AMENDMENT 2008-2009

TO AGREEMENT FOR SERVICES OF INDEPENDENT CONTRACTOR

This is an amendment (hereafter referred to as the "First Amended Contract") to the Agreement for Services of Independent Contractor, number **BC 09-015**, by and between the **County of Santa Barbara** (County) and **PathPoint** (Contractor), for the continued provision of **Residential & Rehabilitation Services**.

Whereas, this First Amended Contract incorporates the terms and conditions set forth in the contract approved by the County Board of Supervisors in July 2008, except as modified by this First Amended Contract.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, County and Contractor agree as follows:

I. Delete First Paragraph of Exhibit A, Statement of Work and replace with the following:

The following terms shall apply to all programs operated under this contract, included as Exhibits A-1 through A-10.

II. Add sub-section 4 to Exhibit A, Statement of Work, Section 1.A., Staff - Training as follows:

4. For Supported Housing South: Staff shall be trained and skilled at working with persons with SMI, shall adhere to professionally recognized best practices for rehabilitation assessment, service planning, and service delivery, and shall become proficient in the principles and practices of Integrated Dual Disorders Treatment.

III. Add Exhibit A-10, Statement of Work – Supported Housing South, as follows:

AMENDMENT 2008-2009
Exhibit A-10
STATEMENT OF WORK
Supported Housing South
October 1, 2008 – June 30, 2009

1. **PROGRAM SUMMARY.** The Supported Housing Services Program (Paths to Recovery), hereafter referred to as "The Program" shall deliver treatment, rehabilitative and supportive services to clients "in vivo" in regular community settings (e.g., home, apartment, job site). The Program will initially be headquartered at 402 East Carrillo Street, Suite B, Santa Barbara, California. Upon completion of the new facility, the Program headquarters will then relocate to 617 Garden Street, Santa Barbara, California.

   Contractor shall adhere to the requirements specified in the South Santa Barbara County Supported Housing Services Request for Proposals, released by Alcohol, Drug and Mental Health Services in July 2008, and to the terms of the Contractor's Proposal, as accepted by County.

For all Program clients, functioning in major life domains presents significant personal difficulties. These domains include affordable, safe housing; meaningful daily pursuits, including employment; and satisfying interpersonal relationships. Addressing the rehabilitation needs of clients in these key domains will be the Program's essential purpose.

The Program shall provide team-based services that are closely allied with ADMHS County Clinic Psychiatrists to individuals in the identified client population. County Psychiatrists will be accountable for the overall clinical treatment of Program clients. The work of the Program staff (hereafter, "the Supported Housing Team") and County Psychiatrists shall be complementary and driven by a unified assessment and treatment plan. Critical treatment activities will be the responsibility of the Program and shall include but not be limited to:

A. Early identification of changes in a client's symptoms or functioning that could lead to crisis.

B. Recognition and quick follow-up on medication effects or side-effects.

C. Assistance to individuals with symptom self-management.

The foundation of the Program shall be integrated treatment, rehabilitation and support services. At Program start-up, the Program shall incorporate at least two pivotal evidence-based practices: Supported Employment and Integrated Treatment of Co-occurring Disorders.

2. **PROGRAM GOALS**.

A. Build relationships with clients based on mutual trust and respect.

B. Offer individualized assistance. The Program emphasizes a comprehensive bio-psychosocial process of assessment, gathered and documented over time through listening to and learning about each client's subjective experiences.

C. Adopt a no-reject approach to clients. Clients are not terminated from Program services if they express anger and frustration with current or past services, if they do not "follow the rules," if they do not "fit in." Instead, such statements or actions offer an opportunity for staff to learn more about each client and his/her experiences with services, with the effects of mental illness and with general life circumstances.

D. Meet clients at whatever their stage of treatment readiness. While clients are asked to commit to actively working with the team, they are not required to be abstinent from alcohol or other drugs. Housing placements are made in both alcohol and drug free community settings and in settings that do not require abstinence. In working with people who continue to use alcohol or drugs, an emphasis is placed on harm reduction and encouraging the adoption of lifestyle changes that will not jeopardize their housing.

E. Understand and use the strengths of the local culture in service delivery. Assessment, planning and service delivery should be consistent with the resources and practices of each client's racial and ethnic community.

F. Provide continuity across time. The frequency and type of supports can readily be adjusted in response to clients' changing needs or life situations. As a client's goals and preferences change, Contractor's staff follows along as the client "sets the pace."

G. Use a flexible, non-programmatic approach. Program staff shall spend most of their time with clients in the community, offering side by side, "hands on" support to clients who may need help to gain greater control and management of their lives. Adhering to the principle of "whatever it takes," the Supported Housing Team helps prevent mental illness from being the driving force in clients' lives. Service delivery in office or clinic settings should be minimized.

H. Operate as a cohesive team responsible for delivery of most services required by clients with minimal referral to a variety of different programs. As one exception, County Psychiatrists will have overall accountability for the psychiatric treatment of Program clients. Whenever a provider outside the Program is needed (e.g., physical health care), the Program is responsible for making certain that clients receive the required services.

I. Consistent with each client's preferences and wishes, support family members and others with whom the client has significant relationships and assure special consideration to the needs of clients who are parents and to the needs of their minor children.

J. Provide services as long as they are medically needed, not based on predetermined timelines.

3. **CLIENTS/PROGRAM CAPACITY.**

A. Persons served by the Program are individuals who have serious mental illness with symptoms that currently are moderate or intermittent in severity. Clients have significant difficulty living successfully in the community and assuming valued life roles (e.g., employee, student, neighbor, and parent).

B. Most persons served by the Program will not require frequent, multiple daily service contacts, but most will need services, at least weekly, provided through organized treatment, rehabilitation and housing support services that "wraparound" the client.

C. Contractor shall provide the services described in Section 10 to approximately 130 adults with serious mental illness in the Santa Barbara area.

4. **ADMISSION CRITERIA.** Clients shall be adults aged 18 and over who have:

A. Mental illness symptoms which are currently moderate or intermittent in severity.

B. Primary Psychiatric diagnoses of schizophrenia, other psychotic disorders, and bipolar disorders.

C. One or more of the following related to their mental illness:

1. Within the last year, one or more psychiatric inpatient hospitalizations and/or occasional use of emergency departments.

2. Functional impairments over the past year in at least three of the following life domains:

   a. Difficulty in performance of some daily living tasks/personal care activities (e.g., personal hygiene; meeting nutritional needs; obtaining medical, legal and housing services; persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as family, friends or relatives; recognizing and avoiding common dangers to self and possessions; transportation access).

   b. Difficulty keeping and maintaining interpersonal relationships.

   c. Difficulty performing occupation roles (e.g., acquires a job but is not able to remain employed and achieve a self-sustaining income).

   d. Difficulty maintaining safe, secure living situation.

   e. Co-occurring addictions disorders.

   f. History of and/or risk of homelessness.

   g. Involvement or risk of involvement in criminal justice system.

3. Need for mental health services that cannot be met with other available community-based services as determined by an ADMHS Psychiatrist.

5. **REFERRALS.**

A. Contractor shall admit clients referred by the County from County Crisis and Recovery Emergency Services (CARES), CARES Crisis Residential, ADMHS Psychiatric Health Facility, and County Treatment Teams. Referral sources other than these approved by the County must be authorized by designated ADMHS staff. A biannual or more frequent Utilization Management review and ongoing authorization will occur to assure that clients served meet the criteria for the Program.

B. Contractor shall begin the admission process within five (5) days of referral.

C. During the Program startup phase, all clients referred for admission by County shall be admitted to the Program by October 31, 2008.

D. **REFERRAL PACKET**. Contractor shall maintain a referral packet within its files (hard copy or electronic), for each client referred and treated, which shall contain the following items:

   1. A copy of the County referral form.

2. A client face sheet (Form MHS 140).

3. A copy of the most recent comprehensive assessment and/or assessment update.

4. A copy of the most recent medication record and health questionnaire.

5. A copy of the currently valid County Coordination and Service Plan indicating the goals for client enrollment in the Program and identifying the Contractor as service provider.

6. Client's Medi-Cal Eligibility Database Sheet (MEDS) file printout, as provided to Contractor in the initial Referral Packet. Thereafter, it will be Contractor's responsibility to verify continued Medi-Cal eligibility.

7. Other documents as reasonably requested by County.

6. **DISCHARGE CRITERIA.** The appropriateness for client discharge or transfer to less intensive services shall be determined on a case by case basis. Criteria for discharge or transfer to less intensive services include:

A. Client ability to function without assistance at work, in social settings, and at home.

B. No inpatient hospitalization for one year.

C. Stable housing maintained for at least one year.

D. Client is receiving one contact per month from the Program and rated by the Program staff as well as County Psychiatrist as functioning without assistance in key areas of community living.

E. Client declines services and requests discharge, despite persistent, well documented efforts by the Program staff to provide outreach and to engage the client in a supportive relationship.

7. **DISCHARGES/TRANSFER/READMISSION POLICY**

A. **Discharge Requirements**.

1. The Supported Housing Team and County Psychiatrist responsible for treatment shall work in close partnership with each client to establish a written discharge plan that is responsive to the client's needs and personal goals.

2. Contractor shall notify County Utilization Review Department Liaison within ten (10) days of any pending discharge decision made through County/Contractor team planning.

3. County Utilization Review Department shall receive a copy of the final discharge plan summary, which shall be prepared by the Supported Housing Team at the time of

client discharge. Discharge summaries shall be submitted to ADMHS no later than ten (10) days after the client's discharge from the Program.

B. **Transfer Requirements**. In the event of client transfer to another service provider, Contractor shall ensure:

1. Partnership with the client throughout the transfer planning process to assure responsiveness to his/her individual needs, goals and preferences.

2. Continuity of client care before and after transfer which shall include a gradual transfer process with a period of overlapping services.

C. **Discharge and Readmission Policy.** Contractor shall maintain a discharge and readmission policy, subject to approval by designated County staff, to address the following:

1. Discharge of clients to lower or higher levels of care.

2. Discharge based on client requests.

3. Discharge of clients who decline to participate in services or are assessed to be non-compliant with services. The Program shall carry out consistent, outreach efforts to establish supportive treatment. All such contacts must be clearly documented with approval from County Utilization Review prior to termination of services and discharge.

4. Re-admission of clients previously enrolled in the Program.

8. **STAFFING REQUIREMENTS.**

A. Contractor shall adhere to the Program staffing requirements outlined below:

1. The Program shall include qualified bilingual and bicultural clinicians and staff able to meet the diverse needs represented in the local community. Hiring activities to meet this goal shall be a major operational priority of the Program. As needed, the Supported Housing Team shall have access to qualified translators and translator services, experienced in behavioral healthcare, appropriate to the needs of the clients served. In the event that the Program must seek translation services outside of the Supported Housing Team, Contractor shall maintain a list of qualified translators to assist in providing this service.

2. In hiring all positions for the Program, Contractor shall give strong consideration to qualified clients who are or have been recipients of mental health services.

B. Contractor shall hire the Supported Housing Team consisting of 11.0 FTE staff, described below, by October 31, 2008. Staff shall begin providing services immediately, but no later than October 31, 2008, and shall work collaboratively with Clinic-based County Psychiatrists to deliver necessary services.

1. One (1.0) FTE Team Leader who is the clinical and administrative supervisor of the Program. The Supported Housing Team Leader shall have at least a master's degree in nursing, social work, psychiatric rehabilitation, psychology or mental health counseling. The Supported Housing Team Leader shall have at least two years of direct experience treating adults with serious mental illness, including at least one year of program management or supervisory experience in a mental health setting.

2. Two (2.0) FTE Registered Nurses, who work side-by side with the Supported Housing Team Leader and Clinic-based County Psychiatrists to ensure systematic coordination of medical treatment and the development, implementation and fine-tuning of the medication policies and procedures.

3. One (1.0) FTE Master's level lead clinician who has at least two years of direct experience treating adults with serious mental illness. This lead clinician shall provide clinical leadership during treatment planning meetings, conduct psychosocial assessments, assist with the provision of side-by-side supervision to staff, provide supportive counseling to individuals and families and work interchangeably with the Registered Nurses. The lead clinician will provide support and back-up to the Team Leader in his/her absence.

4. Five (5.0) FTE Rehabilitation Specialists with each staff having direct experience working with adults with mental illness or related training or life experiences. These staff will have responsibility for supporting each client's recovery process, helping individuals to restore competencies and gain successes in the major areas of community living. These include: permanent, affordable housing; successful daily life pursuits, particularly regular, competitive employment; and renewed relationships.

    a. At least three (3.0) FTE Rehabilitation Specialists shall have primary responsibility for assuring that supported employment services are integrated into the Program's service delivery, as informed by the Supported Employment evidence-based practice. This practice is endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA). These staff persons shall have, minimally, a bachelor's degree in rehabilitation counseling or career development and, preferably, at least two years of experience providing individualized job development and supported employment on behalf of persons with physical or mental disabilities a related field.

    b. At least one (1.0) FTE Rehabilitation Specialist shall have responsibility for strengthening the Program's capacity to respond to the needs of clients with addictions disorders. This staff person shall help to support the Program's implementation of Integrated Treatment of Co-Occurring Disorders, an evidenced-based practice supported by SAMHSA. This FTE shall be required to have a bachelor's degree and at least two years of supervised experience in providing substance abuse treatment interventions to persons with co-occurring psychiatric and addictions disorders.

c. One (1.0) FTE Rehabilitation Specialist comprised of one full-time or several part-time staff shall provide on-site rehabilitation and support services for some period of time each day (e.g., 4:00PM to 10:00PM) to approximately eight (8) adults living at Casa Del Mural, a County-owned housing facility located on North Antonio Road, Santa Barbara, CA. The need for this on-site rehabilitation and support capacity shall be continuously assessed by the Supported Housing Team Leader and County Psychiatrist. On-site services can be "flexed" and reduced or increased according to need. This Personal Service Coordinator shall be employed as a staff member of the Program, and when not working on-site at Casa Del Mural, shall offer outreach and community support services to Casa Del Mural residents or other clients of the Program.

5. One (1.0) FTE Peer Specialist comprised of one full-time or several part-time staff who are or have been recipients of mental health services for serious mental illness. Peer Specialists provide essential expertise and consultation to the entire team to promote a culture in which each client's subjective experiences, points of view and preferences are recognized, respected and integrated into all treatment, rehabilitation and support services. Peer Specialists participate in all program planning processes and provide direct services in the community that promote client self-determination and decision-making.

6. One (1.0) FTE Administrative Assistant who is responsible for coordinating, organizing, and monitoring all non-clinical operations of the Program, providing receptionist activities including triaging calls and coordinating communication between the Program staff and clients.

C. County shall provide Psychiatric support to clients served by the Program. Psychiatric support for the individuals served will be provided by the treating Psychiatrist, based at the County Outpatient Clinic site. The County shall assume the responsibility for financial oversight and supervision for the Psychiatrist. County staff shall work in conjunction with Contractor staff to deliver provision of seamless multi-disciplinary treatment, rehabilitation and support services.

D. Contractor shall request County approval prior to altering any of the staffing disciplines/specialties or number of staff.

9. SERVICE INTENSITY/ TREATMENT LOCATION/ STAFF CASELOADS

A. **Service Intensity.** The Program shall have the capacity to provide multiple contacts per day or per week to persons served who are experiencing significant mental illness symptoms and/or significant problems in daily living. The Program shall have the capacity to increase the service intensity for a client served within hours of his/her status requiring it.

1. Each client served by the Program shall receive a total of at least four (4) hours of service each month, preferably, but not necessarily provided at a frequency of at least one (1) hour per week. If the overall four (4) hour minimum is not met, an explanation

must be placed in the client's record. Services are provided in the community in the individual's natural setting.

2. Contractor shall ensure that the Supported Housing Team Leader or his/her designee shall be available to staff, either in person or by telephone at all times. Contractor shall promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to assure the health and safety of clients.

B. **Treatment Location**. The majority of Program services (at least 85 percent) will occur outside program offices in the community, within each client's life context. The Program will maintain data to verify these goals are met.

C. **Staff to Client Caseload Ratios**. The Program shall operate with a staff to client ratio that does not exceed 1 to 15 (15 clients per one full-time equivalent (1.0 FTE) Program staff member), excluding the Psychiatrist and Program Assistant. These staff will not carry an individual caseload. Caseloads of individual staff members will vary based upon their overall responsibilities within the team (for example, Team Leader and Nurses will carry smaller caseloads).

D. **Hours of Operation and Coverage.**

1. The Supported Housing Team shall be available to provide treatment, rehabilitation, and support services six (6) days per week and shall operate a minimum of twelve (12) hours per day on weekdays and six (6) hours per day on one weekend day. Program hours should be adjusted so that staff members are available when needed by the client, particularly during evening hours. The Program's hours of operation shall be:

   a. Monday through Friday 8:30 AM to 8:30 PM

   b. Saturday 9:00 AM to 5:00 PM

2. The Program shall operate an after-hours on-call system. Experienced Program staff with skill in crisis-intervention procedures shall be on call and available to respond to requests by the County Crisis and Recovery Emergency Services (CARES) in the event that specialty knowledge from the Program is required. Response to CARES may be by both telephone and in person. If a physical response is required, staff shall arrive no later than 30 minutes from the time of the call.

3. Through CARES, County Psychiatric back up will be available at all times, including evenings, weekends and holidays.

E. **Team Organization and Communications.**

1. The overall Program's organization and communication is structured in two major ways – through meetings and documentation.

2. The Supported Housing Team shall maintain a written Daily Log. The Daily Log shall provide a roster of all persons currently served by the Program, as well as brief documentation of any service contacts which have occurred during the last 24 hours, and a concise, brief description of each client's daily status.

3. The Supported Housing Team shall maintain a Weekly Client Contact Schedule for each client. This schedule shall contain all planned service contacts that staff must carry out to enable each client to achieve the goals and objectives in his/her treatment plan. The time, date, defined interventions and staff assigned shall be specified for each contact on the schedule. A central file of all Weekly Client Contact Schedules updated weekly shall be maintained and available for review by ADMHS.

4. The Supported Housing Team shall develop a Daily Team Assignment Schedule that lists all planned contacts transferred from the Weekly Client Contact Schedule of all the treatment, rehabilitation and service contacts to take place that day.

5. The Supported Housing Team will conduct an organizational clinical staff meeting five (5) days per week at a regularly scheduled time established by the Team Leader and shall occur during weekdays when maximum numbers of staff are present. At least one (1) meeting per week shall begin with a review of the entire Daily Log, which updates staff on the service contacts from the prior day and provides a systematic means for the Supported Housing Team to assess the day-to-day progress and status of each client served by the Program. The remaining meetings may, at the discretion of the Team Leader, review only the clients who received services the previous day and those who are scheduled for services on the day of the meeting. The meeting shall include a review of the Daily Team Assignment Schedule to cover the period until the next organizational clinical staff meeting. During the meeting, the Team Leader or designee shall assign staff to carry out the interventions scheduled to occur during that period. The meeting shall also be an opportunity to revise treatment plans as needed, plan for emergency and crisis situations, and add service contacts to the Daily Team Assignment Schedule per the revised treatment plans.

6. All available staff must be physically present for the weekly comprehensive meeting which reviews the entire Daily Log, which updates staff on the service contacts from the prior day and provides a systematic means for the team to assess the day-to-day progress and status of each client served by the Program.

10. **SERVICES**. The Program shall provide an appropriate combination of services to meet each client's specific needs and preferences, assist each client to achieve and sustain recovery. Services shall include:

A. **Care Management.** Care Management is a core function provided within the Program. Care management activities are led by one Supported Housing Team member, known as the primary care manager. The primary care manager coordinates and monitors the activities of the Program staff who have shared ongoing responsibility to assess, plan, and deliver treatment, rehabilitation and support services to each client. The primary care manager:

1. Develops an ongoing relationship with clients based on mutual trust and respect. This relationship should be maintained whether the client is in a hospital, in the community or involved with other agencies (e.g. in a detox center, involved with corrections).

2. Works in partnership with clients to develop a recovery-focused treatment plan.

3. Provides individual supportive therapy and symptom management.

4. Makes immediate revisions to the treatment plan, in conjunction with the client, as his/her needs and circumstances change.

5. Is responsible for working with clients on crisis planning and management.

6. Coordinates and monitors the documentation required in the client's medical record.

7. Advocates for the client's rights and preferences.

8. Provides the primary support to the client's family.

B. **Crisis Assessment and Intervention.** Contractor shall ensure availability of telephone and face-to-face contact with clients 24 hours per day, seven days per week to respond to requests by the County Crisis and Recovery Emergency Services (CARES) in the event that specialized knowledge from the Program is required. Response to CARES may be by both telephone and in person. If a physical response is required, staff shall arrive no later than 30 minutes from the time of the call.

C. **Housing Services and Support.** Contractor shall provide housing services and support to help clients obtain and keep housing consistent with their recovery objectives. Safe, affordable housing is essential to helping clients fully participate in, and benefit from, all other assistance the Program offers. Some clients referred for Program services may be homeless or have unstable living arrangements. It is important for Program staff to be familiar with the availability and workings of affordable housing programs. Affordable housing units or subsidies may be accessed from other agencies and the general public or private housing market. Program staff need to develop and maintain working relationships with local housing agencies from whom housing units, any necessary rental subsidies, and other available housing-related services or resources may be accessed on behalf of clients. Program housing services and support shall include but not be limited to assisting clients in:

1. Finding apartments or other living arrangements.

2. Securing rental subsidies.

3. Developing positive relationships with landlords.

4. Executing leases.

5. Moving and setting up the household.

6. Meeting any requirements of residency.

7. Carrying out household activities (e.g., cleaning).

8. Facilitating housing changes when desirable or necessary.

D. **Activities of Daily Living.** Contractor shall provide services to support activities of daily living in community-based settings include individualized assessment, problem-solving, side-by-side assistance and support, skills training, ongoing supervision (e.g., monitoring, encouragement) and environmental adaptations to assist clients to gain or use the skills required to:

1. Carry out personal care and grooming tasks.

2. Perform activities such as cooking, grocery shopping and laundry.

3. Procure necessities such as a telephone, microwave.

4. Develop ways to budget money and resources.

5. Use available transportation.

E. **Support Services.** Contractor shall assist clients to access needed community resources, including but not limited to:

1. Medical and dental services (e.g., having and effectively using a personal physician and dentist).

2. Financial entitlements.

3. Social services.

4. Legal advocacy and representation.

F. **Employment and Educational Supports**. Contractor shall provide work-related support services to help clients who want to find and maintain employment in community-based job sites as well as educational supports to help clients who wish to pursue the educational programs necessary for securing a desired vocation.

1. Program staff use their own expertise, service capacities and counseling assistance to help clients pursue educational, training or vocational goals. The Supported Housing Team will maintain relationships with employers, academic or training institutions, and other such organizations of interest to clients.

2. Program staff can help clients find employment that is part or full time, temporary or permanent, based on the unique interests and needs of each client. As often as possible, however, employment should be in real life, independent integrated settings with competitive wages.

3. Services shall include but not be limited to:

    a. Assessment of educational and job-related interests and abilities, through a complete education and work history assessment, as well as on-site assessments in educational and community-based job sites.

    b. Assessment of the effect of the client's mental illness on employment or educational learning, with identification of specific behaviors that interfere with the client's work or learning performance and development of interventions to reduce or eliminate those behaviors.

    c. Development of an ongoing supportive educational or employment rehabilitation plan to help each client establish the skills necessary to find and maintain a job or to remain in an educational setting.

    d. Benefits counseling expertise to help clients understand how gainful employment will affect Social Security Administration (SSA) disability payments and health coverage. The counseling will also be expected to address work incentive benefits available through SSA and other agencies.

    e. Individual supportive therapy to assist clients to identify and cope with symptoms of mental illness that may interfere with work performance or learning

    f. On-the-job or work related crisis intervention to address issues related to the client's mental illness such as interpersonal relationships with co-workers and/or symptom management.

    g. Work-related supportive services, such as assistance with grooming or personal hygiene, securing of appropriate clothing, wake-up calls, transportation, etc.

    h. Building of cooperative relationships with publicly funded "mainstream" employment, education, training, and vocational rehabilitation agencies/organizations in the community.

G. **Community Integration (e.g. Social Relationships, Use of Leisure Time, Peer Support).** Social system interventions help clients maintain and expand a positive social network to reduce social isolation. Contractor shall work with each client to:

1. Assess and identify the client's joys, abilities and accomplishments in the present and in the past, and also what the client would like to occur in the future.

2. Identify the client's beliefs and meanings and determine what role they play in the client's overall well being (e.g. how does the client make sense of his/her life experience? How is meaning or purpose expressed in the client's life? Are there any rituals and practices that give expression to the client's sense of meaning and purpose? Does this client participate in any formal or informal communities of shared belief, etc?).

3. Identify and address potential obstacles to establishing positive social relationships (e.g., shyness; anxiety; client's expectations for success and failure).

4. Give side-by-side support and coaching, as needed, to build client confidence and success in relating to others.

5. Provide supportive individual therapy (e.g., problem-solving, role-playing, modeling and support), social-skill teaching and assertiveness training.

6. Make connections to peer advocates or peer supports.

7. Help make plans with peers or friends for social and leisure time activities within the community.

H. **Peer Support Services.** Contractor shall provide services to validate clients' experiences and guide and encourage clients to take responsibility for and actively participate in their own recovery, as well as services to help clients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce clients' self-imposed stigma:

1. Peer counseling and support.

2. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery.

3. Recovery-oriented training including WRAP (Wellness Recovery Action Plan) and UCLA/PAL Independent Living Skills modules.

I. **Symptom Assessment, Management and Individual Supported Therapy.** These interventions assist clients to address the distressing and disabling problems associated with psychotic symptoms; help to ease the emotional pain associated with having a serious mental illness (e.g., severe anxiety, despair, loneliness, unworthiness and depression) and assist clients with symptom self-management efforts that may reduce the risk of relapse and minimize levels of social disability. Contractor shall provide:

1. Ongoing assessment of the client's mental illness symptoms and his/her response to treatment.

2. Education of the client regarding his/her illness and the effects and side effects of prescribed medication, where appropriate.

3. Encouragement of symptom self-management practices which help the client to identify symptoms and their occurrence patterns and develop methods (internal, behavioral, adaptive) to lessen their effects. These may include specific cognitive behavioral strategies directed at fostering feelings of self-control.

4. Supported psychotherapy to address the psychological trauma of having a major mental illness.

5. Generous psychological support to each client, provided both on a planned and as needed basis, to help him or her accomplish personal goals.

J. **Medication Prescription, Administration, Monitoring and Documentation.** An important distinguishing feature of the Program will be the role of County Clinic-based Psychiatrists as the treating doctors for Program clients. Program and County will establish practices and protocols that promote a seamless interface between Program and County Clinic staff in support of integrated, non-duplicated clinical care.

1. Supported Housing Team members shall work closely with each client and his/her County Psychiatrist to assess and document the client's mental illness symptoms and behavior in response to medication and shall monitor for medication side effects.

2. The Supported Housing Team shall establish medication policies and procedures that identify processes to:

   a. Facilitate client education and informed consent about medication.

   b. Record physician orders.

   c. Arrange for all medication related activities to be organized by the Program and documented in the Weekly Client Contact Schedule and Daily Staff Assignment Schedules.

   d. Provide security for storage of medications, including setting aside a private area for set up of medications by the Program nursing staff.

3. Contractor shall provide medication monitoring weekly. At least monthly, each client shall meet with the County Psychiatrist who prescribes and monitors psychiatric medications and provides psychotherapy as needed.

K. **Substance Abuse Services.** The Program shall provide substance abuse treatment services, based on each client's assessed needs. Services shall include, but not be limited to, individual and group interventions to assist individuals who have co-occurring mental illness and substance abuse problems to:

1. Identify substance use, effects and patterns.

2. Recognize the relationship between substance use and mental illness and psychotropic medications.

3. Provide the client with information and feedback to raise the awareness and hope for the possibility for change.

4. Employ various strategies for building client motivation for change.

5. Enable the client to find the best change action specific to their unique circumstances.

6. Help the client to identify and use strategies to prevent relapse.

7. Help the client renew the processes of contemplation, determination and action, without being stuck or demoralized because of relapse.

8. Develop connections to self-help groups such as Double Trouble and Dual Recovery programs.

L. **Education, Support, and Consultation to Clients' Families and Other Major Supports.** Contractor shall regularly provide services to clients' families and other major supports, with client agreement or consent, include:

1. Individualized psycho education about the client's illness and the role of the family and other significant people in the therapeutic process.

2. Interventions to restore contact, resolve conflict, and maintain relationships with family and or other significant people.

3. Ongoing communication and collaboration, face-to-face and by telephone, between the Program and the family.

4. Introduction and referral to family self-help programs and advocacy organizations that promote recovery.

5. Assistance to clients with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:

a. Services to help clients throughout pregnancy and the birth of a child.

b. Services to help clients fulfill parenting responsibilities and coordinate services for the child/children.

c. Services to help clients restore relationships with children who are not in the client's custody.

M. **Coordination with Health Care and Other Providers.** The Supported Housing Team represents a unique program model, whereby one team of staff provides an integrated package of treatment, rehabilitation, and support services to each client. There shall be minimal referral to external mental health treatment and rehabilitation services. However, successful Supported Housing Teams will include a high degree of coordination with healthcare providers and others with whom clients may come in contact. Contractor shall:

1. Collaborate closely with agencies from whom housing units, any necessary rental subsidies, and other available housing-related services or resources may be accessed on behalf of clients

2. Coordinate and ensure appropriate medical, dental and vision services for each client. Based on client consent, the Supported Housing Team will establish close working relationships with primary care physicians to support optimal health and assist in monitoring any medical conditions (e.g., diabetes, high cholesterol).

3. Coordinate with psychiatric and general medical hospitals throughout a client's inpatient stay. Program staff should be present when the client is admitted and should visit the hospital daily for care coordination and discharge planning purposes.

4. Maintain relationships with detoxification and substance abuse treatment services to coordinate care when Program clients may need these services.

5. Maintain close working relationships with criminal justice representatives to support clients involved in the adult justice system (e.g., courts, probation officers, jails and correctional facilities, parole officers).

6. Know when to be proactive in situations when a client may be a danger to self or others. Program staff should maintain relationships with CARES and other emergency resources and provide backup to CARES through 24-hour on-call capacity.

7. Establish close working relationships with self-help groups (AA, NA, etc.), peer support and advocacy resources and education and support groups for families and significant others.

8. Foster close relationships with local housing organizations.

9. Create a referral and resource guide for self-help groups and other community resources (e.g., legal aid organizations, food co-ops).

11. **DOCUMENTATION REQUIREMENTS.** Contractor shall complete the following for each client.

A. A comprehensive bio-psychosocial assessment, conducted in conjunction with the County Psychiatrist, that establishes the presence of a serious mental illness and details difficulties the client faces in areas of life functioning. This assessment provides a foundation for the treatment plan. The comprehensive bio-psychosocial assessment shall be completed by a Program staff member who is a properly licensed mental health professional within thirty (30) days of admission and updated at least every six (6) months or prior to discharge, or at discharge, whichever comes first.

B. A treatment plan that provides overall direction for the joint work of the client, the Program and client's County Psychiatrist shall be completed within thirty (30) days of admission and reviewed and updated at least every six (6) months with the client. The treatment plan shall include:

1. Client's recovery goals or recovery vision, which guides the service delivery process.

2. Client's major rehabilitation goals, which typically identify one- to two-year targets for the rehabilitative process and may serve as intermediate steps toward the achievement of the client's recovery goals or vision.

3. Objectives describing the skills and behaviors that the client will be able to learn as a result of Program's rehabilitative interventions during the following three (3) to six (6) months.

4. Interventions planned for the following three to six months to help the client reach the objectives.

C. Progress notes that describe the interventions conducted by the Supported Housing Team including, as described in Exhibit A, Section 6, Billing Documentation and Attachment A, Section 3, Progress Notes and Billing Records at minimum:

1. Actual start and stop times.

2. The goal from the rehabilitation plan that was addressed in the encounter.

3. The individualized intervention that was provided by the staff member.

4. The response to that intervention by the client.

5. The plan for the next encounter with the client, and other significant observations.

12. **POLICIES AND PROCEDURES.** Contractor shall develop written policy and procedures to set expectations for Program staff and establish consistency of effort. The written policies and procedures should be consistent with all applicable state and federal standards and should cover:

A. Informed consent for treatment, including medication.

B. Client rights, including right to treatment with respect and dignity, under the least restrictive conditions, delivered promptly and adequately.

C. Process for client filings of grievances and complaints.

D. Management of client funds, as applicable, including protections and safeguards to maximize clients' control of their own money

E. Admission and discharge (e.g. admission criteria and process; discharge criteria, process and documentation).

F. Personnel (e.g. required staff, staffing ratios, qualifications, orientation and training).

G. Hours of operation and coverage, service intensity, staff communication and planning emphasizing a team approach, and staff supervision.

H. Assessment and treatment processes and documentation (e.g. comprehensive assessment, treatment planning, progress notes).

I. Treatment, rehabilitation and support services.

J. Client medical record maintenance.

K. Program evaluation and performance (quality assurance).

L. Procedures for compliance with applicable State and Federal laws, including all Equal Employment Opportunity (EEO)/Affirmative Action (AA) requirements. Contractors must comply with the Americans with Disabilities Act.

13. **PHYSICAL SPACE.** The physical set-up of the Program office shall include:

A. Easy access for clients and families, including access for persons who have physical handicaps.

B. Common work space to facilitate communication among staff.

C. Three or four rooms, which can also serve as office space for the Supported Housing Team Leader, as interview rooms or quiet workspace for all staff to use, including the client's County Psychiatrist on any occasions when he/she may be in the Program offices.

D. Space for temporary storage of client possessions.

E. Room for medication storage.

F. Space for office machines (copy machine, fax machine) and storage of office supplies.

G. Parking for Program staff, clients and families.

14. **PROGRAM EVALUATION, PERFORMANCE AND OUTCOME MEASURES.** In addition to the requirements specified in Exhibit A, Section 3, Contractor shall work with County to ensure satisfactory data collection and compliance with the Outcomes described in Exhibit E, Program Goals, Outcomes and Measures.

A. Implementation Progress Reports. The Program will be required to submit a bi-monthly Implementation Progress Report during the first year of operation. ADMHS will use the reports to:

1. Identify Program areas requiring technical assistance/consultation support.

2. Assess Program status changes that put the Program out of compliance with one or more contract standards or that place the program at risk of non-compliance in any area.

3. Request a Plan for Correction in areas that are not in compliance.

B. Client Outcomes.

1. Yearly goals will be established for key Program outcomes, using the measures described in Exhibit E.

2. Each Program outcome will be reviewed, at a minimum, every six (6) months by County and adjustments will be made as necessary. The Contractor(s) must have in place mechanisms to collect outcome data, analyze the data and incorporate the knowledge gained into the design and/or operation of the program.

3. During the Program start-up phase, County shall work with the Contractor to reach agreement on specific methods for measuring and collecting outcome information.

C. In addition to Implementation Reports and Client Outcomes, other methods County will use to evaluate the Program may include:

1. Periodic review of encounter data to ensure that clients are receiving the majority of needed services from the Program and not from external sources (e.g., hospitals/ERs and other programs).

2. Regular review of a random sample of client assessment, treatment plans and progress notes to assess the quality of the Supported Housing Team's planning and service delivery activities.

3. Annual on-site review of program activities and operations, including:

   a. Policies and procedures.

   b. Admission/discharge criteria.

   c. Service capacity.

   d. Staff requirements.

   e. Program organization.

   f. Assessment and treatment planning.

   g. Services provided.

   h. Performance improvement/program evaluation.

   i. Client and family satisfaction.

IV. Add part E to Item I, Payment for Services, of Exhibit B, Financial Provisions:

E. **Startup Costs.** Contractor shall be reimbursed for expenses associated with Program startup as described in Exhibit B-1.

V. Delete Item II of Exhibit B, Financial Provisions, and replace with the following:

II. **MAXIMUM CONTRACT AMOUNT.**

The Maximum Contract Amount has been calculated based on the total UOS to be provided pursuant to this Agreement as set forth in Exhibit B-1 and shall not exceed $1390313 dollars. The Maximum Contract Amount shall consist of County, State, and/or Federal funds as shown in Exhibit B-1. Notwithstanding any other provision of this Agreement, in no event shall County pay Contractor more than this Maximum Contract Amount for Contractor's performance hereunder without a properly executed amendment.

VI. Add the following paragraph to Item VI.A, of Exhibit B, Financial Provisions:

Startup Costs. Contractor shall submit a written invoice within ten (10) calendar days of the end of the month in which startup costs are incurred that: i) states the amount owed by County, and ii) includes the Agreement number and signature of Contractor's authorized representative. Invoices submitted for payments that are based upon Exhibit B-1 must contain sufficient detail and supporting documentation to enable an audit of the charges.

VII. Delete Exhibit B-1, Schedule of Rates and Contract Maximum, and replace with the following:

AMENDMENT 2008-2009

EXHIBIT B-1
ALCOHOL, DRUG AND MENTAL HEALTH SERVICES
SCHEDULE OF RATES AND CONTRACT MAXIMUM

CONTRACTOR NAME: PathPoint **FISCAL YEAR:** 2008-09

	PROGRAMS										
	Vida Nueva Santa Barbara	Community Independent Living Program (CILP)	Assessment Center Program (ACP)	Housing Support Services (HSS)	Project Life Skills	Vocational Rehab	Casa del Mural	El Carrillo*	Pre-Vocational	Supported Housing Services - South Santa Barbara County*	TOTAL
	Aug. 1, 2008 to Oct. 31, 2008	Aug. 1, 2008 to Oct. 31, 2008	Aug. 1, 2008 to Oct. 31, 2008	Aug. 1, 2008 to Oct. 31, 2008	Aug. 1, 2008 to Oct. 31, 2008	Aug. 1, 2008 to June 30, 2009	Aug. 1, 2008 to Sept. 30, 2008	Aug. 1, 2008 to June 30, 2009	Aug. 1, 2008 to Oct. 31, 2008	Oct 1, 2008 to June 30, 2009	
DESCRIPTION/MODE/SERVICE FUNCTION:	NUMBER OF UNITS PROJECTED (based on history):										
Outpatient - Placement/Brokerage (15/01-09)	372	269	218	138	-	-	243	329	-	1,809	3,378
Outpatient Mental Health Services (15/10-59)	98,295	69,102	54,655	32,302	26,481	7,053	61,906	92,941	3,201	510,744	956,681
Outpatient Crisis Intervention (15/70-79)	155	112	91	58	-	-	100	137	-	753	1,405
SERVICE TYPE: M/C, NON M/C	M/C	M/C	M/C	M/C	M/C	M/C	M/C	M/C	M/C	M/C	
UNIT REIMBURSEMENT	minute	minute	minute	minute	minute	minute	minute	minute	minute	minute	
COST PER UNIT/PROVISIONAL RATE:											
Outpatient - Placement/Brokerage (15/01-09)	$1.09										
Outpatient Mental Health Services (15/10-59)	$1.42										
Outpatient Crisis Intervention (15/70-79)	$3.88										
GROSS COST:	$ 140,520	$ 98,786	$ 78,133	$ 46,178	$ 37,857	$ 10,083	$ 88,500	$ 132,867	$ 4,546	$ 752,843	$1,390,313
LESS REVENUES COLLECTED BY CONTRACTOR: (as depicted in Contractor's Budget Packet)											
A PATIENT FEES											$0
B PATIENT INSURANCE											$0
C CONTRIBUTIONS											$0
D FOUNDATIONS/TRUSTS											$0
E SPECIAL EVENTS											$0
F OTHER (LIST):											$0
TOTAL CONTRACTOR REVENUES	$ -	$ -			$ -						$0
MAXIMUM CONTRACT AMOUNT:	**$ 140,520**	**$ 98,786**	**$ 78,133**	**$ 46,178**	**$ 37,857**	**$ 10,083**	**$ 88,500**	**$ 132,867**	**$ 4,546**	**$ 752,843**	**$ 1,390,313**
SOURCES OF FUNDING FOR MAXIMUM CONTRACT AMOUNT											
A MEDI-CAL/FFP	$ 70,260	$ 49,393	$ 39,067	$ 23,089	$ 18,929	$ 5,042	$ 44,250	$ 66,434	$ 2,273	$ 328,567	$ 647,302
B OTHER FEDERAL FUNDS											$ -
C REALIGNMENT/VLF FUNDS	$ 70,260	$ 49,393	$ 39,067	$ 23,089	$ 18,929	$ 5,042	$ 44,250	$ 66,434	$ 2,273	$ 401,582	$ 720,317
D STATE GENERAL FUNDS											$ -
E COUNTY FUNDS - START UP										$ 22,694	$ 22,694
F HEALTHY FAMILIES											$ -
G TITLE 4E											$ -
H AB 3632											$ -
I EPSDT											$ -
J FIRST 5 GRANT											$ -
K MHSA											$ -
L OTHER (LIST):											$ -
TOTAL (SOURCES OF FUNDING)	$ 140,520	$ 98,786	$ 78,133	$ 46,178	$ 37,857	$ 10,083	$ 88,500	$ 132,867	$ 4,546	$ 752,843	$ 1,390,313

CONTRACTOR SIGNATURE: _____

STAFF ANALYST SIGNATURE: _____

FISCAL SERVICES SIGNATURE: _____

*Contractor rate wil be reassessed based on revised Contractor budget, as appropriate pending changes to other programs.

VI. Add the following to Exhibit E, Program Goals, Outcomes and Measures:

Adult Program Evaluation Supported Housing Services Program Evaluation		
Program Goal	**Outcome**	**Measure**
❖ Reduce mental health and substance abuse symptoms resulting in reduced utilization of involuntary care and emergency rooms for mental health and physical health problems	• Decreased incarceration rates • Decreased inpatient/acute care days and length of hospital stay • Decreased emergency room utilization • Decreased use of substances	➢ Number of incarceration days ➢ Number of hospital admissions; length of hospital stay ➢ Number of emergency room visits for physical and/or psychiatric care ➢ Client and staff reports of a decline in substance use and of gains in working toward the long-term goal of abstinence.
❖ Assist clients in their mental health recovery process and with developing the skills necessary to lead independent, healthy and productive lives in the community	• Reduced homelessness by maintaining stable/permanent housing • Increased life skills needed to participate in purposeful activity and increase quality of life	➢ Number of days in stable/permanent housing ➢ Number of clients employed, enrolled in school or training, or volunteering ➢ Number of clients graduating to a lower level of care

AMENDMENT 2008-2009

SIGNATURE PAGE

Amendment to Agreement for Services of Independent Contractor between the County of Santa Barbara and PathPoint.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective on the date executed by County.

COUNTY OF SANTA BARBARA

By: _____
SALUD CARBAJAL, Chair
Board of Supervisors
Date: _____

ATTEST:
MICHAEL F. BROWN
CLERK OF THE BOARD

By: _____
Deputy
Date: _____

APPROVED AS TO FORM:
DENNIS MARSHALL
COUNTY COUNSEL

By_____
Deputy County Counsel
Date: _____

APPROVED AS TO FORM :
ALCOHOL, DRUG, AND MENTAL HEALTH SERVICES
ANN DETRICK, PH.D.
DIRECTOR

By_____
Director
Date: _____

CONTRACTOR

By:_____
Tax Id No 95-2371668.
Date: _____

APPROVED AS TO ACCOUNTING FORM:
ROBERT W. GEIS, CPA
AUDITOR-CONTROLLER

By_____
Deputy
Date: _____

APPROVED AS TO INSURANCE FORM:
RAY AROMATORIO
RISK PROGRAM ADMINISTRATOR

By: _____

Date: _____

AMENDMENT 2008-2009

CONTRACT SUMMARY PAGE **BC 09-015**

Complete data below, print, obtain signature of authorized departmental representative, and submit this form (and attachments) to the Clerk of the Board (>$25,000) or Purchasing (<$25,000). *See also "Contracts for Services" policy. Form is not applicable to revenue contracts.*

D1. Fiscal Year 08-09
D2. Budget Unit Number 043
D3. Requisition Number .....
D4. Department Name ..... Alcohol, Drug, & Mental Health Services
D5. Contact Person ..... Erin Jeffery
D6. Telephone ..... (805) 681-5168

K1. Contract Type *(check one)*: ρ Personal Service ρ Capital
K2. Brief Summary of Contract Description/Purpose ..... Residential & Rehabilitation
K3. Contract Amount $1390313
K4. Contract Begin Date 8/1/2008
K5. Original Contract End Date 6/30/09
K6. Amendment History ……

Seq#	Effective Date	ThisAmndtAmt	CumAmndtToDate	NewTotalAmt	NewEndDate	Purpose
1	10/1/08	752,843	752,843	1,390,313	6/30/09	Add funds for new Program

B1. Is this a Board Contract? *(Yes/No)* ..... True
B2. Number of Workers Displaced *(if any)* ..... N/A
B3. Number of Competitive Bids *(if any)* ..... N/A
B4. Lowest Bid Amount *(if bid)* ..... N/A
B5. If Board waived bids, show Agenda Date ..... N/A
and Agenda Item Number .....
B6. Boilerplate Contract Text Unaffected? *(Yes / or cite Paragraph)* ... Yes

F1. Encumbrance Transaction Code 1701
F2. Current Year Encumbrance Amount $1390313
F3. Fund Number 0044
F4. Department Number 043
F5. Division Number *(if applicable)* .....
F6. Account Number 7460
F7. Cost Center number *(if applicable)* 4741
F8. Payment Terms ..... Net 30

V1. Vendor Numbers (A=Auditor; P=Purchasing) EID ..... A=891620
V2. Payee/Contractor Name ..... PathPoint
V3. Mailing Address ..... 315 W. Haley St. #102.
V4. City, State (two-letter) Zip (include +4 if known) ..... Santa Barbara, CA 93101
V5. Telephone Number 8059663310
V6. Contractor's Federal Tax ID Number *(EIN or SSN)* 95-2371668
V7. Contact Person ..... Cindy Burton Executive Director
V8. Workers Comp Insurance Expiration Date 10/1/2008
V9. Liability Insurance Expiration Date[s] ..... G=7/1/2009, P=7/1/2009
V10. Professional License Number ..... CCLD#425800267;
V11. Verified by (name of county staff) ..... Erin Jeffery
V12 Company Type *(Check one):* Individual ρ Sole Proprietorship ρ Partnership ☒ Corporation

I certify information complete and accurate; designated funds available; required concurrences evidenced on signature page.

Date: _____ Authorized Signature: _____