FIRST AMENDMENT TO STANDARD CONTRACT
BETWEEN COUNTY OF SOLANO and CAMINAR, INC.

This First Amendment ("First Amendment") is entered into as of the 26th day of June 2023, between the COUNTY OF SOLANO, a political subdivision of the State of California ("County") and CAMINAR, INC. ("Contractor").

1. Recitals

   A. The parties entered into a contract dated July 1, 2022 (the "Contract"), in which Contractor agreed to provide comprehensive case management (CCM) services.

   B. The parties now needs to increase the budget and extend the term of the contract.

   C. This First Amendment represents an increase of $2,016,475.18 to the Contract.

   D. The parties agree to amend the Contract as set forth below.

2. Agreement.

   A. Term

   Section 2 is deleted in its entirety and replaced with: The term of this contract is 7/1/2022 to 6/30/2024.

   B. Amount of Contract

Section 3 is deleted in its entirety and replaced with: The maximum amount of this Contract is: $3,253,099.18.

   C. Scope

   Exhibit A is deleted in its entirety and replaced with the Scope attached to and incorporated by this reference as Exhibit A-1.

   D. Budget.

   Exhibit B-1 is deleted in its entirety and replaced with the Budget attached to and incorporated by this reference as Exhibit B-1.1.

3. Effectiveness of Contract.

Except as set forth in this First Amendment, all other terms and conditions specified in the Contract remain in full force and effect.

COUNTY OF SOLANO, a Political Subdivision of the State of California

By _____
Bill Emlen
County Administrator

CAMINAR, INC.

By Mark Cloutier DIGITALLY SIGNED 09/21/2023 08:16 PM EDT
Mark Cloutier
CEO

APPROVED AS TO FORM

By Megan Callaway DIGITALLY SIGNED 09/22/2023 12:38 PM EDT
Deputy County Counsel

APPROVED AS TO CONTENT

By Gerald Huber DIGITALLY SIGNED 09/21/2023 08:22 PM EDT
Gerald Huber, Director
Health and Social Services

EXHIBIT A-1
SCOPE OF WORK

I. PROGRAM DESCRIPTION

Contractor will provide **Comprehensive Case Management (CCM)** services for individuals referred by the County of Solano, a political subdivision of the State of California (the "County") with the express intent of increasing consumer independence and stability in their lives. Emphasis of the program model is on supportive psychiatric rehabilitation, intensive case management, and counseling focused on behavioral issues critical to sustaining stability of the individuals in their community setting. These services support clients who are transitioning from higher or lower levels of care, have forensic involvement, co-occurring substance use, have current or former homeless histories, housing instability, and other complex needs.

The adult CCM program is outlined in the Solano County Mental Health Services Act (MHSA) Three Year Plan and supports clients referred through the County's Department of State Hospitals Grant, jail diversion programs, and Solano County's Local Homeless Action Plan services, among others.

These services will result in individuals maintaining independent community living and reducing hospitalizations, incarceration, and other more restrictive levels of care.

II. CONTRACTOR RESPONSIBILITIES:

PROGRAM SPECIFIC ACTIVITIES UNDER CCM PROGRAM

Contractor shall provide CCM services that include supportive psychiatric rehabilitation, intensive case management, and counseling to an average caseload ratio of 1:20 and approximately 180 clients annually who experience serious and persistent mental health challenges and co-occurring substance use disorders, and who are living in the community.

A. Services

The program will be expected to provide behavioral health services that include:

1. Case management and coordination of medical, psychiatric, social, vocational, educational, social security income (SSI) advocacy, housing resources as needed, etc.
2. Specialty services that includes supporting those with justice involvement (jail diversion, re-entry, collaborative court participants) and persons with co-occurring substance use and other complex needs. These are distributed across the caseload or when necessary, supported by staff with specialized training/skills, with the goal of all staff on the team having cross-training in these areas.
3. Psychiatric rehabilitation services and independent living skills (i.e., learning how to take the bus, growing social networks and activities, achieving financial wellness, etc.) that enhance individuals' success while living in the community.
4. Nursing support such as supports regarding administering, dispensing, and monitoring of psychiatric medications, teaching clients how to manage their own medication, education around physical health and primary care linkage needs within the scope of the appropriate medical personnel.
5. Short term counseling or therapy when clinically appropriate, but not at the reduction of necessary rehabilitation or case management services.

B. Staffing & Roles

Maintain an average ratio of 1:22 clients to staff, with specialty staff available to all clients as follows:

Role	Caseload Expectations	Focus Area

Program Director (1 FTE)	Does not hold a caseload unless there is an emergent need	oversight of the program, staffing: both clinical and administrative supervision, attendance to Transitions in Care meetings and other workgroups
Assistant Program Director (1 FTE)	Does not hold a caseload unless there is an emergent need	Back up to PD as stated above
Clinician (1 FTE)	At least 1:12 caseload of clients, shared with others on team	Short term therapy, counseling, crisis supports, in addition to CM and rehab services.
Case Managers (8 FTEs)	1:22	Hold the majority of direct cases for CM and rehab services, linkage, etc.
Peer Support Specialist (2 FTEs)	Do not carry a caseload	Supports clients across team as needed for recovery plan goals, advocacy, WRAP groups, etc.
Co-Occurring Disorder Specialist (1 FTE)	At least 1:12 caseload of clients, shared with others on team	Focus on those needing more targeted SUD supports; offers groups and counseling

The CCM program team members will meet at least 1-2 hours weekly to share updates on every person on their caseload, delegate tasks across staff, and receive guidance on next steps. The team, with Contractor leadership that includes the Director of Services and QI staff, will meet at least monthly to discuss program performance metrics, successes, community inclusion tool data, improvements necessary, and coaching or training needed.

C. **Use of Strengths-Based Best Practices**

The full team is trained in recovery-oriented and culturally responsive services. Additionally, the following evidenced-based treatment models may be utilized: Cognitive Behavioral Therapy (CBT and CBT-P for psychosis), Harm Reduction, Motivational Interviewing, Wellness Recovery Action Plans (WRAP), Housing First & Individual Placement and Support (IPS) Employment principles, Strengths Based Case Management, Community Inclusion, and others as approved by Solano County BH.

Specifically, the CCM team will:

- Collaborate with each consumer to create a personalized WRAP that is focused on life skills, housing options, vocational/educational goals, and mental and physical health.
- Ensure each client understands and can access IPS Supported Employment through Jobs Plus.
- Promote personal recovery and wellness, Peer Support Counselors with lived experience in mental health or co-occurring substance use recovery, are an integral part of the CCM team. Peer Counselors provide an array of recovery-oriented supports that may include supporting a person's wellness through WRAP planning, pre-crisis planning, motivational interviewing and mutuality, empowerment and advocacy, coaching and system navigation support.

Services shall be regionally distributed, community-based, and meet the consumer where they are located including in the field, in homeless shelters, in jails to the extent possible, board and care facilities, mental health rehabilitation centers, inpatient hospitals, etc.

D. **Frequency and Intensity of Contacts**

Minimum standard of contact are 1-2 face-to-face contacts each week. This may include more frequent contact during transitions from higher levels of care or when assertive engagement is required to prevent crisis; with reduction in frequency around 1-2 contacts a month phasing out approach as people are ready to step down to a lower level of care.

The staff person will meet with each client at an average of 30-90 minutes per week face to face.

Additionally, at least for 80% of clients, in accordance to client consent, the natural support system (friends, family, other significant persons) are engaged at least monthly in their loved one's care to support treatment and discharge planning discussions.

E. **Entrance Criteria and Level of Care**

In order to support those stepping down from FSPs or higher levels of care, individuals in CCM should have a Recovery Needs Level (RNL) of approximately between 22-38 at a Level 2: Medium Intensity Treatment. The RNL score, clinical recommendation, and client choice will be considered for service provision.

Each consumer shall be referred by a designated County Designee such as the Forensic Triage Team and/or established referral committee e.g., Transitions in Care (TIC) committee held on a weekly basis for participation in the CCM PD. Individuals may not be accepted to the program without approval of a County Designee.

Initial consumer contact should be attempted within 3 business days of receipt of a referral to services. In the event that this timeline cannot be met, the Contractor will notify the appointed the County designee and the referring party within two (2) working days.

F. **Continuity of Care**

1. Establish Releases of Information and any needed formalized agreements for efficient and timely communication with Solano County psychiatrists to ensure continuity of care and bidirectional flow of individuals' medical and behavioral information. Contractor will meet with the County Adult Outpatient Clinics to ensure continuity of care.
2. For individuals transitioning from higher levels of care, coordinate and provide case planning in form of a warm handoff from the referring party to CCM to ensure a smooth transfer of client's clinical services. Collaborate with parties, including existing or developing social supports that are critical to the individuals' recovery, as needed and permitted by regulation and legal consents.
3. For individuals identified to need a higher level of care such as FSP or placement in a residential facility program staff will make a referral to the TIC committee. Any individuals with 3 hospitalizations or more than 21 days of inpatient care during a 12-month period will be referred to TIC.
4. For individuals who have co-occurring substance use conditions, client services shall be provided according to their stage of change and the CAGE-AID, Michigan Alcohol Screening Test (MAST), the Drug Abuse Screening Test (DAST), or American Society of Addition Medicine (ASAM) assessment may be used for initial screening. The COD Specialist will support or link the client to the appropriate Level of Care if necessary and above the scope of the CCM team.
5. Individuals can receive CCM services at an average of 16-24 months, as needed to sustain recovery goals and support a successful step-down.
6. CCM will coordinate ongoing and discharge needs for individuals with specialty supplemental services such as those supported by the Forensic Triage Team, Housing Team, Probation, etc.

7. Collaborate, as needed, with the other programs or systems of care such as Resource Connect Solano, Substance Use providers, Housing Navigators or Service Providers, IPS Supported Employment Teams, Solano Jails, Public Defender's Office and Solano County Probation office, Partnership Health Plan, etc.
    a. Whenever possible and relevant, include partners from the aforementioned systems into Treatment Team and Treatment plan coordination meetings, discharge planning meetings, etc.
8. Contractor will support determining eligibility for the Department of State Hospitals Grant for Justice Involved persons over the course of the grant period, or June 30, 2024.
9. Participate in community based multi-disciplinary meetings to support the individual's progress in the community, as needed
10. Work assertively to step individuals down from this program as appropriate, in concert with County personnel or other designated contractors. Upon initiation of discharge or step-down, the Contractor shall continue a minimum level of service delivery until engaged with the new level of care.
11. Coordinate placement and/or discharge planning with inpatient hospitals, Mental Health Rehabilitation Centers and Augmented Board and Cares, in collaboration as appropriate with County Designees (e.g., Institutional Care Services team and Hospital Liaison team).
12. For justice involved individuals, when requested by the court and authorized by the consumer, case manager or program director/assistant program director will submit progress report to the court or others. County to provide template.
13. Probation involvement- Without Proper Forensic involvement the client may not be eligible to be part of the CCM Case Management program. Probation involvement will need to be identified before referring to CCM program; Failure to properly distinguish involvement will result in referral denial. Clients that are Probation involved will need to abide by all probation expectations as required.

2. GENERAL ACTIVITIES

While providing the specific activities, Contractor agrees to:

A. Provide care coordination to mental health services that are, person-centered, safe, effective, timely and equitable; supported by friends and the community; with an emphasis on promoting wellness and recovery.

B. Ensure that service frequency is individualized and based upon best practices related to the need of each beneficiary and in accordance with the Solano County Behavioral Health Plan (BHP) level of care system (Reaching Recovery level of care, ASAM when needed, etc).

C. Make coordination of service care an integral part of service delivery which includes providing education and support to individuals/family members as well as consulting with community partners including but not limited to: other mental health providers, physical care providers, schools (if appropriate), etc.

D. Maintain documentation/charting according to industry standards and strengths-based best practices.

E. Ensure that direct clinical services are provided by licensed, registered or waivered clinicians, case managers/specialists, or state certified peer support specialists.

1. Assessment activities and therapy treatment services (1:1 therapy, family therapy, and group psychotherapy) can only be provided by licensed or registered clinicians.
2. "Other Qualified Providers", such as mental health specialist level staff, are authorized to bill for Medi-Cal reimbursable mental health services, such as targeted case management, rehabilitative services, collateral, or plan development.

3. "Peer Support Specialists" are authorized to bill for Medi-Cal reimbursable peer mentorship and recovery support services only by certified Peer Support Specialists.
4. If Contractor employs staff with less education than a BA in a mental health or social work field, and less experience than 2 years in a mental health related field, the Contractor will provide and document training around any service activity for which the staff will be providing.

F. Supervise unlicensed staff in accordance with Medi-Cal and the applicable California State Board guidelines and regulations.

G. Provide information (including brochures, postings in lobby, afterhours voicemail message, etc.) that communicates how mental health beneficiaries can access 24/7 services (e.g. crisis stabilization unit phone number and suicide prevention hotlines/text lines,) when medically necessary.

H. All media related to services provided through contract and provided to the public must include a reference to the Solano County Board of Supervisors, Health and Social Services and include the County logo; any programs also funded by the MHSA as the sponsors must also include the Solano Behavioral Health and MHSA logo.

I. Representatives from the Contractor organization must make efforts to attend the local Mental Health Advisory Board meeting at least quarterly, Quality Improvement Committee meetings, and participate in the MHSA community program planning stakeholder meetings, including those for the MHSA annual update or Three-year plan, MHSA Innovation projects, planning for housing services, suicide prevention planning, etc.

J. For any maintenance or repair for Caminar rented office spaces utilized by this program for which the landlord will not cover, and which is estimated to be $1,000 or more Contractor shall:
   1. Obtain at least 2 estimates for the repair and select the lowest bid;
   2. Secure County's approval for repairs prior to work commencing unless it is deemed the immediate responsibility of the Contractor to address a situation that poses a safety or security risk for individuals or program staff such as flooding, fire damage, broken window/door, etc.

3. PERFORMANCE MEASURES

Contractor agrees that services provided will achieve and will report monthly on the following measures:

Performance Measure to Tracked and Updated Quarterly	# or Percent	Project Goal
Clients served annually		**180**
Clients screened		75%
Clients assessed for DSH		23
Clients enrolled in DSH		
Clients who refuse services or drop-out prematurely		
Average length of stay for clients who drop-out prematurely		
Total clients in jail population who are incompetent to stand trial		Lower by 10%
Graduated/discharged to lower level of care within 12 months		≥ 25%
Graduated/discharged to lower level of care within 24 months		≥ 50%
Clients successfully obtaining Medi-Cal or Medicare		>75%
Clients receiving inpatient psychiatric services		< 20%
Clients who have co-occurring disorders and engage in SUD treatment within CCM		>50%
Clients who have a co-occurring disorder and referred to Carelon for SUD services		
Clients who obtain permanent housing/independent living (not a group home)		>25%
Clients graduate from diversion and transition to a voluntary MH program		≤40%
Clients who are successfully housed after homelessness		>25%
Clients who are housed in a group home or similar		

Length of service for clients who discharge successfully		<18 months

4. REPORTING REQUIREMENTS

4.1 MHSA REPORTING REQUIREMENTS

A. Contractor will collect, compile and submit monthly agreed upon contract deliverables and client demographic data by the 15th of each month unless granted an extension by the County Contract Manager or MHSA designee and be responsible for the following:
    1. Submit the monthly service delivery data using the tool developed and provided by the County. Data required may include but is not limited to:
        b. Number of unduplicated individuals served;
        c. Number of services provided per specific program activities;
        c. Unduplicated count of beneficiaries served in each program activity.

B. Contractor will prepare a quarterly evaluation of program activities, submitted by September 15th, January 15th, April 15th, and July 15th of each contract year, including aggregated data and narrative reports on program deliverables. The County Contract Manager or designee will provide report template and discuss content. The following information should be included:
    1. Narrative of collaborative aspects of the program, if applicable;
    2. Agreed upon client outcomes and benchmarks for success;
    3. Any challenges or barriers to the provision of services.
    4. Submit the monthly Demographic Report Form to include demographic categories determined by MHSA regulations, which include:
        a. Race;
        b. Ethnicity;
        c. Primary languages;
        d. Sexual orientation;
        e. Gender assigned sex at birth;
        f. Current gender identity;
        g. Disability status;
        h. Veteran status.

C. Contractor will prepare an annual narrative of program activities, submitted by July 15th of each contract year. The following information will be included:
    1. Overall program outcome tools used to capture impact of services for individuals or participants served;
    2. Overall program milestones/successes and challenges/barriers;
    3. Program efforts to address cultural and linguistic needs of service recipients;
    4. A program success story.

4.2 REPORTING REQUIREMENTS UNDER THE DSH DIVERSION PROGRAM

A. Submit monthly report which summarizes program service delivery and outcomes in accordance with Solano County and DSH requirements.
B. For the DSH Diversion Program: SCBH will develop a quarterly report that will be completed by the contract provider (s). The quarterly report will contain all of the data elements the contractor(s) is to report in order to gather the necessary information to evaluate the program. Additionally, this report will capture all the services provided by staff on a quarterly basis. Finally, the report will have a narrative section which will capture program processes. Caminar will work with the Evaluator hired by Health and Social Services to evaluate this grant.

5. CONTRACT MONITORING MEETINGS

A. Contractor shall ensure at least one member of the leadership team is available to meet with the County Contract Manager or designee for monthly check-in and/or technical assistance meetings. Meetings may be focused on:
   1. Reviewing utilization of services, caseloads and level of care allocation in the context of system resources and demand.
   2. Program outcomes, billing, blocked billing and fiscal expenditures.
   3. Identifying system barriers that require collaborative problem solving.
   4. Identifying any issues or barriers to contract compliance and developing an improvement plan.

B. Contractor shall ensure that staff providing program oversight and management attend the performance review meeting as scheduled by the County Contract Manager and MHSA designees to review the scope of work (SOW) and to discuss performance measures, fiscal impact and clinical progress as appropriate per contract.

C. Meetings can be in person or via teleconference.

6. PATIENT RIGHTS

A. Patient rights shall be observed by Contractor as provided in Welfare and Institutions Code section 5325 and Title 9 of the California Code of Regulations, Health Information Technology for Economic and Clinical Health (HITECH) Act, and any other applicable statutes and regulations. County's Patients' Rights advocate will be given access to clients, and facility personnel to monitor Contractor's compliance with said statutes and regulation.

B. Freedom of Choice: County shall inform individuals receiving mental health services, including patients or guardians of children/adolescents, verbally or in writing that:
   1. Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services.
   2. They retain the right to access other Medi-Cal or Short-Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff persons, therapist and/or case manager.

7. CULTURAL & LINGUISTIC CONSIDERATIONS

Contractor shall ensure the delivery of culturally and linguistically appropriate services to beneficiaries by adhering to the following:

A. Contractor shall provide services pursuant to this Contract in accordance with current State statutory, regulatory, and policy provision related to cultural and linguistic competence as defined in California State Department of Mental Health (DMH) Information Notice No: 97-14, "Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services-Cultural Competence Plan Requirements," and the Solano County BHP *AAA203 Ensuring and Providing Multi-Cultural and Multi-Lingual Mental Health Services* Policy. Specific statutory, regulatory, and policy provisions are referenced in Attachment A of DMH Information Notice No: 97-14, which is incorporated by this reference.

B. Agencies which provide mental health services to Medi-Cal beneficiaries under Contract with Solano County are required to participate as requested in the development and implementation of specific Solano County BHP Diversity and Equity Plan provisions. Accordingly, Contractor agrees at minimum:
   1. Utilize the national Culturally and Linguistically Appropriate Services (CLAS) Standards in Health Care under the Quality Assurance/Quality Improvement (QA/QI) agency functions and policy making. For more information on the CLAS Standards please refer to the following link https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53 .
   2. Contractor will use the agency Cultural Responsivity Plan developed during FY 2019/20 to guide practices and policies in order to ensure culturally and linguistically appropriate service delivery.

i. The agency Cultural Responsivity Plan shall be reviewed and updated at least annually, and a copy submitted to County BHP Ethnic Services Coordinator or Quality Improvement Unit designee by September 30th of each year. The Plan update shall include progress made on the previous goals and newly developed goals for the following fiscal year.
ii. Contractor will submit a revised plan if County determines the plan to be inadequate or not meeting fidelity to the CLAS Standards.

3. Develop and assure compliance with administrative and human resource policy and procedural requirements to support the intentional outreach, hiring, and retention of a diverse workforce.
4. Provide culturally sensitive service provision and staff support/supervision, including assurance of language access through availability of bilingual staff or interpreters and culturally appropriate evaluation, diagnosis, treatment and referral services.

C. Contractor will ensure agency representation for the MHP Diversity and Equity Committee held bi-monthly (every other month) in order stay apprised of—and inform—strategies and initiatives related to equity and social justice as informed by the goals included in the BHP Diversity and Equity Plan and Annual Updates.
1. Assign an agency staff member designated to become an active committee member attending meetings consistently. Designee will be required to complete the *Diversity and Equity Committee Participation Agreement* form.
2. Make an effort to ensure that the designated representative can also participate in ad hoc sub-committee meetings scheduled as needed to work on specific initiatives related to goals in the MHP Diversity and Equity Plan.
3. Identify a back-up person to attend committee meetings in the absence of the designated person.

D. Provision of services in Preferred Language:
1. Contractor shall provide services in the preferred language of the beneficiary and/or family member with the intent to provide linguistically appropriate mental health services per ACA 1557 45 CFR 92, nondiscrimination in healthcare programs. This may include American Sign Language (ASL). This can be accomplished by a bilingual clinician or the assistance of an interpreter. The interpreter may not be a family member unless the beneficiary or family expressly refuses the interpreter provided;
2. Contractor may identify and contract with an external interpreter service vendor, or may avail themselves to using the vendor provided and funded through Solano County Health and Social Services.
3. Contractor shall ensure that interpretation services utilized for communications or treatment purposes are provided by interpreters who receive regular cultural competence and linguistic appropriate training. Training specifically used in the mental health field is recommended.
4. Contractor shall ensure that all staff members are trained on how to access the interpreter services used by the agency;
5. Contractor will provide informational materials as required by Section 8.G below, legal forms and clinical documents that the beneficiary or family member may review and/or sign shall be provided in the beneficiary/family member's preferred language whenever possible;
6. Contractor shall at a minimum provide translation of written informing materials and treatment plans in the County's threshold language of Spanish as needed for beneficiaries and/or family members.

E. Cultural Humility Training:
1. Contractor shall ensure that all staff members including direct service providers, medical staff, administrative/office support, recreation staff, and leadership complete at least one training in cultural humility and/or social justice per year.
a. On a monthly basis, Contractor shall provide County Quality Improvement with an updated list of all staff and indicate the most date of completing Solano MHP approved cultural humility and/or social justice training. Evidence, including sign-in

sheets based on organizational charts, of Contractor staff receiving cultural humility training, should also be provided to County Quality Improvement at that time.

F. Participate in County and agency sponsored training programs to improve the quality of services to the diverse population Solano County.

8. QUALITY ASSURANCE ACTIVITIES

A. Regulation changes that occur during the life of this agreement:
   1. If/When Federal and/or State agencies officially communicate changes/additions to current regulations, County will communicate new expectations via County Quality Improvement Information Notice, and such requirements will supersede contractual obligations delineated in this agreement.

B. Medi-Cal Certification:
   1. If the Contractor has Medi-Cal claiming programs, then Contractor will meet and maintain standards outlined on the most up-to-date Department of Healthcare Services (DHCS) Certification Protocols, as well as any standards added by the County through the most recent County Behavioral Health Division policy;
   2. Contractor shall inform County of any changes in Contractor status, including changes to ownership, site location, organizational and/or corporate structure, program scope and/or services provided, Clinical Head of Service;
   3. Contractor will communicate any such changes within 60 days to County Improvement, utilizing the most up-to-date version of the Solano County Behavioral Health Division Medi-Cal Certification Update Form;
   4. Staff Credentialing:
      a. Contractor shall adhere to credentialing and re-credentialing requirements as stipulated in Department of Health Care Services MHSUDS Information Notice 18-019.
      b. All Contractor staff providing services that are entered into the County billing and information system must have the staff names and other required information communicated to County Quality Improvement using County Staff Master form;
      c. Contractor shall provide County MHP Quality Improvement with a monthly updated list of Contractor staff by the date provided by the MHP Quality Improvement;
      d. Contractor shall not employ or subcontract with any provider excluded from participation in Federal health care programs;
      e. Contractor shall notify County Quality Improvement when a staff provider will be terminating and shall demonstrate a good faith effort to notify in writing all individuals who were actively receiving services of the termination within 15 calendar days of receiving the terminations notice from the staff.
      f. Contractor shall work with County Provider Eligibility Coordinator to ensure that all licensed staff are accurately enrolled in the DHCS PAVE system.

C. Access:
   1. Contractor must have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If Contractor only serves Medi-Cal beneficiaries, Contractor must provide hours of operation comparable to the hours the Contractor makes available for Medi-Cal services that are not covered by the contract or another Mental Health Plan.
   2. Contractor must meet the state standards for timely access to care and services, taking into account the urgency of need for services. If there is a failure to comply with timely access requirements, corrective action can and will take place.
      a. Contractor will ensure that upon receiving written referral or request for service, Contractor will contact beneficiary within 1-2 business days;

b. For urgent service requests, Contractor will offer an assessment appointment that is 48 hours from date of service request from Solano MHP;
c. For routine service appointments, Contractor will offer an assessment appointment within DHCS timeliness requirements, which include:
    i. **Routine Requests:** 10 business days from the date services was requested from Solano MHP.Urgent Care Requests for Services that do not require prior authorization: Must be provided within 48 hours.
        1) Crisis intervention
        2) Crisis stabilization
        3) Mental Health Services
        4) Targeted Case Management
        5) Intensive Care Coordination
        6) Medication Support Services
    ii. **Urgent Care Requests** for Services that require prior authorization: Must be provided within 96 hours. Intensive Home-Based Services
        1) Day Treatment Intensive
        2) Day Rehabilitation
        3) Therapeutic Behavioral Services
        4) Therapeutic Foster Care
d. If Contractor provides psychiatric medication services, Psychiatry appointments (for both adult and children/youth) must be offered to Medi-Cal beneficiaries within 15 business days from the day the beneficiary or provider acting on behalf of the beneficiary, requests a referral for a medically necessary service. Appointment data must be recorded, tracked and submitted to the County Quality Improvement Unit monthly.
e. In the event that this timeline cannot be met:
    i. Notification: Contractor will notify the appointed County Contract manager or the County designee within one business day for Urgent referrals and within two business days for Routine referrals.
    ii. NOABD: For beneficiaries with Medi-Cal insurance who are not offered an assessment appointments within timeliness requirements listed above, a Notice of Adverse Benefit Determination (NOABD) will be completed and sent to the beneficiary and County Quality Improvement in accordance with Solano MHP guidelines.
f. The County will monitor timeliness for every Medi-Cal Behavioral Health program on a monthly basis, per County Behavioral Health Division policy AAA227 – Timely Access Tracking and Monitoring. Programs not meeting the standards 80% of the time for 4 consecutive months will be placed on a Corrective Action Plan (CAP).

3. If Contractor acts as a "point of access" for Solano MHP, the Contractor will utilize the County's electronic health record "Access Screening and Referral" form to screen all new beneficiaries requesting services directly from the Contractor.
4. Contractor will provide staff to work with County Quality Improvement to make multiple (no less than four) test calls for the County businesses and after-hours access telephone line, during one month per FY.
5. Contractor will monitor internally the Contractor's timeliness in terms of responding to requests for service, as indicated above in the "Access" section of this contract. Contractor will review timeliness with County Contract Manager, or designee on a regular basis. Failure to demonstrate consistent adherence to these timeliness standards may result in an official Plan of Correction being issued to the Contractor.
6. Once Contractor initiates the Assessment process with the client (Assessment Start Date), Contractor shall complete and finalize the Assessment for that client as evidenced by

provider signature, credential, date of service and date assessment was entered into the medical record, within 20 business days of the Assessment Start Date.

a. Per CalAIM Documentation Redesign parameters, Contractor shall have the flexibility to initiate treatment services prior to the Assessment being completed and finalized, if the needs of the beneficiary require it and CalAIM Medical Necessity requirements are met.
b. Contractor shall initiate non-urgent, non-psychiatric treatment services no later than 10 business days of the assessment completion date, and for Psychiatric treatment within 15 business days of assessment completion date.

7. Contractor shall abide by CalAIM Medical Necessity requirements that are listed in both DHCS *Behavioral Health Information Notice (BHIN) 21-073 Criteria for beneficiary access to Specialty Mental Health Services (SMHS), medical necessity and other coverage requirements*, as well as any additional clarification of those parameters provided by the County via QI Information Notice and/or formal training.

D. CalAIM Documentation Redesign:

1. Contractor shall abide by and agrees to amend current paper and/or electronic medical record documentation to the standards put forth by DHCS and the County regarding CalAIM Documentation Redesign, in conjunction with BHIN 22-019 Documentation Requirements for all Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services. County will provide contractor with updated requirements as they are made available via DHCS BHINs, County QI Information Notices, policy updates and/or training documentation.

E. CalAIM BHQIP Requirements:

2. County is responsible, per DHCS *BHIN 21-074 CalAIM Behavioral Health Quality Improvement Program (BHQIP)*, for creating a Behavioral Health Quality Improvement Implementation Plan in order to implement system changes in the categories of Payment Reform, Behavioral Health Policy Changes, and Data Exchange. Contractor shall be responsible for any updates to policy, data systems, workflows, and any other aspect of Contractor functioning related to CalAIM BHQIP requested by the County in order for the County and its subcontractors to meet DHCS requirements.

F. CalAIM No Wrong Door requirements:

3. Per DHCS BHIN 22-011, regardless of the system of care or the point of access, whether MCP or BHP, the beneficiary is entitled to receive initial care, prior to being referred to the appropriate system of care. This includes assessment and treatment services. If a beneficiary receives an assessment from a MCP program, the BHP shall honor that assessment and shall not facilitate another complete assessment.

G. CalAIM Screening and Transition in Care Tools:

1. Per DHCS BHIN 22-065, all BHPs must utilize the universal Adult and Youth screening tools to determine appropriate system of care at the point of access. Generally, this will occur at the County level to determine if a beneficiary should be served in the Mild-to-Moderate Managed Care Plan (MCP) system of care or the Moderate to Severe Behavioral Health Plan (BHP) system of care.
2. If a beneficiary has been served by a BHP program and there is evidence that an alternate system of care would be more appropriate, the program should use the universal Transition in Care tool to determine if the beneficiary is appropriate to step down to the MCP system of care.

H. Service Authorization

1 Per County Behavioral Health Division policy AAA219 – Authorization Standards, , as well as BHIN 22-016 Authorization of Outpatient Specialty Mental Health Services (SMHS), Contractor will request prior authorization from the County for the following services:

a. Intensive Home-Based Services
b. Day Treatment Intensive

c. Day Rehabilitation
d. Therapeutic Behavioral Services (TBS)
e. Therapeutic Foster Care (TFC)

2 Also, per County Behavioral Health Division policy AAA219 – Authorization Standards and DHCS BHIN 22-016, Contractor will demonstrate medical necessity via a County initiated Quality Review of a client's assessment and client plan prior to providing the following services for which prior authorization is not permitted:
a. Crisis Intervention
b. Crisis Stabilization
c. MH Services
d. Targeted Case Management (TCM)
e. Intensive Care Coordination (ICC)
f. Medication Support Services

I. Informing Materials:
1. Informing materials include Solano County MHP Guide to Mental Health Services, Provider Directory, Problem Resolution forms, notices of service denial or termination.
2. Contractor shall ensure that informing materials are printable and given to those requesting services within 5 business days in a minimum of 12 point font.
3. Contractor shall ensure that Informing Materials are made available in County threshold language of Spanish as well as the language of Tagalog, and in alternative formats (audio and large font).
4. Contractor shall provide written taglines communicating the availability of written translations or oral interpretation in specific other languages.
a. A hardcopy page of taglines in all prevalent non-English languages in the State of California, as provided by County MHP Quality Improvement, must be attached to all written materials provided to those requesting services.
b. A hard-copy page of taglines must also be available in large print (font no smaller than 18 pt.) for those with visual impairments.

J. Notice of Adverse Benefit Determination:
1. Contractor shall provide an individual requesting services with a NOABD [formerly referred to as NOA-A and NOA-E], per County MHP's Policy and Procedure AAA201 Notices of Adverse Benefits Determination Requirements under the following circumstances:
a. The denial, limited authorization, or modification of a requested service, including determinations based on the type or level of service, based on the type or level of service requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
b. The failure to provide services in a timely manner (within 10 business days from point of access to initial assessment);
c. The denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities.

K. Contractor shall maintain medical records in such a manner that all required documentation for every beneficiary is stored in a secure medical record. Additionally, documentation will be completed with an emphasis on both timeliness and clinical accuracy, in order to establish medical necessity for all specialty mental health services provided by the Contractor, as outlined in Solano County Behavioral Health Quality Improvement documentation trainings and manual.
1. Only one assessment covering the annual service period is necessary to justify medical necessity for services. If another program is the Primary Service Coordinator and has completed and assessment, Contractor will utilize the already completed documentation to establish medical necessity for treatment or complete a brief update to any area in need of supplemental information.
2. Required documentation includes, but is not limited to, the following:
a. Informing Materials;

b. Clinical Behavioral Health Assessment;
c. Beneficiary Problem List
d. Beneficiary Care Plan (for beneficiaries receiving TCM or Peer services)
e. Beneficiary Treatment Plan (only for beneficiaries receiving STRTP or FSP services)
f. Service Authorization (when/if preauthorization is required);
g. General Consent for Treatment;
h. Medication Consent;
i. Authorizations to Release Medical Records;
j. Acknowledgement of Receipt of Notice of Privacy Practices;
k. Notices of Action (if applicable, must be sent to Quality Improvement within 5 business days).

L. Quality Review of MH Assessments, Problem Lists and Plans:

1. Contractor shall coordinate with County Quality Improvement, once the contractor has established medical necessity for a client's care, to provide information as requested regarding the completion of an Assessment, , Problem List, and any Plans required by CalAIM and the County prior to providing planned services.
2. Contractor will respond to County Quality Improvement's request for clinically amended documentation and resubmit documentation within 5 business days of receiving County's request in order to complete the Clinical Quality Review process.

M. Problem Resolution:

1. Contractor shall adopt and implement the County Health and Social Services Department, Behavioral Health Division's Problem Resolution process.
   a. The County Problem Resolution process include Grievance, Appeal, and Expedited Appeals, as stipulated in County policy *ADM141 Beneficiary Problem Resolution Process – Grievances, ADM142 Beneficiary Problem Resolution Process – Appeals, and Expedited Appeals, ADM132 Request to Change Service Provider, AAA210 Beneficiary Right of a Second Opinion and ADM136 Mental Health Services Act (MHSA) Issue Resolution Process.*
2. Contractor duties regarding Problem Resolution include, but are not limited to, the following:
   a. Contractor shall post County notices and make available County forms and other materials informing beneficiaries of their right to file a grievance and appeal. Required materials include the following brochures: "Beneficiary Rights & Problem Resolution Guide", "Appeal Form", "Compliment/Suggestion Form", "Grievance Form", and the "Request to Change Service Provider, and the "MHSA Issue-Suggestion Form". Contractor shall aid beneficiaries in filing a grievance when requested and shall not retaliate in any manner against anyone who files a grievance.
   b. Contractor shall forward all Problem Resolution Process brochures written and completed by or on behalf of a beneficiary of the MHP to County Quality Improvement, immediately but no later than 24 hours from receipt, whether or not Contractor has resolved the problem.
   c. Contractor shall provide "reasonable assistance" to individuals completing problem resolution forms, such as providing interpreting services and free access to TTY/TTD services.
   d. Contractor shall communicate and collaborate directly with the County Quality Improvement Problem Resolution Coordinator to provide any additional information needed regarding any follow up actions to investigate/resolve the problem identified through the problem resolution process.
   e. Contractor shall provide at no cost and sufficiently in advance of a resolution timeframe for appeals, information and the beneficiary may want to use to support the case, including parts of their medical records, other documents and records,

and any new or additional evidence considered, relied upon, or generated by the Plan in connection with the appeal of adverse benefit determination.

N. Serious Incident Reports (SIRs):

1. Contractor will communicate the occurrence of serious incidents to the County by completing an official County Serious Incident Report form following the process outlined in County policy ADM-1.10 Serious Incident Reporting, including but not limited to the following:
    a. Contractor shall verbally notify County Quality Improvement immediately but not later than 4 hours after a serious incident;
    b. Contractor shall submit the SIR electronically to County Quality Improvement within 24 hours of the incident or sooner via the Comply Track website;
    c. Contractor shall communicate directly with the County Quality Improvement designee to provide any additional information needed regarding the reported incident;
    d. Contractor and County Behavioral Health Administration/Quality Improvement shall discuss and develop recommendations to achieve more desired outcomes in the future. An Adverse Outcome meeting may be scheduled in which the contractor may need to attend, in order to discuss the SIR, interventions and recommendations for policy/program improvement;
    e. Data breaches or security incidents are required to be reported to both County Quality Improvement and County Health and Social Service Compliance Unit concurrently immediately upon discovery and no later than 24 hours.

O. Contractor Quality Improvement Process:

1. Contractor will establish and maintain an internal agency quality improvement and quality assurance process, including but not limited to the following:
    a. Internal Quality Improvement Work Plan – the plan will set goals around Access, Timeliness, Quality and Outcomes for the Contractor and will be evaluated at least annually. A new plan will be created annually, and a copy submitted to County Quality Improvement by July 30th of each FY for the current FY. Contractor will submit a revised plan if County determines the plan to be inadequate;
    b. Internal review of Assessments–A quarterly report will be sent to County Quality Improvement;
    c. Internal review of provider progress notes. A quarterly report will be sent to County Quality Improvement;
    d. Monitoring safety and effectiveness of medication practices – if Contractor provides medication services, Contractor will establish official policy for monitoring medication practices, including operating a Medication Prescriber peer review process. Contractor policy will specifically address procedures Contractor utilizes to monitor prescribing to children and youth.

P. Quality Improvement Committee:

1. Contractor will provide a representative to participate in County quarterly Quality Improvement Committees (QIC).
2. If Contractor's place of business is not located within Solano County boundaries, Contractor's representative may request to participate remotely via conference call and/or or web-based interface.
3. Contractor will provide data related to objectives/goals outlined in the County Quality Assessment and Performance Improvement Plan in a timely fashion prior to quarterly QIC meeting as requested by the County designee.

Q. Annual County review of Contractor service delivery site and chart audit:

1. County will engage in a site and chart review annually, consistent with practices outlined in the most up-to-date- version of the County *Mental Health Utilization Review Handbook and County Chart Audit tools which are consistent with DHCS Reasons for Recoupment*;

2. Contractor will provide all requested medical records and an adequate, private space in which for County staff to conduct the site review and chart audit;
3. If Contractor operates a fee-for-services program and the chart audit results in service disallowances, County will subtract the audit disallowance dollars from a future vendor claim, once County audit report is finalized;
4. County, State or Federal Officials have the right to audit for 10 years from any previous audit, therefore Contractor will retain records for 10 years from the completion of any audit.

R. Fraud, Waste and Abuse:

1. Contractor shall maintain policies and procedures designed to detect and prevent fraud, waste and abuse, and to promptly inform County Behavioral Health Administration and Quality Improvement when detected.
2. Contractor must have a mechanism in place to report to the County when it has received an overpayment, to return the overpayment to the County within 45 calendar days after the date the overpayment was identified, and to notify the MHP in writing of the reason for the overpayment.
3. At any time during normal business hours and as often as the County may deem necessary, Contractor shall make available to County, State or Federal officials for examination all of its records with respect to all matters covered by this Contract. Additionally, Contractor will permit County, State or Federal officials to audit, examine and make excerpts or transcripts from such records, and to make audits of all invoices, materials, payrolls, records of personnel, information regarding beneficiaries receiving services, and other data relating to all matters covered by this Contract.

S. Service Verification:

1. Contractor will submit an executed copy of Contractor Service Verification Policy once created and will provide County a copy of Contractor's revised policy any time policy is revised/updated;
2. Contractor policy will contain measures as strict or stricter than the current County policy QI620 Service Verification Requirements;
3. Contractor will provide evidence of following policy to Quality Improvement Service Verification Coordinator at intervals during the FY as stipulated by County policy QI620.

T. Conflict of Interest – Expanded Behavioral Health Contract Requirements:

1. Contractor will abide by the requirements outlined in County policy *ADM146 Disclosure of Ownership, Control and Relationship Information of Contracted Agencies*, including but not limited to the following:
    a. Contractor will disclose the name of any person who holds an interest of 5% or more of any mortgage, deed of trust, not or other obligation secured by the Contractor to the County;
    b. Contractor will ensure all service providers receive a background check as a condition of employment as stringent as the County background policy requirements;
    c. Contractor will require any providers or any other person within the agency with at least a 5% ownership interest to submit a set of fingerprints for a background check;
    d. Contractor will terminate involvement with any person with a 5% ownership interest in the Contractor who has been convicted of a crime related to Medicare, Medicaid, or CFR title XXI within the last 10 years.

U. Contractor will ensure that all Contractor staff, including administrative, provider, and management staff, receive formal Compliance training on an annual basis.

1. On a monthly basis, Contractor shall provide County QA with an updated list of all staff and indicate the most recent date of completing Solano BHP approved compliance training. Evidence, including sign in sheets, training syllabi, certificates of completion, and tracking sheets based on organizational charts, of Contractor staff receiving compliance training, should also be provided to County QA at that time.

V. Performance Data:

1. Contractor will provide County with any data required for meeting 1915b Waiver Special Terms and Conditions requirements communicated by California DHCS, within the timeline required by DHCS.
2. Contractor will provide County with data required by DHCS on a monthly basis, including but not limited to CANS, PSC-35, CSI Timeliness, Provider Director, 274 Expansion data, etc.

W. Utilization Management:

1. Contractor will work with the County Contract Manager to monitor the following Contractor efforts:
    a. Expected capacity to serve Medi-Cal Eligible beneficiaries;
    b. Expected service utilization;
    c. Number and types of providers needed in terms of training, experience and specialization;
    d. Number of Contractor providers not accepting new clients;
    e. Geographical location to beneficiaries in terms of distance, travel time, means of transportation typically used by beneficiaries, and physical access for disabled beneficiaries;
    f. Contractor ability to communicate with limited English proficient beneficiaries in their preferred language;
    g. Contractor's ability to ensure: physical access; reasonable accommodations; culturally competent communications; accessible equipment for beneficiaries with physical or mental disabilities;
    h. Available triage lines or screening systems;
    i. Use of telemedicine or other technological solutions, if applicable.
2. Additional areas of monitoring include:
    a. Blocked billing due to missing treatment plans or MH diagnosis that results in lost revenue.

X. Performance Outcome Measures:

1. Adult
    a. Adult Programs will utilize Reaching Recovery Measures, or another set of measures approved by County Contract Manager and County Quality Improvement for adult clients ages 18 and older. Frequency of reevaluation is determined by County Quality Improvement.
    b. Adult services contractors will also be required to complete a CANS measure with any young adults, ages 18-20.
    c. Adult services contractors will also be required to request authorization from any 18 year old client to complete Pediatric Symptom Checklist (PSC-35) with the client's identified parent/caregiver. PSC-35 shall only be initiated if client authorizes the caregiver to participate in the treatment process.
2. Child and Adolescent Services Providers:
    a. CANS measures shall be used with all County beneficiaries 0-17 years old. PSC-35 shall be provided to the caregiver of any beneficiaries 3-17 years old. These measures shall be completed every six months.
3. Only one set of measures shall be completed at each required interval per beneficiary. The Primary Service Coordinator administer the measures.
4. When acting as the Primary Service Coordinator, Contractor shall administer the CANS and PSC-35 measures at the required intervals of initial assessment, every 6-months thereafter, and at discharge from treatment.
5. Primary Service Coordinators and Treatment planning teams shall use Outcome measure data to determine treatment progress, areas of treatment focus, and level of care.
6. Contractor shall manually data enter or submit a data upload of CANS and PSC-35 data monthly by the deadline established by County MHP Quality Improvement.

Y. Network Adequacy Certification:

1. Contractor must submit network adequacy data to the County a frequency (either annually, quarterly or monthly), in a manner and format determined by the County, by or before deadlines officially communicated to the Contractor by County Quality Improvement Unit.
2. Contractor will maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered by this contract, per California MHSUDS Information Notice 18-011 (dated February 13, 2018).

Z. Provider Directory:

1. Contractor will ensure that Contractor's Provider Directory captures various elements about their providers, including their license number and type, NPI, language(s), cultural capabilities, specialty, services, if the provider is accepting new beneficiaries, and any group affiliations.
2. Contractor will also ensure that the Provider Directory captures basic information about the facility where the provider serves beneficiaries to include address, telephone number, email address, website URL, hours of operation, and whether the providers' facility is accessible to persons with disabilities.
3. Any changes to the Provider Directory must be reported to the County monthly per MHSUDS Info. Notice No. 18-020 (dated April 24, 2018) – Federal Provider Directory Requirements for Mental Health Plans (MHPs) and by deadlines established by the County.

AA. Physical Accessibility Requirements:

1. Contractor must provide physical access, reasonable accommodations, and accessible equipment for Medi-Cal beneficiaries with physical or mental disabilities.
2. County Quality Improvement will provide Physical Accessibility ratings for Contractor's facilities/offices during Medi-Cal certification site visits. Contractor's facilities/offices will be rated as having "Basic" or "Limited" accessibility for seniors and persons with disabilities.
    a. "Basic" access is granted when the facility/office demonstrates access for the members with disabilities to parking, interior and exterior building, elevator, treatment/interview rooms, and restrooms.
    b. "Limited" accessibility is granted when the facility/office demonstrates access for a member with a disability are missing or incomplete in on or more features for parking, building, elevator, treatment/interview rooms, and restrooms.
    c. If Contractor's facility/offices are given a "Limited" rating, a Plan of Correction will be issued.
3. If there is a change to the physical accessibility of the contracted agency/individual, it must be reported to the County via the County's MHP monthly Provider Directory update process.

AB. Language Line Utilization:

1. If not using the County Health & Social Services (H&SS) interpreter vendor, contracted agencies/individual must submit language line utilization data monthly detailing use of interpretation services for beneficiaries' face-to-face and telephonic encounters.
2. Language line utilization data submission should include (for each service encounter that required language line services):
    a. The reporting period;
    b. The total number of encounters requiring language line services;
    c. The language utilized during the encounter requiring language line services;
    d. The reason services were not provided by a bilingual provider/staff or via face-to-face interpretation.
3. Language line utilization data must be submitted to and as requested by County MHP Quality Improvement Unit, using the template provided by the County MHP Quality Improvement Unit and following the instructions contained on the reporting tool.

9. CONFIDENTIALITY OF MENTAL HEALTH RECORDS

A. Contractor warrants that Contractor is knowledgeable of Welfare and Institutions Code section 5328 respecting confidentiality of records. County and Contractor shall maintain the confidentiality of any information regarding individuals (or their families) receiving Contractor's services. Contractor may obtain such information from application forms, interviews, tests or reports from public agencies, counselors or any other source. Without the consumer's written permission, Contractor shall divulge such information only as necessary for purposes related to the performance or evaluation of services provided pursuant to this Contract, and then only to those persons having responsibilities under this Contract, including those furnishing services under Contractor through subcontracts.

B. In the event of a breach or security incident by contractor or contractor's staff, any damages or expenses incurred shall be at the expense of the contractor.

C. In the event of a breach or security incident by Contractor or Contractor's staff, any damages or expenses incurred shall be at Contractor's sole expense.

III. COUNTY RESPONSIBILITIES:

A. Provide technical assistances in the form of phone consolations, site visits and in-person or virtual meetings to provide clinical guidance and address challenges in the clinical program, implementation and/or performance of the SOW.

B. Provide training and technical assistance on the use of Netsmart Avatar electronic health record system.

C. Provide feedback on performance measures objective in a timely manner to seek a proactive solution.

D. Provide clinical documentation training meeting Medi-Cal Title 9 Specialty Mental Health service standards.

E. Assign a Quality Improvement Liaison for programs under the MHP billing Medi-cal.

F. Make available electronically all policies and procedures referenced herein and inform the Contractor as policies are reviewed and updated to ensure Contractor is aware of changes.

G. Provide Contractor with adequate facilities and any necessary equipment for Contractor to fulfill their responsibilities that occur in the County Jail (e.g., conference room, desk space, telephone for in-reach services).

H. Make available to Contractor all current applicable Sheriff's General Orders and County policy and procedures.

EXHIBIT B-1-1
Caminar Comprehensive Case Management (CCM)
July 1, 2022 – March 31, 2023

Budget Line Items	FTE	FY22/23 Budget July 1, 2022 – March 31, 2023
Personnel (Management & Admin. Support)		
Executive Director SMI	0.09	$12,073.43
Director of Services	0.20	$6,008.53
Program Director	0.40	$34,118.77
Assistant Program Director	1.00	$34,943.39
Operations Manager	0.10	$6,227.64
Data Analyst	0.06	$3,714.88
Administrative Assistant	1.00	$30,719.79
Admin Assistant 2	0.20	$16,319.47
Personnel (Direct Client Service)		
Clinic Manager (RN Nurse Manager)	0.11	$12,853.94
Licensed Vocational Nurse (LVN)	0.80	$12,147.33
Case Manager 1	4.00	$195,387.99
Clinician 1 Reg/Lic	2.00	$0
Peer Case Manager	2.00	$28,389.47
Total Salaries		**$392,904.63**
Fringe Benefits		**$88,488.30**
Total Personnel	***11.96***	***$481,392.93***
Operating Expenses		
Occupancy		$40,059.68
Utilities		$4,512.68
Insurance		$2,748.61
Communication		$13,968.05
IT Supports		$9,397.62
Office Expense		$7,744.29
Equipment Expense		$3,364.31
Travel		$4.473.28
Vehicle Expense		$4,833.11
Training		$1,883.22
Hiring Expense		$8,324.86
Client Supports		$3,193.57
Total Operating Expenses		***$104,503.28***
Subtotal Personnel and Operating Expenses		***$585,896.21***
Indirect Costs – 13%		$76,166.51
Subcontractor – Professional Clinical Supervision		$717.33
Total Contract Amount		***$662,780.05***

EXHIBIT B-1-1
Caminar Comprehensive Case Management (CCM) *Merged*
April 1, 2023 to June 30, 2023

Budget Line Items	FTE	FY22/23 Budget April 1, 2023 – June 30, 2023	
Personnel (Management & Admin. Support)		**DSH**	**CCM**
Executive Director SMI	0.13		$6,518.79
Director of Services	0.20		$8,878.71
Program Director	1.00	$2,720.18	$25,780.89
Assistant Program Director	1.00	$916.33	$23,346.38
Operations Manager	0.20		$5,461.93
Data Analyst	0.06		$1,294.50
Administrative Assistant	1.20	$1,410.38	$12,745.55
Administrative Assistant 2	0.40		$4,963.07
Personnel (Direct Client Service)			
Clinic Manager (RN Nurse Manager)	0.11		$3,346.93
Licensed Vocational Nurse (LVN)	0.80		$12,886.29
Case Manager 1	6.00	$12,269.24	$76,762.41
Case Manager 2	2.00		$32,952.00
Clinician 1 Reg/Lic	1.00		$21,535.17
Peer Case Manager (CCM)/ Peer Support Specialist (DSH)	2.00	$9,091.47	$12,901.74
SUD Counselor	1.00		$17,003.21
Clinical Case Manager	1.00		$20,035.71
Total Salaries		$26,407.60	$286,413.28
Fringe Benefits		$7,394.13	$80,195.72
Total Personnel	***18.10***	***$33,801.73***	***$366,609.00***
Operating Expenses			
Occupancy	-	$2,571.43	$29,698.07
Utilities	-	$428.57	$2,666.57
Insurance	-	$321.43	$1,834.50
Communication	-	$1,071.43	$8,139.86
IT Supports	-	$1,071.43	$4,928.57
Office Expense	-	$857.14	$2,276.57
Equipment Expense	-		$2,233.50
Travel	-	$107.14	$2,909.79
Vehicle Expense	-	$1,928.57	$5,612.57
Training	-		$3,704.57
Hiring Expense	-		$2,057.14
Client Supports	-	$1,071.43	$2,484.00
Total Operating Expenses	-	***$9,428.57***	***$68,545.71***
Subtotal Personnel and Operating Expenses		***$43,230.30***	***$435,154.71***
Indirect Costs – 13%		$5,619.94	$56,570.11
Subcontractor: Professional Clinical Supervision			$1,071.43
Total Contract Amount		***$48,850.24***	***$492,796.25***

EXHIBIT B-1-1

Caminar Comprehensive Case Management (CCM) *Merged*
July 1, 2023 to June 30, 2024

Budget Line Items	FTE	FY23/24 Budget July 1, 2023 – June 30, 2024	
Personnel (Management & Admin. Support)		**DSH**	**CCM**
Executive Director SMI	0.13		$26,075.14
Director of Services	0.20		$35,514.86
Program Director	1.00	$9,974.00	$94,529.93
Assistant Program Director	1.00	$3,359.89	$85,603.40
Operations Manager	0.20		$21,847.71
Data Analyst	0.06		$5,178.00
Administrative Assistant	1.20	$5,171.38	$46,733.70
Administrative Assistant 2	0.40		$18,197.93
Personnel (Direct Client Service)			
Clinic Manager (RN Nurse Manager)	0.11		$13,387.71
Licensed Vocational Nurse (LVN)	0.80		$51,545.14
Case Manager 1	6.00	$44,987.20	$281,462.16
Case Manager 2	2.00		$131,808.00
Clinician 1 Reg/Lic	1.00		$86,140.69
Peer Case Manager (CCM)/ Peer Support Specialist (DSH)	2.00	$33,335.41	$47,306.38
SUD Counselor	1.00		$68,012.84
Clinical Case Manager	1.00		$80,142.86
Total Salaries		$96,827.86	$1,093,486.45
Fringe Benefits		$27,111.80	$306,176.21
Total Personnel	***18.10***	***$123,939.66***	***$1,399.662.66***
Operating Expenses			
Occupancy	-	$9,428.57	$108,892.93
Utilities	-	$1,571.43	$9,777.43
Insurance	-	$1,178.57	$6,726.50
Communication	-	$3,928.57	$29,846.14
IT Supports	-	$3,928.57	$18,071.43
Office Expense	-	$3,142.86	$8,347.43
Equipment Expense	-		$8,189.50
Travel	-	$392.86	$10,669.21
Vehicle Expense	-	$7,071.43	$20,579.43
Training	-		$13,583.43
Hiring Expense	-		$7,542.86
Client Supports	-	$3,928.57	$9,108.00
Total Operating Expenses	-	***$34,571.43***	***$251,334.29***
Subtotal Personnel and Operating Expenses		***$158,511.09***	***$1,650,996.95***
Indirect Costs – 13%		$20,606.43	$214,629.60
Subcontractor: Professional Clinical Supervision			$3,928.57
Total Contract Amount		***$179,117.52***	***$1,869,555.12***