THE INFORMATION IN THIS BOX IS NOT A PART OF THE CONTRACT AND IS FOR COUNTY USE ONLY

SAN BERNARDINO COUNTY

Contract Number

21-943 A-2

SAP Number
4400018265

Department of Behavioral Health

Department Contract Representative	Tamela Hutchinson
Telephone Number	909-388-0861
Contractor	Pacific Clinics
Contractor Representative	Kim Wells
Telephone Number	909-266-2713
Contract Term	January 1, 2022 – December 31, 2026
Original Contract Amount	$27,750,000
Amendment Amount	$8,762,436
Total Contract Amount	$36,512,436
Cost Center	9206352200 and 9206362200

AMENDMENT NO. 2

THIS CONTRACT is entered into in the State of California by and between San Bernardino County, hereinafter called the County, and Pacific Clinics referenced above, hereinafter called Contractor.

IT IS HEREBY AGREED AS FOLLOWS:

WITNESSETH:

IN THAT CERTAIN Contract No. 21-943 by and between San Bernardino County, a political subdivision of the State of California, and Contractor for Pacific Clinics, which Contract first became effective January 1, 2022, the following changes are hereby made and agreed to, effective upon date of execution:

I. ARTICLE V FUNDING AND BUDGETARY RESTRICTIONS, paragraphs I and J are hereby amended to read as follows:

I. The Contract amendment amount of $8,762,436 shall increase the total contract amount from $27,750,000 to $36,512,436 for the contract term.

- Fiscal year 23/24 increase of $1,251,776.00
- Fiscal year 24/25 increase of $3,004,264.00
- Fiscal year 25/26 increase of $3,004,264.00
- Fiscal year 26/27 increase of $1,502,132.00

J. The Schedules A and B will be submitted to, and approved by, the Director or designee at a later date.

II. ADDENDUM I DESCRIPTION OF SB 163 WRAPAROUND PROGRAM SERVICES is hereby replaced with revised ADDENDUM I.

III. ADDENDUM II DESCRIPTION OF CHILDREN'S SUCCESS FIRST/EARLY WRAP MENTAL HEALTH SERVICES is hereby replaced with revised ADDENDUM II.

IV. All other terms, conditions and covenants in the basic agreement remain in full force and effect.

This Agreement may be executed in any number of counterparts, each of which so executed shall be deemed to be an original, and such counterparts shall together constitute one and the same Agreement. The parties shall be entitled to sign and transmit an electronic signature of this Agreement (whether by facsimile, PDF or other email transmission), which signature shall be binding on the party whose name is contained therein. Each party providing an electronic signature agrees to promptly execute and deliver to the other party an original signed Agreement upon request.

SAN BERNARDINO COUNTY

Dawn Rowe

Dawn Rowe, Chair, Board of Supervisors

Dated: MAR 26 2024

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRMAN OF THE BOARD

Lynna Monell
Clerk of the Board of Supervisors
of San Bernardino County

By _____ Deputy

Pacific Clinics

(Print or type name of corporation, company, contractor, etc.)

By ► DocuSigned by: _____
6AE97DDC243C4D4...
(Authorized signature - sign in blue ink)

Name Kim M. Wells
(Print or type name of person signing contract)

Title Chief Legal Officer
(Print or Type)

Dated: 3/18/2024

Address 251 Lewellyn Avenue
Campbell, CA 95008

FOR COUNTY USE ONLY

Approved as to Legal Form
► Dawn Martin
Dawn Martin, Deputy County Counsel
Date 3/15/2024

Reviewed for Contract Compliance
► Natalie Kessee
Natalie Kessee, Contracts Manager
Date 3/15/2024

Reviewed/Approved by Department
► Georgina Yoshioka
Georgina Yoshioka, Director
Date 3/15/2024

CHILDREN'S SB 163 WRAPAROUND MENTAL HEALTH SERVICES PROGRAM SERVICE DESCRIPTION

Pacific Clinics
572 N. Arrowhead Avenue, Suite 100
San Bernardino, CA 92401
909-266-2713

I. DEFINITION OF RECOVERY, WELLNESS, RESILIENCE AND REHABILITATIVE MENTAL HEALTH SERVICES

A. Mental Health Recovery, Wellness, and Resilience (RWR) is an approach to helping the individual to live a healthy, satisfying, and hopeful life despite limitations and/or continuing effects caused by his or her mental illness according to his or her own values and cultural framework. RWR focuses on client strengths, skills and possibilities, rather than on illness, deficits, and limitations, in order to encourage hope (in staff and clients) and progress toward the life the client desires. RWR involves collaboration with and encouragement of clients and their families, support systems and involved others to take control of major life decisions and client care; it encourages involvement or re-involvement of clients in family, social, and community roles that are consistent with their values, culture, and predominate language; it facilitates hope and empowerment with the goal of counteracting internal and external "stigma"; it improves self-esteem; it encourages client self-management of his/her life and the making of his/her own choices and decisions, it re-integrates the client back into his/her community as a contributing member; and it achieves a satisfying and fulfilling life for the individual. It is believed that all clients can recover, even if that recovery is not complete. This may at times involve risks as clients move to new levels of functioning. The individual is ultimately responsible for his or her own recovery choices.

For children, the goal of the RWR philosophy of care is to help children (hereinafter used to refer to both children and adolescents) to recover from mistreatment and trauma, to learn more adaptive methods of coping with environmental demands and with their own emotions, and to joyfully discover their potential and their place in the world. RWR focuses on a child's strengths, skills, and possibilities rather than on illness, deficits and limitations. RWR encourages children to take increasing responsibility for their choices and their behavior, since these choices can lead either in the direction of recovery and growth or in the direction of stagnation and unhappiness. RWR encourages children to assume and to regain family, social, and community roles in which they can learn and grow toward maturity and that are consistent with their values and culture. RWR promotes acceptance by parents and other caregivers and by the community of all children, regardless of developmental level, illness, or handicap, and it addresses issues of stigma and prejudice that are related to this. This may involve interacting with the

community group's or cultural group's way of viewing mental and emotional problems and differences.

"Rehabilitation" is a strength-based approach to skills development that focuses on maximizing an individual's functioning. Services will support the individual, family, support system, and/or involved others in accomplishing the desired results. Families, caregivers, human service agency personnel and other significant support persons should be encouraged to participate in the planning and implementation process in responding to the individual's needs and desires, and in facilitating the individual's choices and responsibilities.

B. Accordingly, program staffing should be multi-disciplinary and reflect the cultural, linguistic, ethnic, age, gender, sexual orientation, and other social characteristics of the community in which the program serves. Families, caregivers, human service agency personnel and other significant support persons should be encouraged to participate in the planning and implementation process in responding to the individual's needs and desires, and in facilitating the individual's choices and responsibilities. Programs may be designed to use both licensed and non-licensed personnel who are experienced in providing behavioral health services.

C. Additionally, the Contractor shall develop admission policies and procedures that incorporate the multi-agency collaboration inherent in Wraparound regarding those persons who are eligible for Wraparound and for EPSDT Medi-Cal services. Non-EPSDT eligible children and youth in need of treatment should be screened and referred to an appropriate behavioral health service provider or be treated under separate funding streams. **DBH will not reimburse Contractor for services provided to Non-Medi-Cal beneficiaries.** Further, DBH cannot reimburse Contractor for services provided to out-of-county Medi-Cal beneficiaries.

II. WRAPAROUND MISSION AND GOALS:

A. Overview:

There are four different influences on the specific elements included within Wraparound: (1) the establishment of Wraparound with California, (2) the implementation of Full Service Partnerships (FSP) as part of the MHSA Community Support Services component, (3) the Integrated Core Practice Model, as outlined by the Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS), and (4) the creation of additional EPSDT Specialty Mental Health Services (i.e., ICC & IHBS) that were initially designed to serve Katie A. Subclass members and are now available to all EPSDT Medi-Cal Beneficiaries.

Wraparound is a community-based, family-centered, strength-based, needs-driven planning process designed to maintain seriously emotionally disturbed children in their community at the lowest level of care possible. A series of bills from 1997 through 2001 (e.g., Senate Bill 163, Assembly Bill 2706, and Assembly Bill 429) established the legal statutes which allow for the provision of Wraparound

in California. In San Bernardino, CFS and DBH have collaboratively implemented Wraparound since June 1, 2002.

The Mental Health Services Act (MHSA) has allowed DBH to implement Full Service Partnerships since 2006, and one of the first FSPs was Success First/Early Wrap which was designed as a Wrap-Informed FSP to serve children and youth who did not meet Wraparound Criteria. "Comprehensive Child and Family Support Services" (CCFSS) is the name of the MHSA program which includes Success First/Early Wrap. Children's MHSA FSPs (i.e., CCFSS) have been expanded over the past 8 years so that Wraparound is an FSP as well.

The Integrated Core Practice Model (ICPM) outlines the basic elements of a program that is able to meet the needs of Katie A. Subclass members. Wraparound and CCFSS, with some slight modifications from the original designs, have been one of the primary means by which this population has been served. These modifications still allow for non-dependents to be served through Success First/Early Wrap, but there is even greater uniformity between these programs with the adoption of the ICPM.

One element of these programs is the provision of EPSDT Specialty Mental Health Services. The Katie A. Settlement included the creation of new EPSDT services, which allow program staff to capture more of the activities needed to coordinate the care of children and youth.

A new provision of the Wraparound program is added to comply with Family First Prevention Services Act (FFPSA) – Section 672(k)(4)(F) of Title 42 of the United States Code. This legislation requires six months of aftercare services to be provided to youth exiting Qualified Residential Treatment Programs (QRTPs). California operationalized FFPSA's mandate in Welfare Institutions (WIC) Code 4096.6, which states that each county child welfare agency, probation department, and mental health plan will jointly provide, arrange for, or ensure the provision of the six months of aftercare services for youth and nonminor dependents transitioning from a Short-Term Residential Therapeutic Program (STRTP) to a family-based setting.

For the San Bernardino County Mental Health Plan, youth transitioning to family-based settings will be referred to Wraparound providers who will provide six months of High Fidelity wraparound services with these youth and families.

a. Note: All of the requirements noted in **RFP-DBH 20-113 Request for Proposals for Comprehensive Child and Family Support Services (Success First / Early Wraparound Services) and SB 163 Wraparound Program Services** are incorporated into this Addendum by reference.

B. Program Objective:

1. The overall objective for Wraparound is to reduce the risk of out-of-home placement and recidivism by bringing individuals, agencies, and the

community together as the decision-making team with the central focus being to meet the needs of the child and family.

2. The program objective for this contract, which addresses the EPSDT Medi-Cal Specialty Mental Health Services, is:

   a. To assist and support the mental health needs of children and adolescents at great risk of institutional placement and their families, to prevent the need for locked hospital care and to allow safe and appropriate care in the least restrictive and least intrusive manner.

   b. To provide specialty mental health services within the context of the individual's placement, family, culture, language, community and according to developmental age-appropriate needs.

   c. To provide specialty mental health services in the placement, clinic, home, school and community, as appropriate to the treatment needs and service goals of the child and family, as outlined in the Individualized Service Plan (ISP).

   d. To promote coordination and collaboration in care planning efforts with other program team members and with other child-serving agencies and institutions involved in delivering services to children and their families and to insure comprehensive and consistent care.

   e. To direct service objectives towards achieving the individual, family and system desired results as identified in the Mental Health Service Plan and the program care plan.

3. Additionally, all services shall be provided within the context of a Full Service Partnership (FSP) which is operationalized in accordance to the values, principles, basic tenets, and philosophies of the Integrated Core Practice Model and Wraparound.

C. <u>Values, Principles, Basic Tenets, and Philosophies of the Integrated Core Practice Model and Wraparound:</u>

1. Children are first and foremost protected from abuse and neglect and maintained safely in their own homes.

2. Services are needs driven, strength-based, and family focused from the first conversation with or about the family.

3. Services are individualized and tailored to the strengths and needs of each child and family.

4. Wraparound is a community-based effort.

5. Services are delivered through a multi-agency collaborative approach that is grounded in a strong community base.

6. Parent/Family voice, choice, and preference are assured throughout the process.

7. Services incorporate a blend of formal and informal resources designed to assist families with successful transition that ensure long-term success.
8. Services are culturally competent and respectful of the culture of children and their families.
9. Services and supports are provided in the child and family's community.
10. Children have permanency and stability in their living situation.

III. PERSONS TO BE SERVED (TARGET POPULATION)

Contractor will provide specialty mental health services to San Bernardino County Medi-Cal beneficiaries who are enrolled in Wraparound by San Bernardino County Probation (Probation) or Children and Family Services (CFS), meeting the criteria for seriously emotionally disturbed, and in need of specialty mental health services. Services may also be provided to siblings of children enrolled in Wraparound if they meet all other target population requirements. Additionally, the target population includes these children and siblings if (1) the plan is to enroll the child into Wraparound in approximately the next 30 days, or (2) the child has been enrolled in Wraparound and the Child and Family Team (CFT) believes continuing EPSDT Specialty Mental Health Services with the same provider is in the best interest of the child.

A. "Seriously Emotionally Disturbed" (SED): For the purposes of this contract, "Seriously emotionally disturbed children or adolescents" refers to minors under the age of 18 years or clients up to age 21 who have a mental disorder as identified in the current psychiatric diagnostic nosology system (e.g., ICD-10-CM), other than a primary substance use disorder 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:

1. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or 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; or
    b. The mental disorder and impairments have been present for more than six (6) months or are likely to continue for more than one year without treatment.
2. The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder.
3. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code (AB 3632/2726).

B. Full Service Partnership (FSP): Clients must meet the criteria to be eligible for a Full Service Partnership (FSP), which are easily met by the requirements of being enrolled in Wraparound. FSP criteria are:

1. Meets criteria for 1, 2, or 3 as described above in Seriously Emotional Disturbed (SED) listed above.
2. OR, If 16 years of age or older, they must meet the SED criteria and:
    a. Be unserved or underserved, AND
    b. Be in one of the following situations:
    c. Homeless or at risk of being homeless
    d. Aging out of the child and youth mental health system
    e. Aging out of the child welfare system
    f. Aging out of the criminal justice system
    g. Involved in the criminal justice system
    h. At risk of involuntary hospitalization or institutionalization, or
    i. Have experienced a first episode of serious mental illness

C. Medical Necessity: Members of this target population shall meet medical necessity criteria. "Medical Necessity" is determined by the following factors:

1. The child/youth has an included diagnosis, as specified into the current psychiatric diagnostic nosology system (e.g., ICD-10-CM).
2. As a result of the included diagnosis, the child/youth must have, at least, one of the following criteria:
    a. A significant impairment in an important area of life functioning.
    b. A probability of significant deterioration in an important area of life functioning.
    c. A probability that the child will not progress developmentally as individually appropriate.
3. And the planned interventions will address the identified condition
4. And the proposed intervention will do, at least, one of the following:
    a. Significantly diminish the impairment.
    b. Prevent significant deterioration in an important area of life functioning.
    c. Allow the child to progress developmentally as individually appropriate.
5. And, the identified condition would not be responsive to treatment by a physical healthcare-based provider.In the new CalAIM access criteria for

SMHS, effective January 1, 2022, all children in child welfare (in out-of-home placement and/or with an open case) will meet criteria for an assessment in the SMHS program based on the trauma, grief, and loss associated with child welfare involvement. They do not have to demonstrate impairment or diagnosis in order to qualify for an assessment and medically necessary SMHS.

D. Katie A. Subclass Members: Specific efforts should be made to reach foster youth who have been identified by either CFS or DBH as meeting the following criteria:

1. Currently in or being considered for Therapeutic Foster Care, specialized care rate due to behavioral health needs or other intensive EPSDT services, including but not limited to Therapeutic Behavioral Services or crisis stabilization/intervention; or,
2. Currently in or being considered for a psychiatric hospital or 24-hour mental health treatment facility (e.g., community residential treatment facility); or,
3. Has experienced three or more placements within past 24 months due to behavioral health needs.

E. Provider Adequacy (If Applicable)

Contractor shall submit to DBH documentation verifying it has the capacity to serve the expected enrollment in its service area in accordance with the network adequacy standards developed by DHCS. Documentation shall be submitted no less frequently than the following:

1. At the time it enters into this Contract with the County;
2. On an annual basis; and
3. At any time there has been a significant change, as defined by DBH, in the Contractor's operations that would affect the adequacy capacity of services, including the following:
   a. A decrease of twenty-five percent (25%) or more in services or providers available to beneficiaries;
   b. Changes in benefits;
   c. Changes in geographic service area; and

909. Details regarding the change and Contractor's plans to ensure beneficiaries continue to have access to adequate services and providers.

IV. PROGRAM DESCRIPTION:

A. Referrals: All referrals for Wraparound services will come through either the Interagency Placement Council (IPC) or the Wraparound Administrative Sub-Committee (ASC) and the Contractor is required to attend each of these as requested. Attendee should be in a position to accept a referral to the program.

B. Integrated Core Practice Model Components: EPSDT Specialty Mental Health Services are provided within the context of an Integrated Core Practice Model Full Service Partnership. These services are intended to compliment the phases of Wraparound and the components of the Integrated Core Practice Model, which include:

1. Engagement: The engagement phase is the initial stage of ICPM/Wraparound Planning and is the foundation of building trusting and mutually beneficial relationships.

2. Screening and Assessment: Assessment is a continuous process. The initial assessment should include screening for unique concerns (e.g., medical, or educational) as well as thorough assessment of needs and strengths to ensure an accurate understanding of the child and family.

3. Service Planning and Implementation

   a. Service planning involves creating and tailoring plans to build on the strengths and protective capacities of the child and family in order to meet the individual needs for each child and family member that were identified in the engagement and assessment components.

   b. Implementation follows directly after the initial Individual Child and Family Service Plan, EPSDT Service Plan, and Safety Plan have been completed and includes implementing services and clarifying roles of people involved (e.g., clear identification of the ICC Coordinator).

4. Monitoring and Adapting: Monitoring and adapting are part of the practice of continually monitoring and evaluating the effectiveness of the plan while assessing current circumstances and resources. It is the part of the planning cycle where the plan is reworked as needed. Effective monitoring and adapting may, or may not, require changes to the formal plans.

5. Transition Planning: Transition is the process of moving from formal supports and services to informal supports.

C. Specific Program Task Requirements:

1. Initial Mental Health Assessment: A formal mental health assessment will be completed within fourteen (14) calendar days of Wraparound start date (i.e., enrollment date).

2. ICC Coordinator & Service Authorization: Ensure the ICC Coordinator is identified and that needed EPSDT Specialty Mental Health Services are authorized and started within thirty (30) days of Wraparound start date.

3. Notify any mental health provider involved with the child of the date, time, and place set for all Child and Family Team Meetings (CFTM).

4. Notify all involved parties as soon as possible of changes or cancellations in any CFTM.

5. Evaluate the mental health needs of the child, siblings, and family members throughout the course of care and facilitate the obtainment of needed services. Provider has the discretion to provide EPSDT Specialty Mental Health Services to any family member, or significant person in the child's life who qualifies for EPSDT Specialty Mental Health Services.

6. As needed, continue to provide EPSDT Specialty Mental Health Services to qualified beneficiaries after child is dis-enrolled from Wraparound. EPSDT Specialty Mental Health Services may continue for 9 months past disenrollment and be extended past 9 months with DBH consultation.

D. Parent Support Program:

Contractor's Wraparound operational plan shall include a parent support program focusing on (but not limited to):

1. Understanding the child's unique needs;
2. Becoming informed advocates for their children;
3. Negotiating formal systems such as Juvenile Court, schools, and other agencies;
4. Participating in cross-disciplinary teams such as the Child and Family Team or an Individualized Education Planning group;
5. Assuming leadership positions in parent groups and related forums; and
6. Strengthening parenting skills and appropriate parent support systems.

E. Discharge:

Discharge planning will occur throughout the treatment process, with follow-up services provided in coordination with the referring agency. Any discharge planning will take place within the context of the Child and Family Team and will not be a unilateral decision by any one team member other than the youth and/or parent/guardian. If a youth is enrolled in Wraparound services and concurrently receiving intensive services from another program (e.g., hospital program, partial hospital program, day treatment program) and the CFT is determining to close the case, the Director of the Wraparound program will notify the designated DBH Administrator of the intention to close.

Clients shall be discharged from Wraparound mental health services under the following circumstances:

1. Upon mutual agreement of the family and Contractor that the goals of treatment have been met;
2. Upon parent or guardian refusal of services, or refusal to comply with objectives outlined in the Mental Health Services Plan;
3. Upon parent or guardian's unilateral decision to terminate treatment;

4. Upon a good faith determination by Contractor that the individual youth cannot be effectively served by the program;

5. Upon a determination that the individual is a danger to other youth, or staff and a safety plan will not likely be effective at addressing the danger.

6. By agreement of the Child and Family Team appropriate follow-up or other service linkage will be made.

7. Children will not be automatically terminated from wraparound services if involved in the juvenile justice system and should be assessed for further wraparound services upon discharge.

910. High Fidelity Implementation- Success of the Wraparound process—including progress toward meeting needs, strategy implementation, and task completion—is measured objectively, reviewed routinely, and used to inform changes to the plan as needed. Needs statements are linked to measurable outcomes and data from standardized instruments are integrated into the planning process.

V. WRAPAROUND GEOGRAPHIC SERVICE AREAS

West Valley		
ZIP	City	County
91701	Alta Loma, CA	San Bernardino
91737	Alta Loma, CA	San Bernardino
92316	Bloomington, CA	San Bernardino
91709	Chino Hills, CA	San Bernardino
91708	Chino, CA	San Bernardino
91710	Chino, CA	San Bernardino
92334	Fontana, CA	San Bernardino
92335	Fontana, CA	San Bernardino
92336	Fontana, CA	San Bernardino
92337	Fontana, CA	San Bernardino
91743	Guasti, CA	San Bernardino
92358	Lytle Creek, CA	San Bernardino
91763	Montclair, CA	San Bernardino
91758	Ontario, CA	San Bernardino
91761	Ontario, CA	San Bernardino
91762	Ontario, CA	San Bernardino
91764	Ontario, CA	San Bernardino
91798	Ontario, CA	San Bernardino
91701	Rancho Cucamonga, CA	San Bernardino

91737	Rancho Cucamonga, CA	San Bernardino
91729	Rancho Cucamonga, CA	San Bernardino
91730	Rancho Cucamonga, CA	San Bernardino
91739	Rancho Cucamonga, CA	San Bernardino
92376	Rialto, CA	San Bernardino
92377	Rialto, CA	San Bernardino
91784	Upland, CA	San Bernardino
91785	Upland, CA	San Bernardino
91786	Upland, CA	San Bernardino

Central Valley		
ZIP	**City**	**County**
92305	Angelus Oaks, CA	San Bernardino
92318	Bryn Mawr, CA	San Bernardino
92324	Colton, CA	San Bernardino
92339	Forest Falls, CA	San Bernardino
92313	Grand Terrace, CA	San Bernardino
92346	Highland, CA	San Bernardino
92350	Loma Linda, CA	San Bernardino
92354	Loma Linda, CA	San Bernardino
92357	Loma Linda, CA	San Bernardino
92359	Mentone, CA	San Bernardino
92369	Patton, CA	San Bernardino
92373	Redlands, CA	San Bernardino
92374	Redlands, CA	San Bernardino
92375	Redlands, CA	San Bernardino
92401	San Bernardino, CA	San Bernardino
92402	San Bernardino, CA	San Bernardino
92403	San Bernardino, CA	San Bernardino
92404	San Bernardino, CA	San Bernardino
92405	San Bernardino, CA	San Bernardino
92406	San Bernardino, CA	San Bernardino
92407	San Bernardino, CA	San Bernardino
92408	San Bernardino, CA	San Bernardino
92410	San Bernardino, CA	San Bernardino
92411	San Bernardino, CA	San Bernardino
92412	San Bernardino, CA	San Bernardino
92413	San Bernardino, CA	San Bernardino
92414	San Bernardino, CA	San Bernardino
92415	San Bernardino, CA	San Bernardino
92418	San Bernardino, CA	San Bernardino

92423	San Bernardino, CA	San Bernardino
92424	San Bernardino, CA	San Bernardino
92427	San Bernardino, CA	San Bernardino
92399	Yucaipa, CA	San Bernardino

High Desert		
ZIP	**City**	**County**
92301	Adelanto, CA	San Bernardino
92307	Apple Valley, CA	San Bernardino
92308	Apple Valley, CA	San Bernardino
92309	Baker, CA	San Bernardino
92311	Barstow, CA	San Bernardino
92312	Barstow, CA	San Bernardino
92323	Cima, CA	San Bernardino
92327	Daggett, CA	San Bernardino
92310	Fort Irwin, CA	San Bernardino
92342	Helendale, CA	San Bernardino
92340	Hesperia, CA	San Bernardino
92345	Hesperia, CA	San Bernardino
92347	Hinkley, CA	San Bernardino
92356	Lucerne Valley, CA	San Bernardino
92338	Ludlow, CA	San Bernardino
92366	Mountain Pass, CA	San Bernardino
92365	Newberry Springs, CA	San Bernardino
92364	Nipton, CA	San Bernardino
92368	Oro Grande, CA	San Bernardino
92329	Phelan, CA	San Bernardino
92371	Phelan, CA	San Bernardino
92372	Pinon Hills, CA	San Bernardino
93558	Red Mountain, CA	San Bernardino
93562	Trona, CA	San Bernardino
93592	Trona, CA	San Bernardino
92392	Victorville, CA	San Bernardino
92393	Victorville, CA	San Bernardino
92394	Victorville, CA	San Bernardino
92397	Wrightwood, CA	San Bernardino
92398	Yermo, CA	San Bernardino

Eastern Desert		
ZIP	**City**	**County**
92304	Amboy, CA	San Bernardino
92242	Earp, CA	San Bernardino
92332	Essex, CA	San Bernardino
92252	Joshua Tree, CA	San Bernardino
92285	Landers, CA	San Bernardino
92256	Morongo Valley, CA	San Bernardino
92363	Needles, CA	San Bernardino
92267	Parker Dam, CA	San Bernardino
92268	Pioneertown, CA	San Bernardino
92277	Twentynine Palms, CA	San Bernardino
92278	Twentynine Palms, CA	San Bernardino
92280	Vidal, CA	San Bernardino
92284	Yucca Valley, CA	San Bernardino
92286	Yucca Valley, CA	San Bernardino

Mountains to Arrowhead		
ZIP	**City**	**County**
92317	Blue Jay, CA	San Bernardino
92321	Cedar Glen, CA	San Bernardino
92322	Cedarpines Park, CA	San Bernardino
92325	Crestline, CA	San Bernardino
92326	Crest Park, CA	San Bernardino
92341	Green Valley Lake, CA	San Bernardino
92352	Lake Arrowhead, CA	San Bernardino
92378	Rimforest, CA	San Bernardino
92382	Running Springs, CA	San Bernardino
92385	Skyforest, CA	San Bernardino
92391	Twin Peaks, CA	San Bernardino

Mountains to Big Bear		
ZIP	**City**	**County**
92314	Big Bear City, CA	San Bernardino
92315	Big Bear Lake, CA	San Bernardino
92333	Fawnskin, CA	San Bernardino
92386	Sugarloaf, CA	San Bernardino

VI. DESCRIPTION OF SPECIFIC SERVICES TO BE PROVIDED

A. Mental Health Services Activities:

Mental health services are interventions designed to provide the maximum reduction of mental disability and restoration or maintenance of functioning consistent with the requirements for learning, development, independent living and enhanced self-sufficiency. Services shall be directed toward achieving the individual's goals/desired result/personal milestones. All recipients of services shall meet or exceed the target population descriptions.

EPSDT may not be billed on any client who is detained in a Juvenile Detention & Assessment Center (Juvenile Hall, Camp or Educational Facility) or who is admitted into an acute-care psychiatric hospital or facility.

All services listed below are potentially available for provision to a client; however, Therapeutic Behavioral Service (TBS) has additional qualifying criteria which must be met when provided, and not all children or youth served will meet these additional requirements.

1. Assessment is defined as a service activity designed to evaluate the current status of a child's mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the child's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.

2. Evaluation is an appraisal of the individual's community functioning in several areas including living situation, daily activities, social support systems and health status. Cultural issues may be addressed where appropriate.

3. Therapy is defined as a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to a child or a group of children and may include family therapy at which the child is present.

4. Rehabilitation is a service activity that may include, but is not limited to, assistance in improving, maintaining, or restoring a child's or group of children's functional skills, daily living skills, social and leisure skills, and grooming and personal hygiene skills; obtaining support resources; and/or obtaining medication education.

    a. Assistance in restoring or maintaining an individual's or group of individual's functional skills, social skills, grooming, medication compliance, and support resources.
    b. Age-appropriate counseling of the individual and/or family, support systems and involved others.
    c. Training in leisure activities needed to achieve the individual's goals/desired results/personal milestones.

d. Medication education for family, support systems and involved others.

5. Plan Development is defined as a service activity that consists of development of client plans, approval of client plans, and/or monitoring and recording of a child's progress.

6. Medication Support Services include staff persons practicing within the scope of their professions by prescribing, administering, dispensing and/or monitoring of psychiatric medications or biological necessary to alleviate the symptoms of mental illness. This service includes:
   a. Evaluation of the need for medication.
   b. Evaluation of clinical effectiveness and side effects of medication.
   c. Obtaining informed consent.
   d. Medication education (including discussing risks, benefits, and alternatives with the individual or significant support persons).
   e. Plan development related to the delivery of this service.

7. Crisis Intervention is a quick emergency response service enabling the individual, his or her family, support system, and/or involved others to cope with a crisis, while maintaining the child's status as a functioning family and/or "immediate community" member to the greatest extent possible, and in the least restrictive care as applicable. A crisis is an unplanned event that results in the individual's need for immediate service intervention. Crisis intervention services are limited to stabilization of the presenting emergency. This service does not include Crisis Stabilization, which is provided in a 24-hour health care facility or hospital outpatient program. Service activities include but are not limited to assessment, evaluation, and therapy (all billed as crisis intervention).

8. Targeted Case Management means services that assist a beneficiary to access needed medical, educational, social, prevocational, rehabilitative, or other needed community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development. Targeted Case Management may be either face-to-face or by telephone with the child/youth or significant support systems and may be provided anywhere in the community.

9. Linkage and Consultation – The identification and pursuit of resources necessary and appropriate to implement the service plan, treatment plan or coordination plan, which include, but are not limited to the following:
   a. Interagency and intra-agency consultation, communication, coordination, and referral.

b. Monitoring service delivery and service plan, treatment plan or coordination plan implementation to ensure an individual's access to service and the service delivery system.

10. Placement Services – Supportive assistance to the client in the assessment, determination of need and securing of adequate and appropriate living arrangements, including, but not limited to the following:

a. Locating and securing an appropriate living environment.

b. Locating and securing funding.

c. Pre-placement visit(s).

d. Negotiation of housing or placement contracts.

e. Placement and placement follow-up.

11. Intensive Care Coordination (ICC)

Within the Integrated Core Practices Model (ICPM) there is a need for thorough collaboration between all Child and Family Team (CFT) members. Planning within the ICPM is a dynamic and interactive process that addresses the goals and objective necessary to accomplish goals. The ICC coordinator is responsible for working within the CFT to ensure that plans from any of the system partners are integrated to comprehensively address the identified goals and objectives and that the activities of all parties involved with the service to the child/youth and/or family, are coordinated to support an ensure successful and enduring change.

ICC is similar to the activities provided through Targeted Case Management. ICC must be delivered using a Child and Family Team to develop and guide the planning and services delivery process. ICC may be utilized by more than one mental health provider; however, there must an identified mental health ICC coordinator that ensure participation by the child or youth, family or caregiver and significant others so that the child/youth's assessment and plan addresses the child/youth's needs and strengths in the context of the values and philosophy of the ICPM.

ICC must be provided, at a minimum, every 30 days. It should be provided more frequently if the situation warrants.

Activities coded as ICC may include interventions such as:

- Facilitation of the development and maintenance of a constructive and collaborative relationship among child/youth, his/her family or caregiver(s), other providers, and other involved child-serving systems to create a Child and Family Team (CFT);
- Facilitation of a care planning and monitoring process which ensures that the plan is aligned and coordinated across the mental health and child serving systems to allow the child/youth to be served in his/her community in the least restrictive setting possible;

- Ensure services are provided that equip the parent/caregiver(s) to meet the child/youth's mental health treatment and care coordination needs, described in the child/youth's plan;
- Ensure that medically necessary mental health services included in the child/youth's plan are effectively and comprehensively assessed, coordinated, delivered, transitioned and/or reassessed as necessary in a way that is consistent with the full intent of the Integrated Core Practice Model (ICPM);
- Provide active participation in the CFT planning and monitoring process to assure that the plan addresses or is refined to meet the mental health needs of the child/youth.

NOTE: ICC was initially developed solely for use with children with an open child welfare case who meet the 'Subclass' Criteria of a class action lawsuit; however, ICC is a service available to all EPSDT Medi-Cal beneficiaries in need of this service.

Contractor must provide ICC for all children with an open child welfare case who meet the criteria for the 'Subclass' at least once every thirty (30) days, as this is the least frequent level of coordination needed for this population.

ICC may be provided in any setting; however, when provided in a hospital, psychiatric health facility, community treatment facility, STRTP or psychiatric nursing facility, it may be used solely for the purpose of coordinating placement of the child/youth on discharge from those facilities and may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility as part of discharge planning.

Additional information on ICC may be obtained from the DHCS publication "Medical Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) & Therapeutic Foster Care (TFC) for Katie A. Subclass Members.

12. Intensive Home Based Services (IHBS) are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of the child/youth and his/her significant support persons and to help the child/youth develop skills and achieve the goals and objectives of the plan. IHBS are not traditional therapeutic services.

Activities coded as IHBS may include interventions such as:

- Medically necessary skill-based interventions for remediation of behaviors or improvement of symptoms, including but not limited to the implementation of a positive behavioral plan and/or modeling interventions for the child/youth's family and/or significant other to assist them in implementing the strategies;

- Development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace non-functional behavior that interferes with daily living tasks or the avoidance of exploitation by others;
- Development of skills or replacement behaviors that allow the child/youth to fully participate in the CFT and service plans including but not limited to the plan and/or child welfare services plan;
- Improvement of self-management of symptoms, including self-administration of medications as appropriate;
- Education of the child/youth and/or their family or caregiver(s) about, and about to manage the child/youth's mental health disorder or symptoms:
- Support of the development, maintenance and use of social networks including the use of natural and community resources;
- Support to address behaviors that interfere with the achievement of a stable and permanent family life;
- Support to address behaviors that interfere with a child/youth's success in achieving educational objectives in an academic program in the community; and
- Support to address behaviors that interfere with transitional independent living objectives such as seeking and maintain housing and living independently.

NOTE: IHBS was initially developed solely for use with children with an open child welfare case who meet the 'Subclass' Criteria of a class action lawsuit; however, IHBS is a service available to all EPSDT Medi-Cal beneficiaries in need of this service.

IHBS was developed to be provided within the context of the Integrated Core Practice Model and requires the provision of ICC to ensure a participatory CFT. IHBS may be provided to all EPSDT Medi-Cal Beneficiaries in need of this service; however, IHBS still requires the provision of ICC to ensure a participatory coordination of services.

IHBS must be authorized through the authorization process established by the DBH ACCESS Unit. The requirements provided by DHCS shall be followed and as new requirements are published, the new requirements shall be followed.

IHBS are typically, but not only, provided by paraprofessionals under clinical supervision. IHBS is well-suited to be provided outside the STRTP setting to children/youth that are transitioning to a permanent home environment to facilitate the transition during single day and multiple day visits. IHBS may be provided within the STRTP setting.

Additional information on ICC may be obtained from the DHCS publication "Medical Manual for Intensive Care Coordination (ICC), Intensive Home

Based Services (IHBS) & Therapeutic Foster Care (TFC) for Katie A. Subclass Members."

13. Therapeutic Behavioral Service (TBS) is a one-to-one behavioral mental health service available to children/youth with serious emotional challenges who are under age 21, and who are eligible for a full array of Medi-Cal benefits without restrictions or limitations. TBS helps children/youth/TAY (Transitional Age Youth), and their parents/caregivers, foster parents, STRTP staff and school staff learn new ways of reducing and managing challenging/ problematic behaviors, as well as strategies and skills to increase the kinds of behavior that will allow children/youth/TAY to be successful in their current environment and avoid more restrictive placements. Accordingly, TBS never exist alone, but are an adjunct, specialized service to an existing mental health service as above. **Contractor shall only provide TBS to children and youth enrolled in the agency's SB163 Wrap Program. Contractor shall NOT function as a TBS Program, but rather will be a wraparound program that includes TBS.**

    a. TBS Class Criteria: Emily Q Class members are defined as "all current and future beneficiaries of the Medicaid program under the age of 21 in California who:

        (1) are placed in a Rate Classification Level (RCL) facility of 12 or above and/or a locked treatment facility for the treatment of mental health needs, but not presently detained at Juvenile Detention Centers, IMD's or psychiatric hospitals (excluding Psychiatric Health Facility or where the child/youth/TAY is "at risk" only of being detained at Juvenile Detention Centers, IMD's or In-Patient Psychiatric Hospitals)

        (2) are being considered for placement in these facilities as an option to meet the child's/youth's/TAY's needs (not necessarily the only option and whether or not a RCL 12+ facility is actually available); or have at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months (not necessarily the only option and whether or not a RCL 12+ facility is actually available) or is at risk of hospitalization.

    b. TBS "Needs" Eligibility: Once the child/youth is identified as a TBS Class member, then the County as the Mental Health Provider must determine that the child/youth/TAY meets the "needs" criteria below:

        (1) child/youth/TAY is receiving other specialty mental health services; and

(2) in the clinical opinion of the mental health provider, it is highly unlikely that without the additional short-term support of TBS, the child/youth/TAY:

(a) will need to be placed out-of-home, or into a higher level of residential care, including acute care (e.g., acute psychiatric hospital inpatient services, psychiatric health facility services, and crisis residential treatment services), because of the child's/youth's/TAY's behaviors or symptoms which jeopardize continued placement, or

(b) needs this additional support to transition to a home or foster home or lower level of residential placement, or to stabilize the child's/ youth's behavior or symptoms in a new environment/placement.

c. Therefore, Medi-Cal Reimbursement TBS criteria are:

(1) be a full-scope Medi-Cal beneficiary under the age of 21,

(2) meet MH "medical necessity",

(3) be receiving a Medi-Cal mental health service to be supported by TBS short-term interventions, and;

(4) be a member of the TBS certified class (above) or must have previously received TBS while a member of the certified class.

d. TBS is ***NOT*** reimbursable as or when:

(1) services rendered for the convenience of the family or other caregivers, physician, or teacher;

(2) supervision or services provided to assure compliance with Probationary terms;

(3) supervision to ensure the child's/youth's/TAY's safety or safety of others;

(4) services rendered to address conditions that are not part of the child's/youth's/TAY's mental health condition;

(5) services to children/youth/TAY who can sustain non-impulsive, self-directed behavior, handle themselves appropriately in social situations with peers, and who are able to appropriately handle transitions during the day; and

(6) services to children/youth/TAY who will never be able to sustain non-impulsive, self-directed behavior and engage in appropriate community activities without full-time

supervision; or when the beneficiary is an inpatient of a hospital, psychiatric health facility, nursing facility, Institutions for Mental Diseases (IMD), or crisis residential program.

e. TBS Services

(1) TBS Assessment is a clinical analysis of the history and current status of the individual's mental, emotional, or behavioral disorder. Relevant cultural issues and history should be included where appropriate. Assessment may include diagnosis. A TBS assessment also includes identifying the child/youth's target behaviors and/or symptoms that jeopardize continuation of the current residential placement or may interfere in transition to a lower level of care. The assessment must be comprehensive enough to identify that the minor meets medical necessity, is a full-scope Medi-Cal beneficiary under 21 years of age and is a member of the "certified class", and that there is a need for specialty mental health services in addition to TBS. This service is not always a direct face-to-face service.

(2) TBS Collateral is contact with one or more significant support person in the life of the beneficiary, which may include consultation and training to assist in better utilization of TBS services and understanding of mental illness, the behaviors and symptoms being targeted. TBS collateral services can be used in such cases when a TBS Coach or TBS Clinician contacts the therapist providing the mental health services, or beneficiaries caregivers, parent, teacher, STRTP staff, neighbor, siblings, etc.), if it directly relates to the TBS treatment plan. As a rule, if the Contractor is providing services that are linked to target behaviors or TBS treatment plan and the beneficiary is not present, then the Contractor would be delivering "Collateral TBS." An example of "Collateral TBS" would be when the Contractor is working with the parent/caregiver towards the goals of the minor's TBS treatment plan, or while conducting a TBS Treatment Team meeting. TBS collateral contacts must be with individuals identified as significant in the child/youth's life and be directly related to the needs, goals and interventions for the child/youth identified on the TBS Treatment Plan. This service can be delivered either face-to-face or by phone.

(3) TBS Plan Development may include any or all of the following:

(a) Development and approval of treatment or service plans.

(b) Verification of service necessity.

(c) Monitoring of the individual's progress.

(4) TBS Coach Time – is a service that includes one-to-one (face-to-face) therapeutic contact between a mental health provider (TBS Coach) and a beneficiary for a specified short-term period of time, which is designed to maintain the child/youth's placement at the lowest appropriate level by resolving target behaviors and achieving short-term goals.

(a) TBS Coach Time may not begin until the initial assessment is completed.

(b) The majority of TBS billing should fall under this category.

B. Parent Partner

A basic tenet of DBH Children's Services is the involvement of parents and families of children and youth with serious emotional disturbances as full partners in every aspect of the system. To support this basic tenet, DBH developed Parent Partner Network Meetings as a venue to ensure that families and youth have an equal voice and that services meet the needs identified by families and are sensitive to the unique cultural context and history of each family.

To support this basic tenet of DBH Children's Services, the Contractor shall hire one paid Parent Partner who is a parent or family member of a child with serious emotional disturbance to work closely with DBH Parent Partners. The duties and responsibilities of Parent Partners are either administrative or claimable as an allowable billable service, but not both.

Parent Partners are expected to provide the following services:

1. Offer referral and support services to families.
2. Ensure services meet the needs identified by families.
3. Accompany the families to Individualized Education Plan (IEP) meetings.
4. Facilitate parent support groups.
5. Provide in-home support services.
6. Promote collaboration among families, advocates, mental health providers, health care providers and other agency/school personnel.
7. Attend the DBH Regional Parent Partner Network Meeting.
8. Outreach to family members in the community.

Parent Partners may conduct and bill EPSDT Medi-Cal for the following specific activities:

- Case Management: Linkage and Consultation
- Case Management: Intensive Care Coordination
- Mental Health Service: Rehabilitation/Activities of Daily Living (ADL)

C. Coordination of Care (If Applicable)

Contractor shall deliver care to and coordinate services for all of its beneficiaries by doing the following [42 C.F.R. § 438.208(b)]:

1. Ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. The beneficiary shall be provided information on how to contact their designated person or entity [42 C.F.R. § 438.208(b) (1)].

2. Coordinate the services Contractor furnishes to the beneficiary between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. Coordinate the services Contractor furnishes to the beneficiary with the services the beneficiary receives from any other managed care organization, in FFS Medicaid, from community and social support providers, and other human services agencies used by its beneficiaries [(42 C.F.R. § 438.208(b)(2)(i)-(iv), CCR, title 9 § 1810.415.]

VII. HOURS OF PLANNED OPERATION

A. The Contractor facility will be open Monday through Friday. The main clinic office shall be open 40 hours per week and offer clinical services to clients during some evening and/or weekend hours.

B. Contractor staff will be available 24 hours per day to address the regular and emergency needs of the program's clients. Outpatient services will be available seven days a week and evening hours as determined by the appropriate DBH Program Manager or designee.

C. Contractor must have emergency on-call crisis services for all clients being served in the program, which includes emergency responses availability, call back staff, assessment of suicide ideation and other crisis responses as needed. Contractor will have daily on-duty staff rotating on a weekly basis and will be available after normal working hours and on weekends (e.g., through an answering service).

D. Changes to this plan shall be submitted to the appropriate DBH Program Manager in writing, signed and in hard copy, for approval thirty (30) days prior to implementation.

VIII. BILLING UNIT

The billing unit for mental health services, rehabilitation, medication support services, crisis intervention and case management is staff time, based on minutes of time. The

exact number of minutes used by staff providing a reimbursable service shall be reported and billed. In no case shall more than 60 units of time be reported or claimed for any one staff person during a one-hour period. Also, in no case shall the units of time reported or claimed for any one staff member exceed the hours worked.

When a staff member provides service to or on behalf of more than one individual at the same time, the staff member's time must be pro-rated to each individual. When more than one staff person provides a service, the time utilized by all involved staff members shall be added together to yield the total billable time. The total time claimed shall not exceed the actual staff time utilized for billable service. The time required for documentation and travel shall be linked to the delivery of the reimbursable service and shall not be separately billed.

IX. FACILITY LOCATION

Contractor's facility (ies) where outpatient services are to be provided is/are located at:

Central Valley: 572 N. Arrowhead Ave.
San Bernardino, CA 92401

Locations are subject to prior approval by DBH. All facilities must be Medi-Cal certified prior to the provision of services.

The locations for services may change in order to best serve the needs of San Bernardino County residents. Any location change shall be approved by the Director or designee, to ensure that all applicable laws and regulations are followed, and all contract requirements are met.

A. The Contractor shall obtain the prior written consent of the Director of DBH or the designee before terminating outpatient services at the above referenced location(s) or providing services at another location.

B. The Contractor shall comply with all requirements of the State DHCS to maintain Medi-Cal Certification and obtain necessary fire clearances. Short-Doyle/Medi-Cal Contractors must notify the DBH Program Manager at least sixty (60) days prior to a change of ownership or a change of address. The Contractor shall work with the DBH Program Manager to obtain a new provider number from the State if necessary.

C. The Contractor shall provide adequate furnishings and clinical supplies to do outpatient services in a clinically effective manner.

D. The Contractor shall maintain the facility exterior and interior appearances in a safe, clean, and attractive manner.

E. Non-smoking signs shall be clearly posted to the exterior of the building stating: "No Smoking within 20 feet of the Building – Assembly Bill 846, Chapter 342."

F. The Contractor shall have adequate fire extinguishers and smoke alarms, as well as a fire safety plan.

G. The Contractor shall have an exterior sign clearly indicating the location and name of the clinic.

H. The Contractor shall have clinic pamphlets identifying the clinic and its services, in threshold languages, for distribution in the community.

I. If applicable, Contractor shall have hours of operation posted at the facility and visible to consumers/customers that match the hours listed in the Contract. Contractor is responsible for notifying DBH of any changes in hours or availability. Notice of change in hours must be provided in writing to the DBH Access & Referral Unit at fax number 909-890-0353, as well as the DBH program contact overseeing the Contract.

X. STAFFING

A. Staff Hours of Coverage and Documentation

1. Staff coverage should be appropriate to meet the children's and family's mental health needs. This will include, but not be limited to, having after-hours resources and being able to provide some services (e.g., TBS) throughout the day as needed. An initial agency Organizational Chart will be provided to DBH within 30 days of contract signing which includes staff name, title, email, and phone contact information.

2. A staff roster must be kept current and must be provided to DBH Program Manager or designee (e.g., contract monitor). Vacancies or changes in staffing plan shall be submitted to the DBH Program Manager within 48 hours of Contractor's knowledge of such occurrence, in the form of an updated Organizational Chart. Such notice shall include a plan of action to address the vacancy or a justification for the staffing plan change.

B. General Staff Requirements

1. All staff shall be employed by the Contractor, except in the case of a sub-contracted psychiatrist..

2. The staff described will work the designated number of hours per week in full time equivalents (FTE's), perform the job functions specified and shall meet the California Code of Regulations requirements.

3. All staff functioning as a master's level, or above, clinician and providing services with DBH funding shall be licensed or have their licensed waived by the State.

4. All field staff must be CPR/First Aid trained; and an appropriate number (i.e., 1 or more depending on size of program) CPR/First Aid trained staff shall be on duty in the office during ALL hours of operation/shifts.

5. Staff shall reflect the ethnic population of the community served.

C. Specific Descriptions of Staff Qualifications and Job Functions

All staff shall be employed by the Contractor. The staff described will work the designated number of hours per week in full time equivalents (FTE's), perform the job functions specified and shall meet the California Code of Regulations requirements. All staff functioning as a clinical therapist and providing services with DBH funding shall be licensed or have their licensed waived by the State. Staff shall reflect the ethnic population of the community served.

1. Physician/Clinician/Professional Staff – Clinical services and supervision of the program shall be the responsibility of a licensed clinical professional: Licensed Psychologist (Ph.D.), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC) or Marriage and Family Therapist (MFT), who possess experience developing behavioral treatment plans for and working with emotionally and behaviorally disturbed children, as well as their families/care providers. Mental Health Services may include a variety of assessment, evaluation, and therapy activities, which support the child's residential placement, or transition to the least restrictive level of community care, and may be provided by a pre-licensed psychologist, clinical social worker, and/or marriage and family therapist under the supervision of a licensed clinician.

   In addition to providing therapuetic services Clinicians are expected to fulfill one or more of the following roles:

   a. ICC Coordinator – Within the Integrated Core Practices Model (ICPM) there is a need for thorough collaboration between all Child and Family Team (CFT) members. Planning within the ICPM is a dynamic and interactive process that addresses the goals and objectives necessary to accomplish goals. The ICC Coordinator is responsible for working within the CFT to ensure that plans from any of the system partners are integrated to comprehensively address the identified goals and objectives and that the activities of all parties involved with the service to the child/youth and/or family, are coordinated to support and ensure successful and enduring change. For ease of identification purposes, the name of the ICC Coordinator for each youth is to be entered into the client record in Objective Arts. **NOTE**: This role may be one of the responsibilities of a clinical staff who has other duties as well.

   b. Child and Family Team Meeting Facilitator –Together with the client's family and their natural team members, the Facilitator serves as the hub of the process and collaboratively orchestrates the development of the Individualized Child and Family Plans. Each Facilitator is required to hold a Master's Degree in a field related to mental health services (e.g., Social Work, Family Therapy, and Psychology). The Facilitator must attend the DBH training on CFT Meetings prior to facilitating CFT meetings.

c. Family Clinician –The Family Clinician's role is to help the family maintain or develop stability. The Family Clinician may also assist a new client and his/her family to stabilize during times of family upheaval and/or to achieve mutually established safety goals.

d. TBS Clinician/Supervisor – Clinical services and supervision of TBS shall be the responsibility of a licensed clinical professional: Psychologist (Ph.D. or Psy.D.), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC) or Marriage and Family Therapist (MFT), who possesses experience developing behavioral treatment plans for and working with emotionally and behaviorally disturbed children/youth and their families/care providers. This individual will oversee the Initial Treatment Planning meeting to develop the TBS treatment plan and provide ongoing therapeutic supervision of services. The TBS Supervisor will complete the treatment plan with the assistance of the TBS coach. Both the clinician (TBS Supervisor) and the coach are involved in the monthly meetings. The TBS supervisor will meet weekly with TBS coach to provide supervision. The TBS supervisor cannot be the same as the Specialty Mental Health Provider (SMHP).

2. Mental Health Rehabilitation Specialist – Mental Health Rehabilitation Specialists provide non-therapy mental health services, which may, if qualified, be billed for EPSDT Medi-Cal. The minimum requirements for this position are one of the following: (1) Thirty semester (45 quarter) units of completed college coursework in behavioral or social science; (2) Sixty semester (90 quarter units) of completed college coursework, which includes 15 semester (23 quarter) units in behavioral science; or (3) one year of experience providing direct mental health services under supervision of a licensed clinician. **NOTE**: A Bachelor's degree in behavioral or social science may be listed in lieu of detailed coursework. Psychiatric Technician (Psych. Tech.) courses and Alcohol and Drug Certificate courses that are completed as components of a vocational program are acceptable.

3. Family or Parent Partner – This position is defined as a parent who is hired as staff, has personal experience with a special needs youth, and can provide support. Parent Partners must have personal parenting experience with an emotionally/behaviorally-disturbed child. This staff member's role is to provide support and education to the client family and may conduct the following 27illablee services:

- Case Management: Linkage and Consultation
- Case Management: Intensive Care Coordination
- Mental Health Service: Rehabilitation/Activities of Daily Living (ADL)

4. Program Supervisor – Under general direction, this individual supervises the operation and staff of a clinic. A Program Supervisor must be licensed in California as a Marriage and Family Therapist, a Clinical Social Worker, or a Psychologist. The duties of the Program Supervisor include supervision of Clinical Therapists and other support staff and planning and coordination of the work of the clinic staff. The Program Supervisor shall also act as a resource for therapists on issues related to treatment on specific cases or types of cases, review treatment plans and therapeutic techniques utilized, ensure that therapists provide treatment within the scope of licensure, provide comprehensive psychotherapeutic treatment services for the most severely disturbed clients, perform diagnostic evaluations, and develop and implement treatment plans and conduct therapy within the scope of the license.

5. Psychiatrist – This individual must be a licensed physician who has a psychiatric specialty to diagnose or treat mental illness or condition (unless waived in writing by the Director or designee prior to delivery of services). For the purposes of this program, psychiatric services may only be provided by physicians who practice individually or as a member of a group psychiatric practice. The psychiatric services of a Wraparound program may be provided by a psychiatrist who is subcontracted by the Wraparound program to provide Medication Support Services.

6. Coaches – Coaching staff are appropriate for this program due to the inclusion of TBS and IHBS services. The Coach must possess a Bachelor's degree in a behavioral sciences field or 30-45 quarter units of completed college coursework, half of which must be upper division in behavioral science and at least two (2) years of experience working with youth-at-risk and or dually-diagnosed children/youth in residential, community or school settings. Completion of certification in First Aid and CPR are expected within 3 months of starting employment. Knowledge in behavioral management techniques and implementation of behavioral treatment plans is desired. Staff providing IHBS must have training in behavioral analysis with an emphasis on positive behavioral interventions. The IHBS coach must be available at the designated site of service to:

    a. Provide structure and support

    b. Assist the child/youth in engaging in appropriate activities

    c. Minimize impulsivity

    d. Increase social and community competencies by building or restating those daily living skills that will assist the child/youth to live successfully in the community

    e. Serve as a positive role model and assist the child/youth in developing the ability to sustain self-directed appropriate behaviors, internalize a sense of social responsibility, and/or enable appropriate participation in community activities.

f. Be available to participate in weekly/monthly treatment plan meetings and conference calls requiring input and feedback regarding the progress of the intervention and continuing client needs.

g. Coaches must successfully complete a TBS training program and must obtain the following clearances:

(1) Department of Justice fingerprint check

(2) California Driver's License DMV printout

(3) TBS Coaches must possess a valid California driver's license and have access to a vehicle

7. Volunteers – Volunteers are unpaid, unlicensed staff which provide informal supports. Volunteers must still comply with the County's HIPAA training before rendering any service.

NOTE: The contractor should utilize both "non-professional" and "professional" staff in the provision of "formal" and "informal" supports. The term "professional" denotes licensure or certification at a minimum, "formal" supports would be those that are required or recommended by the professional licensure or certification in the practice of their specialty. "Non-Professional" would refer more typically to "Parent/Family Partners/Advocates" or non-agency staff (e.g., friends, religious leaders) providing non-clinical supports to or on behalf of Families and the child/youth.

D. Additional Roles Required for Staff

Contractor is responsible for ensuring all staff are provided sufficient support to maximize their utilization of various data systems which will be utilized during their contract term. Currently, this includes utilization of Objective Arts, the CANS-SB tracking and reporting system and transactional database system, and the local billing system. The expectation is that Contractor will have enough staff fully trained in these systems and functioning as subject matter experts (SME) so that they are able to support other staff as needed. Contractor is also responsible for assigning staff as points of contact for other consumer designated programs.

This responsibility may be assigned to any appropriate staff in any position, but the Contractor must clarify how this requirement will be met and maintained for the duration of the contract.

The roles to be assigned to agency staff are:

- Objective Arts Super User (SME)
- CANS-SB Super User
- myAvatar Super User
- FTP User (2)
- AB 1299 Point of Contact
- Katie A. Liaison

- Hospital Liaison

NOTE: At DBH's request, Contractor will provide complete job descriptions for each classification provided pursuant to the terms of this agreement.

E. Licensure / Certification Requirements

1. Personnel will possess appropriate licenses and certificates and be qualified in accordance with applicable statutes and regulations. Additionally, all copies of licenses and waivers will be provided to the DBH Program Manager or designee (e.g., contract monitor) on a regular basis to be kept current.

2. Contractor will obtain, maintain, and comply with all required government authorizations, permits and licenses required to conduct its operations. In addition, Contractor will comply with all applicable Federal, State and local laws, rules, regulations and orders in its operations. This includes compliance with all applicable safety and health requirements as to the Contractor's employees. Contractor will notify County immediately of loss or suspension of any such licenses and permits.

F. Professional Development and Training Requirements

1. Contractor will provide education and training to staff and make staff available to attend required trainings and workgroups related to DBH policies, procedures, documentation, and outcomes management. This includes, but is not limited to, the following events conducted by CYCS:

   a. CANS Supervisor Training
   b. CANS Supervisor Workgroup

2. Contractor clinical staff that will be working with DBH consumers will register for required DBH Clinical Trainings within 7 days of hire. These trainings include, but are not limited to, the following trainings:

   a. Praed Foundation On-Line – Must pass final review on line
   b. TCOM Post-Certification Training
   c. Chart Documentation Training
   d. CFTM Training

3. To ensure all staff have the skills needed for their position, the Contractor will provide education and training to staff and make staff available to attend trainings related to the clinical services provided. This will include, but not be limited to, the following topics:

   a. Integrated Core Practice Model and Wraparound values, principles, philosophy, and necessary skill-development.
   b. Child and Family Team Meeting Facilitation
   c. Risk assessment

d. Clinical trainings targeting increasing cultural competencies. DBH has the expectation that all clinical staff will attend at least, four (4) hours of this type of training each year.

e. Trauma informed care

f. Child and Adolescent Needs and Strengths-San Bernardino (CANS-SB)

4. Contractor shall provide additional trainings to aid in the provision of TBS, including training on:

a. Services to culturally diverse children and their families

b. Trauma informed care

c. Clinically appropriate interventions for specific sub-populations

d. On-going training and in-service for staff regarding TBS and behavioral techniques. These ongoing trainings must incorporate the current versions of support documents developed as tools to aid the implementation of TBS, these currently include:

(1) Therapeutic Behavioral Services (TBS) Coordination of Care Best Practices Manual

(2) Therapeutic Behavioral Services (TBS) Documentation Manual 2.0

G. Background Checks, Criminal Records Review, DOJ Clearances, any Other Required Clearances:

1. Department of Justice fingerprint clearance

Vendor shall obtain from the Department of Justice (DOJ) records of all convictions involving any sex crimes, drug crimes, or crimes of violence of a person who is offered employment or volunteers for all positions in which he or she would have contact with a minor, the aged, the blind, the disabled or a domestic violence client, as provided for in Penal Code Section 11105.3. This includes licensed personnel who are not able to provide documentation of prior Department of Justice clearance. A copy of a license from the State of California is sufficient proof.

2. California Driver's License DMV printout

3. Excluded Parties List Clearance.

Neither Vendor nor its employees or sub vendors shall be named on the EPLS, which includes information regarding entities debarred, suspended, proposed for debarment, excluded or disqualified under the non-procurement common rule, or otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. The EPLS can be accessed at http://www.epls.gov/. This information may include names, addresses, DUNS numbers, Social

Security Numbers (SSNs), Employer Identification Numbers or other Taxpayer Identification Numbers, if available and deemed appropriate and permissible to publish by the agency taking the action. Please be aware that although United States General Service Administration operates this system, individual agencies are responsible for the timely reporting, maintenance, and accuracy of their data.

H. Number of Staff Fluent in Other Languages

There must be direct service staff with bilingual (Spanish) ability available. Contractor should also obtain other linguistic/translation capacity if warranted, including collaboration with the DBH Program Manager on resource identification.

XI. ADMINISTRATIVE AND PROGRAMMATIC REQUIREMENTS

A. Contractor must start providing assessment and treatment services as soon as possible, but no later than ninety (90) days from the contract start date

B. Contractor must obtain and maintain Medi-Cal certification in order to bill EPSDT Medi-Cal for services provided to Medi-Cal eligible children/youth. Contractor must submit Medi-Cal certification paperwork to assigned DBH Program Manager within thirty (30) days of the start date of the contract. Not obtaining Medi-Cal certification within ninety (90) days from the contract start date may result in contract termination.

C. Contractor must comply with all requirements of the State DHCS to maintain Medi-Cal certification and obtain necessary fire clearances. Short-Doyle/Medi-Cal Contractors must notify DBH at least sixty (60) days prior to change of ownership or change of address.

D. The Contractor will provide services in a culturally and linguistically sensitive manner. This includes providing information in the appropriate languages and providing information to persons with visual and hearing impairments.

E. The Contractor will provide services in the most appropriate setting (e.g., home, school, clinic, or community).

F. The Contractor must comply with California Vehicle Restraint Laws which state that children transported in motor vehicles must be restrained in the rear seat until they are eight years old or are at least 4 feet 9 inches in height.

G. The Contractor shall abide by the criteria and procedures set forth in the Uniform Method of Determining Ability to Pay (UMDAP) manual consistent with State regulations for mental health programs. The Contractor shall not charge mental health patients in excess of what UMDAP allows.

H. The Contractor shall maintain client records in compliance with all regulations set forth by the State DHCS and provide access to clinical records by DBH staff. Contractor will satisfy and provide for meeting State DHCS Outcome study requirements.

I. The Contractor shall maintain ongoing compliance with Medi-Cal Utilization Review requirements and Medicare record keeping requirements. The Contractor will participate in on-going Medi-Cal audits by the State DHCS. A copy of the plan of correction regarding deficiencies will be forwarded to the DBH.

J. The Contractor shall maintain high standards of quality of care for the units of service, which it has committed to provide.

1. The Contractor will make every effort to recruit bilingual staff in order to meet community needs.

2. The Contractor's staff shall hold regular case conferences to evaluate the effects of treatment and the need for continued treatment.

3. Summary copies of internal peer review conducted shall be provided to the DBH Program Manager, or designee, upon request.

K. The Contractor shall ensure that Satisfaction Surveys are provided to beneficiaries and parent/caregivers upon completion/termination of this contract

L. The Contractor shall attend, or send an appropriate representative, to all designated Program and/or Agency meetings as notified by DBH.

M. The Contractor shall participate in the DBH's annual evaluation of the program and shall make required changes in areas of deficiency.

N. The Contractor shall allow visits by the DBH Program Manager, or designee, at any time for review of records, contract requirements, or for audit purposes.

O. The Contractor shall provide periodic program reports, as required by DBH.

P. The Contractor shall attend, or send an appropriate representative, to all designated Program and/or Agency meetings as notified by DBH.

Q. The Contractor shall ensure that there are adequate budgeted funds to pay for all necessary treatment staff, supplies and tools.

R. The Contractor shall maintain a separate and clear audit trail reflecting expenditure of funds under this agreement.

S. The Contractor shall make available to the DBH Program Manager, or designee, copies of all administrative policies and procedures utilized and developed for service location(s) and shall maintain ongoing communication, which may include electronic mail, with the Program Manager or designee regarding those policies and procedures.

T. Upon the termination of the contract and discontinuance of the provision of services, all records shall be provided to the county in an organized manner within 60 days of the termination of the contract and discontinuance of services.

U. In addition, if proper documentation is not received by the DBH, payment(s) may be withheld until Contractor is in compliance with terms and conditions of the contract. This includes such provisions as certificate(s) of insurance, staff

changes, reduction or change in staff and documentation regarding all licensed staff.

V. If applicable, Contractor shall have written procedures for referring individuals to a psychiatrist when necessary, or to a physician, if a psychiatrist is not available.

W. The main clinic office will be available a minimum of forty (40) hours per week by appointment. Services will primarily be field-based in the natural settings of the child and parent and access will be available 24 hours per day through answering system and paging system.

X. If applicable, Contractors are required to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the hours of operation must be comparable to the hours made available for Medi-Cal services that are not covered by Contractor or another Mental Health Plan; i.e., must be available during the times that services are accessible by consumers based on program requirements.

XII. DEPARTMENT OF BEHAVIORAL HEALTH RESPONSIBILITIES

B. The DBH shall provide technical assistance to the Contractor in regard to EPSDT/Medi-Cal requirements, as well as charting and Utilization Review requirements.

C. The DBH shall participate in evaluating the progress of the overall program in regard to responding to the mental health needs of the target population.

D. The DBH shall monitor the Contractor on a regular basis in regard to compliance with all of the above requirements.

E. The DBH shall provide linkages with the Comprehensive Mental Health System of Care to assist Contractor in meeting the needs of its clients.

XIII. OUTCOME MEASURES AND DATA REPORTING REQUIREMENTS

A. Process Measures:

1. Ninety percent (95%) of all San Bernardino County Medi-Cal beneficiaries will receive a full assessment within 30 days of enrollment in the Wraparound Services program.

2. The average number of EPSDT Specialty Mental Health Services Hours provided to a client who meets medical necessity will be 2.5 per week during the first three (3) months of service provision.

3. Ninety percent (90%) of foster children identified as "Sub-Class Members" in accordance with the Integrated Core Practice Model and the Kate A. Settlement will be provided Intensive Care Coordination (ICC) at least once per month.

4. Average number of days between the client's first assessment and first treatment service, excluding the upper 5%, will be less than 7 days.

5. Average number of EPSDT Specialty Mental Health Service Hours provided to a client who meets medical necessity will be more than 4 hours per month.

6. Average number of days between EPSDT services, excluding the upper 5%, will be less than 7 days.

7. At least 95% of all billable services provided during a specific month will be included in the monthly billing which is submitted by the seventh (7^{th}) day of the following month.

8. Information for at least 95% of all clients who are either "opened" or "closed" for mental health services will be provided to DBH through the appropriate means within five (5) working days of the admission and discharge.

B. Data Reporting Elements including when data is due, how it should be submitted, and any other specifics:

1. Data is gathered through the billing systems, which will be completed by the seventh (7^{th}) day of the month following the billing for the previous month's Medi-Cal based services.

2. Exception is the "opening" and "closing" of clients within the County's current billing and transactional database system. This will be done within five (5) working days of admission and discharge from the facility.

3. Data shall be entered, either directly or through batch upload processes, into Objective Arts at least every two weeks.

4. Vendor shall enter all required data into the DCR within the timeframes prescribed for FSPs.

C. Use of The Child and Adolescent Needs and Strength – San Bernardino (CANS-SB): CANS-SB shall assessment be completed:

1. Within thirty (30) days of admission,

2. Every three (3) months, and

3. Within thirty (30) days of discharge.

4. Clarifications:

a. A CANS-SB is not required at admission if the client does not meet the criteria for services **AND** there is deemed insufficient information to complete the CANS-SB accurately.

b. In no case shall a period of more than three (3) months pass without completing a CANS-SB.

c. A CANS-SB is not required at discharge if a three (3) month (i.e., Update) CANS-SB, was administered within the past thirty (30) days **AND** no significant change in the client's presentation has occurred.

D. Program Goals:

1. Provide services appropriate to needs based on functioning and cultural background.
2. Reduce the number of multiple out-of-home placements for foster care youth.
3. Provide effective services that are continually reviewed and revised as needed.
4. Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth.

E. Key Outcomes:

1. Key Outcome related to service appropriateness:
   a. Services match the individual consumer's needs and strengths in accordance with system-of-care values and scientifically derived standards of care.
2. Key Outcomes related to reducing multiple out-of-home placements:
   a. Decreased placement changes due to behavioral problems.
   b. Decreased difficulties in home that could lead to removal (e.g., as operationalized by the CANS-SB).
   c. Increased residential stability (e.g., as operationalized by the CANS-SB/ANSA/number of days spent in single location, such as the following DCR categories by age group:
      (1) Children: General Living Arrangement or Residential Program.
      (2) TAY: General Living Arrangement, Supervised Placement, or Residential Program.
3. Key Outcomes related to service effectiveness:
   a. Improved functioning.
   b. Reduction in symptom distress.
   c. Improvement in work or school performance.
   d. Well-being and positive health.
   e. Treatment Involvement.
   f. Progress to Goals.
   g. Discharge Preparation.
   h. Home Visits Caregiver Participation.
   i. Caregiver Interaction.

4. Key Outcomes related to reducing subjective suffering:

   a. Increased resiliency.

   b. Decreased Core Actionable Items Report (CAIR) Scores.

   c. Decreased impairment in general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal/social).

CHILDREN'S SUCCESS FIRST / EARLY WRAP MENTAL HEALTH SERVICES PROGRAM SERVICE DESCRIPTION

Pacific Clinics
572 N. Arrowhead Avenue, Suite 100
San Bernardino, CA 92401
909-266-2713

I. DEFINITION OF RECOVERY, WELLNESS, RESILIENCE AND REHABILITATIVE MENTAL HEALTH SERVICES

A. Mental Health Recovery, Wellness, and Resilience (RWR) is an approach to helping the individual to live a healthy, satisfying, and hopeful life despite limitations and/or continuing effects caused by his or her mental illness according to his or her own values and cultural framework. RWR focuses on client strengths, skills and possibilities, rather than on illness, deficits, and limitations, in order to encourage hope (in staff and clients) and progress toward the life the client desires. RWR involves collaboration with and encouragement of clients and their families, support systems and involved others to take control of major life decisions and client care; it encourages involvement or re-involvement of clients in family, social, and community roles that are consistent with their values, culture, and predominate language; it facilitates hope and empowerment with the goal of counteracting internal and external "stigma"; it improves self-esteem; it encourages client self-management of his/her life and the making of his/her own choices and decisions, it re-integrates the client back into his/her community as a contributing member; and it achieves a satisfying and fulfilling life for the individual. It is believed that all clients can recover, even if that recovery is not complete. This may at times involve risks as clients move to new levels of functioning. The individual is ultimately responsible for his or her own recovery choices.

For children, the goal of the RWR philosophy of care is to help children (hereinafter used to refer to both children and adolescents) to recover from mistreatment and trauma, to learn more adaptive methods of coping with environmental demands and with their own emotions, and to joyfully discover their potential and their place in the world. RWR focuses on a child's strengths, skills, and possibilities rather than on illness, deficits, and limitations. RWR encourages children to take increasing responsibility for their choices and their behavior, since these choices can lead either in the direction of recovery and growth or in the direction of stagnation and unhappiness. RWR encourages children to assume and to regain family, social, and community roles in which they can learn and grow toward maturity and that are consistent with their values and culture. RWR promotes acceptance by parents and other caregivers and by the community of all children, regardless of developmental level, illness, or handicap, and it addresses issues of stigma and prejudice that are related to this. This may involve interacting with the community group's or cultural group's way of viewing mental and emotional problems and differences.

"Rehabilitation" is a strength-based approach to skills development that focuses on maximizing an individual's functioning. Services will support the individual, family, support system, and/or involved others in accomplishing the desired results. Families, caregivers, human service agency personnel and other significant support persons should be encouraged to participate in the planning and implementation process in responding to the individual's needs and desires, and in facilitating the individual's choices and responsibilities.

B. Accordingly, program staffing should be multi-disciplinary and reflect the cultural, linguistic, ethnic, age, gender, sexual orientation, and other social characteristics of the community in which the program serves. Families, caregivers, human service agency personnel and other significant support persons should be encouraged to participate in the planning and implementation process in responding to the individual's needs and desires, and in facilitating the individual's choices and responsibilities. Programs may be designed to use both licensed and non-licensed personnel who are experienced in providing behavioral health services.

C. Additionally, the Contractor shall develop admission policies and procedures that incorporate the multi-agency collaboration inherent in a wrap-informed program. Non-EPSDT eligible children and youth in need of treatment should be screened, assessed, and referred to an appropriate behavioral health service provider or be treated under separate funding streams. **DBH will reimburse Contractor for services provided to Non-Medi-Cal beneficiaries to the extent that alternative funding (i.e., Mental Health Services Act) are available within the contract.** Further DBH cannot reimburse Contractor for services provided to out-of-county Medi-Cal beneficiaries.

II. WRAPAROUND MISSION AND GOALS:

A. Overview:

There are four different influences on the specific elements included within Wraparound: (1) the establishment of Wraparound with California, (2) the implementation of Full Service Partnerships (FSP) as part of the MHSA Community Support Services component, (3) the Integrated Core Practice Model, as outlined by the Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS), and (4) the creation of additional EPSDT Specialty Mental Health Services (i.e., ICC & IHBS) that were initially designed to serve Katie A. Subclass members and are now available to all EPSDT Medi-Cal Beneficiaries.

Wraparound is a community-based, family-centered, strength-based, needs-driven planning process designed to maintain seriously emotionally disturbed children in their community at the lowest level of care possible. A series of bills from 1997 through 2001 (e.g., Senate Bill 163, Assembly Bill 2706, and Assembly Bill 429) established the legal statutes which allow for the provision of Wraparound in California. In San Bernardino, CFS and DBH have collaboratively implemented Wraparound since June 1, 2002.

The Mental Health Services Act (MHSA) has allowed DBH to implement Full Service Partnerships since 2006, and one of the first FSPs was Success First/Early Wrap which was designed as a Wrap-Informed FSP to serve children and youth who did not meet Wraparound Criteria. "Comprehensive Child and Family Support Services" (CCFSS) is the name of the MHSA program which includes Success First/Early Wrap. Children's MHSA FSPs (i.e., CCFSS) have been expanded over the past 8 years so that Wraparound is an FSP as well.

The Integrated Core Practice Model (ICPM) outlines the basic elements of a program that is able to meet the needs of Katie A. Subclass members. Wraparound and CCFSS, with some slight modifications from the original designs, have been one of the primary means by which this population has been served. These modifications still allow for non-dependents to be served through Success First/Early Wrap, but there is even greater uniformity between these programs with the adoption of the ICPM.

One element of these programs is the provision of EPSDT Specialty Mental Health Services. The

Katie A. Settlement included the creation of new EPSDT services, which allow program staff to capture more of the activities needed to coordinate the care of children and youth.

Note: All of the requirements noted in **RFP-DBH 20-113 Request for Proposals for Comprehensive Child and Family Support Services (Success First / Early Wraparound Services) and SB 163 Wraparound Program Services** are incorporated into this Addendum by reference.

B. Program Objective:

1. The overall objective for Success First/Early Wrap is to meet the needs of children who require an intensive wrap-informed program, but who are not eligible for the SB 163 Wraparound Program operated conjointly with Children and Family Services. reduce the risk of out-of-home placement and recidivism by bringing individuals, agencies, and the community together as the decision-making team with the central focus being to meet the needs of the child and family.

2. Success First/Early Wrap will serve children and youth who struggle with emotional disturbances and co-occurring disorders and whose family income is 200 percent or less of the federal poverty level. Services will target children and youth identified as unserved, underserved, or who have experienced inappropriate service delivery in culturally diverse communities and to prevent them from out-of-home placements.

3. Success First/Early Wrap is intended to be a time-limited program (i.e., 4 to 6 months; with approved extensions afterwards). The time limited nature of the program is intended to facilitate rapid change and stabilization of the child and family. The expectation is that many children and families will need additional services through other EPSDT Medi-Cal programs upon discharge from Success First/Early Wrap and this transition planning starts at the onset of services.

4. For children with an open child welfare case who meet Katie A. Subclass membership criteria services may be extended as needed; however, a child needing these services for an extended period likely qualifies for the SB 163 Wraparound Program Services and a transition of care should be facilitated.

5. For all children served in Success First/Early Wrap additional specific program objectives include:

   a. To assist and support the mental health needs of children and adolescents at great risk of institutional placement and their families, to prevent the need for locked hospital care and to allow safe and appropriate care in the least restrictive and least intrusive manner.

   b. To provide specialty mental health services within the context of the individual's placement, family, culture, language, community and according to developmental age-appropriate needs.

   c. To provide specialty mental health services in the placement, clinic, home, school, and community, as appropriate to the treatment needs and service goals of the child and family, as outlined in the Individualized Service Plan (ISP).

   d. To promote coordination and collaboration in care planning efforts with other program team members and with other child-serving agencies and institutions

involved in delivering services to children and their families and to insure comprehensive and consistent care.

e. To direct service objectives towards achieving the individual, family and system desired results as identified in the Mental Health Service Plan and the program care plan.

6. Additionally, all services shall be provided within the context of a Full Service Partnership (FSP) which is operationalized in accordance to the values, principles, basic tenets, and philosophies of the Integrated Core Practice Model and Wraparound.

C. Values, Principles, Basic Tenets, and Philosophies of the Integrated Core Practice Model and Wraparound:

1. Children are first and foremost protected from abuse, neglect, and maintained safely in their own homes.

2. Services are needs driven, strength-based, and family focused from the first conversation with or about the family.

3. Services are individualized and tailored to the strengths and needs of each child and family.

4. Wraparound is a community-based effort.

5. Services are delivered through a multi-agency collaborative approach that is grounded in a strong community base.

6. Parent/Family voice, choice, and preference are assured throughout the process.

7. Services incorporate a blend of formal and informal resources designed to assist families with successful transition that ensure long-term success.

8. Services are culturally competent and respectful of the culture of children and their families.

9. Services and supports are provided in the child and family's community.

10. Children have permanency and stability in their living situation.

III. PERSONS TO BE SERVED (TARGET POPULATION)

Contractor will provide services to children and youth who are seriously emotionally disturbed children and youth residing in San Bernardino County who are un-served, underserved, inappropriately-served, and in need of assessment and treatment related to severe mental health disorders that require specialty mental health service, within a full-service partnership program, and who do not qualify for SB 163 Wraparound Program Services. Children and youth served may or may not be wards or dependents or be Medi-Cal beneficiaries. The primary age range for these services is up to age 18.

A. "Seriously Emotionally Disturbed" (SED): For the purposes of this contract, "Seriously emotionally disturbed children or adolescents" refers to minors under the age of 18 years or clients up to age 21 who have a mental disorder as identified in the current psychiatric diagnostic nosology system (e.g., ICD-10-CM), other than a primary substance use disorder 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:

1. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or 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; or
    b. The mental disorder and impairments have been present for more than six (6) months or are likely to continue for more than one year without treatment.
2. The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder.
3. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code (AB 3632/2726).

B Full Service Partnership (FSP): Clients must meet the criteria to eligible for a Full Service Partnership (FSP), which are easily met by the requirements of being enrolled in Wrap-informed FSP. FSP criteria are:

1. Meets criteria for 1, 2, or 3 as described above in Seriously Emotional Disturbed (SED) listed above.
2. OR, If 16 years of age or older, they must meet the SED criteria and:
    a. Be unserved or underserved, AND
    b. Be in one of the following situations:
    c. Homeless or at risk of being homeless
    d. Aging out of the child and youth mental health system
    e. Aging out of the child welfare system
    f. Aging out of the criminal justice system
    g. Involved in the criminal justice system
    h. At risk of involuntary hospitalization or institutionalization, or
    i. Have experienced a first episode of serious mental illness

C. Medical Necessity: Members of this target population shall meet medical necessity criteria. "Medical Necessity" is determined by the following factors:

1. The child/youth has an included diagnosis, as specified in the current psychiatric diagnostic nosology system (e.g., ICD-10-CM).
2. As a result of the included diagnosis, the child/youth must have, at least, one of the following criteria:
    a. A significant impairment in an important area of life functioning.
    b. A probability of significant deterioration in an important area of life functioning.
    c. A probability that the child will not progress developmentally as individually appropriate.

3. And the planned interventions will address the identified condition
4. And the proposed intervention will do, at least, one of the following:
   a. Significantly diminish the impairment.
   b. Prevent significant deterioration in an important area of life functioning.
   c. Allow the child to progress developmentally as individually appropriate.
5. And the identified condition would not be responsive to treatment by a physical healthcare-based provider.

D. In the new CalAIM access criteria for SMHS, effective January 1, 2022, all children in child welfare (in out-of-home placement and/or with an open case) will meet criteria for an assessment in the SMHS program based on the trauma, grief, and loss associated with child welfare involvement. They do not have to demonstrate impairment or diagnosis in order to qualify for an assessment and medically necessary SMHS.

D. Katie A. Subclass Members: Specific efforts should be made to reach foster youth who have been identified by either CFS or DBH as meeting the following criteria:

1. Currently in or being considered for Therapeutic Foster Care, specialized care rate due to behavioral health needs or other intensive EPSDT services, including but not limited to Therapeutic Behavioral Services or crisis stabilization/intervention; or,
2. Currently in or being considered for a psychiatric hospital or 24-hour mental health treatment facility (e.g., community residential treatment facility); or,
3. Has experienced three or more placements within past 24 months due to behavioral health needs.

E. Provider Adequacy (If Applicable)

Contractor shall submit to DBH documentation verifying it has the capacity to serve the expected enrollment in its service area in accordance with the network adequacy standards developed by DHCS. Documentation shall be submitted no less frequently than the following:

1. At the time it enters into this Contract with the County;
2. On an annual basis; and
3. At any time there has been a significant change, as defined by DBH, in the Contractor's operations that would affect the adequacy capacity of services, including the following:
   a. A decrease of twenty-five percent (25%) or more in services or providers available to beneficiaries;
   b. Changes in benefits;
   c. Changes in geographic service area; and
   d. Details regarding the change and Contractor's plans to ensure beneficiaries continue to have access to adequate services and providers.

IV. PROGRAM DESCRIPTION:

A. Referrals: Referrals for Success First/Early Wrap may be generated from any resource. The Contractor will coordinate all referrals with DBH Program Manager, or designee, and will

collaboratively prioritize referrals as clinically appropriate. Some primary referral sources include Centralized Children's Intensive Case Management (CCICMS), DBH Access Unit, CFS, Probation, and the Interagency Placement Council (IPC). The Contractor is required to attend IPC, as requested. Attendee should be in a position to accept a referral to the program.

B. Integrated Core Practice Model Components: Services are provided within the context of an Integrated Core Practice Model Full Service Partnership (ICPM-FSP). These services are intended to compliment the phases of Wraparound and the components of the Integrated Core Practice Model, which include:

1. Engagement: The engagement phase is the initial stage of services and is the foundation of building trusting and mutually beneficial relationships.
2. Screening and Assessment: Assessment is a continuous process. The initial assessment should include screening for unique concerns (e.g., medical, or educational) as well as thorough assessment of needs and strengths to ensure an accurate understanding of the child and family.
3. Service Planning and Implementation
    a. Service planning involves creating and tailoring plans to build on the strengths and protective capacities of the child and family to meet the individual needs for each child and family member that were identified in the engagement and assessment components.
    b. Implementation follows directly after the EPSDT Service Plan and Safety Plan have been completed and includes implementing services and clarifying roles of people involved (e.g., clear identification of the ICC Coordinator).
4. Monitoring and Adapting: Monitoring and adapting are part of the practice of continually monitoring and evaluating the effectiveness of the plan while assessing current circumstances and resources. It is the part of the planning cycle where the plan is reworked as needed. Effective monitoring and adapting may, or may not, require changes to the formal plans.
5. Transition Planning: Transition is the process of moving from formal supports and services to informal supports.

C. Specific Program Task Requirements:

1. Within three (3) business days of an urgent referral or case assignment by the DBH Coordinator (or designee), the Contractor will assign a Facilitator to the case.
2. The Facilitator assigned to a case will:
    a. Initiate contact with the child and his/her caregiver within three (3) calendar days of being assigned the case.
    b. Contact the DBH Coordinator with notification of either acceptance or rejection; if rejection, reasons will be noted. This is to be done within four (4) business days of being assigned the case.

c. Along with the Parent/Family Partner, conduct an initial face-to-face meeting with the child and family within seven (7) business days of assignment. Issues to be discussed during the initial meeting shall include, but are not limited to:

(1) Wraparound goals

(2) Wraparound process

(3) Role of the referring agency

(4) Expectations of the family/caregiver

(5) Expectations of the child

(6) Development of the Child and Family Team

(7) Child/family/caregiver safety issues

(8) Stability of housing, childcare, respite services, etc.

3. Initial Mental Health Assessment: A formal mental health assessment will be initiated at the first appointment and completed as soon as possible, but absolutely within fourteen (14) calendar days of start date (i.e., enrollment date).

4. If the Contractor determines that the child does not meet criteria for the Success First/Early Wrap FSP program, the Provider shall (i) consult with the referral source, (ii) discuss the assessment results, and (iii) facilitate a mutually agreed upon referral/disposition. If a mutually agreeable disposition is not reached, the Provider must contact Centralized Children's Intensive Case Management Services (CCICMS) to develop an appropriate course of action.

5. ICC Coordinator & Service Authorization: Ensure the ICC Coordinator is identified and that needed EPSDT Specialty Mental Health Services are authorized and started within twenty-one (21) days of start date.

6. The planning process, services, and supports will be provided in the child's home, neighborhood, school, or the area selected by the child and/or family, in conjunction with the Provider.

7. Notify the relevant Multi-disciplinary Team Member(s) of the date, time, and place set for all Child and Family Team Meetings involving the child. Taking into consideration the family's obligations such as work and school, the Facilitator will schedule Child and Family Team meetings to maximize opportunities for the child's social worker, probation officer, or case manager to attend regularly.

8. Notify all involved parties as soon as possible of changes or cancellations in any CFTM.

9. Evaluate the mental health needs of the child, siblings and family members throughout the course of care and facilitate the obtainment of needed services.

10. Ensure linkage and continuity of care as children transition out of Success First/Early Wrap.

D. Parent Support Program:

Contractor's operational plan shall include a parent support program focusing on (but not limited to):

1. Understanding the child's unique needs;
2. Becoming informed advocates for their children;
3. Negotiating formal systems such as Juvenile Court, schools, and other agencies;
4. Participating in cross-disciplinary teams such as the Child and Family Team or an Individualized Education Planning group;
5. Assuming leadership positions in parent groups and related forums; and
6. Strengthening parenting skills and appropriate parent support systems.

E. Discharge:

Discharge planning will occur throughout the treatment process, with follow-up services provided in coordination with the referring agency. The intention is for children to be discharged in four (4) months from the start of services; however, their specific needs will impact the timing of discharges. Additionally, the intensive short-term focus of Success First/Early Wrap requires that many children transition to other services to meet their mental health needs. Clients shall be discharged from Success First/Early Wrap under the following circumstances:

1. Upon mutual agreement of the family and Contractor that the goals of treatment have been met;
2. Upon parent or guardian refusal of services, or refusal to comply with objectives outlined in the Mental Health Services Plan;
3. Upon parent or guardian's unilateral decision to terminate treatment;
4. Upon a good faith determination by Contractor that the individual youth cannot be effectively served by the program;
5. Upon a determination that the individual is a danger to other youth, staff, or self;
6. Upon transfer out of the County or to another region;
7. By agreement of the Child and Family Team appropriate follow-up or other service linkage will be made.
8. Children will not be automatically terminated from services if involved in the juvenile justice system and should be assessed for further services upon discharge.

   NOTE: Children who continue to meet Katie A. Subclass criteria will not be discharged from Success First/Early Wrap unless a successful transition to another ICPM program has been accomplished.

F. Family Urgent Response System (FURS)

A coordinated statewide and county-level system designed to provide collaborative and timely state-level phone-based response and county-level in-home, in-person mobile response during situations of instability, to preserve the relationship of the caregiver and the child or youth. https://www.cdss.ca.gov/inforesources/cdss-programs/foster-care/furs.

For in-person responses to FURS, the service requirements are:

1. Maintain the ability to respond to FURS referrals 24 hours per day 365 days per year. This will include an on-call schedule to be maintained Monday through Friday between 5 p.m.

to 8 a.m. and 24/7 on weekends and Holidays. Note: This requirement will be met as a shared responsibility by awarded vendors who, collectively, will maintain a rotating schedule when possible.

2. An assessment of the information provided by the caller will impact the type of response provided to the FURS referral, but it is expected that two staff will respond as a team. One of these team members will be a clinician to ensure an assessment may be initiated at first contact.

3. The initial contact will either be in response to an urgent FURS call (i.e., meeting with child and family within 1 to 3 hours) or a non-urgent FURS call (i.e., meeting with the child and family within 24 hours). For both types of calls the expectation is that follow-up contact will occur, minimally, for the following 72 hours.

4. The initial contact with the family needs to focus on the immediate need to help the family stabilize in a veryshort period of time. This initial contact with the on-call regional SF/EW teams will include the use of Crisis Intervention (if qualifying) and/or Assessment (if qualifying). If the immediate need or circumstances are such that the service may not be billed to Medi-Cal, then the costs of these services will be reimbursed without billing Medi-Cal. Regardless of the formal specialty mental health service documented, the activities will focus on deescalating the situation, establishing a stable home environment, initiating the mental health assessment, and facilitating follow-up to ensure ongoing support is available.

5. The on-call regional teams which will provide the initial response are also part of the FSP team thatwill provide follow-up services. These follow-up services will, minimally, include follow-up contacts for 72 hours; however, the intention is to provide a more sustained level of support (e.g., 1 to 4 months) during which time the family will be both served and linked to appropriate resources.

6. Through the collaborative assessment and intervention process, the SF/EW team members and family willidentify the current needs and best means to address those needs. The intention is for all youth who need assistance through the FURS hotline to be served as an FSP client until stabilized sufficiently to access ongoing care.

7. The SF/EW program will also connect with the assigned Social Worker (i.e., CFS staff) and ICC Coordinator to be part of the Child and Family Team (CFT) and will attend the Child and Family Team Meeting (CFTM) that should bescheduled in response to the FURS contact. This first CFTM after the crisis is an opportunity to review the members of the team to ensure that the team includes all possible natural supports who could promote the desired healing environment for the family.

8. The regional on-call SF/EW team will transition the child or youth into ongoing care from SF/EW. This FSP will coordinate all involved parties and ensure that the plan or strategy is followed. Additionally, if there is nocurrent behavioral health plan established, the SF/EW team will complete a collaborative assessment and establish an appropriate service plan. This would likely include a SF/EW team member assuming the responsibilities of the ICC Coordinator.

9. Success First/Early Wrap providers are also tasked with conducting an urgent response to initiate services to a youth who is temporarily staying at a CFS office or a shelter. The

expectation is that the SF/EW program will conduct an assessment within the 1-3 hour timeline, if needed, and begin providing intensive services including CFTMs throughout the stay in the office or shelter.

V. WRAPAROUND GEOGRAPHIC SERVICE AREAS

The SB 163 Wraparound Program Service Areas are provided for reference in this contract. While Success First/Early Wrap Contractors are assigned general areas which correspond to the wraparound geographical service areas, there is some overlap between providers. However, since Success First/Early Wrap is designed to work with Dependents and Wards who come from wraparound or need wraparound to address the family's needs more thoroughly it is believed helpful to have these areas readily available for providers.

West Valley		
ZIP	City	County
91701	Alta Loma, CA	San Bernardino
91737	Alta Loma, CA	San Bernardino
92316	Bloomington, CA	San Bernardino
91709	Chino Hills, CA	San Bernardino
91708	Chino, CA	San Bernardino
91710	Chino, CA	San Bernardino
92334	Fontana, CA	San Bernardino
92335	Fontana, CA	San Bernardino
92336	Fontana, CA	San Bernardino
92337	Fontana, CA	San Bernardino
91743	Guasti, CA	San Bernardino
92358	Lytle Creek, CA	San Bernardino
91763	Montclair, CA	San Bernardino
91758	Ontario, CA	San Bernardino
91761	Ontario, CA	San Bernardino
91762	Ontario, CA	San Bernardino
91764	Ontario, CA	San Bernardino
91798	Ontario, CA	San Bernardino
91701	Rancho Cucamonga, CA	San Bernardino
91737	Rancho Cucamonga, CA	San Bernardino
91729	Rancho Cucamonga, CA	San Bernardino
91730	Rancho Cucamonga, CA	San Bernardino
91739	Rancho Cucamonga, CA	San Bernardino
92376	Rialto, CA	San Bernardino
92377	Rialto, CA	San Bernardino
91784	Upland, CA	San Bernardino
91785	Upland, CA	San Bernardino
91786	Upland, CA	San Bernardino

Central Valley		
ZIP	**City**	**County**
92305	Angelus Oaks, CA	San Bernardino
92318	Bryn Mawr, CA	San Bernardino
92324	Colton, CA	San Bernardino
92339	Forest Falls, CA	San Bernardino
92313	Grand Terrace, CA	San Bernardino
92346	Highland, CA	San Bernardino
92350	Loma Linda, CA	San Bernardino
92354	Loma Linda, CA	San Bernardino
92357	Loma Linda, CA	San Bernardino
92359	Mentone, CA	San Bernardino
92369	Patton, CA	San Bernardino
92373	Redlands, CA	San Bernardino
92374	Redlands, CA	San Bernardino
92375	Redlands, CA	San Bernardino
92401	San Bernardino, CA	San Bernardino
92402	San Bernardino, CA	San Bernardino
92403	San Bernardino, CA	San Bernardino
92404	San Bernardino, CA	San Bernardino
92405	San Bernardino, CA	San Bernardino
92406	San Bernardino, CA	San Bernardino
92407	San Bernardino, CA	San Bernardino
92408	San Bernardino, CA	San Bernardino
92410	San Bernardino, CA	San Bernardino
92411	San Bernardino, CA	San Bernardino
92412	San Bernardino, CA	San Bernardino
92413	San Bernardino, CA	San Bernardino
92414	San Bernardino, CA	San Bernardino
92415	San Bernardino, CA	San Bernardino
92418	San Bernardino, CA	San Bernardino
92423	San Bernardino, CA	San Bernardino
92424	San Bernardino, CA	San Bernardino
92427	San Bernardino, CA	San Bernardino
92399	Yucaipa, CA	San Bernardino

High Desert		
ZIP	**City**	**County**
92301	Adelanto, CA	San Bernardino
92307	Apple Valley, CA	San Bernardino
92308	Apple Valley, CA	San Bernardino

92309	Baker, CA	San Bernardino
92311	Barstow, CA	San Bernardino
92312	Barstow, CA	San Bernardino
92323	Cima, CA	San Bernardino
92327	Daggett, CA	San Bernardino
92310	Fort Irwin, CA	San Bernardino
92342	Helendale, CA	San Bernardino
92340	Hesperia, CA	San Bernardino
92345	Hesperia, CA	San Bernardino
92347	Hinkley, CA	San Bernardino
92356	Lucerne Valley, CA	San Bernardino
92338	Ludlow, CA	San Bernardino
92366	Mountain Pass, CA	San Bernardino
92365	Newberry Springs, CA	San Bernardino
92364	Nipton, CA	San Bernardino
92368	Oro Grande, CA	San Bernardino
92329	Phelan, CA	San Bernardino
92371	Phelan, CA	San Bernardino
92372	Pinon Hills, CA	San Bernardino
93558	Red Mountain, CA	San Bernardino
93562	Trona, CA	San Bernardino
93592	Trona, CA	San Bernardino
92392	Victorville, CA	San Bernardino
92393	Victorville, CA	San Bernardino
92394	Victorville, CA	San Bernardino
92397	Wrightwood, CA	San Bernardino
92398	Yermo, CA	San Bernardino

Eastern Desert		
ZIP	**City**	**County**
92304	Amboy, CA	San Bernardino
92242	Earp, CA	San Bernardino
92332	Essex, CA	San Bernardino
92252	Joshua Tree, CA	San Bernardino
92285	Landers, CA	San Bernardino
92256	Morongo Valley, CA	San Bernardino
92363	Needles, CA	San Bernardino
92267	Parker Dam, CA	San Bernardino
92268	Pioneertown, CA	San Bernardino
92277	Twentynine Palms, CA	San Bernardino
92278	Twentynine Palms, CA	San Bernardino
92280	Vidal, CA	San Bernardino

92284	Yucca Valley, CA	San Bernardino
92286	Yucca Valley, CA	San Bernardino

Mountains to Arrowhead		
ZIP	**City**	**County**
92317	Blue Jay, CA	San Bernardino
92321	Cedar Glen, CA	San Bernardino
92322	Cedarpines Park, CA	San Bernardino
92325	Crestline, CA	San Bernardino
92326	Crest Park, CA	San Bernardino
92341	Green Valley Lake, CA	San Bernardino
92352	Lake Arrowhead, CA	San Bernardino
92378	Rimforest, CA	San Bernardino
92382	Running Springs, CA	San Bernardino
92385	Skyforest, CA	San Bernardino
92391	Twin Peaks, CA	San Bernardino

Mountains to Big Bear		
ZIP	**City**	**County**
92314	Big Bear City, CA	San Bernardino
92315	Big Bear Lake, CA	San Bernardino
92333	Fawnskin, CA	San Bernardino
92386	Sugarloaf, CA	San Bernardino

VI. DESCRIPTION OF SPECIFIC SERVICES TO BE PROVIDED

A. Mental Health Services Activities:

Mental health services are interventions designed to provide the maximum reduction of mental disability and restoration or maintenance of functioning consistent with the requirements for learning, development, independent living and enhanced self-sufficiency. Services shall be directed toward achieving the individual's goals/desired result/personal milestones. All recipients of services shall meet or exceed the target population descriptions.

EPSDT may not be billed on any client who is detained in a Juvenile Detention & Assessment Center (Juvenile Hall, Camp or Educational Facility) or who is admitted into an acute-care psychiatric hospital or facility.

All services listed below are potentially available for provision to a client; however, Therapeutic Behavioral Service (TBS) has additional qualifying criteria which must be met when provided, and not all children or youth served will meet these additional requirements.

1. Assessment is defined as a service activity designed to evaluate the current status of a child's mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the child's clinical

history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.

2. Evaluation is an appraisal of the individual's community functioning in several areas including living situation, daily activities, social support systems and health status. Cultural issues may be addressed where appropriate.

3. Therapy is defined as a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to a child or a group of children and may include family therapy at which the child is present.

4. Rehabilitation is a service activity that may include, but is not limited to, assistance in improving, maintaining, or restoring a child's or group of children's functional skills, daily living skills, social and leisure skills, and grooming and personal hygiene skills; obtaining support resources; and/or obtaining medication education.

    a. Assistance in restoring or maintaining an individual's or group of individual's functional skills, social skills, grooming, medication compliance, and support resources.

    b. Age-appropriate counseling of the individual and/or family, support systems and involved others.

    c. Training in leisure activities is needed to achieve the individual's goals/desired results/personal milestones.

    d. Medication education for family, support systems and involved others.

5. Plan Development is defined as a service activity that consists of development of client plans, approval of client plans, and/or monitoring and recording of a child's progress.

6. Medication Support Services include staff persons practicing within the scope of their professions by prescribing, administering, dispensing and/or monitoring of psychiatric medications or biological necessary to alleviate the symptoms of mental illness. This service includes:

    a. Evaluation of the need for medication.

    b. Evaluation of clinical effectiveness and side effects of medication.

    c. Obtaining informed consent.

    d. Medication education (including discussing risks, benefits, and alternatives with the individual or significant support persons).

    e. Plan development related to the delivery of this service.

7. Crisis Intervention is a quick emergency response service enabling the individual, his or her family, support system and/or involved others to cope with a crisis, while maintaining the child's status as a functioning family and/or "immediate community" member to the greatest extent possible, and in the least restrictive care as applicable. A crisis is an unplanned event that results in the individual's need for immediate service intervention. Crisis intervention services are limited to stabilization of the presenting emergency. This service does not include Crisis Stabilization, which is provided in a 24-hour health care

facility or hospital outpatient program. Service activities include but are not limited to assessment, evaluation, and therapy (all billed as crisis intervention).

8. Targeted Case Management means services that assist a beneficiary to access needed medical, educational, social, prevocational, rehabilitative, or other needed community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development. Targeted Case Management may be either face-to-face or by telephone with the child/youth or significant support systems and may be provided anywhere in the community.

9. Linkage and Consultation - The identification and pursuit of resources necessary and appropriate to implement the service plan, treatment plan or coordination plan, which include, but are not limited to the following:

   a. Interagency and intra-agency consultation, communication, coordination, and referral.

   b. Monitoring service delivery and service plan, treatment plan or coordination plan implementation to ensure an individual's access to service and the service delivery system.

10. Placement Services - Supportive assistance to the client in the assessment, determination of need and securing of adequate and appropriate living arrangements, including, but not limited to the following:

    a. Locating and securing an appropriate living environment.

    b. Locating and securing funding.

    c. Pre-placement visit(s).

    d. Negotiation of housing or placement contracts.

    e. Placement and placement follow-up.

11. Intensive Care Coordination (ICC)

    Within the Integrated Core Practices Model (ICPM) there is a need for thorough collaboration between all Child and Family Team (CFT) members. Planning within the ICPM is a dynamic and interactive process that addresses the goals and objective necessary to accomplish goals. The ICC coordinator is responsible for working within the CFT to ensure that plans from any of the system partners are integrated to comprehensively address the identified goals and objectives and that the activities of all parties involved with the service to the child/youth and/or family, are coordinated to support an ensure successful and enduring change.

    ICC is similar to the activities provided through Targeted Case Management. ICC must be delivered using a Child and Family Team to develop and guide the planning and services delivery process. ICC may be utilized by more than one mental health provider; however, there must an identified mental health ICC coordinator that ensure participation by the child or youth, family or caregiver and significant others so that the child/youth's

assessment and plan addresses the child/youth's needs and strengths in the context of the values and philosophy of the ICPM.

ICC must be provided, at a minimum, every 30 days. It should be provided more frequently if the situation warrants.

Activities coded as ICC may include interventions such as:

- Facilitation of the development and maintenance of a constructive and collaborative relationship among child/youth, his/her family or caregiver(s), other providers, and other involved child-serving systems to create a Child and Family Team (CFT);
- Facilitation of a care planning and monitoring process which ensures that the plan is aligned and coordinated across the mental health and child serving systems to allow the child/youth to be served in his/her community in the least restrictive setting possible;
- Ensure services are provided that equip the parent/caregiver(s) to meet the child/youth's mental health treatment and care coordination needs, described in the child/youth's plan;
- Ensure that medically necessary mental health services included in the child/youth's plan are effectively and comprehensively assessed, coordinated, delivered, transitioned and/or reassessed as necessary in a way that is consistent with the full intent of the Integrated Core Practice Model (ICPM);
- Provide active participation in the CFT planning and monitoring process to assure that the plan addresses or is refined to meet the mental health needs of the child/youth.

NOTE: ICC was initially developed solely for use with children with an open child welfare case who meet the 'Subclass' Criteria of a class action lawsuit; however, ICC is a service available to all EPSDT Medi-Cal beneficiaries in need of this service.

Contractor must provide ICC for all children with an open child welfare case who meet the criteria for the 'Subclass' at least once every thirty (30) days, as this is the least frequent level of coordination needed for this population.

ICC may be provided in any setting; however, when provided in a hospital, psychiatric health facility, community treatment facility, STRTP or psychiatric nursing facility, it may be used solely for the purpose of coordinating placement of the child/youth on discharge from those facilities and may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility as part of discharge planning.

Additional information on ICC may be obtained from the DHCS publication "Medical Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) & Therapeutic Foster Care (TFC) for Katie A. Subclass Members.

12. Intensive Home Based Services (IHBS) are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of the child/youth and his/her significant support persons and to help the child/youth develop

skills and achieve the goals and objectives of the plan. IHBS are not traditional therapeutic services.

Activities coded as IHBS may include interventions such as:

- Medically necessary skill-based interventions for remediation of behaviors or improvement of symptoms, including but not limited to the implementation of a positive behavioral plan and/or modeling interventions for the child/youth's family and/or significant other to assist them in implementing the strategies;
- Development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace non-functional behavior that interferes with daily living tasks or the avoidance of exploitation by others;
- Development of skills or replacement behaviors that allow the child/youth to fully participate in the CFT and service plans including but not limited to the plan and/or child welfare services plan;
- Improvement of self-management of symptoms, including self-administration of medications as appropriate;
- Education of the child/youth and/or their family or caregiver(s) about, and about to manage the child/youth's mental health disorder or symptoms:
- Support of the development, maintenance and use of social networks including the use of natural and community resources;
- Support to address behaviors that interfere with the achievement of a stable and permanent family life;
- Support to address behaviors that interfere with a child/youth's success in achieving educational objectives in an academic program in the community; and
- Support to address behaviors that interfere with transitional independent living objectives such as seeking and maintain housing and living independently.

NOTE: IHBS was initially developed solely for use with children with an open child welfare case who meet the 'Subclass' Criteria of a class action lawsuit; however, IHBS is a service available to all EPSDT Medi-Cal beneficiaries in need of this service.

IHBS was developed to be provided within the context of the Integrated Core Practice Model and requires the provision of ICC to ensure a participatory CFT. IHBS may be provided to all EPSDT Medi-Cal Beneficiaries in need of this service; however, IHBS still requires the provision of ICC to ensure a participatory coordination of services.

IHBS must be authorized through the authorization process established by the DBH ACCESS Unit. These requirements provided by DHCS shall be followed and as new requirements are published, the new requirements shall be followed.

IHBS are typically, but not only, provided by paraprofessionals under clinical supervision. IHBS is well-suited to be provided outside the STRTP setting to children/youth that are transitioning to a permanent home environment to facilitate the transition during single day and multiple day visits. IHBS may be provided within the STRTP setting.

Additional information on ICC may be obtained from the DHCS publication "Medical Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) & Therapeutic Foster Care (TFC) for Katie A. Subclass Members."

13. Therapeutic Behavioral Service (TBS) is a one-to-one behavioral mental health service available to children/youth with serious emotional challenges who are under age 21, and who are eligible for a full array of Medi-Cal benefits without restrictions or limitations. TBS helps children/youth/TAY (Transitional Age Youth), and their parents/caregivers, foster parents, STRTP staff and school staff learn new ways of reducing and managing challenging/ problematic behaviors, as well as strategies and skills to increase the kinds of behavior that will allow children/youth/TAY to be successful in their current environment and avoid more restrictive placements. Accordingly, TBS never exist alone, but are an adjunct, specialized service to an existing mental health service as above. **Contractor shall only provide TBS to EPSDT Medi-Cal beneficiaries enrolled in the agency's Success First/Early Wrap Program. Contractor shall NOT function as a TBS Program, but rather will be a program that includes TBS.**

    a. TBS Class Criteria: Emily Q Class members are defined as "all current and future beneficiaries of the Medicaid program under the age of 21 in California who:

        (1) are placed in a Rate Classification Level (RCL) facility of 12 or above and/or a locked treatment facility for the treatment of mental health needs, but not presently detained at Juvenile Detention Centers, IMD's or psychiatric hospitals (excluding Psychiatric Health Facility or where the child/youth/TAY is "at risk" only of being detained at Juvenile Detention Centers, IMD's or In-Patient Psychiatric Hospitals)

        (2) are being considered for placement in these facilities as an option to meet the child's/youth's/TAY's needs (not necessarily the only option and whether or not a RCL 12+ facility is actually available); or have at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months (not necessarily the only option and whether or not a RCL 12+ facility is actually available) or is at risk of hospitalization.

    b. TBS "Needs" Eligibility: Once the child/youth is identified as a TBS Class member, then the County as the Mental Health Provider must determine that the child/youth/TAY meets the "needs" criteria below:

        (1) child/youth/TAY is receiving other specialty mental health services; and

        (2) in the clinical opinion of the mental health provider, it is highly unlikely that without the additional short-term support of TBS, the child/youth/TAY:

            (a) will need to be placed out-of-home, or into a higher level of residential care, including acute care (e.g., acute psychiatric hospital inpatient services, psychiatric health facility services, and crisis residential treatment services), as a result of the child's/youth's/TAY's behaviors or symptoms which jeopardize continued placement, or

(b) needs this additional support to transition to a home or foster home or lower level of residential placement, or to stabilize the child's/ youth's behavior or symptoms in a new environment/placement.

c. Therefore, Medi-Cal Reimbursement TBS criteria are:

(1) be a full-scope Medi-Cal beneficiary under the age of 21,

(2) meet MH "medical necessity",

(3) be receiving a Medi-Cal mental health service to be supported by TBS short-term interventions, and;

(4) be a member of the TBS certified class (above) or must have previously received TBS while a member of the certified class.

d. TBS is ***NOT*** reimbursable as or when:

(1) services rendered for the convenience of the family or other caregivers, physician, or teacher;

(2) supervision or services provided to assure compliance with Probationary terms;

(3) supervision to ensure the child's/youth's/TAY's safety or safety of others;

(4) services rendered to address conditions that are not part of the child's/youth's/TAY's mental health condition;

(5) services to children/youth/TAY who can sustain non-impulsive, self-directed behavior, handle themselves appropriately in social situations with peers, and who are able to appropriately handle transitions during the day; and

(6) services to children/youth/TAY who will never be able to sustain non-impulsive, self-directed behavior and engage in appropriate community activities without full-time supervision; or when the beneficiary is an inpatient of a hospital, psychiatric health facility, nursing facility, Institutions for Mental Diseases (IMD), or crisis residential program.

e. TBS Services

(1) TBS Assessment is a clinical analysis of the history and current status of the individual's mental, emotional, or behavioral disorder. Relevant cultural issues and history should be included where appropriate. Assessment may include diagnosis. A TBS assessment also includes identifying the child/youth's target behaviors and/or symptoms that jeopardize continuation of the current residential placement or may interfere in transition to a lower level of care. The assessment must be comprehensive enough to identify that the minor meets medical necessity, is a full-scope Medi-Cal beneficiary under 21 years of age and is a member of the "certified class", and that there is a need for specialty mental health services in addition to TBS. This service is not always a direct face-to-face service.

(2) TBS Collateral is contact with one or more significant support person in the life of the beneficiary, which may include consultation and training to assist in better utilization of TBS services and understanding of mental illness, the behaviors and symptoms being targeted. TBS collateral services can be used in such cases when a TBS Coach or TBS Clinician contacts the therapist providing the mental health services, or beneficiaries caregivers (parent, teacher, STRTP staff, neighbor, siblings, etc.), as long as it directly relates to the TBS treatment plan. As a rule, if the Contractor is providing services that are linked to target behaviors or TBS treatment plan and the beneficiary is not present, then the Contractor would be delivering "Collateral TBS." An example of "Collateral TBS" would be when the Contractor is working with the parent/caregiver towards the goals of the minor's TBS treatment plan, or while conducting a TBS Treatment Team meeting. TBS collateral contacts must be with individuals identified as significant in the child/youth's life and be directly related to the needs, goals and interventions for the child/youth identified on the TBS Treatment Plan. This service can be delivered either face-to-face or by phone.

(3) TBS Plan Development may include any or all of the following:

(a) Development and approval of treatment or service plans.

(b) Verification of service necessity.

(c) Monitoring of the individual's progress.

(4) TBS Coach Time - is a service that includes one-to-one (face-to-face) therapeutic contact between a mental health provider (TBS Coach) and a beneficiary for a specified short-term period of time, which is designed to maintain the child/youth's placement at the lowest appropriate level by resolving target behaviors and achieving short-term goals.

(a) TBS Coach Time may not begin until the initial assessment is completed.

(b) The majority of TBS billing should fall under this category.

B. Parent Partner

A basic tenet of DBH Children's Services is the involvement of parents and families of children and youth with serious emotional disturbances as full partners in every aspect of the system. To support this basic tenet, DBH developed Parent Partner Network Meetings as a venue to ensure that families and youth have an equal voice and that services meet the needs identified by families and are sensitive to the unique cultural context and history of each family.

To support this basic tenet of DBH Children's Services, the Contractor shall hire one paid Parent Partner who is a parent or family member of a child with serious emotional disturbance to work closely with DBH Parent Partners. The duties and responsibilities of Parent Partners are either administrative or claimable as an allowable billable service, but not both.

Parent Partners are expected to provide the following services:

1. Offer referral and support services to families.

2. Ensure services meet the needs identified by families.
3. Accompany the families to Individualized Education Plan (IEP) meetings.
4. Facilitate parent support groups.
5. Provide in-home support services.
6. Promote collaboration among families, advocates, mental health providers, health care providers and other agency/school personnel.
7. Attend the DBH Regional Parent Partner Network Meeting.
8. Outreach to family members in the community.

Parent Partners may conduct and bill EPSDT Medi-Cal for the following specific activities:

- Case Management: Linkage and Consultation
- Case Management: Intensive Care Coordination
- Mental Health Service: Rehabilitation/Activities of Daily Living (ADL)

C. Coordination of Care (If Applicable)

Contractor shall deliver care to and coordinate services for all of its beneficiaries by doing the following [42 C.F.R. § 438.208(b)]:

1. Ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. The beneficiary shall be provided information on how to contact their designated person or entity [42 C.F.R. § 438.208(b) (1)].
2. Coordinate the services Contractor furnishes to the beneficiary between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. Coordinate the services Contractor furnishes to the beneficiary with the services the beneficiary receives from any other managed care organization, in FFS Medicaid, from community and social support providers, and other human services agencies used by its beneficiaries [(42 C.F.R. § 438.208(b)(2)(i)-(iv), CCR, title 9 § 1810.415.]

VII. HOURS OF PLANNED OPERATION

A. The Contractor facility will be open Monday through Friday. The main clinic office shall be open 40 hours per week and offer clinical services to clients during some evening and/or weekend hours.

B. Contractor staff will be available 24 hours per day to address the regular and emergency needs of the program's clients. Outpatient services will be available seven days a week and evening hours as determined by the appropriate DBH Program Manager or designee.

C. Contractor must have emergency on-call crisis services for all clients being served in the program, which includes emergency responses availability, call back staff, assessment of suicide ideation and other crisis responses as needed. Contractor will have daily on-duty staff rotating on a weekly basis and will be available after normal working hours and on weekends (e.g., through an answering service).

D. Changes to this plan shall be submitted to the appropriate DBH Program Manager in writing, signed and in hard copy, for approval thirty (30) days prior to implementation.

E. As noted earlier, contractors will maintain the ability to respond to FURS referrals 24 hours per day 365 days per year. This will include an on-call schedule to be maintained Monday through Friday between 5 p.m. to 8 a.m. and 24/7 on weekends and Holidays. Note: This requirement will be met as a shared responsibility by awarded vendors who, collectively, will maintain a rotating schedule when possible.

VIII. BILLING UNIT

The billing unit for mental health services, rehabilitation, medication support services, crisis intervention and case management is staff time, based on minutes of time. The exact number of minutes used by staff providing a reimbursable service shall be reported and billed. In no case shall more than 60 units of time be reported or claimed for any one staff person during a one-hour period. Also, in no case shall the units of time reported or claimed for any one staff member exceed the hours worked.

When a staff member provides service to or on behalf of more than one individual at the same time, the staff member's time must be pro-rated to each individual. When more than one staff person provides a service, the time utilized by all involved staff members shall be added together to yield the total billable time. The total time claimed shall not exceed the actual staff time utilized for billable service. The time required for documentation and travel shall be linked to the delivery of the reimbursable service and shall not be separately billed.

IX. FACILITY LOCATION

Contractor's facility (ies) where outpatient services are to be provided is/are located at:

Central Valley: 572 N. Arrowhead Ave.
San Bernardino, CA 92401

Locations are subject to prior approval by DBH. All facilities must be Medi-Cal certified prior to the provision of services.

The locations for services may change in order to best serve the needs of San Bernardino County residents. Any location change shall be approved by the Director or designee, to ensure that all applicable laws and regulations are followed, and all contract requirements are met.

A. The Contractor shall obtain the prior written consent of the Director of DBH or the designee before terminating outpatient services at the above referenced location(s) or providing services at another location.

B. The Contractor shall comply with all requirements of the State DHCS to maintain Medi-Cal Certification and obtain necessary fire clearances. Short-Doyle/Medi-Cal Contractors must notify the DBH Program Manager at least sixty (60) days prior to a change of ownership or a change of address. The Contractor shall work with the DBH Program Manager to obtain a new provider number from the State if necessary.

C. The Contractor shall provide adequate furnishings and clinical supplies to do outpatient services in a clinically effective manner.

D. The Contractor shall maintain the facility exterior and interior appearances in a safe, clean, and attractive manner.

E. Non-smoking signs shall be clearly posted to the exterior of the building stating: "No Smoking within 20 feet of the Building – Assembly Bill 846, Chapter 342."

F. The Contractor shall have adequate fire extinguishers and smoke alarms, as well as a fire safety plan.

G. The Contractor shall have an exterior sign clearly indicating the location and name of the clinic.

H. The Contractor shall have clinic pamphlets identifying the clinic and its services, in threshold languages, for distribution in the community.

I. If applicable, Contractor shall have hours of operation posted at the facility and visible to consumers/customers that match the hours listed in the Contract. Contractor is responsible for notifying DBH of any changes in hours or availability. Notice of change in hours must be provided in writing to the DBH Access & Referral Unit at fax number 909-890-0353, as well as the DBH program contact overseeing the Contract.

X. STAFFING

A. Staff Hours of Coverage and Documentation

1. Staff coverage should be appropriate to meet the children's and family's mental health needs. This will include, but not be limited to, having after-hours resources and being able to provide some services (e.g., TBS) throughout the day as needed. An initial agency Organizational Chart will be provided to DBH within 30 days of contract signing which includes staff name, title, email, and phone contact information.

2. A staff roster must be kept current and must be provided to DBH Program Manager or designee (e.g., contract monitor). Vacancies or changes in staffing plan shall be submitted to the DBH Program Manager within 48 hours of Contractor's knowledge of such occurrence, in the form of an updated Organizational Chart. Such notice shall include a plan of action to address the vacancy or a justification for the staffing plan change.

B. General Staff Requirements

1. All staff shall be employed by the Contractor.

2. The staff described will work the designated number of hours per week in full time equivalents (FTE's), perform the job functions specified and shall meet the California Code of Regulations requirements.

3. All staff functioning as a master's level, or above, clinician and providing services with DBH funding shall be licensed or have their licensed waived by the State.

4. All field staff must be CPR/First Aid trained; and an appropriate number (i.e., 1 or more depending on size of program) CPR/First Aid trained staff shall be on duty in the office during ALL hours of operation/shifts.

5. Staff shall reflect the ethnic population of the community served.

C. Specific Descriptions of Staff Qualifications and Job Functions

All staff shall be employed by the Contractor, with the exception of psychiatrists who may conduct Medication Support Services for the provider under and sub-contracting relationship.. The staff described will work the designated number of hours per week in full time equivalents (FTE's), perform the job functions specified and shall meet the California Code of Regulations

requirements. All staff functioning as a clinical therapist and providing services with DBH funding shall be licensed or have their licensed waived by the State. Staff shall reflect the ethnic population of the community served.

1. Physician/Clinician/Professional Staff – Clinical services and supervision of the program shall be the responsibility of a licensed clinical professional: Licensed Psychologist (Ph.D.), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC) or Marriage and Family Therapist (MFT), who possess experience developing behavioral treatment plans for and working with emotionally and behaviorally disturbed children, as well as their families/care providers. Mental Health Services may include a variety of assessment, evaluation, collateral, and therapy activities, which support the child's residential placement, or transition to the least restrictive level of community care, and may be provided by a pre-licensed psychologist, clinical social worker, and/or marriage and family therapist under the supervision of a licensed clinician.

   In addition to providing therapuetic services Clinicians are expected to fulfill one or more of the following roles:

   a. ICC Coordinator - Within the Integrated Core Practices Model (ICPM) there is a need for thorough collaboration between all Child and Family Team (CFT) members. Planning within the ICPM is a dynamic and interactive process that addresses the goals and objectives necessary to accomplish goals. The ICC Coordinator is responsible for working within the CFT to ensure that plans from any of the system partners are integrated to comprehensively address the identified goals and objectives and that the activities of all parties involved with the service to the child/youth and/or family, are coordinated to support and ensure successful and enduring change. For ease of identification purposes, the name of the ICC Coordinator for each youth is to be entered into the client record in Objective Arts. **NOTE**: This role may be one of the responsibilities of a clinical staff who has other duties as well.

   b. Child and Family Team Meeting Facilitator –Together with the client's family and their natural team members, the Facilitator serves as the hub of the process and collaboratively orchestrates the development of the Individualized Child and Family Plans. Each Facilitator is required to hold a Master's Degree in a field related to mental health services (e.g., Social Work, Family Therapy, and Psychology). The Facilitator must attend the DBH training on CFT Meetings prior to facilitating CFT meetings.

   c. Family Clinician –The Family Clinician's role is to help the family maintain or develop stability. The Family Clinician may also assist a new client and his/her family to stabilize during times of family upheaval and/or to achieve mutually established safety goals.

   d. TBS Clinician/Supervisor - Clinical services and supervision of TBS shall be the responsibility of a licensed clinical professional: Psychologist (Ph.D. or Psy.D.), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC) or Marriage and Family Therapist (MFT), who possesses experience developing behavioral treatment plans for and working with emotionally and behaviorally disturbed children/youth and their families/care providers. This

individual will oversee the Initial Treatment Planning meeting to develop the TBS treatment plan and provide ongoing therapeutic supervision of services. The TBS Supervisor will complete the treatment plan with the assistance of the TBS coach. Both the clinician (TBS Supervisor) and the coach are involved in the monthly meetings. The TBS supervisor will meet weekly with TBS coach to provide supervision. The TBS supervisor cannot be the same as the Specialty Mental Health Provider (SMHP).

2. Mental Health Rehabilitation Specialist – Mental Health Rehabilitation Specialists provide non-therapy mental health services, which may, if qualified, be billed for EPSDT Medi-Cal. The minimum requirements for this position are one of the following: (1) Thirty semester (45 quarter) units of completed college coursework in behavioral or social science; (2) Sixty semester (90 quarter units) of completed college coursework, which includes 15 semester (23 quarter) units in behavioral science; or (3) one year of experience providing direct mental health services under supervision of a licensed clinician. **NOTE**: A Bachelor's degree in behavioral or social science may be listed in lieu of detailed coursework. Psychiatric Technician (Psych. Tech.) courses and Alcohol and Drug Certificate courses that are completed as components of a vocational program are acceptable.

3. Family or Parent Partner – This position is defined as a parent who is hired as staff, has personal experience with a special needs youth, and can provide support. Parent Partners must have personal parenting experience with an emotionally/behaviorally-disturbed child. This staff member's role is to provide support and education to the client family and may conduct the following billable services:

    - Case Management: Linkage and Consultation
    - Case Management: Intensive Care Coordination
    - Mental Health Service: Rehabilitation/Activities of Daily Living (ADL)

4. Program Supervisor - Under general direction, this individual supervises the operation and staff of a clinic. A Program Supervisor must be licensed in California as a Marriage and Family Therapist, a Clinical Social Worker, or a Psychologist. The duties of the Program Supervisor include supervision of Clinical Therapists and other support staff and planning and coordination of the work of the clinic staff. The Program Supervisor shall also act as a resource for therapists on issues related to treatment on specific cases or types of cases, review treatment plans and therapeutic techniques utilized, ensure that therapists provide treatment within the scope of licensure, provide comprehensive psychotherapeutic treatment services for the most severely disturbed clients, perform diagnostic evaluations, and develop and implement treatment plans and conduct therapy within the scope of the license.

5. Psychiatrist – This individual must be a licensed physician who has a psychiatric specialty to diagnose or treat mental illness or condition (unless waived in writing by the Director or designee prior to delivery of services). For the purposes of this program, psychiatric services may only be provided by physicians who practice individually or as a member of a group psychiatric practice. For this contract, psychiatrists may provide services under a sub-contract.

6. Coaches – Coaching staff are appropriate for this program due to the inclusion of TBS and IHBS services. The Coach must possess a Bachelor's degree in a behavioral sciences field or 30-45 quarter units of completed college coursework, half of which must be upper division in behavioral science and at least two (2) years of experience working with youth-at-risk and or dually-diagnosed children/youth in residential, community or school settings. Completion of certification in First Aid and CPR are expected within 3 months of starting employment. Knowledge in behavioral management techniques and implementation of behavioral treatment plans is desired. Staff providing IHBS must have training in behavioral analysis with an emphasis on positive behavioral interventions. The IHBS coach must be available at the designated site of service to:

   a. Provide structure and support

   b. Assist the child/youth in engaging in appropriate activities

   c. Minimize impulsivity

   d. Increase social and community competencies by building or restating those daily living skills that will assist the child/youth to live successfully in the community

   e. Serve as a positive role model and assist the child/youth in developing the ability to sustain self-directed appropriate behaviors, internalize a sense of social responsibility, and/or enable appropriate participation in community activities.

   f. Be available to participate in weekly/monthly treatment plan meetings and conference calls requiring input and feedback regarding the progress of the intervention and continuing client needs.

   g. Coaches must successfully complete a TBS training program and must obtain the following clearances:

      (1) Department of Justice fingerprint check

      (2) California Driver's License DMV printout

      (3) TBS Coaches must possess a valid California driver's license and have access to a vehicle

7. Volunteers - Volunteers are unpaid, unlicensed staff which provide informal supports. Volunteers must still comply with the County's HIPAA training before rendering any service.

   NOTE: The contractor should utilize both "non-professional" and "professional" staff in the provision of "formal" and "informal" supports. The term "professional" denotes licensure or certification at a minimum, "formal" supports would be those that are required or recommended by the professional licensure or certification in the practice of their specialty. "Non-Professional" would refer more typically to "Parent/Family Partners/Advocates" or non-agency staff (e.g., friends, religious leaders) providing non-clinical supports to or on behalf of Families and the child/youth.

D. Additional Roles Required for Staff

Contractor is responsible for ensuring all staff are provided sufficient support to maximize their utilization of various data systems which will be utilized during their contract term. Currently, this

includes utilization of Objective Arts, the CANS-SB tracking and reporting system and transactional database system, and the local billing system. The expectation is that Contractor will have enough staff fully trained in these systems and functioning as subject matter experts (SME) so that they are able to support other staff as needed. Contractor is also responsible for assigning staff as points of contact for other consumer designated programs.

This responsibility may be assigned to any appropriate staff in any position, but the Contractor must clarify how this requirement will be met and maintained for the duration of the contract.

The roles to be assigned to agency staff are:

- Objective Arts Super User (SME)
- CANS-SB Super User
- myAvatar Super User
- FTP User (2)
- AB 1299 Point of Contact
- Katie A. Liaison
- Hospital Liaison

NOTE: At DBH's request, Contractor will provide complete job descriptions for each classification provided pursuant to the terms of this agreement.

E. Licensure / Certification Requirements

1. Personnel will possess appropriate licenses and certificates and be qualified in accordance with applicable statutes and regulations. Additionally, all copies of licenses and waivers will be provided to the DBH Program Manager or designee (e.g., contract monitor) on a regular basis to be kept current.

2. Contractor will obtain, maintain, and comply with all required government authorizations, permits and licenses required to conduct its operations. In addition, Contractor will comply with all applicable Federal, State, and local laws, rules, regulations and orders in its operations. This includes compliance with all applicable safety and health requirements as to the Contractor's employees. Contractor will notify County immediately of loss or suspension of any such licenses and permits.

F. Professional Development and Training Requirements

1. Contractor will provide education and training to staff and make staff available to attend required trainings and workgroups related to DBH policies, procedures, documentation, and outcomes management. This includes, but is not limited to, the following events conducted by CYCS:

   a. CANS Supervisor Training

   b. CANS Supervisor Workgroup

2. Contractor clinical staff that will be working with DBH consumers will register for required DBH Clinical Trainings within 7 days of hire. These trainings include, but are not limited to, the following trainings:

a. Praed Foundation On-Line – Must pass final review on line

b. TCOM Post-Certification Training

c. Chart Documentation Training

d. CFTM Training

3. To ensure all staff have the skills needed for their position, the Contractor will provide education and training to staff and make staff available to attend trainings related to the clinical services provided. This will include, but not be limited to, the following topics:

a. Integrated Core Practice Model and Wraparound values, principles, philosophy, and necessary skill-development.

b. Child and Family Team Meeting Facilitation

c. Risk assessment

d. Clinical trainings targeting increasing cultural competencies. DBH has the expectation that all clinical staff will attend at least, four (4) hours of this type of training each year.

e. Trauma informed care

f. Child and Adolescent Needs and Strengths-San Bernardino (CANS-SB)

4. Contractor shall provide additional trainings to aid in the provision of TBS, including training on:

a. Services to culturally diverse children and their families

b. Trauma informed care

c. Clinically appropriate interventions for specific sub-populations

d. On-going training and in-service for staff regarding TBS and behavioral techniques. These ongoing trainings must incorporate the current versions of support documents developed as tools to aid the implementation of TBS; these currently include:

(1) Therapeutic Behavioral Services (TBS) Coordination of Care Best Practices Manual

(2) Therapeutic Behavioral Services (TBS) Documentation Manual 2.0

G. Background Checks, Criminal Records Review, DOJ Clearances, any Other Required Clearances:

1. Department of Justice fingerprint clearance

Vendor shall obtain from the Department of Justice (DOJ) records of all convictions involving any sex crimes, drug crimes, or crimes of violence of a person who is offered employment or volunteers for all positions in which he or she would have contact with a minor, the aged, the blind, the disabled or a domestic violence client, as provided for in Penal Code Section 11105.3. This includes licensed personnel who are not able to provide documentation of prior Department of Justice clearance. A copy of a license from the State of California is sufficient proof.

2. California Driver's License DMV printout

3. Excluded Parties List Clearance.

   Neither Vendor nor its employees or sub vendors shall be named on the EPLS, which includes information regarding entities debarred, suspended, proposed for debarment, excluded or disqualified under the non-procurement common rule, or otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. The EPLS can be accessed at http://www.epls.gov/. This information may include names, addresses, DUNS numbers, Social Security Numbers (SSNs), Employer Identification Numbers or other Taxpayer Identification Numbers, if available and deemed appropriate and permissible to publish by the agency taking the action. Please be aware that although United States General Service Administration operates this system, individual agencies are responsible for the timely reporting, maintenance, and accuracy of their data.

H. Number of Staff Fluent in Other Languages

There must be direct service staff with bilingual (Spanish) ability available. Contractor should also obtain other linguistic/translation capacity if warranted, including collaboration with the DBH Program Manager on resource identification.

XI. ADMINISTRATIVE AND PROGRAMMATIC REQUIREMENTS

A. Contractor must start providing assessment and treatment services as soon as possible, but no later than ninety (90) days from the contract start date

B. Contractor must obtain and maintain Medi-Cal certification in order to bill EPSDT Medi-Cal for services provided to Medi-Cal eligible children/youth. Contractor must submit Medi-Cal certification paperwork to assigned DBH Program Manager within thirty (30) days of the start date of the contract. Not obtaining Medi-Cal certification within ninety (90) days from the contract start date may result in contract termination.

C. Contractor must comply with all requirements of the State DHCS to maintain Medi-Cal certification and obtain necessary fire clearances. Short-Doyle/Medi-Cal Contractors must notify DBH at least sixty (60) days prior to change of ownership or change of address.

D. The Contractor will provide services in a culturally and linguistically sensitive manner. This includes providing information in the appropriate languages and providing information to persons with visual and hearing impairments.

E. The Contractor will provide services in the most appropriate setting (e.g., home, school, clinic, or community).

F. The Contractor must comply with California Vehicle Restraint Laws which state that children transported in motor vehicles must be restrained in the rear seat until they are eight years old or are at least 4 feet 9 inches in height.

G. The Contractor shall abide by the criteria and procedures set forth in the Uniform Method of Determining Ability to Pay (UMDAP) manual consistent with State regulations for mental health programs. The Contractor shall not charge mental health patients in excess of what UMDAP allows.

H. The Contractor shall maintain client records in compliance with all regulations set forth by the State DHCS and provide access to clinical records by DBH staff. Contractor will satisfy and provide for meeting State DHCS Outcome study requirements.

I. The Contractor shall maintain ongoing compliance with Medi-Cal Utilization Review requirements and Medicare record keeping requirements. The Contractor will participate in on-going Medi-Cal audits by the State DHCS. A copy of the plan of correction regarding deficiencies will be forwarded to the DBH.

J. The Contractor shall maintain high standards of quality of care for the units of service, which it has committed to provide.

1. The Contractor will make every effort to recruit bilingual staff in order to meet community needs.
2. The Contractor's staff shall hold regular case conferences to evaluate the effects of treatment and the need for continued treatment.
3. Summary copies of internal peer review conducted shall be provided to the DBH Program Manager, or designee, upon request.

K. The Contractor shall ensure that Satisfaction Surveys are provided to beneficiaries and parent/caregivers upon completion/termination of this contract

L. The Contractor shall attend, or send an appropriate representative, to all designated Program and/or Agency meetings as notified by DBH.

M. The Contractor shall participate in the DBH's annual evaluation of the program and shall make required changes in areas of deficiency.

N. The Contractor shall allow visits by the DBH Program Manager, or designee, at any time for review of records, contract requirements, or for audit purposes.

O. The Contractor shall provide periodic program reports, as required by DBH.

P. The Contractor shall ensure that there are adequate budgeted funds to pay for all necessary treatment staff, supplies and tools.

Q. The Contractor shall maintain a separate and clear audit trail reflecting expenditure of funds under this agreement.

R. The Contractor shall make available to the DBH Program Manager, or designee, copies of all administrative policies and procedures utilized and developed for service location(s) and shall maintain ongoing communication, which may include electronic mail, with the Program Manager or designee regarding those policies and procedures.

S. Upon the termination of the contract and discontinuance of the provision of services, all records shall be provided to the county in an organized manner within 60 days of the termination of the contract and discontinuance of services.

T. In addition, if proper documentation is not received by the DBH, payment(s) may be withheld until Contractor is in compliance with terms and conditions of the contract. This includes such provisions as certificate(s) of insurance, staff changes, reduction or change in staff and documentation regarding all licensed staff.

U. If applicable, Contractor shall have written procedures for referring individuals to a psychiatrist when necessary, or to a physician, if a psychiatrist is not available.

V. The main clinic office will be available a minimum of forty (40) hours per week by appointment. Services will primarily be field-based in the natural settings of the child and parent and access will be available 24 hours per day through answering system and paging system.

W. If applicable, Contractors are required to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the hours of operation must be comparable to the hours made available for Medi-Cal services that are not covered by Contractor or another Mental Health Plan; i.e., must be available during the times that services are accessible by consumers based on program requirements.

XII. DEPARTMENT OF BEHAVIORAL HEALTH RESPONSIBILITIES

A. The DBH shall provide technical assistance to the Contractor regarding EPSDT/Medi-Cal requirements, as well as charting and Utilization Review requirements.

B. The DBH shall participate in evaluating the progress of the overall program regarding responding to the mental health needs of the target population.

C. The DBH shall monitor the Contractor on a regular basis regarding compliance with all of the above requirements.

D. The DBH shall provide linkages with the Comprehensive Mental Health System of Care to assist Contractor in meeting the needs of its clients.

XIII. OUTCOME MEASURES AND DATA REPORTING REQUIREMENTS

A. Process Measures:

1. Ninety percent (95%) of all San Bernardino County Medi-Cal beneficiaries will receive their first treatment service within 21 days of enrollment in the program.

2. The average number of EPSDT Specialty Mental Health Services Hours provided to a client who meets medical necessity will be 2.5 per week during the first three (3) months of service provision.

3. Ninety percent (90%) of foster children identified as "Sub-Class Members" in accordance with the Integrated Core Practice Model and the Kate A. Settlement will be provided Intensive Care Coordination (ICC) at least once per month.

4. Average number of days between the client's first assessment and first treatment service, excluding the upper 5%, will be less than 7 days.

5. Average number of EPSDT Specialty Mental Health Service Hours provided to a client who meets medical necessity will be more than 4 hours per month.

6. Average number of days between EPSDT services, excluding the upper 5%, will be less than 7 days.

7. At least 95% of all billable services provided during a specific month will be included in the monthly billing which is submitted by the seventh (7^{th}) day of the following month.

8. Information for at least 95% of all clients who are either "opened" or "closed" for mental health services will be provided to DBH through the appropriate means within five (5) working days of the admission and discharge.

B. Data Reporting Elements including when data is due, how it should be submitted, and any other specifics:

1. Data is gathered through the billing systems, which will be completed by the seventh (7^{th}) day of the month following the billing for the previous month's Medi-Cal based services.

2. Exception is the "opening" and "closing" of clients within the County's current billing and transactional database system. This will be done within five (5) working days of admission and discharge from the facility.

3. Data shall be entered, either directly or through batch upload processes, into Objective Arts at least every two weeks.

4. Vendor shall enter all required data into the DCR within the timeframes prescribed for FSPs.

5. Vendor shall submit Monthly Program reports to DBH, in a format accpetable to DBH, containing at a minimum the following information:

   a. Name, date of birth, and ethnicity of each child in the Contractor's Wraparound program.
   b. Medi-Cal eligibility status.
   c. Date of program enrollment of each child.
   d. Name and position title of key staff assigned to each child and family.
   e. Update on status of each family receiving services.
   f. Any information obtained from client completion interview, and/or any follow-up contacts.
   g. Date of program completion or discharge date of each child.

C. Use of The Child and Adolescent Needs and Strengths Assessment - San Bernardino (CANS-SB): The CANS-SB shall be completed:

1. Within thirty (30) days of admission,

2. Every three (3) months, and

3. Within thirty (30) days of discharge.

4. Clarifications:

   a. A CANS-SB is not required at admission if the client does not meet the criteria for services **AND** there is deemed insufficient information to complete the CANS-SB accurately.

   b. In no case shall a period of more than three (3) months pass without completing a CANS-SB.

   c. A CANS-SB is not required at discharge if a three (3) month (i.e., Update) CANS-SB, was administered within the past thirty (30) days **AND** no significant change in the client's presentation has occurred.

D. Program Goals:

1. Provide services appropriate to needs based on functioning and cultural background.
2. Provide effective services that are continually reviewed and revised as needed.
3. Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth.

E. Key Outcomes:

1. Key Outcome related to service appropriateness:
   a. Services match the individual consumer's needs and strengths in accordance with system-of-care values and scientifically derived standards of care.
2. Key Outcomes related to service effectiveness:
   a. Improved functioning.
   b. Reduction in symptom distress.
   c. Improvement in work or school performance.
   d. Well-being and positive health.
   e. Treatment Involvement.
   f. Progress to Goals.
   g. Discharge Preparation.
   h. Caregiver Participation.
   i. Caregiver Interaction.
3. Key Outcomes related to reducing subjective suffering:
   a. Increased resiliency.
   b. Decreased Core Actionable Items report (CAIR) Scores.
   c. Decreased impairment in general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal/social).