AMENDMENT NO. 1
TO MENTAL HEALTH SERVICES AGREEMENT A-13221
BETWEEN COUNTY OF MONTEREY AND
INTERIM, INC.

THIS AMENDMENT is made to the AGREEMENT A-13221 for mental health services and supportive housing for mental health consumers by and between **INTERIM, INC.**, hereinafter "CONTRACTOR", and the **County of Monterey**, a political subdivision of the State of California (hereinafter referred to as "COUNTY."

WHEREAS, the COUNTY and CONTRACTOR wish to amend the AGREEMENT revise the EXHIBIT A: PROGRAM DESCRIPTION; COMMUNICATION AND COORDINATION BETWEEN CONTRACTOR AND COUNTY; REPORTING REQUIREMENTS; the EXHIBIT B: PAYMENT AND BILLING PROVISIONS; the EXHIBIT G: BEHAVIORAL HEALTH COST REIMBURSEMENT INVOICE; and the EXHIBIT H: BUDGET AND EXPENDITURE REPORT.

NOW THEREFORE, the COUNTY and CONTRACTOR hereby agree to amend AGREEMENT in the following manner:

1. EXHIBIT A-1: PROGRAM DESCRIPTION; COMMUNICATION AND COORDINATION BETWEEN CONTRACTOR AND COUNTY; REPORTING REQUIREMENTS replaces EXHIBIT A. All references in the Agreement to EXHIBIT A shall be construed to refer to EXHIBIT A-1.

2. EXHIBIT B-1: PAYMENT AND BILLING PROVISIONS replaces EXHIBIT B. All references in the Agreement to EXHIBIT B shall be construed to refer to EXHIBIT B-1. The revisions are limited to the following: Program Six: Shelter Cove and Program Eight: Lupine Gardens.

3. EXHIBIT G-1: BEHAVIORAL HEALTH COST REIMBURSEMENT INVOICE replaces EXHBIT G. All references in the Agreement to EXHIBIT G shall be construed to refer to EXHIBIT G-1. The revisions are limited to the following: Program Six: Shelter Cove and Program Eight: Lupine Gardens.

4. EXHIBIT H-1: BUDGET AND EXPENDITURE REPORT replaces EXHBIT H. All references in the Agreement to EXHIBIT H shall be construed to refer to EXHIBIT H-1. The revisions are limited to the following: Program Six: Shelter Cove and Program Eight: Lupine Gardens.

5. Except as provided herein, all remaining terms, conditions and provisions of the AGREEMENT are unchanged and unaffected by this AMENDMENT and shall continue in full force and effect as set forth in the AGREEMENT.

6. This Amendment No. 1 shall be effective March 1, 2017.

7. A copy of this AMENDMENT shall be attached to the original AGREEMENT executed by the COUNTY on July 14, 2016.

(The remainder of this page is intentionally left blank.)

IN WITNESS WHEREOF, COUNTY and CONTRACTOR have executed this Amendment No. 1 to Agreement A-13221 as of the day and year written below.

COUNTY OF MONTEREY

By: _____
Contracts/Purchasing Officer

Date: 3-1-17

By: _____
Department Head

Date: 3/3/17

Approved as to Form [1]

By: _____
County Counsel

Date: 2/24/17

Approved as to Fiscal Provisions[2]

By: _____
Auditor-Controller

Date: 2/27/17

Approved as to Liability Provisions[3]

By: _____
Risk Management

Date: _____

CONTRACTOR

INTERIM, INC.
Contractor's Business Name*

By: _____
(Signature of Chair, President, or Vice-President)*

Barbara L. Mitchell
Name and Title Executive Director

Date: 2/20/17

By: _____
(Signature of Secretary, Asst. Secretary, CFO, Treasurer or Asst. Treasurer)*

Pal: Weerasekera
Director of Finance
Name and Title

Date: 2/20/17

*INSTRUCTIONS: If CONTRACTOR is a corporation, including limited liability and non-profit corporations, the full legal name of the corporation shall be set forth above together with the signatures of two specified officers. If CONTRACTOR is a partnership, the name of the partnership shall be set forth above together with the signature of a partner who has authority to execute this Agreement on behalf of the partnership. If CONTRACTOR is contracting in an individual capacity, the individual shall set forth the name of the business, if any, and shall personally sign the Agreement.

[1] Approval by County Counsel is required.

[2] Approval by Auditor-Controller is required

[3] Approval by Risk Management is necessary only if changes are made in Sections XI or XII.

EXHIBIT A-1
PROGRAM DESCRIPTION; COMMUNICATION AND COORDINATION BETWEEN CONTRACTOR AND COUNTY; REPORTING REQUIREMENTS

A. PROGRAM DESCRIPTION

CONTRACTOR acknowledges all programs providing mental health treatment services will be provided based on medical necessity criteria, in accordance with an individualized Client Plan, and approved and authorized according to State of California requirements. All individuals served in these programs, with the exception of the following programs: TWELVE through EIGHTEEN and TWENTY must meet the criteria of a serious mental illness diagnosis and have a functional impairment that is temporary and reversible with therapeutic mental health interventions.

PROGRAM ONE:

1. **Program Name:** Manzanita House

2. **Program Description:**

Type of Facility:	Short term Adult Crisis Residential
Address of Delivery Site:	200 Casentini Street, Salinas, CA 93907
Program Schedule:	Provides 24-hour care, 7 days a week. Intake shall be on a 24-hour basis with all County referrals made by Monterey County Behavioral Health Bureau (MCBHB) designated staff and Interim Case Coordinators.
Continued Stay Criteria:	Any extension of care beyond 30 days requires authorization from the Behavioral Health Director or designee. No consumer may stay longer than 90 days.
Total # of Beds Available:	15
Target # of Consumers:	200+ Annually

Manzanita House ("Manzanita") is a short term crisis residential treatment program which offers community-based rehabilitative services in a non-institutional residential setting with a structured program. Manzanita is an alternative to inpatient psychiatric care for adult clients of the Monterey County Behavioral Health System experiencing an acute psychiatric episode or crisis who do not require in-patient psychiatric treatment and who do not have medical

complications requiring nursing care. The program and facility are licensed by the State of California, Department of Social Services Community Care Licensing (CCL) as a "Social Rehabilitation Facility" and are certified by the Department of Health Care Services as a short-term Crisis Residential Treatment Service Facility. Interventions concentrate on symptom reduction, medication and functional stabilization. Service activities include behavioral health assessment, behavioral health treatment and discharge plan development, individual and group counseling, as well as development of a community support system. Psychiatry services are provided by MCBHB.

3. **Program Purpose**

This community-based short-term crisis residential program is an alternative to in-patient hospitalization. Manzanita focuses on reduction of the crisis, stabilization, and referrals for further treatment or support services to ease the transition into community living. All MCBH referrals will be offered an assessment for program admission.

4. **Desired Results**

Crisis residential services are therapeutic and/or rehabilitation services that are provided in a 24-hour residential treatment program for individuals experiencing an acute psychiatric episode or crisis, and who do not present criteria for inpatient acute psychiatric care. The program supports individuals in their efforts to restore, maintain and apply interpersonal and independent living skills, and access to community support systems.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practices: Motivational Interviewing, Seeking Safety, Wellness Recovery Action Plan (WRAP) and Trauma-Informed approaches. Licensed/licensed eligible staff also provides Cognitive Behavioral Therapy.

Goal	Measurement & Data Source
1. 75% of consumers will improve their mental health recovery.	• Measured via the pre and post "Illness Management and Recovery Outcome Survey."
2. 75% of consumers will discharge to a lower level of care.	• Measured by Exit Data in Avatar; "Discharge Location" module. (Lower level of care is anything except in-patient psych or jail)
3. 75% of consumers will meet or partially meet their discharge goals.	• Measured by "Type of Discharge" category in Avatar. (Type of discharge is treatment goals reached, treatment goals partially reached, no further care needed at this facility.)

4. 80% of consumers will report satisfaction with the quality of services provided.	• Measured by client self-report via "Consumer Satisfaction" survey instrument at exit.

6. **Who are the partners involved in program implementation?**

MCBHB Medical Director or designee provides medical consultation to nursing staff at the facility. MCBHB also provides psychiatry services for all residents of Manzanita.

7. **What is the eligibility criteria for admission to the program?**

- Priorities for admission are those clients from a higher level of care such as inpatient Mental Health Unit or an IMD.
- Financial Eligibility: Short-Doyle/Medi-Cal eligible or based on referral from MCBHB or from Interim, Inc. case coordinators.
- Ambulatory adults 18 years of age and older with acute to moderate level of impairment but do not meet 5150 criteria that are under conservatorship or under voluntary terms. A maximum of two non-ambulatory residents with assistive devices and three clients age 60 and over at any time as per CCL restrictions.
- Adults with DSM 5 serious mental illness Diagnostic Categories including but not limited to: schizophrenia, bipolar disorders, schizoaffective disorders, mental health disorders that substantially interfere with the person's functional ability to carry out primary aspects of daily living in the community
- All clients must meet the general DSS Community Care Licensing, and DHCS requirements for health and safety, including Needs Appraisal and Physician's Report that indicates the program can meet the client's needs in the following areas: social/family, emotional, physical, mental, functioning, and suicide prevention. Admission eligibility determined by Interim Program Director or designee.

When a client is referred, and staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?

- Interim program staff will collaborate with MCBHB and Interim case coordinators to create an alternative referral plan for appropriate services that may include other Interim program services.
- Discharge is when clients are no longer meeting medical necessity, i.e. client has been restored to his/her prior level of functioning prior to the crisis.
- Length of stay depends on the client's functional stability for community living.
- Maximum length of stay is 30 days without additional MCBHB authorization to ensure successful completion of treatment plan.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

MCBHB refers all clients. Interim, Inc. serves economically disadvantaged populations who meet the standards for no/low-income status or are Short-Doyle/Medi-Cal eligible.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

Staff is trained in Motivational Interviewing to ensure services align with the consumer's readiness for change. They are trained in and use a strengths-based and recovery focused model and deliver services that are based on individualized goals, set jointly between staff and individual residents. Psychosocial educational and skill development groups are based on observed needs as well as ongoing feedback from participants. All services are voluntary, and eligible admissions/assessments are available 24/7. Admissions are based on most-in-need versus first on waiting list based on MCBHB and Interim evaluation.

Input from consumers is provided through the consumer run Recovery Task Force. Interim offers support team meetings that include family and other support team members as designated by consumers. Interim also hires peers and family members in every area of agency operations.

Staff receive training on Cultural and Linguistic Competency and Trauma Informed services. Bilingual Spanish services are provided as needed. Interpreters are available in other languages.

Services are integrated and coordinated with MCBHB.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity at Manzanita House is 15, and annual number to be served is approximately 200.

PROGRAMS TWO & THREE

1. **Program Names:** Bridge House Dual Diagnosis Program Residential and Full Day, Day Rehabilitation Program (The Wellness and Recovery Academy)

2. **Program Descriptions:**

Type of Facility:	24-Hour Adult Transitional Residential Treatment
Address of Delivery Site:	343 Dela Vina Ave, Monterey, CA 93940

Program Schedule:	Provides residents 24 hour care, 7 days a week. Intake will be pre-arranged by appointment. The Day Rehabilitation Program operates Monday through Friday, at least 4 hours of therapeutic groups offered per day.
Limitation of Service	Consumers may receive up to 6 months of transitional residential treatment.
Continued Stay Criteria:	Any extension beyond the 6 residential months requires authorization by the Monterey County Behavioral Health Bureau Director or designee.
Total # of Beds Available:	13 beds and slots in Day Rehabilitation Program. Clients must be enrolled in the Bridge House Residential Treatment Program in order to be enrolled in the Day Rehabilitation Program.
Target # of Consumers:	30+

A. Residential

Bridge House ("Bridge") is a transitional residential treatment program for adults with co-occurring serious mental illnesses and substance use disorders. Staff utilize Motivational Interviewing in providing counseling services and other activities. Clients' goals are focused mental health wellness and substance use recovery principles. Clients work to improve symptom management, personal, social and family functioning, and gain substance use recovery skills. The program is licensed by the California Dept. of Social Services, Community Care Licensing as a social rehabilitation facility and certified by the Department of Healthcare Services for transitional residential treatment. Clients are referred by the Monterey County Behavioral Health Bureau or by Interim case coordinators.

B. Full Day, Day Rehabilitation

The Bridge Wellness & Recovery Academy is certified by the State of California, Department of Healthcare Services as a Day Rehabilitation Program, serving consumers with serious mental illnesses and substance use disorders. Program services include skills building groups, group therapy, community meetings, process groups, therapeutic milieu, service plan development, community outings, and adjunctive therapies.

3. **Programs' Purpose**

Transitional residential services for individuals with dual diagnosis in non-institutional residential setting where consumers are supported in their efforts to stabilize their psychiatric symptoms while restoring, maintaining, and applying interpersonal and skill building techniques are more cost efficient, and more effective in helping clients transition to being productive community members than institutional alternatives. Bridge's transitional residential treatment program provides a therapeutic/wellness and recovery community including a range of activities and services for consumers who would be at risk of hospitalization or other more restrictive living settings if they were not in a transitional residential program.

The Bridge Day Rehabilitation program (The Wellness and Recovery Academy) uses wellness and recovery principles to develop the coping and recovery skills needed to successfully reintegrate into the community. It provides evaluation, rehabilitation, and mental health services to maintain or restore personal independence and functioning consistent with requirements for learning and development.

4. **Desired Results**

Through both the transitional residential program, and the day rehabilitation program, consumers learn how to engage in a dual recovery process so they can reach and maintain recovery goals and lead safe, meaningful, and healthy lives. Consumers learn and practice recovery skills specifically in relapse prevention, symptom management, emotional, social and family functioning with the goal of successfully integrating into the community.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practice: Motivational Interviewing, Seeking Safety, Wellness Recovery Action Plan (WRAP), Trauma-Informed approaches, Double Trouble in Recovery and Cognitive Skills for Relapse Prevention in Criminal Behavior. Licensed/licensed eligible staff provides Cognitive Behavioral Therapy and Dialectical Behavioral Therapy.

Bridge Residential

Goal	Measurement & Data Source
1. 70% of consumers will discharge to a lower level of care.	• Measured by Exit Data in Avatar; "Discharge Location" module. (Lower level of care is anything except in-patient psych, Manzanita or jail.)
2. 75% of consumers will remain clean and sober during their stay at Bridge.	• Measured by data from results of regular urinalysis testing. Testing results log, staff observations and clients' self-reports as documented in Avatar/EMR; "substance use testing" module.

3. 80% of consumers served during the FY will eliminate all psychiatric hospitalizations, while in the program.	• Measured by psychiatric hospitalization data records in EMR/Avatar
4. 85% of consumers will appropriately engage with a PCP.	• Measured by staff observations and clients' self-reports of engagement in primary care physician appointments. • Data source: EMR/Avatar "PCP Information" module.

Bridge Day Rehabilitation (The Wellness and Recovery Academy)

Goal	Measurement & Data Source
1. 85% of consumers will improve their mental health recovery.	• Measured via the pre and post "Illness Management and Recovery Outcome Survey."
2. 80% of consumers will report satisfaction with the quality of services provided.	• Measured by client self-report via "Consumer Satisfaction" survey instrument at exit.

6. **Who are the partners involved in program implementation?**

Monterey County Behavioral Health Bureau.

MCBHB Medical Director or her/his designee provides psychiatry services and medical consultation to nursing staff at the facility.

7. **What is the eligibility criteria for admission to these programs? When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?**

- Financial Eligibility: Short-Doyle/Medi-Cal eligible, or meet the standards for low-income status, or referral by MCBHB.
- Referral through Interim case coordinators and MCBHB Service Coordinators with admission approval by Interim, Inc. staff. Referrals from other community providers will be approved by the Deputy Director of Adult System of Care. Program staff will assess consumers for appropriateness to the level of care, for compatibility with other residents, and safety.
- The populations to be served are adults with major psychiatric disabilities age 18 and older who have a substance abuse disorder diagnosis and who require support to acquire and apply coping, recovery, interpersonal, and independent living skills to function in the community.
- DSM V Diagnostic Categories for both serious mental illness and substance abuse disorder includes schizophrenia, bipolar disorders, schizoaffective disorders, and major depression with psychotic features that substantially interferes with the person's ability to carry out primary aspects of daily living in the community.

- Program staff will collaborate with case coordinators to create an alternative referral plan for appropriate services.
- Discharge is when clients are no longer meeting medical necessity.
- Length of stay depends on medical necessity and ability to place clients into appropriate discharge placements.
- Admission eligibility determined by Interim Program Director or designee.

Bridge Residential eligibility criteria only:

- Maximum length of residential stay is 6 months without additional MCBHB authorization to ensure successful completion of treatment plan.
- All clients must meet the general DSS Community Care Licensing, and DHCS requirements for health and safety, including Needs Appraisal and Physician's Report that indicates the program can meet the client's needs in the following areas: Social/family, emotional, mental, physical, functioning, and suicide prevention.
- Until April 2018 consumers must reside in Bridge's Residential Program to be included in the Day Rehabilitation Program.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

MCBHB refers all clients. Interim serves economically disadvantaged populations who meet the standards for low-income status or are Short-Doyle/Medi-Cal eligible.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

Staff is trained in Motivational Interviewing to ensure services align with the consumer's readiness for change. They are trained in and use a strengths-based and recovery focused model and deliver services that are based on individualized goals, set jointly between staff and individuals seeking services. Psychosocial educational and skill development groups are based on observed needs as well as ongoing feedback from participants. All services are voluntary, and eligible admission/assessment is available by appointment. Admissions are based on readiness for change versus first on waiting list based on MCBHB evaluation.

Input from consumers is provided through the consumer run Recovery Task Force as well as resident or consumer council and community meetings. Interim offers support team meetings that include family members and other support team members as designated by consumers. Interim also hires peers and family members in every area of agency operations.

Staff receive training on Cultural and Linguistic Competency and Trauma Informed services. Bilingual Spanish services are provided as needed. Interpreters are available in other languages.

Services are integrated and coordinated with MCBHB.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity is 13 beds as well as 13 clients in the Day Rehabilitation program.

PROGRAM FOUR:

1. **Program Name:** Community Housing

2. **Program Description:**

Address of Delivery Sites:	Casa de Perla, Monterey, CA Casa de Los Robles, Monterey, CA Dela Vina (Horizons), Monterey, CA Pearl Street Apartments, Monterey, CA Acacia House, Salinas, CA California House, Salinas, CA Casa de Paloma, Salinas, CA Catalyst Apartments, Salinas, CA Mariposa Apartments Salinas, CA MCHOPE scattered-site apartments other potential locations that may be developed
Program Schedule:	Typically Monday through Friday, 8:00 a.m. to 5:00 p.m. Staff are on-call and available via cellphone for emergencies. Staff schedule may vary based upon consumers' needs.
Limitation of Service:	For some Community Housing locations, there are income limitations and individuals must meet the criteria of being homeless as defined by current HUD regulations.
Target # of Consumers:	One hundred (100+) consumers

Community Housing is a permanent supportive housing program, which provides 100+ affordable housing placements for community independent living for adults with serious and persistent, long term psychiatric disabilities. These placements are provided as individual apartments and/or cooperative group housing units. Interim, Inc. provides case coordination, case management, crisis intervention, and mental health treatment services for residents in all the supported housing programs in accordance with state guidelines established under the rehabilitation option.

3. **Program Purpose**

Community Housing provides mental health services and permanent supportive housing to low income individuals with a serious and long term psychiatric disability. Mental health services are interventions designed to minimize disability and maximize the restoration or maintenance of functioning consistent with the requirements for learning, development, independent living, and enhancing self-sufficiency.

4. **Desired Results**

The primary public health benefit is providing and assisting low income individuals with serious psychiatric disabilities to maintain safe, affordable, supportive permanent housing. This prevents people from homelessness or institutional placement, and improves their quality of life. Federal law requires public mental health systems to provide services in integrated community settings, and Permanent Supportive Housing is a proven approach for doing so. It presents an alternative to hospitals, shelters, and other settings that segregate people by disability, such as nursing homes, board and care homes, and other residential care facilities, in which residency is tied to receiving the particular services the facility offers. Once an individual achieves a higher level of recovery and no longer meets the medical necessity criteria, only with resident consent, Interim will work on locating other sources of permanent housing.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practice: Motivational Interviewing, Wellness Recovery Action Plan (WRAP), Trauma-Informed approaches, and Permanent Supportive Housing. Licensed/licensed eligible staff provides Cognitive Behavioral Therapy and Dialectical Behavioral Therapy.

Goal	Measurement & Data Source
1. 90% of consumers will maintain or improve their mental health recovery.	• Measured at entry, annually, and at exit thereafter via the "Illness Management and Recovery Outcome Survey."
2. 85% of consumers will appropriately engage with a PCP.	• Measured by staff observations and clients' self-reports of engagement in primary care physician appointments. • Data source: EMR/Avatar "PCP Information" module.
3. 80% of consumers will report satisfaction with the quality of services provided.	• Measured by client self-report via annual "Consumer Satisfaction" survey instrument.

6. **Who are the partners involved in program implementation?**

Interim works with the County of Monterey Housing Authority to provide Section 8 housing subsidies for units when possible. Interim administers other rent subsidies through a HUD funded program.

7. **What is the eligibility criteria for admission to the program?**

- Financial Eligibility: Short-Doyle/Medi-Cal eligible or meet the standards for low-income status.
- Referral through Interim case coordinators or MCBHB service coordinators with admission approval by Interim staff.
- The populations to be served are adults with major psychiatric disabilities (including transition age youth age 18 and older) with serious mental illnesses, i.e. schizophrenia, schizoaffective disorder or bipolar disorders that substantially interfere on a long term basis with their functional ability to carry out primary aspects of daily living in the community and are receiving psychiatry services through MCBHB or a designee. (Exceptions to this criteria are only approved by MCBHB and Interim Inc. Deputy Director or designees.) Upon discharge from MCBHB services or Interim, rehabilitative mental health, case coordination, and case management services will be terminated. However, housing may not be terminated except as allowed under the lease. Upon discharge or termination from housing, clients will be referred to MCBHB case coordination.
- Housing eligibility is governed by funding sources regulatory agreements; some housing is limited to people with specific income levels. Each property has specific income and asset limitations. Some properties have specific limitations related to criminal records of applicants or rental history.
- Admission eligibility determined by Interim Program Director or designee.

When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?

- Program staff will collaborate with case coordinators to create an alternative referral plan for appropriate services.
- Clients aren't involuntarily discharged from housing unless they violate their lease agreement. Anticipated length of service doesn't pertain to permanent supportive housing.
- Clients who no longer need this level of care of supportive housing are encouraged and assisted with discharge plans into available affordable housing in the community.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

MCBHB refers all clients. Interim serves economically disadvantaged populations who meet the standards for low-income status or are Short-Doyle/Medi-Cal eligible. The program addresses one of the top goals of the Monterey County Lead Me Home 10-year Plan by providing affordable permanent supportive housing. Interim is the only provider of permanent supportive housing for adults with mental illness in Monterey County. MCBHB provides psychiatry services.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

Staff is trained in Motivational Interviewing to ensure services align with the consumer's readiness for change. They are trained in and use a strengths-based and recovery focused model and deliver services that are based on individualized goals, set jointly between staff and individuals seeking services. Psychosocial educational and skill development groups are based on observed needs as well as ongoing feedback from participants. All services are voluntary, and staff are available on-call 24-hours a day to provide emergency support.

Input from residents is provided through the consumer run Recovery Task Force as well as resident council and resident community meetings. Interim offers support team meetings that include family members and other support team members as designated by consumers. Interim also hires peers and family members in every area of agency operations.

Staff receive training on Cultural and Linguistic Competency and Trauma Informed services. Bilingual Spanish services are provided as needed. Interpreters are available in other languages.

Services are integrated and coordinated with MCBHB and other providers in the area.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity and annual number to be served in housing is 100+ clients. Clients transitioning out will be referred to MCBHB coordination services, and Interim coordination will continue for approximately one month after discharge. There are approximately five clients at any given time that transition out.

PROGRAM FIVE:

1. **Program Name:** Sandy Shores

2. **Program Description:**

Address of Delivery Site:	Sandy Shores, Marina, CA
Program Schedule:	Typically Monday through Friday, 8:00 a.m. to 5:00 p.m. Staff are on-call and available via cellphone for emergencies. Staff schedule may vary based upon consumers' needs.

Limitation of Service:	There are income limitations and individuals must meet the criteria of being homeless as defined by HUD regulations. Half the residents must have incomes under 20% AMI and half under 30% AMI.
Target # of Consumers:	28 consumers

Sandy Shores is a permanent supportive housing program, which provides affordable housing for 28 very low-income individuals all of whom are homeless and have a serious mental health diagnosis that substantially interferes with their functional ability to carry out primary aspects of daily living in the community. All individuals receive case management, crisis intervention, mental health services, and housing services in an effort to assist individuals to live in the community.

3. **Program Purpose**

Sandy Shores provides mental health services and permanent supportive housing to individuals with a psychiatric disability who are homeless according to HUD guidelines. Mental health services are interventions designed to minimize mental disability and maximize the restoration or maintenance of functioning consistent with the requirements for learning, development, independent living, and enhancing self-sufficiency. Mental Health services are designed to help residents live successfully in the community.

4. **Desired Results**

Federal law requires public mental health systems to provide services in integrated community settings, and Permanent Supportive Housing is a proven approach for doing so. It presents an alternative to hospitals, shelters, and other settings that segregate people by disability, such as nursing homes, board and care homes, and other residential care facilities, in which residency is tied to receiving the particular services the facility offers.

- The flexibility of support services offered by Permanent Supportive Housing improves residential stability by allowing tenants to remain housed in the same home as their service needs change.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practice: Motivational Interviewing, Trauma-Informed approaches, and Wellness Recovery Action Plan (WRAP). Licensed/licensed eligible staff provides Cognitive Behavioral Therapy.

Goal	Measurement & Data Source
1. 80% of consumers will remain housed at Sandy Shores as of the end of the operating year or exit to other permanent housing destinations during the operating year. (HUD)	• Measured by number of clients remaining housed or exiting to other permanent housing. • Data source: EMR/Avatar exit data; "Discharge Location" module.
2. 80% of consumers will maintain or improve their mental health recovery.	• Measured at entry, annually, and at exit thereafter via the "Illness Management and Recovery Outcome Survey."
3. 25% of consumers will attain employment, attend school or a vocational training program, or volunteer. (CoC)	• Measured by number of clients reporting employment/volunteering, SEES referral and those participating in educational services as documented by Case Coordinator or counselor in client's EMR. • Data source: EMR/Avatar; "Ed/Empl/Vol" module.
4. 85% of consumers will appropriately engaged with a PCP.	• Measured by staff observations and clients' self-reports of engagement in primary care physician appointments. • Data source: EMR/Avatar "PCP Information" module.
5. 80% of consumers will report satisfaction with the quality of services provided.	• Measured by client self-report via annual "Consumer Satisfaction" survey instrument.

6. **Who are the partners involved in program implementation?**

Interim collaborates with the Coalition of Homeless Service Providers as well as the HUD CoC program. MCBHB provides psychiatry services.

7. **What is the eligibility criteria for admission to the program?**

- Financial Eligibility: Short-Doyle/Medi-Cal eligible, and meet the standards for HUD homeless status and income limitations as defined by the project funding sources (50% of residents must have income under 20% AMI and 50% under 30% AMI).
- Referral through HMIS SPDAT score, Interim case coordinators, and MCBHB service coordinators with admission approval by Interim, Inc. staff. The waitlist is managed by rules from various funding sources with prioritization given to chronically homeless individuals per HUD's definition.
- The populations to be served are adults with major psychiatric disabilities (including and transition age youth age 18 and older) with serious mental illnesses, i.e. schizophrenia, schizoaffective disorder or bipolar disorders that substantially interfere on a long term basis

with their functional ability to carry out primary aspects of daily living in the community and are receiving psychiatry services through MCBHB or a designee. (Exceptions to this criteria are only approved by MCBHB and Interim Inc. Deputy Director or designees.) Upon discharge from MCBHB services or Interim, rehabilitative mental health, case coordination, and case management services will be terminated. However, housing may not be terminated except as allowed under the lease. Upon discharge or termination from housing, clients will be referred to MCBHB for case coordination.

- Housing eligibility is governed by funding sources regulatory agreements.
- Admission preference is given to clients who meet HUD chronically homeless criteria.
- Admission eligibility determined by Interim Program Director or designee.

When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?

- Program staff will collaborate with case coordinators to create an alternative referral plan for appropriate services.
- Clients aren't involuntarily discharged from housing unless they violate their lease agreement. Anticipated length of service doesn't pertain to permanent supportive housing.
- Clients who no longer need this level of care of supportive housing are encouraged and assisted with discharge plans into available affordable housing in the community.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

MCBHB or Interim case coordinators refer all clients. Interim serves economically disadvantaged populations who meet the standards for HUD's definition of homeless or are Short-Doyle/Medi-Cal eligible. The program addresses one of the top goals of the Monterey County 10-year Homeless Plan, Lead Me Home, by providing affordable permanent supportive housing. Interim is the only provider of permanent supportive housing for adults with mental illness in Monterey County.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

Staff is trained in Motivational Interviewing to ensure services align with the consumer's readiness for change. They are trained in and use a strengths-based and recovery focused model and deliver services that are based on individualized goals, set jointly between staff and individuals seeking services. Psychosocial educational and skill development groups are based

on observed needs as well as ongoing feedback from participants. All services are voluntary, and staff are available on-call 24-hours a day to provide emergency support.

Input from residents is provided through the consumer run Recovery Task Force as well as resident council and resident community meetings. Interim offers support team meetings that include family members and other support team members as designated by consumers. Interim also hires peers and family members in every area of agency operations.

Staff receive training on Cultural and Linguistic Competency and Trauma Informed services. Bilingual Spanish services are provided as needed. Interpreters are available in other languages.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity and annual number to be served is 28 clients. Clients transitioning out will be referred to MCBHB coordination services and Interim coordination will continue for approximately one month after discharge.

PROGRAM SIX:

1. **Program Name:** Shelter Cove

2. **Program Description:**

Address of Delivery Site:	Shelter Cove, Marina, CA
Program Schedule:	Typically Monday through Friday 8am to 7pm, and Saturday through Sunday 11am to 7pm. Resident Manager provides coverage on an on-call basis 7 days a week from 8pm to 8am. Staff are on-call and available via cellphone for emergencies. Staff schedule may vary based upon consumers' needs.
Limitation of Service:	Transitional housing limited to 2 year stay. There are income limitations and individuals must meet the criteria of being homeless as defined by HUD regulations. This program provides transitional housing in individual bedrooms in two and four bedroom units. Residents have individual leases and share the common areas of the units. The project also provides dinner meal service daily.
Target # of Consumers:	36 consumers at a given time, approximately 60+ served/year through December 2016. 34 consumers at a given time, approximately 50+ served/year starting in April 2017.

Shelter Cove is a supported transitional housing program, which provides housing to 34 very low-income individuals all of whom are homeless, and have a serious mental health diagnosis that substantially interferes with their functional ability to carry out primary aspects of daily living in the community. All individuals receive case management, crisis intervention, mental health services and housing services in an effort to help residents learn the skills they will need to successfully transition to independent living. The program's philosophy is based on the Social Rehabilitation Model.

3. **Program Purpose**

The Shelter Cove program is designed for individuals who are incapable of living completely independently and who need transitional affordable housing with support services in order to live successfully in the community. The program focuses on helping individuals learn the skills necessary to move into more independent housing. Mental health services are interventions designed to minimize disability and maximize the restoration or maintenance of functioning consistent with the requirements for learning, development, independent living, and enhancing self-sufficiency.

4. **Desired Results**

The primary public health benefit is providing clients with case management services which help the clients to develop goals that improve their life in areas of health, education, employment, daily living skills in order to help them prepare for independent living. Federal law requires public mental health systems to provide services in integrated community settings, and Permanent and Transitional Supportive Housing is a proven approach for doing so. It presents an alternative to hospitals, shelters, and other settings that segregate people by disability, such as nursing homes, board and care homes, and other residential care facilities, in which residency is tied to receiving the particular services the facility offers.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practice: Motivational Interviewing, Seeking Safety, Trauma-Informed approaches, and Wellness Recovery Action Plan (WRAP). Licensed/licensed eligible staff provides Cognitive Behavioral Therapy.

Goal	Measurement & Data Source
1. 65% of the consumers discharging from the program will exit to permanent housing. (HUD)	• Measured by the number of clients exiting into permanent housing upon discharge. • Data source: EMR/Avatar exit data; "Discharge Location" module.

2. 75% of consumers will maintain or improve their mental health recovery.	• Measured at entry, annually, and at exit thereafter via the "Illness Management and Recovery Outcome Survey."
3. 20% of consumers will attain employment, attend school or a vocational training program, or volunteer. (CoC)	• Measured by number of clients reporting employment/volunteering, SEES referral and those participating in educational services as documented by Case Coordinator or counselor in client's EMR. • Data source: EMR/Avatar; "Ed/Empl/Vol" module.
4. 85% of consumers will appropriately engaged with a PCP.	• Measured by staff observations and clients' self-reports of engagement in primary care physician appointments. • Data source: EMR/Avatar "PCP Information" module.
5. 80% of consumers will report satisfaction with the quality of services provided.	• Measured by client self-report via annual "Consumer Satisfaction" survey instrument.

6. **Who are the partners involved in program implementation?**

Interim collaborates with the Coalition of Homeless Service Providers program.

MCBHB provides psychiatry services.

7. **What is the eligibility criteria for admission to the program?**

- Financial Eligibility: Short-Doyle/Medi-Cal eligible, and meet the standards for HUD homeless status.
- Referral through HMIS SPDAT score, Interim case coordinators, and MCBHB service coordinators with admission approval by Interim staff.
- The populations to be served are adults with major psychiatric disabilities (including and transition age youth age 18 and older) with serious mental illnesses, i.e. schizophrenia, schizoaffective disorder, major depression with psychotic features or bipolar disorders that substantially interfere on a long term basis with their functional ability to carry out primary aspects of daily living in the community and are receiving psychiatry services through MCBHB or a designee. (Exceptions to this criteria are only approved by MCBHB and Interim Inc. Deputy Director or designees.) Upon discharge from MCBHB services or Interim, rehabilitative mental health, case coordination, and case management services will be terminated. However, housing may not be terminated except as allowed under the lease.
- Sober Living/substance free living environment [SLE] – clients referred are assessed by case coordinators for ability to live in SLE.
- Housing eligibility is governed by funding sources regulatory agreements.
- This project is slated to undergo re-construction starting in April 2017; in preparation for construction the bed total will be reduced to 32 beds through attrition.
- Admission eligibility determined by Interim Program Director or designee.

When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?

- Program staff will collaborate with case coordinators to create an alternative referral plan for appropriate services.
- Clients aren't involuntarily discharged from housing unless they violate their lease agreement. Anticipated length of service is two years.
- Clients who no longer need this level of care of supportive housing are encouraged and assisted with discharge plans into available affordable housing in the community before their two years.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

MCBHB or Interim case coordinators refer all clients. Interim serves economically disadvantaged populations who meet the standards for HUD's definition of homeless or are Short-Doyle/Medi-Cal eligible. The program addresses one of the goals of the Monterey County Lead Me Home 10-year Homeless Plan by providing affordable transitional supportive housing in order to prepare clients for permanent housing in the community.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

Staff is trained in Motivational interviewing to ensure services align with the consumer's readiness for change. They are trained in and use a strengths-based and recovery focused model and deliver services that are based on individualized goals, set jointly between staff and individuals seeking services. Psychosocial educational and skill development groups are based on observed needs as well as ongoing feedback from participants. All services are voluntary, and staff are available on-call 24-hours a day to provide emergency support.

Input from residents is provided through the consumer run Recovery Task Force as well as resident council and resident community meetings. Interim offers support team meetings that include family members and other support team members as designated by consumers. Interim also hires peers and family members in every area of agency operations.

Staff receive training on Cultural and Linguistic Competency and Trauma Informed services. Bilingual Spanish services are provided as needed. Interpreters are available in other languages.

Services are integrated and coordinated with MCBHB and other providers in the area.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity is 36 and annual number to be served is approximately 60+ through December 2016. After December 2016, capacity will drop to 32 with annual total estimated at 50+ clients. Clients transitioning out will be referred to MCBHB coordination services and Interim will continue coordination for approximately one month after discharge.

PROGRAM SEVEN:

1. **Program Name:** Rockrose Gardens

2. **Program Description:**

Address of Delivery Site:	Rockrose Gardens, Marina, CA
Program Schedule:	Typically, Monday through Friday, 8:00 a.m. to 5:00 p.m. Staff are on-call and available via cellphone for emergencies. Staff schedule may vary based upon consumers' needs.
Limitation of Service:	There are income limitations based on regulatory agreements and 9 individuals must meet the criteria of being homeless or at-risk as defined by CalHFA regulations under the MHSA Housing Program at the time of placement.
Target # of Consumers:	20 consumers

Rockrose Gardens is a permanent supportive housing program, which provides housing to 20 very low-income individuals with a serious mental health diagnosis, 9 of these individuals are homeless or at-risk of homelessness. Interim, Inc. provides case management, crisis intervention, and mental health services for residents in accordance with state guidelines established under the rehabilitation option, and in accordance with MHSA funding regulations.

3. **Program Purpose**

Rockrose Gardens provides mental health services and permanent supportive housing to low income and homeless individuals with a psychiatric disability. Mental health services are interventions designed to minimize disability and maximize the restoration or maintenance of functioning consistent with the requirements for learning, development, independent living, and enhancing self-sufficiency.

4. **Desired Results**

The primary public health benefit is providing and assisting low income and homeless individuals with serious psychiatric disabilities to maintain safe, affordable, supportive permanent housing. This prevents people from homelessness or institutional placement, and

improves their quality of life. Federal law requires public mental health systems to provide services in integrated community settings, and Permanent Supportive Housing is a proven approach for doing so. It presents an alternative to hospitals, shelters, and other settings that segregate people by disability, such as nursing homes, board and care homes, and other residential care facilities, in which residency is tied to receiving the particular services the facility offers.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practice: Motivational Interviewing, Trauma-Informed approaches and Wellness Recovery Action Plan (WRAP). Licensed/licensed eligible staff provides Cognitive Behavioral Therapy and Dialectical Behavioral Therapy.

Goal	Measurement & Data Source
1. 90% of consumers will remain housed at Rockrose as of the end of the operating year or exit to other permanent housing destinations during the operating year. (MHSA)	• Measured by number of clients remaining housed or exiting to other permanent housing. • Data source: EMR/Avatar exit data; "Discharge Location" module.
2. 80% of consumers will maintain or improve their mental health recovery. (MHSA)	• Measured at entry, annually, and at exit thereafter via the "Illness Management and Recovery Outcome Survey."
3. 30% of consumers will attain employment, attend school or a vocational training program, or volunteer. (MHSA)	• Measured by number of clients reporting employment/volunteering, SEES referral and those participating in educational services as documented by Case Coordinator or counselor in client's EMR. • Data source: EMR/Avatar; "Ed/Empl/Vol" module.
4. 85% of consumers will appropriately engaged with a PCP. (MHSA)	• Measured by staff observations and clients' self-reports of engagement in primary care physician appointments. • Data source: EMR/Avatar "PCP Information" module.
5. 80% of consumers will report satisfaction with the quality of services provided. (MHSA)	• Measured by client self-report via annual "Consumer Satisfaction" survey instrument.

6. **Who are the partners involved in program implementation?**

Interim collaborates with MCBHB, and HUD. MCBHB provides psychiatry services.

7. **What is the eligibility criteria for admission to the program?**

- Financial Eligibility: Short-Doyle/Medi-Cal eligible or meet the standards for low-income status. Tenants must meet HUD restrictions on income and assets.
- Referral through Interim case coordinators or MCBHB service coordinators with admission approval by Interim staff.
- The populations to be served are adults with major psychiatric disabilities (including and transition age youth age 18 and older) with serious mental illnesses, i.e. schizophrenia, schizoaffective disorder or bipolar disorders that substantially interfere on a long term basis with their functional ability to carry out primary aspects of daily living in the community and are receiving psychiatry services through MCBHB or a designee. (Exceptions to this criteria are only approved by MCBHB and Interim Inc. Deputy Director or designees.) Upon discharge from MCBHB services or Interim, rehabilitative mental health, case coordination, and case management services will be terminated. However, housing may not be terminated except as allowed under the lease. Upon discharge or termination from housing, clients are referred to MCBHB case coordination services.
- Nine residents must meet MHSA housing criteria for being homeless or at-risk of homelessness upon entry.
- Housing eligibility is governed by funding sources regulatory agreements.
- Admission eligibility determined by Interim Program Director or designee.

When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?

- Program staff will collaborate with MCBHB case coordinators to create an alternative referral plan for appropriate services.
- Clients aren't involuntarily discharged from housing unless they violate their lease agreement. Anticipated length of service doesn't pertain to permanent supportive housing.
- Clients who no longer need this level of care of psychiatric supportive housing are encouraged and assisted with discharge plans into available affordable housing in the community per the terms of their lease agreement.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

MCBHB refers all clients. Interim serves economically disadvantaged populations who meet the standards for low-income status or are Short-Doyle/Medi-Cal eligible. The program addresses one of the top goals of the Monterey County 10-year Homeless Plan, Lead Me Home, by providing affordable permanent supportive housing. Interim is the only provider of permanent supportive housing for adults with mental illness in Monterey County.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

Staff is trained in Motivational Interviewing to ensure services align with the consumer's readiness for change. They are trained in and use a strengths-based and recovery focused model and deliver services that are based on individualized goals, set jointly between staff and individuals seeking services. Psychosocial educational and skill development groups are based on observed needs as well as ongoing feedback from participants. All services are voluntary, and staff are available on-call 24-hours a day to provide emergency support.

Input from residents is provided through the consumer run Recovery Task Force as well as resident council and resident community meetings. Interim offers support team meetings that include family members and other support team members as designated by consumers. Interim also hires peers and family members in every area of agency operations.

Staff receive training on Cultural and Linguistic Competency and Trauma Informed services. Bilingual Spanish services are provided as needed. Interpreters are available in other languages.

Services are integrated and coordinated with MCBHB and other providers in the area.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity and annual number to be served is 20 clients. Clients transitioning out will be referred to MCBHB coordination services, and Interim will continue coordination for approximately one month post discharge.

PROGRAM EIGHT:

1. **Program Name:** Lupine Gardens

2. **Program Description:**

Address of Delivery Site:	Lupine Gardens, Salinas, CA
Program Schedule:	Typically, Monday through Friday, 8:00 a.m. to 5:00 p.m. Staff are on-call and available via cellphone for emergencies 24 hours/ day. Staff schedule may vary based upon consumers' needs. A resident manager lives on the premises for night emergencies.
Limitation of Service:	Full Service Partnership (FSP) program. There are income limitations per HUD and criteria of being homeless or at-

risk of homelessness as defined by HCD MHP regulations.

Target # of Consumers: 20 consumers

Lupine Gardens is an intensive permanent supportive housing program, which provides a Full Service Partnership (FSP) level of services to 20 very low-income individuals with a serious mental health diagnosis, all of whom are homeless or at high risk of homelessness. The service array includes: intensive case management provided in the FSP model as required by Mental Health Services Act funding, and assistance with daily living skills i.e., meals, house cleaning, self- administration of medication, and laundry services in order to live independently in the community.

3. **Program Purpose**

Lupine Gardens provides intensive mental health services and permanent supportive housing to vulnerable individuals with a psychiatric disability who are homeless or at-risk of homelessness. The goal is to prevent further homelessness, to avoid costly hospitalization or use of short-term crisis residential programs, hospital crisis teams, and unnecessary institutionalization. The program is designed for individuals who have failed in other placements and who need a high level of support to live in permanent housing.

Mental health services are interventions designed to minimize mental disability and maximize the restoration or maintenance of functioning consistent with the requirements for learning, development, independent living, and enhancing self-sufficiency.

4. **Desired Results**

The primary public health benefit is permanent housing for a vulnerable group of individuals. The program also provides intensive case management and case coordination services in which the client and case manager work together to develop goals to improve client's life in areas of health, education, employment, daily living skills. Federal law requires public mental health systems to provide services in integrated community settings, and Permanent Supportive Housing is a proven approach for doing so. It presents an alternative to hospitals, shelters, and other settings that segregate people by disability, such as nursing homes, board and care homes, and other residential care facilities, in which residency is tied to receiving the particular services the facility offers.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practice: Motivational Interviewing, Trauma-Informed approaches and Wellness Recovery Action Plan (WRAP). Licensed/licensed eligible staff provides Cognitive Behavioral Therapy.

Goal	Measurement & Data Source
1. 60% of consumers will remain housed at Lupine as of the end of the operating year or exit to other permanent housing destinations during the operating year. (MHSA/FSP)	• Measured by number of clients remaining housed or exiting to other permanent housing. • Data source: EMR/Avatar exit data; "Discharge Location" module.
2. 80% of consumers will maintain or improve their mental health recovery. (MHSA)	• Measured at entry, annually, and at exit thereafter via the "Illness Management and Recovery Outcome Survey."
3. 20% of consumers will attain employment, attend school or a vocational training program, or volunteer. (MHSA/FSP)	• Measured by number of clients reporting employment/volunteering, SEES referral and those participating in educational services as documented by Case Coordinator or counselor in client's EMR. • Data source: EMR/Avatar; "Ed/Empl/Vol" module.
4. 85% of consumers will appropriately engaged with a PCP. (MHSA/FSP)	• Measured by staff observations and clients' self-reports of engagement in primary care physician appointments. • Data source: EMR/Avatar "PCP Information" module.
5. 85% of consumers will report satisfaction with the quality of services provided. (MHSA)	• Measured by client self-report via annual "Consumer Satisfaction" survey instrument.
6. 75% of consumers served during the FY will eliminate all psychiatric hospitalizations, while in the program. (MHSA/FSP)	• Measured by clients' reduction in a mental health unit as per client self-report and staff report as documented via a KET and EMR. • Data source: EMR/Avatar
7. 75% of consumers served during the FY will not experience incarceration, while in the program. (MHSA/FSP)	• Measured by clients' reduction in a jail setting as per client self-report and staff report as documented via a KET and EMR. • Data source: EMR/Avatar

6. Who are the partners involved in program implementation?

MCBHB or Interim coordinators provide all referrals for this program. MCBHB provides psychiatry and medication support services.

7. What is the eligibility criteria for admission to the program?

- Financial Eligibility: Short-Doyle/Medi-Cal eligible, or meet the standards for low-income status as well as homelessness or at-risk of homelessness upon entry.
- Referral through Interim case coordinators or MCBHB service coordinators with admission approval by Interim. staff.
- The populations to be served are adults with major psychiatric disabilities (including and transition age youth age 18 and older) with serious mental illnesses, i.e. schizophrenia, schizoaffective disorder or bipolar disorders that substantially interfere on a long term basis with their functional ability to carry out primary aspects of daily living in the community and are receiving psychiatry services through MCBHB or a designee. (Exceptions to this criteria are only approved by MCBHB and Interim Inc. Deputy Director or designees.) Upon discharge from MCBHB services or Interim, rehabilitative mental health, case coordination, and case management services will be terminated. However, housing may not be terminated except as allowed under the lease. Upon discharge or termination from housing, clients are referred to MCBHB for case coordination.
- Housing eligibility is governed by funding sources regulatory agreements; housing is limited to people with specific income levels.
- Admission eligibility determined by Interim Program Director or designee.

When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?

- Program staff will collaborate with case coordinators to create an alternative referral plan for appropriate services.
- Clients aren't involuntarily discharged from housing unless they violate their lease agreement. Anticipated length of service doesn't pertain to permanent supportive housing.
- Clients who no longer need this level of care of supportive housing are encouraged and assisted with discharge plans into available affordable housing in the community.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

MCBHB refers all clients. Interim serves economically disadvantaged populations who meet the standards for low-income status, are homeless or at-risk, and are Short-Doyle/Medi-Cal eligible. The program addresses one of the top goals of the Monterey County 10-year Homeless Plan, Lead Me Home, by providing affordable permanent supportive housing. Interim is the only provider of permanent supportive housing for adults with mental illness in Monterey County.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

Staff is trained in Motivational Interviewing to ensure services align with the consumer's readiness for change. They are trained in and use a strengths-based and recovery focused model and deliver services that are based on individualized goals, set jointly between staff and individuals seeking services. Psychosocial educational and skill development groups are based on observed needs as well as ongoing feedback from participants. All services are voluntary, and staff are available on-call 24-hours a day to provide emergency support.

Input from residents is provided through the consumer run Recovery Task Force as well as resident council and resident community meetings. Interim offers support team meetings that include family members and other support team members as designated by consumers. Interim also hires peers and family members in every area of agency operations.

Staff receive training on Cultural and Linguistic Competency and Trauma Informed services. Bilingual Spanish services are provided as needed. Interpreters are available in other languages.

Services are integrated and coordinated with MCBHB and other providers in the area.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity is 20 housing units and annual number to be served is 20 clients. Housing is provided in studio apartments. The housing units all have Project Based Section 8 vouchers to provide rent subsidies for tenants. Clients transitioning out will be referred to MCBHB coordination services and Interim coordination will continue for approximately one month after discharge

PROGRAM NINE:

1. **Program Name:** Sunflower Gardens

2. **Program Description:**

Address of Delivery Site:	Sunflower Gardens, Salinas, CA
Program Schedule:	Typically, Monday through Friday, 8:30 a.m. to 5:00 p.m. Staff are on-call and available via cellphone for emergencies. Staff schedule may vary based upon consumers' needs. A resident manager is available at night for emergencies.
Limitation of Service:	Full Service Partnership (FSP) program. There are income limitations, and criteria of being homeless or at-risk of homelessness as defined by HCD MHP regulations.
	15 Permanent Supportive Housing Units (13 efficiency and 2 shared 4 bedroom units), and 2 Transitional Housing

Units (2 efficiency units)

Target # of Consumers: 23 consumers

Sunflower Gardens is an intensive permanent and transitional supportive housing program, which provides a Full Service Partnership (FSP) level of services to 23 very low-income individuals with a serious mental health diagnosis, all of whom are homeless or at high risk of homelessness. The service array includes: assessments, evaluation, case coordination, intensive case management provided in the FSP model as required by Mental Health Services Act funding, assistance in accessing benefits, and assistance with daily living skills in order to help consumers meet the terms of their lease, and live independently in the community.

3. **Program Purpose**

Sunflower Gardens provides case coordination, intensive mental health services and permanent or transitional supportive housing to vulnerable individuals with a serious mental illness who are homeless or at-risk of homelessness. The goal is to prevent further homelessness, to avoid costly hospitalization or use of short-term crisis residential programs, hospital crisis teams, and unnecessary institutionalization in residential care homes, and instead to increase resilience and self-sufficiency.

Behavioral health services are interventions designed to minimize functional impairment due to serious mental illness and maximize the restoration or maintenance of functioning consistent with the requirements for learning, development, independent living, and enhancing self-sufficiency.

4. **Desired Results**

Homeless or at risk of homelessness individuals with serious mental illness receive the necessary support system to ensure success in obtaining and maintaining housing as well as integrating into the community. Intensive case management services in which client and case manager work together to develop goals to improve client's life in areas of health, education, employment, daily living skills.

Federal law requires public behavioral health systems to provide services in integrated community settings, and Permanent Supportive Housing is a proven approach for doing so. It presents an alternative to hospitals, shelters, and other settings that segregate people by disability, such as nursing homes, board and care homes, and other residential care facilities, in which residency is tied to receiving the particular services the facility offers.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practice: Motivational Interviewing, Trauma-Informed approaches, Permanent Supportive Housing, and Wellness Recovery Action Plan (WRAP), and Seeking Safety. Licensed/licensed eligible staff provides Cognitive Behavioral Therapy.

Goal	Measurement & Data Source
1. 70% of consumers will remain housed at SFG as of the end of the operating year or exit to other permanent housing destinations during the operating year. (MHSA/FSP)	• Measured by number of clients remaining housed or exiting to other permanent housing. • Data source: EMR/Avatar exit data; "Discharge Location" module.
2. 90% of consumers will maintain or improve their mental health recovery. (MHSA)	• Measured at entry, annually, and at exit thereafter via the "Illness Management and Recovery Outcome Survey."
3. 20% of consumers will attain employment, attend school or a vocational training program, or volunteer. (MHSA/FSP)	• Measured by number of clients reporting employment/volunteering, SEES referral and those participating in educational services as documented by Case Coordinator or counselor in client's EMR. • Data source: EMR/Avatar; "Ed/Empl/Vol" module.
4. 85% of consumers will appropriately engaged with a PCP. (MHSA/FSP)	• Measured by staff observations and clients' self-reports of engagement in primary care physician appointments. • Data source: EMR/Avatar "PCP Information" module.
5. 90% of consumers will report satisfaction with the quality of services provided. (MHSA)	• Measured by client self-report via annual "Consumer Satisfaction" survey instrument.
6. 75% of consumers served during the FY will eliminate all psychiatric hospitalizations, while in the program. (MHSA/FSP)	• Measured by clients' reduction in a mental health unit as per client self-report and staff report as documented via a KET and EMR. • Data source: EMR/Avatar
7. 75% of consumers served during the FY will not experience incarceration, while in the program. (MHSA/FSP)	• Measured by clients' reduction in a jail setting as per client self-report and staff report as documented via a KET and EMR. • Data source: EMR/Avatar

SFG=Sunflower Gardens

6. **Who are the partners involved in program implementation?**

MCBHB or Interim coordinators provide all referrals for this program, including primary health care. MCBHB provides all psychiatry and medication support services.

7. **What is the eligibility criteria for admission to the program?**

- Financial Eligibility: Short-Doyle/Medi-Cal eligible, or meet the standards for low-income status as well as homelessness or at-risk of homelessness upon entry.
- Referral through Interim case coordinators and MCBHB service coordinators with admission approval by Interim staff.

- The populations to be served are adults with major psychiatric disabilities (including and transition age youth age 18 and older) with serious mental illnesses, i.e. schizophrenia, schizoaffective disorder or bipolar disorders that substantially interfere on a long term basis with their functional ability to carry out primary aspects of daily living in the community and are receiving psychiatry services through MCBHB or a designee. (Exceptions to this criteria are only approved by MCBHB and Interim Inc. Deputy Director or designees.) Upon discharge from MCBHB services or Interim, rehabilitative mental health, case coordination, and case management services will be terminated. However, housing may not be terminated except as allowed under the lease.
- Housing eligibility is governed by funding sources regulatory agreements.
- Admission eligibility determined by Interim Program Director or designee.

When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?

- Program staff will provide case coordination to create an alternative referral plan for appropriate services.
- Clients aren't involuntarily discharged from housing unless they violate their lease agreement. Anticipated length of service doesn't pertain to permanent supportive housing. The maximum length of stay in the two transitional units is two years.
- Clients who no longer need this level of care of supportive housing are encouraged and assisted with discharge plans into available affordable housing in the community.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

The MCHOME outreach program (see PROGRAM TEN below) has outreach workers who engage with individuals on the street and Interim case coordinators and Program Director determine their eligibility for this FSP and housing option. Interim serves economically disadvantaged populations who meet the standards for low-income status, are homeless or at-risk, and are Short-Doyle/Medi-Cal eligible.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

Staff is trained in Motivational Interviewing to ensure services align with the consumer's readiness for change. They are trained in and use a strengths-based and recovery focused model and deliver services that are based on individualized goals, set jointly between staff and individuals seeking services. Psychosocial educational and skill development groups are based

on observed needs as well as ongoing feedback from participants. All services are voluntary, and staff are available on-call 24-hours a day to provide emergency support.

Input from residents is provided through the consumer run Recovery Task Force as well as resident council and resident community meetings. Interim offers support team meetings that include family members and other support team members as designated by consumers. Interim also hires peers and family members in every area of agency operations.

Staff receives training on Cultural and Linguistic Competency and Trauma Informed services. Bilingual Spanish services are provided as needed. Interpreters are available in other languages.

Services are integrated and coordinated with MCBHB and other providers in the area.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity and annual number to be served is 23 clients. Clients transitioning out will be referred to MCBHB case coordination, and continue to be served by Interim case coordinators for approximately one month after discharge.

PROGRAM TEN:

1. **Program Name:** MCHOME

2. **Program Description:**

Address of Delivery Sites:	MCHOME, Marina, CA with countywide outreach Soledad House, Salinas, CA Wesley Oaks, Salinas, CA
Program Schedule:	Typically, Monday through Sunday, 8:30 a.m. to 5:00 p.m. Staff are on-call and available via cellphone for emergencies. Staff schedule may vary based upon consumers' needs.
Limitation of Service:	Full Service Partnership (FSP) program. There are income limitations per regulatory agreements for the two houses, and criteria of being homeless or at-risk of homelessness as defined by HUD regulations. Serving homeless adults with serious mental illness and/or functioning limitations that substantially interfere with ability to carry out primary aspects of daily living in the community.
Target # of Consumers:	61 unduplicated consumers per each fiscal year with 7 residing at Soledad and 4 at Wesley Oaks; enroll 20 new clients into MCHOME FSP services each fiscal year.

The MCHOME Program is a Full-Service Partnership ("FSP"), which provides wrap-around services, and outreach for adults with a psychiatric disability who are homeless or at high risk of homelessness. The purpose of the program is to assist adults with mental illness, including those served by the Adult System of Care, and Access, to move off the street into housing and employment and/or on benefits through outreach, assessments, intensive case management services, mental health services, and assistance with daily living skills.

Soledad House serves as transitional housing for MCHOME clients to reside in for no more than one year. This housing operates on the housing first model, and may be used for temporary housing for persons not yet enrolled in the FSP. Soledad provides a central place and a program identity that fosters positive peer support, and provides consumers with the tools to maintain housing.

Wesley Oaks is an intensive permanent supportive housing program, which provides a Full Service Partnership level of services to 4 very low-income individuals with a serious mental health diagnosis, all of whom are homeless or at high risk of homelessness. The service array includes: intensive case management and mental health services provided in the FSP model as required by Mental Health Services Act funding, and independent living skills development in order to help residents live self-sufficiently in the community.

3. **Program Purpose**

MCHOME provides intensive mental health services and shelter/housing support to vulnerable individuals with a psychiatric disability who are homeless or at-risk of homelessness. The goal is to prevent further homelessness, to avoid costly hospitalization or use of short-term crisis residential programs, hospital crisis teams, and unnecessary institutionalization in residential care homes. The program also focuses on helping individuals who are not currently receiving services from the public behavioral healthcare system to obtain psychiatric medications and other needed medical services. The program also works closely with the Department of Social Services to help individuals to enroll in benefits, including SSI.

Mental health services are interventions designed to minimize mental disability and maximize the restoration or maintenance of functioning consistent with the requirements for learning, development, independent living, and enhancing self-sufficiency.

4. **Desired Results**

Individuals with mental illness who are living on the street are stabilized, housed, and reintegrated into the community. Also, law enforcement, veterans' offices, the Probation Department, city officials, business councils, etc. have a program to which to refer when they are concerned about a homeless individual. MCHOME also works to temporarily move homeless individuals off the streets into motels or shelters to help to stabilize or prevent harm to homeless persons who are particularly vulnerable.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practice: Motivational Interviewing, Trauma-Informed approaches, and Wellness Recovery Action Plan (WRAP). Case coordinators may also provide Cognitive Behavioral Therapy and/or Dialectical Behavioral Therapy.

Goal	Measurement & Data Source
1. 80% of consumers will maintain or improve their mental health recovery. (MHSA)	• Measured via the pre and post "Illness Management and Recovery Outcome Survey."
2. Upon discharge from MCHOME, 60% of consumers will be residing in transitional and/or permanent housing. (MHSA/FSP)	• Measured by number of clients discharging to either transitional or permanent housing. • Data Source: Clients self-report and staff observations of discharge locations. Staff will complete a KET and enter into EMR system. • Data source: EMR/Avatar KET & exit data; "Discharge Location" module.
3. 75% of consumers will appropriately engaged with a PCP. (MHSA/FSP)	• Measured by staff observations and clients' self-reports of engagement in primary care physician appointments. • Data source: EMR/Avatar "PCP Information" module.
4. 80% of consumers will report satisfaction with the quality of services provided. (MHSA)	• Measured by client self-report via annual "Consumer Satisfaction" survey instrument.
5. 67% of consumers served during the FY will eliminate all psychiatric hospitalizations, while in the program. (MHSA/FSP)	• Measured by clients' reduction in a mental health unit as per client self-report and staff report as documented via a KET and EMR. • Data source: EMR/Avatar
6. 50% of consumers served during the FY will not experience incarceration, while in the program. (MHSA/FSP)	• Measured by clients' reduction in a jail setting as per client self-report and staff report as documented via a KET and EMR. • Data source: EMR/Avatar

6. **Who are the partners involved in program implementation?**

MCHOME collaborates with MCBHB, the Coalition of Homeless Services providers, Community Housing Improvement Systems and Planning Association, Inc. (CHISPA), the Cities of Monterey and Salinas and numerous community organizations. MCHOME works actively with law enforcement agencies and hospitals to engage homeless persons who are identified as possibly having mental health challenges. MCBHB provides psychiatry and medication support services.

7. **What is the eligibility criteria for admission to the program?**

- No MCBHB referral is required for admission to MCHOME, but MCHOME accepts referrals from MCBHB ASOC, Access, and TAY services and Interim case coordinators. Referrals also come from law enforcement, Hospital Emergency Departments as well as community agencies.
- Financial Eligibility: Short-Doyle/Medi-Cal eligible or meet the standards for low-income status as well as homelessness or at-risk of homelessness upon entry.
- The populations to be served are adults with serious mental illness and/or functioning limitations that substantially interfere with ability to carry out primary aspects of daily living in the community. Upon discharge, rehabilitative mental health and case management services will be terminated.
- Admission eligibility determined by Interim Program Director or designee.

When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?

- Program staff will collaborate with case coordinators to create an alternative referral plan for appropriate services.
- Discharge is when clients are no longer meeting medical necessity.
- Length of service depends on medical necessity and ability to place clients into appropriate discharge placements. Clients must agree to be discharged from an FSP unless the client is no longer willing to engage in services.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

Interim serves economically disadvantaged populations who meet the standards for low-income status, are homeless or at-risk, or are Short-Doyle/Medi-Cal eligible.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

Staff is trained in Motivational Interviewing to ensure services align with the consumer's readiness for change. They are trained in and use a strengths-based and recovery focused model and deliver services that are based on individualized goals, set jointly between staff and individual residents. Psychosocial educational and skill development groups are based on observed needs as well as ongoing feedback from participants. All services are voluntary, and eligible admission/assessment is available Monday through Friday.

Input from consumers is provided through the consumer run Recovery Task Force. Interim offers support team meetings that include family and other support team members as designated by consumers. Interim also hires peers and family members in every area of agency operations.

Staff receive training on Cultural and Linguistic Competency and Trauma Informed services. Bilingual Spanish services are provided as needed. Interpreters are available in other languages.

Services are integrated and coordinated with MCBHB.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity and annual number to be served is 61 clients.

PROGRAM ELEVEN:

1. **Program Name:** Dual Recovery Services

2. **Program Description:**

Address of Delivery Site:	41 E. San Luis St., Salinas, CA 93901
Program Schedule:	Monday through Friday, 8am – 5pm.
Limitation of Service	Clients are referred by the Monterey County Behavioral Health Staff or Interim, Inc. Case coordinators.
Target # of Consumers:	85

Dual Recovery Services (DRS) is an outpatient program for adults with co-occurring serious mental illness and substance use disorders. The program aims to assist clients in developing dual recovery skills to maintain successful community living, and to promote a clean and sober lifestyle as they transition out of dual recovery residential programs. Interim staff provides individual and group counseling to help clients develop skills to adjust to community living and/or maintain housing through the evidenced based practice of Motivational Interviewing. Clients develop goals that are focused on increasing daily structure, improving symptom management skills, personal and social functioning, and substance use recovery skills.

3. **Program Purpose**

DRS uses behavioral health wellness and recovery principles to assist clients to develop the coping and recovery skills needed to successfully live in the community. It provides assessment/evaluation, rehabilitation, and group and individual mental health services to maintain or restore mental health, personal independence and functioning and sobriety.

Best evidence practice indicates that in order to make a successful adjustment back to community living for individuals with dual recovery issues, consumers need activities every day that promote a clean and sober life style. The staff and the consumer develop written daily schedules for individuals to have and to follow. These schedules include various treatment options that include: skill building groups, recovery oriented community based groups and other structured activities which promote healthy community living and help to reduce the triggers that lead to relapse of substance use. Individual written service plans are developed for each consumer moving into this phase of community based treatment and help teach consumers how to avoid drug and alcohol use while strengthening healthy social supports using wellness and recovery principles.

4. **Desired Results**

DRS aims to increase consumers' successful adjustment to community living after completion of dual recovery residential program by reducing the relapse rate.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practice: Motivational Interviewing, Seeking Safety, Trauma-Informed approaches, and Wellness Recovery Action Plan (WRAP).

Goal	Measurement & Data Source
1. Program will serve 85 consumers with co-occurring serious mental illness and substance use disorders.	• Outcome measured by the number of individuals participating in the program services during the fiscal year based on data entered into the EMR and the tracking spreadsheet.
2. 80% of consumers served during the FY will eliminate all psychiatric hospitalization, while in the program. (MHSA)	• Measured by psychiatric hospitalization data records in EMR/Avatar.
3. 85% of consumers will not experience incarceration, while in the program. (MHSA)	• Measured by clients' reduction in a jail setting as per client self-report and staff report as documented via EMR. • Data source: EMR/Avatar; "Incarceration" module.
4. 90% of consumers will report satisfaction with the quality of services provided. (MHSA)	• Measured by client self-report via annual "Consumer Satisfaction" survey instrument, or at exit.

6. **Who are the partners involved in program implementation?**

MCBHB is a key partner in implementation and referrals.

7. **What is the eligibility criteria for admission to the program?**

- Financial Eligibility: Short-Doyle/Medi-Cal eligible.
- Referral through MCBHB or Interim coordinators with admission approval by Interim staff.
- The populations to be served are adults age 18 and older with a primary serious mental illness diagnosis who have a co-occurring substance abuse disorder diagnosis and who require support to acquire and apply coping, recovery, interpersonal, and independent living skills to function in the community.
- Admission eligibility determined by Interim Program Director or designee.

When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?

- Interim program staff will collaborate with MCBHB clinical staff to create an alternative referral plan for appropriate services.
- Discharge is when clients have returned to stable community functioning and are able to maintain sobriety.
- Length of service depends on individual need but no longer than two years.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

MCBHB refers all clients. Interim serves economically disadvantaged populations who are Short-Doyle/Medi-Cal eligible.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

Staff is trained in Motivational Interviewing to ensure services align with the consumer's readiness for change. They are trained in and use a strengths-based and recovery focused model and deliver services that are based on individualized goals, set jointly between staff and individual residents. Psychosocial educational and skill development groups are based on observed needs as well as ongoing feedback from participants. All services are voluntary, and eligible admission/assessment is available by appointment only Monday through Friday. Admissions are based on most-in-need versus first on waiting list based on MCBHB evaluation.

Input from consumers is provided through the consumer run Recovery Task Force. Interim offers support team meetings that include family and other support team members as designated by consumers. Interim also hires peers and family members in every area of agency operations.

Staff receive training on Cultural and Linguistic Competency and Trauma Informed services. Bilingual Spanish services are provided as needed. Interpreters are available in other languages.

Services are integrated and coordinated with MCBHB.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity and annual number to be served is 85 individuals.

PROGRAM TWELVE:

1. **Program Name:** Outreach and Aftercare Services (SAMHSA block grant)

2. **Program Description:**

Address of Delivery Sites:	41 E. San Luis St., Salinas, CA 93901, other services delivered in South County in MCBHB operated clinics.
Program Schedule:	Monday through Friday, 8am – 5pm.
Target # of Consumers:	40

Outreach and Aftercare Services is an outpatient program for adults, with co-occurring serious mental illnesses and substance use disorders, living in the community who are at risk and/or in need of dual recovery or other substance use treatment program. This program focuses on those individuals not currently receiving services from Monterey County Adult System of Care. Staff provides individual and group counseling to help clients with harm reduction, clean and sober living, satisfying structured activity, and successful integration into community life (including obtaining/maintaining housing) through the evidenced based practice of Motivational Interviewing. Clients develop goals that are focused on increasing daily structure, and improving symptom management skills, personal and social functioning, and substance use recovery skills.

Outreach and Aftercare staff help to facilitate formation and operation of Double Trouble in Recovery meetings in Monterey, Marina, and Salinas targeting persons with serious mental illness as well as substance abuse disorders. The program provides outreach to South County and operates outreach and groups at County operated BH clinics at least weekly.

3. **Program Purpose**

Outreach and Aftercare uses wellness and recovery principles to develop the coping and recovery skills needed to successfully live in community. It provides evaluation, rehabilitation, and mental health services to maintain or restore personal independence and functioning consistent with requirements for learning and development. Best evidence practice indicates that

in order to maintain successful community integration individuals with dual recovery issues need activities every day that promote a clean and sober life style.

4. **Desired Results**

Outreach and Aftercare aims to assist clients with developing the recovery skills necessary to maintain successful community integration, and substance use recovery.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practice: Motivational Interviewing, Seeking Safety, Trauma-Informed approaches, and Wellness Recovery Action Plan (WRAP).

Goal	Measurement & Data Source
1. Program will serve 40 consumers with co-occurring mental illness and substance use disorders who are not receiving services from Monterey County Behavioral Heath Bureau (exception: South County).	• Outcome measured by the number of clients participating in services as indicated on tracking spreadsheet.
2. 75% of consumers surveyed will improve their mental health recovery. (MHSA)	• Measured via the pre and post "Illness Management and Recovery Outcome Survey."
3. 85% of consumers will be referred to and obtain services from community resource providers.	• Outcome measured by number of clients referred or participating in community resources. Staff tracking and documentation of referrals made for each individual client.

6. **Who are the partners involved in program implementation?**

Other agencies in the BH system and in the Coalition of Homeless Services providers can provide referrals. This program frequently works with faith communities, local hospitals and outpatient health care providers.

7. **What is the eligibility criteria for admission to the program?**

- The populations to be served are adults with major psychiatric disabilities age 18 and older who have a substance use disorder diagnosis and who require support to acquire and apply coping, recovery, interpersonal, and independent living skills to function in the community.
- Dually diagnosed adults who are not opened to the Monterey County Adult System of Care (except in South County, where clients can also be open to the BH system). Clients open to BH may also be provided non-Medi-Cal eligible services such as organization and recruitment for the Dual Recovery Anonymous system.

When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?

- Program staff will collaborate with case coordinators to create an alternative referral plan for appropriate services.
- Discharge is when clients are no longer meeting medical necessity.
- Length of service depends on medical necessity and ability to place clients into appropriate discharge placements.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

This program reaches those who are not opened to the Monterey County Behavioral Health System of Care (except in South County), because they either do not meet the eligibility criteria for the Adult System of Care or are ineligible for Medi-Cal benefits. OAS also takes referrals for homeless adults, those recently released from jail, and those being monitored by the Probation Department who have dual recovery needs. OAS will refer clients who are eligible to MCBHB and/or other resources in the community.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

Staff is trained in Motivational Interviewing to ensure services align with the consumer's readiness for change. They are trained in and use a strengths-based and recovery focused model and deliver services that are based on individualized goals, set jointly between staff and individual residents. Psychosocial educational and skill development groups are based on observed needs as well as ongoing feedback from participants. All services are voluntary, and eligible admission/assessment is available by appointment only Monday through Friday. Admissions are based on most-in-need versus first on waiting list based on MCBHB evaluation.

Input from consumers is provided through the consumer run Recovery Task Force. Interim offers support team meetings that include family and other support team members as designated by consumers. Interim also hires peers and family members in every area of agency operations.

Staff receive training on Cultural and Linguistic Competency and Trauma Informed services. Bilingual Spanish services are provided as needed. Interpreters are available in other languages.

Services are integrated and coordinated with MCBHB.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity and annual number to be served is 40 individuals.

PROGRAM THIRTEEN:

1. **Program Name:** Supported Education Services (SEES)

2. **Program Description:**

Address of Delivery Site:	339 Pajaro St., Salinas, CA 93901
Program Schedule:	Monday through Friday, 8am – 5pm
Limitation of Service	Clients are referred by the Monterey County Behavioral Health Department.
Target # of Consumers:	40

The Supported Education Services program (SEES) assists adults with psychiatric disabilities to be successful in the educational environment of their choice. The program's services include assistance with class enrollment, coordination of services with the educational institution, and ongoing support while consumers are pursuing their educational endeavors. The SEES program provides at least eight (8) informational presentations within Interim and MCBHB on Supported Education Services, and facilitates two (2) Peer Support Groups each week.

3. **Program Purpose**

SEES provides consumers with the ability to access and sustain their educational endeavors as well as establish possible vocational plans.

4. **Desired Results**

- Supported Education is a SAMHSA Evidence Based Practice. The community benefits include consumers having access and continuing to use the educational environment of their choice. Also, this program allows for diversity within the educational system. The onset of mental illness most commonly occurs between the ages of 15 and 21 when young people are beginning to develop their adult roles. During this time, they are completing their education that prepares them to work, developing relationships that create a social network, and learning their rights and responsibilities within their communities. The onset of a mental illness disrupts this process. Once disrupted, it is extraordinarily difficult to recreate.

- Supported Education programs help consumers pursue their individual educational goals. Offered in tandem with Supported Employment, these programs help consumers develop a sense of self-efficacy and independence. Supported Education encourages consumers to think about and plan for their future. It provides an important step to help consumers use their

innate talents and abilities and pursue their personal recovery goals. Also, Supported Education promotes career development to improve long-term work opportunities.

Supported Education follows the "choose-get-keep" model, which helps consumers make choices about paths for education and training, get appropriate education and training opportunities, and keep their student status until they achieve their goals.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practices: Motivational Interviewing and Stages of Change, and Supported Education.

Goal	Measurement & Data Source
1. Enroll at least 20 consumers each academic semester (fall and spring) in educational institutions within Monterey County of their choice.	• Measured by the number of consumers enrolled each semester during the FY. • Data Source: Data tracking spreadsheet, recording the number of consumers enrolled in school each semester and the institution they are attending.
2. 40% of consumers enrolled in educational institutions will have educational goals that are tied to a vocational plan.	• Measured by number of clients participating in educational services as documented by Case Coordinator or counselor in client's EMR. • Data source: EMR/Avatar; "Ed/Empl/Vol" module.
3. 85% of consumers will report satisfaction with the quality of services provided. (MHSA)	• Measured by client self-report via annual "Consumer Satisfaction" survey instrument, or at exit.

6. **Who are the partners involved in program implementation?**

MCBHB, the California Department of Rehabilitation, and local community colleges disabled student programs are key partners in implementation.

7. **What is the eligibility criteria for admission to the program?**

- Financial Eligibility: Short-Doyle/Medi-Cal eligible.
- Referral through MCBHB case coordinators or Interim case coordinators.
- The populations to be served are adults with major psychiatric disabilities age 18 and older who have mental health disorders that substantially interfere with their functional ability to carry out primary aspects of daily living in the community and are receiving psychiatry services through MCBHB. Upon discharge from MCBHB services or Interim, rehabilitative mental health and case management services will be terminated.

When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?

- Program staff will collaborate with case coordinators/case managers to create an alternative referral plan for appropriate services.
- Clients can self-discharge from the program. Discharge also occurs when clients have met their goals. Lastly, clients are discharged when they stop being in contact with the program.
- Length of service is as long as clients need services.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

MCBHB refers all clients. Interim serves economically disadvantaged populations who are Short-Doyle/Medi-Cal eligible.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

Staff is trained in Motivational Interviewing to ensure services align with the consumer's readiness for change. They are trained in and use a strengths-based and recovery focused model and deliver services that are based on individualized goals, set jointly between staff and individual residents. Psychosocial educational and skill development groups are based on observed needs as well as ongoing feedback from participants. All services are voluntary.

Input from consumers is provided through the consumer run Recovery Task Force. Interim offers support team meetings that include family and other support team members as designated by consumers. Interim also hires peers and family members in every area of agency operations.

Staff receive training on Cultural and Linguistic Competency and Trauma Informed services. Bilingual Spanish services are provided as needed. Interpreters are available in other languages.

Services are integrated and coordinated with MCBHB.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity and annual number to be served is 40 individuals.

PROGRAM FOURTEEN:

1. **Program Name:** Workforce Education & Training (WET)

2. **Program Description:**

Address of Delivery Site:	339 Pajaro St., Salinas, CA 93901
Program Schedule:	Monday through Friday, 8am – 5pm
Limitation of Service	Clients are self – referred
Target # of Consumers:	60

Workforce Education & Training (WET) promotes successful employment of consumers and family members in the public mental health system in Monterey County. The program provides outreach, recruitment, employment support services, job analysis, training, and job coaching for mental health consumers or family members to promote a diverse and stable mental health workforce. The WET program provides twenty-four (24) trainings per fiscal year on skill development and facilitates three (3) vocational support groups per month.

All services are consistent with MHSA guidelines and incorporate the General Standards set forth in Title 9, California Code of Regulations (CCR), Section 3320:1) wellness, recovery and resilience, 2) cultural competence, 3) consumer and family driven mental health services, 4) an integrated service experience, and 5) collaboration with the community.

3. **Program Purpose**

WET provides consumers with gainful employment in the mental health workforce thereby giving them an ability to influence the system of care. This program also helps promote recovery, and creates a more collaborative community.

4. **Desired Results**

The community benefits include having those who understand and who have experienced the mental health system, as consumers or family members, share their first-hand experience. Also, this program allows for diversity and improvement to the mental health workforce. Consumer-operated or peer support services are an evidence based practice recognized by SAMHSA. Consumer-operated services have diverse sets of practices, but research has recognized four basic types of functions: mutual support, community building, providing services, and advocacy. Some consumer-operated services assume all four of these functions; others emphasize only some of them. People with common life experiences have a unique capacity to help each other because they share a deep understanding that might not exist in other relationships. Mutual support exemplifies the "helper's principle" which means that both parties benefit from the process. When peers support each other in this way, there is no need to designate who is the "helper" and who is the "helpee." They might switch back and forth in these roles or act simultaneously. The WET program recruits and trains peers and family member to work in the

public mental health system and provides training and support to help consumers and family members effectively work in their jobs.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practice: Motivational Interviewing, and peer support.

Goal	Measurement & Data Source
1. Serve 60 (unduplicated) consumers or family members employed in the public mental health system each fiscal year, including Wellness Navigators.	• Measured by the number of unduplicated participants each year. • Data source: Data spreadsheet indicating consumers or family members participating in the services, i.e. job coaching, employment training, etc.
2. Provide three vocational support groups per month.	• Measured by staff providing at least three groups and clients attendance in groups. • Data Sources: Agenda for support groups and attendance records with attendees' signatures.
3. Provide 24 trainings per fiscal year on skill development.	• Measured by staff providing at least 24 trainings each year and clients' attendance in trainings. • Data Sources: Agenda for trainings and attendance records with attendees' signatures.

6. **Who are the partners involved in program implementation?**

MCBHB is a key partner in implementation. Persons served can be employed by MCBHB or any non-profit or for-profit agency contracted to the public mental health system.

7. **What is the eligibility criteria for admission to the program?**

- Adults, 18 and over who are mental health consumers or family members and are currently employed by, or interested in becoming employed by the either the public mental health system or a non-profit or profit agency contracted to the public mental health system.
- Referral: Self-referral.

When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?

- Individuals are admitted to the program on a self-referral basis.
- Clients can self-discharge from the program. Clients also discharge when they are no longer working in mental health field or don't require services.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

Interim serves economically disadvantaged individuals who are interested in working in the public mental health system or are currently working in the public mental health system and who have lived experience or who are family members of those with a serious mental illness.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

All services are provided to consumers and family members. These services are not clinical in nature. A curriculum of groups and trainings are offered that promote cultural competency, wellness and recovery principles, healthy boundaries and communication skills. Services are also provided to supervisors who supervise consumers and family members to help them integrate consumers and family members effectively into the workplace.

Input from consumers is provided through the consumer run Recovery Task Force. Interim offers support team meetings that include family and other support team members as designated by consumers. Interim also hires peers and family members in every area of agency operations.

Staff receive training on Cultural and Linguistic Competency and Trauma Informed services. Bilingual Spanish services are provided as needed. Interpreters are available in other languages.

Services are integrated and coordinated with MCBHB.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity and annual number to be served is 60 individuals.

PROGRAM FIFTEEN:

1. **Program Name:** OMNI Resource Center

2. **Program Description:**

Address of Delivery Sites:	339 Pajaro St., Salinas, CA 93901 & other locations for groups.
Program Schedule:	Monday through Friday, 10am – 4pm, some evenings
Target # of Consumers:	500

OMNI's mission is to increase mental health wellness of individuals and the community by providing wellness awareness and innovative programs. The Center is a peer and family member operated facility. The Center serves to assist members in pursuing personal and social growth through self-help groups, socialization groups, and peer support groups in order to specifically address issues of personal growth. Additionally, the Center offers skills and tools to those who choose to become leaders among their peers to take an active role in the wellness and recovery movement through various initiatives.

3. **Program Purpose**

The community benefits include the provision of services for those who are seeking mental health wellness and recovery. The Center works to help individuals find a meaningful role in their community, to gain self-empowerment, to learn advocacy and leadership skills, and to educate the public on mental health and recovery.

4. **Desired Results**

The public health benefits include an inclusive environment where mutual support and resources are available to clients on their pathway to mental health wellness and recovery. Peers come together to socialize, interact with one another, attend support groups and join in planned activities. Additionally, the Center offers skills and tools to those who choose to become leaders among their peers and take an active role in the wellness and recovery movement at the Center and the community. Through mutual support, self-empowerment and effective programming, the Center's goal is that each individual will be able to connect, meet their challenges, and find balance in their life and a meaningful role in their community.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practice: Motivational Interviewing and Consumer-Operated Services (SAMHSA).

Goal	Measurement & Data Source
1. Provide services to 500 unduplicated consumers that will expand knowledge of wellness & recovery.	• Outcomes measured by the number of consumers attending events/services. Also consumers' self-reports will be used. • Data source: Daily sign in sheets, and tracking meeting attendance.
2. 85% of consumers attending the OMNI Center at least 10 or more times per year will report maintained or improved mental health recovery.	• Measured by pre and post self-survey results using the Recovery Assessment Scale (RAS) standardized survey tool.

3. 85% of consumers will report satisfaction with the quality of services provided.	• Measured by client self-report via annual "Consumer Satisfaction" survey instrument.

6. **Who are the partners involved in program implementation?**

The primary partner involved is MCBHB. OMNI also collaborates with community centers in East Salinas to host offsite groups.

7. **What is the eligibility criteria for admission to the program? When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?**

- The Center is open to all mental health consumers; no referrals are necessary.
- OMNI provides outreach to local residential care homes.
- Some activities are offered on the Monterey Peninsula, including peer outreach to the in-patient psychiatric unit at Community Hospital of the Monterey Peninsula (CHOMP).
- The populations to be served are adults over 18, who are self- identified as having mental health challenges. There is no admittance and therefore no discharge.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

The Center serves all individuals who are seeking peer support. OMNI staff conduct at least four outreach opportunities a year and facilitate two groups in Spanish in East Salinas monthly. Staff also facilitate a bilingual Spanish group at the Center three times per week. OMNI also offers OMNI After Hours, a program that specifically serves transition age youth and young adults from 18-30 years old.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

Staff is trained in peer support, active listening, communication skills, and Motivational Interviewing.
All services are voluntary.
Input from consumers is provided through the consumer run Recovery Task Force. Interim also hires peers and family members in every area of agency operations.
Staff receive training on Cultural and Linguistic Competency and Trauma Informed services.
Bilingual Spanish services are provided as needed. Interpreters are available in other languages.
Services are integrated and coordinated with MCBHB.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity and annual number to be served is 500 individuals.

PROGRAM SIXTEEN:

1. **Program Name:** Success Over Stigma

2. **Program Description:**

Address of Delivery Site: 339 Pajaro St. Salinas, CA 93901

The "Success Over Stigma" (SOS) program promotes consumer involvement in advocating for public policies that support and empower people with psychiatric disabilities. The program focuses on consumer involvement in planning and executing mental health services and anti-stigma messaging in the community. SOS provides peer consultation to service providers, including increasing peer involvement in developing and strengthening mental health services both locally and at the state level. Lastly, consumers learn how to better advocate for themselves by providing reciprocal peer support and advocacy in their community.

3. **Program Purpose**

The psychiatrically disabled community needs direct recipient representation in order to obtain services and programs that will better serve their needs. This initiative gives clients the opportunity to share their behavioral health experience and impact policy regarding their services.

4. **Desired Results**

The public health benefits include supporting those with serious mental illness in self-efficacy, and exposing the community to a mental health consumer's experience. This program provides education to the community to directly confront mental health stigma and discrimination issues.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practice: Consumer-Operated Services (SAMHSA).

Goal	Measurement & Data Source

1. Reduce mental health stigma in the community by providing 25 educational opportunities in the community.	• Measured by survey results from presentation attendees and tracking spreadsheet of meetings. • Data sources: Roster of consumers being recruited and receiving training; record of presentations being conducted including locations.
2. Reduce mental health stigma in the community by providing 48 (Hope & Recovery) educational opportunities at in-patient units.	• Measured by the feedback from participants during groups. • Data sources: Roster of consumers being recruited and receiving training; record of presentations being conducted including locations; consumer feedback during groups.
3. 35 consumers/peers will participate and provide feedback and consultation in policy and advocacy committees.	• Measured by the number of consumers attending and participating in committees. • Data sources: Spreadsheet identifying the committees and consumer attendance/participation.

6. **Who are the partners involved in program implementation?**

MCBHB is a key partner, as well as other community-based service organizations.

7. **What is the eligibility criteria for admission to the program?**

- The population to be served are adults with mental health challenges.
- No referral is necessary. Participants are recruited by the SOS Coordinator. Participants for the speakers' bureau are selected and trained based on ability to give public presentations and to share their life stories.

When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?

Not applicable.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

Interim serves economically disadvantaged populations who meet the standards for low-income status. The program distributes information, makes contact with community (including agencies, churches, etc.), attends networking events to reach and engages underserved populations.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

Staff is trained in and use a strengths-based and recovery focused model. Clients are taught self-advocacy techniques.

Input from consumers is provided through the consumer run Recovery Task Force. Interim offers support team meetings that include family and other support team members as designated by consumers. Interim also hires peers and family members in every area of agency operations.

Staff receive training on Cultural and Linguistic Competency and Trauma Informed services. Bilingual Spanish services are provided as needed. Interpreters are available in other languages.

Services are integrated and coordinated with MCBHB.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity and annual number to be served is 35 clients and/or family members, as speakers. The program provides presentations in schools, faith communities, service clubs, and to law enforcement through the Crisis Intervention Training (CIT) trainings.

PROGRAM SEVENTEEN:

1. **Program Name:** Bienestar Wellness Navigators

2. **Program Description:**

Address of Delivery Sites:	339 Pajaro St. Salinas, CA 93901
	and MCBHB's Primary Care Integrated Clinics located in Salinas, Marina, and King City
Limitation of Service:	Clients as assigned by MCBHB

Interim, Inc. collaborates with MCBHB in the implementation of the Health Navigation Partnership - "Bienestar" project, which places primary care services in community mental health clinics operated by MCBHB. Interim, Inc. hires peer Wellness Navigators who provide activities that engage, educate and offer support to individuals, their family members, and caregivers in order to successfully connect them to culturally relevant health services. The Wellness Navigators assist in care coordination, provide prevention assistance (such as peer-to-peer smoking cessation) and help clients build skills needed to access primary care services. As clients make enough progress to transition back into mainstream primary care services, Wellness Navigators accompany them and provide support to make sure they are successful in accessing all the services they need.

3. **Program Purpose**

Research has shown that mental health peer programs significantly improve access to medical and mental health care, and that outcomes are improved in both areas. Clients' quality of life will be improved as their health and ability to navigate through the primary care system is expanded.

4. **Desired Results**

The public health benefits include improved access to medical and mental health care by consumers.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Interim solely provides the Wellness Navigators. Bienestar staff provide on the job supervision and Interim provides evaluative supervision and coaching off site.

Evidence based practices: Consumer-Operated Services (SAMHSA) - Evidenced based practices, goal setting, data collection and analysis will be the responsibility of MCBHB for all MCBHB related goals. Wellness Navigators will enter data on clients served into MCBHB's Avatar System.

6. **Who are the partners involved in program implementation?**

Community mental health clinics operated by MCBHB.

7. **What is the eligibility criteria for admission to the program? When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?**

- The population to be served are adults with mental health challenges who are accessing community mental health clinics operated by MCBHB.
- All clients are referred and monitored by MCBHB.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

MCBHB refers all clients. Interim serves economically disadvantaged populations who meet the standards for low-income status or are Short-Doyle/Medi-Cal eligible.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

The Bienestar program is operated by MCBHB. Interim only provides the Wellness Navigators.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity and annual number to be served is dependent on the number of clients referred by MCBHB.

PROGRAM EIGHTEEN:

1. **Program Name:** Peer Support – Wellness Navigation

2. **Program Description:**

Address of Delivery Site: 339 Pajaro St. Salinas, CA 93901

Limitation of Service: Clients referred by MCBHB

Target # of Consumers: 70

Wellness Navigation is a voluntary peer support program that assists consumers with building mental health recovery skills and integration into community resources. Consumers are referred by MCBHB case coordinators, Mental Health Unit ("MHU"), and Access Clinic staff based on need for peer supportive services. Case coordinators collaborate with consumers by discussing referrals and identifying a specific focus for Wellness Navigator's services. After agreement with the consumer, case coordinators submit a referral for services and select skills building area/s on the referral form in which the consumer would like to participate in Peer Support counseling and coaching.

Examples of services provided by Wellness Navigators:

- Creating and helping to utilize a Wellness Recovery Action Plan (WRAP).
- Teaching and helping practice communication skills for communicating with healthcare providers and others.
- Transportation to healthcare appointments can be provided for clients who need coaching when communicating with providers and who do not have access or cannot utilize transportation.
- Teaching and helping practice medication management skills, e.g. self-organization of medications and ordering refills.
- Assisting with familiarization and integration into the public mental health services system by sharing peer stories and other information.
- Providing connection, referrals, and integration into community based resources.
- Teaching and helping practice how to utilize public transportation.
- Teaching and helping practice time management and organizational skills.

- Teaching and helping practice financial/budget management skills.
- Teaching and helping practice social skills and develop support system.
- Integration into social settings.
- Peer counseling and/or coaching.

3. **Program Purpose**

Research has shown that mental health peer programs significantly improve access to medical and mental health care, and that outcomes are improved in both areas. Clients have support in accessing services and building recovery skills, and feel as part of a community with the help of peer Wellness Navigators. Wellness Navigators work one-on-one with consumers, promoting mental health recovery and evidence-based practices; providing awareness of the signs and symptoms of mental health challenges; and assisting consumers in recovery strategies. Wellness Navigators also connect consumers to community resources to promote consumers' self-management of their mental health recovery. Wellness Navigators also provide support for family members during visiting hours at the MHU.

4. **Desired Results**

The public health benefits include improved access to medical and mental health care by consumers. This peer support initiative plays an important role in the County's efforts to promote mental health recovery, peer advocacy, and peer leadership. This strategy will increase resilience, wellness and self-management of health and behavioral health. Through this support, consumers will be more equipped to transition back to the community.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Interim recruits, trains, and provides the Wellness Navigators to assist clients referred by MCBHB. Wellness Navigators will collect data on clients served. Evidenced Based Practices: Consumer-Operated Services (SAMHSA) and Motivational Interviewing.

Goal	Measurement & Data Source
50% of consumers will be referred to and obtain services from at least two community resource providers as a result of WN linkage.	• Measurement based on staff observation and consumers' self-report of resources contacted. • Data source: WNs recording data on spreadsheet.

6. **Who are the partners involved in program implementation?** MCBHB.

7. **What is the eligibility criteria for admission to the program? When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?**

- The population to be served are adults with mental health challenges referred by MCBHB.
- Adults with mental health challenges who are transitioning out of the crisis residential program and/or hospital in-patient units.
- All clients are referred by MCBHB case coordinators, and MCBHB Mental Health inpatient unit staff.

Duration of services

Wellness Navigation services can be provided to the consumer for a time period of up to three months.

Criteria

Wellness Navigation serves adults with serious mental illnesses (SMI) or serious functional impairments who are referred by MCBHB and who are in need of peer support services. (Services can include adults with SMI who are discharging from the MHU or Manzanita Crisis Residential program.)

Exclusions

Consumers who are currently receiving services from Interim Inc. housing, residential treatment programs, Lupine Gardens FSP or Sunflower Gardens FSP programs. Consumers who are actively suicidal or who exhibit aggressive/threatening behaviors.

Admission

Program Coordinator will assess ability to participate in a peer support program. Once a referral is received from MCBHB, Program Coordinator will access and review clients' psychosocial and treatment plans from Avatar EMR, referral information from MCBHB, and information obtained by meeting with the consumer. Admission eligibility is determined by Interim Program Director or designee.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

MCBHB refers all clients. Interim serves economically disadvantaged populations who meet the standards for low-income status or are Short-Doyle/Medi-Cal eligible. Wellness Navigators serve to create a welcoming environment where individuals accessing services for the first time at the outpatient clinics can feel welcome and supported by someone who may have a similar experience.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

Interim solely recruits, trains, and provides the Wellness Navigators. Wellness Navigators are trained in outreach, wellness and recovery, strength and resiliency, communications, and accessing community services. Wellness Navigators receive training in cultural competency.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Program capacity and annual number to be served is dependent on the number of clients referred by MCBHB. Interim anticipates serving approximately 70 consumers.

PROGRAM NINETEEN:

1. **Program Name:** Choices - Day Treatment Intensive Program

2. **Program Description:**

Type of Program:	**Day Treatment Intensive (DTI)** is a structured, multi-disciplinary program of therapy that is an alternative to hospitalization, avoiding clients' placement in a more restrictive setting and maintaining clients in a community setting. The program provides services to adults with serious mental illnesses. Services are site based group and individual therapeutic services, but not all services are delivered at the site.
Address of Delivery Site:	339 Pajaro St., Salinas, CA 93901
Program Schedule:	Monday through Friday, providing clients with more than four hours per day of therapeutic groups/activities, not including lunch or other breaks, or collateral staff activities that occur outside of the program hours.
Limitation of Service	Clients with serious mental illnesses and/or serious functioning impairments, referred by MCBHB ASOC, Access, TAY, PREP/Felton Institute, and Interim who are able to safely participate with peers and staff in an outpatient, milieu setting. Admission preference is given to clients discharging from the hospital and Manzanita House (Crisis Residential program). Intake will be prearranged by appointments during program hours.
Continued Stay Criteria:	Extension beyond three months requires authorization by the Monterey County Behavioral Health Director or designee.

Target # of Consumers: Up to 16

The Choices - Day Treatment Intensive Program is a community-based, person centered, and trauma informed full day treatment intensive program for up to 16 clients who are diagnosed with serious mental illnesses and referred by the Monterey County Behavioral Health Department Bureau (MCBHB) Adult and TAY Systems of Care in accordance with State/Medi-Cal guidelines. Interim Choices - Day Treatment Intensive staff provide mental health evaluation, treatment plan development, treatment, case management, and discharge planning. Services are site based group and individual therapeutic services and available for at least four hours per day, but not all services are delivered at the site. The program includes psychiatry services five days per week provided by MCBHB, symptom management, medication education and medication self-management support as prescribed by MCBHB psychiatrist. Transportation for clients to and from services is provided, as needed. A daily meal break and lunch are also provided.

The program is structured as a therapeutic milieu and includes daily community meetings, process groups, skill building groups, individual therapy, along with adjunctive therapies for physical and social health, case management, and community resource outings. Program staff have at least monthly contact with a family member, caregiver, or other significant support person identified by the client, such as MCBHB or Interim Case Coordinator. Clients are offered referrals to the Bienestar program (integrated health services) for physical health needs. Mutually agreed-upon written treatment plans are created that are authorized by the MCBHB or Interim case coordination staff.

3. **Program Purpose**

The Choices - Day Treatment Intensive program is a structured, multi-disciplinary program of therapy that is an alternative to hospitalization or step down from psychiatric hospitalization, avoiding clients' placement in a more restrictive setting, and maintaining clients in a community setting.

4. **Desired Results**

- Provide treatment to establish mental health stabilization and psychosocial skills building for consumers with serious mental illnesses.
- Improve emotional regulation, daily functioning, and social skills for clients with serious mental illnesses and personality disorder traits.
- Develop meaningful activities to assist with living independently or interpedently in community settings rather than hospitals, jails, or residential crisis treatment.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practice: Curricula is based on Cognitive-Behavioral Therapy and Skills training, Dialectical Behavior Therapy Skills training and adjunct therapies, Motivational Interviewing and Seeking Safety, and Trauma-Informed approaches.

Goal	Measurement & Data Source
1. 75% of consumers will improve their mental health recovery.	• Measured via the pre and post "Illness Management and Recovery Outcome Survey."
2. 90% of consumers served during the FY will eliminate all psychiatric hospitalization, while in the program.	• Measured by psychiatric hospitalization data records in EMR/Avatar.
3. 75% of consumers will report satisfaction with the quality of services provided.	• Measured by client self-report via "Consumer Satisfaction" survey instrument at exit.

6. **Who are the partners involved in program implementation?**

MCBHB is the primary partner and all clients will have a MCBHB or Interim case coordinator. MCBHB provides psychiatry services.

7. **What is the eligibility criteria for admission to the program?**

- Financial Eligibility: Short-Doyle/Medi-Cal eligible or meet the standards for low-income status.
- Referral through Interim case coordinators or MCBHB service coordinators with admission approval by Interim Program Director.
- Clients with serious mental illnesses and/or serious functioning impairments, referred by ASOC, Access, TAY, PREP/Felton Institute, and Interim Inc. who are able to safely participate with peers and staff in an outpatient, milieu setting. Upon discharge from MCBHB services or Interim, rehabilitative mental health and case management services will be terminated.
- Program staff will assess clients for appropriateness to the level of care, for compatibility with other clients. DSM V and ICD-10 diagnostic categories for serious mental illness: schizophrenia, bipolar disorders, schizoaffective disorders, serious mental illness that substantially interferes with the person's ability to carry out primary aspects of daily living in the community.
- Admission eligibility determined by Interim Program Director or designee.

When a client is referred, but staff at Interim conclude client is not appropriate for the program, how will this be resolved? What is the discharge level of care? What is the anticipated length of service?

- Interim program staff will collaborate with MCBHB case coordinators to jointly create a viable community alternative referral plan for appropriate services.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

Interim serves economically disadvantaged populations who meet the standards for low-income status or are Short-Doyle/Medi-Cal eligible. MCBHB refers all of our clients.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

Staff is trained in Motivational Interviewing to ensure services align with the consumer's readiness for change. They are trained in and use a strengths-based and recovery focused model and deliver services that are based on individualized goals, set jointly between staff and individuals seeking services. Psychosocial educational and skill development groups are based on observed needs as well as ongoing feedback from participants. All services are voluntary.

Input from residents is provided through the consumer run Recovery Task Force and daily community meetings. Interim offers support team meetings that include family members and other support team members as designated by consumers. Interim also hires peers and family members in every area of agency operations.

Staff receive training on Cultural and Linguistic Competency and Trauma Informed services. Bilingual Spanish services are provided as needed. Interpreters are available in other languages.

Services are integrated and coordinated with MCBHB and other providers in the area.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

Maximum program capacity is 16, with average daily attendance projected at 10, and approximate annual number to be served is 40.

PROGRAM TWENTY:

1. **Program Name:** Chinatown Community Learning Center with California State University at Monterey Bay (CSUMB)

2. **Program Description:**

Address of Delivery Site:	20 Soledad St., Salinas, CA 93901
Program Schedule:	Monday through Friday, 9am – 5pm.
Target # of Consumers:	300

Interim continues to sub-contract this service to CSUMB and provides oversight for CSUMB's Chinatown Community Learning Center (CCLC) initiative. The purpose of the collaboration is to enable CSUMB to continue to offer qualified Master of Social Work (MSW) support for the homeless and other marginalized populations in the Chinatown neighborhood of Salinas at the Chinatown Community Learning Center. The Community Learning Center is a resource center with office and classroom space devoted to serving the needs of the homeless and other marginalized residents of the Chinatown neighborhood and surrounding areas. The Center's staff provides structured learning opportunities, access to social services, and supports the development of micro-enterprise activities that serve the needs of the homeless and marginalized in Chinatown, many of whom are also struggling with mental health and addiction issues. Interim provides guidance on setting and meeting goals as well as monitor contract outcomes.

In 2015-16, CSUMB expanded their efforts to include a cohort of 4 MSW students working under the supervision of a faculty member. This unique faculty-led model allows for additional supportive training opportunities in agencies or communities with a dearth of professional social workers who can provide field supervision, or in high-risk, disenfranchised communities where student support is critical. This cohort of MSW students work as a team and provide 64 hours per week of social work service to Chinatown residents. The primary function of the team is to provide ongoing supportive counseling to clients, with a focus on pathways to housing and employment. Students are onsite and available to offer supportive case management, attempting to meet the challenges faced by client residents of Chinatown. They also work closely with related service providers to help clients move off the street and into housing and viable employment.

3. **Program Purpose**

The Chinatown community faces many challenges, as it serves as the main gathering place for homeless persons in our region. With a service-provider-to-client ratio that is sorely tipped toward under-provision, the numbers of encampments growing, and a significant rise in violence and crime over the past year, the neighborhood and its residents continue to be at-risk, disenfranchised, marginalized and woefully underserved.

The Chinatown Community Learning Center program addresses a number of community needs including: providing clients with cognitive behavioral and other psychosocial education classes, which help clients develop coping skills; helping clients enroll in Medi-Cal and thereby helping

them care for their health; helping clients enroll in CalFresh, and providing them with snacks, thereby helping clients increase their basic nutrition ; assisting clients with social security issues thereby helping some of them secure their own housing; assisting some clients secure employment within the Center, which helps them develop work skills, increases their income, and for some, allows them to provide for their own housing.

4. **Desired Results**

The Center provides a safe, warm, respectful, and inviting resource center devoted to serving the needs of the homeless and other marginalized residents of Chinatown. The Center contributes to a safer neighborhood by teaching a portion of the population coping skills, communication skills, conflict resolution skills, mood/anger management skills which all likely result in reduced violence.

5. **What evidence-based practice(s) will be used? How will fidelity be monitored? What are the measurable goals for the program (how will the program assess successful outcomes?)**

Evidenced Based Practice: Motivational Interviewing

Fidelity will be monitored through training, ongoing supervision and observation of intern practice.

Goal	Measurement & Data Source
California State University, Monterey Bay Chinatown Community Learning Center (CSUMB CCLC) staff will work to assist two (2) clients per month toward the completion of supporting documentation necessary to begin the SSI application process as defined by MCBHB.	CSUMB CCLC will track all unique client SSDI/SSI intake information and report activities to the contract monitor on a monthly basis.
CSUMB CCLC will facilitate two (2) groups per week, employing a mental health/substance abuse focused evidence based practice, a skill building focus or a curriculum approved by Interim, Inc. and contract monitor. Groups can be rotated based on client need with approval of Interim Inc. contract monitor.	CSUMB CCLC will track all unique client/student participation information and report activities to the contract monitor on a monthly basis.

Provide assistance in applications for General Assistance, and/or Medi-Cal or other health benefits, and/or CalFresh (Food Stamps) for two (2) individuals with mental illness per month. Services in conjunction with these applications may include assistance in obtaining identification and income verifications. Assistance may also include accompanying consumers to interviews, application appointments, hearings or other appointments necessary to procure benefits.	CSUMB CCLC will track all unique client/student participation information and report activities to the contract monitor on a monthly basis.
Provide access to the Chinatown Community Learning Center to Interim's MCHOME Program. Provide access to Chinatown Learning Center for a substance abuse prevention/treatment provider for counseling/support groups. Sub-Contractor is responsible for developing a method to ensure staff has regular access.	CSUMB CCLC will track all partner organization space use activity and report activities to the contract monitor on a monthly basis.
CSUMB CCLC will serve a minimum of twenty-five (25) unduplicated homeless clients/month.	CSUMB CCLC will track all unique client/student participation information and report activities to the contract monitor on a monthly basis.
CSUMB CCLC coordinators will meet with Interim, Inc. contract monitor bi-monthly and provide monthly reports to contract monitor on contract goals.	Bimonthly meetings will be set and maintained throughout the year. In cases of scheduling conflicts, alternatives will be arranged in order to maintain a minimum of two meetings per month.
A minimum of four (4) MSW students, under the direction of CSUMB Social Work Program staff/faculty, will provide services four (4) days per week in the Learning Center from July 1, 2016 to June 30, 2017. Service provision will be continuous during this time, including during students' traditional holiday breaks.	Student hours will be tracked by a signed and dated timesheet managed by Learning Center Staff. Special scheduling arrangements will be made for each student break to ensure consistent coverage of traditional academic breaks.
A minimum of four (4) CSUMB MSW students will provide 480 hours each of service in the Chinatown Community over the course of the contract.	Student hours will be tracked by a signed and dated timesheet managed by Learning Center Staff.
A minimum of four (4) CSUMB MSW students will carry	CSUMB will track all unique client/student

an ongoing caseload of between 3-5 clients (12-20 total). For these clients they will provide necessary case management and/or situational crisis counseling services.	caseload information and report activities to the contract monitor on a monthly basis.
A minimum of four (4) CSUMB MSW students will assist 1-2 clients within their caseload (4-8 total) to achieve housing and/or employment during this time period.	CSUMB will track all unique client/student caseload information and report activities to the contract monitor on a monthly basis.
CSUMB will ensure that a faculty person will provide the MSW students 8 hours of service and supervision per week and will be responsible for data collection associated with the MSW interns work.	CSUMB will track professor supervision hours and report activities to the contract monitor on a monthly basis. Faculty person will meet with contract monitor bi-monthly.
A minimum of four (4) CSUMB MSW students must use the Homeless Management Information System (HMIS) and enter all clients served into this system. When doing intakes and evaluations, students will use established protocol and paperwork. Services for clients must be coordinated with other service providers to avoid duplication of services, which HMIS helps.	CSUMB will track all unique client/student caseload information pertaining to HMIS entries and report activities to the contract monitor on a monthly basis.
CSUMB will provide clients with transportation to needed services whenever necessary and within the allowable guidelines of University policy.	CSUMB will track all unique client transportation occurrences and report activities to the contract monitor on a monthly basis.

6. **Who are the partners involved in program implementation?**

The Community Learning Center enjoys active collaboration with Interim's MCHOME program as well as other service providers in the Chinatown area including Sun Street Centers, Clinica de Salud, Dorothy's Place, Victory Mission, Center for Independent Living, and others.

7. **What are the eligibility criteria for admission to the program?**

The population to be served is homeless adults in Chinatown Salinas, who may have a serious mental illness and/or substance use disorder. There are no eligibility criteria for engaging in the services the Chinatown Community Learning Center offers. They are voluntary clients who freely engage in services at their will.

8. **What are the health equity goals (how the program will address health disparities and access to services, especially by underserved/unserved populations)?**

The Community Learning Center program serves clients living in Chinatown area. These (approximately 170) people live in makeshift shelters and tents. They are generally jobless. They generally suffer from various degrees of mental health issues. Many are actively addicted to street drugs. Most are disconnected from family or other supportive networks. Many suffer significant health issues. They are a disenfranchised population in a medically underserved area. The Community Learning Center is open to all of them, and as such works to address health disparities through a program of supportive community case management and numerous other supportive education and counseling opportunities, all with a goal of helping this population access services.

9. **How does the program demonstrate the following principles: Family and Consumer Driven; Accessible and Timely Services; Wellness and Recovery; Culturally and Linguistically Competent; Strength and Resiliency; Integrated and Coordinated Services.**

The CSUMB Chinatown Community Learning Center MSW interns and center staff use Motivational Interviewing to ensure services align with the consumer's readiness for change. They are trained in and use a strengths-based and recovery focused model and deliver services that are based on individualized goals, set jointly between staff and individuals seeking services. Psychosocial educational and skill development groups are based on observed needs as well as ongoing feedback from participants. All services are voluntary.

Because the Center is located within the living environment of the homeless population and is open every day for voluntary walk-ins, services are accessible and timely. The addition of the MSW cohort has insured cultural/linguistic diversity among the service providers.

Services are integrated and coordinated with members of the Coalition of Homeless Services Providers and other providers in the Chinatown area.

10. **Program Capacity and Total Annual Number to Be Served in the Program.**

CSUMB's Chinatown Community Learning Center's Program has the capacity to serve up to 20-30 unique service users per day in the wide variety of services and classes offered. The annual number to be served is 300 unique individuals.

B. COMMUNICATION AND COORDINATION BETWEEN CONTRACTOR AND COUNTY

CONTRACTOR, in collaboration with County, will identify service components such as Case Coordination, and by mutual agreement, protocols will be developed and/or modified to assure quality of care and timely access to services.

C. REPORTING REQUIREMENTS

CONTRACTOR will meet regularly with the designated MCBHB Contract Monitor to monitor progress on consumer and program outcomes. MCBHB shall provide to CONTRACTOR the reporting requirements and instructions as required by the State Mental Health Services Oversight and Accountability Commission, the Department of Health Care Services and COUNTY.

For all programs, CONTRACTOR shall collect and report on a quarterly basis client demographic data, i.e. age, gender, race/ethnicity, preferred language and region of residence. CONTRACTOR shall collect and report each program's outcomes data at the mid-point and at the end of each fiscal year.

For programs funded with Mental Health Services Act Community Services & Supports funds and designated as "Full Service Partnership (FSP)" programs, CONTRACTOR shall collect and report the data on each client enrolled in FSP Services.

For programs funded with Mental Health Services Act Prevention & Early Intervention (PEI) funds, CONTRACTOR shall submit reports, consisting of participant demographic data for each service provided, as well as the program outcomes identified in the "Logic Model" document, as required by the PEI regulations. For Programs Fifteen through Eighteen and Twenty, CONTRACTOR will collaborate with Contract Monitor to develop the "Logic Model" and will provide feedback regarding program effectiveness as may be requested.

Reports shall be submitted on a quarterly basis no later than thirty (30) days following the end of each quarter to designated Contract Monitor, and for PEI programs, also to the PEI Coordinator. The "Logic Model' document will be reviewed at least annually and can be revised upon mutual agreement by CONTRACTOR and COUNTY, as part of the PEI Program Evaluation Reporting process.

DESIGNATED CONTRACT MONITOR:
Michael Lisman, L.C.S.W.
Deputy Director, Adult Services
Behavioral Health Administration
1270 Natividad Road
Salinas, CA 93906
831-755-4708

EXHIBIT B-1
PAYMENT AND BILLING PROVISIONS

I. PAYMENT TYPES

Provisional Rates and Cash Flow Advances (CFA)

II. PAYMENT AUTHORIZATION FOR SERVICES

The COUNTY'S commitment to authorize reimbursement to the CONTRACTOR for services as set forth in this Exhibit B-1 is contingent upon COUNTY authorized admission and service, and CONTRACTOR'S commitment to provide care and services in accordance with the terms of this Agreement.

III. PAYMENT RATES

A. PROVISIONAL RATE: COUNTY MAXIMUM REIMBURSEMENT (CMA)

Case Management and Mental Health Services shall be paid at the COUNTY Maximum Reimbursement (CMA) rates, which are provisional and subject to all the cost report conditions as set forth in this Exhibit B-1.

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The following program services will be paid in arrears, not to exceed the CMA rates for a total maximum of **$22,997,892** for **FY 2016-17 through FY 2018-19** as follows:

Program # in Exhibit A	Service Description	Mode of Service	Service Function Code	FY 2016-17 Units Of Service (est)		CMA Rate per Unit of Service ($)	Estimated Total FY 2016-17
1	Adult Crisis Residential	5	40-49	4,553		$ 374.07	$ 1,703,120
2	Bridge House: Residential	5	65-79	4,374		$ 187.28	$ 819,158
3	Bridge House: Day Rehab.	10	95-99	2,746		$ 130.20	$ 357,522
7	Rockrose Gardens - CM & MHS	15	01-09 10-19 & 30-59	54,903	CM MHS	$ 3.45	$ 189,308
8	Lupine Gardens - CM & MHS	15	01-09 10-19 & 30-59	94,514	CM MHS	$ 3.45	$ 325,889
9	Sunflower Gardens - CM & MHS	15	01-09 10-19 & 30-59	95,806	CM MHS	$ 3.45	$ 330,344
10	MCHOME - CM & MHS	15	01-09 10-19 & 30-59	207,413	CM MHS	$ 3.45	$ 715,173
11	Dual Recovery - CM & MHS	15	01-09 10-19 & 30-59	134,716	CM MHS	$ 3.45	$ 464,508
						Estimated Total FY 2016-17 for Programs # 7 - 11:	$ 2,025,222
4	Community Housing - CM & MHS	15	01-09 10-19 & 30-59	281,201	CM MHS	$ 3.45	$ 969,596
5	Sandy Shores - CM & MHS	15	01-09 10-19 & 30-59	112,662	CM MHS	$ 3.45	$ 388,463
6	Shelter Cove - CM & MHS	15	01-09 10-19 & 30-59	215,004	CM MHS	$ 3.45	$ 741,344
13	SEES - CM & MHS	15	01-09 10-19 & 30-59	42,120	CM MHS	$ 3.45	$ 145,231
						Estimated Total FY 2016-17 for Programs # 4, 5, 6 & 13	$ 2,244,634
19	Intensive Day Treatment	10	85-89	2,100		$ 245.86	$ 516,308
						Estimated Total FY 2016-17 for the above listed program:	$ 516,308
						Total FY 2016-17	$ 4,786,164

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Program # In Exhibit A	Service Description	Mode of Service	Service Function Code	FY 2017-18 Units Of Service (est)	CMA Rate per Unit of Service ($)	Estimated Total FY 2017-18
1	Adult Crisis Residential	5	40-49	4,553	$ 374.07	$ 1,703,120
2	Bridge House: Residential	5	65-79	4,374	$ 187.28	$ 819,158
3	Bridge House: Day Rehab.	10	95-99	2,746	$ 130.20	$ 357,522
7	Rockrose Gardens - CM & MHS	15	01-09 10-19 & 30-59	54,903	CM MHS $ 3.45	$ 189,308
8	Lupine Gardens - CM & MHS	15	01-09 10-19 & 30-59	83,903	CM MHS $ 3.45	$ 289,302
9	Sunflower Gardens - CM & MHS	15	01-09 10-19 & 30-59	95,806	CM MHS $ 3.45	$ 330,344
10	MCHOME - CM & MHS	15	01-09 10-19 & 30-59	207,413	CM MHS $ 3.45	$ 715,173
11	Dual Recovery - CM & MHS	15	01-09 10-19 & 30-59	134,716	CM MHS $ 3.45	$ 464,508
	Estimated Total FY 2017-18 for Programs # 7 - 11:					$ 1,988,635
4	Community Housing - CM & MHS	15	01-09 10-19 & 30-59	281,201	CM MHS $ 3.45	$ 969,596
5	Sandy Shores - CM & MHS	15	01-09 10-19 & 30-59	112,662	CM MHS $ 3.45	$ 388,463
6	Shelter Cove - CM & MHS	15	01-09 10-19 & 30-59	225,614	CM MHS $ 3.45	$ 777,931
13	SEES - CM & MHS	15	01-09 10-19 & 30-59	42,120	CM MHS $ 3.45	$ 145,231
	Estimated Total FY 2017-18 for Programs # 4, 5, 6 & 13					$ 2,281,221
19	Intensive Day Treatment	10	85-89	2,737	$ 188.64	$ 516,308
	Estimated Total FY 2017-18 for the above listed program:					$ 516,308
	Total FY 2017-18					$ 4,786,164

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Program # In Exhibit A	Service Description	Mode of Service	Service Function Code	FY 2018-19 Units Of Service (est)	CMA Rate per Unit of Service ($)	Estimated Total FY 2018-19
1	Adult Crisis Residential	5	40-49	4,553	$ 374.07	$ 1,703,120
2	Bridge House: Residential	5	65-79	4,374	$ 187.28	$ 819,158
3	Bridge House: Day Rehab.	10	95-99	2,746	$ 130.20	$ 357,522
7	Rockrose Gardens - CM & MHS	15	01-09 10-19 & 30-59	54,903	CM MHS $ 3.45	$ 189,308
8	Lupine Gardens - CM & MHS	15	01-09 10-19 & 30-59	83,903	CM MHS $ 3.45	$ 289,302
9	Sunflower Gardens - CM & MHS	15	01-09 10-19 & 30-59	95,806	CM MHS $ 3.45	$ 330,344
10	MCHOME - CM & MHS	15	01-09 10-19 & 30-59	207,413	CM MHS $ 3.45	$ 715,173
11	Dual Recovery - CM & MHS	15	01-09 10-19 & 30-59	134,716	CM MHS $ 3.45	$ 464,508
	Estimated Total FY 2018-19 for Programs # 7 - 11:					$ 1,988,635
4	Community Housing - CM & MHS	15	01-09 10-19 & 30-59	281,201	CM MHS $ 3.45	$ 969,596
5	Sandy Shores - CM & MHS	15	01-09 10-19 & 30-59	112,662	CM MHS $ 3.45	$ 388,463
6	Shelter Cove - CM & MHS	15	01-09 10-19 & 30-59	225,614	CM MHS $ 3.45	$ 777,931
13	SEES - CM & MHS	15	01-09 10-19 & 30-59	42,120	CM MHS $ 3.45	$ 145,231
	Estimated Total FY 2018-19 for Programs # 4, 5, 6 & 13					$ 2,281,221
19	Intensive Day Treatment	10	85-89	2,737	$ 188.64	$ 516,308
	Estimated Total FY 2018-19 for the above listed program:					$ 516,308
	Total FY 2018-19					$ 4,786,164

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B. CASH FLOW ADVANCE

Board & Care and other housing supports, dual recovery, homeless outreach, and peer-led wellness and recovery programs that provide non-Medi-Cal billable services shall be paid as Cash Flow Advances for a total maximum of **$7,835,872** for **FY 2016-17 through FY 2018-19** as follows:

Program # in Exhibit A	Interim Cost Reimbursement Services FY 16-17 Service Description	FY 16-17 Amount
1	Manzanita Adult Crisis: Board & Care	$ 95,105
2	Bridge House: Board & Care	$ 78,119
4	Community Housing: Housing	$ 200,535
5	Sandy Shores: Housing	$ 124,709
6	Shelter Cove: Housing	$ 253,449
10	McHome: Non-Medi-Cal/MHSA	$ 440,074
10	McHome: Non-Medi-Cal/PATH Grant	$ 95,497
11	Dual Recovery Services	$ 37,762
12	SAMHSA Support – Dual Diagnosis/SAMHSA Grant	$ 93,276
12	SAMHSA Support – Dual Diagnosis/MHSA	$ 24,572
14	Supported Education Services/WET: Non-Medi-Cal	$ 221,948
15	OMNI Resource Center: Wellness Recovery for Adults	$ 546,132
16	Peer Health Navigation & Advocacy: Success Over Stigma	$ 75,355
17	Peer Health Navigation & Advocacy: Bienestar	$ 73,702
18	Peer Support - Wellness Navigation & Peer Partners for Health	$ 256,216
19	Day Treatment Intensive	$ 20,000
20	Chinatown Community Learning Center with CSUMB	$ 146,317
	TOTAL FY 2016-17	**$2,782,768**

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Program # in Exhibit A	Interim Cost Reimbursement Services FY 17-18 Service Description	FY 17-18 Amount
1	Manzanita Adult Crisis: Board & Care	$ 95,105
2	Bridge House: Board & Care	$ 78,119
4	Community Housing: Housing	$ 200,535
5	Sandy Shores: Housing	$ 124,709
6	Shelter Cove: Housing	$ 253,449
10	McHome: Non-Medi-Cal/MHSA	$ 440,074
10	McHome: Non-Medi-Cal/PATH Grant	$ 95,497
11	Dual Recovery Services	$ 37,762
12	SAMHSA Support – Dual Diagnosis/SAMHSA Grant	$ 93,276
12	SAMHSA Support – Dual Diagnosis/MHSA	$ 24,572
14	Supported Education Services/WET: Non-Medi-Cal	$ 221,948
15	OMNI Resource Center: Wellness Recovery for Adults	$ 546,132
16	Peer Health Navigation & Advocacy: Success Over Stigma	$ 75,355
17	Peer Health Navigation & Advocacy: Bienestar	$ 73,702
18	Peer Support - Wellness Navigation & Peer Partners for Health	pending
19	Day Treatment Intensive	$ 20,000
20	Chinatown Community Learning Center with CSUMB	$ 146,317
	TOTAL FY 2017-18	**$2,526,552**

Program # in Exhibit A	Interim Cost Reimbursement Services FY 18-19 Service Description	FY 18-19 Amount
1	Manzanita Adult Crisis: Board & Care	$ 95,105
2	Bridge House: Board & Care	$ 78,119
4	Community Housing: Housing	$ 200,535
5	Sandy Shores: Housing	$ 124,709
6	Shelter Cove: Housing	$ 253,449
10	McHome: Non-Medi-Cal/MHSA	$ 440,074
10	McHome: Non-Medi-Cal/PATH Grant	$ 95,497
11	Dual Recovery Services	$ 37,762
12	SAMHSA Support – Dual Diagnosis/SAMHSA Grant	$ 93,276
12	SAMHSA Support – Dual Diagnosis/MHSA	$ 24,572
14	Supported Education Services/WET: Non-Medi-Cal	$ 221,948
15	OMNI Resource Center: Wellness Recovery for Adults	$ 546,132
16	Peer Health Navigation & Advocacy: Success Over Stigma	$ 75,355
17	Peer Health Navigation & Advocacy: Bienestar	$ 73,702
18	Peer Support - Wellness Navigation & Peer Partners for Health	pending
19	Day Treatment Intensive	$ 20,000
20	Chinatown Community Learning Center with CSUMB	$ 146,317
	TOTAL FY 2018-19	**$2,526,552**

IV. PAYMENT CONDITIONS

A. If CONTRACTOR is seeking reimbursement for eligible services funded by the Short-Doyle/Medi-Cal, Mental Health Services Act ("MHSA"), SB 90, Federal or State Grants, and/or COUNTY funds provided pursuant to this Agreement, reimbursement for such services shall be based on actual cost of providing those services less any deductible revenues collected by the CONTRACTOR from other payer sources. In order to reduce COUNTY costs, the CONTRACTOR shall comply with all applicable provisions of the California Welfare and Institutions Code (WIC), the California Code of Regulations, the Code of Federal Regulations, and the federal Social Security Act related to reimbursements by non-County and non-State sources, including, but not limited to, collecting reimbursements for services from clients (which shall be the same as patient fees established pursuant to WIC section 5710) and from private or public third-party payers.

CONTRACTOR shall not claim reimbursement from COUNTY for (or apply sums received from COUNTY with respect to) that portion of its obligations which has been paid by another source of revenue. If CONTRACTOR is seeking reimbursement for mental health services provided pursuant to this Agreement, reimbursement for such services shall be based upon the actual allowable costs of providing those services less any deductible revenues, as stated above. Notwithstanding any other provision of this Agreement, in no event may CONTRACTOR request a rate that exceeds the COUNTY'S Maximum Allowances (CMA), which is based on the most recent State's Schedule of Maximum Allowances (SMA) as established by the State's Department of Mental Health. The SMA Schedule shall be used until COUNTY establishes the COUNTY'S rate Schedule of Maximum Allowances. CONTRACTOR shall be responsible for costs that exceed applicable CMAs. In no case shall payments to CONTRACTOR exceed CMAs. In addition to the CMA limitation, in no event shall the maximum reimbursement that will be paid by COUNTY to CONTRACTOR under this Agreement for any Program Amount be more than the amount identified for each Program Amount for each Funded Program, as identified in this Exhibit B-1, Section III. Said amounts shall be referred to as the "Maximum Obligation of County," as identified in this Exhibit B-1, Section V.

B. To the extent a recipient of services under this Agreement is eligible for coverage under Short-Doyle/Medi-Cal or Medicaid or Medicare or any other Federal or State funded program ("an eligible beneficiary"), CONTRACTOR shall ensure that services provided to eligible beneficiaries are properly identified and claimed to the Funded Program responsible for such services to said eligible beneficiaries. For the Short-Doyle/Medi-Cal Funded Program, CONTRACTOR assumes fiscal responsibility for services provided to all individuals who do not have full-scope Medi-Cal or are not Medi-Cal eligible during the term of this Agreement.

C. CONTRACTOR shall be responsible for delivering services to the extent that funding is provided by the COUNTY. To the extent that CONTRACTOR does not have funds allocated in the Agreement for a Funded Program that pays for services to a particular eligible beneficiary, CONTRACTOR shall, at the first opportunity, refer said eligible beneficiary to another CONTRACTOR or COUNTY facility within the same geographic area to the extent feasible, which has available funds allocated for that Funded Program.

D. In order to receive any payment under this Agreement, CONTRACTOR shall submit reports and claims in such form as General Ledger, Payroll Report and other accounting documents as needed, and as may be required by the County of Monterey Department of Health, Behavioral Health Bureau. Specifically, CONTRACTOR shall submit its claims on Cost Reimbursement Invoice Form provided as Exhibit G, to this Agreement, along with backup documentation, on a monthly basis, to COUNTY so as to reach the Behavioral Health Bureau no later than the thirtieth (30th) day of the month following the month of service. See Section III, above, for payment amount information to be reimbursed each fiscal year period of this Agreement. The amount requested for reimbursement shall be in accordance with the approved budget and shall not exceed the actual net costs incurred for services provided under this Agreement.

   CONTRACTOR shall submit via email a monthly claim using Exhibit G, Cost Reimbursement Invoice Form in Excel format with electronic signature along with supporting documentations, as may be required by the COUNTY for services rendered to:

   MCHDBHFinance@co.monterey.ca.us

E. CONTRACTOR shall submit all claims for reimbursement under this Agreement within thirty (30) calendar days after the termination or end date of this Agreement. All claims not submitted after thirty (30) calendar days following the termination or end date of this Agreement shall not be subject to reimbursement by the COUNTY. Any claim(s) submitted for services that preceded thirty (30) calendar days prior to the termination or end date of this Agreement may be disallowed, except to the extent that such failure was through no fault of CONTRACTOR. Any "obligations incurred" included in claims for reimbursements and paid by the COUNTY which remain unpaid by the CONTRACTOR after thirty (30) calendar days following the termination or end date of this Agreement shall be disallowed, except to the extent that such failure was through no fault of CONTRACTOR under audit by the COUNTY.

F. If CONTRACTOR fails to submit claim(s) for services provided under the terms of this Agreement as described above, the COUNTY may, at its sole discretion, deny payment for that month of service and disallow the claim.

G. COUNTY shall review and certify CONTRACTOR'S claim either in the requested amount or in such other amount as COUNTY approves in conformity with this Agreement, and shall then submit such certified claim to the COUNTY Auditor. The County Auditor-Controller shall pay the amount certified within thirty (30) calendar days of receiving the certified invoice.

H. To the extent that the COUNTY determines CONTRACTOR has improperly claimed services to a particular Program Amount, COUNTY may disallow payment of said services and require CONTRACTOR to resubmit said claim of services for payment from the correct Program Amount, or COUNTY may make corrective accounting transactions to transfer the payment of the services to the appropriate Program Amount.

I. If COUNTY certifies payment at a lesser amount than the amount requested COUNTY shall immediately notify the CONTRACTOR in writing of such certification and shall specify the reason for it. If the CONTRACTOR desires to contest the certification, the CONTRACTOR must submit a written notice of protest to the COUNTY within twenty (20) calendar days after the CONTRACTOR'S receipt of the COUNTY notice. The parties shall thereafter promptly meet to review the dispute and resolve it on a mutually acceptable basis. No court action may be taken on such a dispute until the parties have met and attempted to resolve the dispute in person.

V. MAXIMUM OBLIGATION OF COUNTY

A. Subject to the limitations set forth herein, COUNTY shall pay to CONTRACTOR during the term of this Agreement a maximum amount of **$ 30,833,764** for services rendered under this Agreement.

B. Maximum Annual Liability:

Payment Rates	FY 16-17	FY 17-18	FY 18-19
Provisional Rate	$ 7,665,964	$ 7,665,964	$ 7,665,964
Cash Flow Advance	$ 2,782,768	$ 2,526,552	$ 2,526,552
Annual Total	$10,448,732	$ 10,192,516	$ 10,192,516
AGREEMENT TOTAL MAXIMUM COUNTY LIABILITY			**$ 30,833,764**

C. If, as of the date of signing this Agreement, CONTRACTOR has already received payment from COUNTY for services rendered under this Agreement, such amount shall be deemed to have been paid out under this Agreement and shall be counted towards COUNTY'S maximum liability under this Agreement.

D. If for any reason this Agreement is canceled, COUNTY'S maximum liability shall be the total utilization to the date of cancellation not to exceed the maximum amount listed above.

E. As an exception to Section D. above with respect to the Survival of Obligations after Termination, COUNTY, any payer, and CONTRACTOR shall continue to remain obligated under this Agreement with regard to payment for services required to be rendered after termination.

VI. BILLING AND PAYMENT LIMITATIONS

A. Provisional Payments: COUNTY payments to CONTRACTOR for performance of eligible services hereunder are provisional until the completion of all settlement activities and audits, as such payments are subject to future Federal, State and/or COUNTY adjustments. COUNTY adjustments to provisional payments to CONTRACTOR may be based upon COUNTY'S claims processing information system data, State adjudication of Medi-Cal and Healthy Families claims files, contractual limitations of this Agreement, annual cost and MHSA reports, application of various Federal, State, and/or COUNTY reimbursement limitations, application of any Federal, State, and/or COUNTY policies, procedures and regulations, and/or Federal, State, or COUNTY audits, all of which take precedence over monthly claim reimbursements.

B. Allowable Costs: Allowable costs shall be the CONTRACTOR'S actual costs of developing, supervising and delivering the services under this Agreement, as set forth in the Budget provided in Exhibit H. Only the costs listed in Exhibit H of this Agreement as contract expenses may be claimed as allowable costs. Any dispute over whether costs are allowable shall be resolved in accordance with the provisions of applicable Federal, State and COUNTY regulations.

C. Cost Control: CONTRACTOR shall not exceed by more than twenty (20%) percent any contract expense line item amount in the budget without the written approval of COUNTY, given by and through the Contract Administrator or Contract Administrator's designee. CONTRACTOR shall submit an amended budget using Exhibit H, or on a format as required by the COUNTY, with its request for such approval. Such approval shall not permit CONTRACTOR to receive more than the maximum total amount payable under this Agreement. Therefore, an increase in one line item shall require corresponding decreases in other line items.

D. Other Limitations for Certain Funded Programs: In addition to all other limitations provided in this Agreement, reimbursement for services rendered under certain Funded Programs may be further limited by rules, regulations and procedures applicable only to that Funded Program. CONTRACTOR shall be familiar with said rules, regulations and procedures and submit all claims in accordance therewith.

E. Adjustment of Claims Based on Other Data and Information: The COUNTY shall have the right to adjust claims based upon data and information that may include, but are not limited to, COUNTY'S claims processing information system reports, remittance advices, State adjudication of Medi-Cal claims, and billing system data.

VII. LIMITATION OF PAYMENTS BASED ON FUNDING AND BUDGETARY RESTRICTIONS

A. This Agreement shall be subject to any restrictions, limitations, or conditions imposed by State which may in any way affect the provisions or funding of this Agreement, including, but not limited to, those contained in State's Budget Act.

B. This Agreement shall also be subject to any additional restrictions, limitations, or conditions imposed by the Federal government which may in any way affect the provisions or funding of this Agreement.

C. In the event that the COUNTY'S Board of Supervisors adopts, in any fiscal year, a COUNTY Budget which provides for reductions in COUNTY Agreements, the COUNTY reserves the right to unilaterally reduce its payment obligation under this Agreement to implement such Board reductions for that fiscal year and any subsequent fiscal year during the term of this Agreement, correspondingly. The COUNTY'S notice to the CONTRACTOR regarding said reduction in payment obligation shall be provided within thirty (30) calendar days of the Board's approval of such action.

D. Notwithstanding any other provision of this Agreement, COUNTY shall not be obligated for CONTRACTOR'S performance hereunder or by any provision of this Agreement during any of COUNTY'S current or future fiscal year(s) unless and until COUNTY'S Board of Supervisors appropriates funds for this Agreement in COUNTY'S Budget for each such fiscal year. In the event funds are not appropriated for this Agreement, then this Agreement shall terminate as of June 30 of the last fiscal year for which funds were appropriated. COUNTY shall notify CONTRACTOR of any such non-appropriation of funds at the earliest possible date and the services to be provided by the CONTRACTOR under this Agreement shall also be reduced or terminated.

VIII. BILLING PROCEDURES AND LIMITATIONS ON COUNTY'S FINANCIAL RESPONSIBILITY FOR PAYMENT OF SERVICES UNDER FEDERAL SOCIAL SECURITY ACT, TITLE XIX SHORT-DOYLE/MEDI-CAL SERVICES AND/OR TITLE XXI HEALTHY FAMILIES

The Short-Doyle/Medi-Cal (SD/MC) claims processing system enables California county Mental Health Plans (MHPs) to obtain reimbursement of Federal funds for medically necessary specialty mental health services provided to Medi-Cal-eligible beneficiaries and to Healthy Families subscribers diagnosed as Seriously Emotionally Disturbed (SED). The Mental Health Medi-Cal program oversees the SD/MC claims processing system. Authority for the Mental Health Medi-Cal program is governed by Federal and California statutes.

A. If, under this Agreement, CONTRACTOR has Funded Programs that include Short-Doyle/Medi-Cal services and/or Healthy Families services, CONTRACTOR shall certify in writing annually, by August 1 of each year, that all necessary documentation shall exist at the time any claims for Short-Doyle/Medi-Cal services and/or Healthy Families services are submitted by CONTRACTOR to COUNTY.

   CONTRACTOR shall be solely liable and responsible for all service data and information submitted by CONTRACTOR.

B. CONTRACTOR acknowledges and agrees that the COUNTY, in under taking the processing of claims and payment for services rendered under this Agreement for these Funded Programs, does so as the Mental Health Plan for the Federal, State and local governments.

C. CONTRACTOR shall submit to COUNTY all Short-Doyle/Medi-Cal, and/or Healthy Families claims or other State required claims data within the thirty (30) calendar day time frame(s) as prescribed by this Agreement to allow the COUNTY to meet the time frames prescribed by the Federal and State governments. COUNTY shall have no liability for CONTRACTOR'S failure to comply with the time frames established under this Agreement and/or Federal and State time frames, except to the extent that such failure was through no fault of CONTRACTOR.

D. COUNTY, as the Mental Health Plan, shall submit to the State in a timely manner claims for Short-Doyle/Medi-Cal services, and/or Healthy Families services only for those services/activities identified and entered into the COUNTY'S claims processing information system which are compliant with Federal and State requirements. COUNTY shall make available to CONTRACTOR any subsequent State approvals or denials of such claims upon request by the CONTRACTOR.

E. CONTRACTOR acknowledges and agrees that COUNTY'S final payment for services and activities claimed by CONTRACTOR Short-Doyle/Medi-Cal services and/or Healthy Families services is contingent upon reimbursement from the Federal and State governments and that COUNTY'S provisional payment for said services

does not render COUNTY in any way responsible for payment of, or liable for, CONTRACTOR'S claims for payment for these services.

F. CONTRACTOR'S ability to retain payment for such services and/or activities is entirely dependent upon CONTRACTOR'S compliance with all laws and regulations related to same.

G. Notwithstanding any other provision of this Agreement, CONTRACTOR shall hold COUNTY harmless from and against any loss to CONTRACTOR resulting from the denial or disallowance of claim(s) for or any audit disallowances related to said services, including any State approved Title XIX Short-Doyle/Medi-Cal and/or Medi-Cal Administrative Activities, and/or Title XXI Healthy Families services/activities, by the Federal, State or COUNTY governments, or other applicable payer source, unless the denial or disallowance was due to the fault of the COUNTY.

H. CONTRACTOR shall repay to COUNTY the amount paid by COUNTY to CONTRACTOR for Title XIX Short-Doyle/Medi-Cal and/or Medi-Cal Administrative Activities, and/or Title XXI Healthy Families services/ activities subsequently denied or disallowed by Federal, State and/or COUNTY government.

I. Notwithstanding any other provision of this Agreement, CONTRACTOR agrees that the COUNTY may off set future payments to the CONTRACTOR and/or demand repayment from CONTRACTOR when amounts are owed to the COUNTY pursuant to Subparagraphs G. and H. above. Such demand for repayment and CONTRACTOR'S repayment shall be in accordance with Exhibit I, Section IV (Method of Payments for Amounts Due to County) of this Agreement.

J. CONTRACTOR shall comply with all written instructions provided to CONTRACTOR by the COUNTY, State or other applicable payer source regarding claiming and documentation.

K. Nothing in this Section VIII shall be construed to limit CONTRACTOR'S rights to appeal Federal and State settlement and/or audit findings in accordance with the applicable Federal and State regulations.

IX. PATIENT/CLIENT ELIGIBILITY, UMDAP FEES, THIRD PARTY REVENUES, AND INTEREST

A. CONTRACTOR shall comply with all Federal, State and COUNTY requirements and procedures relating to:

(a) The determination and collection of patient/client fees for services hereunder based on the Uniform Method of Determining Payment (UMDAP), in accordance with the State Department of Mental Health guidelines and WIC sections 5709 and 5710.

(b) The eligibility of patients/clients for Short-Doyle/Medi-Cal, Medicaid, Medicare, private insurance, or other third party revenue, and the collection, reporting and deduction of all patient/client and other revenue for patients/clients receiving services hereunder. CONTRACTOR shall pursue and report collection of all patient/client and other revenue.

B. All fees paid by patients/clients receiving services under this Agreement and all fees paid on behalf of patients/clients receiving services hereunder shall be utilized by CONTRACTOR only for the delivery of mental health service/activities specified in this Agreement.

C. CONTRACTOR may retain unanticipated program revenue, under this Agreement, for a maximum period of one Fiscal Year, provided that the unanticipated revenue is utilized for the delivery of mental health services/activities specified in this Agreement. CONTRACTOR shall report the expenditures for the mental health services/activities funded by this unanticipated revenue in the Annual Report(s) and Cost Report Settlement submitted by CONTRACTOR to COUNTY.

D. CONTRACTOR shall not retain any fees paid by any sources for, or on behalf of, Medi-Cal beneficiaries without deducting those fees from the cost of providing those mental health services for which fees were paid.

E. CONTRACTOR may retain any interest and/or return which may be received, earned or collected from any funds paid by COUNTY to CONTRACTOR, provided that CONTRACTOR shall utilize all such interest and return only for the delivery of mental health services/activities specified in this Agreement.

F. Failure of CONTRACTOR to report in all its claims and in its Annual Report(s) and Cost Report Settlement all fees paid by patients/clients receiving services hereunder, all fees paid on behalf of patients/clients receiving services hereunder, all fees paid by third parties on behalf of Medi-Cal beneficiaries receiving services and/or activities hereunder, and all interest and return on funds paid by COUNTY to CONTRACTOR, shall result in:

1. CONTRACTOR'S submission of a revised claim statement and/or Annual Report(s) and Cost Report Settlement showing all such non-reported revenue.
2. A report by COUNTY to State of all such non-reported revenue including any such unreported revenue paid by any sources for or on behalf of Medi-Cal beneficiaries and/or COUNTY'S revision of the Annual Report(s).
3. Any appropriate financial adjustment to CONTRACTOR'S reimbursement.

X. CASH FLOW ADVANCE IN EXPECTATION OF SERVICES/ ACTIVITIES TO BE RENDERED OR FIXED RATE PAYMENTS

A. The Maximum Contract Amount for each period of this Agreement includes Cash Flow Advance (CFA) or fixed rate payments which is an advance of funds to be repaid by CONTRACTOR through the provision of appropriate services/activities under this Agreement during the applicable period.

B. For each month of each period of this Agreement, COUNTY shall reimburse CONTRACTOR based upon CONTRACTOR'S submitted claims for rendered services/activities subject to claim edits, and future settlement and audit processes.

C. CFA shall consist of, and shall be payable only from, the Maximum Contract Amount for the particular fiscal year in which the related services are to be rendered and upon which the request(s) is (are) based.

D. CFA is intended to provide cash flow to CONTRACTOR pending CONTRACTOR'S rendering and billing of eligible services/activities, as identified in this Exhibit B-1, Sections III. and V., and COUNTY payment thereof. CONTRACTOR may request each monthly Cash Flow Advance only for such services/activities and only to the extent that there is no reimbursement from any public or private sources for such services/activities.

E. Cash Flow Advance (CFA) Invoice. For each month for which CONTRACTOR is eligible to request and receive a CFA, CONTRACTOR must submit to the COUNTY an invoice of a CFA in a format that is in compliance with the funding source and the amount of CFA CONTRACTOR is requesting. In addition, the CONTRACTOR must submit supporting documentation of expenses incurred in the prior month to receive future CFAs.

F. Upon receipt of the Invoice, COUNTY, shall determine whether to approve the CFA and, if approved, whether the request is approved in whole or in part.

G. If a CFA is not approved, COUNTY will notify CONTRACTOR within ten (10) business days of the decision, including the reason(s) for non-approval. Thereafter, CONTRACTOR may, within fifteen (15) calendar days, request reconsideration of the decision.

H. Year-end Settlement. CONTRACTOR shall adhere to all settlement and audit provisions specified in Exhibit I, of this Agreement, for all CFAs received during the fiscal year.

I. Should CONTRACTOR request and receive CFAs, CONTRACTOR shall exercise cash management of such CFAs in a prudent manner.

XI. AUTHORITY TO ACT FOR THE COUNTY

The Director of the Health Department of the County of Monterey may designate one or more persons within the County of Monterey for the purposes of acting on his/her behalf to implement the provisions of this Agreement. Therefore, the term "Director" in all cases shall mean "Director or his/her designee."

	INTERIM INC - FY 16-17, AMENDMENT NO. 1										
					FUNDING SOURCES						
Prog #	Program	Mode of Service	Service Function Code	Payment Rate	Realignment	SAMHSA	FFP/Medi-Cal	PATH	MHSA/CSS	MHSA/PEI	Total Funding Needed County Contract Programs
1	Manzanita Hse - Adult Crisis Residential	05	40-49	Provisional	851,560		851,560				1,703,120
2	Bridge - Adult Residential	05	65-79	Provisional	409,579		409,579				819,159
3	Bridge - Day Rehabilitation	10	95-99	Provisional	178,761		178,761				357,522
19	Intensive Day Treatment			Provisional	258,154		258,154				516,308
	Sub-Total				1,698,054	-	1,698,054	-	-	-	3,396,108
11	Dual Recovery - Case Mgmt/Mental Health Srvcs	15	01-09 / 10-19	Provisional			232,254		232,254		464,508
7	Rockrose- Case Mgmt/Mental Health Srvcs	15	01-09 / 10-19	Provisional			94,654		94,654		189,308
8	Lupine - Case Mgmt/Mental Health Srvcs	15	01-09 / 10-19	Provisional			162,945		162,945		325,889
9	Sunflower - Case Mgmt/Mental Health Srvcs	15	01-09 / 10-19	Provisional			165,172		165,172		330,344
10	McHome - Case Mgmt/Mental Health Srvcs (Includes Soled	15	01-09 / 10-19	Provisional			357,587		357,587		715,173
	Sub-Total	-			-	-	1,012,612	-	1,012,612	-	2,025,222
4	Community Housing - Case Mgmt/Mental Health Srvcs	15	01-09 / 10-19	Provisional	484,798		484,798				969,596
5	Sandy Shores - Case Mgmt/Mental Health Srvcs	15	01-09 / 10-19	Provisional	194,232		194,232				388,463
6	Shelter Cove - Case Mgmt/Mental Health Srvcs	15	01-09 / 10-19	Provisional	370,672		370,672				741,344
13	SEES Supp ED - Case Mgmt/Mental Health Srvcs	15	01-09 / 10-19	Provisional	72,616		72,616				145,231
	Sub-Total				1,122,317	-	1,122,317	-	-	-	2,244,635
1	Manzanita Hse - Adult Crisis Board & Care	60	40-49	CF Advance	95,105						95,105
2	Bridge - Residential - Board & Care	60	40-49	CF Advance	78,119						78,119
4	Community Housing	60	70	CF Advance	200,535						200,535
5	Sandy Shores - Housing	60	70	CF Advance	124,709						124,709
6	Shelter Cove - Housing	60	70	CF Advance	253,449						253,449
10	McHome - Outreach (Includes Soledad House & Wesley C	60	70	CF Advance				96,332	439,239		535,571
11	Dual Recovery Services	60	70	CF Advance					37,782		37,782
12	SAMHSA Support - Dual Diagnosis	60	78	CF Advance		93,276			24,572		117,848
14	WET - Fixed Rate	60	70	CF Advance	221,948						221,948
15	OMNI - Wellness Recovery Center - Adults	60	70	CF Advance					-	546,132	546,132
16	Success Over Stigma (SOS)	60	70	CF Advance						75,355	75,355
17	Bienestar	60	70	CF Advance						73,702	73,702
18	Peer Support & Peer Partners for Health	60	70	CF Advance						256,216	256,216
19	Intensive Day Treatment	60	40-49	CF Advance	20,000						20,000
20	CSUMB	60	70	CF Advance						148,317	148,317
	TOTALS				3,814,236	93,276	3,832,983	96,332	1,514,193	1,097,722	10,448,732

COUNTY reserves the right to adjust the funding sources as may be necessary during the term of the Agreement.