services needs are also prioritized:

- High use of acute psychiatric hospitalization (e.g., two or more admissions per year) or psychiatric emergency services;
- Intractable (i.e., persistent or recurrent) severe major symptoms (e.g., affective, psychotic, suicidal);
- Coexisting substance-use disorder of significant duration (e.g., greater than 6 months);
- High risk or a recent history of being involved in the criminal justice system;
- in substandard housing, homeless, or at imminent risk of becoming homeless;
- Living in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live more independently if intensive services are provided; and
- Inability to participate in traditional office-based services.

Look at data on hospital use to determine what proportion of consumers in your system use the highest number of days of inpatient services. Then determine if any patterns are evident about the communities from which these consumers come. This will give you a sense of the proportion of which consumers are most likely to benefit from ACT, what your system currently spends on hospitalization, and which communities might most benefit from having an ACT program.

To the extent that information is available, you also want to find out how many consumers in jails and homeless shelters are likely to be eligible for this service. Understand the current collateral costs associated with those services.

Develop administrative rules for discharge

Often administrators ask whether consumers who receive ACT services can eventually be transferred to less intensive services. Two studies shed light on this issue.

The first study found that, when consumers were transferred to standard care after 1 year of ACT, they experienced substantial setbacks (Stein & Test, 1980). **The lesson: Discontinuing ACT at an arbitrary point in time does not work.**

In the second study, team members from an ACT program and a step-down program met and made case-by-case decisions about which consumers were appropriate for less intensive services (Salyers, et al., 1998). On average, the consumers selected for the step-down program had received ACT services for about 6 years. They tended to be consumers who:

- Had an affective disorder rather than schizophrenia,
- did not have a substance abuse problem,
- had not been hospitalized in over a year living in stable housing,
- received only one contact from the team per month, and
- were rated by team members as functioning independently.

Some consumers transferred back to the ACT program; however, many continued to function well and avoid psychiatric hospitalization.

This success was attributed to the fact that:

- The decision to transfer consumers was made on case-by-case basis, carefully considering individual clinical needs.
- Continuity of care was ensured before and after transfer.
- The transfer was gradual with overlapping services.
- Consumers could readily transfer back to the ACT program when needed.

These findings suggest that **some consumers, selected on the basis of clinical need, can be transferred to less intensive services without deleterious effects.** However, mental health systems that consider step-down programs should recognize that in any given year the proportion of consumers who might be appropriate for transfer using the flexible standards applied in the Salyers study is likely to be small.

Program standards in *A Manual for ACT Start-Up* (Allness & Knoedler, 2003) suggest that consumers' ability to function independently in all major roles (e.g., work, social, and self-care) for 2 years should be an element of discharge criteria for ACT programs.

Another important distinguishing characteristic of ACT is that no preset limit exists on the length of time that consumers can receive ACT services. The consumers targeted by ACT programs initially have very intensive needs. Even when symptoms subside, they remain prone to relapse.

Rather than discontinuing services at some arbitrary point or discharging consumers the first time they experience a period of progress, ACT teams decrease the intensity of services but maintain enough contact so that, if circumstances change, they can step in quickly to keep the situation from worsening and can prevent minor problems from snowballing into crises.

Devise administrative rules for staffing

We encourage mental health authorities to develop administrative rules to support the staffing requirements under the ACT model. ACT teams are composed of members of the various professions and disciplines. Achieving the right mix and number of professionals on ACT teams is essential to ensure that they will be able to serve as the primary provider of comprehensive services.

The intense nature of ACT programs and the types of consumers targeted make it necessary for programs to use qualified and competent team members. Most team members should have at least a master's degree.

It is also important that ACT teams reflect the cultural diversity of the communities in which they operate.

Typically, two team members are assigned leadership responsibilities to support the ACT leader—the lead mental health professional and the lead registered nurse. The lead mental health professional helps supervise comprehensive assessment, treatment planning, and delivering services. The lead registered nurse serves as the lead nurse in medication, pharmacy, and other medical-service activities. The many functions of self-contained teams require that other team members, however, assume lead responsibilities.

Include consumers and family members as ACT team members

Including consumers as team members has been codified in the ACT Fidelity Scale. On some ACT teams, consumers hold a position called *peer specialist*. In some cases, peer specialists may be unable to generate revenue for their services; you must plan support for these positions.

In addition to hiring consumers to fill peer specialist positions, we also suggest that consumers fill any position on the team for which they are qualified with accommodations, consistent with the Americans with Disabilities Act, if needed.



More recently, the contribution of family members to ACT teams has also received recognition (Dixon et al., 1998). Although including family members on ACT teams is not on the ACT Fidelity Scale, we

Who is on a typical ACT team?

ACT teams with 10 to 12 staff members might include:

- **ACT leader** — One full-time employed mental health professional who provides direct services at least 50% of the time
- **Psychiatrist**—at least one full-time employee per 100 consumers
- **Psychiatric nurses** — at least two full-time nurses per 100 consumers (You may find that you need more nurses to cover all shifts.)
- **Employment specialists** — at least two full-time specialists who have 1 year of specialized training or supervised experience
- **Substance abuse specialists** — at least two full-time specialists with 1 year of specialized substance abuse training or supervised experience
- **Mental health consumer** — these people sometimes fill a position called peer specialist
- **Program assistant** — person with an Associate or Bachelors degree who works with the ACT leader to provide office management and to triage situations that emerge throughout the day
- **Additional mental health professionals** — people with Master’s or doctoral degrees in social work, nursing, rehabilitation counseling, psychology, or occupational therapy

Create administrative rules for operations

Having ACT team members available 24 hours a day, 7 days a week, 365 days a year is very important in helping consumers live safely and successfully in the community. When teams do not provide evening, weekend, or holiday staff coverage, problems that might be addressed by pre-emptive interventions often become crises and consumers are more likely to be hospitalized or entangled in the criminal justice system.

ACT team hours of operation are:

Monday–Friday:

Two shifts per day
(e.g., 8 am-4:30 pm, 1 pm-10 pm)

Saturday–Sunday:

8-hour shift each day
(e.g., 10 am-6 pm)

Holidays:

8-hour shift
(e.g., 10 am-6 pm)

A team member is on call during all other hours.

Most ACT team members work the weekday shifts because most of the work must be done during these hours. At least two team members work evenings, weekends, and holidays and focus primarily on consumers in crises (or intensive interventions to prevent crises), and consumers who need help 7 days a week.

If you are interested in developing administrative rules to define these and other minimum program requirements to support ACT implementation, review the model program standards in *A Manual for ACT Start-Up* (Allness & Knoedler, 2003). You may also want to contact other mental health systems that provide ACT to look at their administrative rules.

Achieve high-fidelity ACT

Programs that adhere more closely to the ACT model are more effective. To ensure that your community receives the full benefit of this model:

Step 1 Set up State and local advisory groups made up of key stakeholders

Step 2 Designate a clinical coordinator at the State or county mental health office who has experience with the ACT model to provide side-by-side assistance to new teams.

Step 3 Assess programs' fidelity to the ACT model regularly using the tools in *Evaluating Your Program* in this KIT.

Step 4 Include program standards in State plans and contracts. Make adherence to those standards part of a certification process.

Achieving the outcomes associated with ACT depends on how faithfully agencies adhere to the model. Too many excellent initiatives had positive beginnings and enthusiastic support but floundered at the end of a year because they did not plan how they would maintain the ACT program.

As a central part of the initial planning process, you must address how ACT programs will be sustained. You can use strategies (e.g., rules, contracts) to address this issue and ensure that it is attended to in such a way that ACT programs will continue to grow and develop.

The ACT Fidelity Scale measures how well programs follow key elements of the ACT model. Adhering to the model is called *ACT fidelity*. Studies of ACT programs tell us that the higher an agency scores on the ACT Fidelity Scale, the greater the likelihood that the agency will achieve the favorable outcomes described above (Bond & Salyers, 2004; Teague et al., 1998).

Simply put, **providing ACT involves substantially reorganizing resources**. The best way to protect your investment is to make certain that agencies actually provide ACT.

The characteristics of an ACT program that would have a perfect score on the ACT Fidelity Scale are shown on the next page. For the entire ACT Fidelity Scale, see *Evaluating Your Program* in this KIT.



Characteristics of an ACT program that would have a perfect score on the ACT Fidelity Scale

<p>Human resources, structure, team composition</p>	<ul style="list-style-type: none"> ■ Staff-to-consumer ratio: 10 or fewer consumers per team member, excluding team psychiatrist and program assistant ■ Team approach: 90% or more of consumers have contact with more than one team member per week ■ Practicing ACT leader: A full-time program supervisor (also called <i>program leader</i>) provides direct services at least 50% of the time ■ Continuity of staffing: Less than 20% turnover per year ■ Staff capacity: Program has operated at 95% or more at full staffing in the past 12 months ■ Psychiatrist on staff: A 100-consumer program has at least one full-time psychiatrist 	<ul style="list-style-type: none"> ■ Nurse on staff: A 100-consumer program has at least two full-time nurses ■ Substance-abuse specialist: A 100-consumer program has at least two full-time substance abuse specialists with at least 1-year specialized training in substance abuse treatment or 1-year supervised experience ■ Employment specialist: A 100-consumer program has at least 2 full-time employment specialists with at least 1 year specialized training or 1 year supervised experience ■ Program size: A total of at least 10 FTE staff
<p>Organizational boundaries</p>	<ul style="list-style-type: none"> ■ Explicit admission criteria: The program actively recruits a specifically defined population and all consumers meet the explicit admission criteria ■ Intake rate: The highest monthly intake rate in the previous 6 months was no more than six consumers per month ■ Full responsibility for treatment: The program provides all of the following: <ul style="list-style-type: none"> D psychiatric services, D case management, D supportive counseling and psychotherapy, D housing support, D substance abuse treatment, D employment support, and D rehabilitative services. 	<ul style="list-style-type: none"> ■ Responsibility for crisis services: Provides 24-hour coverage ■ Responsibility for hospital admissions: 95% or more of inpatient psychiatric admissions are initiated through the program ■ Responsibility for hospital discharge: 95% or more of discharges are planned jointly with the program ■ Time-unlimited services: All consumers are served on a time-unlimited basis with fewer than 5% expected to graduate annually
<p>Nature of services</p>	<ul style="list-style-type: none"> ■ In vivo services: At least 80% of total service time is spent in the community ■ No drop-out policy: 95% or more of consumers are retained over a 12-month period ■ Assertive engagement mechanisms: Program demonstrates consistently well thought out strategies, including street outreach ■ Intensity of service: Average of 2 hours per week or more per consumer ■ Frequency of contact: Average of four or more contacts per week per consumer 	<ul style="list-style-type: none"> ■ Work with support system: Each month, team members have four or more contacts in the community with members of the consumer's support network ■ Individualized substance abuse treatment: Consumers with a substance-use disorder spend 24 minutes or more per week in substance-abuse treatment ■ Dual disorders model: Program is fully based in dual disorders treatment principles with treatment provided by team ■ Role of consumers on treatment teams: Consumers are employed as practitioners with full professional status

Other issues to consider

Adapt the ACT model

We understand that for various reasons — often fiscal — mental health systems may consider varying certain elements of the ACT model. For example, a mental health system may want to reduce the overall number of team members on an ACT team or limit the hours of operation. At this point, we can no longer offer advice informed by research; administrators will have to rely on the experience of others.

Research shows that ACT teams that adhere more closely to elements of the ACT Fidelity Scale are most likely to achieve the beneficial outcomes associated with ACT. Current research is insufficient to tell us which elements can or cannot be “tweaked” under what particular circumstances without adversely affecting outcomes. Further, current research is largely silent on how differences in the quality and actual content of staff-consumer interactions influence outcomes.

As we discuss various aspects of ACT, where research is lacking, we have chosen to “default” to describing ACT as the originators of the model practiced it or rely on input from those who have experience implementing and managing ACT programs.

We recommend that you encourage agencies to obtain high-fidelity ACT and develop a system to routinely monitor fidelity and outcomes before adapting components of the ACT model. This way, ACT programs can monitor how adaptations effect the desired client outcomes.

Many consumer groups and providers have expressed concerns about the potential for coercive practices within the ACT framework. One in ten consumers felt ACT was too intrusive or coercive. While the ACT model does not advocate using coercive measures, some suggest that a fine line exists between “assertive” and coercive treatment practices.

What are coercive practices?

Often legal status and other objective measures that rely on incidences of seclusion, restraints, and forced medication are used to predict whether a consumer experiences coercion. However, coercive practices are more widespread than these objective measures. For many consumers, coercion is endemic to the experience of mental illness and mental health treatment. Stigma, confinement, monitoring, and the pressure to follow a treatment plan may lead to feelings of being coerced or controlled (Scheid, 2001).

Monahan and colleagues found that in hospital admission settings, using negative pressures, such as threats and force, tends to engender feelings of coercion while using positive pressures, such as persuasion and inducement, do not (Monahan et al., 2001). Further, consumers who believe that they have been allowed a “voice” and have been treated with respect, concern, and good faith by family and practitioners experience fewer feelings of coercion.

How coercion is harmful

Using coercive measures fails to recognize the fundamental value of consumer choice and the rights of consumers to share responsibility for their recovery. Research generally suggests that coercion elicits fear of mental health services, noncompliance, hopelessness, confusion, and sadness and, therefore, can undermine efforts towards recovery (Monahan et al., 1995; Campbell, 1997; Hiday, 1996; Penny, 1995).

Traditional services were developed with a biomedical approach to mental health treatment and, therefore, focus on reducing symptoms and preventing relapse. With ACT services, team members *partner* with consumers to define recovery goals and help them to fulfill their goals.

ACT teams must be true to the recovery principles within the ACT model. Team members should be careful not to replicate those elements of traditional services that simply emphasize medication compliance with at-home drug deliveries.

Since ACT is a 24-hour, 7-days-a-week service that is available on a continuous basis for an unlimited time, it can easily interfere with individual autonomy. For example, if a consumer of an ACT team does not show up for work, a team member would go to the consumer's home to help with problems that were interfering with the consumer's ability to work. The consumer's medical status would be carefully monitored and treated and, routinely, medication would be prescribed (Davis, 2002). Such attention does not automatically respect the consumer's wishes. Consumers may interpret these services as coercive if team members do not listen and understand their experiences and focus on their preferences.

Coercive actions employed by ACT team members can include a range of behaviors from friendly persuasion to using force (Diamond, 1996). Financial management of consumer money and steps taken to ensure treatment compliance are controlling elements in ACT services. Whether they are undertaken in a coercive or an assertive way may determine the effectiveness of these strategies.

Provide assertive, not coercive treatment

The value of consumer choice in service delivery and the importance of consumer perceptions of coercion must be infused in how ACT services are provided. Most team members have never examined their own attitudes and behaviors about consumer recovery and, therefore, uncritically accept many social control functions without paying attention to how disempowering these practices are for consumers.

In recovery-based ACT services, establishing a trusting relationship is critical. Consumer-provider interactions should be based on mutuality and respect. Providers should:

- be challenged to listen to, believe in, and understand consumers;
- take into account consumers' reasons for "noncompliance;"
- focus on consumer-defined needs and preferences; and
- accept consumer choice in service delivery.

Like any mental health practice, ACT has the choice of using negative coercion or assertive strategies that support empowerment. ACT services that are provided "assertively" mean that team members go the extra mile to support and empower consumers to achieve their individual goals.

Mental health authorities can facilitate providing non-coercive ACT services by:

- clearly explaining consumer rights in the mental health authority's administrative rules;
- encouraging agencies to incorporate recovery principles, consumer rights, and discussions about the difference between assertive and coercive treatment into team members' training;
- holding community forums using the multimedia in the KIT;
- involving consumers in State and local advisory groups; and
- encouraging the inclusion of consumers as members of ACT teams.

Develop a training structure

Team members who implement evidence-based practices (EBPs) are often stymied in their efforts because people misunderstand the model or lack information. It is important that key stakeholders (consumers, families, and other essential community members) and agency-wide staff develop a basic understanding of ACT.

We encourage you to support agency administrators in their efforts to develop a training structure for ACT implementation.

The training plan should include:

- basic training for key community stakeholders, including:
 - consumers,
 - families,
 - mental health authorities, and
 - staff from key community organizations
- basic training for staff at all levels across the agency;
- intensive training for ACT team members; and
- basic training for selected ACT team members on complementary EBPs.

See *Using Multimedia to Introduce Your EBP* for materials to support basic training. Once trained, ACT team members will be able to use these materials to conduct routine community workshops and in-service seminars.

Choose your trainer

You may design an intensive training plan for ACT team members in several different ways, but you must first decide who will conduct the training. Initial training for ACT team members may be facilitated by the ACT leader using the training tools in *Training Frontline Staff*. Some choose to hire an external trainer.

One successful strategy in training ACT teams entails having members of a new team visit an existing, well-functioning, high-fidelity team to observe how the program works and the roles of team members. Members of new teams will benefit most from this visit if they have a basic understanding of the ACT model.

Effective training is ongoing

Throughout the first year, we encourage you to offer intermittent booster training sessions and ongoing onsite and telephone consultation, particularly for ACT leaders. Along with the team psychiatrists and the lead mental health professionals, ACT leaders are mid-level managers who are responsible for running the ACT program. ACT leaders have administrative responsibilities, such as hiring, preparing administrative reports, and ensuring that policies and procedures are developed and followed. ACT leaders also provide direct services.

Perhaps more importantly, ACT leaders are responsible for ensuring that the team operates with fidelity to the ACT model, including ensuring the quality and content of staff-consumer interactions. Through day-to-day leadership, the ACT model is faithfully carried out.

Leading an ACT team requires a complex set of administrative and clinical skills. Clinically, it requires a shift in thinking about consumers and their potential, about how services are delivered, and about how colleagues work together. Leaders of new ACT programs must learn to work in a system that is structured differently from other programs with which they are familiar. They must think differently about the potential of consumers and facilitate a process where team members work very differently with one another.

It is very difficult for anyone to grasp everything that has to be learned in a brief time.

Understanding what needs to be done and translating that understanding into action are different processes. ACT leaders and psychiatrists are also responsible for making certain that all other team members understand.

Well-delineated training can help to ensure that ACT team members understand the ACT model. For at least the first year a new program is in operation, ACT leaders need someone who is experienced in managing ACT teams to provide ongoing consultation and mentorship on organizational and clinical issues. Consultation ranges from integrating ACT principles into the agency's policies and procedures to case consultation.

Consultation may also include having a lead consultant periodically involve other consultants with expertise on nursing, substance-abuse treatment, employment, or the role of peer specialists.

Some states develop teams in stages so that the first teams developed can help train teams that are developed later. It may take 2 to 3 years for a new team to become sufficiently proficient in the ACT model to assume the added responsibility of training other teams.

A state- or county-wide clinical coordinator who is experienced with the ACT model can also help facilitate developing new teams through ongoing contact, assessment, and troubleshooting.

ACT as an adjunct to criminal justice programming

ACT program staff have a long history of working with consumers who have the most difficult challenges, including those who have been arrested and incarcerated. In recent years, interest has increased in using ACT programs to divert consumers from the criminal justice system. The mental health community tends to support such efforts.

Treatment is generally preferred to incarceration so that mental illness is not criminalized and to ensure that consumers receive adequate and humane treatment. Programs, such as Community Treatment Alternatives in Madison, Wisconsin, have a history of working successfully with consumers who are involved in the criminal justice system.

However, problems arise when the boundaries between clinical staff and criminal justice personnel or probation officers become blurred. The argument has been that, when consumers view ACT team members as part of the criminal justice system working in concert with those who have the power to revoke their liberty, the therapeutic alliance is strained or at least qualitatively altered.

A study by Solomon and Draine looked at the 1-year outcomes of consumers who were released from jail to one of three programs: ACT, individual case management, and routine community mental health center services (Solomon, & Draine, 1995). Unfortunately, the authors found that the ACT program was not fully implemented in terms of staffing or treatment philosophy.

The poorly implemented ACT program resulted in a greater number of consumers being returned to jail than in the other two other service models. The authors concluded that, since the team members of this poorly implemented ACT team worked closely with consumers, they were more aware of probation violations. The connections with the criminal justice system resulted in the high number of sanctions.

This study illustrates two points:

- The study points out the importance of ensuring that ACT programs are appropriately implemented in terms of both organizational structure and the quality of clinical care.
- The study demonstrates that working closely with corrections adds a very different twist to treatment. Teams must be clear about their role as therapeutic agents.

Financing ACT

What ACT costs

Rigorous economic studies have found that when ACT teams adhere closely to the ACT model, reduced hospitalization costs offset the costs of the ACT program (Bond et al., 2001; Essock et al., 1998).

While many factors affect the cost of ACT, a **ballpark figure is \$9,000 to \$12,000 per year per person** (Linkins et al., 2002).

Budget projections

Several factors will influence the cost of ACT in your mental health system. In 2002, the Lewin Group, Inc., a health care and human services consulting firm, under a contract with SAMHSA and the Centers for Medicare and Medicaid Services (CMS), developed *A Resource Guide for State Officials Implementing and Financing Assertive Community Treatment Programs*. A companion tool was created for this guide in the form of an Excel-based program that can be used to project the cost of ACT given different parameters.

Parts of the ACT budget simulation model

Part 1 Average cost estimates are produced for an ACT program using a set of core elements:

- State where program will be implemented
- number and type of consumers
- staff-to-consumer ratio
- percentage of community-based (in vivo) care

Part 2 A set of parameters that alter the core's average cost estimates.

Based on knowledge gained from an advisory panel and the process evaluation of seven ACT programs, the model adjusts the average cost depending on:

- urban vs. rural program
- program size
- age of the program
- level of benefit management and use of managed care contractor to

As an example of why the model adjusts the average costs, consider when ACT teams see consumers in the community and also provide transportation for them. In rural areas, team members may cover substantial distances. To make certain that adequate resources are allocated to transportation, you may want to confer with administrators of other systems when they project costs.

ACT programs must decide whether it is more economical to buy or lease vehicles for team members or whether team members should use their own vehicles and be reimbursed for mileage and additional liability coverage. Typically, team members prefer using program cars because using their own cars, even with reimbursement, greatly increases mileage on their cars and adds to wear and tear. Programs often underestimate the number of cars needed, mileage costs, and costs for additional insurance for personal vehicles.

For more information on Lewin’s ACT budget simulation model, contact:

The Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042
(703) 269-5500
www.lewin.com

The Human Services Research Institute (HSRI) has also developed a computer simulation model. In this model:

- consumers are categorized according to their functional levels and service needs,
- service package options and their costs are identified for each consumer group, and
- the effects of service packages on outcomes are estimated in terms of functional level improvement.

The model can then estimate a variety of aspects of system operations, including service use (e.g., hospital beds, residential beds, ACT teams), costs, outcomes, and revenue generation over any time period.

For more information and technical support for using this model contact:

Human Services Research Institute (HSRI)
2336 Massachusetts Avenue
Cambridge, MA 02140
(617) 876-0426

<http://modeling.hsri.org>

How ACT is funded

ACT is a Medicaid-reimbursable service; however, it may require an amendment to the State plan. Service system administrators will want to work closely with your State’s Medicaid authority to develop the appropriate financial constructs for ACT.

Revenue sources

In considering potential funding sources for ACT, mental health system administrators must decide whether:

- their localities will be expected to pay a share of the costs,
- Medicaid will be used, or
- other outside funds, such as grants or money from other State or local agencies (e.g., vocational rehabilitation, substance abuse) will be used.

Using State funds might encompass giving State aid to localities, redeploying existing State staff, and using shared State staff as an adjunct to a locally operated ACT team. For example, the Connecticut Department of Mental Health created ACT teams by reconfiguring community staff and reallocating staff employed by the State hospital (Essock, & Kontos, 1995).

Medicaid has become an increasingly appealing option for funding ACT since 1999 when CMS advised State Medicaid directors that programs based on ACT principles can be supported under Medicaid policy. CMS also advised States that they should consider the recommendations of the Schizophrenia Patient Outcomes Research Team (PORT) in developing comprehensive approaches to community-based mental health systems.

This advisement not only makes it clear that CMS supports EBPs, but it strongly encourages States to adopt the principles of ACT, including:

- interdisciplinary treatment teams,
- shared caseloads,
- 24-hour crisis availability,
- individualized treatment inpatients' environments, and
- rehabilitative and supportive services.

Some States (for example, New York) have developed a case payment method for Medicaid-funded programs that enables providers to bundle ACT services under a monthly bill structure. This practice allows programs to provide a broad range of services without having the burden of fee-for-service billing.

Mental health system administrators must work with their Medicaid counterpart to establish the financial constructs to support ACT.

What about capitation?

Chandler and colleagues reported the findings from a study that examined the cost-effectiveness of an ACT program operated with capitated payments in Alameda County, California (Chandler et al., 1999).

The basic capitation rate per person per year was \$26,000, with Alameda County and the managed care company sharing the risk for inpatient and emergency room costs. Inpatient and emergency costs up to \$60,000 aggregate were paid for by the county, and the provider assumed the next \$60,000; over that amount, the county again was responsible.

Medication costs were billed separately to the State through fee-for-service Medicaid. Start-up costs were offset by savings from being able to discharge program participants earlier from the sub-acute facilities from which they were selected.

Costs for consumers referred into the ACT program were compared to costs for a similar group of consumers receiving routine care. During the first year of capitation, the gross per person cost for consumers receiving ACT was 25% less than for the comparison group.

The net cost to the county (considering that 100% of facility expenses, but only part of the expense for the Medicaid-reimbursable community-based services, had been borne by the county) was 75% less for the ACT program.

For more information, we encourage you to take advantage of two other resources:

Assertive Community Treatment Association
810 East Grand River Avenue, Suite 102
Brighton, MI 48116
(810) 227-1859
www.actassociation.com

National Alliance on Mental Illness
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-304
(800) 950-NAMI
www.nami.org

Through these organizations, you can find people who can speak from experience about the implications of different choices you might consider.

Building Your Program

Tips for Agency Administrators and ACT Leaders

Whether your agency is interested in enhancing an existing program or developing a program anew, you will need a broad range of activities to successfully implement ACT. This section outlines the range of implementation activities in which agency administrators and ACT leaders are often involved.

Recruit team members for your ACT program

ACT teams are different from other programs that may operate in your agency. The consumers who are eligible for ACT are those who have the most serious psychiatric symptoms and who, consequently, have the most severe problems with social functioning.

Typically, ACT programs serve consumers who:

- have extensive histories of psychiatric hospitalization,
- are homeless,
- have co-occurring substance abuse or medical problems, and
- are involved in the criminal justice system.



They are also consumers whose needs have not traditionally been well met by the mental health system. (See *Develop policies and procedures, Admissions and discharge* in this section.)

ACT programs can help consumers with these challenging needs to live safely and autonomously in the community because members on ACT teams assume responsibility for providing all the services consumers might need. These services might include helping consumers with:

- housing,
- parenting,
- benefits,
- symptom management,
- medical care,
- substance abuse treatment, and
- employment.

Rather than referring consumers to other programs, the team provides them. To do this, practitioners with a variety of skills and experiences compose the ACT team. They carefully integrate interventions and provide support as necessary.

To ensure that services are comprehensive, you must achieve an appropriate mix and number of team members on your ACT team. Your ACT team must be small enough to communicate easily. Each team member must be able to become familiar enough with consumers' status that they can step in to provide care at any time.

To have a sufficient range of expertise on the team and enough team members to provide adequate coverage (See *Providing adequate coverage* in this section.), we suggest that you have a team of 10 to 12 FTE positions with a total caseload of 100 persons. (See *Monitor staff-to-consumer ratio.*)

Who is on a typical ACT team?

- an ACT leader—1 full-time employed mental health professional;
- 1 psychiatrist;
- 2 or more nurses;
- 2 or more employment specialists;
- 2 or more substance abuse treatment specialists;
- 1 full-time consumer/peer specialist;
- mental health professionals and paraprofessionals (master-level social workers, occupational therapists, rehabilitation counselors, psychologists); and
- 1 program assistant.

Choosing an ACT leader

It is important to hire or designate a leader for your ACT program. Successful ACT leaders have administrative and clinical skills and authority.

Their administrative responsibilities include:

- hiring team members,
- training team members,
- managing the team,
- monitoring the program's faithfulness to the ACT model, and
- overseeing various other quality control and financial responsibilities.

ACT leaders' clinical responsibilities include:

- monitoring consumers' status,
- delivering direct services to consumers,
- supervising the clinical performance of team members, and
- providing feedback to team members.

ACT leaders are often mid-level managers who have the authority to make or suggest administrative changes within the agency. We suggest that ACT leaders be full-time employees whose time is 100% dedicated to the ACT program and who commonly provide direct services at least 50% of the time. ACT leaders should have at least a master's degree in nursing, social work, psychiatric rehabilitation, or psychology.

We encourage you to make the KIT available to candidates during the hiring process so they will understand what they must do. As an ACT leader, they must have an active role in setting up the structures and processes needed to support the ACT team.

Because building an effective, well-functioning team is very much a developmental process, we encourage you and the ACT leader to revisit the information in the KIT periodically throughout the first year of the new program. We believe that these materials will take on new meaning as the process of implementing an ACT team evolves.

Choosing a psychiatrist

Psychiatrists play several important roles on ACT teams. Psychiatrists:

- share responsibility for monitoring consumers' clinical status,
- deliver clinical services,
- provide clinical leadership, and
- share responsibility with ACT leaders for ensuring that quality ACT services are provided.

We suggest that you recruit or designate at least one full-time psychiatrist for every 100 consumers in your ACT program.

Selecting other team members

In addition to the ACT leader and psychiatrist, ACT teams have:

- **Psychiatric nurses** — at least 2 FTE per 100 consumers — who carry out medical functioning, including:
 - basic health and medical assessment and education;
 - coordination of health care provided to consumers in the community;
 - psychiatric medical assessment, treatment, and education; and
 - psychotropic medication administration.
- **Employment specialists** — at least 2 FTE with 1 year's specialized training or supervised experience. Employment specialists provide work-related services, including assessing the effect of consumers' mental illness on employment, and planning and implementing an ongoing employment strategy to enable consumers to get and keep jobs.
- **Substance abuse specialist** — at least 2 FTE with 1 year's specialized substance abuse training or supervised experience. Substance abuse specialists provide and coordinate substance abuse assessment, treatment planning, and services delivery tailored to consumers' needs.
- **Peer specialist** — a person with serious mental illness who functions as a fully integrated team member and who:
 - shares personal, practical experience to benefit the team and its consumers;
 - provides expertise about symptom management and the recovery process;
 - promotes a team culture that maximizes consumer choice and self-determination;
 - provides peer counseling to ACT consumers and families; and
 - carries out other rehabilitation and support functions.

- **Mental health professionals** — people with master’s or doctoral degrees in social work, nursing, rehabilitation counseling, psychology, or occupational therapy. Mental health professionals:
 - D provide case management;
 - D teach illness management and recovery skills; and
 - D develop, direct, and provide other treatment and support services.

- **Program assistant** — This team member organizes, coordinates, and monitors all clinical operations of the team, including:
 - D managing medical records;
 - D operating and coordinating the management information system;
 - D maintaining accounting and budget records for consumer and program expenditure; and
 - D triaging and coordinating communication between the team and consumers.

Requirements for ACT team members

- Be interested in working in the community.
- Be pragmatic and “street smart.”
- Be willing to work non-traditional hours.
- Be willing to work both independently and collaboratively as a team.
- Have strong clinical and rehabilitative skills.
- Have specific knowledge of mental illness.
- Be willing and able to actively involve consumers in making decisions about their own treatment and services

Reflect your community’s cultural diversity

Teams should reflect the cultural diversity of the communities in which they operate. Because team members work with consumers in communities rather than in clinic or hospital settings, they are actively involved in the lives of the consumers they serve. In this context, it is more important that teams are aware of and sensitive to cultural differences and consumer preferences.

Teams that reflect the cultural diversity of the communities in which they operate should include bilingual team members as needed. Your team must also have resources available to allow it to work with consumers who have hearing and visual impairments.

Consider these hiring tips

The ability to hire and retain team members has been linked to salary level. If salaries are not similar to the typical rates for each discipline in other health settings in your community, attracting and retaining qualified candidates will be very difficult.

We also recommend that you thoroughly check references for job candidates. The best predictor of work performance is likely to be the candidate’s performance in previous jobs, particularly jobs that required some of the same skills and personal qualities that are desirable for ACT team members.

The ACT leader should talk to previous supervisors, inquire in detail about candidates’ previous work responsibilities and performance, and ask for opinions about their capabilities in team-based work with consumers. If candidates have had little experience in the mental health field or have just finished school, you can gather valuable information from field supervisors, training mentors, and teachers.

You should invite all candidates who are being seriously considered for employment to spend half a day or more with your team so that they can see the team at work. Candidates can then better evaluate how well they might fit in and can make a more informed decision about taking the job.

This visit will also give ACT team members a chance to talk with and observe candidates. Ask them to offer their feedback during the hiring process. This type of screening may help you weed out people who may be too authoritarian or patronizing to be appropriate for an ACT program.

Develop policies and procedures

Starting a new team means developing policies and procedures that fit the activities of the ACT model. These policies and procedures should be consistent with Medicaid and Joint Commission on Accreditation of Healthcare Organization standards. For model policies and procedures, see *A Manual for ACT Start-Up* (Allness & Knoedler, 2003).

Admission and discharge

You must set up a process to identify consumers who are appropriate for your program and acquaint referral sources with referral procedures. ACT studies have demonstrated positive outcomes in programs where the most common diagnoses were schizophrenia, schizoaffective disorder, and bipolar disorder and consumers showed substantial functional impairment (Calsyn et al., 1998; Chandler et al., 1996; Dixon et al., 1998; Hadley et al., 1997). Other studies have documented benefits for consumers with co-occurring substance abuse disorders (Drake et al., 1998; Teague et al., 1995).

The effectiveness of ACT has been documented in programs with consumers from diverse ethnic backgrounds, males and females, and a wide range of age groups (Bond et al., 1991).

For this reason, admission guidelines for ACT programs should target consumers who experience the most severe symptoms and, consequently, have chronic problems functioning in basic adult roles in the community. Some ACT programs focus on very specific groups of consumers, such as those with coexisting substance abuse disorders, those who are homeless, or those who have been repeatedly hospitalized.

What policies and procedures should cover

- admission and discharge (e.g., admission criteria, admission process, discharge criteria, discharge documentation);
- personnel issues (e.g., staff-to-consumer ratios, job descriptions);
- hours of operation, coverage, and service intensity;
- communicating with staff, emphasized by the team approach and recovery;
- administering medications and delivering services;
- planning assessment and treatment;
- managing consumer service funds;
- maintaining consumer records;
- ensuring consumers' rights; and
- evaluating program and staff performance.

There has been increasing interest in using ACT as a jail diversion program or with consumers who are involved in other ways with the criminal justice system. When working with the criminal justice system, conflicts may arise between ethical responsibilities to consumers and obligations to report consumers' behaviors to criminal justice entities. It is particularly important that programs working with criminal justice populations establish clear boundaries between their clinical role and their commitment to criminal justice agencies (Solomon & Draine, 1995).

The ACT leader must put these criteria into operation and identify and educate referral sources about the ACT program. You also need a process for explaining your ACT program to consumers in a way that lets them make an informed decision about accepting services.

The number of new consumers admitted to the program is deliberately restricted to five to six per month. This allows new teams time to become thoroughly acclimated to new processes without being overwhelmed by trying to serve a large number of consumers with multiple, complex needs all at once.

Schedule an admission meeting

When your team receives a referral, the ACT leader should confirm that the person meets the program's admission criteria. Arrange a meeting that includes:

- the current provider (e.g., crisis services, inpatient unit, etc.);
- the ACT leader;
- the consumer;
- family members or significant others of the consumer's choice,
- team members who will be consistently working with the new consumer; and
- the team psychiatrist.

At the admission meeting, have team members introduce themselves and explain the ACT program. If the consumer is acutely ill, it may take several contacts before you feel comfortable that the person understands the services that are being offered.

Sometimes consumers want to think about whether they want to receive services. In these instances, you may conduct a follow-up meeting. During these meetings, consumers learn about the program, but team members also learn about consumers' immediate history and current needs. They also get to know family members and other supporters.

When consumers decide that they wish to receive ACT services, your team should immediately open a record and schedule initial service contacts for the next few days.

One of the premises of ACT is that the program is there for consumers "for life." Working with a consumer across time is really a luxury and a privilege. Because you have time, there is less pressure for a quick fix and you can forge an alliance that respects the person and their individual needs and preferences.

Barbara Julius, Outreach Program, South Carolina

Monitor the staff-to-consumer ratio

Generally, ACT teams should plan on having a staff-to-consumer ratio of no more than 10 consumers per team member, not including the program assistant and psychiatrist. Keep in mind that, although we talk of a staff-to-consumer ratio, this is simply for planning purposes. In practice, team members do not have individual caseloads; instead, the team as a whole is responsible for all consumers in the team’s caseload.

To figure your program capacity:

Total number of team members = 10-12 FTE

Average number of consumers per team member = 10:1

	12	FTE
X	10	consumers per team members
	120	maximum program capacity

This staff-to-consumer ratio is small enough to ensure that all team members know all consumers and that good communication is maintained. No matter how well a team is organized or how competent team members may be, the team cannot maintain effective communication if its caseload is too large.

If you exceed the maximum number of consumers, work effectiveness breaks down and the team will react to crises (or the imminent threat of crises) rather than help consumers take proactive steps toward recovery.

If your ACT team serves a large number of consumers with acute needs, you may find that you need a smaller caseload until consumers stabilize. The total caseload for which your team can provide intensive services and maintain the intimate communication needed to ensure quality care will be affected in part by the needs of the consumers you are serving.

That is, if your team serves consumers who have received services for several years, have relatively few crises, and require less frequent contact, you may be able to handle slightly more consumers per team member.

If most of the consumers that your team works with require frequent contacts, you may find that the staff-to-consumer ratio (and consequently the total case size) may need to be smaller. The same is true if consumers’ living conditions are chaotic, housing is hard to secure, and daily living is very stressful, or if most of the consumers have co-occurring substance abuse issues or complicated medical needs.

You may recoup the cost of this more intensive staff by decreasing the use of more expensive inpatient services because ACT team members share many roles and strive to function interchangeably.

Create useful job descriptions

You should develop task-specific descriptions for each team position. A good description clarifies for job applicants whether a particular position matches their skills and expectations. In the position description, outline the main task categories and detail specific duties. For model position descriptions, see *A Manual for ACT Start-Up* (Allness & Knoedler, 2003).

After hiring, job descriptions allow ACT leaders to effectively supervise new employees. They also allow employees to focus on the basic elements of their job.

Hours of operation and service intensity

Having team members available 24-hours a day, 7- days a week, 365-days a year is very important in helping ACT consumers live safely and successfully in the community. When a team does not provide any evening, weekend, or holiday staff coverage,

problems that might be addressed by pre-emptive interventions often become crises and consumers are more likely to be hospitalized or entangled in the criminal justice system.

To ensure adequate coverage, your ACT leader should set a policy about how many team members can be on vacation at a time; ideally this will be no more than one team member at a time. All hours that ACT team members are not on duty, a team member must be on call to respond to crises.

ACT team hours of operation are:

Monday–Friday:

2 shifts per day

(e.g., 8 am-4:30 pm, 1 pm-10 pm)

Saturday–Sunday:

8-hour shift each day

(e.g., 10 am-6 pm)

Holidays:

8-hour shift

(e.g., 10 am-6 pm)

A team member is on call during all other hours.

Since most work for ACT teams is done during traditional business hours, most staff will work regular weekday shifts. When possible, have your team members rotate shifts for evening, weekend, holiday, and on-call duty to ensure that all team members regularly participate in daily team meetings.

Rotating team members may not be possible if some members of your ACT team are not trained to handle crises. Since assistance provided during evening, weekend, and holiday hours primarily focuses on consumers in crises (or intensive interventions to prevent crises), it is optimal to have a registered nurse on these shifts.

Paraprofessional mental health workers should work these hours only when you pair them with more highly trained team members. If your team serves non-English speaking consumers, you should plan how each shift will have access to team members who speak the appropriate languages.

If the total number of consumers is too small to justify having a 10-person team (for instance, in some rural areas), you will not have enough staff to cover all evening, weekend, and holiday shifts. If your team is in a rural area, you may have to coordinate with the on-call service of the larger mental health system.

Communicating with team members — the team approach and recovery

An ACT team is not a consortium of specialists or a group of individual case managers. Rather, it is an integrated, self-contained treatment program in which team members work together collaboratively. While certain team members will work more often with some consumers than with others, all team members should be familiar with each consumer and should be available when needed.

As a whole, the team is responsible for providing whatever is needed to assist consumers in their recovery from mental illness. This shared-caseload approach is an important component of ACT and is a characteristic that distinguishes it from other community-based programs.

It's tricky to move people away from "owning" consumers. One thing that helps is to repeatedly articulate the differences in people's skills and how those skills can be combined to better serve the consumers.

Michael Neale, Ph.D., Veterans Administration

Skills to help build effective teams

Contributing

Contributing team members pay attention to discrete pieces of information and, in thoughtful ways, notice patterns that emerge overtime concerning consumers, the team, or the community. For example, a contributing team member may notice a consumer's early warning sign of relapse. By sharing this information with the team, you can help the consumer avoid a crisis.

Representing

For an ACT team to be successful, team members must remember that their individual actions are connected to the actions of others. It is important for each team member to update other members about all their interactions with consumers.

Subordinating

ACT team members value the decisions and actions that the team agrees on more than their own individual decisions and actions. Effective team members always interrelate their actions with the actions of other team members.

Learning to trust

Successful ACT team members cooperate rather than compete with one another. They are able to cooperate well because they trust the team process. They trust that members of the team will complete their tasks successfully either by themselves or by involving others who have the appropriate expertise.

An atmosphere of trust is facilitated when team members listen, avoid premature judgments, respect differences rather than unrestricted candor, share more than the minimal amount of information required by each person to do the job, and think of the team goals rather than their own goals.

Daily team schedule and team meeting

The daily team schedule and daily team meeting facilitate the team approach. Initially, the ACT leader is very involved in preparing the daily schedule. Once you establish a routine, assign team members as daily shift managers to organize and schedule that day's activities, make assignments for work that wasn't planned, and ensure follow-through on work that couldn't be carried out as planned.

Have the shift manager:

- coordinate and write the daily team schedule during the daily team meeting,
- supervise and monitor the daily team schedule throughout the day to ensure that all daily assignments are completed or rescheduled, and
- shift the daily team schedule or reassign work activities to accommodate emergency and other urgent situations that arise.

Daily team meetings give you opportunities to exchange information. Each day, update the team on the results of the previous day's contacts with consumers. Then jointly plan the activities for the current day. If some team members are not working effectively with a consumer, have the team problem solve and agree on what steps to take so that you consistently offer service across the whole team.

The daily meeting is a key factor in team cohesion. The team needs to renew itself and reassert its cohesiveness, which is what a morning meeting is doing. It grounds you and refocuses you.

Michael Neale, Ph.D., Veterans Administration

Throughout the day, ACT team members move in and out of the office. When team members connect with one another, they share information from many viewpoints and develop a common understanding of consumers' strengths, weaknesses, and goals. When you understand consumers' goals in a new way, you open new possibilities for the team to respond and for better consumer outcomes.

All team activities relate to one another and, at the same time, are directed toward helping consumers reach their recovery goals. Nobody works at cross-purposes — the team should operate as a single unit of expertise, with ACT team members being accountable to one another.

ACT leaders may help team members work together as a team by making sure that team members' expertise is diverse. You should recruit team members with expertise in specific areas but who also deeply understand how their expertise relates to the expertise of other team members. Effective ACT leaders have the ability to combine the insights of different team members (who represent different areas of expertise) in ways that produce a new understanding of a complex situation.

You can also increase team cohesion by encouraging informal leadership. As the number of informal leaders on a team increases, team members' ownership of the team process increases as well.

Once your ACT team is up and running, it is by no means a finished work! To be effective the ACT team must be alive—it must adapt and be flexible, intelligent, reflective, renewing, resilient, and constantly learning.

The ACT team is a living system with an identity that shapes what it sees and does. It is nourished by an abundance of information and lives and learns within a web of relationships.

Administering medications

Work closely with your team's psychiatrist and nurses to setup procedures that ensure medications are being used wisely. Procedures should also guide other team members who participate in non- medical aspects of the system, such as delivering medication and assessing consumers' responses to medications.

Procedures should include guidelines for:

- recording medication orders,
- filling orders,
- procuring medications,
- storing medications,
- coordinating with medical providers,
- educating consumers about their medication,
- ensuring that necessary lab work is done in a timely manner, and
- keeping team members informed of changes in medication and medication side effects.

As you think about medications, keep in mind that unit dosing of each medication may be preferable to undivided bottling or packaging. If an undivided supply is sent, a nurse must take the time to separate the medication into the unit doses, which can be very time consuming, especially when the nursing team has to package unit doses for a large number of consumers.

Also, in systems with fee-for-service reimbursement structures, this chore may not be billable. If you can't avoid undivided packaging, consider having nurses prepare medications for several days at once.

Some consumers cannot afford some or all of the medications they need. The team should budget money to purchase medications for consumers in these instances (see budgeting below) and aggressively solicit the indigent consumer programs of pharmaceutical companies. The psychiatrist and nurses can also work with the representatives of these companies to obtain medication samples. Collectively, these measures can adequately cover many indigent consumers.

Rules of medication administration and distribution may vary from State to State. Make sure you are familiar with the rules for your State. Consider also speaking to a consultant pharmacist to find out if she or he can devise a streamlined system for ordering, dispensing, and storing medications.

Consultant pharmacists can:

- provide upfront and ongoing education to team members on appropriately using medication,
- resolve billing problems, and
- manage quality assurance processes.

To find out more about how a consultant pharmacist may help you, contact:

American Society of Consultant Pharmacists
1321 Duke Street
Alexandria, VA 22314
www.ascp.com
703-739-1300

Delivering services

In addition to the daily team schedule (discussed before), ACT teams use two tools to organize the way they deliver services:

- the *Weekly Consumer Schedule* and
- the *Daily Communication Log*.

The *Weekly Consumer Schedule* includes the specifics (i.e., what will be done when, by whom, where, how often) about the services and interventions outlined in the treatment plan. The Individual Treatment Team (ITT) should record this information and update it whenever it changes. Write the *Weekly Consumer Schedule* in pencil on 5"x8" index cards so that changes can be easily made and keep these cards in a central file in the team meeting room.

Then, to make sure that consumers receive the planned interventions and services, have the designated shift manager for the day review each consumer's weekly schedule. Write the activities scheduled for that day on the daily team schedule. If needed, adjust it during the daily team meeting to ensure that all the work that needs to be done to carry out consumers' treatment plans occurs. This may require some minor adjustments in the schedule. For instance, if a consumer's primary case manager is scheduled to take the person grocery shopping but another consumer with whom that case manager works is victimized overnight, your team may decide that the case manager must see the consumer who was victimized. In that case, have another team member take care of the trip to the grocery store.

The *Daily Communication Log* is a three-ring binder that has an index tab for each consumer, followed by several sheets of notebook paper. During the daily meeting, the team member who is responsible for the *Daily Communication Log* states the first consumer's name. Anyone who has had contact with that person in the last 24 hours briefly describes the purpose of that contact and what happened. The person with the *Communication Log* writes a brief statement in the log.

Any team member can pick up the log and quickly have up-to-the-minute information on the consumer's current situation without having to track down charts. This is a particularly important resource for those who cover the evening shift.

The most important thing a new team leader needs to understand are the tools of ACT... timelines, comprehensive assessments, treatment plans, daily/weekly schedules, the communication log and the daily team meeting...

Once you have these tools in place and you're using them the way they're supposed to be used, you become very efficient and you can do more than you ever thought possible.

Dawn Petersen, MS, Gulf Coast Treatment Center

At times, despite everyone's best efforts, inpatient psychiatric hospitalization will be necessary. Hospitalization typically occurs in collaboration with consumers. When this happens, the goal is for the team to make the transition from outpatient to inpatient status and back again as smooth as possible, keeping resources, such as housing, in place and coordinating discharge plans to keep the stay as brief as possible.

Planning assessment

Many consumers have a long history of receiving services. The assessment process is a way of piecing together consumers' history in a way that allows the team to get a clear picture of each person's experience with mental illness and previous treatments.

The initial assessment addresses consumers' most urgent needs.

What the initial assessment documents

- reason for admission;
- consumer's psychiatric history, including onset, course, effects of illness, past treatment, status, and diagnosis;
- physical health;
- use of alcohol or drugs;
- education and employment;
- social development and functioning;
- activities of daily living; and
- family structure and relationship.

After you gather and organize this information, bring it together and present it at a treatment planning meeting. Based on this assessment, you can formulate an initial, problem-oriented treatment plan.

As your team begins to address these needs, you will conduct a more thorough assessment. The team approach helps bring together the expertise of different professionals in understanding consumers' histories and needs.

Unlike traditional office-based assessment procedures, ACT team members conduct comprehensive assessments as they work with consumers in the community delivering the services outlined in the initial treatment plan.

This approach has the advantage of allowing team members to actually observe how consumers manage in the community and what the consumers' environment is like.

When you do an assessment, you need to ask yourself if you're assessing the person from where they're at, or are you saying, "This is how we operate."

An in-depth, comprehensive assessment that looks at each person in context and considers his or her preferences and goals is an important part of ACT.

Michael Neale, Ph.D., Veterans Administration

The purpose of the comprehensive assessment is to collect information from multiple perspectives about consumers and how their lives are affected by mental illness and then to assemble the information coherently. Under the supervision of the ACT leader, the primary case manager and other team members are responsible for obtaining the appropriate releases of information and for completing comprehensive assessments within 30 days after consumers are admitted.

Parts of a comprehensive assessment

- psychiatric history, mental status, and diagnosis;
- physical health;
- use of drugs or alcohol;
- education and employment;
- social development and functioning;
- activities of daily living; and
- family structure and relationship

Another tool that ACT team members use to organize and make sense of vast amounts of information collected during comprehensive assessments is the *Psychiatric/Social Functioning History Timeline*. Your procedures for conducting comprehensive assessments should encourage your team to use this tool. For a more detailed discussion of each of these tools, see *Training Frontline Staff*.

Planning treatment

Within 1 week after new consumers are admitted to the program, the ACT leader should designate team members who will be responsible for establishing relationships with them and for providing continuous and integrated services.

This lead group of team members is called the Individual Treatment Team (ITT). The ITT is also continuously responsible for:

- assessing consumers' status and needs,
- initiating the treatment planning process with consumers and families, and
- providing the majority of consumers' treatment and support services.

Key members of the ITT

To coordinate consumers' care across the whole team, the ITT must collectively possess a blend of treatment and rehabilitation skills. In rural areas, you may not be able to exceed three team members for each ITT, but in urban areas where large ACT teams exist, the ITT should have the following team members:

- **Primary case manager** — a mental health professional who coordinates and monitors the activities of the ITT
 - D has primary responsibility to write the treatment plan;
 - D provides individual supportive therapy and illness management education;
 - D ensures immediate revisions to the treatment plan as consumers' needs change; and
 - D advocates for consumers' rights and preferences.

The primary case manager is usually the first team member contacted when consumers are in crisis and provides the primary support to consumers' families.

- **Backup case manager** — also a mental health professional — shares tasks related to coordinating care and is responsible for performing them when the primary case manager is absent.
- **Psychiatrist** — performs duties that are regularly coordinated and collaborated with the ITT.
- **Nurse** — arranges and coordinates consumers' medical care with community medical providers. Nurses may carry out some physical assessments and treatment; however, their primary responsibilities are psychiatric, not medical.
- **Other team members** — team members selected to best match consumers' needs and interests. For instance, if a consumer has a co-occurring substance abuse disorder, one of the team's substance abuse specialists may be assigned to the consumer's ITT. If the consumer is interested in work, an employment specialist may be assigned.

One strength of ACT is that the entire ACT team, not just the ITT, participates in the assessments and treatment planning process. The collaborative process ensures that:

- treatment plans holistically address consumers' needs,
- the details with treatment plans are carried out, and
- goals and objectives are revised when new needs arise.

Treatment plans are specific to consumers

Treatment planning involves taking the information in the comprehensive assessment and *Psychiatric/Social Functioning History Timeline* and translating it into objective goals based on consumers' preferences. Treatment plans are person-specific; they are built to address each consumer's goals and the services a particular consumer needs to reach those goals. Treatment plans detail the specific interventions or services to be provided, including *who* will provide them, as well as *how long* and *where*.

Although developing treatment plans seems straightforward, new teams often struggle with developing person-specific plans that consider consumers' unique experience of mental illness and personal goals. Team members often have difficulty thinking of consumers' histories in terms of their experience of mental illness, rather than just their behavior. Some team members will have a hard time giving up the notion that they know what's best for consumers and letting consumers work on what's important to them. We highly recommend clinical consultation from experienced ACT leaders.

Although most consumers' service contacts are with members of the assigned ITT, the larger team is also involved in providing services. To coordinate treatment, the ITT continuously monitors the services consumers receive, coordinates all team members' activities, and provides information and feedback to the whole team.

The stigma of mental illness is ever present — not just in our community; not just on TV; but also in ourselves, in our fellow providers, and in the system we work in. It can be found in the way we talk about people; when we include them and when we don't.

The tendency has been to treat people who have a mental illness differently, to isolate them, and to dictate to them.

Michael Neale, Ph.D., Veterans Administration

The treatment planning meetings give the ITT opportunities to exchange information with the larger team. ACT leaders run the treatment plan meeting, which all other team members attend when possible. Depending on consumers' preferences, they may also attend.

Because so many team members work with each consumer, treatment plans require total team understanding and agreement. If some team members do not work effectively with a consumer, or if they disagree with the treatment plan, the ITT's role is to discuss the plan, problem solve, and get consensus so the whole team consistently implements service.

Managing consumer-service funds

Your program needs written policies and procedures to cover disbursing and tracking consumer-service funds. ACT budgets allocate consumer-service funds to provide direct financial grants or loans to consumers, for example, when disability benefit payments have not started, when benefit checks are delayed, or when the first check from a new job is insufficient to cover expenses.

You may use consumer-services money for:

- emergencies,
- rent,
- security deposits,
- food,
- clothing,
- recreation, and
- consumers' transportation costs.

Your policies and procedures should cover how, when, and under what circumstances team members may access these funds.

Maintaining consumer records

You must maintain records for each consumer and you must safeguard the records and their contents against loss, tampering, and unauthorized use. The records should be consistent with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Medicaid requirements.

If you are creating a new recordkeeping system, you need to buy materials to create records (e.g., binders, forms) and to store them appropriately. You also need written policies and procedures for documenting and maintaining records. Educate your team members and supervise them in the required documentation practices.

Because ACT teams serve consumers who often have many immediate needs, and because team members spend most of their time in the community, maintaining documentation and progress notes can be particularly challenging. Some teams have found that they must designate times in the team schedule to spend on documentation.

Many consumer groups and providers have expressed concerns about the potential for coercive practices within the ACT framework. One in ten consumers felt ACT was too intrusive or coercive. While the ACT model does not advocate using coercive measures, some suggest that a fine line exists between “assertive” and coercive treatment practices.

What are coercive practices?

Often legal status and other objective measures that rely on incidences of seclusion, restraints, and forced medication are used to predict whether a consumer experiences coercion. However, coercive practices are more widespread than these objective measures.

For many consumers, coercion is endemic to the experience of mental illness and mental health treatment. Stigma, confinement, monitoring, and the pressure to follow a treatment plan may lead to feelings of being coerced or controlled (Scheid, 2001).

Monahan and colleagues found that in hospital admission settings, using negative pressures, such as threats and force, tend to engender feelings of coercion while using positive pressures, such as persuasion and inducement, do not (Monahan et al., 2001). Further, consumers who believe that they have been allowed a “voice” and treated with respect, concern, and good faith by family and practitioners experience fewer feelings of coercion.

How coercion is harmful

Using coercive measures fails to recognize the fundamental value of consumer choice and the rights of consumers to share responsibility for their recovery. Research generally suggests that coercion elicits fear of mental health services, noncompliance, hopelessness, confusion, and sadness and, therefore, can undermine efforts towards recovery (Monahan et al, 1995; Campbell, 1997; Hiday, 1996; Penny, 1995).

Traditional services were developed with a biomedical approach to mental health treatment and, therefore, focus on reducing symptoms and preventing relapse. With ACT services, team members *partner* with consumers to define recovery goals and help them to fulfill their goals.

ACT teams must be true to the recovery principles within the ACT model. Team members should be careful not to replicate those elements of traditional services that simply emphasize medication compliance with at-home drug deliveries.

Since ACT is a 24-hour, 7-days-a-week service that is available on a continuous basis for an unlimited time, it can easily interfere with individual autonomy. For example, if a consumer of an ACT team does not show up for work, a team member may go to the consumer’s home to help with problems that were interfering with the consumer’s ability to work. The consumer’s medical status would be carefully monitored, treated, and routinely medication would be prescribed (Davis, 2002). Such attention does not automatically respect the consumer’s wishes. Consumers may interpret these services as coercive if team members do not listen and understand their experiences and focus on their preferences.

Coercive actions employed by ACT team members can include a range of behaviors from friendly persuasion to using force (Diamond, 1996). Financial management of consumer money and steps taken to ensure treatment compliance are controlling elements in ACT services. Whether they are undertaken in a coercive or an assertive way may determine the effectiveness of these strategies.

Providing assertive, not coercive treatment

The value of consumer choice in service delivery and the importance of consumer perceptions of coercion must be infused in how ACT services are provided. Most team members have never examined their own attitudes and behaviors about consumer recovery and, therefore, uncritically accept many social control functions without paying attention to how disempowering these practices are for consumers.

In recovery-based ACT services, establishing a trusting relationship is critical. Consumer-provider interactions should be based on mutuality and respect. Providers should:

- be challenged to listen to, believe in, and understand consumers;
- take into account consumers' reasons for "noncompliance;"
- focus on consumer-defined needs and preferences; and
- accept consumer choice in service delivery.

Like any mental health practice, ACT has the choice of using negative coercion or assertive strategies that support empowerment. ACT services that are provided "assertively" mean that team members go the extra mile to support and empower consumers to achieve their individual goals.

Administrators and program leaders can facilitate providing non-coercive ACT services by:

- clearly explaining consumer rights in ACT policies and procedures;
- offering training on recovery principles, consumer rights, and the difference between assertive and coercive treatment;
- holding community forums using the multimedia in the KIT;
- involving consumers in local advisory groups; and
- including consumers as members of ACT teams.

Evaluating program and team member performance

When properly implemented, ACT reduces the amount of time consumers spend in the hospital. When employment specialists and integrated substance-abuse treatment is a part of the program, employment rates and use of illegal substances also improve.

Evaluating the performance of your ACT program will help you provide high-quality services to consumers. We recommend developing procedures for ACT program evaluation early using the guidelines in *Evaluating Your Program* in this KIT.

Additionally, develop procedures for how you will supervise and evaluate your ACT team members. Clinical supervision is the process that will, to a large extent, determine whether the team will simply be a menagerie of mental health professionals doing what they've always done or whether they will truly change and provide services in an evidenced-based way.

We recommend that ACT leaders and psychiatrists share responsibility for clinically supervising ACT team members. The lead mental health professionals and nurses may assist with clinical supervision when ACT leaders or psychiatrists are absent.



Because 50% of ACT leaders' time is dedicated to direct services, ACT leaders will be familiar with all of the consumers that the team serves; ACT leaders will not just review "cases" that team members present.

Clinical supervision is provided in the context of the team's daily work. Daily work in an ACT team includes daily team meetings that assess each consumer's status and response to treatment. ACT leaders and psychiatrists direct each case to ensure good clinical care and provide feedback on team members' performance.

Daily work in an ACT team also includes treatment planning. ACT leaders, with the participation of the psychiatrists, supervise individual treatment teams in developing and reviewing written treatment plans. They help team members master the technical and analytical aspects of individualized treatment planning.

ACT leaders and psychiatrists also provide individual, side-by-side supervision to assess performance, give feedback, and model interventions. ACT leaders may schedule regular meetings with individual team members to review cases, evaluate performance, and give feedback. ACT leaders and psychiatrists should be regularly available at office headquarters or by beeper or cell phone to consult with team members as needed.

In providing clinical supervision, ACT leaders and psychiatrists translate a new way of working into the daily actions of team members. It is essential that ACT leaders and psychiatrists thoroughly understand the ACT model. For training tools and recommendations, see *Training Frontline Staff* in this KIT.

If the ACT team is working with a consultant, the ACT leader should involve the consultant in the supervision and team processes and should elicit feedback.

Selecting a location for your ACT program

Think about two key things when you decide where the program will be physically located:

- the need for the program to be readily accessible to consumers and team members, and
- the need for a workspace that is laid out in a way that facilitates communication.

Accessibility

Members of the ACT team spend most of their workday in the community, returning to the office intermittently between appointments to get messages and to consult with other team members.

Selecting the location of your ACT office

- **a convenient, central location** that allows the team members to easily reach the neighborhoods where consumers live.
- **parking areas** near the office for program and personal vehicles so that team members and consumers can easily and safely come and go.
- **available times** allowing the building to be open during all hours that the team works, including evenings, weekends, and holidays.
- **accessibility** so that consumers and their families must be able to immediately reach the team's reception area without having to check in at other reception counters (as is the case in many community mental health centers' medical clinics).

Designing your ACT office

- a directly accessible **reception area**;
- **large meeting and work room** with:
 - a conference table and chairs;
 - several telephones;
 - treatment records;
 - storage space for treatment records; and
 - storage space for each team member.
- **medication room** with
 - a sink;
 - medical exam equipment (e.g., thermometer, scale, blood-pressure cuff);
 - locked storage capacity for medication;
 - refrigerator for specimen storage; and
 - work space for the medical staff to set up medications.
- **interviewing rooms** that can also serve as office space for the ACT leader and the psychiatrist or as interviewing or quiet work space for all team members.
- **space to temporarily store consumers' possessions**, as well as for purchased and donated clothing, furniture, and household supplies for consumers.
- **space for office machines** (e.g., copy machine, fax machine) and for storing office supplies.

Office layout

ACT team members should share a common work space rather than having individual offices. This allows a free flow of conversation and an opportunity to informally exchange information and ideas.

You will also need a room in which substance abuse treatment groups can be held. This room must allow for privacy.

Reviewing your ACT program budget and revenue sources

It is important for you to understand the program budget and revenue sources so that you can actively participate in the budgeting process, make informed management decisions, and understand where collateral revenue sources are most needed. If you will be involved in actual budget preparation, you may find it useful to review the budget simulation information in *Financing ACT* in the *Tips for Mental Health Authorities* section.

Transportation is a practical as well as an economic issue in starting an ACT team. We suggest that you deal with it up front.

ACT teams see consumers in community settings and provide them with transportation when necessary because most consumers do not have cars. Many consumers may have difficulty using public transportation, if it exists in their areas.

You must decide whether it is more economical to buy or lease vehicles for team members or whether team members should use their own vehicles and be reimbursed for mileage and additional liability coverage. Agencies that have provided only clinic-based services may also need to develop written policies and procedures about transportation. Travel and transportation costs that may be included in your ACT budget include vehicle lease or purchase, travel reimbursement, and parking and liability insurance for personal vehicles.

You should understand how programs generate revenue. In some mental health systems, ACT programs receive a fixed rate for each consumer that the team serves. In other systems, teams are reimbursed based only on the specific services provided during any given encounter with consumers. In that case, you should be familiar with which team members can capture billing for what services. You will also need to know the billing process and billing codes.

What your budget must include

- competitive staff salaries and fringe benefits;
- rent, utilities, and facility maintenance;
- telephone and communication equipment, including pagers and cellphones;
- office supplies (e.g., treatment charts, binders and dividers, progress notes, and other forms);
- office equipment (e.g., fax machine, copier, printer, chart racks, storage cabinets, file cabinets);
- office furniture;
- medication and medical supplies and equipment (e.g., scale, blood-pressure cuffs, stethoscopes, thermometers, injection supplies, small refrigerator, otoscope, first-aid kit);
- professional insurance;
- consumer services money;
- team members education and training; and
- consultation.

Sometimes teams find it helpful to procure other forms of funding to supplement revenues generated through the mental health system. For instance, teams might pursue grants to subsidize housing for consumers, to cover the costs of the dual diagnosis group, or to pay for a peer specialist.

You must be aware of and avoid the fact that the mission and work of programs over time are defined by the funding that comes into the program. You must know the principles of ACT and be vigilant that funding opportunities support the model rather than shape and corrode it.

Developing a training plan

Developing an ACT team is a complex undertaking. Recruiting and retaining team members who know the ACT model or how to treat consumers can be difficult. Agencies that have successfully implemented ACT indicate that offering one-time training for team members is not enough. You should assess the knowledge level of key stakeholders (see *Evaluating Your Program* in this KIT) and develop a training plan.

The training plan should include:

- basic training for key stakeholders, including consumers, families, mental health authorities, and team members from key community organizations;
- basic training for team members at all levels across the agency;
- intensive training for ACT team members; and
- basic training for selected ACT team members on complementary EBPs.

Team members who implement evidence-based practices are often stymied in their efforts because people misunderstand the model or lack information. It is important that key stakeholders (consumers, families, and other essential community members) and agency-wide staff develop a basic understanding of ACT. This training will help your ACT team's work.

See *Using Multimedia to Introduce Your EBP* in this KIT for materials to support this basic training. Once trained, ACT team members will be able to use these materials to conduct routine community workshops and in-service seminars.

In addition to the multimedia training tools, the ACT KIT includes *Training Frontline Staff*, which gives team members in-depth information about the ACT model and skills for providing ACT services. ACT leaders may facilitate a four-part structured group training.

Once team members have a basic understanding of the model, we recommend that they visit an existing, well-functioning, high-fidelity ACT team to observe how team members work with consumers and how they interact with one another.

In addition to in-depth training on ACT, we suggest that you have at least one team member attend a basic training in other evidence-based practices. They can then cross-train other team members.

During the first 1 to 2 years of a new team's existence, many agencies have found it helpful to work together with an external trainer or consultant. Establishing the initial processes that must be in place to provide quality services requires great attention to detail. Consultants and ACT leaders often work together over the 2 years of implementation to ensure that the ACT program is structured appropriately. They work together to integrate EBP principles into the agency's policies and tailor ACT program procedures to meet local needs.

Once the program has been launched, it is important that you do not allow teams to revert to older and more familiar, more comfortable ways of doing things. External trainers or consultants who are experienced in running ACT programs can provide ongoing technical assistance, side-by-side supervision, and periodic booster training sessions.

This type of assistance, along with ongoing evaluation of fidelity and outcomes, has been found to be critical in reducing the chance that team members will revert to old, more familiar ways of operating.

Two places where you might identify a mentor are:

Assertive Community Treatment Association
810 East Grand River Avenue, Suite 102
Brighton, MI 48116
(810) 227-1859
www.actassociation.org

National Alliance on Mental Illness
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042
(800) 950-NAMI
www.nami.org



Building Your Program

Voices of Experience

Voices of Experience is a series of three interviews with administrators and ACT leaders who have experience implementing ACT. The interviews contain information that will help you implement ACT and anticipate some of the practical challenges associated with developing and leading ACT teams.

Interview 1

Michael Neale, Ph.D.
Veterans Administration

It is very important from the beginning to have a sense that ACT is a crusade. It's a crusade for possibility, opportunity, hope, and recovery in the face of difficulty, stigma, and despair. Be aware that you're stepping into a revolution in health care. Think about managed care, consumer

advocacy, and psychosocial rehabilitation. The Americans with Disabilities Act, also known as the ADA, itself was a revolution — the whole idea of having legislation saying that people with disability have to be treated equally. In addition, there's the information/communication technology revolution.

These have all changed how services are provided and where they're provided. You're going to see a piece of all these revolutions in ACT, and a piece of ACT in all of these revolutions.

Congratulations! You're the ACT leader

Many of the ACT leaders within the VA have not previously been managers. The typical selection process goes something like: "You look like you're a good person and you've done work in the community. We want to start a program. Congratulations! You're the ACT leader."

So, now you have to learn to be part administrator and part practitioner. In our system, we expect half of the ACT leader's time to be focused on direct clinical services and half on administrative linkage. Of course, when you're first starting it's more administrative because there are so many details to be worked out: you've got to work with your team members; get sub-processes going within the team; develop certain policies and procedures; do education; and meet with administrative and clinical leaders within your system.

Getting resources in place

ACT is a crusade to change the way people think and behave regarding serious mental illnesses and the people who have them. The first question is whether the system is interested in joining that crusade. You have to fight that battle before you can get the resources for an ACT program.

The earlier you begin to work with the system, the better chance you have of getting the leadership to understand what's expected and you'll have fewer battles later on. That way the team's energy can be directed toward providing community-based care and not spent fighting about why you need a certain number of cars, or a certain kind of office space, or a social worker on the team, or whatever resource it might be.

It's very important to be sure that resources and people are in place, that they're organized properly, and that you're targeting the right people, developing a system for treatment planning and service delivery that addresses the needs of those

consumers, and that you look to see that you're getting the outcomes you want. Within the VA, we use a "yes/no" checklist to help programs figure out if they have the fundamentals in place: Do you have this, or do you not have this? If not, why not? By going over the checklist, people can identify things they haven't thought about or issues that need to be resolved.

Embedded within the checklist are factors and outcome variables that we use to monitor programs. Right from the beginning, we say to the program, "This is what we're going to train you to do, what we're going to monitor, and the outcomes we expect. And, if you have big issues with any aspect of this, we should address them up front." The checklist is a way for the programs to focus from the very beginning on what they're doing and what they're trying to achieve. It also becomes the basis for monitoring the development of the team.

Mentors

When resources are in place, members of the team undergo training on the content and structure of ACT. As part of their training, team members visit a mentor site. The legacy of ACT is that we've all made a pilgrimage either to Madison (where ACT began) or to some other site that has done this work to see how it operates, to shadow a team, and to see how home visits are conducted. It's important that people being trained in ACT have this experience.

At the mentor site, new team members observe a team meeting, and they shadow the team throughout the day. That usually generates a long list of questions. Ideally, the new team stays in contact with the mentor site and has conference calls. The visit is followed by onsite visits to the new program to see that processes and practices are being put in place.

It's important for people who are planning to do this program to look around to see whom they can learn from. It is important to have consulting, technical assistance, and side-by-side support to help ACT leaders through the process of developing a program. Otherwise, the tendency is for new ACT leaders to see the ACT program through the eyes of a traditional treatment provider. While traditional programs have value, ACT requires a conceptual and attitudinal shift. A consultation structure is very important; if one isn't in place, try to figure out how to set it up. Contact someone as a consultant, or just ask if you can call him or her periodically.

Program monitoring

You want to set up a process in which data is collected as part of intake, and implement a regular follow-up process. Within the VA, we do this on thousands of veterans. We have to be collecting data with the right level of detail to catch what we think are interesting and meaningful variables without weighing down the clinical process by collecting so much data that everybody has to spend extra time on it. The goal is to facilitate that process, not weigh it down.

Our monitoring system makes it possible for us to go to our database and look at the services that were provided — not just by the team, but by the rest of the system as well. Using that data, we can assess, for example, the impact of community services on hospital use and costs for each veteran. Most State systems have a data system similar to ours, but people aren't used to looking at it, and they're not used to asking that the output be organized in a way that can be made meaningful to the team.

We publish a report that includes information on how every team is doing on every variable we collect. We see how the teams compare. We look at the extent teams vary on critical variables. We look to see if any teams are doing particularly poorly, but we also look for teams that are doing particularly well. The latter we look to as centers for excellence.

As part of monitoring, we're looking at who receives ACT services. You want to make sure programs target the people who most need their services because these services are relatively expensive and not everyone needs services that are this intensive.

Our monitoring in the VA also looks at who provides the services — are there in fact the team member resources available that are supposed to be there? We look at what services are provided, how the team members organize themselves, where they deliver services, what kind of outcomes they're getting, and what it's costing.

In addition to monitoring whom the program targets and how it's set up, we also conduct consumer interviews at the very beginning when a person first enters the program, at 6 months, and then at a year. After a year, interviews are conducted annually. At each of those points in time, the team also assesses how a person is doing in the program and what services the program provided. Then, each fiscal year we ask each team to give us an account of the veterans still in the program, those who have been discharged, and any big events that have happened on their team.



There are two basic reasons for monitoring: one is to provide feedback so that adjustments can be made if the program isn't achieving expected outcomes; the other is to check to see if the program is eroding. There's a lot of pressure on people who provide ACT services to increase caseloads, reduce staffing, and to do things in as minimized a way as possible. That pressure tends to eat away at teams: team members get pulled away, positions don't get filled, or all of a sudden you have double the caseload you're supposed to have. This undermines the fundamental principles of intensive community-based services.

One of the reasons this happens is that ACT programs operate in settings dominated by traditional mental health programs. Within the VA, most administrators learned mental health work in a traditional service delivery model. Even programs at Community Mental Health Centers (CMHC's) use a traditional model (e.g., day treatment, inpatient care, outpatient office-type services). They're not really familiar with or trained to do services where the quintessential work is done out in the community.

Monitoring how programs are structured and how they're operating echoes the original ACT program in Madison, Wisconsin. Once the first ACT program demonstrated success, there was an initiative to replicate it. Bill Knoedler, one of the originators of the model, realized that, while various sites were operating programs that they thought replicated the original program, there were differences between the programs. He said, "Okay, you're talking about this over here, and someone else is talking about that over there. You're both saying you're doing the same thing, but you're not. Let's come up with some consistent way to describe what's being put in place."

The key elements of what Dr. Knoedler and others thought was ACT were put into a standardized checklist that evolved into the ACT Fidelity Scale. There are about 20 elements measured by the DACTS using Likert-scale items. Greg Teague and his colleagues used the measure to see which programs had better outcomes. Although the results aren't definitive, it certainly appears that teams that adhere to more elements described in the DACTS tend to do better and have better outcomes.

Getting connected

A lot of this work is about connections — connections between team members, between consumers and team members, between consumers and family members, and connections with other agencies so they understand how your program functions and you know how they can help you. And, potentially, it's about connections that generate new resources. In our system, we've had occasions when new teams got going and when folks in the community learned about the team, they'd say, "You know, if you guys are going to do this, I'll give you a house, or a group of houses, or jobs." When people see there's a reliable structure out there willing to help, they're often willing to pitch in, too.

New teams have the luxury of time. Some of that time can be used going out and getting to know your community: the storekeepers, law enforcement, other agencies and providers, church programs. Introduce yourself; describe what you're trying to do so you're not seen as aliens in the real world out there.

In the VA, we're very hospital based, but we also have outpatient clinics that need to be educated when a new program starts. In another system, it might just be the mental health people at the CMHC, or you might start dealing with the benefit people in your area, or with State vocational rehabilitation people. You need to have their phone numbers, directories, and fax numbers, and they need to have yours so you can communicate. You need to learn what resources they have to offer and they should know what services you're going to provide and how someone gets into your program.

You'll also want to invite people to participate in a meeting with your team members, particularly when you have relationships with emergency people or other service teams. You might either go to their program or invite them to come to your site.

Finally, have people in leadership accompany you on home visits. That's the best way for people to get an idea of what you're taking on. People will feel uncomfortable about it and it's easy to say, "Oh, she's too busy. She's a department head." I think it's easy to bail out on this process and leave it to practitioners to take care of everything, but certainly leaders should be able to spend an hour or two to see what their team members and consumers are doing.

I also encourage people to set up structures for information flow, whether its e-mail groups or conference calls, to link with other teams or consumer-community advisory groups.

Sharing a caseload

It's very easy for people to say, "Oh good, we're going to do community-based treatment. Here's my 10 people, there's your 10 people." That's not a good idea because if you leave, then your 10 people are my 10 people. So, the caseload is shared. That doesn't mean that everybody does everything (although there's definitely an element of generalization of skills), but that the individuals receiving services are connected to the team and not just one person. They may have a favorite person, but the team is the factor. That way, the absence of a team member's member doesn't become the basis for a dramatic upset.

It's tricky to move people away from 'owning' consumers. One thing that helps is to repeatedly articulate the differences in people's skills and how those skills can be combined to better serve the consumers. Team members will have different skills, talents, and experiences that have nothing to do with their formal training. When you get out in the community, your professional training may take a back seat to your life experience and your innate abilities. For instance, some people may be particularly good at skills training even though they don't have the same degree as another person. It may be the way they relate to people or because they know about teaching.

You want to know what skills your team members have and make sure you have a mixture of what you need on the team. That involves more than just saying, "I have a nurse, a social worker, a substance abuse specialist, a psychiatrist, a psychologist, and a rehab worker." You're looking for communication and relationship skills, and the ability to deal with legal and housing issues. Everybody on the team needs to have some of each of these skills, but there are people who will excel in some areas.

To move people toward a shared caseload, you have to communicate the rationale that we're doing this because it's a way for everyone on the team to participate in a person's care. It truly puts the skills of a multidisciplinary team in the service of the consumer. It's very different from a multidisciplinary model where the person just has a social worker unless he or she has a medical appointment; or the person only sees a doctor unless he or she needs to apply for benefits.

The idea is to create a team that works together and maximizes its specialties, but at the same time, there's less specialized tasks — going shopping, taking people to set up a bank account, meeting with a landlord. There are certain things that have to happen that are related more to the team members' personal experience than their professional training; not that you couldn't be better trained and more effective at those things, but they call for a more general approach to life rather than highly specialized training.

In addition to the generic aspect of what everybody has to do, there's an expectation that team members strike a balance between the specialty work of their particular disciplines and what they can train others on the team to do that's related to their discipline. Early on in a new team you may want to have people do home visits in pairs, teaming up people from different disciplines. What happens is that those people cross-teach each other. The social worker asks questions that are different from the questions the nurse asks; the nurse asks questions that are different from the ones the social worker asks. Each person gets to know there are things he or she needs to monitor even though they're not specific to his or her discipline. That doesn't mean the social worker all of a sudden tries to practice medicine, but there's an extent to which all team members can monitor signs and symptoms and relay that information back to the team.

Sharing caseloads can be tricky. If you're not as good as I'd like you to be, I might have to tell you that. Or, you might have to tell me I'm not as good as you'd like me to be. Or, what if I might tell you what I think is going on with a person or what my guts are telling me and you discount it or tell me I'm naïve or uninformed.

Not only do we place ourselves in a more vulnerable position with our co-workers, but also we're more vulnerable with our consumers. When you turn the wrong way down a one-way street with a consumer in the car who says, "You know — I've done that," you've allowed your consumer to see you as another person who can have problems just like he or she has. That vulnerability is a very essential piece of the work.

But, that vulnerability is also a double-edged sword. When you're working in the community, you don't have little buttons to push and you don't have a crisis team around the corner, and you're not likely to say, "Hey, wait a minute, I'm going to restrain you." You have the same thing anyone else does. If there's a major problem and you can't de-escalate the situation, you can dial 911 or you can run. It's not that you particularly need to do those things, but there's an awareness of greater vulnerability.

Not all people diagnosed with a mental illness behave or act the same, but some can look or sound a little scary, and some of the places some consumers live might be a little frightening. At first, going out in the community individually or even in pairs can be a scary process. For many people, the most anxiety filled thought to begin with is: "Can I press that cell phone button fast enough?"

The truth is, people who experience psychiatric symptoms are just people. They're not predisposed or wired to go running around beating people up. There may be people who use aggression as a coping strategy and that may need to be dealt with through behavior modification or even, potentially, the criminal justice system. But that's a minority. Most people are friendly and want the support you're offering.

What the team really needs to be thinking about is what they can do to keep issues from coming up in the first place. It's like driving: if you only focus on the steering wheel and immediately in front of the car, you may miss an important road sign or the congestion on the road up ahead. The best way to drive is by checking what's ahead. Not that you ignore what's right in front of the car, but you have to look down the road.

Even though we're talking about a minority of people, the risk is that team members who may not be expecting difficulties will get in over their heads. That's why you need to think ahead, do careful assessments and treatment planning, and trust your guts. As an ACT leader, you also have to create an atmosphere where everybody's free to express when they're feeling anxious and concerned, and put that on the table. That's why you have a team process rather than individuals functioning solo.

In your assessment, you want to know if somebody has a history of assaulting people, but that doesn't mean a lot. If you sufficiently antagonize anyone, that person could assault you even if he or she has never before assaulted someone. And, that's usually the basis for incidents that occur — setting down limits or walking into a difficult situation and trying to impose limits.

So, what you want to do is say, "I need to get to know this person in a situation like an interview or in a neutral location and find out how he or she responds to different things," and the team needs to share information about that sort of thing.

A key feature of ACT is the cohesiveness and communication of the team. When the team is anticipating a visit to a difficult person, you want to know if he or she has weapons. If there is a weapon, has it been an issue in the past? If it has, you might talk to the person about that. If there are weapons in the house, will they be out? If they are not out, you might propose meeting somewhere else.

It may not be your consumer who is the concern but people in the consumer's environment. You'll want to get to know the neighborhoods and communities where your consumers live. If you know that in a certain neighborhood there's likely to be drug dealers sitting outside, you might ask the person to meet you at the door. That way you can go in together with the consumer, so you're not seen as a person who might be law enforcement and therefore a threat to the dealers. It all depends on the nature and circumstances, but you're trying to anticipate what it's going to be like when you're there. The more you do it, the easier it gets, but when you're first starting it's worth nibbling around the edges to get familiar with your communities.

As you get to know people, you'll get to know when they're acting as if they aren't taking their meds or they're getting more irritated. When you see that happen, you will want to time your visits differently and use phone calls differently. You can have the person communicate to you. You may have him or her leave a phone message or send an e-mail. You might want to anticipate what the weekend will be like. Rather than just waiting to see what happens, you might ask the person, "How are you going to handle yourself this weekend when you meet with this person? Do you need to call somebody after that or do you want me to set up something?"

There's a lot of looking down the road to prevent things. There are still many things that are going to come up that you can't anticipate, but you do the best job you can and it gets better the more you have a multidisciplinary perspective.



Assessment and treatment plans

The stigma of mental illness is ever-present—not just in our community, not just on TV, but also in ourselves, in our fellow providers, and in the systems we work in. It can be found in the way we talk about people, when we include them, and when we don't.

The tendency has been to treat people who have a mental illness differently, to isolate them, and to dictate to them. When you do an assessment, you need to ask yourself if you're assessing the person from where they're at, or are you saying, "This is how we operate." "This is the way things are supposed to be." "This is what you're supposed to do next."

I think many folks fall into "pigeonholing" people when they do an assessment. It's partly because that's how we work as humans. We categorize things and pigeonhole things. If you start doing that with people, it's not therapeutic, it's not beneficial to them, and it disrespects their individuality and rights.

An in-depth, comprehensive assessment that looks at each person in context and considers his or her preferences and goals is an important part of ACT. You can't do this all at once. It takes a bit of time to get to know where someone's strengths lie, where his or her weaknesses lie, and what that person's hopes and aspirations are.

To illustrate how an in-depth community-based assessment differs from other assessments, I often ask people to imagine the information they get about a person in an inpatient setting and what the advantages and disadvantages are for learning about people and helping them to change their behavior. Then, I ask them to think about day treatment, then outpatient services, and finally community-based services.

Community services have the advantages of flexibility, intensity of services, seeing things as they happen, seeing who is facilitating something or interfering with something, engaging other people to help, and you can do this over time. Other modes of treatment don't have these advantages. They're either artificial or so stress-inducing that what you see in the way of behavior is not particularly where that person's really at. The setting is driving it. If you wanted to stress someone out just to see how they handle it, put them in an inpatient unit, give them a set of rules, and tell them they have to follow them or they lose privileges.

A thorough assessment paves the way for the team to develop a treatment plan that addresses problems, in context, based on the priorities of that period. The treatment plan is flexible, it isn't cast in stone, and it isn't a template. We all know the standard lingo: "Will deal appropriately with peers," etc. That leads to a repetitiveness that's not connected to what's going on with the patient.

Consumers can be overwhelmed in a big meeting so, after the treatment plan is developed, we have the person's primary contact person on the team and maybe another team member sit down and say, "Look, the team has gone over this and this is what we're thinking. Let's talk about this and see how you feel about it." And we make sure there's a comfortable understanding there.

Several times a year, the consumer gives feedback on the program as part of the follow-up assessment. We also assess the therapeutic alliance between the consumer and team members. The team members know if their alliance scores and satisfaction scores are going down. If that's happening, there's probably some miscommunication. There are other ways you'll know if the consumer doesn't feel like they're being heard: they'll leave, they'll act out, they'll go in the hospital, or they'll look for treatment elsewhere.

Hopefully that isn't an issue because you're basing the treatment plan on what folks want to accomplish, and what you're trying to do is help them do what they want to do. You have them sign the treatment plan on that basis. It's not like having them rubber-stamp what you've decided to do.

To have meaningful and effective treatment plans, you have to have a cohesive group that meets regularly and that systematically reviews the people in the program, ensures the treatment plans are put into effect, and that they're revised if they're not appropriate. It's a much different approach than doing a treatment plan, than setting it aside and dealing with current events, and then coming back 6 months later and saying, "Did we do any of this stuff?" This is where you'll see the subtle, insidious effect of increasing caseloads. What you should get with an ACT team is attention to detail and consistency over time so you have a basis for judging how people are doing, what kind of changes need to be made in the treatment plan, and how far you can go.

The daily meeting

The spine of treatment is translating the treatment plan into services on a day-to-day basis. This process begins with translating the treatment plan into a monthly or weekly schedule of services for a particular person. We use a monthly schedule because it's a calendar. You have a blank calendar for each person for each month that lists the scheduled contacts based on the treatment plan, and it says who's going to be there, when they're going to be there, and what they're going to do. And, to facilitate the shared caseload, it isn't always the same person.

In the daily morning meeting, we take the services listed for that day on the monthly calendar and integrate them with the available resources on that day (who showed up) and with the real world. For example, you might find out that the night before someone called because he was thrown out of his

house and the team needs to help him. Unplanned things come up that have to be accommodated. That's what the team meeting is about. You're making sure that everything that needs to happen that day does happen.

You are also making sure people have the vehicles they need. Sometimes you may need a van for an activity at one point in the day, so you need to have that free. That means the person that starts the day with the van has to come back and trade it for a car.

There's a bit of fine-tuning based on who can do what or based on who can help with what. If there are two things in a particular geographic area or someone needs a "reminder," a team member might say, "Since you're going to see him anyway, would you bring this paper with you?"

That's the essence. That's the art of laying out the work. Of course there's traffic jams and stuff that comes up all of a sudden— like maybe someone's suicidal and you have to spend half a day with them. You need cell phones and the capacity for communication so you can make adjustments when they're needed. However, having developed the schedule and having gone through it, you'll know who's going to be where and when.

Building a cohesive team

You have to have a cohesive team and communication is a very important part of that. You have to be comfortable saying what's going on in your head and your gut. If you're not able to do that with the team of people you're working with, you're not going to be providing effective services.

It's particularly important as you're bringing people in early on to establish the norm of open communication. The ACT leader can model this by saying, "I don't know what's going on here. I can't figure this one out. What are we going to do about it?" By doing that, what you're saying to the team is, "Your anxiety, your concern, your

irritation, the despair, is real.” These feelings should be on the table...but not running all over it or dominating a meeting. You just put it out there and say, “I heard him talk about his daughter he hasn’t seen in 10 years. It was amazing, all of a sudden he was talking coherently and he hasn’t done that before.” Expressing the feelings that go with the work is what binds the group and then the group can be more willing to take chances and risks with each other.

The essence of clinical work is being objective. Part of being able to step back is to know where the feelings are and what you’re thinking and what the situation requires. That’s where boundaries come in and being able to sort yourself out from the situation to say, “Look, this isn’t appropriate.” The consumers aren’t carrying the boundaries, you are.

In the meeting, you need to be able to say, “Let me tell you this one.” It’s to share with the team what’s going on and what your reaction was. It’s not to make fun of anybody or to abuse it. It’s sharing and grounding. Those episodes and incidents become anchor points and signposts for the team in forming their boundaries and approach. You need open communication and if you have people who are being shut down or are shutting themselves down, that’s a bad process and it’s not going to work and the team won’t be as cohesive.

It’s very important for the ACT leader to be sensitive to cohesiveness and spend time on it. I try to make sure right from the beginning individuals (particularly someone who seems shy or is a paraprofessional) feel as if they can say what they want.

Cohesiveness is important if the team is going to have a stable membership. Sometimes you’re going to go overboard and you’re going to be too hung up on one thing and not enough on another. That balancing process is something the team gets better and better at as you go along. But if that cohesiveness isn’t there, you won’t go on together because someone is going to leave and you’ll have

to do a new thing. It’s not the end of the world, but the more you can keep that crew of people together the better the team is going to function.

The daily meeting is a key factor in team cohesion. The team needs to renew itself and reassert its cohesiveness, which is what a morning meeting is doing. It grounds you and refocuses you.

Real world, real time interventions

You have to realize that out in the real world - the community- you are going to make smaller interventions and you have to expect small increments of change. But the changes that occur take effect in the real world. When you work with people in an artificial setting, those changes may not translate to the real world. One of the key features of ACT is that you can make a difference where it’s needed. You can see how someone reacts, process that on the spot, and not wait until the next session a week later or the next hospitalization to talk about it. You have the immediacy of the circumstance and the observational data.

It’s all advocacy, all the time

Once you start doing ACT, you become an agent of mental health care for whomever you encounter. It’s all advocacy all the time because that’s the mode you go into when you start doing community-based services. You don’t know where, when, and how, but you know you’ll do it. And you need to. You need to educate everybody — all the stakeholders from yourself to your consumer, family members, others out in the community, other providers, and providers on your team, providers back in your system, and community members. It’s the whole spectrum of education about what you do, what the potential is for people diagnosed with a serious mental illness, and how mental health treatment can work. Essentially, you’re trying to change perception and behaviors at every level.

Barbara Julius Outreach Program, South Carolina

In 1987, the South Carolina Department of Mental Health gave our not-for-profit organization, Palmetto Pathway Homes (PPH), funding to replicate the Program for Assertive Community Treatment (PACT) that operated in Madison, Wisconsin. Until that point, our agency had only operated a residential treatment program. At about that same time, Al Santos, a psychiatrist at the Medical University of South Carolina, received a grant to research the effectiveness of ACT. The grant allowed Charleston to start two new, separate ACT programs: the Outreach Program operated under the not-for-profit umbrella of PPH and the Onsite Program within the Charleston Mental Health Center. The mission of these programs was to decrease hospitalization, increase community tenure, and improve the quality of life for people with serious and persistent mental illness.

The first consumers targeted for eligibility were those who were costing the State the most money. These consumers tended to fall into one of two groups. One group was people who had been institutionalized at the state hospital for many years. Frequently, these people didn't have family to go home to, or their towns didn't want them back because they had been so disruptive. They had literally been living in the hospital for years, which was miserable for the consumers and cost the State a fortune. The other group was people who had a high recidivism rate. For one reason or another, these individuals had been in and out of the emergency room and the hospital and tended to have multiple contacts with the police and the judicial system.

As the Director of Outreach, I began by hiring team members and creating the infrastructure to support the new program. The mental health center staffed their team by re-deploying and re-training existing team members, which was a challenge.

The director of the Onsite Program was working with people who were accustomed to the "old way" of providing services. The team members also had "old ways" of thinking about what consumers could achieve in their lives. It was difficult at first for the team to embrace community-based services because they were so used to meeting with consumers in their offices once a week for an hour. I had the advantage of getting to start with team members who were new to the program.

When the Outreach Program started, I did not have a lot of experience working with people diagnosed with schizophrenia. When it was time for me to review charts and I began to read about the bizarre behavior and incidents that had led to people being in the state hospital for long periods of time, I found myself thinking, "Oh no! This person could never live in the community. That would be a huge risk. What about our program's liability? This isn't possible!"

During a consultation with Debbie Allness, a member of the original program for Assertive Community Treatment team, I shared these concerns and I remember her saying, "If you think this is impossible, maybe you shouldn't be doing the work." Her comment was a turning point for me. I realized that if you can't, as an ACT leader or program director, hold the dream of possibility for another person, then you shouldn't be leading an ACT team. If you can't envision people who experience a serious mental illnesses "getting better" and you think they'll require constant supervision, then why do ACT?



Admitting and assessing new consumers

As the process of finding consumer candidates began, we used a printout from the state hospital that listed the number of days consumers had spent in the hospital over the last few years. We used this rather than the number of hospitalizations because some consumers had only been hospitalized once, but the hospitalization lasted for months or years.

In the early days, our intention was to weed out people who had a primary diagnosis of substance abuse, those with profound mental retardation, and people who were sociopathic. Many of the people who were admitted to our program had some history of violence or problems with the law. That alone didn't dissuade us. The question was whether the problems were related to their illness or whether they had been violent or committed criminal acts when they weren't sick.

After we examined the consumer's chart, we talked with hospital staff, social workers, attendants, and therapists. Eventually, I would meet the potential consumer to introduce myself and describe the program. The hospital staff would also help to prepare consumers for our program. Sometimes we would arrange for the consumer to come to Charleston to visit before they were discharged from the hospital. We also got permission to talk with relatives and other significant people in the person's life so that we could lay the groundwork for a smooth transition.

Most consumers were thrilled to get out of the hospital. We found out that, over the years, some people had formed very close relationships with other consumers and team members at the hospital and we had to respect these. We found that, after the initial excitement of being discharged was over, being alone and "independent" could be pretty lonely and stressful. To ease the transition, we would often take people back for visits at the hospital to see their friends when we interviewed new prospective consumers.

Each consumer who left the state hospital had a unique situation. Some had been institutionalized so long, they didn't have the skills needed to take care of everyday activities. In these extreme cases, an option might be to start by placing the person in a board and care home, knowing the ultimate goal was to move them quickly into an independent living situation. For others leaving the state hospital, we were able to immediately find them an apartment and provide the support required to transition into the community.

Day-to-day team leadership

The day-to-day running of an ACT program is like a dance in the sense that there are a lot of things going on at the same time. A critical part of running an ACT program is creating a cohesive team. To that end, team members didn't have individual offices; all work was done in a large meeting room. The theory behind this is that, when staff members are in close contact with each other, small pieces of information about consumers are exchanged in casual conversation. Also, because most of the clinical work was done outside the office, it wasn't necessary to have separate offices. There were rooms available for private conferences and the physician and some support team members had individual offices, but the team operated in a shared space.

Every morning the team would gather around a large table and do "rounds" by reading through the Cardex. The Cardex was a working document that held a schedule and monthly treatment plan for each consumer. During the day, if a practitioner scheduled an appointment for a consumer, it was noted on their Cardex. As the group leader, I would move the meeting along. As each consumer's name was read, we quickly reviewed that consumer's schedule. Some consumers might just need medication delivery; others might be scheduled to go grocery shopping, spend time cleaning their apartment, or meet with a landlord to talk about a complaint. Not every consumer had something planned each day.

As I read off the “to do” list, somebody else would write down what needed to be done for the day on the team schedule. During the meeting, team members quickly reported any potential concerns, observations, and alerted the team to any problems. Complicated, non-emergency situations were put on another list to be covered in depth during a weekly staffing. In a well-run meeting, it took about 40 minutes to cover 130 consumers.

After going through the Cardex, assignments were made for the day. Our program was under a lot of pressure to “capture time” through Medicaid billing because it was our only source of income. During the morning meeting, as the ACT leader I was thinking about which consumers needed to be seen, who on the team could best provide a service, who could capture billing for what, and whether a variety of team members were having contact with the consumers.

Usually one of the nurses would stay in the office to assist with any “walk-ins,” dispense medications, or give injections if necessary. If it was a day when the doctor was in, the nurse would assist with medication changes. This might involve working with a pharmacist to order a new medicine in a way that Medicaid would cover the expense. If the program held medicine for a consumer, the nurse would meet with the consumer weekly to assist them in filling their “med-minder.” This would be an opportunity for the nurse to teach people what each medication was, to get feedback on side effects and, in general, assess how the person was doing. The “in-house nurse” also had the task of coordinating and labeling small packets of medication that were taken from individual med-minders so they could be delivered by the team members that evening and early the next morning.

Initial assessment

When someone comes into your program and you’re taking total responsibility for their well-being, the first needs you look at are the primary needs— food, clothing, shelter, and safety. Where are they living? Are they sheltered? What medicines are they taking? What about their health? What are they eating? The needs we determined at that point would begin to shape our interventions.

When a consumer first entered the program, the first thing we would do is send somebody into the community to do a clinical assessment. Usually it was a nurse. It wasn’t so much that we needed the nurse to do a psych assessment, but we needed the nurse to find out if there were medical problems.

Many of the consumers in our program had been living on the streets and had no resources. Coordinating care and acting as a liaison and advocate involved making sure entitlements were in place and working with the homeless shelter to find housing and guarantee that the person’s medical needs were getting attention.

Our initial visits helped new consumers become acquainted with the team members and program. Most visits took place in consumers’ homes. In a very short period, an appointment was set up for the doctor to see the consumer — either in the office or in the community. We were lucky to work with a doctor who felt comfortable going into the community, wherever that may be—under bridges, in dangerous neighborhoods, or in the hospital.

Quite often, one of the team members would bring the consumer by the office, introduce him or her to whoever was around, and begin to familiarize them with the program. For some consumers, this initial visit was very difficult, particularly for those who experienced paranoia or who didn’t think they were ill. It might take weeks with these individuals to build enough of a trusting relationship with a team member that they would be willing to visit the office.

A period of re-learning

When consumers had a history of going in and out of the hospital, we often found that their lives were largely defined by being “sick.” There is usually extreme chaos that surrounds such lives. We would often find that people’s family had often become their social workers, friends, or police rather than just being able to relate to the person as family.

Some families had given up hope of being able to help their loved ones. We also often found the consumers who were admitted to our program had pending legal charges. Many had “friends” who had exploited them in one way or another. Sometimes consumers had learned that, when life became too overwhelming, they could use the hospital as a place to “crash” and knew how they needed to behave to be admitted.

For a number of individuals, our program would begin by taking on the bulk of the responsibility for meeting their needs. We would encourage them to give their systems a chance to recover and focus on having them get used to a lifestyle that wasn’t driven by being “sick.” This period of re-learning allowed people to build confidence and hope. It was an opportunity for the person to relax and open their eyes and once again see the world around them.

We started with the basic needs—food, clothing, shelter, and safety. Until there was a period of stability, we might deliver medications to consumers, take them shopping, and meet with them to plan ways they could spend their time.

During this initial period, we might see consumers at their homes or in the community five times a day and then give them a call at night to check in and say hello. Since our work was focused on supporting people so they could care for themselves, manage their illness, and build a life in the community, as a person got better, we gradually withdrew our support. For instance, if the team was delivering a person’s medication twice away, we might start

dropping off the evening medicine and leaving the morning dose for the person to take on his or her own. Then, the next morning we would call them to make sure it was taken.

There is no perfect path to recovery. Some people did well for a while and then would think they were “cured” and stop taking their medicine. There would also be times when people wouldn’t want to take medications at all, or they would be abusing street drugs, or getting into arguments with their landlords, or wandering around and getting into trouble. Despite everything, consumers were never “fired” or transferred somewhere else because they “failed” or were “noncompliant” in anyway.

There were times when individuals would need to be hospitalized. Staff would work closely with the consumer and hospital staff in these instances to assure smooth and comfortable transition. When someone went into the hospital, an Outreach staff person would attend hospital rounds to offer help and insight. The hope was that by coordinating care, the hospital stay could be less upsetting to the consumer, the stay could be shortened, entitlements could be kept in place, and there would be a home and place for the person to be discharged to.

Time-unlimited services

One of the premises of ACT is that the program is there for consumers “for life.” Working with a consumer across time is really a luxury and privilege. Because you have time, there is less pressure for a quick fix and you can forge an alliance that respects the person and their individual needs and preferences. For instance, if someone did not like a medicine he or she had been prescribed for some reason, we would change it or see what else was available. Together with the consumer we learned what worked, what needed to be fine-tuned, and what needed to be set aside.

Because of the long-term relationship that develops between the consumer and the team, a critical task that an ACT leader has to do is have the consumer bond with the team and program rather than with individual team members. Many people who receive ACT services will need support for the rest of their lives. Of course, that support may get to a point where it's very minimal as people recover and are able to do things they value. Over time, people may reach the point where they only come in once every 3 months to be seen by the doctor for a medication check. Team members, on the other hand, come and go and, if a person has bonded with just one person, it's difficult when that person leaves.

Consumer-staff relationships

There's perhaps a tendency for professionals on an ACT team to develop closer relationships with consumers than in office-based practice because you're in people's homes and lives in ways that are more intimate. Therefore, it is particularly important for the team members to maintain their integrity and sense of who they are as a professional. Some boundaries are inviolate: you do not have personal relationships with consumers outside of the context of clinical intervention. But, in other ways, boundaries may be different from what mental health professionals are used to.

The ACT leader tends to set the general tone for team members' relationships with consumers but, to some extent, boundaries are personal. For instance, because I'm a person who likes to bring people into my life, I don't mind consumers knowing about my children, my pets, what I like to do in my free time. I think that sharing these sorts of personal things helps the consumer to see him or herself relating to someone in a role other than that of patient. That's what I'm comfortable with. Other team members were more private or shy and maybe even a little reserved in the way they interacted with consumers. These differences are perfectly okay as long as team members care about and value the consumers as individuals.

Relationships are very important to the success of this program. Team members develop relationships with the consumers that are more than the traditional mental health relationship. In the traditional relationship, a consumer comes to your office and sees you for an hour once or twice a week. In an ACT program, there's much broader involvement in the sense that team members are taking consumers places in their cars, meeting their friends, meeting parents, dealing with their children, talking to their medical doctors. All of these things bring us closer to the consumers over time.

Call

If you're running a smooth program, you shouldn't have many after-hours calls, so being called really isn't a burden. Some people might be worried that they're going to be called all night long. If you are doing your job right during the day, you are going to have a very quiet night.

It is important to help consumers understand that calls are for emergencies. I discouraged consumers from using calls for trivial things like whether they should make a hot dog or a hamburger for dinner. What we would do instead is to put "pre-emptive" on our "to-do" list for the evening staff. For instance, we might do this in cases where we knew a consumer was not doing well and we wanted to check on them, or to remind somebody to do something. If there was someone we thought just wouldn't be able to resist calling an "emergency" at three in the morning, we might make a call to them at nine o'clock just to ask if they were okay and see how things were going. We tried to be proactive rather than reactive.

When there were true emergencies and team members had to go out to work, we always had them call the backup person who was either the Assistant Director or myself. Everybody had phones and beepers. Naturally, we were concerned about safety and, unless the team members knew the consumer and their surroundings well, the backup person would go with them. If a team members went out on call alone, we would stay in constant contact. It was often the case that the on-call person would be contacted after the police or local mobile crisis team had been pulled into a situation. Because we had good working relationships with them and were known in the community, these events were handled quickly and smoothly.

Team members as investigators

As an ACT leader, one of the important things that you have to do is be an investigator. It isn't always apparent why a consumer begins to experience an increase in symptoms. After going through some of the common reasons, (the person stopped taking a medication or is using drugs) you start thinking creatively about the whole picture. For instance, we had a consumer who had been successfully living on his own, but then his life started getting out of hand on a regular basis and he would wind up in the hospital in a manic state. We knew he had been taking his medication, he loved where he lived, he had many friends, and he was happy with the program. We were stumped and the multiple hospitalizations were taking a toll on him. They seemed to be happening more frequently and he was having more difficulty bouncing back. To figure out what was going on, we went back through his records and made a timeline. That helped us to detect a pattern.

It turned out that this individual was diagnosed with schizoaffective disorder. He was also a heavy smoker and had bad asthma. As we charted the timeline, we saw that when he had an asthma attack

he would use his inhalant. The inhalants tended to make him feel "wired" which, in turn, would lead to him smoking more cigarettes. As he got more wired, he would move around and do too much which worsened his asthma, and eventually everything spiraled out of control.

We began to identify contributing factors, like which months were particularly bad, and found that, when he cut the lawn for his mother, an acute asthma attack would occur. Once we saw the pattern, we shared it with him. Then we formulated a treatment plan where we held onto his cigarettes and gave him a pre-determined number each day. He agreed that if he was up to three inhalant sprays a day, he would need to go to the hospital before he was in an acute manic state. Over time, he was able to break the pattern that we had observed.

Timelines helped us participate with consumers to get a picture over time of their life and illness. When you recognize the patterns, you can work with consumers to think about ways of changing those patterns.

One of the most important things team members, consumers, and their families need to learn is how to identify the consumer's pre-morbid symptoms. What are those very small things that begin to occur that tip us off that consumers might be beginning a relapse? For some reason, those small characteristics are usually the same. If a person gets ill and becomes delusional, their delusion is always the same. For consumers who become manic, there are subtle changes that you and the consumer need to learn to recognize. Once, our team worked with a consumer who would fill small glass dishes with colored water and build amazing structures with them when he began experiencing manic symptoms. Every day the structure grew and got more elaborate. It got to the point where we recognized that, when there were three colored dishes on the table, he needed to be seen by the doctor for a possible increase in medication.

Medication

In order to work with people diagnosed with a serious mental illness, you have to know about medications. Even though the social workers on the team didn't dispense medications, they had to know about the medicine, dosages, side effects, and the types of changes to look for. We not only had to deal with psychotropic medications, but also other medications that consumers frequently took for a variety of reasons.

When there was a medication change, it was reported during the morning meeting. Whoever took the order would make a note on the consumer's Cardex so the team would be aware of what to look for in the way of side effects. During the morning meeting we could talk about why the medication had been changed and the team members would know to check on how the consumer was feeling, and whether they were getting better or worse.

Some consumers would not be taking medications when they entered the program. In many cases it wasn't that they had made a decision not to take medication, but because they couldn't keep up with refilling prescriptions, or the way they were supposed to take the medication was too hard to remember, and the whole process was too confusing and complicated.

If you think about it, Medicaid pays for three prescriptions a month. If those three prescriptions were used for psychotropic medications and, say, an antibiotic, and a doctor prescribed a medication for another ailment, how would you get it and pay for it? Our nurses were able to organize the medical regime so that orders could be staggered and they worked with the local pharmacist to bulk order certain items.

The program might begin by "housing" a consumer's medicine. However, consumers would come in and organize their medication minders. This was an opportunity to educate consumers about the medications they were taking and to create an alliance. I would say that within 1 year to 3 years most consumers progressed to the point where they could come in, fill their med- minders with a week's worth of medication, and take it home to take on their own. Naturally, there were those folks who could handle their medication regime just fine and we had no need to help in that area.

There were also people who just didn't want to take medications because they didn't like them or didn't think that they benefited from them. In those situations, we would respect their choices and focus our work on other issues the consumer might have (e.g., housing, transportation, etc.). Even though a person might choose not to take medicine, we continued to support them in all other ways and, if they become psychotic and were a risk to them or someone else, we would arrange and coordinate hospitalization.

Some people would come to realize that, when they didn't take medications, they would get sick and end up in the hospital. They began to recognize what being hospitalized costs them — not money-wise, but in terms of the disruption to their lives.

For people who took medication, a big part of the process was working very carefully with the psychiatrist to find which medications had an optimal effect. With ACT, you have the luxury of time to be respectful of people's needs. I remember a consumer who just hated Lithium, but it was the medicine that seemed to do well for her in terms of her mood. She disliked it because her skin would break out. We worked with her for 15 years and many, many, many times we worked closely with her to switch her medicines around to give her a break from Lithium.

Sometimes we would feel strongly about not wanting to change someone's medicine – particularly when we had been witness to repeated episodes of acute symptoms. One of the costs of continued psychotic breaks is that it often takes longer for the person to get back to baseline (one's optimal health) and there can be cognitive decline following a severe break. It just gets harder for people to bounce back. For some people the risk of fiddling with their medications was so huge that we might really try to discourage them from changing their medications. In the end, however, we respected their choice.

Housing

The need for housing is a need that never goes away. The team has to be prepared for a lot of moving. One piece of advice I can give is to encourage your consumers to sign up for housing programs as soon as they come into the program. Even though the wait may be years, time goes by and before you know it the consumer is eligible for affordable housing. Until then, be prepared to help consumers move!

Over the years, we tried many different things. A friend of mine in Charleston started a not-for-profit organization called the Humanities Foundation. Her husband was a real estate developer and she partnered with Volunteers of America. They would build low-cost housing and then Volunteers of America would come in and run it. Some of the consumers were able to take advantage of this option. Another thing we did was to try to set up roommate situations. Sometimes we would rent houses and try to put three people together, mostly to keep costs down so housing would be affordable. At one point, our agency owned a home that had four bedrooms. Four of the consumers being served by the program moved in there together, but it began to feel like a program and we realized it wasn't optimal; after all, we were trying to move away from the institutionalized setting to a more normal situation.

Working in the community

Frequently the consumers in our program lived in neighborhoods where there was a lot of drug activity and crime. There would be times when consumers would be exploited. Some of our female consumers were involved in prostitution and there would be pimps in their homes. Drug dealers might hang out in someone's apartment to do their transactions. In return, the dealer might make drugs available to the consumer.

There were situations where we asked the police to help us. We would coordinate our visit so that before our team members arrived, the police would do a couple of "drive-throughs" to scatter the drug dealers. Then the team members would drive up, do what they needed to do and leave. If team members felt frightened about going to a particular place, they might take another team member with them.

Of course, what constitutes a 'bad' neighborhood depends on who you are, where you're from, and what you've done. My background was with hospice, so I was comfortable going to lots of different neighborhoods.

What I found working for Hospice is that neighbors know what is going on with people. They know who is sick and needs help. They are usually grateful that the person is getting the help they need and will be your allies. Neighbors can let you know about potential problems, provide support, and help you locate people if necessary.

Celebrate success

It is also important for the ACT leader to help the team members keep perspective. Progress can seem very slow and it can be difficult for team members to see the progress individual consumers are making on a day-in, day-out basis. The ACT leader helps the team focus on the positive by pointing out progress. For instance, it might seem to the team members that a consumer is making little progress and continuing to go in and out of the hospital.

Yet, when you count the number of days he or she spent in the hospital since entering the program and compare it to the year before, you see the person was hospitalized 50 days less! That's when you celebrate and acknowledge that you're making a difference. Remember to look at the whole picture.

Maybe success means that the consumer has a friend, stayed within their budget for the week, or only called afterhours five times in a week instead of 50 times. For team members that want to see a quick fix, this is the wrong job.



Interview 3

**Dawn Petersen, MS,
Gulf Coast Treatment Center**

Teaching versus doing

ACT is about teaching people to be more independent. You need to adopt the mindset that, “I’m going to teach somebody something today,” rather than “I’m going to do something for somebody today.” Teaching people is what helps people become more independent, gain self-esteem, and gives them a sense of what they are capable of achieving.

ACT is about teaching people how to manage their symptoms so that they can advocate for themselves and take control of their lives. The goal is for consumers to be in charge of their recovery. It is very exciting when a consumer reaches a place where he or she can say to the doctor, “You know, my Depakote level was 35 last week and I haven’t been feeling well. I feel like I’m starting to get depressed again, what if we increase my Depakote?”

We know that in the long run people are going to have some really good periods and they’re going to have some really bad periods. We’re going to like them no matter what and we’re not going to kick them out of the program because they’re going through a bad period. We’re going to work with the person to figure out what’s not working and come up with something that will work.

I want to emphasize that ACT is looking at every aspect of a person’s life. If a consumer has diabetes, we’re going to work with that individual to figure out how he or she can get whatever support is needed and, if the support isn’t available, we’re going to figure out how we can provide it. We’re looking at how the person is interacting with their peers, their family, the social aspect, and we’re doing what fits each person’s goals.

ACT tools

The most important things a new ACT leader needs to understand are the tools of ACT. By tools, I’m referring to timelines, comprehensive assessments, consumer-centered treatment plans, the daily/weekly Cardex, the daily schedule, the communication log, and the daily team meeting. The ACT leader is the person responsible for making sure these tools are used. Initially, it can be very difficult to get into the routine of making sure team meetings occur every day, that timelines are done, and comprehensive assessments are pieced together. But, once you have these tools in place and you’re using them the way they’re supposed to be used, you become very efficient and you can do more than you ever thought possible.

One of the things that new ACT leaders sometimes have a problem grasping is the way ACT programs do assessments. From a clinical perspective, the quality of the assessment and the thorough evaluation of the outcomes of contacts with consumers is what really make a difference.

The assessment process starts with a historical timeline. The timeline is a tool for doing “detective work.” What you’re doing with the timeline is piecing together a person’s life history. It’s likely that no one has ever taken the time to do this before. You start from the time the person first started to have unusual behaviors. That could be when the person was 9, 17, or 25. The timeline helps you identify the pieces that are missing so they can be tracked down.

Another tool is the comprehensive assessment. The assessment process occurs over a 30-day period. It’s not a “sit down” assessment; instead, you’re gathering information in a casual environment while you’re helping an individual meet his or her basic needs. It may be while you’re at the grocery store or while you’re helping them look for an apartment. Many times you get a lot more information if you just do a lot of listening and get out of the office atmosphere. When you

piece together the comprehensive assessment it looks very structured, but gathering the information occurs informally. The comprehensive assessment is completed within 30 days, but assessment is really ongoing because you're gathering pieces of information as you work and, even after the initial 30 days, you can continue to add information to your timeline and assessment.

Once you have the assessment, you start finding out what the consumer wants in his or her own words. You're asking the person: "How are we going to get to these steps?" "What are you willing to buy into?" and "What can we do for you?" The actual plan is what the team member is going to do and the schedule for doing it. We might decide that every Monday we're going to do "X," and every Tuesday we're going to do "Y," and every Wednesday we'll do "Z;" and everything is treatment oriented to keep people moving toward their goals.

The nice thing is that, if the plan isn't working, the team comes back together and says, "What are we doing wrong, how can we present this in a different way, or has that person's goal changed and do we need to revise the treatment plan?" Usually the problem is that we're not doing something right and we need to be creative and try a different approach.

The scheduled contacts are listed on the weekly Cardex. The Cardex describes what contacts we'll have with people on a daily basis and the reason for those contacts. Those become the basis for the daily schedule; when you're putting together the daily schedule, it relates specifically back to the treatment plan. Once you do the daily contact, then you already know what the purpose was and so you write your SOAP note based on that purpose and whether or not the plan is being changed. Then you go back to the assessment. It's a complete circle.

It's just constantly going around. If you don't have movement and it's stagnant, then you're not doing what you need to do.

At the daily team meeting you want to review, using a behavioral approach, what has happened with each person in the past 24 hours. You do it in short concrete statements. That way, if someone is working the nightshift, they can step in and figure out quickly what's been happening with a person. During the daily meeting, one person takes the daily log and starts calling out consumers' names. We use a three-ring binder that has a section for each consumer. When the consumer's name is called, team members report what has happened in the last 24 hours and the person with the log makes a brief note. If you need to do some treatment planning, that happens after the team meeting.

We also use a team calendar. What we put on that calendar reappointments that aren't necessarily part of the ongoing treatment plan. It might be an appointment with a neurologist, a dental appointment, or it might be a team member's person's dental appointment. We also have a team schedule that shows who's working when; it has time blocked out for paperwork, time for nurses to reorder medicines, for the dual diagnosis group, and for standing administrative obligations like program director meetings. The person putting together the daily schedule knows if there's a special appointment or if a team member's person is not going to be available.

We're very respectful of the times team members block out for paperwork. It can be a challenge to get paperwork completed in a way that it doesn't become overwhelming. What happened to us is that team members were spending so much time with the consumers they would be doing their paperwork at home or falling behind on paperwork. Getting paperwork done was probably the team's biggest stressor. I would guess that team members' turnover is probably directly related to not having enough time to do paperwork, so scheduling time to get it done and then respecting that schedule is very important.



Supervising team members

ACT leaders teach primarily through modeling. They don't just sit in their office and delegate, but they go out and work side by side with each team member to teach them how to do the informal assessment process, how to work with people in the consumers' support network, etc. An ACT leader is very involved with team members and consumers. Typically, at least 50% of the leader's time should be spent in direct services and supervising team members. The best way to supervise team members is to go with them on consumer contacts.

Red tape

One of the things an ACT leader has to do is break down barriers so that his or her team members can do what they need to do. That might mean changing policies or procedures within the parent agency, figuring out how to do something in a legal and safe way, and constantly advocating, not just for the consumers, but also for the team.

For example, one of the challenges in the mental health arena is that mental health hasn't traditionally monitored medications as closely as an ACT team is going to. There's usually no regulations covering this in the mental health system—it's more a home health agency type of contact for the doctors and nurses. You have to know what your State nursing guidelines are and have an understanding that there's a difference between a mental health clinic nursing standard and community home health standard and figure out what will work within your State's guidelines. Another key part is how the doctor orders the medications, because that's where a lot of your support for change is going to come from—the doctor saying he or she wants the medication delivered daily.

Billing

As an ACT leader, you have to know what is reimbursable and what is not. One of the choices this team had to make several years ago was whether we were going to do case management or rehabilitation. What we found was that a majority of our work was NOT case management, but rehabilitation. That is, we were teaching individuals how to become more independent versus linking them somewhere else. We decided we wanted to continue doing that. Then we had to figure out how to get reimbursed. You have to identify within your State what is reimbursable and whether you're going to be able to generate enough revenue doing what an ACT team is supposed to be doing. If not, you need to have plans for bringing about change.

We also write grants — capitol funds for the building, housing subsidies, and a dual-diagnosis grant. You really have to be creative and identify what the needs are and how you can address those needs.

Outcomes monitoring

There is a wonderful tool for measuring fidelity—that is, how closely your team is following the ACT model. I use it as the team's "treatment plan." I don't think you can ever be a perfect ACT team; if you think you are, you're in trouble. What you want to do (it's just like the consumer's treatment plan) is to have continuous ongoing movement. If you're not moving closer toward meeting fidelity and you're staying set in your ways, you're not going to see the benefits for consumers that are expected with this model.

Once a quarter, our team meets to see where we're at on the fidelity checklist and plan where we want to go. It's a program assessment: Have we taken a couple steps back in this area? Are we doing what we need to be doing? Where are we doing well? Can we do even better?

We also do consumer satisfaction surveys. We have our consumer advocacy group administer them and we hopefully get very good feedback. We also have a level of functioning scale we use; it monitors 14 areas — residential, employment, and that type of thing. When we see a dip, we assess what changes we need to make to see improvement. When we see something that's working, we figure out what we need to do to sustain it. For instance, if we have more consumers employed than ever before, what are we doing differently? If the number of consumers who are employed has dropped, what do we need to do?

Safety

Safety is probably one of the biggest issues that new teams are going to have. My response is that the key to safety, and what is different about ACT, is the thorough, detailed, assessment that is done on each individual.

This is actually a safer place to be than an intake or an inpatient unit because you've done the leg work and determined what a person's symptoms are, what makes him or her have an increase in symptoms, whether the person is likely to be symptomatic, etc. You're piecing together this information and you know what helps and what doesn't help.

One of the nice things about working with the team, and one of the important things about the daily team meeting, is that you know whether a situation is escalating or not. You can figure out if you need to double team or involve the police department or sheriff's office because you're constantly communicating with the team and you know what's going on with the consumer.

Usually, the consumer isn't the safety issue; it's the environment we're going into. In my mind, I always say that, if I don't feel comfortable going into an environment, why would we have the consumer living there? It may be the consumer's choice, and so we try to figure out why they feel comfortable there and we try to help them take steps toward moving away from dangerous environments.

Payees

Finances are a big issue for anyone, regardless of whether they have a serious and persistent mental illness or not. Many times our Social Security Administration will not allow people to be their own payee, especially if that person has a history of substance abuse or dependency.

So we try to create a situation where the person can be as independent as possible with the limitation that has been placed on them by Social Security. We've also found that when you get involved with someone clinically you cannot be involved with their finances; this is seen as shaving control over someone's life and not conducive to good clinical care.

One of the things we work hard on— and it's very challenging—is having a payee outside of the clinical treatment team. We may serve as liaison and make special requests to make sure the consumer's needs are met, but we don't become payees.

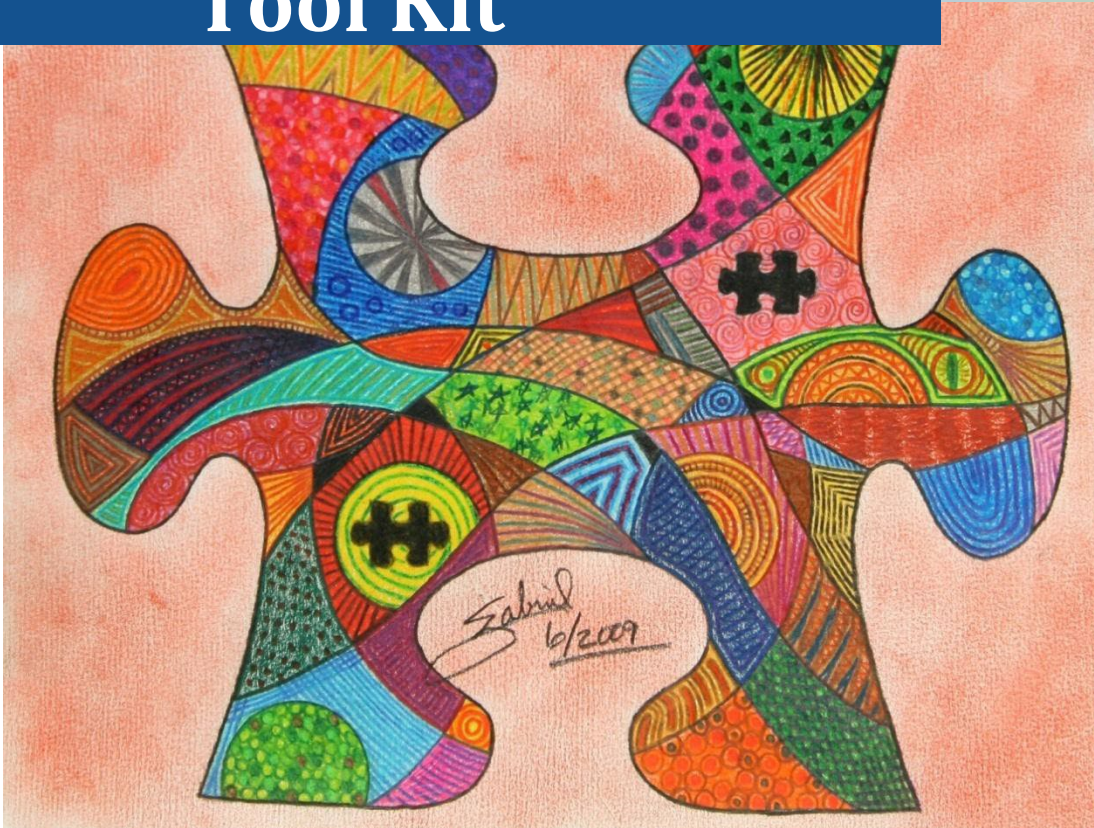






ADULT

Full Service Partnership
Tool Kit



Only when
we are no
longer afraid
do we begin
to live.
*Dorothy
Thompson*

California Institute
for Mental Health

2011

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Preface

Full service partnership (FSP) programs were designed under the leadership of the California Department of Mental Health in collaboration with the California Mental Health Directors Association, the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, mental health clients and their family members, mental health service providers, and other key stakeholders of the mental health system. Although they have been in existence since 2005, full service partnership programs are continuing to develop the distinguishing characteristics that lead to good outcomes for mental health clients and their families.

The FSP Tool Kit is intended to provide FSP supervisors and team members with written guidance to support the ongoing development of the programs and integration of practices. This publication series encompasses a Tool Kit for each age group — children, transition-age youth, adults, and older adults — in recognition of the programmatic differences that exist across the four age groups.

Preface (cont'd)

The Tool Kit has numerous unique characteristics that include:

- Development with close involvement of diverse, statewide advisory committees that represented all of California's public mental health constituents, including clients, family members, counties, and mental health service providers
- Identification not only of service delivery models for age-specific full service partnerships, but also an overview of practices that can be integrated into full service partnerships
- Reference and access to website links that offer additional in-depth information on the majority of practices included in the ToolKit
- Recommended resources to assist in the ongoing development of full service partnership programs that support clients in their recovery

Acknowledgements

This Tool Kit is dedicated to all the people with lived experience, whether children and their families, transition-age youth, adults or older adults, who continually demonstrate their belief in possibilities.

This project was funded through California's Department of Mental Health (DMH). Creation of this Tool Kit resulted from the ideas, experience, and suggestions from many groups and people throughout California. Participants from the statewide advisory committee, age-specific committees, and the performance measurement subcommittee demonstrated tireless dedication to ensure a practical outcome. Representatives from all 58 counties — through county departments, regional networks, and partner agencies — participated via meetings, conference calls, and interviews.

Additional appreciation is extended to the staff and consultants at the California Institute for Mental Health (CiMH) for their excellent leadership and compassionate guidance in this visionary endeavor.

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Terminology

We appreciate that no one term may fit the same situation. The writers also realize that one term does not convey the same meaning across all age groups. However, to facilitate the writing of this project, selection of only one expression for certain concepts became necessary. We thank the committee members who, for the sake of clarity, provided us guidance through this process.

For example, we designated the term “client” as the universal identifier for an individual with lived experience, even though we acknowledge that the term “consumer” or “person” may be more common in some areas or in some groups. Exceptions to this selected term may be found throughout the text if written within a direct quotation

Domain #1

Philosophy

The *Philosophy* domain of the Adult Full Service Partnership (FSP) Tool Kit presents an overview of the basic tenets of an Adult FSP. It emphasizes the Mental Health Act (MHSA) core principles as they are integrated into the FSP model: client and family-driven mental health services within the context of a partnership between the client and provider; accessible, individualized services and supports tailored to a client's readiness for change that leverage community partnerships; delivery of services in a culturally competent manner, with a focus for wellness, outcomes and accountability.

“Whatever It Takes”

Purpose

To guide the actions and motivation of full service partnership staff regardless of the array of services provided.

Definition

Whatever it takes means finding the methods and means to engage a client, determine his or her needs for recovery, and create collaborative services and support to meet those needs. This concept may include innovative approaches to “no-fail” services in which service provision and continuation are not dependent upon amount or timeliness of progress, or on the client’s compliance with treatment expectations, but rather on individual needs and individual progress and/or pace on their path to recovery. Clients are not withdrawn from services based on pre-determined expectations of response.

Implementation Strategies

Using the following strategies, FSP teams can develop interventions based on individualized needs, utilizing the creativity of the entire team to identify client needs and offer options and choices that best respond to the identified needs throughout all arrays of services. Interventions should be based on a “whatever it takes” approach, which means that that FSP teams do not rely on traditional, pre-prescribed menus of services. Rather, they focus on the specific needs and strengths of the client and then develop new interventions that utilize those strengths to meet the needs.

- Create a “no fail” rule in order for staff to find ways to work with clients who present unique challenges yet need FSP assistance.
- Create an expectation that goal setting at the beginning of treatment is not limited to short term goals but that embedded in long term goals and associated objectives is the belief that recovery can and does occur. Goals should reflect an eventual transition to lower levels of service and ultimately, for many, a transition to natural community supports outside of the mental health system.
- Do not place time limits on the engagement phase of FSP services. Failure is not likely to occur as long as staff members keep trying.
- Develop Individual Services and Supports Plans (ISSP) with clients that contain not only symptom reduction goals but also quality-of-life goals that reflect the client’s cultural values. These goals may focus on living arrangements, social supports, education, and employment.
- Use the expertise of various team members when working with difficult-to-engage clients.
- Use a recovery scale to gauge progress toward recovery from mental illness.

Ensuring Cultural Responsiveness of Interventions

Purpose

To present strategies for developing a culturally responsive approach for working with diverse clients in FSPs.

Definition

Cultural responsiveness means the ability to work effectively and sensitively within various cultural contexts. *Ensuring cultural responsiveness of interventions* entails promoting a set of congruent behaviors, attitudes, and policies in a system, agency or among client providers, family member providers, and professionals that enable them to work effectively in cross-cultural situations.¹

¹Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards a culturally competent system of care, volume I*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Implementation Strategies

The effective engagement of diverse communities requires a dedicated, long-term, multidisciplinary approach. Some initial strategies for promoting cultural competence in FSPs at the organizational, systemic, provider and client levels are listed below.

Organizational and Systemic Level

- Recruit and train at all levels, a workforce that is reflective of the cultural groups in the county.
- Develop leadership capacity for employees from diverse cultural groups.
- Ensure that all materials are furnished in threshold and other languages, and that an effective and timely system for translation services is in place.
- Require contracting agencies to demonstrate a standard of cultural competence in service delivery.
- Collect data including race, ethnicity and language of clients to enable systems to identify unserved communities and address disparities.
- Involve target communities in leadership roles in planning, developing, and implementing FSP programs.

Provider Level

- Create opportunities and training for providers to develop:
 - *Awareness* — Providers must have an awareness of their own cultural experiences and background, and the ways in which these affect their beliefs, values and behaviors in the clinical setting.
 - *Knowledge* — Providers must have knowledge about the historical background and cultural worldview of communities served.

Implementation Strategies (cont'd)

- *Skills* — Providers must have skills in communicating effectively, understanding nonverbal and verbal communication differences, and building rapport in cross-cultural interactions.

Client Level

- Be aware that distrust and fear of mental health systems prevent many ethnic and cultural minority clients from seeking care and advocating effectively for the services they need.
- Empower clients of all cultures to be active participants in planning their care, and to obtain care that is consistent with their cultural values and beliefs.
- Develop strategies to assist clients in navigating systems of care, such as client navigator and parent partner programs.

Being Fully Served, Ensuring Integrated Experience

Purpose

To understand and adopt comprehensive and integrated services and supports that meets the needs of clients throughout the recovery spectrum.

Definition

The concepts of *being fully served* and *ensuring integrated experience* are inherent aspects of the carefully selected phrase *full service partnership*. Their principles must be understood and embraced in order to apply FSP practices constructively.

Fully served as defined by the California Code of Regulations (CCR), Section 3200.160 means "clients, and their family members, who obtain mental health services, receive the full spectrum of community services and supports needed to advance the client's recovery, wellness, and resilience."

Definition (cont'd)

The practical application of being “fully served” is defined in CCR Section 3620 et seq. and California Department of Mental Health ... Letter 05-05 (the document that originally set forth the processes of FSP)² in the following ways:

- Each FSP client must have a single point of responsibility — a Personal Service Coordinator (PSC).
- The PSC should have a caseload low enough so that:
 - 1) their availability to the client and family is appropriate to their service needs,
 - 2) they are able to provide intensive services and supports when needed, and
 - 3) they can give the client served and/or family member considerable personal attention.
- Services must include the ability of the PSC or team members known to the client or family member to respond to clients and family members 24 hours a day, seven days a week. This “best practice” service strategy is intended to enable immediate “after-hours” interventions that will reduce negative outcomes for clients including, but not limited to, unnecessary hospitalizations, incarcerations or evictions. Exceptions may be made for small counties, which may meet the 24/7 criteria requirement through peers or community partners known to the client or family rather than exclusively through the PSCs or team members. While the regulations address peer support as a small-county strategy, integrating peers into services, including crisis response is a good practice regardless of county size.

² California Department of Mental Health. (2005). *Mental Health Services Act community services and supports—three year program and expenditure plan requirements, fiscal years 2005-06, 2006-07, and 2007-08*. (DMH Letter No: 05-05). Retrieved from <http://www.dmh.ca.gov/dmhdocs/docs/letters05/05-05.pdf>

Definition (cont'd)

Full spectrum of community services is defined by the CCR, Section 3200.150, as "the mental health and non-mental health services and supports necessary to address the needs of the client, and when appropriate the client's family, in order to advance the client's goals and achieve outcomes that support the client's recovery, wellness and resilience."

Full spectrum of services as defined by the CCR, Section 3620, means "services to be provided for each client with whom the County has a full service partnership agreement may include the Full Spectrum of Community Services necessary to attain the goals identified in the Individual Services and Supports Plan [ISSP]. The services to be provided may also include services the County, in collaboration with the client, and when appropriate the client's family, believe are necessary to address unforeseen circumstances in the client's life that could be, but have not yet been included in the ISSP."

Full service partnership as defined by the CCR, Title 9, Division 1, Chapter 14, Section 3200.130, is "the collaborative relationship between the County and the client, and when appropriate the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals." Inherent in the term *full service partnership* is the idea of being *fully served* and providing an integrated service experience.

Implementation Strategies

- Create teams with staff from multiple disciplines, backgrounds, and cultures, including establishing opportunities for peers as providers.
- Develop plans with clients to reduce the need for after-hours crisis response, including:
 - Using Wellness Recovery Action Plans. (Refer to Domain #2 Service Array, Tool: “Client Self-Management.”)
 - Helping clients to identify positive and useful coping strategies.
 - Identifying early signs or precursors of an increase in symptoms.
 - Assisting clients in receiving support from other clients or peer providers.
 - Pairing a licensed staff member with other staff members, such as a peer provider or specialist, in responding to after-hours crises.
- Create an integrated approach to services that can help clients by developing personal relationships with organizations in the community:
 - Disabled student centers of local colleges.
 - Health clinics.
 - Vocational rehabilitation programs.
 - Substance abuse programs.
 - Community-based agencies.
 - Faith-based organizations.
- Offer provider on-site support to these programs so that expertise is mutually shared.

Tailoring Service Coordination to Client Stage of Recovery

Purpose

To identify and to define levels of service and support that create a continuum of services based on the client's stage of recovery, to ensure that clients are *fully served*.

Definition

Tailoring service coordination involves establishing a process for identifying a client's level of recovery. Determining "stage of recovery" requires identifying degree of recovery in risk, engagement, skill mastery, and self-responsibility. While recovery scales vary on specific terms, they usually cover the same general areas. Services then focus on those recovery elements.

Definition (cont'd)

An overall framework must be established to indicate how services should flow from one level to the next. *Levels of service* refer to a guideline for determining the level of care that a client may need. The levels of service listed below constitute an example³ of a service continuum designed to meet clients' needs as they recover.

- Level 4: Intensive services and supports for clients imminently at risk of institutionalization or homelessness.
- Level 3: Focused on strategic services for clients who generally engage at some level with the mental health system and natural supports but are minimally to moderately coping.
- Level 2: Services geared toward self-management, with less reliance on the mental health system. Services are more peer-based and focused on wellness.
- Level 1: Community-based, often peer-run services, geared toward clients who have achieved relative independence from the mental health system.

³ A guideline developed and adopted for use by the California Mental Health Directors Association (CMHDA) Adult System of Care Committee. Retrieved from http://cmhda.org/committees/documents/ASOC/Handouts/0805_ASOC_documents_LOS_policy_and_guidelines_April_08.pdf

Implementation Strategies

- Create a seamless set of services at each level of service that focus on the milestones associated with each level of service.
- Obtain training for and use a recovery scale to assist FSP teams in determining a client's level of recovery and associated services.
- Review client recovery scores on a regular basis, tracking client and program progress.
- Tailor services to client needs, interests, and level of recovery in the following ways:
 - Clients at extreme risk
 - Refer to Domain #2 — Service Array*
 - Reducing Involvement in the Criminal Justice System
 - Crisis Intervention and 24/7 Team Availability
 - Coordination of Inpatient Care
 - Unengaged clients
 - Refer to Domain #1 — Philosophy*
 - Outreach and Engagement
 - Welcoming Environments
 - Clients who are building skills and mastery
 - Refer to Domain #2 — Service Array*
 - Use of Strength-Based Approach
 - Client Self-Management
 - Integrated Services for Clients with Co-Occurring Substance Use and Mental Health Disorders
 - Role of Medication and Psychotherapy
 - Increasing Social Supports
 - Education, Employment, and Volunteering
 - Community Integration
 - Linkage to and Coordination of Health and Dental Care
 - Refer to Domain #4 — Housing*
 - Creating an Array of Readily Available Housing Options
 - Supportive Housing and Housing First Models
 - Use of FSP Funds for Non-Mental Health Services and Supports

Outreach and Engagement

Purpose

To form the foundation of a partnership by bringing clients successfully into an FSP as well as to retain clients in an FSP while they need services.

Definition

Outreach and engagement as codified by the CCR, Section 3200.240, means to “reach, identify and engage unserved clients and communities in the mental health system and reduce disparities identified by the county.”

Definition (cont'd)

Using the state's definition as a starting point, FSP programs must practically apply the elements of reaching and identifying clients, and engaging them in services. Operationally, engagement involves establishing a trusting relationship, and is a critical component of the outreach process.

Further, outreach and engagement have been described as a dance, in the sense that each step in the outreach and engagement process is contingent upon the client's response to the previous set of actions.⁴

Implementation Strategies

- Identify the unserved adults with serious mental illnesses who meet the eligibility criteria of candidates for outreach services in the community as indicated in the Welfare and Institutions Code (WIC) 5600.3(b). This eligibility list may include ethnic and cultural groups who have historically faced barriers to accessing services. It also includes homeless people, people cycling in and out of psychiatric hospitals or emergency rooms, those frequently incarcerated, or people living precariously with family members.
- Determine the key issues and needs, as well as the barriers faced by these groups, and create a plan for outreach services that includes:
 - Deciding which staff members will conduct outreach services, and defining the role of peer outreach workers. Those with lived experience who are participating in outreach functions for specific populations are essential to the successful development and implementation of outreach and engagement.

⁴ Erickson, S., and Page, J. (October, 1998) *To dance with grace: outreach and engagement to persons on the street*. Paper presented at the National Symposium on Homelessness Research, Arlington, VA. Retrieved from <http://aspe.hhs.gov/progsys/homeless/symposium/6-Outreach.htm>

Implementation Strategies (cont'd)

In addition, employing staff members who have constructive relationships with specific ethnic and cultural communities and have bilingual capabilities that enable them to work with groups who have limited English proficiency is critical for reducing barriers to engagement.

- Establishing which outreach staff will maintain primary responsibility for outreach and engagement, or if they will follow clients into FSP services. The answer, in part, may depend upon the strengths and interests of outreach staff members. Some staff members have particular skills and are comfortable working in specific field-based environments.
- Considering separate outreach and engagement from ongoing services and supports if some staff have particular skills and are comfortable working in specific field based environments.
- Minimizing transitions between key staff with clients being involved in transitional decisions is important.
- Specifying locations where teams will perform outreach.
- Being aware that some clients may not access services due to fear of disclosing their identities. For example, some clients may risk legal consequences if they access services. Other clients may face violence and harassment if their sexual identity is discovered. Efforts should be made to maximize client safety and confidentiality.
- Considering resources available and collaborations to develop and to ensure success.
- Identifying existing community resources such as faith-based organizations, community-based agencies that have established relationships with target communities, and traditional or spiritual healers.
- Identifying and obtaining resources needed to meet the basic needs of each population. This could include recommendations such as how to furnish emergency shelter, food, clothing, medications, or legal assistance before or after enrollment in an FSP.

Implementation Strategies (cont'd)

- Using Motivational Interviewing (MI) to build rapport. “MI is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change.”⁵ Consider adopting the following outreach strategies by:
 - Valuing the outreach client as person.
 - Understanding the cultural and belief system of each client. For example, homeless clients often feel much safer and in control on the streets than in a shelter or in housing. Therefore, outreach strategies must take into account the beliefs the client has about mental illness, social services, and changes to one’s daily activities.
 - Using an approach that is responsive to cultural differences. Understanding the ways in which culture may affect the client’s willingness to seek help, attitudes about his or her illness, and attitudes toward treatment.
 - Displaying respect for the outreach environment and the clients for whom outreach services are designed.
 - Having and expressing hope.
 - Being patient, persistent and non-threatening.
 - Identifying client strengths, including survival skills.
 - Creating opportunities for client empowerment and self-determination by presenting clients with choices.
- Provide orientation and training to staff in the following areas:⁶
 - Knowing field safety.
 - Understanding the characteristics of the specific populations that are the focus of outreach, including ethnic and cultural minority groups.

⁵ Miller, W.R., & Rollnick, S. (2009). Ten things that motivational interviewing is not. *Behavioural and Cognitive Psychotherapy*, 37, 129-140.

⁶ Erickson, S., and Page, J. (October, 1998). *To dance with grace: outreach and engagement to persons on the street*. Paper presented at the National Symposium on Homelessness Research, Arlington, VA. Retrieved from <http://aspe.hhs.gov/progsys/homeless/symposium/6-Outreach.htm>

Implementation Strategies (cont'd)

- ❓ Recognizing co-occurring substance use and mental health disorders.
- Knowing the criminal justice system, public assistance benefits, and available resources in the community.
- Understanding abuse reporting laws (particularly when working with children, families, and dependent adults).
- Identifying engagement strategies and relationship development.
- Engaging community and family members in recovery planning and process.
- De-escalating and establishing a framework for outreach services that includes boundaries and limits to the work.

Welcoming Environments

Purpose

To convey a sense of welcoming to clients that reflects the belief in recovery. The healing and recovery process will not truly begin until a client feels welcomed and accepted into the services and supports of an FSP team.

Definition

Welcoming refers to the positive and accepting attitude conveyed by team members. It also is an expression of the environment where the team provides services and supports and the degree to which team members believe in the recovery philosophy.

Implementation Strategies

- Consider the potential barriers to creating a welcoming environment that exist in the clinic setting, along with potential solutions that achieve the purpose the barrier served, yet contribute to a positive and accepting environment.

POTENTIAL BARRIERS TO CREATING A WELCOMING ENVIRONMENT	POTENTIAL STRATEGIES FOR CREATING A WELCOMING ENVIRONMENT
Having a security guard.	<p>Creating a safe and secure environment is critical to any program’s success. The role of safety is not limited just to the presence of security guards. Staff and clients must be empowered to assume responsibility for ensuring a safe environment as well.</p> <p>If a county or agency must have security guards present, consider having the guards function as part of the overall team and knowing FSP clients by name. Ask clients what they like most and least about the presence of guards, and how they could be used most effectively.</p>
Using metal detectors to provide environmental safety and security.	<p>What is the purpose of the metal detector? Is it effective? How do clients and family members perceive it? How do team members perceive it? Can you devise a better way to achieve the purpose of the metal detector?</p> <p>Whether providing a service in the office or the community, consider the power of observation of team members and clients, coupled with a good therapeutic relationship or alliance, to determine when clients are acting in ways that might place themselves or others at potential risk.</p>
Posting multiple signs depicting rules and regulations generally telling clients what they cannot do.	<p>What does the team want to convey, and what is the best strategy to convey it?</p> <p>What is the role of peer specialists or peer greeters in conveying these messages?</p>

POTENTIAL BARRIERS TO CREATING A WELCOMING ENVIRONMENT	POTENTIAL STRATEGIES FOR CREATING A WELCOMING ENVIRONMENT
<p>Locking a door that causes separation between team members, and clients between the entry or waiting room and service areas.</p>	<p>Determine which areas of the site require controlled access and why.</p> <p>Examine team beliefs regarding the need for separation between themselves and clients.</p> <p>If some restrooms are designated only for team use, why is that? What are the underlying assumptions and beliefs about sharing restrooms or space with clients?</p>
<p>Lack of cultural diversity among staff members</p>	<p>For many clients of diverse ethnicities, entering an agency in which the staff is composed primarily of a different ethnicity can be threatening and perceived as unwelcoming. The environment can be improved by:</p> <p>Increasing staff diversity and bilingual capabilities.</p> <p>Ensuring that language minority clients are respected and receive translation services promptly.</p> <p>Posting signs in several languages.</p> <p>Choosing décor reflecting diverse cultures.</p> <p>Advertising local cultural events.</p> <p>Providing waiting room materials (magazines, children’s books, videos) in several languages.</p>

Debbie Innes-Gomberg, PhD, District Chief – MHSa Implementation Unit, Los Angeles County DMH

- Adopt strategies for developing staff and client relationships and communication. Inherent in the name “full service partnership” is the *partnership* between the client and the team. As with any partnership, the client and team must make joint decisions. Developing a partnership involves:
 - Understanding the client’s culture, the way in which he or she makes decisions and the involvement of family members or community in the client’s recovery.

Implementation Strategies (cont'd)

- Establishing an investment in a relationship that, at times, requires more from one partner than from the other partner.
- Knowing that because the healing or therapeutic relationship is equal, it may encompass hierarchical service aspects.
- Developing the capacity for team members and clients to share decision making with regard to care. In order to facilitate client self-responsibility and coordination, clients must be equal partners in treatment decisions.
- Instilling and maintaining hope for the client.

Harm Reduction and Stage of Readiness for Change

Purpose

To effect change by focusing interventions based on a client's motivation toward changing behaviors in that area of his or her life.

Definition

Harm reduction is the process of reducing the detrimental consequences of drug or alcohol use or other behaviors based on the client's level of readiness for change. It requires acceptance that, for a variety of reasons, a client may not be able to abstain from drug or alcohol use, or change other maladaptive behaviors. Quality of life and well-being, rather than abstinence and mandatory behavior change, become the focus points of success. Harm reduction occurs within the context of a client's readiness for change.

Definition (cont'd)

Five stages of change⁷ that have been identified include:

- Pre-contemplation: not currently considering change or a need for change.
- Contemplation: ambivalent about change.
- Preparation: attempts are being made to change.
- Action: change has been made, new behaviors are being practiced.
- Maintenance: commitment to sustained change and new behaviors.

Implementation Strategies

- Use a “readiness for change” approach to service delivery, assessment, and goal development.
- Utilize Motivational Interviewing (MI) strategies, based on a client’s stage of change, that identify the harmful effects of the maladaptive behavior and the benefits of reducing or stopping the behavior.
- Balance contingency-focused services (through which the client receives a service or benefit contingent upon a successful behavior change) with an overall approach to behavior change based on a client’s readiness to change that behavior, and on longer-term approaches to attaining the ultimate goal of behavior change.
- Explore alternative, safer behaviors that minimize risk.
- Praise small successes with meaningful reinforcements such as gift cards, tokens associated with progress, or acknowledgement in group activities.

⁷ Prochaska, J. O., & DiClemente, C. C. (1983). Stages of change in psychotherapy: Measurement and sample profiles. *Psychotherapy: Theory, Research, and Practice*, 20, 368–375.

Client-Centered Treatment Planning and Service Delivery

Purpose

To promote a foundation for healing through the relationship between the client and Personal Services Coordinator (PCS) or FSP team.

Definition

Client-centered treatment planning and service delivery involve services that are individualized to the needs, interests, and strengths of each client. The client-centered approach involves an equal relationship between provider and client. This type of relationship may be difficult to establish, especially if clients have the cultural expectation that providers are “experts.”

Implementation Strategies

- Take care when providing orientation to this approach — particularly for clients of diverse cultures, who may expect a more hierarchical relationship with their provider.
- Approach assessment and service delivery within the context of establishing and building a relationship that will result in healing and recovery.
- Conduct a thorough assessment of each client that results in the development of an integrated summary or clinical formulation based on the client data.
- In partnership with the client, develop a clinical formulation, assessment, and service plan based on the client’s unique cultural attributes, strengths, age, gender, sexual orientation, and readiness for change. Interventions are then based on the uniqueness of each client.
- Approach service planning and delivery as a collaboration of the Personal Services Coordinator and the client.
- Refer to the table below that illustrates the differences between a client-centered approach and that of a more traditionally used illness-centered approach.

ILLNESS-CENTERED APPROACH	CLIENT-CENTERED APPROACH
The diagnosis is the foundation.	The relationship is the foundation.
It begins with an illness assessment.	It begins with welcoming — outreach and engagement.
Diagnosis and treatment are needed to determine the services provided.	Personal suffering and help needed determine the services provided.
Services work is defined within the context of illness reduction goals.	Services work is defined in terms of quality-of-life goals.

ILLNESS-CENTERED APPROACH	CLIENT-CENTERED APPROACH
Treatment is symptom driven, and rehabilitation is disability driven.	Treatment and rehabilitation are goal driven.
Recovery from the illness sometimes results after the illness and then the disability are treated.	Personal recovery is the objective of a client-centered approach from beginning to end.
Track illness progress toward symptom reduction and cure.	Track personal progress toward recovery.
Use techniques that promote illness control and reduction of risk of damage from the illness.	Use techniques that promote personal growth and self-responsibility.
Services end when the cure to the illness occurs.	Services end when clients manage their own life and attain meaningful roles.
The relationship exists only to treat the illness, and must be carefully restricted throughout to maintain a professional relationship.	The relationship may change and grow throughout the process, and may continue even after services end.

Source: Mark Ragins, MD, Mental Health America of Los Angeles



Fostering Independence, Self-Determination and the Transition to Community Supports

Purpose

To assist clients in becoming more engaged in their recovery, in order to reduce reliance on the mental health system, as mental health interventions become less necessary.

Definition

Fostering independence, self-determination and the transition to community supports involves availability of interventions and approaches that focus on clients assuming more responsibility for their recovery and their daily life and changing their role from that of a client in a mental health system to a community member.

Implementation Strategies

- Create opportunities for shared decision making between Personal Service Coordinators and clients by using shared decision-making aids that can help clients weigh risks and benefits associated with various types of treatment and service, and make informed decisions.
- Help clients interested in physical activity, crafts, or reading find opportunities in their community to engage in those activities instead of creating groups at the mental health center.
- Acknowledge and respond to difficulties that unserved and underserved groups encounter when trying to access services.
- Identify programs that provide culturally appropriate supports and services and that adequately help members of unserved and underserved groups cope with difficulties they experience.
- Minimize the need to transport clients by helping them learn to take public transportation when available. Encourage clients to explore group transportation options.
- Provide community-based services to help clients become accustomed to accessing community resources.
- Encourage the use of self-help services and supports in order to self-manage symptoms.
- Hire clients as part of the FSP team.
- Consider the role of faith-based organizations and other naturally occurring groups in supporting clients in the community.
- Use program and client outcome data wherever possible as part of a larger strategy to facilitate joint or shared decision-making regarding client transitions.
- Assist clients in creating a sense of community based on client interests and strengths, or ways in which clients identify ethnically or culturally.

Community Capacity Building

Purpose

- To assist clients in managing and living productive lives in their community.
- To reduce unnecessary client reliance on the mental health system.
- To increase capacity within the system to serve new clients.

Definition

Community capacity means the “ability of community members to use the assets of its residents, associations, and institutions to improve quality of life.”⁸ *Community capacity building* involves finding or creating opportunities that enable clients, as they recover, to rely on services and supports from the community rather than the mental health system.

⁸ *Mental health promotion toolkit: A practical resource for community initiatives.* (n.d.) *Glossary of terms.* Retrieved from http://www.cmha.ca/mh_toolkit/intro/glossary.htm

Definition (cont'd)

Generally, community capacity building has five elements:⁹

1. Knowledge building within the community — to assist communities in understanding the needs of diverse populations that exist within the community, such as those recovering from mental illness and striving to live independently.
2. Leadership — to identify and support a collective vision and interest of all community stakeholders and develop a strategic direction.
3. Network building — to enable formation of partnerships and strategic alliances for the benefit of the community.
4. Valuing of community — to recognize importance of the distinctive qualities of the community that support an investment of effort to work together.
5. Supporting information and analysis — to track and report on data and outcomes of community integration efforts and the mental health program.

Implementation Strategies

- Build community capacity by facilitating trust of mental health clients within communities by:
 - Educating the community about mental illness, including resource information and speakers bureau composed of clients, family members, and non-clients, to illustrate inclusion and recovery.

⁹ McGinty, S. (2002). *Community capacity building*. Paper presented at the Australian Association for Research in Education Conference, Brisbane, Queensland, Australia. Retrieved from <http://www.aare.edu.au/02pap/mcg02476.htm>

Implementation Strategies (cont'd)

- ❓ Collaborating with Prevention and Early Intervention (PEI) programs targeting PEI programs with non-mental health community-based agencies, programs, and faith-based groups.
- Reducing the stigma of mental illness through the process of de-bunking myths that persons diagnosed with mental illness are violent or unpredictable.
- Establishing partnerships between mental health programs and community organizations such as the YMCA, local parks or recreational establishments, gyms, health-care organizations, businesses, community-based organizations, traditional or spiritual healers, and advocacy groups.
- Establishing a positive presence by becoming partners with the community. Providers should strive to build constructive relationships with their communities by attending community events and cultural celebrations. In addition, providers may consider serving on local committees and governing boards. Mental health providers should strive to receive as much support from the community as is given to the community.
- Assisting in establishing community “safety nets” for residents and clients.
- Assisting in establishing, developing, and supporting community or neighborhood coalitions that are empowered to solve community-level problems.
- Identifying existing official and “non-official” resources in communities, and making that information widely available and easily accessible.
- Creating networking opportunities for existing resource providers to encourage warm hand-off referrals from resource to resource.

Resource Guide

Each of the tools listed below has specific resources that you can locate in the general resource section on pages 44–48. This guide enables you to focus on the pertinent resources linked directly to each tool.

Name of Tool	Resource Number(s)
Whatever It Takes	10 , 11 , 12 , 13
Ensuring Cultural Responsiveness of Interventions	4 , 17 , 21
Being Fully Served, Ensuring Integrated Experience	15
Tailoring Service Coordination to Client Stage of Recovery	8 , 9 , 10,11
Outreach and Engagement	1 , 6 , 14 , 16
Welcoming Environments	26
Harm Reduction and Stage of Readiness for Change	2 , 5 , 14 , 20 , 24 , 25
Client-Centered Treatment Planning and Service Delivery	3 , 18
Fostering Independence, Self-Determination and the Transition to Community Supports	19 , 22 , 23
Community Capacity Building	7 , 15 , 16

Resources

✓ Articles

1. Dixon, L., Krauss, N., Lehman, A. (1994). Consumers as service providers: The promise and challenge. *Community Mental Health Journal*, 30(6), 615–625.
2. Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51, 390-395.

✓ Books

3. Adams, N., & Grieder, D. M. (2005). Treatment planning for client-centered care, the road to mental health and addiction recovery. Burlington, MA: Elsevier Academic Press.
4. Betancourt, J.R., Green, A.R., & Carrillo, J.E. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches*. New York: The Commonwealth Fund.

Resources (cont'd)

5. Van Tosh, L., Finkle, M., Hartman, B., Lewis, C., Plumlee, L. A., & Susko, M. A. (1993). *Working for a change: Employment of consumers/survivors in the design and provision of services for persons who are homeless and mentally disabled*. Rockville, MD: The Center for Mental Health Services.

✓ Newsletter

6. Community capacity building. (1999, Summer). *Prevention Outlook, Vol. 9(1)*. University of Wisconsin. Retrieved from http://wch.uhs.wisc.edu/03-Resources/Outlook/v09n1-Summer99/Outlook_mainframe-v9n1.htm

✓ Policy Guideline

7. California Mental Health Directors Association. (2008). *Levels of service policy guideline*. Retrieved from http://cmhda.org/committees/documents/ASOC/Handouts/0805_ASOC_documents_LOS_policy_and_guidelines_April_08.pdf

✓ Recovery Scales

8. Adult Needs and Strengths Assessment (ANSA). Retrieved from www.praedfoundation.org/ANSA%20Manual%202.0.pdf
9. LOCUS: Level of Care Utilization System. Retrieved from http://www.communitypsychiatry.org/publications/clinical_and_administrative_tools_guidelines/locus.aspx

Resources (cont'd)

✓ Recovery Scales (cont'd)

10. MORS: Milestones of Recovery. Retrieved from [http://www.cmhda.org/committees/documents/ASOC_handouts_\(2-14-07\)_Milestones_of_Recovery_Paper_\(Dave_Pilon\).pdf](http://www.cmhda.org/committees/documents/ASOC_handouts_(2-14-07)_Milestones_of_Recovery_Paper_(Dave_Pilon).pdf)
11. National Consensus Statement on Mental Health Recovery. Retrieved from <http://www.power2u.org/downloads/SAMHSA%20Recovery%20Statement.pdf>

✓ Reports and Research Papers

12. California Department of Mental Health — MHSA Community Services and Supports (CSS) plan three-year program and expenditure plan requirements. Letter on August 1, 2005. Retrieved from <http://www.dmh.ca.gov/DMHDocs/docs/letters05/05-05CSS.pdf>
13. Erickson, S., & Page, J. (1998, October). *To dance with grace: outreach and engagement to persons on the street*. Symposium conducted at the meeting of the National Symposium on Homelessness Research, Arlington, VA. Retrieved from <http://aspe.hhs.gov/progsys/homeless/symposium/6-Outreach.htm>
14. McGinty, S. (2002). *Community capacity building*. Presentation at the Australian Association for Research in Education Conference, Brisbane. [Abstract]. Retrieved from <http://www.aare.edu.au/02pap/mcg02476.htm>
15. UC Davis Center for Reducing Health Disparities. (2008). *Building partnerships: Key considerations when engaging underserved communities under MHSA*. Retrieved from http://www.dmh.ca.gov/PEIStatewideProjects/docs/Reducing_Disparities/BP_Key_Considerations.pdf

Resources (cont'd)

✓ Reports/Research Papers (cont'd)

16. U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care*. Retrieved from <http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>

✓ Websites

17. CalMEND — Resources for Mental Health Care Organizations and Providers of Mental Health: <http://www.calmend.org>
18. Common Ground — Supported Recovery through Shared Decision Making — A web-based software application that empowers clients to communicate with psychiatrists via shared decisions: <http://www.patdeegan.com/AboutCommonGround.html>
19. Harm Reduction Coalition: <http://www.harmreduction.org/>
20. NAMI, Cultural Competence in Mental Health: http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Cultural_Competence/Cultural_Competence.htm
21. SAMHSA Mental Health Decision Aids: http://www.samhsa.gov/consumersurvivor/pdf/SAMHSA_Ddecision_Aid_Chart_Jan08.pdf
22. SAMHSA's Shared Decision-Making: Making Recovery Real in Mental Health Care Project: <http://www.samhsa.gov/consumersurvivor/shared.asp>

Resources (cont'd)

✓ Websites (cont'd)

23. Stages of Change: UCLA Center for Human Nutrition:
http://www.cellinteractive.com/ucla/physician_ed/stages_change.htm
↓
24. Transtheoretical Model, Cancer Prevention Research Center:
<http://www.uri.edu/research/cprc/TTM/StagesOfChange.htm>

✓ Workbook

25. Anderson, B. & Paton, D. (2004). *Welcome! Creating welcoming places workbook*. Retrieved from <http://www.communityactivators.com/>

Domain #2

Service Array

The *Service Array* domain identifies the specific practices, tools and interventions associated with adult FSP programs. These practices place the *Philosophy* domain into operation.

Use of a Strength-Based Approach

Purpose

To help a client identify and use his or her individual strengths in treatment as an effective way to help achieve goals and believe that recovery is possible.

Definition

A strength-based approach involves development of an assessment, treatment plan, and service delivery through a collaborative partnership between the client and treatment team. This approach capitalizes on a client's strengths, a holistic view of the client, and the belief that recovery is achievable. For many clients, particularly clients of ethnic and cultural minority groups, the relationships may not be only with the client but also with the extended family, traditional or spiritual healers, and other community members important to the client.

Implementation Strategies

- Explore with each client his or her strengths, as they relate to each goal, while acknowledging mental health barriers. Also include what the client — and in some cases, the client’s family and support network — bring to the treatment process, including identifying client interests, talents, abilities, and resources.
- Assist the client in identifying and using the types of “capital” he or she brings to services: personal (values, skills, and knowledge), family or social, community (resources and culture), and physical and financial health.
- Identify and build upon cultural strengths, such as a positive and strong ethnic identity, sexual orientation, traditional cultural customs and heritage, tribal traditions, and cultural celebrations.



Client Self-Management

Purpose

To help clients learn to assume more responsibility for their overall care by becoming more involved in decision making and successfully managing their symptoms.

Definition

Client self-management is the process by which clients increase their involvement in decisions about their care and recovery.

Implementation Strategies

Client self-management strategies vary in their use of peers and mental health staff, but all focus on educating and empowering clients to make decisions and actions that support their recovery. Among the universe of strategies to enhance client self-management, consider the following:

Shared Decision Making

This collaborative process between a mental health professional and a client is intended to help clients understand the advantages and disadvantages of mental health treatment options, with the goal of creating decision aids to guide clients in making informed choices.

- Place computers in waiting rooms or resource areas of mental health programs, and encourage clients to access on-line information and decision aids that can assist them in making decisions related to their care.
- Create opportunities for clients and staff to discuss decision-making strategies, individually, in groups, or using technology.
- Consider reviewing client data (outcome, recovery level, or client-completed questionnaires) with clients to create opportunities for clients and FSP team members to discuss progress.
- Provide information in a variety of languages.

Implementation Strategies (cont'd)

Wellness Recovery Action Planning (WRAP)

WRAP is an approach to client self-management, facilitated by trained WRAP leaders who usually are clients in recovery. In this approach, clients help clients by developing:

- Daily maintenance plans that list the characteristics of clients when they are feeling well, daily activities that maintain wellness, and additional activities that would contribute to wellness.
 - Wellness toolboxes that could be a notebook or container where daily maintenance plans, triggers, trigger plans, and plans for crisis and post-crisis are kept.
 - Ways to identify early warning signs that symptoms are increasing.
 - An action plan defining what to do when triggers develop.
 - A crisis plan that identifies what the client is like when he or she is feeling well; symptoms that indicate that others need to take over full responsibility for care and make decisions on their behalf; who those trusted individuals are and how to contact them; medications and supplements the client takes, including preferences and those that must be avoided; treatments that reduce symptoms and those that should be avoided; and preferred treatment facilities.
 - A post-crisis plan indicating the signs or symptoms that the crisis plan no longer needs to be utilized.
- Develop a training and implementation plan that involves the role of all team members and that focuses on what WRAP uniquely brings to the services that already are being provided. Involve the client's community and family support network in the implementation plan.
 - Use WRAP strategically to assist clients in transitions — for example, in living independently, obtaining employment, returning to school, or making the transition from mental health services.

Implementation Strategies (cont'd)

Peer Support

A peer's presence can signal hope that recovery can, and does occur, and lends legitimacy to the program more convincingly than the assertions of staff members without lived experience.

- Target efforts to increase the cultural and linguistic diversity of peer staff to improve the effectiveness of peer support programs.
- Be aware that, depending on the varied needs of clients on the team, peer support may take different forms and may consist of paid peer staff members, volunteers, or clients helping other clients.
- Consider the following specific roles for peers:
 - Having peers initially act as outreach workers and welcoming as clients consider entering the system.
 - Accompanying clients to appointments.
 - Assisting clients in obtaining needed services.
 - Lending a hand in looking for housing or grocery shopping.
 - Serving to assist clients in crisis.
 - Offering alternatives to crisis, such as staffing warm lines.
 - Providing peer counseling.
 - Assisting clients in seeking crisis residential programs and other outpatient alternatives to hospitalization.

Implementation Strategies (cont'd)

Illness Management and Recovery (IMR)

Illness Management and Recovery (IMR) is a SAMHSA evidence-based practice for teaching clients, either individually or in groups, how to identify and manage symptoms effectively. Approaches include relapse prevention training, psychoeducation, coping skills training, and social skills training.

- Provide 5 to 12 months of weekly or twice-weekly sessions focused on recovery strategies, facts on mental illness, building social support, using medication effectively, reducing relapse, coping with stress, coping with symptoms and problems, and fulfilling needs within the mental health system.
- Have clients set personal recovery goals.
- Remember, the client is the expert, with the FSP staff facilitating the client's learning in a partnership.

Integrated Services for Clients with Co-Occurring Substance Use and Mental Health Disorders

Purpose

To integrate substance abuse and mental health services into one treatment plan. Doing so is critical to the recovery process for both disorders.

Definition

The concept of *integrated services for clients with co-occurring substance abuse and mental health disorders* (COD) means “providing both substance use and mental health interventions concurrently and in relation to each other, as part of one treatment plan provided by one team or within a network of services with shared goals. These integrated services must appear seamless to the individual and family participating in services.”¹⁰

¹⁰ Department of Mental Health and Addiction Services, State of Connecticut. (2010). *Serving individuals and families with co-occurring mental health and substance use disorders*.1-4. Retrieved from: <http://ct.gov/dmhas/lib/dmhas/policies/chapter6.4.pdf>

Implementation Strategies

Developing the Capacity for Integrated Services

- Consider hiring a Dual Diagnosis Specialist who assists and leads the team with developing COD services.
- All team members should participate in specialized dual recovery training initially and at least annually.
- All staff members should be trained in and practice Motivational Interviewing (MI) and stage-wise treatment.

Integrated Service Strategies

- Begin the integrated services process with an assessment of a client's patterns of use of alcohol and other substances and their impact on mental illness.
- Use a stages of change model, such as Prochaska and DiClemente's Stages of Change model, or a similar model, as a way to match a client's stage of change to intervention strategies. Approach services from the perspective of the client and his or her degree of perception that substance abuse is a problem and is crucial to address.
- Coordinate and match interventions and services to the client's readiness or willingness to change.
- Use MI, after identifying a client's stage of change. MI can serve as a strategy to stimulate conversation about readiness for change and therapeutic commitments.

Implementation Strategies (cont'd)

- Offer an array of services options. Services should range from outpatient individual and group COD services, 12-Step programs, sober living homes and residential drug treatment programs. These options are often useful living arrangements as long as alignment exists between the client's agreement to the approach and the treatment strategies.
- Develop integrated assessments, service plans and crisis plans that promote recovery.

Role of Medication and Psychotherapy

Purpose

To understand the potential role and value of psychotherapy as a treatment modality within an FSP, and to identify strategies for FSP teams to work collaboratively with clients regarding psychiatric medications.

Definition

Medication and psychotherapy are therapeutic interventions designed to reduce the symptoms associated with a serious mental illness and improve a client's quality of life by helping a client gain insight into behaviors and symptoms and adopting behaviors that contribute to recovery goals. While the goals of both cognitive behaviorally based psychotherapies and the administration of psychiatric medication are not always explicitly grounded in the language of recovery, both are elemental in the recovery process.

Definition (cont'd)

Helping clients to make the connection between these interventions and the recovery process is critical to the success of these interventions.

Common diagnoses for FSP populations include depression, anxiety, and/or psychotic disorders. It is strongly recommended that counties use evidence-based practices as part of the FSP service array. These may include but are not limited to:

- Cognitive Behavioral Therapy (CBT). CBT is an efficacious, evidence-based practice used in individual or group treatment. The basis for CBT is the assumption that negative thoughts can lead to negative emotions and behaviors. By helping people change the way they think (cognitive) and the way they act (behavior), CBT can help people resolve problems that would otherwise interfere with daily living.
- Dialectical Behavior Therapy (DBT). Like CBT, DBT is an evidence-based practice targeting emotional dysregulation. DBT augments the techniques of CBT by helping the client acquire skills in mindfulness and non-judgmental acceptance.
- In order to review more commonly used evidence-based practices, refer to SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) or a similar source of evidence-based practices.¹¹

¹¹ National Registry of Evidence-based Programs and Practices. <http://nrepp.samhsa.gov/>

Implementation Strategies

- Identify clinicians interested in obtaining training in empirically supported treatments such as CBT or DBT. Treatment teams should be well-versed in the overall approach of the psychotherapies being offered in order to support and make referrals for interventions.
- Use daily team meetings to facilitate referrals for psychotherapy and medication issues.
- Consider the use of shared decision models and decision aids to assist a client in making a responsible and informed choice regarding psychiatric medications.
- Take care to explore the attitudes of team members, including the client and his or her support network, regarding these approaches to treatment and to respect the client's experience and values. Attitudes toward medication and psychotherapy vary across cultures. For some clients, particularly those from unserved and underserved groups, these interventions may seem oppressive or harmful.
- Provide an orientation, when appropriate and particularly for those clients with little exposure to the mental health system, to the process, benefits, and risks of medication and psychotherapy.
- Respect a client's choice regarding taking psychiatric medication, and use Motivational Interviewing (MI) approaches where appropriate.
- Identify delivery strategies for clients who cannot easily access pharmacies to routinely obtain their medication.

Reconnecting with Family

Purpose

To facilitate the recovery process and add an element of social support to the client.

Participation of the family in services is contingent upon the wishes of the client.

Definition

Family refers to “anyone committed to the care and support of the person with mental illness, and does not have to be a blood relative”¹² as identified by the client. The role of the family in the recovery process may also be a function of the cultural context. For example, in many Latino families, family obligations, roles, and family bonds and ties continue to exert a strong influence into adulthood. For many Native Americans, the treatment of the client often is seen as a process involving the entire community.

¹² SAMHSA’s Evidence-Based Practices KIT: Family Psychoeducation Implementation Resource Kit. Retrieved from http://dare-to-dream.us/recovery/EBP_FamilyPsychoeducation.pdf

Definition (cont'd)

Care should be taken to explore the cultural context of recovery for the client, and identify a level of family and community participation that reflects the client's wishes and is culturally congruent.

Implementation Strategies

- Establish the client's wishes for family involvement in services. If the client initially declined, periodically check to see if the client has changed his or her mind and now wishes to establish a connection with family and involve them in the care. A client's definition of *family* may encompass friends who have significant and supportive relationships with the client.
- Be aware and respectful of differing cultural roles, communication, decision-making processes, and expectations within diverse families.
- Include key community members, per client wishes and when culturally appropriate, in developing and implementing the recovery plan.
- Use family psychoeducation, involving engaging families in and offering ongoing education about the illness, to develop problem solving and coping skills and to create social supports.
- Implement other educational supports for family members.
- Attend local National Alliance on Mental Illness (NAMI) groups, and advise family members about NAMI services that are available.

Increasing Social Supports

Purpose

To increase clients' social networks and increase opportunities to meet new people. Doing so can help make recovery seem achievable.

Definition

Social supports encompass ongoing social, nonprofessionally oriented interactions with people who act as supports for clients, yet who are not mental health staff members.

Implementation Strategies

- Create opportunities for social networking by creating bulletin boards and posting social activities.
- Link clients to natural social networking opportunities, including those based in the community (for example, book clubs and hiking clubs) and on-line resources (such as Facebook and Twitter).
- Create non-professionally led groups based on interests, such as weight loss and cooking programs.
- Identify resources and activities for unserved and underserved clients, such as support groups, recreational programs, older adult activity groups, cultural ceremonies, spiritual celebrations, and musical festivals.

Education, Employment, and Volunteering

Purpose

To engage in activities that are meaningful, create self-sufficiency and give back to the community. These are critical elements of recovery.

Definition

Education, employment and volunteering are activities that are meaningful to clients, contribute to their personal well-being, and help them transcend their role as a client of the mental health system. Supported employment has the following principles: (1) employment is based on client choice, rather than on provider belief of client readiness; (2) services are integrated with comprehensive mental health services; (3) competitive employment is the goal; (4) job searches start as soon as the client expresses an interest in working; (5) follow-along supports are continuous, and generally gradually decrease over time; (6) client preferences are important.

Implementation Strategies

EDUCATION

- Promote returning to school by advertising or publicizing opportunities in newsletters or posters in the building.
- Establish relationships with a range of local academic programs and institutions.
- Achieve a thorough understanding of the unique needs of the clients as they consider returning to school, including key educational pursuits.
When composing a strategy, consider the following questions:
 - Can the educational program tailor courses to the needs of clients with certain specific interests?
 - How closely associated is the educational program with local employers?
 - What other services does the educational program offer? Are enriching experiences such as gym memberships, groups, and other opportunities available by which students can attain greater community integration?
 - Does the mental health program require a certain type of job classification and can the educational program develop a set of classes resulting in a certification that qualifies clients for the job classification, thus creating career opportunities?

Implementation Strategies (cont'd)

EMPLOYMENT

- Create a vision for client employment opportunities within and outside the mental health system, based on the principles and goals of supported employment (SE) and recruit a lead employment specialist with designated job functions.
- Form one or more advisory groups to identify and remove bureaucratic barriers¹³ and inform the program of findings. Ideally, advisory groups would include members of unserved and underserved groups, because guidance in developing resources for ethnic and cultural minority clients is critical to the success of these programs.
- Establish program standards.
- Identify and resolve any financial insufficiencies or other problems. Explore the use of non-mental health services and support funds for use in paying salaries for jobs. (Refer to Domain #4 Housing, Tool: “Use of FSP Funds for Non-Mental Health Services and Supports.”)
- Develop a training structure.
- Monitor the program and its outcomes.
- Develop collaborative relationships with other agencies (state and local), thereby leveraging capital to support a client employment program.
- Consider establishing shared procedures for referrals and providing ongoing support for mutual clients.
- Create part-time and full-time hiring and promotional opportunities within the local mental health system. Clients interested in a career within mental health, as a peer specialist, peer advocate or other position, may benefit from the following functions:

¹³ SAMHSA’s Evidence-Based Practices: Supported Employment KIT. Retrieved from http://www.samhsa.gov/samhsanewsletter/Volume_18_Number_2/EvidenceBasedPracticesKits.aspx

Implementation Strategies (cont'd)

- Exploring any opportunities the county's Workforce, Education and Training (WET) Plan may offer related to funding for client mental health career pathways or other relevant components of WET. For more information on WET, consult the CCR, Title 9, Division 1, Articles 2, 3, 5 and 8.
- Developing a plan for peers to enter county or contract agency mental health programs as employees, including specific positions and a career ladder.
- Developing and implementing training or certification for peers to gain the essential skills to enter the mental health workforce.
- Establishing specific, targeted recruitment activities for ethnic and cultural minority clients.
- Linking certification completion with the employment application process.
- Conducting ongoing educational support for peers as they enter the mental health workforce, perhaps through the resources of the county's WET Plan, including establishing a loan assumption program or a scholarship program.
- Establishing and funding mental health career pathway programs in the mental health system for clients currently employed, whether full-time or part-time, who want to increase their skills and scope of responsibility. Encourage participation of clients within populations and communities that have been identified as unserved or underserved by the public mental health system.
- Establishing policies and parameters on peer employment within the same setting where clients received mental health services.
- Developing educational opportunities for interested peer staff members, and encourage them to apply.
- Overcoming benefit-related barriers — such as changes in SSI benefits as a result of working — that can impede clients from seeking employment.
- Referring clients to Social Security benefits counselors as a way to help them understand how employment may affect benefits.

Implementation Strategies (cont'd)

VOLUNTEERING

Clients who are uninterested in seeking employment or returning to school may find volunteering — either within the mental health system, in other organizations or in general community settings — an appealing way to contribute to a sense of well-being and recovery.

- Help clients identify opportunities for meaningful volunteering through peer support groups or by creating volunteer opportunities posted on bulletin boards or websites created by clients.
- Consider creating volunteer positions within FSP teams, including clerical support, assisting clients in completing annual satisfaction surveys, and other tasks as identified by the FSP team.

Community Integration

Purpose

To shift client supports and activities from the mental health system to those in the community as the client's recovery progresses.

Definition

Community integration occurs when friends, colleagues, and others take a more active role in the life of a client who is undergoing the transition from the primary support of the mental health system. The role of an FSP team shifts to supporting the client in initiating activities and taking further responsibility for recovery and community integration through “interpersonal connectedness and citizenship.”¹⁴

¹⁴ SAMHSA Supported Employment Kit. (2010). Retrieved from <http://store.samhsa.gov/product/SMA08-4365>

Implementation Strategies

- Assist clients in using the Internet or other community guides to plan activities.
- Help clients identify ways and opportunities to meet people, by defining their interests, strengths, hobbies, and cultural and ethnic affiliations.
- Be aware of and responsive to differing cultural attitudes regarding the disclosure of mental illness in public settings.
- Identify recreation centers, community centers, faith-based and spiritual supports, advocacy groups, and ethnic organizations that may provide support and social activities for clients.
- Assist the client's support network (family and community members) in developing a plan to integrate the client into traditional celebrations and cultural activities.
- Focus peer support toward community engagement activities.
- Encourage clients to celebrate holidays in their own apartment, rather than at a mental health center or at community organizations.
- Motivate clients to organize their own trips and outings rather than confining themselves to those that the mental health program may conduct.
- Assist clients in identifying low-cost or no-cost organizations they may join in their community.

Reducing Involvement in the Criminal Justice System

Purpose

To minimize client contact with law enforcement agencies, as a means of improving client quality of life.

Definition

Reducing involvement in the criminal justice system can be achieved through strategies designed to minimize client contact with law enforcement, including detainment and arrests.

Implementation Strategies

- In partnership with the client, determine whether he or she has been issued any outstanding warrants or unpaid tickets that could result in an arrest. Assist the client in resolving these infractions to reduce the likelihood of criminal justice involvement for activities that occurred before the partnership.
- Engage in proactive, advocacy-related work with the court when clients do become involved in the criminal justice system. Depending upon circumstances and history, a judge may suspend or reduce a sentence for a client who is enrolled in an intensive program.
- Conduct advocacy and education activities to help counter the stigmatization and discrimination that confront mental health clients in the criminal justice system.
- Establish relationships or partnerships with local probation offices. Such collaborations can identify individuals with a mental illness who are involved in the criminal justice system and may benefit from a referral to a FSP team.
- Consider involvement of mental health courts where they exist and when appropriate.
- Consider involving the probation officer, with client consent, as part of the FSP team.
- Issue identification cards for interested clients, requesting law enforcement or psychiatric mobile response personnel to contact the FSP team in the event the client is in need or in trouble. Use of these cards is voluntary and at the discretion of the client.

Linkage to and Coordination of Health and Dental Care

Purpose

To ensure access for all FSP clients to needed health and dental care. Access to these services is particularly critical because mental health clients often have undiagnosed and untreated medical conditions that result in chronic medical conditions and premature death.

Definition

Linkage to and coordination of health and dental care entail engaging in activities that result in a client-patient relationship with a primary-care physician for health care and with a dentist for dental care.

Implementation Strategies

- Determine which health-related services the FSP team will offer. Such functions may include health screenings, health promotion and prevention activities, on-site diagnostic and treatment services, and assistance in understanding the interactions between medical and psychiatric medications.
- Identify prevalent health conditions among the FSP client population, and create education, prevention, and linkage services to help resolve them.
- Develop collaborative relationships with local health-care organizations that accept clients without a payor source or those with Medi-Cal. Identify local community clinics that accept clients without a payor source.
- Identify the role of a nurse, nurse practitioner or psychiatrist on the FSP team when determining the health needs of clients. Such an individual may act as a liaison to primary-care programs.
- Consider different strategies that convey to clients the importance of paying attention to health status, including the presence of groups focused on managing health conditions, smoking cessation, weight loss, and healthy eating and living.
- Assist clients in developing health literacy: knowing how to communicate with health-care providers, navigating the health-care system, asking the right questions, and receiving adequate translation services when appropriate.
- Accompany clients to their first medical appointments and subsequent appointments, as necessary.
- Attend dental appointments with clients, with the understanding that it may have been the client's first dental appointment in years.
- Consider adding healthy living activities, such as handing out dental floss and teaching clients about proper flossing.
- Prepare clients for the information they will need to present to their primary-care provider regarding their medical histories.

Implementation Strategies (cont'd)

- Ask the client to sign releases of information and authorization, as a matter of practice, to help initiate comprehensive, integrated health and mental health treatment and to ensure that information on health and mental health care is shared appropriately. Authorizations should be specific to a primary-care physician to achieve coordination of care and in accordance with HIPAA regulations.

Crisis Intervention and 24/7 Availability

Purpose

To ensure that someone known to the client is available to respond during a crisis 24 hours per day, seven days per week.

Definition

Providing *crisis intervention and 24/7 availability* is the responsibility of the Personal Services Coordinator (PSC) and the entire FSP team. The team shares responsibility for each client but the PSC is immediately accountable for 24/7 response to client needs. The team approach ensures continuity of care for clients, and creates a supportive organizational environment for practitioners. The team ensures that a PSC is available 24/7 to respond to crisis needs if and when they arise. This team approach to around the clock availability helps to minimize the impact of staff absences or turnover and assure that a PSC, who is known by the client, is always available.

Implementation Strategies

- In team meetings, identify clients who are likely to need response during the workday or after hours.
- Develop plans with clients to reduce the need for after-hours crisis response, including:
 - Using Wellness Recovery Action Plans. (Refer to Domain #2 Service Array, Tool: “Client Self-Management.”)
 - Helping clients to identify positive and useful coping strategies.
 - Identifying early signs or precursors of an increase in symptoms.
 - Assisting clients in receiving support from other clients or peer providers.
- Ensure that bilingual staff members are available to meet the needs of clients with limited English-language proficiency.
- Consider use of 23-hour urgent care centers associated with FSP programs to manage crises after hours. These programs can treat clients for up to 23 hours, 59 minutes, and can provide crisis services, medication, and linkage to immediate needs such as housing or outpatient mental health services. Be aware of language limitations at the centers, and prepare for potential linguistic complications before they occur.
- Consider creating crisis respite centers with staffs composed of peers who can furnish care support and housing during a mental health crisis.

Coordination of Inpatient Care

Purpose

To ensure coordination of services when an FSP client is in a psychiatric hospital.

Definition

Coordination of inpatient care is the process by which the FSP team ensures continuity of care while a client is hospitalized, and manages a seamless transition to ongoing self-care once the hospital discharges the client.

Implementation Strategies

Before a Hospitalization Occurs

- Develop relationships with local psychiatric inpatient units to help achieve continuity of care.
- Assist each client in identifying a plan for the care of children, pets, or housing in the event of a psychiatric hospitalization. Document these needs in the client's medical record.

Once a Hospitalization Occurs

- Contact the attending psychiatrist and discharge planner immediately, after obtaining appropriate releases and authorizations, when a psychiatric hospitalization occurs without the knowledge or involvement of the FSP team.
- Make sure that the hospital staff understands the services associated with the FSP team and has pertinent information related to the client's care.
- Visit each client regularly while he or she is in the hospital, and meet with the discharge planner and treatment team to coordinate discharge. Help family members, when appropriate, and other support team members to visit the client in the hospital.
- Meet the client's emergent needs. (Refer to the second bullet item in "Before a Hospitalization Occurs" above.)

Implementation Strategies (cont'd)

At the Conclusion of a Psychiatric Hospitalization

- Pick up the client, furnish transportation to his or her place of residence, ensure that the client's supply of medication is adequate, and confirm that the team is prepared to render follow-up care.
- Review with the client any precursors that may have contributed to the hospitalization, and develop strategies to avert future incidents or episodes. Include the family in that review process (when applicable to the client's wishes), and engage the support team in developing a plan to prevent future hospitalization.
- Modify the treatment plan as needed.

Resource Guide

Each of the tools listed below has specific resources that you can locate in the general resource section on pages 85–91. This guide lists and links pertinent resources within each tool name.

Name of Tool	Resource Number(s)
Use of a Strength-Based Approach	3 , 7 , 14 , 15
Client Self-Management	1 , 4 , 23 , 25 , 27 , 33 , 36 , 39 , 44
Integrated Services for Clients with Co-Occurring Substance Use and Mental Health Disorders	2 , 8 , 18 , 20
Role of Medication and Psychotherapy	11 , 13 , 28 , 37 , 38
Reconnecting with Family	17 , 30 , 40
Increasing Social Supports	16
Education, Employment and Volunteering	19 , 29 , 43
Community Integration	3 , 12 , 42
Reducing Involvement in the Criminal Justice System	9 , 10 , 24
Linkage to and Coordination of Health and Dental Care	5 , 31 , 32 , 34 , 35 , 41
Crisis Intervention and 24/7 Availability	21
Coordination of Inpatient Care	6 , 22 , 44

Resources

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2. Drake, R. E., Mercer-McFadden, C., Mueser, K. T., McHugo, G. J., Bond, G. R. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin*. 24(4), 589–608. [PubMed] PMID: 9853791. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/9853791>
3. Marty, D., Rapp, C., & Carlson, L. (2001). The experts speak: The critical ingredients of strengths model case management. *Psychiatric Rehabilitation Journal*, 24(3), 214–221.

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9. Steadman, H. J. (1992). Boundary spanners: A key component for the effective interactions of the justice and mental health systems. *Law and Human Behavior*, 16(1), 75-87.
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13. Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York: The Guilford Press.
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Resources (cont'd)

✓ Handout

16. Building Social Support. Retrieved from <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/illness/workbook/handout4.asp>

✓ Tool Kits

17. Family Psychoeducation Evidence-Based KIT from SAMHSA. Retrieved from <http://store.samhsa.gov/product/SMA09-4423>
18. Integrated Treatment for Co-Occurring Disorders, SAMHSA Evidence-Based Practices Kit. Retrieved from <http://store.samhsa.gov/product/SMA08-4367>
19. Supported Employment — Evidence- Based Practice. Retrieved from <http://store.samhsa.gov/product/SMA08-4365>

✓ Treatment Improvement Protocol

20. Center for Substance Abuse Treatment. *Substance abuse treatment for persons with co-occurring disorders*. Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3922. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005. Retrieved from <http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A74073>

✓ Video

21. National Empowerment Center. (Vimeo). *Resources for starting a peer-run crisis alternative in your area* [Video]. Available from <http://www.power2u.org/starting-a-peer-run-crisis-alternative.html>

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✓ Websites

22. Assertive Community Treatment:
<http://store.samhsa.gov/pages/product/advSearchResult/?keyword=assertive%2Bcommunity%2Btreatment&pubNumber=&selectedTerms=Kit&pubDate=200>
23. CalMEND: <http://www.calmend.org>
24. CMHS National GAINS Center: <http://www.gainscenter.samhsa.gov>
25. Common Ground:
<http://www.patdeegan.com/AboutCommonGround.html>
26. Consumer/Survivor Mental Health Information, from SAMHSA's Center for Mental Health Services:
<http://mentalhealth.samhsa.gov/consumersurvivor>
27. Dartmouth Psychiatric Research Center:
<http://www.dartmouth.edu/~prc/>
28. Dialectical Behavior Therapy Information and Training: <http://www.behavioraltech.org>
29. Disability Benefits (DB) 101 Benefits Planning Calculator: www.db101.org
30. Family to Family:
<http://store.samhsa.gov/pages/searchResult/Family+Psychoeducation+Evidence+Based+KIT>

Resources (cont'd)

✓ Websites (cont'd)

31. Healthcare Communities, offering information on management of diabetes, asthma, depression, and cardiovascular disease: <http://www.healthcarecommunities.org/>
32. Health Management Systems website, with key health indicator screening tools: <http://www.hmscweb.com/>
33. Illness Management and Recovery, from SAMHSA's National Mental Health Information Center: <http://www.mentalhealth.samhsa.gov>
34. National Association of State Mental Health Program Directors: <http://www.nasmhpd.org>
35. National Council for Community Behavioral Healthcare: <http://www.nccbh.org>
36. Office of Consumer Affairs Website SAMHSA: <http://mentalhealth.samhsa.gov/consumersurvivor>
37. On Seeking Safety for Treatment of PTSD: <http://www.seekingsafety.org>
38. SAMHSA's Treatment, Prevention and Recovery Publications: <http://store.samhsa.gov/facet/Treatment-Prevention-Recovery>
39. Shared Decision Making: The Center for Shared Decision Making, Dartmouth Hitchcock Hospital: <http://www.dhmc.org>
40. Stigma Busters: http://www.nami.org/template.cfm?section=fight_stigma
41. The National Council, for information about integrating health and mental health care: <http://www.thenationalcouncil.org>

Resources (cont'd)

✓ Websites (cont'd)

42. University of Pennsylvania, Collaborative on Community Integration: <http://www.upennrrtc.org/>
43. Working While Receiving Benefits: <http://www.socialsecurity.gov/work/receivingbenefits.html>
44. WRAP: Mary Ellen Copeland — Mental Health Recovery and WRAP: www.mentalhealthrecovery.com

Domain #3

Team Structure

The term *Team Structure* refers to the staffing, operations, decision-making, and organization of adult FSP teams, and to their overall approach to the coordination of client care.



Team Service Approach and Meeting Structure

Purpose

To use the FSP team as a cohesive entity in treatment and service planning, and to maximize use of team meetings.

Definition

A team service approach and meeting structure is an essential element of a team-based approach to service planning and delivery in an assertive community treatment context.

Implementation Strategies

- Devote certain team meetings to conducting a review of short and longer term goals for particular clients and group service planning. Some teams find that a helpful approach is using a large dry erase white board in a secured area to organize service planning, staff priorities, and daily assignments.
- Review level of client recovery (through the use of the MORS, LOCUS, and other means) routinely during team meetings. Parameters can include aggregate recovery scores for all clients on the team to determine what percentage of clients are at particular recovery stages.
- Use team meetings to ensure outcome Key Event Tracking (KET) and 3-Month Assessment Updates (3Ms) are completed, thus maintaining up-to-date monitoring of outcomes. As changes occur in a client's status related to housing, employment, education, entry or exit from a psychiatric hospital, emergency department or jail, complete KET during the team meeting.
- Use team meetings to prioritize outreach and engagement services, and identify and develop plans for clients who are likely to use after-hours services.

Peer Staff as Part of the FSP Team

Purpose

To identify meaningful roles for peer employees as part of an FSP team.

Employing clients is transformational and not only helps clients give back to the system that helped them recover, but also — if done with care — will reduce the stigma associated with mental illness.

Definition

Peer staff are clients with lived mental health service experience who serve as a member of the FSP team in the role of a peer advocate; a peer bridger (assisting FSP clients with the transition from institutional or psychiatric inpatient settings to the community); a peer provider or specialist; or as a Personal Services Coordinator.

Implementation Strategies

- Determine staffing qualifications for peer employees.
- Determine initial and ongoing training and support needs, including whether a training certification process is necessary as a qualification for employment.
- Identify roles for clients in recovery on an FSP team, including:
 - Accompanying clients to appointments.
 - Assisting clients in obtaining needed services.
 - Assisting clients in locating housing or shopping for groceries.
 - Serving to assist clients in crisis.
 - Offering alternatives to crisis, such as staffing warm lines for clients to call when needing non-emergent support.
 - Providing peer counseling.
 - Considering peers as equal team members when integrating them within an FSP team with a particular specialization or background.
 - Developing career pathways for clients in recovery, perhaps by utilizing MHSWA Workforce, Education, and Training opportunities.

Assertive Community Treatment (ACT)

Purpose

To consider the elements of ACT within the context of creating a team structure for comprehensive and coordinated services that support and promote recovery. Adoption of select ACT program elements will help FSP teams achieve the team structure referenced in the MHSR regulations.

Definition

Assertive community treatment encompasses field-based, comprehensive, team-based services characterized by a small and shared caseload, time-unlimited services with flexible service delivery, a fixed point of responsibility for each client, and crisis management services available 24 hours per day, seven days per week. The elements of ACT listed next have been highly researched and demonstrated to be effective in achieving favorable quality-of-life outcomes for clients.

Implementation Strategies

- To establish and enrich an FSP program as defined in the MHSA regulations, consider incorporating the following essential elements:
 - Team approach to services, affording clients access to any team member.
 - Small caseload of one staff member per 10 clients.
 - Nurse assigned to each team.
 - Psychiatrist (or prescribing professional) assigned to each team.
 - Housing and employment specialists.
 - Shared caseloads.
 - Daily team meetings.
 - 24-hour availability.
 - Capacity for frequent contacts.
 - Coordination of services when a client enters an institutional setting.
- Select practices that support the outcomes that FSP teams and their clients wish to achieve.

Resource Guide

Each of the tools listed below has specific resources that you can locate in the general resource section on page 100. This guide enables you to focus on the pertinent resources linked directly to each tool.

Name of Tool	Resource Number(s)
Team Service Approach and Meeting Structure	3
Peer Staff as Part of the FSP Team	1
Assertive Community Treatment (ACT)	2 3 4 5

Resources

✓ Articles

1. Felton, C., Stastny, P., Shern, D. L., Blanch, A., Donahue, S. A., Knight, E., & Brown, C. (1995). Consumers as peer specialists on intensive case management teams: Impact on clients. *Psychiatric Services, 46*, 1037–1044.
2. McGrew, J., Bond, G., Dietzen, L., & Salyers, M. (1994). Measuring the fidelity of implementation of a mental health model. *Journal of Consulting and Clinical Psychology, 62*, 670–678.
3. Phillips, S., Burns, B. J., Edgar, E. R., Mueser, K. T., Linkins, K. W., Rosenheck, R.A.,...McDonel Herr, E.C. (2001). Moving assertive community treatment into standard practice. *Psychiatric Services, 52*, 771–779.
4. Rapp, C., & Goscha, R. (2004). The principles of effective case management of mental health services. *Psychiatric Rehabilitation Journal, 27*(4):319–333. doi: [10.2975/27.2004.319.333](https://doi.org/10.2975/27.2004.319.333)

✓ Toolkit

5. Assertive Community Treatment (ACT) KIT: <http://store.samhsa.gov/product/SMA08-4345>

Domain #4

Housing

The *Housing* domain identifies approaches to establishing an array of housing options for adult FSP clients, including approaches to creating permanent, supported housing. Non-Mental Health Service and Support strategies are also identified as ways to fund housing and the supports necessary for recovery.

Creating an Array of Readily Available Housing Options

Purpose

To establish safe, affordable, and permanent housing for each client, one of the most important practices in an FSP. Such living arrangements will greatly contribute to desirable client outcomes, including reductions in emergency room and hospital visits, with corresponding increase in use of primary-care and substance abuse services, as well as participation in employment services.

Definition

An array of readily available housing options includes access to emergency and short-term housing such as shelter beds, hotel rooms, and transitional housing, as well as access to affordable apartments, houses and other long-term, stable housing accommodations.

Implementation Strategies

- Recruit and train for the FSP team a dedicated housing specialist to develop community-housing options. That individual would be responsible for developing relationships with property owners to increase rental options. The housing specialist also would work directly with clients to help them obtain housing, including completing rental assistance and other housing applications. Peer specialists often make excellent housing specialists because they act as sources of hope and models for other clients to emulate. Peers also uniquely understand the barriers to housing and strategies to overcome them.
- Use FSP funding to subsidize a variety of housing options. Subsidies could include a portion of fees for rentals, utilities, first and last month's rent, eviction prevention, and purchase of household goods.
- Develop an array of housing options including shelter beds, motels and other emergency housing provisions, as well as accommodations for sharing of apartments, single-family homes and other forms of permanent housing. Also, develop relationships with local housing authorities that may be willing to set aside Homeless Section 8 housing vouchers and Shelter Plus Care certificates for clients with psychiatric disabilities and their families.
- Consider evidence from a Pathways Housing First project in New York and other studies that have demonstrated the benefit of “housing first” approaches to assisting clients and building trust.¹⁵
- Use MHSA Housing Program units which provide permanent supportive housing specifically for MHSA-eligible clients.
- Identify opportunities to partner with housing developers to create additional housing with units for clients who have psychiatric disabilities, and for their families.

¹⁵ Pathways to Housing, Inc. (2005). Providing housing first and recovery services for hopeless adults with severe mental illness. *Psychiatric Services*, 56(10): 1301-1305. doi: 10.1176/appi.ps.56.10.1303

Implementation Strategies (cont'd)

- Identify clients who are living in board-and-care facilities but, with appropriate supports, could make the transition to independent living. Develop a clinical and a fiscal plan to facilitate those transitions.
- Create roommate groups or networking opportunities for clients interested in congregate or completely independent living.

Supportive Housing and Housing First Models

Purpose

To assist and support clients in finding and maintaining permanent housing of their choice.

Definition

Supportive housing and *housing first* models support clients in finding residential accommodations and in becoming good tenants, neighbors, and community members. Regardless of the level of recovery, the team will assist clients who seek safe and affordable permanent housing. Both models emphasize and require collaboration between the client, FSP team, and landlord. Both also include community-based (not clinic-based) services geared toward building the skills and supports necessary for living in the community.

Implementation Strategies

- Ensure that funding and housing options are available at the time the client expresses an interest in obtaining housing.
- Teach clients about the expectations of tenancy and lease agreement requirements, and encourage them to pay rent on time, maintain cleanliness and upkeep in their unit, and remain courteous and peaceful in consideration of other tenants.
- Engage in case management to support residential stability.
- Assist clients in accessing and using non-mental health resources.
- Teach clients about tenant rights and responsibilities.
- Direct support that emphasizes fulfilling the needs of the client rather than focusing on specific housing facilities to enable a smooth transition in case the client decides to relocate.
- Integrate stage-specific services for clients who have co-occurring substance use and mental health disorders, matching client readiness for change with interventions.
- Assist clients with vocational and employment services.
- Assist with money management.
- Support community building and tenant advocacy.
- Arrange for peer support. Research indicates that clients often require approximately six weeks of peer support, within the context of supported housing, before they can see a change in themselves.
- Develop a self-sufficiency plan or agreement before subsidizing client rent in order to reduce ongoing, long-term dependence on housing subsidies. Over time, clients would assume more responsibility for the monthly rent or lease payment. A self-sufficiency plan, coupled with a focus on benefits establishment, employment, and education, will help clients work toward complete housing self-sufficiency.

Use of FSP Funds for Non-Mental Health Services and Supports

Purpose

To understand the Mental Health Services Act California Code of Regulations, Title 9, Section 3620,(a)(1)(B), authorizing use of a portion of FSP funds for non-mental health services and supports. These funds are part of an approach to doing “whatever it takes” to help clients achieve their recovery goals.

Definition

Non-mental health services and supports encompass funding for food; clothing; housing, including, but not limited to, rent subsidies, house payments, residence in drug or alcohol rehabilitation programs, and transitional and temporary housing; health-care treatment; and treatment for co-occurring substance abuse disorders, such as substance abuse and respite care.

Implementation Strategies

- Determine what portion of FSP funds should be dedicated for this purpose.
- Balance the use of these funds with the ability of each client to provide for himself or herself. In using these funds, teams should help clients identify ways to attain self-sufficiency.
- Consider the following key uses for these funds:
 - Client housing support expenditures: housing subsidies, master leases, motel and other housing vouchers, rental security deposits, first and last month's rental deposits.
 - Client flexible support expenditures: food, clothing, items necessary for daily living, travel and transportation, medication, respite services for caretakers, goods necessary for caretaking, medical and dental expenses, school or vocational supplies, furniture, and household products and appliances.
 - Other non-Medi-Cal client support expenditures: costs of salaries and benefits for employment specialists, housing specialists or peer support staff who do not bill for their services.

Resource Guide

Each of the tools listed below has specific resources that you can locate in the general resource section on page 110. This guide enables you to focus on the pertinent resources linked directly to each tool.

Name of Tool	Resource Number(s)
Creating an Array of Readily Available Housing Options	1
Supportive Housing and Housing First Models	2 3
Use of FSP Funds for Non-Mental Health Services and Supports	

Resources


✓ Article

1. Rogers, E.S., Kash, M., Olschewski, A. (2009). *Systematic review of supportive housing literature. 1993–2008*. Boston, MA: Boston University Center for Psychiatric Rehabilitation.

✓ Websites

2. Housing First:<http://www.beyondshelter.org>
3. Supported Housing: <http://www.csh.org>, <http://www.bazelon.org> or <http://www.pathwaystohousing.org>

ATTACHMENT 3: DETERMINATION FOR MEDICAL NECESSITY AND TARGET POPULATION

 <p>Sacramento Department of Health Services Division of Behavioral Health Services Policy and Procedure</p>	County of	Policy Issuer (Unit/Program)	QM
	Department of	Policy Number	QM-01-07
	Division of Behavioral Health Services	Effective Date	07-01-2005
	Policy and Procedure	Revision Date	09-01-2020
Title: Determination for Medical Necessity and Target Population		Functional Area: Access	
Approved By: (Signature on File) Signed version available upon request Alexandra Rechs Program Manager, Quality Management			

BACKGROUND/CONTEXT:

Sacramento County Mental Health Plan (MHP) is dedicated to serving people with psychiatric disabilities from various target populations, ages, cultural and ethnic communities. The goal is to promote recovery and wellness for adult and older adults with severe mental illness, and resiliency for children with serious emotional disorders and their families.

DEFINITIONS:

Medical Necessity: The criteria that identify service need based on inclusion of specific signs, symptoms, and conditions and proposed treatment associated with mental illness. Determination of medical necessity requires inclusion of a covered diagnosis; an established level of impairment; an expectation that specialty mental health treatment is necessary to address the condition; and the condition would not be responsive to physical health care based treatment. Medical necessity is defined by the California Code of Regulations and is contained in a variety of State Department of Health Care Services (DHCS) notices and letters delineating requirements for county mental health services.

Target Population: For the purposes of county mental health services, target population refers to individuals with severe disabling conditions that require mental health treatment giving them access to available services based on these conditions. Public mental health systems are obligated to serve those identified individuals across the age spectrum and acuity of need. Services for each target population are based on acuity of need and impairment as well as varying eligibility criteria. Uninsured individuals are served to the extent resources are available. (W&I 5600.2, W&I 5600.3).

The following target population groups are served in Sacramento County.

Adults:

- (a) Individuals insured by MediCal
- (b) Uninsured individuals (served as resources permit through realignment or other identified funding)

Youth:

(a) Youth insured by MediCal

(c) Uninsured youth (served as resources permit through realignment or other identified funding).

The following attached documents guide this policy:

1. Adult Target Population: Adult Target Population will be in accordance to the Mental Health Plan definition (see Attachment A)
2. Children's Target Population: Child Target Population will be in accordance to the Mental Health Plan definition (see Attachment C)

Serious and Persistent Mental Illness – W&I Code Section 5600.3(2): An adult is considered to have a serious mental disorder if he/she has an identified mental disorder that is severe in degree, persistent in duration, which cause behavioral functioning that interferes substantially with the primary activities of daily living, and result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time.

Seriously Emotionally Disturbed - W&I Code Section 5600.3(a) (2): A child or adolescent is considered to have a serious emotional disturbance if they have he/she has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria as a result of the mental disorder:

- Has substantial impairment in at least 2 areas (self-care, school functioning, family relationships, ability to function in the community);
- Is either at risk of removal from home or has already been removed OR the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than 1 year without treatment;
- Displays psychotic features, risk of suicide or risk of violence due to mental disorder.

PURPOSE:

This policy and procedure establishes Sacramento County medical necessity parameters for the following populations:

1. Medical Necessity for Adults ages 21 and older, determination will be made in accordance to Title 9, Section 1830.205 and MHP Contract, Exhibit A, Attachment 3. (See Attachment B)
2. Medical Necessity for Child/Youth ages 0 – 21 determination will be made in accordance to Title 9, Section 1830.210 and MHP Contract, Exhibit A, Attachment 3. (See Attachment D)

This document provides operational guidance for access to services for different target populations and the conditions that determine medical necessity.

DETAILS:

Determination of Medical Necessity Criteria: All Staff conducting the initial assessment meet the qualifications for Licensed Professional of Healing Arts (LPHA) and function as part of the MHP Access Team or specifically designated entry points of services.

1. Adult Outpatient Services

- a. The Access Team will make an initial determination of Medical Necessity criteria for outpatient services. The Access Team will document their determination and refer to the appropriate provider based on said determination.
- b. The Access Team designates additional specified points of entry for vulnerable population in order to provide presumptive determination of eligibility to prevent barriers to care.
- c. Service providers receiving assignments from the Access Team are required to confirm medical necessity and to complete the appropriate assessment upon contact with referred individuals.
- d. Service providers will continue to review and confirm medical necessity annually at minimum.

2. Child & Family Outpatient Services

- a. The Access Team will make an initial determination of Medical Necessity criteria for outpatient services except as delineated in #2(b) below. The Access Team will document their determination and refer to the appropriate provider based on said determination.
- b. If a client has full scope MediCal, an assignment to a provider will be made for a face-to-face assessment to confirm that medical necessity is met. For children and youth under the age of 21, this assignment to a provider may be made even if, based on initial Access Team screening, medical necessity is not met.
- c. Service providers receiving assignments from the Access Team are required to confirm medical necessity and to complete the appropriate assessment upon contact with referred individuals.
- d. Service providers will continue to review and confirm medical necessity annually at minimum.

REFERENCE(S)/ATTACHMENTS:

- California Code of Regulations, Title 9
- [9 CCR § 1830.205](#)
- [Behavioral Health Information Notice No. 20-043](#)
- [All Plan Letter No. 18-006](#)

RELATED POLICIES:

- All MHP P&P's
- All MHTC P&P's

DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff		
X	Mental Health Treatment Center		
X	Adult Contract Providers		
X	Children's Contract Providers		
X	Substance Use, Prevention, and Treatment Services		

	Specific grant/specialty resource		

CONTACT INFORMATION:

- Quality Management Program QMInformation@saccounty.net

**ATTACHMENT A
ADULT TARGET POPULATION**

For services in the adult specialty mental health system, individuals must meet Criteria A, B, C and D to meet service requirements for operational definition or core target population irrespective of funding.

Criteria A: At least one of the following diagnoses as defined in the current edition of the Diagnostic and Statistical manual of Mental Disorders Fifth Edition (DSM 5):

<u>ICD-10</u> (Codes for Included Diagnosis for Adult Target Population)	<u>DSM 5 Classification</u>
F20.9 F28 F29* F20.81*	<p align="center">1. Schizophrenia Spectrum Disorder and Other Psychotic Disorders</p> <p>Schizophrenia Other Specified Schizophrenia Spectrum and Other Psychotic Disorder Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (previously Psychotic Disorder NOS) Schizophreniform</p> <p>* Re-evaluation and resolution of diagnosis must be done within 6 months of initial diagnosis</p>
F25.0 F25.1	<p align="center">2. Schizoaffective Disorder</p> <p>Schizoaffective Disorder Bipolar Type Schizoaffective Disorder Depressive Type</p>

<p>F31.11 F31.12 F31.13 F31.2 F31.73 F31.74 F31.9</p> <p>F31.31 F31.32 F31.4 F31.5</p> <p>F31.75 F31.76 F31.9</p> <p>F31.9</p> <p>F31.9</p> <p>F31.81</p>	<p>3. Bipolar Disorders</p> <p>Bipolar I Disorder current or most recent episode manic, mild Bipolar I Disorder current or most recent episode manic, moderate Bipolar I Disorder current or most recent episode manic, severe Bipolar I Disorder current or most recent episode manic, with psychotic features Bipolar I Disorder current or most recent episode manic, in partial remission Bipolar I Disorder current or most recent episode manic, in full remission Bipolar I Disorder current or most recent episode manic, unspecified</p> <p>Bipolar I Disorder current or most recent episode depressed, mild Bipolar I Disorder current or most recent episode depressed, moderate Bipolar I Disorder current or most recent episode depressed, severe Bipolar I Disorder current or most recent episode depressed, with psychotic features</p> <p>Bipolar I Disorder current or most recent episode depressed, in partial remission Bipolar I Disorder current or most recent episode depressed, in full remission Bipolar I Disorder current or most recent episode depressed, unspecified</p> <p>Bipolar Disorder current or most recent episode unspecified</p> <p>Unspecified Bipolar and Related Disorder (previously Bipolar NOS)</p> <p>Bipolar II Disorder</p>
<p>F33.9 F33.0 F33.1 F33.2 F33.3 F33.41 F33.42</p>	<p>4. Major Depressive Disorder Recurrent Episode</p> <p>Major Depressive Disorder, recurrent episode, unspecified Major Depressive Disorder, recurrent episode, mild Major Depressive Disorder, recurrent episode, moderate Major Depressive Disorder, recurrent episode, severe Major Depressive Disorder, recurrent episode, with psychotic features Major Depressive Disorder, recurrent episode, in partial remission Major Depressive Disorder, recurrent episode, in full remission</p>
<p>F43.10 F43.8* F43.9*</p>	<p>5. Trauma- and Stressor-Related Disorders</p> <p>Posttraumatic Stress Disorder Other Specified Trauma and Stressor Related Disorder Unspecified Trauma and Stressor Related Disorder</p> <p>* Re-evaluation and resolution of diagnosis must be done within 6 months of initial diagnosis</p>
<p>F60.3</p>	<p>6. Borderline Personality Disorder</p> <p>Borderline Personality Disorder</p>

Exclusions: Individuals with a primary diagnosis of substance abuse or those with a sole diagnosis of developmental disability. The criteria exclude those with organic brain syndromes such as dementia or delirium.

Criteria B: Severe impairment in community functioning that includes consideration of sociocultural issues in one or more areas as a result of covered above-listed covered diagnosis. Specific functional impairment must be clearly documented. Functional areas include:

Functional Area	Criteria
Basic self-care, independent living skills, consistent behaviors of endangerment of self or others	Consistent failure to maintain basic activities of independent living; inability to obtain food, clothing, and/or shelter without supports; serious disturbances in physical health such as weight change, disrupted sleep or fatigue that threatens health, separate from physical symptoms due to general medical conditions.
Productive Activities: Includes employment, education, volunteer, parent/caregiver, or other meaningful activities.	Inability to maintain participation in client specific meaningful activities and/or obligations to job, school, self, or others.
Interpersonal Relationships	Marked impairment of interpersonal interactions with consistently contentious or otherwise disrupted relations with others, which may include impulsive or abusive behaviors.
Co-morbidity – Substance Use	Inability to maintain roles in the following (see above parameters): self-care, productive activities, or interpersonal relationships due to a co-occurring substance use disorder.
Co-morbidity – Medical	Inability to attend to crucial medical needs as directed by a physician.

Criteria C: Focus of the proposed intervention will be to significantly diminish impairment or prevent significant deterioration in an identified important area of functioning.

Criteria D: Impairments and conditions require specialty mental health services and would not be responsive to physical health care based treatment.

Criteria A, B, C and D will be documented in the client medical record and will be the conditions that support medical necessity for continued services.

**ATTACHMENT B ADULT MEDICAL NECESSITY
CRITERIA FOR SECONDARY OR TERTIARY
DIAGNOSIS**

Must have **all**, (A, B, and C) as per [Title 9, CCR, Chapter 11, Section 1830.205\(b\)\(1\)](#) and MHP Contract, Exhibit A, Attachment 3 A. **Covered Psychiatric Diagnosis**

Must have one of the following DSM-5 diagnoses, which will be the focus of the intervention being provided:

INCLUDED DIAGNOSIS:

- Pervasive Developmental Disorders, except Autistic Disorders
- Attention Deficit and Disruptive Behavior Disorders
- Feeding & Eating Disorders of Infancy and Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia and other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality disorder
- Medication-Induced Movement Disorders

EXCLUDED DIAGNOSIS

- Mental Retardation
- Learning Disorders
- Communication Disorders
- Autism Spectrum Disorder*
- Tic Disorders
- Delirium, Dementia, and Amnesic and Other Cognitive Disorders
- Mental Disorders due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder
- Other conditions that may be a focus of clinical attention, except Medication Induced Movement Disorders, which are included

B. Functional Impairment Criteria

Must have one of the following as a result of the mental health disorder(s) identified in the diagnostic “A” criteria:

1. A significant impairment in an important area of life functioning
OR
2. A probability of significant deterioration in an important area of life functioning

A client may receive services for an included diagnosis when an excluded diagnosis is also present.

**Refer to [APL No. 18-006](#) and [Behavioral Health IN No. 20-043](#)*

C. Intervention Related Criteria

1. The focus of proposed intervention is to address the condition identified in impairment criteria “B” above,
AND
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning
AND
3. Not responsive to physical health care based treatment.

**CHILDREN’S/YOUTH MENTAL HEALTH SERVICES
ATTACHMENT C TARGET POPULATION - CHILD &
YOUTH**

Children and youth to be served in a System of Care are found eligible in one of two main categories:

1. MEDI-CAL ELIGIBLE:

Full-SCOPE Medi-Cal eligible children and youth ages 0-21 are entitled by federal mandate to services to “treat or ameliorate any mental health condition” through Early and Periodic Screening, Diagnosis and Treatment (EPSDT). County Mental Health is required by law to ensure access to appropriate service to these individuals in a timely manner.

2. REALIGNMENT:

Children and youth up to age 18 who have a serious emotional disturbance may be the responsibility of the county under Realignment. Realignment resources are not utilized for children or youth with other eligibility or forms of insurance. Realignment Legislation (Welfare and Institutions Code Section 5600.3) secures services for eligible children and youth to the **extent that resources allow**. Children and youth who qualify for services using realignment funding meet the following criteria:

Must have a current included DSM 5 diagnosis. Clients with a primary included DSM 5 diagnosis may have a co-occurring substance abuse or developmental disorder as a secondary focus of treatment. Organic mental disorders are included only if the child currently manifests behaviors that are a danger to self or others and is amenable to treatment interventions which will ameliorate the presenting condition.

Child and youth shall meet one or both of the following criteria:

A. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas:

1. Self-care,
2. School functioning,
3. Family relationships,
4. Ability to function in the community; **AND either of the following occurs:**
 - a. The child is at risk of removal from home or has already been removed from the home.
 - b. The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

B. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

**ATTACHMENT D CHILDREN’S MEDICAL NECESSITY
CRITERIA**

Must have all, (A, B, and C) as per [Title 9, CCR, Chapter 11, Section 1830.205\(b\)\(1\)](#) and MHP Contract, Exhibit A, Attachment 3

A. Covered Psychiatric Diagnosis

Must have one of the following DSM-5 diagnoses, which will be the focus of the intervention being provided:

INCLUDED DIAGNOSIS:

- Pervasive Developmental Disorders, except Autistic Disorders
- Attention Deficit and Disruptive Behavior Disorders
- Feeding & Eating Disorders of Infancy and Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia and other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality disorder
- Medication-Induced Movement Disorders

EXCLUDED DIAGNOSIS

- Mental Retardation
- Learning Disorders
- Communication Disorders
- Autism Spectrum Disorder*
- Tic Disorders
- Delirium, Dementia, and Amnesic and Other Cognitive Disorders
- Mental Disorders due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder
- Other conditions that may be a focus of clinical attention, except Medication Induced Movement Disorders, which are included

A client may receive services for an included diagnosis when an excluded diagnosis is also present. *Refer to [APL No. 18-006](#) and [Behavioral Health IN No. 20-043](#)

B. Functional Impairment Criteria

Must have one of the following as a result of the mental health disorder(s) identified in the diagnostic "A" criteria:

1. A significant impairment in an important area of life functioning;
OR
2. A probability of significant deterioration in an important area of life functioning;
OR
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriated. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated.

C. Intervention Related Criteria

Must have all (1, 2, and 3 listed below):

1. The focus of proposed intervention is to address the condition identified in impairment criteria "B" above;
AND
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning;
AND
3. The condition would not be responsive to physical healthcare based treatment.

ATTACHMENT 4: KEY INGREDIENTS FOR TRAUMA INFORMED CARE

FACT SHEET | AUGUST 2017



Key Ingredients for Trauma-Informed Care

A trauma-informed approach to care acknowledges that in order to provide effective health care services, care teams need to have a complete picture of a patient's life situation — past and present.

Health policymakers and practitioners are increasingly aware of the detrimental effects of trauma on health. The landmark **Adverse Childhood Experiences (ACE) study**¹ demonstrated that the more an individual is exposed to adverse experiences like physical, emotional or sexual abuse, neglect, discrimination, and violence, the greater the risk for chronic health conditions and health-risk behaviors later in life such as heart disease, depression, liver disease, sexually transmitted diseases, and substance use. By recognizing trauma as an important factor impacting health throughout the lifespan, and by offering trauma-informed approaches and treatments in health care settings, provider organizations can more effectively treat patients, thereby potentially improving health outcomes, reducing avoidable care utilization, and curbing excess costs.

Supporting Key Organizational and Clinical Practices

A comprehensive approach to trauma-informed care must involve both organizational and clinical practices. Health care organizations often train their clinical staff in trauma-specific treatment approaches, but may not implement broad changes across their organizations to address trauma. Widespread changes to organizational policy and culture need to be adopted across a health care setting for it to become truly trauma-informed. Organizational practices that recognize the impact of trauma reorient the culture of a health care setting to address the potential for trauma in patients and staff, while trauma-informed clinical practices address the impact of trauma on individual patients.





This fact sheet describes key ingredients necessary for establishing a trauma-informed approach at the organizational and clinical levels. Drawing from the insights of experts across the country, the Center for Health Care Strategies (CHCS) compiled these elements to help guide practitioners interested in making the transformation to providing trauma-informed care. To bring each key ingredient to life, this fact sheet outlines a tangible example from one of the six pilot sites participating in *Advancing Trauma-Informed Care*, a national initiative made possible by the Robert Wood Johnson Foundation. The three-year initiative aims to increase understanding of how trauma-informed approaches can be implemented in the health care sector to improve patient outcomes and increase staff wellness.

Key Ingredients for Trauma-Informed Care

ORGANIZATIONAL







-  Lead and communicate about the transformation process
-  Engage patients in organizational planning
-  Train clinical as well as non-clinical staff members
-  Create a safe physical and emotional environment
-  Prevent secondary traumatic stress in staff
-  Hire a trauma-informed workforce

CLINICAL





-  Involve patients in the treatment process
-  Screen for trauma
-  Train staff in trauma-specific treatment approaches
-  Engage referral sources and partner organizations



Organizational Ingredients in Practice

Ingredient	In Practice
 Lead and communicate about the transformation process	To reach its goal of becoming a trauma-informed system, the San Francisco Department of Public Health (SFDPH) is providing its staff of more than 9,000 employees with a foundational trauma training and spreading trauma knowledge throughout the system via staff champions.
 Engage patients in organizational planning	The University of California at San Francisco (UCSF) Women's HIV Program hosts monthly stakeholder meetings, including at least four patient representatives at the table. Designed to ensure open channels of communication between patients and staff, these meetings have led to innovations such as new patient education and support groups.
 Train clinical as well as non-clinical staff members	Montefiore Medical Group (Montefiore) works to ensure a positive overall experience at each practice by training both clinical and non-clinical staff, including front-desk personnel, to respectfully communicate with patients and understand how trauma influences behavior.
 Create a safe physical and emotional environment	The bright atrium of Stephen & Sandra Sheller 11 th Street Family Health Services (11 th Street) was designed to serve as a calm and welcoming space for visitors. 11 th Street is also creating an <i>emotionally safe</i> place for clients and staff by committing to open communication and democratic decision-making.
 Prevent secondary traumatic stress in staff	Montefiore's clinics are in underserved areas in the Bronx and West Chester County, NY. Violence in these communities can have an emotional toll on staff. Montefiore's <i>Critical Incident Management Team</i> , including behavioral health specialists, visit clinics following a violent incident to provide support. These interventions help staff feel cared for, and may help prevent post-traumatic stress disorder.
 Hire a trauma-informed workforce	When patients first arrive at the UCSF Women's HIV Program, they are greeted by someone who, like themselves, has been diagnosed with HIV. These peer clinic hosts help make patients feel welcome by reducing the stigma HIV-positive individuals often face in society.

Clinical Ingredients in Practice

Ingredient	In Practice
 Involve patients in the treatment process	11 th Street Family Services is seeking to address the anxiety that someone with a history of trauma may feel in specific situations—for example, in a “compromised” position in the dental exam chair. Patients develop a treatment plan with the dental staff to identify what they are comfortable with and what they are not, and treatment will not begin until the patient approves the approach.
 Screen for trauma	The Center for Youth Wellness (CYW) in San Francisco is connected to the Bayview Child Health Center, located in one of the city's poorest neighborhoods. Staff screen each patient and caregiver using the ACE-Q — a screening tool developed by CYW. After reviewing a patient's score, the physician discusses the effect of toxic stress on health, and if necessary, coordinates referrals to trauma-informed partners.
 Train staff in trauma-specific treatment approaches	The Greater Newark Healthcare Coalition (GNHCC) is a nonprofit collaborative of stakeholders committed to improving the quality of, and access to, health services in Newark, New Jersey. GNHCC is partnering with Rutgers University Behavioral Healthcare to provide trauma-informed care training to pediatric residents at Newark Beth Israel Medical Center and the staff of BRICK Academy schools.
 Engage referral sources and partner organizations	GNHCC is conducting a citywide environmental scan of health care and social service providers to assess each organization's trauma-informed care knowledge and competency. GNHCC will provide trauma-informed care training to organizations based on the results of the scan, with the goal of all city providers becoming trauma-informed.

¹ V.J. Felitti, R.F. Anda, D. Nordenberg, D.F. Williamson, A.M. Spitz, V. Edwards, et al. “Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study.” *American Journal of Preventive Medicine*, 14, no. 4 (1998): 245-258.

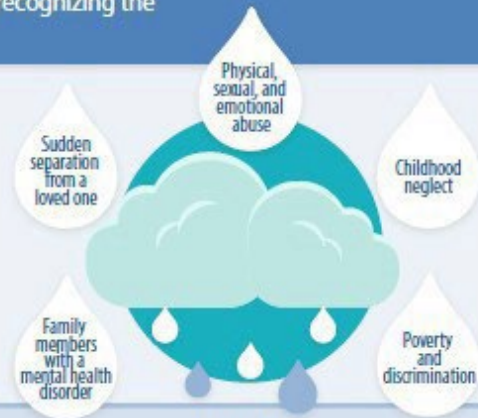


10 KEY INGREDIENTS FOR TRAUMA-INFORMED CARE

As health care providers become aware of the harmful effects of trauma on physical and mental health, they are increasingly recognizing the value of **trauma-informed approaches to care**.

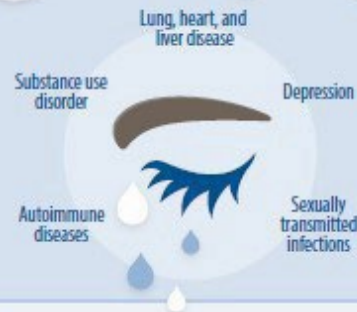
→ WHAT IS TRAUMA?

The Substance Abuse and Mental Health Services Administration (SAMHSA) describes trauma as **events or circumstances** experienced by an individual as **physically or emotionally harmful** or **life-threatening**, which result in adverse effects on the individual's **functioning and well-being**.



→ WHAT IS THE IMPACT OF TRAUMA ON HEALTH?

The Adverse Childhood Experiences (ACE) Study, conducted by the CDC and Kaiser Permanente, revealed that the more an individual is exposed to a variety of stressful and potentially traumatic experiences, the greater the risk for **chronic health conditions** and **health-risk behaviors** later in life.



→ HOW CAN PROVIDERS BECOME TRAUMA-INFORMED?

Trauma-informed care acknowledges that understanding a patient's life experiences is key to potentially improving engagement and outcomes while lowering unnecessary utilization. In order to be successful, trauma-informed care must be adopted at the **organizational and clinical levels**.



Organizational practices reorient the culture of a health care setting to address the potential for trauma in patients *and* staff:



- 1 Lead and communicate about being trauma-informed
- 2 Engage patients in organizational planning
- 3 Train both clinical and non-clinical staff
- 4 Create a safe physical and emotional environment
- 5 Prevent secondary traumatic stress in staff
- 6 Build a trauma-informed workforce

Clinical practices address the impact of trauma on individual patients:



- 7 Involve patients in the treatment process
- 8 Screen for trauma
- 9 Train staff in trauma-specific treatments
- 10 Engage referral sources and partner organizations



For more details, read CHCS' brief, *Key Ingredients for Successful Trauma-Informed Care Implementation*. Visit www.chcs.org for additional resources.

ATTACHMENT 5: SSI/SSDI OUTREACH, ACCESS, AND RECOVERY: AN OVERVIEW



SSI/SSDI OUTREACH, ACCESS, AND RECOVERY: AN OVERVIEW



THE ISSUE

Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) are disability income benefits administered by the Social Security Administration (SSA) that also provide Medicaid and/or Medicare health insurance to eligible children and adults. The application process for SSI/SSDI is complicated and difficult to navigate. Nationally, about 30 percent of adults who apply for these benefits are approved on initial application and appeals take an average of over 1.5 years to complete.

For people who are experiencing or at-risk of homelessness or who are returning to the community from institutions (jails, prisons, or hospitals), access to these programs can be extremely challenging. Approval on initial application for people who are experiencing or at-risk of homelessness and who have no one to assist them is about **10-15 percent**. For those who have a serious mental illness, substance use issues, or co-occurring disorders that impair cognition, the application process is even more difficult – yet accessing these benefits is often a critical first step in building resiliency and supporting recovery.

A SOLUTION

The Substance Abuse and Mental Health Services Administration (SAMHSA) developed the SSI/SSDI Outreach, Access, and Recovery (SOAR) model to address this critical need. SOAR-trained case managers submit complete and quality applications that are approved quickly. By maximizing income supports through benefits access and employment support, individuals experiencing or at risk of homelessness can achieve housing stability. The SAMHSA SOAR TA Center provides a three-step approach to SOAR implementation:



STRATEGIC PLANNING

Strategic planning meetings bring key state/local stakeholders (e.g., SSA and Disability Determination Services (DDS); State Mental Health Agency and Department of Corrections leadership; and community homeless, health, behavioral health providers, youth, family, and adult peer representatives) together to **collaborate and agree** upon a SOAR process for the submission and processing of adult SSI/SSDI and child SSI applications and **develop** an action plan to implement their SOAR program.



TRAINING LEADERS

Training of case managers using the **SOAR Online Course: Adult and Child Curricula**. These free, web-based courses include the development of a practice case using a fictional applicant. A **Leadership Academy** program creates strong local leaders to support SOAR-trained case managers and coordinate local SOAR programs.



TECHNICAL ASSISTANCE

Individualized technical assistance for supporting **action plan implementation**, identifying funding opportunities for **sustainability**, developing **quality review** procedures, and assisting with **tracking outcomes** to document success and identify areas for improvement and expansion.

OUTCOMES



Since 2006, over **55,210** people are receiving benefits because of SOAR.



The 2020 approval rate on initial SOAR-assisted applications averages **65 percent** in **115 days**.



In 2020 alone, SSI/SSDI brought at least **\$518 million** into the economies of the participating localities.

For more information, e-mail us at soar@prainc.com or visit <https://soarworks.prainc.com/>



Getting Involved with SOAR

You want to be a SOAR provider? That's great! Here's what to expect.

SOAR promotes recovery and wellness through increased access to Social Security disability benefits for eligible individuals who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorder. SOAR providers assist individuals with complete and quality applications. This is not an easy task, and we want to be sure that you understand the commitment required – we believe it is well worth the effort!

Training

The SOAR Online Course trains providers to assist individuals with the Social Security disability application process. The course includes an Adult Curriculum for assisting with Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) claims for adults and a Child Curriculum for assisting with SSI claims for children.

- The SOAR Online Course: Adult and Child Curriculums are free and are located on the SOARWorks website (<https://soarworks.prainc.com/content/soar-online-course-catalog>).
- Each curriculum consists of seven classes, each of which has a series of articles, short quizzes, and a practice case component. The practice case provides an opportunity for trainees to apply what they have learned in the course by completing a sample application packet for a fictitious applicant using SOAR techniques.
- It takes approximately 20 hours to complete each curriculum and participants can work at their own pace, starting and stopping as they wish. However, we encourage students to complete the curriculum within 30 days to retain the information learned.
- Upon successful completion, participants will receive 20 CEUs (continuing education units) from the National Association of Social Workers (NASW).

Many SOAR Local Leads offer one-day SOAR Online Course Review Sessions to review key components of the curriculum, discuss local/state practices, and connect new providers to local Social Security Administration (SSA) and DDS (Disability Determination Services) offices.

Time Commitment

We estimate that each SOAR application will take approximately 20-40 hours to complete, from initial engagement to receiving a decision on a claim. This generally occurs over the course of 60-90 days.

- The time spent on each application will vary depending on the amount of engagement that is needed as well as other variables such as the experience level of the SOAR worker. For example, engagement with an applicant who is residing in an institution may take 20 hours, while it may take longer to connect with someone who is living outside or difficult to contact.

SOAR Critical Components

SOAR providers with higher approval rates credit their success to implementing the SOAR critical components¹ and submitting high quality applications. Use of these components significantly increases the

¹ <https://soarworks.prainc.com/article/soar-model-critical-components>



likelihood of an approval on initial application for those who are eligible.² The five SOAR critical components of application assistance are:

- Serve as the applicant's appointed representative using the SSA-1696: *Appointment of Representative* form.
- Complete all required SSA application forms online, when available.
- Collect medical records, assessments, case management notes and collateral information.
- Write a comprehensive Medical Summary Report that includes psychosocial, treatment, and functional information and is co-signed, when possible, by an acceptable medical source.
- Perform quality review of application prior to submission.

Follow Up

The work of a SOAR provider does not end after submitting an application. SOAR providers are expected to:

- Communicate regularly with SSA and DDS regarding the status of applicants' claims.
- Continue ongoing outreach to stay connected throughout the determination process.
- Help individuals obtain other needed services (e.g. housing, employment, health care).

Outcome Tracking

Tracking SOAR outcomes is a critical way to document successes and target technical assistance needs.

- Use the SOAR Online Application Tracking (OAT) system³ or your state's preferred method to track applications submitted, critical components used, approvals/denials, and time to decision (i.e. from application submission to receipt of SSA's decision).
- Tracking outcomes is an essential piece of funding and sustainability efforts.

Local Involvement

Many SOAR communities have local steering committees and/or SOAR practitioner meetings. Getting involved locally can be a great way to connect with others who are doing similar work. You can seek support, obtain refresher training and help with growing and expanding your local SOAR initiative.

- Find your state and local SOAR leads at: <https://soarworks.prainc.com/directory>

Benefit to Your Agency and the Individuals You Serve

Access to SSI/SSDI can be a major tool in recovery, both from mental illness and homelessness. With the income support and health insurance that SSI/SSDI provides, individuals are able to meet their basic needs, maintain housing, and pay their bills. As a result, they are more likely to keep appointments and engage in treatment. If your agency is Medicaid (or Medicare) reimbursable, you can recoup the cost of uncompensated care and receive payment for future services.

Without the support of a SOAR provider, it can take as long as 1-3 years to obtain approval for SSI/SSDI, during which time people are often lost to the process and require a great deal of community support simply to survive. With the SOAR approach, providers are achieving a national approval rate of 65 percent in an average of 100 days. The rewards are great for all involved!

² Based on data from January 15, 2005 to February 14, 2014 obtained from the SOAR Online Application Tracking (OAT) system. Data includes 4,200 application outcomes from 35 states.

³ <https://soartrack.prainc.com>



YES, YOU CAN WORK!

Interested in returning to work or trying out work for the first time, but unsure how work will impact your Social Security benefits or if work is even possible for you?

Many people receiving disability benefits, or applying for benefits, really want to work, but fear the consequences. This handout will give you the information you and your family need to learn more about programs, which will assist you with returning to work, or trying out work for the first time!

We can help you find success! These recommended resources provide information on where you can go for assistance to learn more about employment for people with disabilities. Quality services are available to help you better understand all of the federal work incentive programs, including Social Security work supports, for people with disabilities.

MYTHS WE'VE HEARD ON THE STREETS AND FACTS TO BUST THEM UP!

<p>MYTH</p> <p>“People with mental illness shouldn’t work.”</p>	<p>FACT</p> <p>People with mental health conditions are just as productive as other employees. Employers who hire people with mental health conditions report good attendance and punctuality as well as motivation, good work, and job tenure on par with or greater than other employees.</p>
<p>MYTH</p> <p>“I will lose my disability benefits, income and health insurance, which I have worked so hard to obtain!”</p>	<p>FACT</p> <p>Not so fast! SSA offers comprehensive work incentives which allows you to keep your benefits for quite a long time. Should you be unable to continue working as a result of your disability, SSA may restart your benefits. Because some SSA rules may be hard to understand, all states have benefit planning resources to help you get started. https://www.ssa.gov/redbook/</p>
<p>MYTH</p> <p>“I have never worked before, so I have no skills an employer needs.”</p>	<p>FACT</p> <p>People with disabilities with little or no work history do find work that meets their strengths, preferences, abilities, and skills. Supported employment services focus on these factors to help you seek and find competitive employment in the community.</p>
<p>MYTH</p> <p>“My family does not want me to work because they fear my symptoms will get worse.”</p>	<p>FACT</p> <p>Recent studies found that employment actually improves symptoms! Work offers less social isolation and a sense of purpose, just to name two benefits! Work is more than just a paycheck, and this brochure offers helpful resources for your family and friends to be supportive and understanding of your career goals.</p>

MORE INFORMATION & RESOURCES

Social Security Administration (SSA)

SSA has a free Ticket to Work Program available to all SSI/SSDI beneficiaries. Specialists connect individuals to employment supports in their area, such as career counseling, training, and job placement. Also, they can explain in detail how going back to work will impact a person's benefits. The website includes links to local employment resources and offers free training webinars for beneficiaries and service providers. <https://www.choosework.net/>

Department of Labor

Disability Program Navigators (DPNs)/ Disability Resource Coordinators (DRCs) provide comprehensive services to people with disabilities seeking resources and support with work incentives in DOL One Stop Centers. One Stop Centers provide job seekers with job listings, job finding workshops, and access to computers, copiers, and fax machines. <http://www.doleta.gov/disability/DPN.cfm>

Supported Employment

The Association of Persons in Supported Employment (ASPE) helps improve and expand integrated employment opportunities, services, and outcomes for persons with disabilities and has numerous resources for individuals, employers, and community organizations. <http://apse.org/>

SOAR (SSI/SSDI Outreach, Access, and Recovery) Website

The SOAR TA Center has gathered a number of employment resources and links for your reference. Check out the *Brief Overview of SSI/SSDI Work Incentives!* <http://bit.ly/2cqaFj2>

VCU National Training and Data Center

The Virginia Commonwealth University National Training and Data Center provides comprehensive training and technical assistance to Work Incentives Planning and Assistance (WIPA) projects, the Ticket to Work Help Line, and community partners to ensure accurate and timely support for beneficiaries on the road to employment and financial independence. <http://vcu-ntdc.org/index.cfm>

Disability.gov

Disability.gov provides one-stop online access to disability-related resources, services, and information available throughout the federal government. <https://www.disability.gov/>



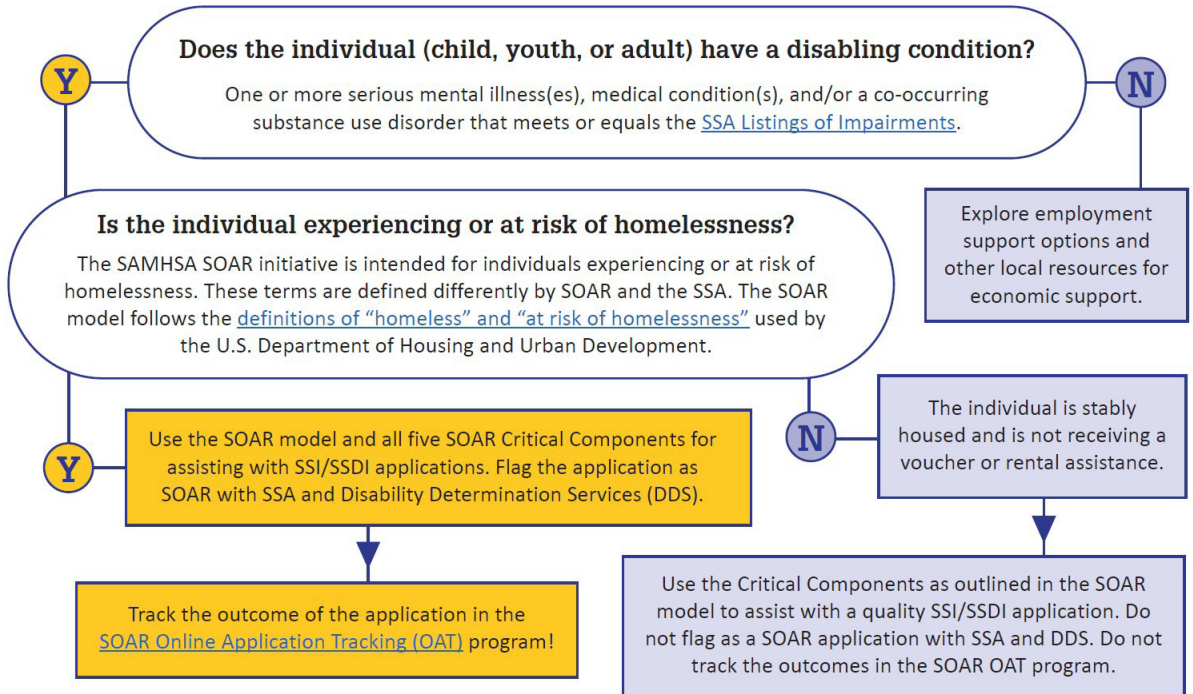
SAMHSA SOAR Technical Assistance Center
<https://soarworks.prainc.com/>



SOAR Eligibility: Decision Tree

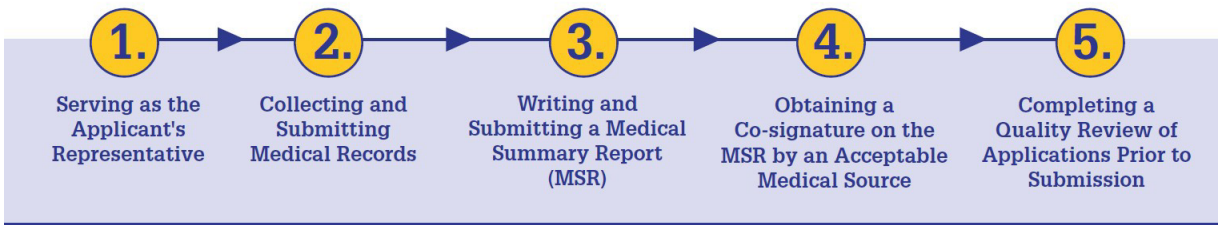
SSI/SSDI Outreach, Access, and Recovery (SOAR) is funded by the [Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#) and is a national program designed to increase access to the disability income benefit programs administered by the [Social Security Administration \(SSA\)](#) for eligible adults and children who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorder.

Should I complete a SOAR-assisted SSI/SSDI application?




SOAR Critical Components

Using these five SOAR Critical Components, case workers play a central role in gathering complete, targeted, and relevant information for SSA and DDS, resulting in high-quality SSI/SSDI applications. These components significantly increase the likelihood of an approval for those who are eligible.



For more information: soar@prainc.com | (518) 439-7415 | soarworks.samhsa.gov

ATTACHMENT 6: STAFF REGISTRATION POLICY

 <p>County of Sacramento Department of Health and Human Services** Division of Behavioral Health Services Policy and Procedure</p>	Policy Issuer (Unit/Program)	QM
	Policy Number	QM-03-07
	Effective Date	06-07-2005
	Revision Date	05-30-2018
Title: Staff Registration	Functional Area: Beneficiary Protection	
Approved By: (Signature on File) Signed version available upon request		
Alexandra Rechs, MFT Program Manager, Quality Management		

BACKGROUND/CONTEXT:

Sacramento County Behavioral Health Services Mental Health Plan (MHP) is responsible for assuring that the mental health services provided are commensurate with the scope of practice, training and experience of the staff utilized. Behavioral Health Services - Quality Management (QM) must certify all staff that provides mental health and alcohol and drug services in accordance with Title 9, Welfare and Institution Code, and Business and Professions Code regulations. QM is responsible for issuing a Staff Registration Number when the certification requirements are met. In addition, QM maintains confirmation of licensure for the County staff performing in a licensed position whether or not they provide direct mental health services, even if they do not bill for those services provided.

DEFINITIONS:

Licensed Professional of the Healing Arts (LPHA)

An LPHA is an individual who can function as “Head of Service” on the agency Application and possesses a valid California Professional License in one of the following professional categories (California Code of Regulations, Title 9, Division 1, Article 8.):

1. **Psychiatrist, Medical Doctor, Psychiatric Resident (Licensed or Unlicensed) (MD)**
2. **Licensed Clinical Psychologist (PSY)**
3. **Licensed Clinical Social Worker (LCSW)**
4. **Licensed Marriage and Family Therapist (LMFT)**
5. **Licensed Professional Clinical Counselor I (LPCC I)**
6. **Licensed Professional Clinical Counselor II (LPCC II)***

7. Registered Nurse, Nurse Practitioner, Nurse Practitioner Intern (RN, NP, NPI)* 8. Physician Assistant (PA)*

***Licensed Professional Clinical Counselor II (LPCC II)** must verify completion of additional training and education of six semester units or nine quarter units specifically focused on the theory and application of marriage and family therapy or a named specialization or emphasis are on the qualifying degree in marriage and family therapy, marital and family therapy, marriage, family and child counseling; or couple and family therapy. In addition, submit proof of no less than 500 hours of documented supervised experience working directly with couples, families, or children and a minimum of six hours of continuing education specific to marriage and family therapy, completed in each licensed renewal cycle. The Board of Behavioral Science must confirm these qualifications have been met and the LPCC II is to provide a copy of that confirmation to couples and family clients prior to the commencement of treatments and to Associate Marriage and Family Therapists, LPCC I, and Associate Professional Clinical Counselors who are gaining the supervised experience necessary to treat couples and families. Business and Professions Code 4999.20 and California Code of Regulations, Title 16, Sections 1820.5 and 1820.7.

***Registered Nurse, Nurse Practitioner, Nurse Practitioner Intern (RN, NP, NPI)**

- See Policy and Procedures # QM-03-04-Nurse Practitioner for additional details

***Physician Assistant (PA)**

- See Policy and Procedures # QM-03-09-Physician Assistant for additional details

Licensed Waived

A “waived” individual may function as an LPHA with the exception of “Head of Service”. This individual is an Associate Marriage and Family Therapist (AMFT), an Associate Social Worker (ASW), an Associate Professional Clinical Counselor (APCC), Registered Psychologist (RPS) or a Registered Psychological Assistant (PSB), and is registered with their respective Board and is one of the following:

1. An individual with a **Master’s Degree** who is granted a waiver by the County, which allows them to function as an LPHA for up to six years.
2. An individual with a **PhD** who has registered with the Board of Psychology and is granted a waiver by the State Department of Mental Health*, *exception UCD Interns/ Fellows. (See Business and Professions Code Section 2909)*

***See P & P #03-06 Licensure Waiver and Monitoring of Accrued Supervised Hours for details.**

Student

A Student Trainee may function as an LPHA throughout the placement time period with appropriate co-signatures and is one of the following:

1. **“Medical Student Clinical Clerkship”** participating in a field trainee placement while enrolled in an accredited Medical School. Psychiatrist co-signature required.
2. **“Post Graduate Student”** participating in a field trainee placement while enrolled in an accredited PhD Psychology program. LPHA- co signature required
3. **“Master’s Level Student”** participating in a field trainee placement while enrolled in an accredited Masters in Social Work (MSW) or Masters of Art (MA)/Masters of Science (MS) counseling program. LPHA co-signature required.

Licensed Vocational Nurse (LVN)

An LVN possesses a valid California LVN License. Must meet specific criteria to function as “Head of Service. (See P&P # 04-01 Site Certification for details).

Psychiatric Technician (PT)

A PT possesses a valid California PT License. Must meet specific criteria to function as “Head of Service.” (See P&P # 04-01 Site Certification for details)

Mental Health Rehabilitation Specialist (MHRS)

An MHRS is an individual who meets one of the following requirements:

1. **Master’s Degree or PhD** and two years of full-time/equivalent (FTE) direct care experience in a mental health setting.
2. **Bachelor’s Degree** and 4 years FTE direct care experience in a mental health setting.
3. **Associate Arts Degree** and six years of FTE direct care experience in a mental health setting. At least two of the six years must be post AA degree experience in a mental health setting.

FTE Experience may be direct services provided in a mental health setting in the field of:

1. **Physical Restoration**
2. **Psychology**
3. **Social Adjustment**
4. **Vocation Adjustment**

Mental Health Assistant (MHA)

MHA-III: “Mental Health Assistant-III” is an individual with **at least four** (4) years of full time/equivalent (FTE) direct care experience in the mental health field. Up to two (2) years of education in a mental health or alcohol and drug related field can substitute for years of experience.

1. Four years of FTE direct care experience in a mental health related field providing mental health. Or
2. Two years of FTE direct care experience in a mental health related field providing mental health; and two (2) years of education (60 semester or 90 quarter units) with a minimum of 12 semester (18 quarter) units in a mental health related subject area such as child development, social work, human behavior, rehabilitation, psychology, or alcohol and drug counseling.

MHA-II: “Mental Health Assistant-II” is an individual who has at least two (2) years but less than four (4) years of full-time/equivalent (FTE) experience in a mental health or related field providing direct mental health. There is no educational requirement.

MHA-I: “Mental Health Assistant-I” is an individual who has less than two (2) years of FTE in a mental health related field providing direct mental health. There is no educational requirement.

Alcohol and Drug Counselor

ADS Assistant: Is an individual who has not yet enrolled into a certification program. This candidate must register, within the first 6 months from the date of hire, and enroll in a State Department of Health Care Services (DHCS) Designated Certifying Organization.

ADS Counselor I is an individual who is successfully registered in a DHCS Designated Certifying Organization. This candidate must remain in good standing and complete certification within five (5) years from the date of registration

ADS Counselor II is an individual who has completed program requirements and is certified by a DHCS Designated Certifying Organization.

Graduate Student

Graduate student is an individual enrolled in the UCD Pre/Post Doctorial Training program.

Peer Staff

Peer staff is an individual identified by a provider whose contract contains provisions for Peer Partner Program staff. There is no education or direct care experience requirement. Lived experience is the basis for this classification.

PURPOSE:

The purpose of this policy and procedure is to delineate the staff classifications and the corresponding qualifications, education, documentation requirements, for all staff providing mental health and drug and alcohol services. It is the policy of Behavioral Health Services to certify each qualifying staff providing mental health and/or alcohol and drug services, directly or indirectly. A Staff Registration Number is issued based on meeting requirements for each classification.

This policy is not meant to supersede specific program design or contractual obligations.

DETAILS:

I. AVATAR Staff Registration Application

The completed Avatar Staff Registration Application Form (Attachment A) and a copy of the NPI printout is submitted to Quality Management with all the required supporting documentation for the requested professional classification.

A. Specify the reason for the application:

1. New – this staff is unknown to the MHP and does not possess a Staff Identification (ID) Number.
2. Update- this staff possesses a Staff ID and the agency wishes to change information previously submitted. Example: Name change, agency change, professional class or employment status changes.

B. Name and your **Social Security number (required to query State and Federal databases mandated as part of the credentialing process) - indicate the current name to be used for certification. ***It must match the name on NPI Registry*****

1. If this is an Update, indicate any previous name(s) submitted in the AKA.

- C. Program Name and Address
- D. Date of Employment
- E. Employment status – indicate appropriate status
- F. Professional Class – indicate the specific classification for which this staff qualifies.
- G. License or registration number
- H. National Provider Identifier (NPI) number. Write the NPI number on the form and attach the NPPES printout. MFT/Associate Marriage and Family Therapist must use Taxonomy 106H00000X; LPCC/Associate Professional Clinical Counselor must use 101YM0800X
- I. Termination is completed when a staff is no longer employed at a provider agency. The original copy of the registration may be faxed or a copy sent to QM with the information added for termination.

II. Professional Classification Supporting Documentation

A. LPHA Licensed Professional Class

1. Submits copy of appropriate license, which indicates the original was verified and is initialed by the Provider or a copy of the appropriate Board printout indicating the name and license status.
2. Provider will verify that the LPCC II classification provided proof of the additional training and education described in the definition and in accordance with Business and Professions Code 4999. (See Attachment B)
3. Provider will verify the LPCC II completed six (6) hours of continuing education specific to marriage and family therapy in each licensing cycle.
4. May co-sign for any staff's work.
5. May provide services and supervision in accordance with the professional class scope of practice. *LPCC I does not include the assessment or treatment of couples or families until they complete additional training and education as defined in LPCC II.*

B. Licensed Waived Professional Class: Associate Social Worker, Associate Marriage and Family Therapist, and Associate Professional Clinical Counselor.

1. LPHA Licensure Waiver Application for (Attachment C)
2. Copy of current, valid registration issued by the Board of Behavioral Science (BBS).
3. Completed copy of the appropriate Responsibility Statement for Supervisors of an Associate Social Worker, Associate Marriage and Family Therapist, or Associate Professional Clinical Counselor. Copies available on the following website: <http://www.bbs.ca.gov/-/Forms-Applicant-Materials-> Select appropriate discipline.
4. Registration with the BBS must be maintained until licensure is confirmed.
5. A Supervisors Statement of Responsibility must be maintained until the candidate is licensed. During the licensure process, the Supervisor's Statement located at the bottom portion of the LPHA Licensure Waiver Application may be utilized.

6. May not co-sign for Graduate Student therapy work.
- C. Licensed Waived Professional Class RPS & PSB
1. Licensure Waiver Application for Psychologist (Attachment D).
 2. Copy of current, valid registration issued by the Board of Psychology, if applicable. (UCD Program exempt)
 3. Copy of Doctoral Degree or letter, on School letterhead, stating the date the candidate was conferred.
 4. Copy of Resume
 5. May not co-sign for Graduate Student therapy notes.
- D. Student Professional Class
1. Student Application Form completed and signed. (Attachment E)
 2. Co-signature is required by a licensed individual of the same discipline or higher.
 3. LPHA status terminates when the placement term expires. The student must then submit an application for an appropriate classification for which they qualify.
 4. **May not co-sign for other staff.**
- E. MHRS Professional Class
1. MHRS Application completed and signed (Attachment F)
 2. Proof of Degree
 3. Copy of Resume indicating proof of qualifying experience (specify hours worked per week and months per year)
- F. MHA Professional Classes_
- MHA III
1. Mental Health Assistant Application (Attachment G)
 2. Copy of Resume indicating proof of qualifying experience (specify hours worked per week and months per year)
 3. Copy of transcripts indicating number of units and classes completed (if applicable)_
- MHA II
1. Mental Health Assistant Application (Attachment G)
 2. Copy of Resume indicating proof of qualifying experience (specify hours worked per week and months per year)
- MHA I
1. Mental Health Assistant Application (Attachment G)
- G. Alcohol and Drug (ADS) Counselor_
- ADS Counselor III
1. ADS Counselor Application (Attachment H)
 2. Copy of Certification from a DHCS Designated Certifying Organization._
- ADS Counselor II
1. ADS Counselor Application (Attachment H)
 2. Proof of enrollment in a DHCS Designated Certifying Organization. This must include the date of enrollment.
- ADS Assistant I
1. ADS Counselor Application (Attachment H)

- H. Graduate Student: UCD Pre/Post Doctorial Candidates
 - 1. Student Application Form completed and signed (Attachment E)
 - 2. Co-signature is required by a licensed individual of the same discipline or higher.
 - 3. LPHA status terminates when the placement term expires. The student must then submit an application for an appropriate classification for which they qualify.
 - 4. **May not co-sign for other staff.**

- I. Peer Staff Professional Class
 - 1. Agency submits only the Avatar Staff Registration Application.
 - 2. The supervisor is the contact person.
 - 3. This classification is for tracking peer program activities only. Staff must be part of a specific program. Not for use without prior program approval.

III. Quality Management Staff Certification document

- A. QM will return the signed Application to the agency following inspection of all the required supporting documents.
 - 1. The Staff ID number will be issued/activated when QM certifies the staff.
 - 2. The documents must be maintained in the agency staff file.

IV. Registry Staff

- A. Registry staff may be utilized by the MHP provider agency provided the staff meets the requirements for the professional class being requested and submits the supporting required documentation.
- B. The Agency must document that an appropriate orientation was provided to this staff. Orientation must include but not limited to, Documentation and program level HIPAA Training.
- C. The Registry must provide the agency with verification that the staff completed the general HIPAA training.

REFERENCE(S)/ATTACHMENTS:

- Title 9. Division I, Chapter 3, Article 8; Welfare & Institutions Code Section 5600, 5750, 5751
- Title 9 Division 4, Chapter 3, Subchapter 3, Article 1 • Title 9 Division 4, Chapter 4, Subchapter 3, Article 1
- Title 9 Division 4, Chapter 5, Subchapter 3, Article 2
- Title 9 Division 4, Chapter 8, Subchapter 1, 2, 3
- Business and Professions Code Section 2900-2918, 4980.02, 4996.9, 4999.20, 4989.14
- DMH Letter No. 10-03; 14-005
- MHSUDS Information Notice No. 14-0013

RELATED POLICIES:

- No. 03-06 Licensure Waiver and Monitoring of Accrued Supervised Hours
- No. 04-01 Site Certification of Physical Plant
- No. 03-04 Nurse Practitioner
- No. 03-09 Physician Assistant

DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff	X	Children's Contract Providers
X	Mental Health Treatment Center	X	Alcohol and Drug Services
X	Adult Contract Providers		

CONTACT INFORMATION:

- Quality Management Information QMInformation@SacCounty.net



Sacramento County
Department of Health and Human Services
Division of Behavioral Health Services

AVATAR STAFF REGISTRATION APPLICATION

County Staff ID Number (if known): _____ New: Update:

<u>Agency</u>			
Agency Name: _____	Phone Number: _____	Date: _____	
Contact Person: _____	Contact Email: _____		
Program Name: _____	Address: _____		
	Street	City	Zip Code

<u>Applicant</u>			
Applicant Name: _____	Last	First	DOB: _____ (required)
		MI	
Previous Name/AKA: _____	Last	First	SSN: _____ (required)
		MI	
Secondary Language: _____	Additional language		Gender: _____ (required)
Date of Employment: _____	Employment Status:		
Start Date in Classification: _____	<input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Contracted <input type="radio"/> Temporary/On-Call <input type="radio"/> Volunteer		

<u>Professional Classification</u> (choose one and attach license/certification)		
<input type="radio"/> Psychiatrist	<input type="radio"/> Licensed Clinical Social Worker (LCSW)	<input type="radio"/> Licensed Psychiatric Technician (PT)
<input type="radio"/> Psychiatric Resident, licensed	<input type="radio"/> Licensed Marriage & Family Therapist (LMFT)	<input type="radio"/> Mental Health Rehabilitation Specialist (MHRSS)
<input type="radio"/> Psychiatric Resident, unlicensed	<input type="radio"/> Licensed Professional Clinical Counselor I (LPCC I)	<input type="radio"/> Mental Health Assistant I (MHA I)
<input type="radio"/> Medical Physician	<input type="radio"/> Licensed Professional Clinical Counselor II (LPCC II)	<input type="radio"/> Mental Health Assistant II (MHA II)
<input type="radio"/> Licensed Clinical Psychologist (PSY)	<input type="radio"/> PHD, Unlicensed, Waived	<input type="radio"/> Mental Health Assistant III (MHA III)
<input type="radio"/> Nurse Practitioner (NP)	<input type="radio"/> Master's Level Unlicensed, Waived (ASW, DMF, PCCI)	<input type="radio"/> ADS Assistant
<input type="radio"/> Nurse Practitioner Intern (RN, NP Intern)	<input type="radio"/> Medical Student Clinical Clerkship	<input type="radio"/> ADS Counselor I
<input type="radio"/> Physician Assistant (PA)	<input type="radio"/> Psychologist Student "Post Graduate"	<input type="radio"/> ADS Counselor II
<input type="radio"/> Pharmacist	<input type="radio"/> Master's Level Student	<input type="radio"/> Graduate Student (UC Davis Only)
<input type="radio"/> Registered Nurse (RN)	<input type="radio"/> Licensed Vocational Nurse (LVN)	<input type="radio"/> Peer Staff - Peer Partner Program
License Number: _____	Expiration Date: _____	NPI Number: _____
(also include an NPI printout with this form)		

<u>Staff Termination</u>
Date of Termination: _____

Send completed form to:
Email: DHSQMStaffReg@saccounty.net
-or- Fax: (916) 875-0877

Notify Quality Management of any staffing changes.

7001-A East Parkway, Suite 300 • Sacramento, California 95823 • phone (916) 875-6069 • fax (916) 875-0877

Revised 5/30/2018



Sacramento County
Department of Health and Human Services
Division of Behavioral Health Services
LICENSED PROFESSIONAL CLINICAL COUNSELOR APPLICATION

Agency: _____ Date: _____

Contact Person: _____ Phone: _____

I attest that I, _____, have the following education and experience required to qualify for the designation of Licensed Professional Clinical Counselor, according to Business and Professions Code 4999. I meet at least one of the indicated options below:

- Licensee Professional Clinical Counselor II (LPCC II). I have the additional education and experience to qualify for this classification. I have obtained confirmation from the Board of Behavioral Sciences and submitted to the agency Clinical Director proof of at least six (6) hours of continuing education specific to marriage and family therapy, completed in each licensing cycle.
Licensee Professional Clinical Counselor I (LPCC I) I understand that until I meet the requirements for LPCC II, this classification scope of practice does not include the assessment or treatment of couples or families.

Signature of Applicant _____ Date _____

I have retained a copy of proof of education, experience and specified continuing education for our agency on-site credentialing file and have submitted the initial supporting documents for this application. Based on the LPCC requirements, I believe this candidate qualifies for the identified classification indicated above. This file is available for review by Quality Management Services at any time.

Agency Clinical Director Signature _____ Date _____

Approval: Rolanda Reed, LCSW _____ Date _____
Quality Management Services



Sacramento County
Department of Health and Human Services
Division of Behavioral Health Services
LPHA LICENSURE WAIVER APPLICATION
(AMFT, ASW, APCC)

Agency: _____ Date: _____

Contact Person: _____ Phone: _____

This letter is to request a waiver of licensure for the following employee under Section 5600.2, Welfare and Institutions Code.

I, _____, am applying for a licensure waiver.
Print Name

I earned a _____ degree on _____
MSW, MS, MA, PhD, or EdD Date

I initially registered with the Board of Behavioral Sciences (BBS) on _____
Date

Attached are copies of my current BBS Internship Registration, BBS licensure status printout, and BBS Supervisor's Responsibility Statement. I understand that my waiver will expire six (6) years from the initial date of BBS registration. I understand that I must remain registered with the BBS and under supervision until I become licensed. QM must receive renewal of the BBS registration prior to the expiration date. I will not be considered waived for any period during which I allowed my registration to expire. If there is a change in supervisor, I must submit a new BBS Supervisor's Responsibility Statement to Quality Management (QM).

Applicant: _____ Date: _____
Signature and Date

SUPERVISOR'S STATEMENT - This Statement meets the requirements for supervision in lieu of the BBS Supervisor's Responsibility Statement if the candidate is in the testing process for licensure.

As the agency supervisor, I attest that I have and will maintain a current license in good standing in California. I have had sufficient experience, training and education in the area of clinical supervision to competently supervise trainees, interns and associates.

Clinical Supervisor's Name _____ Type of licensure: _____
Print Name

Clinical Supervisor: _____ Date _____
Signature



Sacramento County
Department of Health and Human Services
Division of Behavioral Health Services
LPHA LICENSURE WAIVER APPLICATION
For Registered Psychologist and Psychological Assistant

Agency: _____ Date: _____

Contact Person: _____ Phone: _____

This letter is to request a waiver of licensure under Section 5751.2, Welfare and Institutions Code for the following person employed as a psychologist.

Agency: _____ Contact Person: _____ Phone: _____

I _____ am applying for a licensure waiver.

Print Name

The type of waiver requested #1 _____ I received a _____ degree on _____
Percent FTE PhD, EdD, or PsyD Date

I first began employment with this agency as a psychologist on _____
Date

I initially registered with the Board of Psychology as a: PSB _____ RPS _____ on _____
Date

Clinical Supervisor's Name _____ Type of Licensure: _____
Print Name

Attached is a copy of my current Board of Psychology registration, doctoral degree and resume. I understand a waiver is granted by the State Department of Mental Health and may not exceed five years (or three years if candidate is a license-ready out of state recruitment). I understand that the waiver is not effective until the Medical Oversight regional office receives the application. It is not retroactive to the date of hire.

I understand that I must provide the Sacramento County Behavioral Health Services, Quality Management, with subsequent renewals of registration within 60 days of the annual expiration date, informed of my progress toward licensure with the Board of Psychology. I also understand that I must remain under formal supervision by appropriately licensed staff at all times for my State DHCS waiver to remain valid, and that I must notify Quality Management of any change in supervisor.

Signature of Waiver Applicant _____ Date _____

Signature of Clinical Supervisor _____ Date _____

#1. Normal, Part-time, Out-of-State, Extenuating Circumstances. Attach explanation if request is for extenuating circumstances or percentage F.T.E. if request is for part-time.



Sacramento County
Department of Health and Human Services
Division of Behavioral Health Services
STUDENT APPLICATION

Agency: _____ Date: _____

Contact Person: _____ Phone: _____

I attest that I, _____, am a student at an accredited college or university participating in a field placement at this agency. I understand that I may provide services as an LPHA, with the exception of the privilege of co-signing for other staff, throughout this placement.

Name of College/University _____

- Medical Student Clinical Clerkship. I understand that all of my documentation must be co-signed by a psychiatrist.
Doctoral Level Student. I understand that all of my documentation must be co-signed by a licensed PHD or MD.
Master's Level Student. I understand that all of my documentation must be co-signed by an LCSW, LMFT, LPCC, PhD, or MD.

My internship begins on _____ and ends on _____
Date Date

Clinical Supervisor's Name: _____ Discipline _____ License#: _____
Print Name

Student: _____ Date _____
Signature

Clinical Supervisor: _____ Date _____
Signature

Reviewed by Quality Management _____ Date: _____



Sacramento County
Department of Health and Human Services
Division of Behavioral Health Services
MENTAL HEALTH ASSISTANT APPLICATION

Agency: _____ Date: _____

Contact Person: _____ Phone: _____

I attest that I, _____, have the following education and experience required to qualify for the designated Mental Health Assistant category.

- MHA-III: An individual with at least four (4) years of full-time/equivalent (FTE) experience in a mental health related field providing direct mental health services. Two (2) years of education in a mental health related subject may be substituted for (2) years of work experience.* There is a minimum requirement of two (2) years of actual work experience.
MHA-II: An Individual who has at least two (2) years but less than four years of full-time/equivalent (FTE) experience in a mental health related field providing direct mental health services. There is no educational requirement.
MHA-I: An individual who has less than two (2) years of FTE experience in a mental health related field providing direct mental health services. There is no educational requirement.

Attached is a resume and college degree/transcript, if applicable, which qualifies me for this position.

*The education requirement must be a minimum of two (2) years of education (60 semester or 90 quarter units) with a minimum of 12 semester (18 quarter) units in a mental health related subject area such as child development, social work, human behavior, rehabilitation, psychology, or alcohol and drug counseling.

Applicant: _____ Signature _____ Date _____

Agency Representative: _____ Signature _____ Date _____

Quality Management: _____ Signature _____ Date _____



Sacramento County
Department of Health and Human Services
Division of Behavioral Health Services
ADS COUNSELOR APPLICATION

Agency: _____ Date: _____

Contact Person: _____ Phone: _____

I attest that I, _____, have the following qualifications required to register for the counselor classification category indicated below.

- ADS Assistant: An individual who has not enrolled into a certification program. This candidate must register, within six (6) months from the date of hire, and enroll in a State Department of Health Care Services (DHCS) Designated Certifying Organization.
- ADS Counselor I –An individual who is successfully registered in a DHCS Designated Certifying Organization. This candidate must remain in good standing and complete certification within five (5) years from the date of registration.
Must submit proof of registration with a DHCS Designated Certifying Organization
- ADS Counselor II. An individual who has completed program requirements and/or passed an exam issued by the DHCS Designated Certifying Organization and is a “certified AOD Counselor”. Must submit proof as a Certified AOD Counselor from a DHCS Designated Certifying Organization.

Applicant: _____
Signature Date

Agency Representative: _____
Signature Date

Quality Management: _____
Signature Date

ATTACHMENT 7: QUALITY MANAGEMENT PROGRAM ANNUAL WORK PLAN

Sacramento County Division of Behavioral Health Services

Quality Management Program Annual Work Plan - Fiscal Year 18/19

(July 1, 2018 to June 30, 2019)

Our Mission: *To provide a culturally competent system of care that promotes holistic recovery, optimum health, and resiliency.*

Our Vision: *We envision a community where persons from diverse backgrounds across the life continuum have the opportunity to experience optimum wellness.*

Our Values:

- *Respect, Compassion, Integrity*
- *Client and/or Family Driven*
- *Equal Access for Diverse Populations*
- *Culturally Competent, Adaptive, Responsive & Meaningful*
- *Prevention and Early Intervention*
- *Full Community Integration and Collaboration*
- *Coordinated Near Home and in Natural Settings*
- *Strength-Based Integrated and Evidence-Based*
- *Innovative and Outcome-Driven Practices and Systems*
- *Wellness, Recovery, & Resilience Focus*

Sacramento County Mental Health Plan (MHP) develops an annual Quality Improvement Work Plan (QI Plan) to guide its performance improvement activities. The QI Plan describes in detail the MHP activities of performance indicator development and refinement, ongoing and time-limited performance improvement projects or focused studies and other monitoring to ensure quality care. QI Plan activities derive from a number of sources of information about quality of care and service issues. These include State and Federal requirements, Department initiatives, client and family feedback, and community stakeholder input.

Cultural Competence is critical to promoting equity, reducing health disparities and improving access to high-quality mental health, mental health that is respectful of and responsive to the needs of the diverse clients in Sacramento County. The MHP recognizes the importance of developing a QI Plan that integrates the goals of the MHP Cultural Competence Plan as well as cultural competence elements throughout the plan to help us better understand the needs of groups accessing our mental health services and to identify where disparities may exist. Cultural Competence Plan goals and elements are noted throughout the plans with a “(CC)”.

Structure of the Plan

The QI Plan includes four essential domains: Access, Timeliness, Quality and Consumer Outcomes. The “SCOPE” details the areas that make up each domain. Each SCOPE contains a:

Standard: This is the threshold expectation for Sacramento County’s performance.

Benchmark: A point of reference drawn from Sacramento County’s own experience (historical data) and/or legal and contractual requirements. Benchmarks are used to establish goals for improvement that reflect excellence in care.

Goal: Reflects Sacramento County MHP annual goals toward reaching the identified Benchmark.

Sacramento County Division of Behavioral Health Services

Quality Management Program Annual Work Plan - Fiscal Year 18/19

(July 1, 2018 to June 30, 2019)

DOMAIN	SCOPE
1. ACCESS	<ul style="list-style-type: none"> 1.1 Retention & Service Utilization- CC 1.2 Penetration – CC 1.3 Geographically Diverse 1.4 Crisis Services Continuum 1.5 Monitoring Service Capacity 1.6 24/7
2. TIMELINESS	<ul style="list-style-type: none"> 2.1 Timeliness –CC (PIP) 2.2 No Shows
3. QUALITY	<ul style="list-style-type: none"> 3.1 Problem Resolution 3.2 UR and doc standards 3.3 Med Monitoring 3.4 Access to PCP 3.5 Coordination of care 3.6 Diverse Workforce – CC 3.7 Culturally Competent System of Care – CC 3.8 Training/Education - CC
4. CONSUMER OUTCOMES	<ul style="list-style-type: none"> 4.1 Beneficiary Satisfaction 4.2 CANs and PSC-35 4.3 ANSA 4.4 Recidivism

Sacramento County Division of Behavioral Health Services
 Quality Management Program Annual Work Plan - Fiscal Year 18/19
 (July 1, 2018 to June 30, 2019)

1.ACCESS			
Ensuring that members have ready access to all necessary services within the MHP: this includes access to culturally relevant services to address the unserved, underserved and inappropriately served communities.			
1.1 Retention and Service Utilization (CC)			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
1.1a Standard: The MHP will demonstrate parity in mental health services across all cultures. 1.1a Benchmark: TBD 1.1a Goal: TBD	<ul style="list-style-type: none"> Adjust retention and utilization methodology to be consistent with EQRO and DHCS POS report methodology Utilize approved claims data provided by the EQRO to review retention, high utilizer, and mental health service costs across all cultures Develop trend charts to explore differences and create strategies to address disparities Update Work Plan to include goals and additional planned activities based on analysis of approved claims data 	MHP Team, Research, Evaluation & Performance Outcome (REPO), Cultural Competence/Ethnic Services (CC/Ethnic Services)	Annual Report to Cultural Competence Committee (CCC), Management Team (MT) and QIC
1.1b Standard: Costs of mental health services are distributed proportionately across all cultures 1.1b Goal: TBD			
1.2 Penetration (CC)			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
1.2a Standard: There is equal access to the MHP for all cultures 1.2a Benchmark: TBD after data analysis 1.2a Goal: TO have measureable benchmark by January 1, 2019	<ul style="list-style-type: none"> Utilize Medi-Cal eligible data provided annually by the EQRO to track and trend penetration rates by age, gender, race/ethnicity, and language (when data is available) based on approved claims data as well as MHP all services data Utilize published prevalence rates and analyze Sacramento County penetration rates in comparison to other Large county and Statewide penetration rates to determine possible concerns for equal access for certain cultures 	MHP Team, Research, Evaluation & Performance Outcome (REPO), CC/Ethnic Services	Annual Report to Cultural Competence Committee (CCC), MT, and QIC

Sacramento County Division of Behavioral Health Services
 Quality Management Program Annual Work Plan - Fiscal Year 18/19
 (July 1, 2018 to June 30, 2019)

1.3 Geographically Diverse Services			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>1.3a Standard: Mental health services are provided in geographically diverse locations that best represent the community needs.</p> <p>1.3a Goal: Maintain service delivery sites across county care system through a variety of contracts with organizational and enrolled network providers</p>	<ul style="list-style-type: none"> • Develop maps to assist in siting new and/or existing service locations. • Utilize population indicators such as poverty status, demographics, etc. to determine siting and service needs. (CC) • Annual report on changes in numbers of organizational and enrolled network providers from previous year. • Monitor MHP organizational capacity by tracking the number of contracts (hospitals, outpatients and enrolled network providers). • Utilize the Network Adequacy Certification Tool (NACT) to monitor geographic locations meet time and distance standard. 	REPO, MHP, QM, CC/Ethnic Services	Review periodically with management team, QIC, CCC
1.4 Crisis Service Continuum			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>1.4a Standard: The MHP will have a continuum of Mental Health Crisis services available to residents in Sacramento County.</p> <p>1.4a Goal: Develop a multi-tiered crisis service continuum</p>	<ul style="list-style-type: none"> • Continue to collaborate with community partnersto come up with solutions to offer an array of crisis services to Sacramento County residents (hospital systems, law enforcement). • Continue work to implement SB82, crisis residential grants. • Increase access to crisis stabilization and crisis residential services. 	Program, REPO, QM	Review periodically at Management Team, CC, QIC

Sacramento County Division of Behavioral Health Services
 Quality Management Program Annual Work Plan - Fiscal Year 18/19
 (July 1, 2018 to June 30, 2019)

1.4 Crisis Service Continuum (Cont'd)			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
	<ul style="list-style-type: none"> Track and monitor programs already in place to address crisis services (CST, Mobile Crisis, Navigators). Analyze results to determine outcomes. At least annually, analyze data by race, ethnicity and language, sexual orientation and gender identity. (CC) Work with partners and the community to plan and implement an Innovation project that sites a crisis stabilization unit on the same campus as a local emergency room. Continue to support and collaborate with hospital partner(s) to open a new Psychiatric Health Facility. 		
1.5 Monitoring Service Capacity			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>1.5a Standard: All inpatient TARs must be approved within 14 calendar days of receipt of final TAR.</p> <p>1.5a Benchmark: 100% of TARS will be approved or denied for inpatient TARs within 14 days of final TAR.</p> <p>1.5a Goal: Continue to meet the benchmark</p>	<ul style="list-style-type: none"> Monitor Utilization Management compliance with State wide standards for approving or denying Inpatient TARs within 14 calendar days of the receipt of final TAR. Enhance the current tracking tool and explore the feasibility of integrating the tracking into Avatar (EHR). Update standard and benchmark upon receiving additional guidance from DHCS regarding concurrent review process for inpatient hospitalizations. 	QM	Review quarterly at QIC

Sacramento County Division of Behavioral Health Services
 Quality Management Program Annual Work Plan - Fiscal Year 18/19
 (July 1, 2018 to June 30, 2019)

1.6 24/7 Access Line with appropriate language access			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>1.6a Standard: Provide a statewide, toll-free telephone number that can be utilized 24 hours a day, 7 days a week (24/7 line) with language capability in all languages spoken by beneficiaries of the county</p> <p>1.6a Goal: Continue to have a 24/7 line with linguistic capability. (CC)</p>	<ul style="list-style-type: none"> • Conduct year round tests of 24 hour call line and MHP follow-up system to assess for compliance with statewide standards. • Conduct test calls in all threshold languages. (CC) • Provide periodic training for Access Team, after- hour’s staff, and test callers. • Provide feedback to supervisors on results of test calls. • Provide quarterly reports showing level of compliance in all standard areas. • Monitor timeliness of obtaining interpreter services (CC) • Attend trainings provided by DHCS • Develop Call Log for MHTC to use within Avatar 	Quality Management (QM), REPO, CC/Ethnic Services	Quarterly to Management Team, QIC and CCC
<p>1.6b Standard: The 24/7 line will provide information to beneficiaries about how to access specialty mental health services</p> <p>1.6b Benchmark: 100% of test calls will be in compliance with the standard</p> <p>1.6b Goal: Increase percent in compliance annually until benchmark is met</p>			

Sacramento County Division of Behavioral Health Services
 Quality Management Program Annual Work Plan - Fiscal Year 18/19
 (July 1, 2018 to June 30, 2019)

<p>1.6c Standard: The 24/7 line will provide information to beneficiaries about how to use the beneficiary problem resolution and fair hearing processes</p> <p>1.6c Benchmark: 100% of test calls will be in compliance with the standard</p> <p>1.6c Goal: Increase the percent in compliance annually until benchmark is met.</p>			
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1.6 24/7 Access Line with appropriate language access (Cont'd)			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>1.6d Standard: The 24/7 line will provide information to beneficiaries about services needed to address a beneficiary's crisis</p> <p>1.6d Benchmark: 100% of test calls will be in compliance with the standard</p> <p>1.6d Goal: Increase the percent in compliance annually until benchmark is met.</p>	<ul style="list-style-type: none"> • Same as above 	Quality Management (QM), REPO, CC/Ethnic Services	Quarterly to Management Team, QIC and CCC

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<p>1.6e Standard: All calls coming in to the 24/7 line will be logged with the beneficiary name, date of the request and initial disposition of the request 1.6e Benchmark: 100% of test calls will be in compliance with the standard 1.6e Goal: Increase the percent in compliance annually until benchmark is met.</p>			
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2.TIMELINESS Ensure timely access to high quality, culturally sensitive services for individuals and their families.			
2.1 Timeliness to Service			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>2.1a Standard: The time between request for MHP Outpatient services and the initial service offered and/or provided to consumers will be 14 calendar days or less. 2.1a Benchmark: 100% of Adult and Children will meet the 14 calendar day standard 2.1a Goal: Increase in percent meeting standard annually until benchmark is met.</p>	<ul style="list-style-type: none"> Produce quarterly reports that monitor benchmarks and track timely and appropriate access to mental health plan services. Produce annual report that evaluate benchmarks and timely access to mental health plan services by race, ethnicity, language, sexual orientation and gender identity (CC). Provide feedback to MHP providers of quarterly report findings at provider meetings. 	REPO, Ethnic Services, QM	Review quarterly with management team, QIC, CCC

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<p>2.1b Standard: The time between request for MHP Outpatient services and the first psychiatric service offered and/or provided to consumers will be 21 calendar days or less.</p> <p>2.1b Benchmark: 100% of Adult and Children will meet the 21 calendar day standard</p> <p>2.1b Goal: Increase in percent meeting standard annually until benchmark is met.</p>	<ul style="list-style-type: none"> • Review data measurement and reporting methodologies to ensure accurate timeliness measurement consistent with DHCS requirements. • Explore implementing successful strategies from Non-Clinical and Clinical PIPs across the system to address engagement and time to service. • Explore the feasibility of utilizing the scheduler in Avatar across the MHP. • Utilize technical assistance provided by EQRO and DHCS to identify additional strategies to address timely access to services. • Continue to track and report on timeliness of authorization of referrals and evaluate business process at County Access team to ensure timeliness and efficiency in processing referrals. 		
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2.1 Timeliness to Service (Cont'd)			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>2.1c Standard: The time between acute hospital discharge to first OP psychiatric service offered and/or provided to consumers will be 21 calendar days</p> <p>2.1c Benchmark: 100% of Children and 100% of Adults will meet the 21 day standard.</p> <p>2.1c Goal: Increase the percent meeting standard annually until benchmark is met.</p>	<ul style="list-style-type: none"> • Same as above 		

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<p>2.1d Standard: The time between acute hospital discharge to first OP service provided to consumers will be 4 calendar days/ (96 hours) 2.1d Benchmark: 100% of Children and 100% of Adults will meet the 4 day standard 2.1d Goal: Increase the percent meeting standard annually until benchmark is met.</p>			
<p>2.1e Standard: The time between referral for psychological testing and 1st psychological testing appointment offered and/or provided to children will be 14 days or less</p>	<ul style="list-style-type: none"> • Hire 4th psychologist to add capacity • Train and collaborate with outpatient providers regarding the appropriateness of psychological testing referrals • Review psych testing referral and business processes 	REPO	Review quarterly with management team and QIC

2.1 Timeliness to Service (Cont'd)			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>2.1e Benchmark: 65% of children and youth will meet the 14 day standard. 2.1e Goal: Increase the percent meeting standard annually until the benchmark is met.</p>			
2.2 No Shows/ Cancellations for scheduled appointments			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>2.2a Standard:</p>		REPO	

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<p>The time between authorization for MH Services and 1st engagement activity where actual verbal or face-to-face contact is made is 3 business days.</p> <p>2.2a Benchmark: 70% of Children and Adults will meet the 3 business day standard 2.2a Goal: Increase the percent meeting standard annually until benchmark is met.</p>	<ul style="list-style-type: none"> • Continue implementing successful strategies from Non-Clinical and Clinical PIPs across the system to address engagement and timeless to service. • Evaluate current engagement activities and billing codes to assist in accurately measuring outreach and engagement efforts prior to initial appointment. 		<p>Review quarterly with management team, QIC, CCC</p>
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3. QUALITY

Analyzing and supporting continual improvement of MHP clinical and administrative processes in order to achieve the highest standard of care, with care processes that are recovery oriented, evidence-based and culturally sensitive

3.1 Problem Resolution

<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
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<p>3.1a Standard: The MHP will have a Problem Resolution process that provides tracking of all grievances and appeals and ensures that all grievances and appeals are logged and resolved in a timely manner.</p> <p>3.1a Benchmark: Grievances and appeals logged within 1 business day 100% of all grievances will be resolved within 90 days 100% of all appeals will be completed within 30 days 100% of all expedited appeals will be resolved in 72 hours 3.1a</p> <p>Goal: Percent of appeals logged and resolved in a timely manner will increase annually until benchmark has been met</p>	<ul style="list-style-type: none"> • Monitor the problem resolution process tracking and reporting system. Make adjustments as needed to ensure integrity of data. • Track, trend and analyze beneficiary grievance, appeal and State Fair Hearing actions. Include type, ethnicity, race, and language as part of this tracking. (CC) • Track the timeliness of grievance, appeals and expedited appeal resolution for non-compliance tracking. • Track and analyze provider level complain, grievance process with concomitant corrective plans. 	<p>QM</p>	<p>Quarterly at QIC, CCC</p>
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3.2 Utilization Review and documentation standards			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>3.2a Standard: The MHP will have a rigorous utilization review process to ensure that all documentation standards are met.</p> <p>3.2a Goal: Monthly adult and child clinical chart reviews.</p>	<ul style="list-style-type: none"> • Conduct monthly utilization review utilizing electronic health record for providers using Avatar (go to provider site for providers not using Avatar quarterly). 	<p>QM</p>	<p>Quarterly at QIC</p>

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<p>3.2b Standard: All client treatment plans must have a client, staff signature and caregiver signature if applicable. If no client or caregiver signature, there must be documentation of the reason of refusal.</p> <p>3.2b Benchmark: 100% of treatment plans from UR chart review will have a client/caregiver signature.</p> <p>3.2b Goal: Increase in percent annually until benchmark is met.</p>	<ul style="list-style-type: none"> • Information obtained through monthly reviews will be evaluated and issues will be reviewed at UR Committee. • All agencies will complete a monthly internal chart review which may include focused review of progress notes; assessments and client plans. • Identify specific QI reports in Avatar to develop monitoring and rapid feedback loop across system. • Develop quality assurance measures in Avatar reports to establish data measurement for MHP service system. Providers will use tracking measures to monitor documentation standards following minimum Medi-Cal and MHSA requirements. • Providers and county staff will review timeliness for documentation monthly through the use of the Avatar reports including: Active Client Final Assessment. Active Client Plan and Core Status, Active Client Psychiatric Assessments, Services with No Diagnosis and Progress Notes Remaining in Draft. 		
<p>3.2c Standard: All client charts will have documentation justifying medical necessity.</p> <p>3.2c Benchmark: 100% of client charts from UR chart review will have documented justifying medical necessity.</p> <p>3.2c Goal: Increase in percent annually until benchmark is met.</p>			

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3.2 Utilization Review and documentation standards (Cont'd)			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
	<ul style="list-style-type: none"> Targeted chart review at provider sites when significant non-compliance issues are discovered. Provide documentation training to MHP providers at least quarterly. Provide targeted documentation and technical assistance to providers that have identified compliance issues. 		
<p>3.2d Standard: All Client Plan's will be completed within 60 days from request for services unless exception given.</p> <p>3.2d Benchmark: 100% of client plans will be completed within 60 days of request for services unless exception has been given</p> <p>3.2d Goal: Increase in percent annually until benchmark is met.</p> <p>3.2e Standard: All client objectives documented in the client plan will be measureable.</p> <p>3.2e Benchmark: 100% of client objectives in charts selected for UR will be measurable.</p> <p>3.2e Goal: Increase in percent annually until benchmark is met.</p>	<ul style="list-style-type: none"> Same as above 	QM	Quarterly at QIC

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3.2 Utilization Review and documentation standards (Cont'd)			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>3.2f Standard: Progress notes should always indicate interventions that address the mental health condition.</p> <p>3.2f Benchmark: 100% of progress notes will have interventions that address MH condition</p> <p>3.2f Goal: Increase in percent annually until benchmark is met.</p>			
3.3 Medication Monitoring			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>3.3a Standard: Providers practice in accordance with community standards for medication/pharmacology 3.3a</p> <p>Benchmark: Review medication/pharmacology in 5% of open episodes for each provider/program.</p> <p>3.3a Goal: Continue to monitor and meet benchmark.</p>	<ul style="list-style-type: none"> • Study, analyze and continuously improve the medication monitoring and medication practices in the child and adult system. • Conduct monthly medication monitoring activities and report and discuss issues at the P & T committee meeting. • Strongly encourage all treatment providers to use practice guidelines developed by the P&T committee for the treatment of schizophrenia, bipolar disorders, depressive disorders and ADHD. • Continue improvements in criteria for medication monitoring of outpatient clinics based on best practices. • Create a reporting methodology for Medication Monitoring reviews. 	MHTC, QM, Med Monitoring Committee	Review Pharmacy and Therapeutics Committee Quarterly at QIC

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3.4 Member Access to PCP			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>3.4a Standard: All clients will be connected to a primary care physician, unless otherwise indicated by the client.</p> <p>3.4a Benchmark: 75% of adults and 60% of children will be connected to a PCP within 60 days of admission to a mental health treatment program</p> <p>3.4a Goal: Increase the percent of adults & children with a PCP each year until benchmark has been met.</p>	<ul style="list-style-type: none"> Monitor the number of adults and children connected to a PCP as indicated in the Client Resources in the MHP's electronic health record. 	REPO, Program	Review annually with management , Quarterly at QIC
3.5 Coordination of Care			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>3.5a Standard: The MHP will collaborate with other government agencies/stakeholders to facilitate coordination and collaboration to maximize continuity of services for clients with mental health needs.</p> <p>3.5a Goal: Continue to work with our partners to provide coordination and collaboration.</p>	<ul style="list-style-type: none"> Pathways to Wellness -Monitor the use of ICC,ICC-CFT and IHBS services for children involved in the child welfare receiving intensive services. Continue to have MHP representatives on task forces, initiatives and projects that involve clients with mental health issues (Commercially Sexually Exploited children, Crossover Youth Practice Model, MH Courts, TAY Homeless Initiative, Whole Person Care, etc.). 	REPO, Program, QM, Avatar, CC/Ethnic Services	Report annually at QIC, CCC

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	<ul style="list-style-type: none"> • Collaboration with Child Welfare for completion and submission of CANS and PSC-35 documents required by State agencies. 		
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3.5 Coordination of Care (Cont'd)			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
	<ul style="list-style-type: none"> • Actively participate in CFTs for children involved with Probation and Child Welfare • Update Avatar to track referrals coming in from and going out to GMCs. • Explore methods of tracking care coordination between GMC, PCP and MHP. Develop and implement a bi- lateral screening and referral tool. • Explore data sharing across public agencies. • Evaluate data by age, ethnicity, race, language, and gender to look for disparities. (CC) • Continue implementation of CCR 		
3.6 Diverse Workforce (CC)			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>

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<p>3.6a Standard: The MHP will have a diverse workforce that is representative of the clients and community they serve.</p> <p>3.6a Benchmark: The make-up of direct services staff is proportionate to the racial, cultural and linguistic make-up of Medi-Cal beneficiaries plus 200% of poverty population</p> <p>3.6a Goal: Increase the diversity of direct service staff by 5% each year until benchmark is met.</p>	<ul style="list-style-type: none"> • Complete the annual Human Resources Survey and analyze findings 	REPO, CC/Ethnic Services and Workforce Education and Training	CCC, QIC, Management Team
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3.7 Culturally Competent system of care (CC)			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>3.7a Standard: The MHP will have a culturally competent system of care.</p> <p>3.7a Goal: The MHP will complete a biennial system-wide Agency Self-Assessment of Cultural Competence</p>	<ul style="list-style-type: none"> • Biennially complete and analyze a system-wide Agency Self-Assessment of Cultural Competence. 	CC/Ethnic Services	CCC, QIC, Management Team
3.8 Training -Education			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>

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<p>3.8a Standard: The County will provide and/or offer on-going training opportunities to the MHP workforce 3.8a1 Goal: The MHP will have a well-trained, culturally and linguistically competent workforce that is adequately trained to provide effective services and administer programs based on wellness and recovery. (CC)</p> <p>3.8a2 Goal: By the end of FY 18/19, 75% of all BHS direct service staff and supervisors will have completed the California Brief Multicultural Competence Scale (CBMCS) and cultural competence training. (CC)</p>	<ul style="list-style-type: none"> • Utilize Mental Health Services Act (MHSA) principles to enhance skill level through training and education at all levels of the MHP. • Continue implementation of MHP WET Training Plan based n community input and MHP prioritization. • Administer California Brief Multicultural Competence Scale (CBMCS) to service delivery and supervisory staff and provide CBMCS training modules across the system. (CC) • Provide Mental Health Interpreter training for interpreter staff and providers who use interpreters. (CC) • Develop and implement curriculum for integrating cultural competency and wellness, recover and resiliency principles for different levels and types of providers and stakeholders. 	<p>CC/Ethnic Services, QM</p>	<p>Annual and Periodic Report to QIC, CCC</p>
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3.8 Training - Education (Cont'd)			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>3.8a3 Goal: 98% of staff identified as interpreters complete the approved mental health/behavioral health interpreter training and receive certification. (CC)</p>	<ul style="list-style-type: none"> • Refine system wide implementation of trauma informed and trauma specific trainings to address all ages and cultural groups served by the MHP. • Utilize training/educational opportunities to include methods to enhance the array of culturally competent skill sets and community interfaces for mental health and partner agencies. (CC) • Conduct at least one workshop on consumer culture with trainers to include consumer/youth/parent/caregiver/family perspective on mental illness. • Conduct at least annual in-house training/consultation to MHP's mandated key points of contact to ensure competence in meeting the access needs of diverse communities. (CC) • Continue expansion and targeted implementation of MH training for law enforcement and first responders within and outside of the mental health provider community. • Explore training opportunities to provide a continuum of crisis intervention trainings to address all age groups and a variety of service specific issues to enhance crisis intervention competency skills across MHP services. (CC) 		

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4. CONSUMER OUTCOMES			
Ensure the accountability, quality and impact of the services provided to clients in the Sacramento County MHP through research, evaluation and performance outcomes.			
4.1 Beneficiary Satisfaction			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>4.1a Standard All consumers served during the Consumer Perception Survey (CPS) collection period will be given the opportunity to provide feedback on the services they receive from the MHP 4.1a</p> <p>Benchmark The MHP will obtain a 75% response rate during each CPS collection period 4.1a</p> <p>Goal: Increase the response rate each year until Benchmark is met.</p>	<ul style="list-style-type: none"> • Provide mandatory training to MHP providers on survey distribution and collection prior to CPS survey distribution periods. • Administer State required Consumer Perception Survey and English, Spanish, Chinese, Hmong, Russian, Tagalog, Vietnamese and any other available language. (CC) • Produce reports after each CPS survey period and share with providers. • Monitor response rate and establish protocols for both the system and those providers that fall below the benchmark. • Analyze results of CPS and provide written report on analysis of data. • Analysis to include examination of disparities by race, ethnicity and language. (CC) 	<p>REPO in collaboration with CC/Ethnic Services</p>	<p>Review semi-annually with management team, QIC, CCC</p>
<p>4.1b Standard Consumers will be satisfied with the services received in the MHP</p> <p>4.1b Benchmark Percent overall agreement in the General Satisfaction domain will be 90% or greater for each CPS sampling period</p>	<ul style="list-style-type: none"> • Monitor performance on the six perception of general satisfaction indicators (questions 1, 4, 7, 5, 10 and 11) bi-annually and consider improvement project if significantly below the overall CPS percent agreement. • Track and trend on Division Dashboard 		

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4.1 Beneficiary Satisfaction (Cont'd)			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
4.1b Goal Increase the percent of consumer satisfaction on each domain each year until benchmark has been met.			
4.1 Beneficiary Satisfaction			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
4.1c Standard: Consumers will feel a higher social functioning as a result of receiving services in the MHP. 4.1c Benchmark: Percent overall agreement in the Perception of Functioning domain will be 70% or greater for each CPS sampling period 4.1c Goal: Increase the percent of consumer agreement on the Functioning domain each year until benchmark has been met	<ul style="list-style-type: none"> Monitor performance on the five perception of better functioning indicators (questions 16, 17, 18, 20 and 22) bi-annually and consider improvement project if significantly below the overall CPS percent agreement. Track and trend on Division Dashboard 	REPO	Review semi-annually with management team, QIC, CCC

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4.2 Recovery Tool			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>4.2 Standard: The MHP will track and measure recovery</p> <p>4.2 Goal: The MHP will implement the use of a recovery tool within FY18/19</p>	<ul style="list-style-type: none"> • Work with MH advocates to analyze available recovery tools and develop a plan to implement a culturally sensitive recovery tool. (CC) • Explore other MHPs and how they measure recovery. • Explore client self-administered recovery tool options. 	REPO, Advocates, Management Team, CC/Ethnic Services	Annual update to QIC
4.3 CANS and PSC 35			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>4.3a Standard: All children providers in the MHP will complete a CANS at intake assessment, every 6 months and discharge for all children ages 6-21 served.</p> <p>4.3a Benchmark: 100% of children ages 6-21 will receive a CANS assessment at time of intake 100% of children ages 6-21 will receive a CANS every six months unless discharged prior to the 6 month assessment period 100% of children ages 6-21 will receive a CANS at discharge</p> <p>4.3a Goal: Increase percent completion annually until benchmarks have been met.</p>	<ul style="list-style-type: none"> • Monitor the percent completion of CANS assessment at intake, six months and at discharge. • Provide annual reports with analysis of data. Analysis to include examination of disparities by race, ethnicity and language. (CC) • Provide CANS training and certification to providers. 	REPO, QM	Annual Report to Management and QIC, CCC


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4.3 CANS and PSC 35 (Cont'd)			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>4.3b Standard: All children providers in the MHP will complete a PSC-35 at intake assessment, every 6 months and discharge for all children ages 6-18 served.</p> <p>4.3b Benchmark: 100% of children ages 6-18 will receive a PSC-35 assessment at time of intake. 100% of children ages 6-18 will receive a PSC-35 every six months unless discharged prior to the 6 month assessment period 100% of children ages 6-18 will receive a PSC-35 at discharge</p> <p>4.3b Goal: Increase percent completion annually until benchmarks have been met.</p>	<ul style="list-style-type: none"> • Monitor the percent completion of PSC-35 assessment at intake, six months and at discharge. • Provide annual reports with analysis of data. Analysis to include examination of disparities by race, ethnicity and language. (CC) • Provide CANS training and certification to providers. 	REPO, QM	Annual Report to Management and QIC, CCC
4.4 ANSA			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>4.4a Standard: The MHP will have a standardized way of assessing the appropriateness of care for all adults receiving services</p> <p>4.4a Goal: Pilot the Adult Needs and Strengths Assessment (ANSA) for possible implementation across the entire adult system.</p>	<ul style="list-style-type: none"> • Develop implementation plan for the use of (ANSA) for system wide outcome measures for adult programs. 	REPO, QM, Program	Annual Report to Management and QIC

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4.5 Recidivism			
<i>Standard/Benchmark/Goal</i>	<i>Planned Activities</i>	<i>Resp Party</i>	<i>Review Process</i>
<p>4.5a Standard: The majority of clients will not return to acute psychiatric care within 30 days of discharge from acute psychiatric hospitalization.</p> <p>4.5a Benchmark: 15% Recidivism rate 4.5a</p> <p>Goal: To reduce the recidivism rate to 15% by end of FY 18/19</p>	<ul style="list-style-type: none"> • Monitor rates comparing with overall MHP rates from previous fiscal year. • Analysis to include examination of disparities by race, ethnicity, language, sexual orientation and gender identity and development of strategies to ameliorate. (CC) • Evaluate impact of crisis system rebalance efforts on recidivism 	REPO in collaboration with CC/Ethnic Services	Review quarterly with Management team, QIC, CCC
<p>4.5b Standard: Low proportion of hospital days should be attributable to recidivist admits.</p> <p>4.5b Benchmark: 25% of total acute days are attributed to recidivist clients 4.5b</p> <p>Goal: To reduce the percent of days attributed to recidivist admits to meet the benchmark by the end of FY 18/19</p>	<ul style="list-style-type: none"> • Quarterly monitoring and reporting on inpatient days attributed to consumers with 2 or more acute admissions during the quarter- dashboard item. 	REPO	Review quarterly with Management team, QIC

ATTACHMENT 8: REVIEW PROCESS FOR IMPLEMENTATION OF NEW CLINICAL PRACTICES POLICY

 <p>County of Sacramento</p> <p>Department of Health Services Division of Behavioral Health Services Policy and Procedure</p>	Policy Issuer (Unit/Program)	QM
	Policy Number	QM-14-01
	Effective Date	04-01-2008
	Revision Date	10-01-2020
Title: Review Process for Implementation of New Clinical Practices	Functional Area: Clinical Care	
Approved By: (Signature on File) Signed version available upon request Alexandra Rechs, LMFT Program Manager, Quality Management		

BACKGROUND/CONTEXT:

The Sacramento County Division of Behavioral Health Services (BHS) supports the adoption of Evidence-Based Practices (EBP), Promising Practices (PP), Community-Defined Evidence (CDE) and innovative service efforts to meet the needs of behavioral health clients. This support is anchored in a vision of clients achieving maximum positive outcomes based on a system of service providers that deliver safe, effective, culturally and linguistically competent services.

The Division of Behavioral Health Services recognizes that adoption of EBP’s PP’s and other innovative service efforts require significant new efforts in the area of education, training, documentation and evaluation. These initiatives are expected to evolve as the guidelines and directions are released.

DEFINITIONS:

The following definitions will be applied by the BHS to evaluate proposed EBPs, PPs, CDEs and SSs.

Evidence-Based Practice (EBP): The range of treatment and services of well-documented effectiveness. An EBP has been, or is being evaluated and meets the following criteria:

- Has some quantitative and qualitative data showing positive outcomes, but does not yet have enough research or replication to support generalized positive outcomes. **And**
- Has been subject to expert/peer review that has determined that a particular approach or strategy has a significant level of evidence of effectiveness in research literature. [Adapted from President’s New Freedom Commission & MHPA Prevention & Early Intervention Guidelines Enclosure 4]

Promising Practice (PP): Innovations in clinical or administrative practice that respond to critical needs of a particular program, population or system and which seem to produce good outcomes but do not have enough research or replication to support generalized outcomes. [Adapted from California Institute of Mental Health “Toward Values-Driven, Evidence-Based Mental Health Practices]

Community-Defined Evidence (CDE): Practices that have a base for effectiveness in achieving mental health outcomes for underserved communities. It also defines a process underway that will develop specific criteria by which effectiveness may be documented that will eventually give the procedure equal standing with current EBP. [National Network to Eliminate Disparities Latino Work Group] (MHSA Prevention & Early Intervention Guidelines Enclosure 4)

Service Strategies (SS): Programs, interventions and approaches that are focused on particular population groups as the target for receiving service(s) with goal of positive outcomes in prevention or intervention. Frequently, service strategies are non-proprietary and have great variability in use and application.

Practice Review Panel (PRP): The PRP is the DBHS structure responsible for reviewing EBPs, PPs, CDEs and SSs.

PURPOSE:

The purpose of this policy is to outline the decision making process by which the BHS will determine whether proposed EBPs, PPs, CDEs or SSs will be implemented by contracted providers and county operated programs.

DETAILS:

A. Roles and Responsibility

The review process described below applies to proposed practices that fall within the definitions provided. The only exceptions to these definitions are the six SSs currently approved for Client Service Information (CSI) coding and included in documentation training by the DBHS. The approved SSs currently utilized are: Peer and/or Family Delivered Services (Code 50); Psychoeducation (Code 51); Family Support (Code 52); Supportive Education (Code 53); Delivered in Partnership with Law Enforcement (Code 54); and Unknown Evidence-Based Practice/Service Strategy (Code 99).

Any proposed EBP, PP, CDE or SS must be submitted in writing via a Clinical Practice Submission Packet (if the proposal is for a new EPB, PP, CDE, or SS that has **NOT** been identified and approved through the PRP), or Implementation Packet (if the proposal is for an EBP, PP, CDE, or SS that has been previously reviewed and approved), for review. Coding and documentation guidelines will be provided following approval. For example, if a CSI Senior age-specific SS is reviewed and approved, an existing CSI code (Code 61) will be utilized. Other Sacramento County specific practices will be coded with special local codes. For example, Cue-Centered Therapy or Parent Child Interaction Therapy (PCIT) are local practices. When approved for local coding and tracking, a newly developed code would be utilized, separate from CSI tracking.

B. PRP for EBPs, PPs, CDE & SSs

The BHS PRP was established as an extension of the DBHS Executive Quality Improvement Committee (QIC) structure. This panel includes: Adult Mental Health Services Division Manager or designee, Child & Family Mental Health Services Division Manager or designee, Substance Use, Prevention and Treatment (SUPT) Division Manager or designee, Support Services Division Manager or designee, Quality Management (QM) Manager or designee, Research, Evaluation and Performance Outcomes (REPO) Manager or designee, Cultural Competence Manager or designee, and an Advocate representation (Consumer, Family and/or Child and/or Adult Family), Program Coordinators, Medical Directors (Child and/or Adult) as needed, Mental Health Services Act representatives or other subject matter experts are included as participants in the PRP as indicated.

Any member of the PRP with direct involvement or perceived potential conflict of interest in any proposal shall disclose such involvement as part of the initial review process and can choose to recuse themselves for specific reviews. In addition, a consensus determination is made by the PRP members to include or exclude such member from final review decisions based on the type and level of involvement.

The charge of the PRP will be to review any EBP, PP, CDE or SS packet submitted by providers. In addition to the approval process, the PRP will conduct an annual system review. During this review the PRP will work on specific topics and administrative issues related to this subject, including exploring and making recommendations regarding EBPs, PPs, CDEs and SSs and related knowledge base. The PR will report findings and make recommendations to the QIC

C. Provider Responsibility

A provider must request and receive approval to implement the selected EBPs, PPs, CDEs or SSs. To receive this approval, a provider is required to submit a packet to the designated Contract Monitor or Program Manager for review. The designated Contract Monitor or Program Manager reviews the packet for completion of all requested materials, attaches any additional pertinent information or comments, and submits the documents to the Chair of there. Pertinent information may include contract or system impact or other information available to the Contract Monitor or Program Manager with relevance to the proposal.

Should a proposal be applicable across multiple providers or programs, the Contract Monitor or Program Manager may attach that information to the packet. The PRP decision will consider and approve a standard applicable to all providers within BHS implementing this practice. This proposal may also be coordinated by the BHS SUPT, Adult or Children's Programs on behalf of multiple providers (e.g. System wide Motivational Interviewing, Trauma Focused CBT, etc.).

1. Clinical Practice Submission Packet: If the proposal is for a new EPB, PP, or CDE, or SS that has **NOT** been identified and approved through the PRP the following information must be provided as part of the Clinical Practice Submission Packet below:
 - a. Model Description - Information about the model including: Who within the Sacramento County MHP would this model benefit, proposed target population, supporting evidence/literature discussing the merits of implementation with the target population including cultural groups served in the Sacramento County MHP, modifications available to increase cultural competence, and any other information relevant to how this model differs from models currently approved by the MHP.
 - b. Training: Cost analysis for initial training and implementation, what type of training is available (Train-the-trainer, one time training, on-line models, training stages, local trainer's vs out-of-town trainers, annual re-certification requirements, etc.)

2. Implementation Packet: If the proposal is for an EBP, PP, CDE, or SS that has been previously reviewed and approved by the PRP BHS, and QIC or has submitted through the process outlined above, the provider will only need to submit an Implementation Packet that will outline the implementation strategies for the specific program to the Contract Monitor or Program Manager. Once the Contract Monitor and/or Program Manager have reviewed and provided any feedback, the Implementation Packet will be sent to the PRP to begin the approval process. The Implementation Packet must include:

- a. Strategies: An outline of strategies to assess model fidelity including the provider's plan to adhere and monitor model fidelity. This plan or procedure should contain sufficient detail for the PRP to determine the feasibility of efforts to assess fidelity including outcome tools and measures such as pre-posttests.
- b. Sustainability: A sustainability analysis addressing such factors as staff turnover, supervision, ongoing funding for oversight and training activities, etc.
- c. Training (Program Specific): Describe the selection criteria of staff to be trained, how training will be conducted, and by whom, to provide the EBP, PP, CDE or SS and ongoing staff oversight and training, and re-certification needs.
- d. Other Key Information: For any proposed EBP, PP, CDE or SS, EPSDT providers must include the number of clients using EPSDT dollars from existing contracted slot capacity.

D. Panel Review And Approval Process

The PRP will convene a meeting to review a proposed request within 30 days of receipt of the packet from the Contract Monitor or Program Manager. The PRP may request additional information or meet with additional subject matter experts prior to making a final decision.

Within 30 days of the meeting, the PRP will submit a written response to the requestor, indicating the results of the review. "Approval," "Disapproval" or "Resubmission with instructions." Any requests for additional information will also be included in the response to the requestor.

E. Post Approval Plan

After approval by the PRP, the following administrative activities are conducted:

1. Provider submits response to approval letter, if applicable, and proceeds to incorporate updates, data and other information as part of quarterly report to Contract Monitor or Program Manager.
2. Contract Monitor works with the provider and DBHS administrative units to set up cost centers provider episodes in Avatar or other means of tracking services as decided by the PRP.
3. REPO, QM and Ethnic Services/Cultural Competence units will work with provider or Program Manager/designee to determine method of recording outcomes, including the documentation of the appropriateness of the model for services to cultural, ethnic and racial groups. In addition, providers will be given specific coding and documentation requirements to record information accurately into client records. Any unique coding or tracking decisions relating to EBP, PP, CDE and SS will be resolved on a case by case basis consultation with QM, Cultural Competence, REPO and Program staff.

F. Post-Implementation Review

Contract Monitors and Program Managers will receive updates of any significant changes related to the approved EBP, PP, CDE or SS in the quarterly report. Some examples of relevant areas for updates are staff turnover, additional costs for implementation of the model, new or additional training. PRP approval letter or subsequent Contract Monitor follow-up letters will provide any specific items requiring ongoing quarterly report from provider.

At the end of the first year of implementation the outcomes will be assessed by the PRP, with

particular attention paid to the appropriateness of the model for services to cultural, ethnic and racial groups.

An annual or otherwise determined schedule for review of EBP, PP, CDE, and SS will be established.

REFERENCE(S)/ATTACHMENTS:

N/A

RELATED POLICIES:

N/A


DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff		
X	Mental Health Treatment Center		
X	Adult Contract Providers		
X	Children's Contract Providers		
X	Substance Use, Prevention, and Treatment Services		
X	Specific grant/specialty resource		

CONTACT INFORMATION:

- Quality Management_
QMInformation@SacCounty.net

ATTACHMENT 9: TIMELY ACCESS POLICY

	County of Sacramento Behavioral Health Services	Policy No.	QM-20-04
		Issued Date	07/01/2019
		Revision Date	
AREA: Federal Managed Care Regulations		TITLE: Timely Access	
Approved by: (Signature on File) Signed version available upon request		Approved by: (Signature on File) Signed version available upon request	
Alexandra Rechs, LMFT Program Manager, Quality Management			

BACKGROUND

It is the policy of the Sacramento County Division of Behavioral Health Services (DBHS) and the Mental Health Plan (MHP) to comply with all state and federal statutory and regulatory requirements for timely access to services established by Title 42, Code of Federal Regulations (CFR), Part 438.68: Network Adequacy Standards, Part 438.206: Availability of Services, and Part 438.207: Assurances of Adequate Capacity and Services; Title 28, California Code of Regulations (CCR) § 1300.67.2.2: Timely Access to Non-Emergency Health Care Services; MHSUDS Information Notice No.: 18-011. Federal Network Adequacy Standards for Mental Health Plans (MHPS) and Drug MediCal Organized Delivery System (DMC-ODS) Pilot Counties; and MHSUDS Information Notice No.: 19020. Client Services Information (CSI) Assessment Record.

DEFINITIONS

New Client - Any Medi-Cal beneficiary requesting a Specialty Mental Health Service that was not served within that system in the last 3 years.

Urgent Services - A request for service shall be considered urgent when the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function.

PURPOSE

This policy establishes the timely access to service standards and tracking requirements for Sacramento County Mental Health Plan (MHP).

DETAILS

Effective immediately, mental health and substance use disorder treatment providers in the Mental Health Plan (MHP) will comply with the network adequacy standards for timely access to services as specified in the table below. Timely access standards for outpatient services refers to the number of business days or hours in which a MHP provider must make an appointment available to a beneficiary from the date the beneficiary or a provider acting on behalf of the beneficiary, requests a medically necessary service. The initial assessment for outpatient services will begin with the Access Team or another designated entry point (e.g. Guest House, Intensive Placement Team) upon receipt of a service request.

Sacramento County MHP Timely Access Standards		
Type of Service	Non-Urgent	Urgent
Psychiatry	Within 15 business days from request to appointment	Within 48 hours of the request
Outpatient Services with a non-physician mental health providers where prior authorization is not required	Within 10 business days from request to appointment	Within 48 hours of the request
Outpatient Services with a non-physician mental health providers where prior authorization is required	Within 10 business days from request to appointment	Within 96 hours of the request

A. Tracking Requirements

For all new clients, providers who receive direct referrals from the public must track the following data in accordance with MHP procedures:

1. Date & Time of First Contact to Request Services
2. Urgency of the need for service (see definitions section for definition of Urgent Service)
3. Assessment Appointment First Offer Date & Time
4. Assessment Appointment Accepted Date & Time
5. Assessment Start Date
6. Assessment End Date
7. Treatment Appointment First Offer Date & Time

8. Treatment Appointment Accepted Date & Time
9. Treatment Start Date
10. Closed Out Date
11. Closure Reason
12. Referral Source
13. Referred To

B. Monitoring

The MHP will monitor the service delivery system for compliance with the timeliness standards and with this policy. MHP will also monitor each provider for compliance with timeliness standards, data collection and reporting, and issuing appropriate notices of action.

C. Non-Compliance with Timely Access Standards

1. If any timely access to service standard is not met for a beneficiary, the beneficiary will be sent a "Notice of Adverse Benefit Determination
2. NOABD-Timely Access shall be issued as follows:
 - a. The beneficiary or the parent or legal guardian will be sent a NOABD-Timely Access by the provider responsible for providing the services.
 - b. The issuing provider shall fax or send via US Mail a copy of the NOABD-Timely Access to Sacramento County Member Services immediately upon issuance to the beneficiary:

Mail: Sacramento County Member Services
Quality Management
7001-A East Parkway, Suite 300
Sacramento, CA 95823
Fax: (916) 875-0877

D. Non-Compliance with Timely Access Policy

Any failure to comply with this policy will result in a plan of correction

REFERENCES/ATTACHMENTS:

- CMS Medicaid and CHIP Managed Care Final Rule (Final Rule)
- California Health and Safety Code (HSC) §1367.01
- Title 42, Code of Federal Regulation-s (CFR), Part 438.68: Network Adequacy Standards, Part 438.206: Availability of Services, and Part 438.207: Assurances of Adequate Capacity and Services.
- Title 28, California Code of Regulations (CCR) §1300.67.2.2: Timely Access to Non Emergency Health Care Services

RELATED POLICIES:

- No. 02-01 Notices of Action

DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff	X	Mental Health Treatment Center
X	Adult Contract Providers	X	Children Contract Providers

CONTACT INFORMATION:

- Quality Management Information QMInformation@SacCounty.net

ATTACHMENT 10: SAMPLE AGREEMENT BOILERPLATE

AGREEMENT

THIS AGREEMENT is made and entered into as of this ___ day of _____, 20___, by and between the COUNTY OF SACRAMENTO, a political subdivision of the State of California, hereinafter referred to as "COUNTY", and «CONTRACTORNAME», a _____ [nature of business, such as an individual, sole proprietorship, non-profit California corporation, partnership, etc.], hereinafter referred to as "CONTRACTOR".

RECITALS

WHEREAS, _____ [County’s reasons for contracting]

WHEREAS, _____

WHEREAS, _____ [Contractor’s reasons for contracting]

WHEREAS, _____

WHEREAS, COUNTY AND CONTRACTOR desire to enter into this Agreement on the terms and conditions set forth herein.

NOW, THEREFORE, in consideration of the mutual promises hereinafter set forth, COUNTY and CONTRACTOR agree as follows:

I. SCOPE OF SERVICES

CONTRACTOR shall provide services in the amount, type, and manner described in Exhibit A, which is attached hereto and incorporated herein.

II. TERM

This Agreement shall be effective and commence as of the date first written above and shall end on «enddate».

III. NOTICE

Any notice, demand, request, consent, or approval that either party hereto may or is required to give the other pursuant to this Agreement shall be in writing and shall be either personally delivered or sent by mail, addressed as follows:

<p>TO COUNTY</p> <p>DIRECTOR Department of Health Services 7001-A East Parkway, Suite 1000 Sacramento, CA 95823-2501</p>	<p>TO CONTRACTOR</p> <p>«ContractorName» «Address» «CITYSTATEZIP»</p>
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Either party may change the address to which subsequent notice and/or other communications can be sent by giving written notice designating a change of address to the other party, which shall be effective upon receipt.

IV. COMPLIANCE WITH LAWS

CONTRACTOR shall observe and comply with all applicable federal, state, and county laws, regulations, and ordinances.

V. GOVERNING LAWS AND JURISDICTION

This Agreement shall be deemed to have been executed and to be performed within the State of California and shall be construed and governed by the internal laws of the State of California. Any legal proceedings arising out of or relating to this Agreement shall be brought in Sacramento County, California.

VI. LICENSES, PERMITS, AND CONTRACTUAL GOOD STANDING

- A. CONTRACTOR shall possess and maintain all necessary licenses, permits, certificates, and credentials required by the laws of the United States, the State of California, County of Sacramento, and all other appropriate governmental agencies, including any certification and credentials required by COUNTY. Failure to maintain the licenses, permits, certificates, and credentials shall be deemed a breach of this Agreement and constitutes grounds for the termination of this Agreement by COUNTY.
- B. CONTRACTOR further certifies to COUNTY that it and its principals are not debarred, suspended, or otherwise excluded from or ineligible for, participation in federal, state, or county government contracts. CONTRACTOR certifies that it shall not contract with a subcontractor that is so debarred or suspended.

VII. PERFORMANCE STANDARDS

CONTRACTOR shall perform its services under this Agreement in accordance with the industry and/or professional standards applicable to CONTRACTOR's services. COUNTY may evaluate CONTRACTOR's performance of the scope of services provided in Exhibit A in accordance with performance outcomes determined by COUNTY. CONTRACTOR shall maintain such records concerning performance outcomes as required by COUNTY and provide the records to COUNTY upon request.

VIII. OWNERSHIP OF WORK PRODUCT

All technical data, evaluations, plans, specifications, reports, documents, or other work products developed by CONTRACTOR hereunder shall be the exclusive property of COUNTY and shall be delivered to COUNTY upon completion of the services authorized hereunder. CONTRACTOR may retain copies thereof for its files and internal use. Publication of the information directly derived from work performed or data obtained in connection with services rendered under this Agreement must first be approved in writing by COUNTY. COUNTY recognizes that all technical data, evaluations, plans, specifications, reports, and other work products are instruments of CONTRACTOR's services and are not designed for use other than what is intended by this Agreement.

IX. STATUS OF CONTRACTOR

- A. It is understood and agreed that CONTRACTOR (including CONTRACTOR's employees) is an independent contractor and that no relationship of employer-employee exists between the parties hereto. CONTRACTOR's assigned personnel shall not be entitled to any benefits payable to employees of COUNTY. COUNTY is not required to make any deductions or withholdings from the compensation payable to CONTRACTOR under the provisions of this Agreement; and as an independent contractor, CONTRACTOR hereby indemnifies and holds COUNTY harmless from any and all claims that may be made against COUNTY based upon any contention by any third party that an employer-employee relationship exists by reason of this Agreement.
- B. It is further understood and agreed by the parties hereto that CONTRACTOR in the performance of its obligation hereunder is subject to the control or direction of COUNTY as to the designation of tasks to be performed, the results to be accomplished by the services hereunder agreed to be rendered and performed, and not the means, methods, or sequence used by CONTRACTOR for accomplishing the results.
- C. If, in the performance of this Agreement, any third persons are employed by CONTRACTOR, such person shall be entirely and exclusively under the direction, supervision, and control of CONTRACTOR. All terms of employment, including hours, wages, working conditions, discipline, hiring, and discharging, or any other terms of employment or requirements of law, shall be determined by CONTRACTOR, and COUNTY shall have no right or authority over such persons or the terms of such employment.
- D. It is further understood and agreed that as an independent contractor and not an employee of COUNTY, neither CONTRACTOR nor CONTRACTOR's assigned personnel shall have any entitlement as a COUNTY employee, right to act on behalf of COUNTY in any capacity whatsoever as agent, nor to bind COUNTY to any obligation whatsoever. CONTRACTOR shall not be covered by workers'

compensation; nor shall CONTRACTOR be entitled to compensated sick leave, vacation leave, retirement entitlement, participation in group health, dental, life, and other insurance programs, or entitled to other fringe benefits payable by COUNTY to employees of COUNTY.

- E. It is further understood and agreed that CONTRACTOR must issue W-2 and 941 Forms for income and employment tax purposes, for all of CONTRACTOR's assigned personnel under the terms and conditions of this Agreement.

X. CONTRACTOR IDENTIFICATION

CONTRACTOR shall provide COUNTY with the following information for the purpose of compliance with California Unemployment Insurance Code Section 1088.8 and Sacramento County Code Chapter 2.160: CONTRACTOR's name, address, telephone number, social security number or tax identification number, and whether dependent health insurance coverage is available to CONTRACTOR.

XI. COMPLIANCE WITH CHILD, FAMILY, AND SPOUSAL SUPPORT REPORTING OBLIGATIONS

- A. CONTRACTOR's failure to comply with state and federal child, family, and spousal support reporting requirements regarding a contractor's employees or failure to implement lawfully served wage and earnings assignment orders or notices of assignment relating to child, family, and spousal support obligations shall constitute a default under this Agreement.
- B. CONTRACTOR's failure to cure such default within ninety (90) days of notice by COUNTY shall be grounds for termination of this Agreement.

XII. BENEFITS WAIVER

If CONTRACTOR is unincorporated, CONTRACTOR acknowledges and agrees that CONTRACTOR is not entitled to receive the following benefits and/or compensation from COUNTY: medical, dental, vision and retirement benefits, life and disability insurance, sick leave, bereavement leave, jury duty leave, parental leave, or any other similar benefits or compensation otherwise provided to permanent civil service employees pursuant to the County Charter, the County Code, the Civil Service Rule, the Sacramento County Employees' Retirement System and/or any and all memoranda of understanding between COUNTY and its employee organizations. Should CONTRACTOR or any employee or agent of CONTRACTOR seek to obtain such benefits from COUNTY, CONTRACTOR agrees to indemnify and hold harmless COUNTY from any and all claims that may be made against COUNTY for such benefits.

XIII. CONFLICT OF INTEREST

CONTRACTOR and CONTRACTOR's officers and employees shall not have a financial interest, or acquire any financial interest, direct or indirect, in any business, property or source of income which could be financially affected by or otherwise conflict in any manner or degree with the performance of services required under this Agreement.

XIV. LOBBYING AND UNION ORGANIZATION ACTIVITIES

- A. CONTRACTOR shall comply with all certification and disclosure requirements prescribed by Section 319, Public Law 101-121 (31 U.S.C. § 1352) and any implementing regulations.
- B. If services under this Agreement are funded with state funds granted to COUNTY, CONTRACTOR shall not utilize any such funds to assist, promote, or deter union organization by employees performing work under this Agreement and shall comply with the provisions of Government Code Sections 16645 through 16649.
- C. If services under this Agreement are funded in whole or in part with Federal funds no funds may be used to support or defeat legislation pending before Congress or any state legislature. CONTRACTOR further agrees to comply with all requirements of the Hatch Act (Title 5 USC, Sections 1501-1508).

XV. NONDISCRIMINATION IN EMPLOYMENT, SERVICES, BENEFITS, AND FACILITIES

- A. CONTRACTOR agrees and assures COUNTY that CONTRACTOR and any subcontractors shall comply with all applicable federal, state, and local anti-discrimination laws, regulations, and ordinances and to not unlawfully discriminate, harass, or allow harassment against any employee, applicant for employment, employee or agent of COUNTY, or recipient of services contemplated to be provided or provided under this Agreement, because of race, ancestry, marital status, color, religious creed, political belief, national origin, ethnic group identification, sex, sexual orientation, age (over 40), medical condition (including HIV and AIDS), or physical or mental disability. CONTRACTOR shall ensure that the evaluation and treatment of its employees and applicants for employment, the treatment of COUNTY employees and agents, and recipients of services are free from such discrimination and harassment.
- B. CONTRACTOR represents that it is in compliance with and agrees that it will continue to comply with the Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.), the Fair Employment and Housing Act (Government Code § 12900 et seq.), and regulations and guidelines issued pursuant thereto.
- C. CONTRACTOR agrees to compile data, maintain records, post required notices and submit reports to permit effective enforcement of all applicable anti-discrimination laws and this provision.
- D. CONTRACTOR shall include this nondiscrimination provision in all subcontracts related to this Agreement.

XVI. INDEMNIFICATION

- A. To the fullest extent permitted by law, for work or services (including professional services), provided under this Agreement, CONTRACTOR shall indemnify, defend, and hold harmless COUNTY, its governing Board, officers, directors, officials, employees, and authorized volunteers and agents, (individually an “Indemnified Party” and collectively “Indemnified Parties”), from and against any and all claims, demands, actions, losses, liabilities, damages, and all expenses and costs incidental thereto (collectively “Claims”), including cost of defense, settlement, arbitration, expert fees, and reasonable attorneys' fees, resulting from injuries to or death of any person, including employees of either party hereto, and damage to or destruction of any property, or loss of use or reduction in value thereof, including the property of either party hereto, and recovery of monetary losses incurred by COUNTY directly attributable to the performance of CONTRACTOR, arising out of, pertaining to, or resulting from the negligent acts, errors, omissions, recklessness, or willful misconduct of CONTRACTOR, its employees, or CONTRACTOR’s subconsultants or subcontractors at any tier, or any other party for which CONTRACTOR is legally liable under law.
- B. The right to defense and indemnity under this indemnity obligation arises upon occurrence of an event giving rise to a Claim and, thereafter, upon tender in writing to CONTRACTOR. Upon receipt of tender, CONTRACTOR shall provide prompt written response that it accepts tender. Failure to accept tender may be grounds for termination of the Agreement. CONTRACTOR shall control the defense of Indemnified Parties; subject to using counsel reasonably acceptable to COUNTY. Both parties agree to cooperate in the defense of a Claim.
- C. This indemnity obligation shall not be limited by the types and amounts of insurance or self-insurance maintained by CONTRACTOR or CONTRACTOR’S subcontractors at any tier.
- D. Nothing in this indemnity obligation shall be construed to create any duty to, any standard of care with reference to, or any liability or obligation, contractual or otherwise, to any third party.
- E. The provisions of this indemnity obligation shall survive the expiration or termination of the Agreement

XVII. INSURANCE

Without limiting CONTRACTOR’s indemnification, CONTRACTOR shall maintain in force at all times during the term of this Agreement and any extensions or modifications thereto, insurance as specified in Exhibit B. It is the responsibility of CONTRACTOR to notify its insurance advisor or insurance carrier(s) regarding coverage, limits, forms, and other insurance requirements specified in Exhibit B. It is understood and agreed that COUNTY shall not pay any sum to CONTRACTOR under this Agreement unless and until COUNTY is satisfied that all insurance required by this Agreement is in force at the time services hereunder

are rendered. Failure to maintain insurance as required in this Agreement may be grounds for material breach of contract.

XVIII. INFORMATION TECHNOLOGY ASSURANCES

CONTRACTOR shall take all reasonable precautions to ensure that any hardware, software, and/or embedded chip devices used by CONTRACTOR in the performance of services under this Agreement, other than those owned or provided by COUNTY, shall be free from viruses. Nothing in this provision shall be construed to limit any rights or remedies otherwise available to COUNTY under this Agreement.

XIX. WEB ACCESSIBILITY

CONTRACTOR shall ensure that all web sites and web applications provided by CONTRACTOR pursuant to this Agreement shall comply with COUNTY's Web Accessibility Policy adopted by the Board of Supervisors on February 18, 2003, as well as any approved amendment thereto.

XX. COMPENSATION AND PAYMENT OF INVOICES LIMITATIONS

- A. Compensation under this Agreement shall be limited to the Maximum Total Payment Amount set forth in Exhibit C, or Exhibit C as modified by COUNTY in accordance with express provisions in this Agreement.
- B. CONTRACTOR shall submit an invoice on the forms and in accordance with the procedures prescribed by COUNTY **insert - upon completion of services, on a monthly basis**. Invoices shall be submitted to COUNTY no later than the fifteenth (15th) day of the month following the invoice period, and COUNTY shall pay CONTRACTOR within thirty (30) days after receipt of an appropriate and correct invoice.
- C. COUNTY operates on a July through June fiscal year. Invoices for services provided in any fiscal year must be submitted no later than July 31, one (1) month after the end of the fiscal year. Invoices submitted after July 31 for the prior fiscal year shall not be honored by COUNTY unless CONTRACTOR has obtained prior written COUNTY approval to the contrary.
- D. CONTRACTOR shall maintain for four (4) years following termination of this Agreement full and complete documentation of all services and expenditures associated with performing the services covered under this Agreement. Expense documentation shall include: time sheets or payroll records for each employee; receipts for supplies; applicable subcontract expenditures; applicable overhead and indirect expenditures.
- E. In the event CONTRACTOR fails to comply with any provisions of this Agreement, COUNTY may withhold payment until such non-compliance has been corrected.

XXI. LEGAL TRAINING INFORMATION

If under this Agreement CONTRACTOR is to provide training of County personnel on legal issues, then CONTRACTOR shall submit all training and program material for prior review and written approval by County Counsel. Only those materials approved by County Counsel shall be utilized to provide such training.

XXII. SUBCONTRACTS, ASSIGNMENT

- A. CONTRACTOR shall obtain prior written approval from COUNTY before subcontracting any of the services delivered under this Agreement. CONTRACTOR remains legally responsible for the performance of all contract terms including work performed by third parties under subcontracts. Any subcontracting will be subject to all applicable provisions of this Agreement. CONTRACTOR shall be held responsible by COUNTY for the performance of any subcontractor whether approved by COUNTY or not.
- B. This Agreement is not assignable by CONTRACTOR in whole or in part, without the prior written consent of COUNTY.

XXIII. AMENDMENT AND WAIVER

Except as provided herein, no alteration, amendment, variation, or waiver of the terms of this Agreement shall be valid unless made in writing and signed by both parties. Waiver by either party of any default, breach, or condition precedent shall not be construed as a waiver of any other default, breach, or condition precedent, or any other right hereunder. No interpretation of any provision of this Agreement shall be binding upon COUNTY unless agreed in writing by DIRECTOR and counsel for COUNTY.

XXIV. SUCCESSORS

This Agreement shall bind the successors of COUNTY and CONTRACTOR in the same manner as if they were expressly named.

XXV. TIME

Time is of the essence of this Agreement.

XXVI. INTERPRETATION

This Agreement shall be deemed to have been prepared equally by both of the parties, and the Agreement and its individual provisions shall not be construed or interpreted more favorably for one party on the basis that the other party prepared it.

XXVII. DIRECTOR

As used in this Agreement, "DIRECTOR" shall mean the Director of the Department of Health Services, or his/her designee.

XXVIII. DISPUTES

In the event of any dispute arising out of or relating to this Agreement, the parties shall attempt, in good faith, to promptly resolve the dispute mutually between themselves. Pending resolution of any such dispute, CONTRACTOR shall continue without delay to carry out all its responsibilities under this Agreement unless the Agreement is otherwise terminated in accordance with the Termination provisions herein. COUNTY shall not be required to make payments for any services that are the subject of this dispute resolution process until such dispute has been mutually resolved by the parties. If the dispute cannot be resolved within 15 calendar days of initiating such negotiations or such other time period as may be mutually agreed to by the parties in writing, either party may pursue its available legal and equitable remedies, pursuant to the laws of the State of California. Nothing in this Agreement or provision shall constitute a waiver of any of the government claim filing requirements set forth in Title 1, Division 3.6, of the California Government Code or as otherwise set forth in local, state and federal law.

XXIX. TERMINATION

- A. Either party may terminate this Agreement without cause upon thirty (30) days' written notice to the other party. Notice shall be deemed served on the date of mailing. If notice of termination for cause is given by COUNTY to CONTRACTOR and it is later determined that CONTRACTOR was not in default or the default was excusable, then the notice of termination shall be deemed to have been given without cause pursuant to this paragraph (A).
- B. COUNTY may terminate this Agreement for cause immediately upon giving written notice to CONTRACTOR should CONTRACTOR materially fail to perform any of the covenants contained in this Agreement in the time and/or manner specified. In the event of such termination, COUNTY may proceed with the work in any manner deemed proper by COUNTY. If notice of termination for cause is given by COUNTY to CONTRACTOR and it is later determined that CONTRACTOR was not in default or the default was excusable, then the notice of termination shall be deemed to have been given without cause pursuant to paragraph (A) above.

- C. COUNTY may terminate or amend this Agreement immediately upon giving written notice to CONTRACTOR that funds are not available because: 1) Sufficient funds are not appropriated in COUNTY'S Adopted or Adjusted Budget; 2) the COUNTY is advised that funds are not available from external sources for this Agreement or any portion thereof, including if distribution of such funds to the COUNTY is suspended or delayed; 3) if funds for the services and/or programs provided pursuant to this Agreement are not appropriated by the State; 4) funds that were previously available for this Agreement are reduced, eliminated and/or re-allocated by COUNTY as a result of budget or revenue reductions during the fiscal year.
- D. If this Agreement is terminated under Paragraph A or C above, CONTRACTOR shall only be paid for any service completed and provided prior to notice of termination. In the event of termination under paragraph A or C above, CONTRACTOR shall be paid an amount which bears the same ratio to the total compensation authorized by the Agreement as the services actually performed bear to the total services of CONTRACTOR covered by this Agreement, less payments of compensation previously made. In no event, however, shall COUNTY pay CONTRACTOR an amount which exceeds a pro rata portion of the Agreement total based on the portion of the Agreement term that has elapsed on the effective date of the termination.
- E. CONTRACTOR shall not incur any expenses under this Agreement after notice of termination and shall cancel any outstanding expense obligations to a third party that CONTRACTOR can legally cancel.

XXX. REPORTS

- A. CONTRACTOR shall, without additional compensation therefore, make fiscal, program evaluation, progress, and such other reports as may be reasonably required by DIRECTOR concerning CONTRACTOR's activities as they affect the contract duties and purposes herein. COUNTY shall explain procedures for reporting the required information.
- B. CONTRACTOR agrees that, pursuant to Government Code section 7522.56, CONTRACTOR shall make best efforts to determine if any of its employees or new hires providing direct services to the COUNTY are members of the Sacramento County Employees' Retirement System (SCERS). CONTRACTOR further agrees that it shall make a report bi-annually (due no later than January 31st and July 31st) to the COUNTY with a list of its employees that are members of SCERS along with the total number of hours worked during the previous 6 months. This report shall be forwarded to where Notice is sent pursuant to Roman numeral III of this Agreement.

XXXI. AUDITS AND RECORDS

Upon COUNTY's request, COUNTY or its designee shall have the right at reasonable times and intervals to audit, at CONTRACTOR's premises, CONTRACTOR's financial and program records as COUNTY deems necessary to determine CONTRACTOR's compliance with legal and contractual requirements and the correctness of claims submitted by CONTRACTOR. CONTRACTOR shall maintain such records for a period of four (4) years following termination of the Agreement, and shall make them available for copying upon COUNTY's request at COUNTY's expense. COUNTY shall have the right to withhold any payment under this Agreement until CONTRACTOR has provided access to CONTRACTOR's financial and program records related to this Agreement.

XXXII. PRIOR AGREEMENTS

This Agreement constitutes the entire contract between COUNTY and CONTRACTOR regarding the subject matter of this Agreement. Any prior agreements, whether oral or written, between COUNTY and CONTRACTOR regarding the subject matter of this Agreement are hereby terminated effective immediately upon full execution of this Agreement.

XXXIII. SEVERABILITY

If any term or condition of this Agreement or the application thereof to any person(s) or circumstance is held invalid or unenforceable, such invalidity or unenforceability shall not affect other terms, conditions, or

applications which can be given effect without the invalid term, condition, or application; to this end the terms and conditions of this Agreement are declared severable.

XXXIV. FORCE MAJEURE

Neither CONTRACTOR nor COUNTY shall be liable or responsible for delays or failures in performance resulting from events beyond the reasonable control of such party and without fault or negligence of such party. Such events shall include but not be limited to acts of God, strikes, lockouts, riots, acts of war, epidemics, acts of government, fire, power failures, nuclear accidents, earthquakes, unusually severe weather, acts of terrorism, or other disasters, whether or not similar to the foregoing, and acts or omissions or failure to cooperate of the other party or third parties (except as otherwise specifically provided herein).

XXXV. TRANSITION OF CARE

If CONTRACTOR provides services to patients/clients under the terms of this AGREEMENT, CONTRACTOR shall cooperate with COUNTY and any other Provider of services in circumstances where Patient care is transferred from CONTRACTOR to another Provider. CONTRACTOR understands and agrees that such cooperation is necessary for coordination of care and will make all reasonable efforts to make such transfers as seamless for the Patient as is possible.

XXXVI. SURVIVAL OF TERMS

All services performed and deliverables provided pursuant to this Agreement are subject to all of the terms, conditions, price discounts and rates set forth herein, notwithstanding the expiration of the initial term of this Agreement or any extension thereof. Further, the terms, conditions, and warranties contained in this Agreement that by their sense and context are intended to survive the completion of the performance, cancellation, or termination of this Agreement shall so survive.

XXXVII. DUPLICATE COUNTERPARTS

This Agreement may be executed in duplicate counterparts. The Agreement shall be deemed executed when it has been signed by both parties.

Signatures scanned and transmitted electronically shall be deemed original signatures for purposes of this Agreement, with such scanned signatures having the same legal effect as original signatures. This Agreement may be executed through the use of an electronic signature and will be binding on each party as if it were physically executed.

XXXVIII. BUSINESS ASSOCIATE REQUIREMENTS

If COUNTY determines that under this Agreement CONTRACTOR is a “Business Associate” of COUNTY, as defined in the Health Insurance Portability and Accountability Act (45 CFR 160.103), then CONTRACTOR shall comply with the Business Associate provisions contained in Exhibit G, which is attached hereto and incorporated by reference herein.

XXXIX. AUTHORITY TO EXECUTE

Each person executing this Agreement represents and warrants that he or she is duly authorized and has legal authority to execute and deliver this Agreement for or on behalf of the parties to this Agreement. Each party represents and warrants to the other that the execution and delivery of the Agreement and the performance of such party’s obligations hereunder have been duly authorized.

XL. DRUG FREE WORKPLACE

If the contract is funded in whole or in part with State funds the CONTRACTOR shall comply, and require that its Subcontractors comply, with Government Code Section 8355. By executing this contract Contractor certifies that it will provide a drug free workplace pursuant to Government Code Section 8355.

XLI. CLEAN AIR ACT AND WATER POLLUTION CONTROL ACT

Revised 10/25/21

CONTRACTOR shall comply with applicable standards of the Clean Air Act (42 U.S.C. 7401-7671q) and the Federal Water Pollution Control Act (33 U.S.C. 1251-1387), as amended. Subcontracts (Subgrants) of amounts in excess of \$150,000 must contain a provision that requires the non-Federal awardee to agree to comply with all applicable standards, orders or regulations issued pursuant to the two Acts cited in this section. Violations must be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

XLII. CULTURAL AND LINGUISTIC PROFICIENCY

To ensure equal access to quality care by diverse populations, CONTRACTOR shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards, which can be found at <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53>.

XLIII. CHARITABLE CHOICE 42 CFR PART 54

CONTRACTOR certifies that if it identified as a faith-based religious organization, and receives direct funding of substance abuse prevention and treatment services under the Substance Abuse Prevention and Treatment Block Grant (SAPT), the Projects for Assistance in Transition from Homelessness (PATH) formula grant program, Substance Abuse and Mental Health Services Administration (SAMSHA), or Temporary Assistance to Needy Families (TANF) discretionary grants that:

1. CONTRACTOR shall adhere to the requirements contained in Title 42, Code of Federal Regulations (CFR) Part 54;
2. CONTRACTOR's services shall be provided in a manner consistent with the Establishment Clause and the Free Exercise Clause of the First Amendment of the United States Constitution (42 CFR § 54.3);
3. If CONTRACTOR offers inherently religious activities, they shall be provided separately, in time or location, from the programs or services for which the organization receives funds from federal, state, or local government sources. Participation in religious activities must be voluntary for program beneficiaries (42 CFR § 54.4);
4. CONTRACTOR shall not expend any federal, state, or local government funds to support any inherently religious activities such as worship, religious instruction, or proselytization (42 CFR § 54.5);
5. CONTRACTOR shall not, in providing program services or engaging in outreach activities under applicable programs, discriminate against a program beneficiary or prospective program beneficiary on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice (42 CFR § 54.7);
6. CONTRACTOR shall inform program beneficiaries that they may refuse to participate in any religious activities offered by CONTRACTOR;
7. CONTRACTOR shall inform program beneficiaries that, if they object to the religious character of the program, they have the right to a referral to an alternate service provider to which they have no objections (42 CFR § 54.8); and,
8. CONTRACTOR shall, within a reasonable time of learning of a beneficiary's objection to the religious character of the program, refer the program beneficiary to an alternate service provider (42 CFR § 54.8).

If 42 U.S.C. 2000e-1 regarding employment practices is applicable to this Agreement, it shall supersede 42 CFR § 54.7 to the extent that 42 CFR § 54.7 conflicts with 42 U.S.C. 2000e-1.

XLIV. COVID-19 REQUIREMENTS

CONTRACTOR shall be solely and completely responsible for implementing the applicable COVID-19 guidelines from the California Division of Industrial Safety and the applicable COVID-19 guidance from the Centers for Disease Control and Prevention (CDC) including staff education, staff training, routine cleaning of staff and public space, on-site washing facilities, and to the extent applicable Personal Protective Equipment (PPE) donning and maintenance. CONTRACTOR shall submit a plan for compliance with these

standards to the COUNTY. This safety plan and/or narrative description shall describe the education, training, routine cleaning, on-site washing facilities and the PPE to be used or provided by the CONTRACTOR. CONTRACTOR shall make any reasonable corrections that COUNTY requests to such plans.

XLV. ADDITIONAL PROVISIONS

The additional provisions contained in Exhibits A, B, C, D, E, F, and G attached hereto are part of this Agreement and are incorporated herein by reference.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed as of the day and year first written above.

Revised 10/25/21

**ATTACHMENT 11: SAMPLE EXHIBIT TO AGREEMENT
"ADDITIONAL PROVISIONS"**

**EXHIBIT D to Agreement
between the COUNTY OF SACRAMENTO,
hereinafter referred to as "COUNTY", and
«CONTRACTORNAME»,
hereinafter referred to as "CONTRACTOR"**

ADDITIONAL PROVISIONS

I. LAWS, STATUTES, AND REGULATIONS

- A. CONTRACTOR shall abide by all applicable state, federal, and county laws, statutes, and regulations, including but not limited to the Bronzan-McCorquedale Act (Welfare and Institutions Code, Divisions 5, 6, and 9, Sections 5600 et seq., and Section 4132.44), Title 9 and Title 22 of the California Code of Regulations, Title XIX of the Social Security Act, State Department of Health Care Services (DHCS) Policy Letters, and Title 42 of the Code of Federal Regulations, Section 434.6 and 438.608, in carrying out the requirements of this Agreement.
- B. CONTRACTOR shall comply with all Policies and Procedures adopted by COUNTY to implement federal/state laws and regulations.
- C. CONTRACTOR shall comply with the requirements mandated for culturally competent services to diverse populations, including but not limited to California Code of Regulations, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 11, Medi-Cal Specialty Mental Health Services, Subchapter 1, General Provisions, Article 4, Section 1810.410 (a-e). CONTRACTOR agrees to abide by the Assurance of Cultural Competence Compliance document, as provided by COUNTY, and shall comply with its provisions.

II. LICENSING, CERTIFICATION, AND PERMITS

- A. CONTRACTOR agrees to furnish professional personnel in accordance with the regulations, including all amendments thereto, issued by the State of California or COUNTY. CONTRACTOR shall operate continuously throughout the term of this Agreement with at least the minimum of staff required by law for provision of services hereunder; such personnel shall be qualified in accordance with all applicable laws and regulations.
- B. CONTRACTOR shall make available to COUNTY, on request of DIRECTOR, a list of the persons who will provide services under this Agreement. The list shall state the name, title, professional degree, and work experience of such persons.

III. OPERATION AND ADMINISTRATION

- A. CONTRACTOR agrees to furnish at no additional expense to COUNTY beyond the amounts identified as NET BUDGET/MAXIMUM PAYMENT TO CONTRACTOR in Exhibit C, all space, facilities, equipment, and supplies necessary for its proper operation and maintenance.
- B. CONTRACTOR, if incorporated, shall be in good standing and operate according to the provisions of its Articles of Incorporation and By-Laws. Said documents and any amendments thereto shall be maintained and retained by CONTRACTOR and made available for review or inspection by DIRECTOR at reasonable times during normal business hours.
- C. CONTRACTOR shall forward to DIRECTOR all copies of its notices of meetings, minutes, and public information, which are material to the performance of this Agreement.
- D. CONTRACTOR agrees that all materials created for public dissemination shall reflect the collaborative nature of all programs and/or projects. All program announcements, websites, brochures, and press releases shall include the Sacramento County logo, and shall adhere to the Logo Style Guide provided by COUNTY. Additionally, the program announcements, websites, brochures and press releases shall state the following language:
 - 1. If MHSA funding is present in Exhibit C of this Agreement, "This program is funded by the Division of Behavioral Health Services through the voter approved Proposition 63, Mental Health Services Act (MHSA)."

1. If MHSA funding is present in Exhibit C of this Agreement, “This program is funded by the Division of Behavioral Health Services through the voter approved Proposition 63, Mental Health Services Act (MHSA).”
2. If MHSA funding is not present in Exhibit C of this Agreement, “This program is funded by the Sacramento County Division of Behavioral Health Services”.
3. Oral presentations shall include the above required statement.

IV. CONFIDENTIALITY

- A. CONTRACTOR is subject to, and agrees to comply and require his or her employees to comply with the provisions of Sections 827, 5328, 5330, 5610 and 10850 of the Welfare and Institutions Code, Division 19-000 of the State of California Department of Social Services Manual of Policies and Procedures, Code of Federal Regulations Title 45, Section 205.50, and all other applicable laws and regulations to assure that:
 1. All applications and records concerning an individual made or kept by CONTRACTOR, COUNTY, or any public officer or agency in connection with the Welfare and Institutions Code relating to any form of public social services or health services provided under this Agreement shall be confidential and shall not be open to examination for any purpose not directly connected with the administration of such public social or health services.
 2. No person will publish or disclose, or use or cause to be published, disclosed, or used, any confidential information pertaining to an applicant or recipient of services. Applicant and recipient records and information shall not be disclosed by CONTRACTOR to third parties without COUNTY’s consent or the consent of the applicant/recipient.
- B. CONTRACTOR agrees to inform all of his/her employees, agents, subcontractors and partners of the above provisions and that knowing and intentional violation of the provisions of said state and federal laws is a misdemeanor.
- C. CONTRACTOR is subject to, and agrees to comply when applicable, with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)(42 USC § 1320d) and regulations promulgated thereunder by the U.S. Department of Health and Human Services and other applicable laws and regulations.

V. CLINICAL REVIEW AND PROGRAM EVALUATION

- A. CONTRACTOR shall permit, at any reasonable time, personnel designated by DIRECTOR to come on CONTRACTOR’s premises for the purpose of making periodic inspections and evaluations. CONTRACTOR shall furnish DIRECTOR with such information as may be required to evaluate fiscal and clinical effectiveness of the services being rendered.
- B. DIRECTOR or his designee shall represent COUNTY in all matters pertaining to services rendered pursuant to this Agreement, including authorization for admission, care, and discharge of all clients for whom reimbursement is required under this Agreement.

VI. REPORTS

- A. CONTRACTOR shall provide accurate and timely input of services provided in the COUNTY’s Electronic Health Record (EHR), in accordance with COUNTY’s policy, so that COUNTY can generate a monthly report of the units of service performed.
- B. CONTRACTOR shall, without additional compensation therefore make further fiscal, program evaluation and progress reports as may be reasonably required by DIRECTOR or by the DHCS concerning CONTRACTOR’s activities as they affect the contract duties and purposes herein. COUNTY shall explain procedures for reporting the required information.

VII. RECORDS

- A. Patient Records: CONTRACTOR shall maintain adequate patient records on each individual patient, which shall include diagnostic studies, records of patient interviews, treatment plans, progress notes, and records of services provided by various professional and paraprofessional personnel, in sufficient detail to permit an evaluation of services. Such records shall comply with all applicable federal, state, and COUNTY record maintenance requirements.

- B. Service and Financial Records: CONTRACTOR shall maintain complete service and financial records, which clearly reflect the actual cost and related fees received for each type of service for which payment is claimed. The patient eligibility determination and the fees charged to and collected from patients shall also be reflected therein. Any apportionment of costs shall be made in accordance with Generally Accepted Accounting Principles (GAAP).
- C. Review, Inspection, and Retention of Records: At reasonable times during normal business hours, the DHCS, COUNTY or DIRECTOR, the appropriate audit agency of any of them, and the designee of any of them shall have the right to inspect or otherwise evaluate the cost, quality, appropriateness and timeliness of services performed and to audit and inspect any books and records of CONTRACTOR which pertain to services performed and determination of amount payable under this Agreement. Upon expiration or termination of this Agreement all patient records shall be kept for a minimum of 7 years from the date of discharge and in the case of minors, for at least 1 year after the minor patient's eighteenth birthday, but in no case less than 7 years from the date of discharge. Service and financial records shall be retained by CONTRACTOR for a minimum period of 4 years after the termination of this Agreement, or until audit findings are resolved, whichever is later.

VIII. PATIENT FEES

- A. The Uniform Method of Determining Ability to Pay prescribed by DHCS shall be applied when services to patients are involved, in accordance to applicable COUNTY policies and procedures.
- B. Charges for services to either patients or persons responsible shall approximate estimated actual cost.
- C. CONTRACTOR shall use the Uniform Billing and Collection Guidelines prescribed by DHCS.

IX. AUDIT/REVIEW REQUIREMENTS

- A. Federal OMB Audit Requirements (also known as Omni Circular or Super Circular) for Other Than For-Profit Contractors 2 CFR 200.501 requires that non-Federal entities that expend \$750,000 or more (from all Federal sources) in a year in Federal Awards must have an annual single or program specific Audit in accordance with the OMB requirements. 2 CFR 200.512 sets forth the requirements for filing the Audit with the Federal Audit Clearinghouse (FAC).
- B. COUNTY Requirements for Non-Profit, For-Profit, Governmental and School District Contractors
In addition to the OMB requirements of paragraph A of this section, COUNTY requires CONTRACTOR to provide an annual Audited or Reviewed financial statement as follows:
 - 1. Annual Audited financial statements and accompanying Auditor's report and notes is required from CONTRACTOR when DHS has awarded contracts totaling \$150,000 or more for any twelve month period. The Audited financial statement shall be prepared in accordance with Generally Accepted Accounting Principles (GAAP) and the Audit shall be performed by an independent Certified Public Accountant in accordance with Generally Accepted Auditing Standards (GAAS).
 - 2. Annual Reviewed financial statements are required from CONTRACTOR when DHS has awarded contracts totaling less than \$150,000, but more than \$50,000 for any twelve month period. The Reviewed financial statement shall be prepared by an independent Certified Public Accountant in accordance with Statements on Standards for Accounting and Review Services issued by the AICPA. Audited financial statements may be substituted for Reviewed financial statements.
 - 3. Should any audit findings be noted in the Audit or Review CONTRACTOR must submit a Corrective Action Plan with the Audit or Review detailing how the audit findings will be addressed.
 - 4. If management letters are issued by a Certified Public Accountant separate from the audit CONTRACTOR is required to provide copies to COUNTY, and submit corrective action plans to address findings or recommendations noted in the management letters.
 - 5. The annual Audited or Reviewed financial statement shall include a Summary of Auditor's Results.
- C. Term of the Audit or Review
The Audit(s) or Review(s) shall cover the entire term of the contract(s). If CONTRACTOR'S fiscal year is different than the contract term, multiple Audits or Reviews shall be required, in order to cover the entire term of the contract.

D. Termination

If the Agreement is terminated for any reason during the contract period, the Audit or Review shall cover the entire period of the Agreement for which services were provided.

E. Submittal and Due Dates for Audits or Reviews

CONTRACTOR shall provide to COUNTY 1 copy of the Audit or Review, as required in this section, due six months following the end of CONTRACTOR'S fiscal year. Audit or Review shall be sent to:

Contracts Manager
County of Sacramento
Department of Health Services
7001 –A East Parkway, Suite 1000C
Sacramento, CA 95823

F. Request for Extension of Due Date

CONTRACTOR may request an extension of the due date for the Audit or Review in writing. Such request shall include the reason for the delay, a specific date for the extension and be sent to:

Contracts Manager
County of Sacramento
Department of Health Services
7001 –A East Parkway, Suite 1000C
Sacramento, CA 95823

G. Past Due Audit/Review

COUNTY may withhold payments due to CONTRACTOR from all past, current and future DHS contracts when past, current or future audits/reviews are not provided to COUNTY by due date or approved extended due date.

H. Overpayments

Should any overpayment of funds be noted in the Audit or Review, CONTRACTOR shall reimburse COUNTY the amount of the overpayment within 30 days of the date of the completion of the Audit or Review.

X. SYSTEM REQUIREMENTS

- A. CONTRACTOR shall adhere to the guidelines, policies and procedures issued by the County Department of Technology (DTech) for use of COUNTY computers, software, and systems.
- B. CONTRACTOR shall utilize the COUNTY'S Electronic Health Record (EHR) for all County Mental Health Plan (MHP) functions including, but not limited to, client demographics, services/charges, assessments, treatment plans and progress notes. CONTRACTOR has the right to choose not to use the COUNTY'S EHR system but must comply with all necessary requirements involving electronic health information exchange between the CONTRACTOR and the COUNTY. The CONTRACTOR must submit a plan to the COUNTY for approval demonstrating how the requirements will be met.

XII. EQUIPMENT OWNERSHIP

COUNTY shall have and retain ownership and title to all equipment identified to be purchased by CONTRACTOR under Exhibit C of this Agreement. CONTRACTOR shall furnish, and amend as necessary, a list of all equipment purchased under this Agreement together with the bills of sale and any other documents as may be necessary to show clear title and reasonableness of the purchase price. The equipment list shall specify the quantity, name, description, purchase price, and date of purchase of all equipment. CONTRACTOR shall make all equipment available to COUNTY during normal business hours for tagging or inventory. CONTRACTOR shall deliver all equipment to COUNTY upon termination of this Agreement.

XIII. PATIENTS RIGHTS/GRIEVANCES

- A. CONTRACTOR shall give to all patients written notice of their rights pursuant to and in compliance with California Welfare and Institutions Code Section 5325 et seq.; California Code of Regulations Title 9, Section 860 et seq.; Title XIX of the Social Security Act; and Title 42, Code of Federal Regulations. In addition, in all facilities providing the services

described herein, CONTRACTOR shall have prominently posted in the predominant language of the community a list of the patient's rights.

- B. As a condition of reimbursement, CONTRACTOR shall provide the same level of treatment to beneficiaries served under this Agreement as provided to all other patients served.
- C. CONTRACTOR shall not discriminate against any beneficiary of services provided under this Agreement in any manner.
- D. CONTRACTOR agrees to provide a system through which recipients of service shall have the opportunity to express and have considered their views, grievances, and complaints regarding the delivery of services, including affording recipients notice of adverse determination and a hearing thereon to the extent required by law.

XIV. ADMISSION POLICIES

CONTRACTOR's admission policies (if applicable) shall be in writing and available to the public and shall include a provision that patients are accepted for care without discrimination as described in this Agreement.

XV. HEALTH AND SAFETY

- A. CONTRACTOR shall maintain a safe facility.
- B. CONTRACTOR shall store and dispense medication in compliance with all applicable state, federal, and COUNTY laws and regulations.

XVI. MANDATED REPORTING

CONTRACTOR shall comply with the training requirements for identification and reporting of child abuse, adult, and dependent adult abuse as defined in Penal code Section 11165.7 and the Welfare and Institutions Code Section 15630-15632. All training shall be documented in an individual personnel file. CONTRACTOR shall establish procedures for paid and volunteer staff for reporting suspected child abuse cases.

XVII. BACKGROUND CHECKS

CONTRACTOR shall not assign or continue the assignment of any employees, agents (including subcontractors), students, or volunteers ("Assigned Personnel") who have been convicted or incarcerated within the prior 10 years for any felony as specified in Penal Code § 667.5 and/or 1192.7, to provide direct care to clients.

XVIII. GOOD NEIGHBOR POLICY

- A. CONTRACTOR shall comply with COUNTY's Good Neighbor Policy, a copy of which is attached as Exhibit F.
- B. If COUNTY finds CONTRACTOR has failed to perform, COUNTY shall notify CONTRACTOR in writing that corrective action must be taken by CONTRACTOR within an agreed upon time frame. If CONTRACTOR fails to comply, COUNTY shall take the required corrective action and deduct the actual cost to correct the problem from CONTRACTOR's claim, when appropriate, to ensure compliance with the Good Neighbor Policy.

XIX. BASIS FOR ADVANCE PAYMENT

- A. Pursuant to Government Code § 11019(c) this Agreement allows for advance payment once per fiscal year when CONTRACTOR submits a request in writing, and request is approved in writing by DIRECTOR or DIRECTOR's designee.
- B. If DIRECTOR finds both that CONTRACTOR requires advance payment in order to perform the services required by this Agreement and that the advance payment will not create an undue risk that payment will be made for services which are not rendered, DIRECTOR, or DIRECTOR's designee, may authorize, in her/his sole discretion, an advance in the amount not to exceed 10% of the "Net Budget/Maximum Payment to CONTRACTOR" as indicated in Exhibit C.

- C. In the case of Agreements with multiple-year terms, DIRECTOR or DIRECTOR's designee may authorize annual advances of not more than 10% of the "Net Budget/Maximum Payment to CONTRACTOR" for each fiscal year as indicated in the Exhibit C.
- D. CONTRACTOR's written request for advance shall include a detailed written report substantiating the need for such advance payment, and such other information as DIRECTOR or DIRECTOR's designee may require.
- E. All advanced funds shall be offset against reimbursement submitted during the fiscal year.
- F. COUNTY reserves the right to withhold the total advance amount from any invoice.

These provisions apply unless specified otherwise in Exhibit C of this Agreement

XX. AMENDMENTS

- A. DIRECTOR may execute an amendment to this Agreement provided that:
 - 1. An increase in the maximum contract amount resulting from the amendment does not exceed DIRECTOR's delegated authority under Sacramento County Code Section 2.61.100 (c) or any amount specified by Board of Supervisor's resolution for amending this Agreement, whichever is greater; and
 - 2. Funding for the increased contract obligation is available within the Department's allocated budget for the fiscal year.
- B. The budget attached to this Agreement as Exhibit C is subject to revision by COUNTY upon written notice by COUNTY to CONTRACTOR as provided in this Agreement. Upon notice, CONTRACTOR shall adjust services accordingly and shall within 30 days submit to DIRECTOR a revised budget. Said budget revision shall be in the form and manner prescribed by DIRECTOR and, when approved in writing, shall constitute an amendment to this Agreement.
- C. The budget attached to this Agreement as Exhibit C may be modified by CONTRACTOR making written request to DIRECTOR and written approval of such request by DIRECTOR. Approval of modifications requested by CONTRACTOR is discretionary with DIRECTOR. Said budget modification shall be in the form and manner prescribed by DIRECTOR and, when approved, shall constitute an amendment to this Agreement.

XXI. RUSSIAN ECONOMIC SANCTIONS

Pursuant to California State Executive Order N-6-22 (Order) imposing economic sanctions against Russia and declaring support of Ukraine, County shall terminate any contract with any individual or entity that is in violation of the Order or that is subject to economic sanctions therein, and shall not enter a contract with any such individual or entity while the Order is in effect.

If the total amount of this Agreement is \$5,000,000 or more, CONTRACTOR shall provide a written report to COUNTY within 60 days of the effective date of the contract or 60 days upon request regarding compliance with economic sanctions and steps taken in response to Russia's action in Ukraine, including but not limited to, desisting from making new investments in, or engaging in financial transactions with Russia or Russian entities, and directly providing support to Ukraine, while the Order is in effect. The COUNTY shall keep the report on file as evidence of compliance with the Order.

ATTACHMENT 12: GOOD NEIGHBOR POLICY

COUNTY OF SACRAMENTO GOOD NEIGHBOR POLICY

Contact: Penelope Clarke
Public Protection & Human Assistance Agency
916 874-5886

Preamble

The County is a political subdivision of the State of California, that is mandated by state and federal law to provide certain services to all residents of the County, and that also provides non-mandated, desired or necessary services to enhance the wellbeing and quality of life for its residents. Such services are provided within the territorial boundaries of all cities within Sacramento County and in the unincorporated areas of the County.

County facilities are generally located in close proximity to the constituent population served, and in areas that are easily accessible to public transportation. The siting of facilities is ultimately a County responsibility. The County requires its departments to have conducted reasonable outreach to affected neighborhoods in siting County facilities. The County takes into consideration a whole range of factors, including location of clients served, proximity of other related services needed by clientele, and any neighborhood revitalization plans and adoption siting policies of cities. The County will solicit the affected city's input and recommendation as to location, but retains the ultimate decision as to the parameters of the search area and determination of the most appropriate sites.

As a general rule, the County does not do site searches for programs, services or facilities operated by non-county entities that may receive County funding, but requires contractors to have conducted reasonable outreach to affected neighborhoods. The County contracts for services, but does not dictate the location of the facility. All businesses within the incorporated and unincorporated areas of the county must be in good standing with whatever city or County zoning laws apply in order to receive funding.

The County of Sacramento is committed to being an integral part of the neighborhoods and communities in which it is located and will implement measures in order to minimize the impact of such facilities on those neighborhoods and communities. Through its placement and management of facilities and its provision of appropriate services, the County endeavors to enhance revitalizing and strengthening of neighborhoods and communities.

Sacramento County -- Good Neighbor Policy

This policy is focused on those County-owned and County-leased facilities and those service providers under contract with the County where programs provide direct service to County constituents that have a potential impact on neighborhoods through increased traffic, noise, trash, parking, people congregating, and security risks to neighborhoods and program participants.

Generalized good neighbor policies that prohibit loitering, require litter control services, mandate removal of graffiti, provide for adequate parking and restroom amenities, require landscape and facility maintenance consistent with the neighborhood and require identification of a contact person for complaint resolution have general application to all county facilities and programs.

Good neighbor policies will also address specific and individualized impacts of proposed facilities and services based on actual circumstances which must be determined through a case by case analysis.

Good Neighbor Policies

This policy applies only to County-owned and leased facilities and those service providers under contract with the County if the facility programs and projects provide direct services to County constituents. In addition these service facilities must have a potential impact on neighborhoods and communities through increased traffic, noise, trash, parking, people congregating, and security risks to both neighborhoods and program participants.

The County requires, with regard to the actual location of a particular facility or service that all applicable zoning laws have been complied with. The focus of this good neighbor policy does not include the propriety of the location of a facility or program in a properly zoned neighborhood or community.

While location is a consideration and input from cities, neighborhoods and communities will be sought, the ultimate decision as to location rests with the County.

Once a facility is sited and in compliance with zoning laws, the intent of this policy is to identify physical impacts and measures to mitigate those impacts so as to be an integral part of the neighborhood and community the County serves.

Provision A: Establish a cooperative relationship with all cities, neighborhoods and communities for planning and siting facilities and contracting for services where the service or project has a high impact on the neighborhood and mitigation of those physical impacts is necessary.

Sacramento County -- Good Neighbor Policy

Provision B: Promote decentralization of County services where feasible as a means to improve accessibility and service delivery and reduce physical impact on the environment, neighborhoods and communities.

Provision C: Promote collocation of services, where feasible, as a way to enhance efficiency and reduce costs in the delivery of services.

Provision D: Promote exploration of innovative ways to increase accessibility to services that could also reduce physical impacts on the environment, neighborhoods and communities.

Provision E: Establish early communication with affected cities, neighborhoods and communities as a way to identify potential physical impacts on neighborhoods and to establish mitigation as necessary as well as appropriate property management practices so as not to be a nuisance.

Provision F: Maintain ongoing communication with cities, neighborhoods and communities as a way to promote integration of facilities into the community, to determine the effectiveness of established good neighbor practices, and to identify and resolve issues and problems expediently.

Provision G: Establish generalized good neighbor practices for high impact facilities, services and projects that include:

- Provision of adequate parking
- Provision of adequate waiting and visiting areas
- Provision of adequate restroom facilities
- Provision for litter control services
- Provision for removal of graffiti
- Provision for control of loitering and management of crowds
- Provision for appropriate landscape and facility maintenance in keeping with neighborhood standards
- Provision for identification of a contact person for complaint resolution
- Provision in contracts for the County to fix a deficiency and deduct it from the money owed to the program if the program fails to fix them.
- Provision to participate in area crime prevention and nuisance abatement efforts.

Provision H: Establish specific good neighbor practices for high impact facilities, services and projects based on a factual analysis of circumstances that would require more oversight and extraordinary measures to ensure the resolution of problems as they occur.

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Provision I: Establish requirements that all facilities, services and projects be in compliance with various nuisance abatement ordinances and any other provision of law that applies.

Provision J: Establish a central point of contact, within the County, for resolving noncompliance with this Good Neighbor Policy when all other administrative remedies have been exhausted. This requires contact with funding agencies, site contacts, call report logs, database maintenance, and trends analysis.

Provision K: Conduct a periodic review of all sites and projects included in this policy to determine the effectiveness of the application of the Good Neighbor Policy.

Provision L: Continued non-compliance by contractor to this policy and it's provisions may result in contract termination and ineligibility for additional or future contracts.